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Self-Reflexivity, Intersubjectivity, and Therapeutic Change

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Intersubjectivity theory holds that the self forms through relationships with others in a dialectic process. Although affect attunement is central to early self–other differentiation, infants do not see themselves as separate entities until 18 months and their minds as separate until approximately age 4. Transitional object relatedness thus often influences early childhood functioning. In self disorders, childhood disruptions in intersubjec-

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tivity create disturbances in integrating transitional fantasy with realistic cognition, such that one's own mental states are often confused with others'. In treatment, self–other differentiation is aided by adaptive projective identification, in which patients find in their therapists their own positive qualities and then reappropriate them in more integrated ways. Case material from a research study of significant-figure descriptions in long-term psychoanalytically oriented treatment illustrates this process.

Let us begin with an old joke: Plato, Aristotle, and Descartes are drinking in a bar, and last call comes around. The bartender inquires of Plato, "What'll ya have?", and the eminent philosopher replies, "Give me a scotch and water, single malt." The bartender then turns to Aristotle and says, "And you?" Aristotle orders a martini. "Dry," he says; "very dry." Finally, the bartender asks Descartes if he would like one more for the road. Descartes, who was the designated thinker that night, replies, "I think not," and promptly vanishes.

Now what are we to make of this cautionary tale? Descartes, as we all know, is best known for having tried to infer his existence from his mental activity: "I think; therefore, I am" (Descartes, 1637/1968a, p. 53). Descartes created his philosophical system by starting from a position of radical doubt. In his *Discourse on Method*, Descartes (1637/1968a) noted that he could not trust the evidence of his senses, that he could not trust the conclusions of reason, and that he could not necessarily distinguish between dreaming and waking cognition. In his *Meditations* (Descartes, 1641/1968b), he further stipulated that perhaps all of the contents of his mind were consequences of the cunning and deceiving actions of some evil demon. Under these conditions of radical doubt, he could not even assume that he had a body. In the face of illusion, paralogism, and deception, the cogito was the one proposition that Descartes found indubitable because even if he were mistaken or worse yet deceived in all of his beliefs, it could not be doubted that to have any mental activity at all, he had to exist. Thus Descartes (1637/1968a) concluded that he had a mind, a mind that is "entirely distinct from the body" (p. 54). He also concluded, "If I had only ceased to think, . . . I would have no reason to believe that I existed" (Descartes, 1637/1968a, p. 54). The joke is therefore truly on Descartes but also, insofar as all of us today are unwitting Cartesians, on us as well. In this article, we propose a relational, rather

than Cartesian, theory of mind. Alternatively, we attempt to move from Descartes to Hegel (see Auerbach, 1998).

Intersubjectivity Theory and Psychoanalysis

Thanks to the classic clinical contributions of Fairbairn (1952), Sullivan (1953), Lichtenstein (1977), Winnicott (1971/1982), and Kohut (1977), it is a commonplace in psychoanalytic thinking nowadays that normal development in infancy and childhood occurs within an intersubjective matrix—that is, within a dyad in which two subjectivities, that of the caregiver and that of the infant, meet. However, we argue that intersubjectivity is a fundamentally paradoxical notion, for a sensitive caregiver relates to her baby as an independent subject from the moment of birth, long before an infant has intentionality, feelings of bodily cohesion, self-reflexivity, and language—in short, long before the emergence of capacities that are essential to human subjectivity. Furthermore, a sensitive caregiver relates to her baby as a subject long before an infant has any conception of other minds and other subjectivities, let alone his or her own. It is a fundamental contention of intersubjectivity theory that children become independent subjects only if they are recognized as such—that is, as beings with minds, wills, and feelings of their own—by their caregivers (Benjamin, 1990; Fonagy et al., 1995; Ogden, 1994; Winnicott, 1971/1982). This proposition is, as stated, a commonplace these days.

Intersubjectivity theory further holds, however, that a child becomes an independent subject only if he or she in turn recognizes the independent subjectivity—in more familiar language, the autonomy and separateness—of his or her caregiver. In other words, the term *intersubjectivity* refers not only to an interpersonal situation in which parents regard their children as independent subjects but also to a psychological capacity—that is, the ability to appreciate another's independent subjectivity—that emerges developmentally from this interpersonal matrix. This cognitive–affective capacity, which is also a consequence of the evolutionary development of the human brain (see Povinelli & Prince, 1998), enables a child in turn to come to understand her parent's mind. It is this mutual recognition, by caregiver and child, of each other's mental states, that ultimately constitutes the intersubjective situation. Thus, intersubjectivity as an interpersonal interaction—in Aron's (1996) phrase, a meeting of minds—and intersubjectivity as a psychological capacity are deeply intertwined concepts, with the former constituting the transactional matrix from which the latter emerges.

Nearly 200 years ago, Hegel (1807/1977) described the dilemmas of intersubjectivity this way: "Self-consciousness [Hegel's term for independent subjectivity] exists in and for itself when, and by the fact that, it so exists for another; that is, it exists only in being acknowledged" (p. 111). In Hegel's view, human subjectivity emerges from a dialectic between lord and bondsman, or master and slave, and is deeply paradoxical. On the one hand, the human subject wants to assert absolute will—omnipotence—much as a master controls a slave. On the other, the subject exists only if recognized as such by another subject, for without recognition by another, one's subjectivity, one's autonomy, one's self-conscious freedom is meaningless. However, this dependence on another's recognition also means that the autonomy of the human subject is limited in the very moment that it is constituted. As Jessica Benjamin (1990, p. 39) has noted, "The need for recognition involves this fundamental paradox: In the very moment of realizing our independent will, we are dependent on others to recognize it." Under these circumstances, the subject's wish for omnipotence—in the terminology of our Freudian age, to establish a narcissistic, perverse, or sadomasochistic relationship with the other (Bach, 1985, 1994; Gorney & Muller, 1989)—is illusory. There is, in short, no subjectivity without intersubjectivity, no self without an other, although there is always a wish to retreat from the tensions of intersubjectivity to the safety of narcissism (Auerbach, 1993; Benjamin, 1990). In stating this dialectical and Hegelian view of intersubjectivity, we are differentiating our ideas from those of Atwood and Stolorow (1984), who use the term intersubjectivity to capture the important notion that the psychoanalytic field is always defined by the intersection of two independent subjectivities, by a dialogue between two personal universes. Although we agree with their conceptualization of the psychoanalytic field (see Blatt & Behrends, 1987), we believe that their formulation does not go far enough in capturing the dialectical nature of intersubjectivity—that is, that one's very existence as a subject depends on being recognized by another independent subject and cannot exist without such recognition—and that it therefore does not explain how one becomes an independent subject in the first place (see also Aron, 1996).

This dialectical conception of intersubjectivity was introduced into psychoanalytic discourse by Lacan (1977a) but was formulated most evocatively and compellingly by Winnicott (1971/1982), who posed the following question about human infancy: "What does the baby see when he or she looks at the mother's face?" (p. 112). His answer was that "what the baby sees is himself or herself. In other words, the mother is looking

at the baby, and *what she looks like is related to what she sees there"* (p. 112). That is, Winnicott understood mirroring in infancy to be the foundation of intersubjectivity, and he thought intersubjectivity, rather than the Cartesian cogito, to be the ground from which the self emerges, as the following quotation about the infant's response to maternal mirroring suggests: "When I look I am seen, so I exist" (Winnicott, 1971/1982, p. 114). Existence, psychological as well as physical, depends not only on one's own mental activity but on the response of others to it. In short, it depends on having a mother.

Pace Descartes, Winnicott (1955/1975) also held, to cite one of his many statements on the subject, that a baby has acquired a state of wholeness or has become a unit self when, as a result of adequate maternal provision, it is "living in the body" (p. 264). Alternatively, as Freud (1923/1961, p. 25) stated, "The ego is first and foremost a bodily ego." Winnicott (1955/1975, 1963/1965, 1971/1982) argued that once an infant is living in the body and has begun to have a sense of existence, he or she can allow an object to exist outside of his or her area of omnipotence—that is, can allow an object to exist separately and can even develop concern for it. In other words, Winnicott's claim is that without this sense of embodiment, an infant cannot regard the objects he or she depends on for survival, both physical and psychological, as existing in their own right. The development of embodiment—in Stern's (1985) term, a *core self*—in response to adequate maternal affective provision is a gradual process. Nevertheless, for Winnicott, as for Hegel, the human subject exists only if recognized as such by an other, and a failure to return this recognition to the other results in an atrophy of subjectivity and the self.

Alternatively, and in a broader sense, it can be argued that human subjectivity evolves out of a dialectical and dynamic tension between two fundamental developmental lines—the need for relatedness and the need for self-definition (Blatt & Blass, 1990, 1996)—and this dialectic provides a theoretical framework for understanding the development of intersubjectivity, considered as both a psychological capacity and an interpersonal situation. In this framework, relatedness and self-definition can be conceptualized as distinct but interacting motivational systems that evolve throughout the life cycle. An increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships, and, conversely, the continued development of increasingly mature and satisfying relationships is contingent on the development of a more mature self-concept or identity. In normal personality development, these two developmental processes evolve in an interactive, reciprocally

balanced, mutually facilitating fashion from birth through senescence (Blatt, 1991; Blatt & Blass, 1990, 1992, 1996; Blatt & Shichman, 1983).

Erikson's (1963) epigenetic model of psychosocial development—if extended to include a new stage, mutuality versus competition, in middle childhood (Blatt & Blass, 1990; Blatt & Shichman, 1983)—can be used to delineate specific developmental stages in the emergence and growth of both interpersonal relatedness and self-definition. Thus, interpersonal relatedness develops from a sense of trust as in the early relationship between infant and mother, through the oedipal child's sense of collaboration and cooperation in his or her relationships with parents and peers, to a mature sense of intimacy in early adulthood. Self-definition develops from an initial sense of separateness and autonomy, through a capacity for initiative and industry, to a sense of identity in young adulthood.

Even in normal development, there is always a potential for conflict between relational and self-definitional needs, primarily because of the emergence, as we discuss later, of the capacity for reflexive self-awareness in the second year of life. With the discovery of one's separateness comes the recognition that one's wishes and fantasies may conflict with those of the person on whom one depends for psychological and physical existence. For example, the conflicts of the anal stage (Freud, 1905/1953, 1917/1955) and of the rapprochement subphase (Mahler, Pine, & Bergman, 1975) would not be possible without a capacity for self-recognition, and it is the capacity for self-recognition that makes possible the psychological representation of conflicts between relational and self-definitional needs. Nevertheless, the concurrent maturation of these two developmental lines, the relational and the self-definitional, is well coordinated in normal functioning. For example, one needs a sense of basic trust to venture in opposition to the caregiving other in asserting one's autonomy and initiative, and later one needs a sense of autonomy and initiative to establish cooperative and collaborative relationships (Blatt & Blass, 1996). By contrast, in pathology, one establishes a sense of identity to the exclusion of relatedness with others or becomes preoccupied with significant attachments to the neglect of one's own self-definition (Blatt & Shichman, 1983; Feldman & Blatt, 1996).

Intersubjectivity Theory and Developmental Psychology

Empirical infancy research provides striking confirmation for a dialectical account of the development of intersubjectivity, although with the significant proviso that the fantasies of fusion and omnipotence that most

psychoanalytic theorists attribute to early infancy in fact require language, self-reflexivity, and a capacity to recognize one's own separateness—achievements of the second year of life (Auerbach, 1993; Broucek, 1991; Stern, 1985). As a result of the work of Stern (1985), Beebe (Beebe & Lachmann, 1988; Beebe, Lachmann, & Jaffe, 1997), and other developmental researchers (e.g., Gergely & Watson, 1996; Tronick, 1989), infancy is now conceptualized as a period characterized by mutual interactive regulation between caregiver and baby. This mutual interactive regulation occurs through processes that have been variously labeled affect matching, affect mirroring, and affect attunement. Common to all of these processes is that the caregiver attempts to match or to attune herself to the affect displayed by the baby. Under normal circumstances, cycles of affective match, mismatch, and repair between infant and caregiver occur with split-second coordination. This sharing of affective states is essential to caregiver–infant bonding, yet it is also essential to the process of differentiation, especially insofar as the caregiver's responses, although contingent on the infant's affective displays, are not exact replicas of them (Beebe et al., 1997; Gergely & Watson, 1996; Stern, 1985; Tronick, 1989). In essence, the caregiver establishes an emotional communion with the baby while at the same time standing just outside of that communion. Alternatively, from the baby's point of view, early relationships with parental figures involve a dialectic between gratifying involvements (i.e., communion) and experienced incompatibility (i.e., separation; see Behrends & Blatt, 1985; Blatt & Behrends, 1987).

Under these circumstances, because even very young babies are capable of differentiating their own actions from those initiated by others (Gergely & Watson, 1996; Stern, 1985), the caregiver's partially contingent affective responses help the infant to differentiate his or her own emotions from those of the parenting figure, as well as to acquire a capacity for affective self-regulation. However, if the caregiver's affective responses either are largely noncontingent on the baby's affective displays or instead mirror the baby's emotional expressions too faithfully—that is, if the caregiver either is dismissive of the baby's emotional reality or is too caught up in it—then the infant fails to acquire the procedural skills necessary for self-regulation of affect and fails to learn clear differentiations between his or her own emotions and those of the parent. Caregivers who are capable of affect attunement—that is, of responding to their infants' emotional states as shareable but separate from their own—are already treating their children as separate subjects, even though their children still lack capacities necessary for independent subjectivity. Yet

there is a limit to the degree of differentiation that can be produced through mirroring because mirroring is essentially a preverbal, presymbolic process (Muller, 1985). The recognition of another's subjectivity, by contrast, requires symbolic representation (Cavell, 1993, Fonagy et al., 1995), for only through symbolization—that is, through self-reflexivity and language—can one differentiate one's own mind from that of one's parent..

The symbolic capacities that make intersubjectivity possible first become manifest in the second year of life. In particular, reflexive self-awareness—as indexed by the capacity for self-recognition in the mirror, in photographs, and on videotape—emerges between 18 and 24 months (Lewis & Brooks-Gunn, 1979) and matures from the physicalistic emphases of the toddler's self-concept to the abstract, systematic self-understandings of adolescence and beyond (Damon & Hart, 1988). From a psychoanalytic perspective, however, the emergence of self-awareness in the second year of life is a mixed blessing. With the capacity for self-recognition, a child also discovers that he or she is an object in the eyes of others and, furthermore, that he or she is a small and separate being in a large world. The emergence of self-reflexivity between 18 and 24 months, then, is coincident with the rapprochement subphase (Mahler et al., 1975) and is accompanied by a potential upsurge in the child's experience of shame and embarrassment (Amsterdam & Levitt, 1980; Broucek, 1991; Kagan, 1981), by a potential lowering of self-esteem that can be documented experimentally in adults' avoidant responses to the presence of a mirror or a camera (Duval & Wicklund, 1972), although it should be added that under normal circumstances these dysphoric affects constitute a relatively minor part of a toddler's typical emotional experience.

Intersubjectivity and Transitional Object Usage

Two-year-old children are faced, therefore, with a highly problematic psychological situation, but fortunately the same symbolic capacity that led to the discovery of their separateness also enables them to cope with this difficult prospect. For coincident with the emergence of self-reflexivity is the emergence of pretend play (Piaget, 1945/1962)—of transitional object usage (Winnicott, 1953, 1971/1982); and 2-year-olds are adept at distinguishing between pretense (i.e., make-believe) and reality (Bretherton, 1989; Harris & Kavanaugh, 1993; Leslie, 1987). Transitional object usage, as Winnicott proposed, is the means by which a child

negotiates the dilemma of becoming separate and autonomous while remaining attached to caregivers. However, if children at age 2 are quite capable of distinguishing pretense from reality and of using this distinction to cope with emotional dilemmas in their lives, they have much difficulty, prior to age 4 or 5, in grasping the distinction between appearance and reality, between how things look and how they actually are (Flavell, Green, & Flavell, 1986). They also have difficulty before they reach this age in recognizing that a person's beliefs about the world can be false (Perner, Leekam, & Wimmer, 1987) and in understanding the subtleties of secrecy and lying (Astington, 1993; Meares, 1993). In short, although children come to understand the separateness of their bodies sometime in the second year of life, they do not come to understand that their minds are distinct from those of others until sometime in the 5th or 6th year (Mayes & Cohen, 1996). The discovery of the separateness of one's mind is a crucial step in the development of self-reflexivity because it is then that a child learns that his or her beliefs about the world differ from those of others. It is with a child's discovery of his or her mind's separateness, therefore, that transitional object usage comes to be integrated with realistic cognition (Fonagy & Target, 1996; Target & Fonagy, 1996)—at least under normal circumstances.

On the other hand, as Fonagy and Target (1996; Target & Fonagy, 1996) have argued, children's capacity to distinguish between fantasy play and realistic cognition is easily compromised, especially when the emotional material is too compelling (see also Bretherton, 1989; Erikson, 1963; Meares, 1993; Piaget, 1945/1962; Winnicott, 1971/1982). When emotional material becomes too intense, children begin to regard their fantasies as realistic perceptions on which they must take action. Furthermore, under such circumstances, the child's inadequate differentiation between mind of self and mind of other leads to self–other confusions that are normal in early childhood but that become increasingly problematic if they continue into middle childhood and preadolescence. Under conditions of adequate parental responsiveness, toddlers use play and fantasy to cope with the dilemma of remaining attached while becoming separate. As the research of Main (1991, 1995) and of Fonagy (Fonagy et al., 1995) suggests, however, inadequate parental responsiveness to children's affective states, especially distress, results in a disruption of symbolization or, per a more psychoanalytic formulation, in a failure to integrate fantasies of omnipotence and fusion with perceptions of separateness and difference.

Thus, it should come as no surprise that confusion between the mind

of the other and the mind of the self is central to borderline and narcissistic states, the basic differentiation between the body of self and the body of the other having been established in the first few months of life and the ability to recognize the separateness of one's own body having emerged by approximately 18 months. This confusion between the mind of the other and the mind of the self can be conceptualized as a form of transitional object usage, as a reliance on selfobject states (Kohut, 1977), as a form of projective identification (Klein, 1946), or, in Lacanian terms, as *mirror miscognition* (Lacan, 1949/1977b), and it is common among more primitively organized patients, who often speak about themselves when they want to speak about others and who talk about others when they want to talk about themselves. Such individuals exhibit an impairment in the mutual self-recognition—in the recognition of difference between self and other—that Hegel theorized was essential to the establishment of independent subjectivity. Nevertheless, the therapeutic dialogue, by permitting such patients to use others to talk about themselves, can also help these individuals to make such differentiations. A stable therapeutic relationship is a central factor in helping these patients to find in others their own positive qualities and to reappropriate them in a more integrated fashion, although of course therapeutic change involves an interaction among relational, interpretative, and experiential components. We have previously termed the process of identifying positive aspects of oneself in one's therapist and then reappropriating those qualities *adaptive projective identification* (Blatt, Stayner, Auerbach, & Behrends, 1996). This process is often played out in the transference and is crucial to therapeutic change in borderline and narcissistic patients.

Case Example

To illustrate these clinical phenomena, we present material from the case of a 13-year-old female borderline inpatient, Patient A, who was treated for 19 months at our psychoanalytically oriented hospital during the early 1980s. This case has been discussed previously by Auerbach and Blatt (1996), Blatt et al. (1996), Diamond, Kaslow, Coonerty, and Blatt (1990), and Gruen and Blatt (1990). The older of two children, Patient A had come from a family background marked by parental divorce when she was 3½ years old and by paternal alcoholism. She was raised by her mother, whom she regarded as critical and intrusive, until age 12, when she was sent to live with her father. On admission to our facility, Patient A was given *DSM-III* diagnoses of major depression with psychotic features and of

mixed personality disorder with histrionic, compulsive, and paranoid features. Her psychotic symptoms, which had a persecutory tone, dated back to age 8, when she began to have hallucinations of the devil's voice and face and to believe that her body was possessed by the devil. As her adolescence approached, she became involved with drugs and progressed from cannabis and alcohol to diazepam, methaqualone, and eventually intravenous heroin. She had attempted suicide once and had been hospitalized psychiatrically twice before coming to our small long-term facility. In our hospital, she received multifaceted inpatient treatment comprising psychoanalytically oriented individual and group psychotherapy three times weekly; milieu therapy, including a privileges-level system based on behavioral contingencies; involvement in community responsibilities and triweekly community meetings; weekly individual family and multifamily therapy; occupational and recreational therapy; participation in an accredited special school; and psychopharmacological evaluation and treatment. During her hospitalization, we also administered to her the Object Relations Inventory (ORI), an interview-based procedure for collecting descriptions of self and significant figures, at admission and at 6-month intervals thereafter until the time of her discharge 1½ years later. The ORI inquires about the following significant figures in the following order: mother, father, a significant other, a pet, self, and therapist. It is administered by asking the patient first to describe the figure in question and then to clarify the meanings of any adjectives that seem unexplained in the description. Thus, if the patient describes mother as "Cold and overbearing," the examiner might ask, "What do you mean by 'cold'?" and "What do you mean by 'overbearing'?" In the present discussion, to demonstrate the use of self to talk about others and the use of others to talk about self, we focus on Patient A's descriptions of self and therapist. Although these significant-figure descriptions may lack the extensive clinical detail that is often reported in the psychoanalytic literature, we note here that our methodology has the advantage of enabling other readers to check the evidentiary basis of our inferences and to develop alternative readings for themselves. Only the use of actual session transcripts would enable us, or for that matter any psychoanalytic investigator, to document fully how adaptive projective identification, or any other complex mental phenomenon, is enacted in the therapeutic situation. Our use of significant-figure descriptions taken at multiple points in a long-term treatment does provide at least a suggestive illustration of this process. Thus, although it is a brief assessment procedure, the ORI is a surprisingly powerful method for elucidating changes in an individual's representational world.

Table 1 contains Patient A's admission self- and therapist descriptions. Her self-description at admission, although basically negative in tone, contained perplexing polarities that suggested a beginning recognition of contradictory aspects of herself and a realization that her self-concept, as is often the case in borderline patients, was highly dependent on her affect state. Although her sensitivity to feelings of exposure, shame, and grandiosity were suggestive of a narcissistic disturbance, as well as consistent with her self-critical, paranoid orientation, her recognition of some antecedents of her self-variability suggested that she might be capable of developing more subtle differentiations. Nevertheless, her thinking was dominated by polarization and splitting, and she very much wanted to avoid the task of self-description. By contrast, Patient A characterized her therapist in positive, idealized terms that emphasized the potential for relatedness. Notes from the treatment review prepared by her therapist after 3 months of hospitalization described her as very needy and as desperately hoping that her female therapist would become her wished-for, idealized mother, who would care for and nurture her. She reacted to rescheduled therapy hours and the therapist's absence during a vacation with feelings of rejection and anger. She became psychotic at times in response to these perceived losses.

Table 2 contains Patient A's 6-month self- and therapist descriptions. At 6 months, her self-description continued to comprise generally contradictory images, but her sense of self was no longer based solely on the juxtaposition of polarized attributes. Despite her continuing narcissistic vulnerability and her considerable ambivalence about the task of self-description itself, she now also expressed a sense of hope and optimism—in her words, "confidence." This struggle for mastery was also enacted in her instruction to the interviewer to revise her statement,

Table 1
Patient A: Self- and Therapist Descriptions at Admission

Significant figure	Description
Self	Depends on how I'm feeling. Sometimes I'm outgoing, but other times I'm withdrawn. (What else?) I don't know. I don't want to describe myself. (?) Cause I get upset when I do. *Inquiry:* (Can you tell me what upsets you?) I'm either too conceited or too modest to answer something like this.
Therapist	Sweet, supportive, trusting, and caring.

Note. Examiner's questions appear in parentheses.

Table 2
Patient A: Self- and Therapist Descriptions at 6 Months

Significant figure	Description
Self	I can't describe myself; you describe me. It's hard; no, it's easy. Vulnerable, hurt, lonely. Sort of happy. Getting more confident—no—please write, "gaining confidence." Considerate. *Inquiry:* (Vulnerable?) I can be easily hurt. (Hurt?) Can't say more. (Lonely?) I'm suffering from a lack of caring. I'm not cared about in the way I'd like to be. (Considerate?) Care about others' feelings.
Therapist	I can't describe her because I don't know her. Seems to care about me. That's it.

Note. Examiner's questions appear in parentheses.

"getting more confident," to "gaining confidence." This exchange around Patient A's concern about the precision of her verbalizations conveyed in word and deed her self-reflectiveness and her increased self-esteem, as well as her ability to form a working relationship with the examiner.

The 6-month description of the therapist indicated that the idealized view of the therapist at admission was beginning to change. Positive adjectives at admission were now omitted, and Patient A expressed some reservations about her therapist's feelings about her: "[She] seems to care about me."

Table 3 contains Patient A's 1-year self- and therapist descriptions. Her self-description at 1 year indicated a movement toward a more differentiated, unified, and coherent sense of self. The self-description

Table 3
Patient A: Self- and Therapist Descriptions at 1 Year

Significant figure	Description
Self	Depressed, suspicious, alone, manipulative, musical, artistic, sensitive, hopeless, drug abuser. Sympathetic. Can be friendly. Opinionated. Withdrawn. Angry. Chain smoker. Can be humorous. That's it. *Inquiry:* (Depressed?) I don't enjoy life. (Suspicious?) Don't trust people easily. (Manipulative?) Do whatever I can to get things my way. (Sensitive?) I take things personally. (Hopeless?) I'm a failure. I'll never make it. Doomed to be depressed. (Sympathetic?) Self-explanatory. (Opinionated?) I form my own opinions. (Withdrawn?) Keep to myself. (Angry?) Lots of hidden rage. Someday it will come out.
Therapist	I don't know her. I won't do it. I don't like her. Unaware without knowing it. Has too much faith in me. [Refused inquiry.]

Note. Examiner's questions appear in parentheses. Examiner's comments appear in brackets.

contained several alternations between juxtaposed series of first negative and then positive attributes before ending with a more positive conditional note. Although much of the description reflected her continuing dysphoria, her growing acknowledgment of these painful affects was an important part of her ability to achieve a greater cohesion in her self-description. With her growing capacity for self-reflection, as well as with her attempts to share painful thoughts and feelings with another, she was now able also to view herself as "sensitive" and "sympathetic."

As significant as the changes in her self-description were, still more important were the transformations in Patient A's therapist description. Her account at 1 year indicated that the therapeutic relationship had shifted dramatically from the idealization at admission. Now Patient A said that she did not like her therapist, and she refused to describe her. These developments reflected both intense hostile feelings toward the therapist and the consolidation of a negative maternal transference.

Indeed, therapist notes from a treatment review at 1 year confirm that, in the therapist's view, an intense, psychotic, negative maternal transference had gradually developed during the previous 6 months. Although Patient A continued to put the therapist in the role of a mothering figure, she perceived the therapist's failure to gratify her wishes for nurturance and the therapist's request that she put these wishes into words as a rejection. Patient A became increasingly critical, oppositional, hostile, and sadistic toward the therapist. On one occasion, she had to be restrained to control her homicidal impulses toward the therapist, and for a period of time, Patient A discontinued her therapy sessions. Prominent attitudes of contempt and devaluation also emerged as defenses against neediness and vulnerability. This transient psychotic transference seemed to have derived in part from the emergence of very painful persecutory ideation that her mother wanted to kill her. Prior to her hospitalization, for example, she often slept with a knife under her pillow to protect herself from her mother, who wandered around the house at night because of her insomnia. As this material was worked through in the transference, Patient A began to feel close to her therapist again. Alternatively, the experienced incompatibility of Patient A's psychotic maternal transference was transformed into more advanced psychological functioning by the gratifying involvement of the therapeutic relationship (Behrends & Blatt, 1985; Blatt & Behrends, 1987).

Thus, significant change, reflective of considerable clinical improvement, was noted in the self- and therapist descriptions obtained at 18 months, 1 month prior to Patient A's discharge from the hospital, as

presented in Table 4. Although her concern with suicide indicated her continuing dysphoria, she was now able to modulate this concern through intellectualization. That is, she could think about suicide as an ethical issue. The primary change at discharge, however, was her increased capacity for self-reflection. Having finally begun to think about herself in a formal operational mode, she could now clearly distinguish between her feelings of loneliness and insecurity and the facade she presented to the world.

In contrast to her prior refusal to describe her therapist at 1 year, Patient A now described her therapist in positive terms. She emphasized the therapist's kindness, ethical standards, emotional sensitivity, and verbal facility. It is noteworthy, per our previous comments about adaptive projective identification, that Patient A's description of her therapist at discharge emphasized the very same capacities in the therapist that she enacted in her self-description at 6 months when she revised her statement, "getting more confident," to the more adroit phrase, "gaining confidence." These are the capacities that Patient A again displayed in this termination description of her therapist—namely, an ability to select appropriate words or phrases to communicate effectively her thoughts and feelings and, especially, to moderate destructive feelings and wishes. Similarly, Patient A's recognition of her therapist's high moral standards paralleled her own formation of ethical beliefs, specifically about suicide. Thus, in the process of developing as an independent subject, Patient A unconsciously used her description of her therapist to talk about herself.

Notes from the treatment review at discharge indicated that from the end of the first year of treatment to discharge some 7 months later, Patient

Table 4
Patient A: Self- and Therapist Descriptions at Discharge (1½ Years)

Significant figure	Description
Self	Lonely. Insecure. Hiding behind a facade. Has common sense. Abnormal opinions. One of my abnormal opinions is that people who want to kill themselves should be allowed to kill themselves—and I wasn't referring to myself either. Mature—can be mature—haven't really acted it during the psych. testing. I sort of fooled around. Should have more confidence.
Therapist	I'm trying to think of a word. Tactful in approaching situations. That wasn't the word I was thinking of. Not blunt; can say things in a better fashion. She can put things in a better way that doesn't sound so intimidating or so cruel. She's sweet, generous, and has high morals. She's a nice person. Has high standards.

A became increasingly able not only to recognize that her hostile feelings derived from a long-standing sense of deprivation and rejection experienced in relation to her mother but also to verbalize her feelings of deprivation and anger. As she did, she shifted from a paranoid to a depressive organization, in which persecutory feelings and psychotic symptoms were replaced by self-critical ideation (Blatt, 1974; Blatt & Shichman, 1983; cf. Klein, 1935, 1946; Winnicott, 1955/1975) that reflected a greater capacity for self-reflexivity. Although her self-concept was still highly reactive to emotional states, she was now much better able to make smooth transitions, as Bach (1985, 1994) has put it, between subjective self-awareness, in which her view of herself reflected her affect at the moment, and objective self-awareness, in which she could view herself as a self among selves, a subject among subjects. Acknowledging therefore that her view of her therapist had been distorted by persecutory concerns during much of the treatment, she was now able to express strong positive feelings for the therapist.

Nevertheless, the most striking feature of Patient A's significant-figure descriptions was the way in which she used her description of the therapist to find and reappropriate positive aspects of herself. Thus, as previously noted, she displayed in her 6-month self-description a concern with verbal precision that reemerged in her discussion at discharge of her therapist's ability to be tactful and precise in her statements. In short, what she seems to have found most meaningful about her therapist—the therapist's verbal facility and tact in modulating aggressive wishes—is highly congruent with the very things that she enacted in her treatment both at 6 months and at discharge. This clinical example suggests that some patients, particularly those who are primitively organized and who have trouble with self–other differentiation, may try not only to take as their own the therapist's activities, attitudes, and functions but also to identify and construct in the therapist qualities that meet some of their own needs, the development of which had been previously thwarted by their own psychological disturbances and conflicts.

With the resolution in the transference of conflict-laden object relationships that are displaced onto the therapist earlier in the treatment, such patients are increasingly able to identify and to acquire for themselves qualities that they have long sought to take as their own and that they have identified or constructed in the therapist. We have, as noted, previously termed this process adaptive projective identification (Blatt et al., 1996), although it might be less cumbersome to describe it as a form of transitional object usage, in exactly the way that Winnicott (1971/1982) used

this term. That is, we cannot say whether our patients discovered these positive aspects of the self in the therapist or instead created them there, although the phenomenon of adaptive projective identification does tell us that we help our patients not only by being good objects but by being objects who are potentially congruent with the people our patients want to become. The patient's discovery of positive aspects of the self in the other, in this case the therapist, is therefore a crucial way station on the route to discovering the independent subjectivity of an other who recognizes the independent subjectivity of the self.

Conclusion

The term *projective identification* is a cumbersome one, so much so that several prominent theoreticians (e.g., Demos, 1999; Eagle, 1999; Meissner, 1980; Porder, 1987, Stolorow, Orange, & Atwood, 1998) have argued that researchers would be well served to dispense with it altogether. To coin new terms like *adaptive projective identification* (Blatt et al., 1996), *normal projective identification* (Bion, 1967/1993), *healthy projective identification* (Joseph, 1983), *positive projective identification* (Hamilton, 1986), or *constructive projective identification* (Adler, 1989) would seem only to add to the confusion in this area of psychoanalytic discourse. Indeed, we are sympathetic with the extant critiques of this notion, mainly because we object to the latent Cartesianism involved in regarding as an explanatory psychological principle the fantasy of putting unwanted parts of the self into another, yet we retain the concept of projective identification in this discussion because it does seem to capture the self–other confusions that are common in both primitively organized patients and developmentally normal preschool children and of which even normal, well-functioning individuals are capable under conditions of regression, both adaptive (e.g., artistic creativity, intimate relatedness) and pathological (e.g., anxiety, stress, fatigue). These self–other confusions, confusions between the mind of self and the mind of another, are essential, we have argued, to the development of the cognitive capacity for intersubjectivity—that is, the ability to understand another person's mind.

Perhaps the best one-sentence description of Klein's (1946) problematic yet pervasive concept is found in Bion's (1952/1961) terse comment that projective identification involves a manipulation to play a part in someone else's fantasy, and yet this definition neglects an essential feature of projective identification. Projective identification involves both (a) an enactive component involving the manipulative attempt to control another

and, as Bion (1967/1993) well described, (b) a fantasy component in which self is confused for other and other is confused for self. In describing this second component of projective identification, we are simplifying our language for rhetorical effect, but we are in fact referring to confusions between the mind of self and the mind of the other, not between the body of self and the body of the other. In any case, without this latter component, we can indeed dispense with the concept of projective identification altogether, for there are numerous ways in which one person can, via manipulation, induce another to enact a role complementary to the first person's wishes or fears, but none of them should be regarded as projective identification, either positive or negative, unless, as was the case with Patient A, there is also a failure to recognize that one is locating the other in oneself or oneself in the other. Thus, we are in agreement with Adler (1989), who noted the similarity between projective identification and transitional object phenomena.

Both projective identification and transitional phenomena, then, are attempts to negotiate the dilemmas of remaining connected to a significant object while being separate. In projective identification, especially as it is classically conceived (e.g., Bion, 1967/1993; Klein, 1946; Segal, 1973; see also Ogden, 1979), the main purpose seems to be to destroy potential space by enacting hostile, destructive fantasies, fantasies that presumably reflect anger and fear over separation, and by attributing those fantasies to another who then serves as a container. On the other hand, although transitional object usage is usually conceptualized in terms of fantasy, these phenomena also contain an enactive component. What is enacted is not the fantasy of destroying the object but instead an invitation to play, and indeed playing with reality (Fonagy & Target, 1996; Target & Fonagy, 1996) is what an adult is induced to do when a child comes forward with a teddy bear. That is why we argued that Patient A's adaptive projective identification—her finding of positive aspects of herself in her therapist without recognizing that she has done so—can be conceptualized as a form of transitional object usage, as means of staying connected to her therapist while differentiating from her, just as much as it is means of protecting good aspects of herself that she has found in another and that she fears she might destroy with her hostility, if we return to the language of projective identification.

Whichever terminology we use—adaptive projective identification or transitional object usage—we are still describing the process by which a severely disturbed patient comes to know the mind of another, in this case her therapist, without destroying the other person as an independent

subject. This, we have argued, is always a painful, difficult process for someone whose independent subjectivity was not recognized but instead traumatically suppressed. For such patients, the risk involved in permitting another to be an independent subject is that of being retraumatized, and that is why such patients are often so impaired in their capacities for fantasy and symbolization. It is also perhaps another reason why Patient A located her good qualities in her therapist as termination approached, for assigning these qualities to the therapist enabled her to keep her therapist with her. In any event, it is because Patient A's therapist did indeed recognize her as an independent subject that Patient A could begin to play with language and the reality of separation and, through this play, begin both to establish herself as her own person and to allow her therapist to exist as a subject separate from her. Thus, psychoanalytic treatment is essentially an intersubjective process, a situation in which two minds constitute each other through mutual recognition. In other words, in analytic treatment, patients come to know their own minds by virtue of dialogue with their analysts, and although the purpose of analysis is for a patient to come to know his or her own mind, this happens only because, to some extent or other, analysts also come to know their minds through the minds of their patients (Blatt & Behrends, 1987). The Cartesian project, the belief that one could know one's own mind via introspection, without the mediation of dialogue with an other, is therefore erroneous, and psychoanalytic treatment gains its power to help a patient's mind develop because of the dialogic processes that the analytic process unleashes—in simpler terms, because analyst and patient must speak to each other. As we have argued, intersubjectivity as an interpersonal process constitutes the relational matrix from which intersubjectivity as a cognitive capacity emerges, and intersubjectivity as a cognitive capacity makes possible the mutual recognition that is the essence of intersubjectivity as an interpersonal process. We close, therefore, by paraphrasing Mahler in describing Patient A as on the way to intersubjectivity in both of these senses.

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