

This commentary has as its point of departure essential questions about selfhood, self-knowledge, and therapeutic action. Frank's contemporary redefinition of "mutual analysis" and its impact on the clinical surround are examined, with a special emphasis placed on the willingness of the analyst to change and grow. The vital role and theme of the analyst's emotional honesty are explored with an eye toward the clinical impact of contextualism, psychoanalytic complexity, and the personal attitudes that inevitably permeate the analytic relationship and its trajectory. This commentary, in concert with Frank's paper, encourages clinicians to embrace a more collaborative, mutually analytic posture in their clinical endeavors.

The true story of a therapeutic exchange begins not with the patient's present problem but with the healer's past.

— Rafael Yglesias

We must not forget that the analytic relationship is based on a love of truth.

— Sigmund Freud

In important respects "the individual self" is not a state of nature but of language.

— Kenneth Gergen

Somewhere midway through my own analysis, after I had undergone much change, I visualized the core of myself as being, none the less, like a steel ball bearing, with varicolored sectors on its surface. At least, I told myself, this would not change. I have long since lost any such image of the core of my identity; it became dissolved in grief and my sense of identity now possesses something of the fluidity of tears. But for a number of years anything which threatened that so-rigid view of the core of myself was experienced as terrifying craziness.

— Harold Searles

Frank's compelling paper and this commentary have as their point of departure the essential and perplexing questions about selfhood, self-knowledge, and what is therapeutic in an exploratory, healing relationship. These familiar inquiries—answers to which are numbered far greater than all the proverbial elephant's parts—have shaped our philosophies and sciences for centuries: How can we glimpse what is largely not accessible to consciousness, what comprises problems in the

human spirit, and what can transform them? For centuries these questions have been inextricably intertwined, such that in many instances we have presumed that to know oneself is to heal oneself (**Freud, 1897**; Socrates, as cited in **Jowett, 2007**), and it follows that to know an *other* might lead to healing an other. To be known is second only to being known and loved. More contemporarily and more precisely, to respect and acknowledge the *limits* of our knowing someone, despite our good intentions and heartfelt efforts, may not be simply the best we can do, but the best thing *to* do (**Levinas, 1987**; **Orange, 2009**).

There *is* much to know about oneself and the other, and by repositioning and redefining the notion of “mutual analysis,” Frank expands our understanding of the pathways to self and other knowledge (**Ferenczi, 1993**) within our contemporary psychoanalytic landscape. One essential distinguishing feature between the traditional notion of mutual analysis and that which Frank proposes is that the latter ultimately keeps the patient in mind, and despite this focus (or because of it?), the analyst inevitably grows throughout the process. Indeed, the analyst *does* change, perhaps *must* change (**Slavin & Kriegman, 1998**), and presumably it is this transformation which bears fruit for both parties.

Frank's beautifully written and well-researched paper—including his invoking neuroscience to substantiate what we intuitively have sensed all along—centers on four essential themes: the nature of human subjectivity (and the fact that it just isn't considered *noise* anymore); the nature of the self and how it comes into being and relentlessly evolves over the life span; the pathways to self-awareness; and, perhaps especially wished for by many clinicians, how these ideas might extend our understanding of therapeutic action in psychoanalytic therapy. The first two themes are of course mutually informing, as are, not surprisingly, the second two. I am indebted to Frank for articulately encapsulating several of the perplexing questions that perpetually preoccupy each of us clinicians. Furthermore, embedded in his work (though I do not think explicitly stated) and, central to our understanding of therapeutic action, is an invitation to examine the essential role of emotional honesty in psychoanalytic relationships, a theme that **Davies (2004, 2005)** and others have explicitly addressed. In this commentary, I highlight the need to position emotional honesty more prominently than perhaps was reflected in Frank's paper. For the sake of variety and perspectivalism (**Aron, 1996**; **Mitchell, 1994**; **Orange, 1995**; **Stolorow & Atwood, 1996**), I address these themes with an eye toward contextualism, psychoanalytic complexity, and Frank's clinical example. I also examine a few of the attitudes embedded in Frank's work, as how our underlying attitudes—our formal and personal philosophies, our personal organizing themes, our theories, our mentors, our reading lists, and much more—inform so much of how we think and feel: what we say and what we do, what gets noticed and talked about and what does not, ultimately, the trajectory of the therapeutic relationship. In my own work, I have asserted that “many contemporary analysts not only increasingly attempt to account for the inevitable impact on the patient of the analyst's subjectivity, but feel that it may be exactly the conveyance of this subjectivity that is facilitative and constitutive for the patient” (**Coburn, 1999**, p. 105). And this naturally includes our fundamental attitudes.

ATTITUDES

Elsewhere I have underscored and elaborated the primary role played by the attitudes that emanate from our histories, our theories, our unique proclivities, and their implications in understanding relating, enactment, and therapeutic action:

Attitudes, often implicit and prereflective, exert powerful influences on the patient, the dyad, and the trajectory of the analytic relationship... . To extrapolate from the work of Benjamin (2004) and **Aron (2006)**, our interventions, verbal or otherwise, are always necessarily “marked” or accompanied by an associated attitude, just as our “mirroring” responses always include aspects of our own subjectivity, are *marked* by them. This action not only allows for the potential of increasing one's sense of self/other delineation in the process of getting to know oneself through the mind of the other, but also provides the underpinning for one coming to “know” the *other*, whether we like it or not. (**Coburn, 2011**, pp. 130–131)

Ferenczi (1928) was onto this when he spoke of empathy as part of a two-stage process: *Einfühlung* and *Abschätzung*—the former referring to an empathic process in which something of the other's emotional world is grasped and understood, and the latter referencing the assessment and appraisal of that which was discerned through empathy, including, importantly, the communication of that assessment to the other, often in the form of an implicit attitude.

As a specific instance of the role of influential attitudes in psychoanalysis, I have always found compelling **Aron's (1996)** attitude that underlies his verbal self-disclosures: His “to the best of my knowledge” sensibility, embedded in his communications about how he experiences himself, perhaps in contrast to his patient's experience of him, always conveys that he (the analyst) too has an unconscious and that the patient may be glimpsing something of that to which Aron is not yet privy. This form of fallibilism (**Orange, 1995**) reflects a powerful attitude that opens possibilities for expanding self awareness and human relating. But it does require a willingness to tolerate a healthy if painful dose of Cartesian anxiety (**Bernstein, 1983**), including the unease of either not knowing and/or of knowing that an other might know something more about the one thing we would expect to have the best grasp of: our selves.

Frank comments that

we must strive, perhaps more conscientiously than ever before, to remain accountable for our own subjectivity, which rather than simply interfering ‘noise’ has come to be seen as a source of information vital to our work and the process of healing. (p. 315)

Our attitudes toward human subjectivity in psychoanalytic history have evolved into more intelligent and clinically useful directions, and the evolution of our countertransference literature since the early 20th century (**Bacal & Thomson, 1996; Balint & Balint, 1939; Epstein & Feiner, 1979; Freud, 1910, 1912, 1913; Hoffman, 2009; Little, 1951; Orr, 1954; Stern, 1924** [just to name a few out of hundreds]), for example, reflects that evolution. This literature, slowly but surely, was onto something essential in discussing the impact of how we hold the idea and experience of our personal subjectivities. Happily, we have more recently arrived at the sense that our subjectivities, rather than being an obstinate impediment to reasoned and sound clinical work, are pathways to insight and therapeutic action and deserve our central focus and respect.

A closer examination of our attitudes toward our subjectivity and their epistemological frameworks will help illuminate how self-experience and countertransference develop within us and ultimately how we will interact with our patients in the context of

an intersubjective field. They also determine how we regard the experiences of certainty and conviction, how we respond to the feeling that we “know a thing” and that we are “committed to knowing that thing.” Further, our meta-organizing principles also shape and inform our perspectives regarding unconscious communication and other vital concepts such as affect attunement and information transfer. (**Coburn, 1999**, p. 102)

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I believe Frank's theoretical and clinical work beautifully reflects this sensibility and respect, not just toward the specificity and uniqueness of our own personal subjective experiences but, of course, that of the patient as well. Hence, attitudes are vital to take into consideration when thinking of our clinical work and therapeutic action, and indeed it is Frank's attitudes about human subjectivity, about coming to know self and other, about really listening to the other, in concert with Joan's tenacity to question and explore, that drive this particular treatment situation.

SELFHOOD

Prodigious attention has been given to speculating about the nature of “the self.” Tackling these speculations and assumptions would fill—indeed, *has* filled—volumes. For purposes of this commentary, I wish only to call attention to the fact that our notions of “the self” and its development—or what today might more usefully be referred to as “selfhood” and its emergence in complex human systems¹—have transitioned from our more traditional, monadic understanding of the solitary, individual person to a radically contextualized, relationalized experience of selfhood. Even Kohut, who with more traditional language frequently spoke of the self as an individual entity or structure, understood the context-sensitive and context-dependent nature of selfhood. Selfobject theory arguably can be seen as one of the more notable transitional perspectives that helped introduce, at least in psychoanalysis, a more realistic rendition of selfhood. Though for many theorists considered to be transitional figures in our shift to a more contextualist and systems attitude, selfhood remained rather unitary, and it was not until the last few decades that we began to witness not only the more dynamic, sometimes ephemeral, and distributed nature of selfhood, but also the highly variegated, multiple (and dissociative) quality of our individualism (**Bromberg, 2006; Davies, 2004, 2005; Frie, 2011**). From a psychoanalytic complexity perspective, selfhood (explanatorily speaking) is understood as distributed across multiple relational systems of which each of us is but a constituent, whereas (phenomenologically speaking) it can emerge experientially in any form (i.e., as distinct and isolated or as dissolved, annihilated, and/or subsumed by the environment).² Indeed, our more traditional notions of the encapsulated self have yielded untoward consequences:

The longstanding and much cherished tradition of the individual self carries with it enormous costs... . This tradition invites a sense of fundamental separation and loneliness; encourages narcissism at the expense of relationships; generates unending threats to one's person, and transforms the self into a marketable commodity... . In the end, we also come to see nations as bounded units, and the result is global alienation and distrust. (**Gergen, 2009**, p. 27)

Frank's references and treatment of the self reflect the more salutary, contemporary shift in our thinking about selfhood. Indeed, his work with Joan and its positive outcome depend upon it.

¹ See **Stolorow (2005)** on the importance of use of language, as well as **Wittgenstein (1953)** and **Orange (2003)**, in defining how we think and how we interact in and with the world.

² See **Coburn (2007, 2009)** for an examination of the importance of distinguishing between “the explanatory” and “the phenomenological” dimensions of discourse.

Early on Frank cites **Anzieu (1986)**, that “‘there can be no proper self-analysis unless it is communicated to someone else: That is something which seems to me indisputable’ (p. 569)” (p. 312). I would argue that any communication, any voices spoken or heard, are *always* necessarily relational. Even to speak to oneself is to speak to an other, to the object me which the subject I is addressing. Drawing from the work of George Herbert Mead, **Sugarman and Martin (2011)** elaborated this theme—“perspective taking”—as the hallmark of the development of selfhood:

Mead distinguishes between the “I” and the “Me” to capture conceptually the rendering of subjectivity through self-reactivity. The agentive “I,” present only in the immediate moment of action, reacts to a recollected “Me” brought forward as an object of reflection. The reaction of the “I” to the “Me” produces a reconstituted perspectival understanding of the “Me.” This reconstructed self is subsequently made present as the next recollected “Me” to which an immediately future “I” responds. The “I” is experienced, but not knowable... . In this way, selfhood and psychological subjectivity result from a self-determining agency that generates its own psychological emergence by simultaneous occupation of perspectives of a reconstructed past and an anticipated future, joined in deliberative determination of action in the present. (pp. 81–82)

Given this contemporary sensibility about the development of our selfhood, as well as our preoccupation with epistemology (particularly, in this context, how we obtain meaningful information about ourselves and others), it naturally follows that we must look to others to come to know something of ourselves. As Frank highlights early on, “We must continue not only to look inward to gain self-understanding but also *beyond* [emphasis added] ourselves to the interaction and, importantly, to the patient, who ... is able to offer ... critical data for our self-understanding” (pp. 312--313). He further states that “it behooves us to open ourselves to the notion that our patients are indispensable collaborators who help us gain self-awareness” (p. 313). This latter assertion (revisited next), as much as it reflects an essential and useful clinical attitude, is indeed quite humbling and necessarily proves challenging for many of us clinicians.

PATHWAYS TO SELF-AWARENESS

Freud (1913) was certainly grasping, as Frank and many others now have, a striking and essential aspect of relationality when he stated that “everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people” (p. 320). What he may not have considered at the time, as least as I can tell from the literature, was that this phenomenon naturally must work in both directions. The patient has a “telephone receiver” (**Freud, 1912**, p. 115) as well. Joan had one. And what is more, what is received, from and by both parties, is not solely informing but also *transforming* each sender and each recipient as well. Frank makes clear this highly relational nature of gaining self knowledge, the necessity of the presence of the other in not solely coming to know oneself but indeed in coming to *be* oneself. In Frank's view, in his implicit attitude, human subjectivity and the expansion of self and other knowledge are coextensive, inextricably intertwined processes: Quintessentially relational, we humans, our selfhoods, evolve not through the unfolding of a “nuclear program of the self” in a context of selfobject provision (**Kohut, 1977**) but through largely implicit, moment-by-moment

interactions that are mutually and reciprocally determinative.³ These interactions determine the nature of our selfhood in concert with what we come to *know* of our selfhood.⁴ (We might think of the notion of the “nuclear program of the self” *and* its interaction with mirroring, idealizing, and twinship selfobject experiences as Kohut's efforts to relationalize “the self.”) The development of our human subjectivity informs what we are learning about others and ourselves, just exactly as what we are learning about others and ourselves informs the nature and evolution of our human subjectivity.⁵ Neither constitutes insignificant “noise,” and this assertion resonates with a psychoanalytic complexity perspective that avers that the action lies precisely in the noise, the messiness, the apparent randomness of emotional experience and meaning.⁶ We cannot but lift a finger without our actions being embedded in and determined by the unrelenting relational bath in which we all live, what **Gergen (2009)** referred to as “bounded being” (p. 31) and what **Frie (2011)** referred to as “situated personal experience” (p. 14).

THERAPEUTIC ACTION

Recall Freud's (1910) notation—highly reflective of the more traditional doctor-knows-best sensibility—that “one of the necessary preliminaries to the treatment” involves “informing the patient of what he does not know” (p. 225). This emerges in reverse with Frank and Joan. Joan is informing Frank of what he does not know, or, more precisely, of what he does not know he knows in the moment, and Frank's sincere reflection and, ultimately, his emotional honesty, leads to a pivotal and an enormously mutative exchange. Here, understanding therapeutic action is not an easy venture. At the risk of stepping on the slippery slope of reductionism, let us examine in what ways the aforementioned themes and questions emerge in his clinical work with Joan and how his (and Joan's) attitudes about them inform the emergent outcome. And let us raise a few more questions regarding Joan and Frank's collaboration.

The emerging impasse and ultimately the crux of their clinical process necessarily emerge from a multitude of variables—broadly speaking, from their personal and combined histories,

³ I do not imply that these perspectives are mutually exclusive—it depends on how they might be elaborated and understood—but rather that they reflect contrasting “language games” (**Wittgenstein, 1953**). Among other considerations, understanding their meanings rests on determining whether we are thinking phenomenologically or explanatorily.

⁴ See **Lichtenberg, Lachmann, and Fosshage (2011)** for a more recent and persuasive understanding of “the self” through the lens of self and motivational systems theory.

⁵ In contexts of danger and fear (given a sound responsiveness from the environment), while the child is learning that he can be safe, calm, and secure in the presence of a stronger, idealized figure, the idealized figure is learning, via the responsiveness of the child, that she can be, in fact, a strong, idealizable, efficacious, and nurturing person. Each is learning something about oneself and about the other, and each is becoming a self and an other as well.

⁶ For a thorough explication of the application of complexity theory to a variety of fields, including psychoanalysis, see **Poincaré et al. (1900)**; **Thom (1983)**; **Bak (1996)**; **Waddington (1966)**; **Kauffman (1995)**; **Lorenz (1993)**; **Cilliers (1998)**; **Taylor (2001)**; **Prigogine and Holte (1993)**; **Coburn (2002, 2007)**; **Galatzer-Levy (1978)**; **Sashin and Callahan**

(1990); Moran (1991); Spruiell (1993); Thelen and Smith (1994); Stolorow (1997); M. Shane, Shane, and Gales (1997); Palombo (1999); Miller (1999); Lichtenberg, Lachmann, and Fosshage (1992); Varela, Thompson, and Rosch (1991); Scharff (2000); Beebe and Lachmann (2001); Trop, Burke, and Trop (2002); Charles (2002); Magid (2002); Bacal and Herzog (2003) Ghent (2002); Harris (2005); E. Shane and Coburn (2002); Seligman (2005); Thelen (2005); Weisel-Barth (2006); Pickles (2006); Sucharov (2002); Sander (2002); Piers (2005); Orange (2006); Dubois (2005); and Steinberg (2006).

their current states of mind, and their environmental circumstances.⁷ And doubtless Frank and Joan *are* collaborators. Indeed we wish always to be collaborators and contextualists with our patients (and wish to invite them into such a worldview), despite our traditional underpinnings that may still haunt us with questions such as “But where is the authority in the room? Who is in charge here? Who is the expert? And if there *is* one, expert in what?⁸ Who has the final say? Anyone? No one? Shouldn't there be a bedrock truth we are striving to uncover? Who is the one who really *knows*?” And so forth. In our postmodern world (Lyotard, 1984), real answers to these questions might include *everyone and no one* and *yes and no*. Indeed we must be collaborators in each of our clinical endeavors, and the medium for expanding our knowledge and emotional connection with our interlocutor is usefully captured, I believe, in Orange's ideas about expanding our “horizons” of understanding through a “communitarian dialogue” (Orange, 1995). (Emotional truth and reality are not “relative;” they can be conceptualized as hermeneutically emergent properties of human systems.) This is one way to speak about what Frank does, and does with struggle, with loss and risk, with a relentless desire to know and not to settle on knowing one thing, and, especially, with emotional honesty.

Frank treats us to an evocative clinical exchange—one that emanates from what palpably feels like a history of closeness, compassion, struggle, and intimacy. Was it this history that enabled Joan to be exceptionally curious and confrontational with Frank? I think so. Joan is willing to be emotionally honest with one for whom she deeply cares, inviting Frank to respond in kind. “Search yourself.” Prior to that juncture, during the more preliminary enactment in which Joan felt Frank was disappointed in her and in which Frank began an introspective countertransference examination, he began to feel that her “points had merit.” By which I assume Frank means aspects of Joan's experiential world here corresponded somewhat with facets of *his* experiential world. Of course a patient's “points” always have merit, given his or her own unique subjective world, and to think otherwise propels us back into the very objectivist, one-person model from which we clinicians have struggled to extricate ourselves. And so, as for a question, what of a context in which the analyst is left feeling that there *is* no “merit” in what a patient asserts? I suspect in this clinical instance, after invitations and pleas to consider alternatives to Frank's initial perspective, Joan would not have continued “this time around.” Imbuing a dimension of the patient's experience with a sense of “merit” does not necessitate analyst *agreement* with such experience. But exploring and understanding it can forestall a permanent impasse, as was the case with Frank and Joan.

Thus far, a great deal of what was mutative and developmental for Joan rests on her having risked being insistently curious and confrontational—a mode of being, as Frank acknowledges, that is not enjoyed by all patients—as well as Frank's willingness to reflect more deeply, to really search himself, and then to be present and forthcoming with Joan in an emotionally honest way. (Frank not only held himself to the “same standard of self scrutiny” but also dared to be emotionally honest, first with himself and then with Joan.) It rests on an explicit and verbal focus on Joan's sense of knowing something about Frank to which he himself was not yet privy: Indeed, an

⁷ Emotional experience emerges always at the interface of one's history, one's current state, and one's environment, and the lines of demarcation between each can never be clearly drawn, if at all. This psychoanalytic complexity sensibility helps subvert our natural human propensity to simplify reductionistically emotional experience and meaning into neat,

understandable components.

⁸ See **Layton (1999)** on the role and meaning of “expert.”

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elegant illustration of the collaborative and context-driven nature of the clinical exchange, of the necessity of the “mutual analysis” quality of relational work. As I had quoted from Frank earlier, “It behooves us to open ourselves to the notion that our patients are indispensable collaborators who help us gain self-awareness” (p. 313). And I would add, it behooves us to attend, as much as possible, not only to our patients' verbal curiosity and confrontation in matters of the analyst's subjectivity, but also to the non-verbal, usually implicit communications of the patient that are frequently—perhaps more frequently than we wish to imagine—reflecting their knowledge of us, knowledge at which we ourselves have yet to arrive. This is particularly the case when working with individuals who may be more organized around “systems of pathological accommodation” (**Brandchaft, 2007**) in which the terror of loss of the connection with the other far outweighs the desire for self-delineation in an interpersonal, perhaps love-centered context.

Occasionally I have had the very humbling experience of witnessing specific affect states move across a patient's face that I experienced as perhaps reflections of something of my own less distinct, more subtle emotional state, and, with this “knowledge,” failed to mention it or to inquire of the patient's experience for fear of my being discovered in a way that would be intensely anxiety provoking for me. Perhaps it was something I wished to hide from the patient. Perhaps it was something I wished to hide from myself. And then my clinical shame emerges for not stretching my own analytic curiosity and daring to open up something potentially useful for us in regards to something the patient might know about me but doesn't want to know that she knows, and/or perhaps does not want me to know that she knows. This type of (silent) intersubjective conjunction (**Stolorow & Atwood, 1996**) is perhaps the most insidious, partly because it can emerge and then dissolve in the span of a moment, perhaps never to return again. If we are fortunate, it does return. **Searles (1955, 1966)**, whom Frank references, wrote about the importance of being open to understanding the hallucinations of his patients as reflecting something of his own personal subjectivity, as has **Atwood, Orange, and Stolorow (2003)** at length from a more contemporary and radical contextualist perspective. As Frank states, “I suspect that often such phenomena remain unrecognized because patients do not, and are not encouraged to push us” (p. 315). Joan and Frank were fortunate in this instance, in that an opening for self and other discovery ultimately became more accessible and verbalizable.

What might the clinician do with this understanding? I think remaining extraordinarily alert is essential, followed by the willingness to stretch ourselves, as Frank did, into dimensions of experience that are uncomfortable for us. Recall the remainder of the **Freud (1912)** passage I quoted earlier:

But if the doctor is to be in a position to use his unconscious in this way as an instrument in the analysis, he must himself fulfil [*sic*] one psychological condition to a high degree. He may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious [or, by his patient!]; otherwise he would introduce into the analysis a new species of selection and distortion which would be far more detrimental than that resulting from concentration of conscious attention. (pp. 115–116)

Recall also **Brandchaft's (2002)** insightful comment that “nothing is more important as a defining ingredient in a truly therapeutic system than that the analyst safeguard the extension of the inquiry into realms of the patient's

experience that are threatening to the analyst's sense of self' (p. 740). I
always know I am, eventually, onto something important when it persistently
emerges at the

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edges of my emotional experience, though I may stubbornly bat it away like a pesky insect. For me, clinically, this is usually where the action is (or will be).

As I mentioned, Frank's more explicit focus lies in his crucial attitude that the psychoanalytic endeavor is (or should be) fundamentally collaborative: Given the plethora of theory and research supporting the fact that being and acting in the world, including the process of self discovery, is intensely relational—we come to know ourselves reflexively through the mind of the other, through perspective-taking (**Aron, 2000; Sugarman & Martin, 2011**). However, less emphasized in his article but equally important, the experience of emotional honesty, while depending greatly on the willingness to reflect more deeply, remains an enormous element in what was, I believe, therapeutic for Joan and what is, generally, therapeutic in any analytic relationship. **Davies (2004)** has repeatedly and rightly argued that if we are to invite the patient to be present and honest, with himself and with us, to face shame- and terror-inducing states of mind, then we had better be prepared to do the same when the time comes for us, as it inevitably does. As she points out (**Davies, 2005**), to retreat from emotional honesty, particularly when the patient is already experiencing that about which we are inclined to be deceptive, can collapse the treatment relationship in a devastating way, perhaps overthrowing years of hard won clinical advances.

But what of analyst privacy, the analyst's right to a private life? What if I sense, explicitly or implicitly, that my patient is onto something that I wish to keep hidden? Certainly Frank had that choice. Emotional honesty, as I am using the term, of course does not mean self-disclosure with unreasoned abandon. Neither the patient nor the analyst ultimately should be an authoritarian interrogator; despite that at times we may enact roles that feel that way. Emotional honesty does not mean giving up personal rights. It means being willing to meet the patient in the very arena into which we have implicitly if not explicitly already invited the patient. Frank elegantly states that “if we, as analysts, hide or even believe we can, whether behind our proverbial reflecting mirrors or other technical contrivances, we may think we are making ourselves appropriately difficult to discover” (p. 319), when actually we are disclosing ourselves to our patients as an analyst who is trying to hide and perhaps even trying to hide the fact of our trying to hide. Some form of emotional honesty is the only way out of *that* relational conundrum. Added to which is Frank's well-reasoned assertion that “it is not *whether* the analyst shows vulnerability that is at issue but *how* the analyst manages it when it happens—which then forms an important part of the good-enough object that the analysand internalizes” (pp. 320--321).

We witness Frank's emotional honesty *and* his asserting his right to a private life when he said, “I think you're right, Joan. There *is* something. But I'd rather not go into it right now. Trust me that I recognize it, and I'll deal with it and try harder. We can probably talk about it later” (p. 314). Subsequently he was quite forthcoming and specific with Joan, but did he need to be? That is a clinical decision entirely based on the unique context of that particular dyad and what Frank felt would be most useful to the patient at that point in time (**Bacal, 2011**), in conjunction with his own wish to disclose something of intense, emotional import—something that was not only decisive and excruciating in his own life but something that leaned into and impacted his relationship with Joan. There are no rules to follow here, but rather, essential clinical attitudes about how we come to know something of others and ourselves that inevitably inform how we are and how we act in relationships. In this clinical instance, these attitudes proved mutative for Joan and advanced the treatment.

As for now understanding the patient and the analyst as collaborators, as companions of sorts who journey and discover together, one potential pitfall—a caricature of respecting

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the experiences and perspectives of the patient—resides in the analyst's overprivileging and impulsive acceptance of the patient's forceful or otherwise contentions about the analyst's subjectivity. Frank's well-founded sensibility here should not be construed as a “customer is always right” perspective. The extreme version of this pitfall is reflected in the rather pejorative quip about the traditional Kleinian greeting: “You're fine, how am I?” To collaborate does not mean to collapse one's own sense and ownership of one's subjectivity. Indeed, this topic has consumed many typeset pages in our books and journals.⁹

I am grateful to Kenneth Frank for advancing even further the very relational, contextualist sensibility that has opened our eyes and ears to the “dialogue of unconscious” to which Ferenczi had referred. As Frank acknowledges, this particular kind of dialogue is responsible for the trajectory of our relationships, our experiences, and generally our meaning-making processes. No longer can the development of the self (Kohut, 1977) be understood as simply a function of selfobject nurturance or even the “good enough” maternal (or paternal) environment (Winnicott, 1965). Clearly we are subject to, and provide, so much more—for better or for worse. Rather, from a contemporary psychoanalytic contextualist perspective, the development of our selfhood and our self and other knowledge reflects an amalgam of the continuous expansion of and interchange between perpetually interacting subjects, and such expansion and interaction relentlessly evolve in nonlinear, often unpredictable ways, as Frank's clinical illustration reflects. This knowledge enjoins us, as clinicians, to embrace more fully the highly collaborative, mutually analytic nature of our clinical endeavors.

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⁹ For an extensive treatment of the distinctions between empathy and authenticity, see **Orange (2002)**.

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