Preface

Two clinical models have been dominant in psychoanalysis: first, the classical paradigm, the view of the analyst as an objective mirror. The interpersonal turn in psychoanalysis led to a second view of the analyst as an intersubjective participant-observer. Participant-observation, in its broadest sense, refers to the clinical perspectives of interpersonal psychoanalysis, self-psychology, relational analysis, intersubjectivity theory, social constructivism, and some aspects of contemporary Freudian analysis, all of which, despite their many differences, share a clinical focus on the analysis of the interpsyche (the social mind).

However, an evolutionary shift in psychoanalytic consciousness has been taking place. A newly emerging, or more accurately, reemerging third paradigm, *coparticipant inquiry*, represents a shift in analytic clinical theory. This is a major shift, with profound clinical implications (which are examined throughout the book). Coparticipant inquiry, as a unique form of clinical participation, is marked by a radical emphasis on patients' and analysts' analytic equality, emotional reciprocity, psychic symmetry, and relational mutuality. The concept of coparticipant inquiry builds upon and extends the concepts of inquiry of the two previous models of psychoanalytic praxis.

This book draws upon and is developed from arguments advanced in Fiscalini (1988, 1990, 1991, 1994a,b). Part 1, in particular (chapters 1–3), is a study and exploration of coparticipant inquiry as an evolving clinical paradigm. My aim is to delineate its salient characteristics and to articulate its radical advantages over the other models of analytic therapy. Coparticipant inquiry integrates the individualistic focus of the classical tradition and the social focus of the participant-observer viewpoint, forming, as it were, a third clinical paradigm.

Coparticipant inquiry avoids a reductionistic biological individualism (the isolated individual mind or the intrapsychic), which fails to take sufficient account of the clinical role of object relations or interpersonal relations. It also avoids the reductionistic social determinism of the participant-observer tradition in clinical work (the intersubjective mind), which has failed to take sufficient clinical account of human agency, will, and personal responsibility.

Coparticipant inquiry integrates the dialectic of human singularity and human similarity in a way that participant-observation and classical paradigms do not. Further, whereas the clinical emphases of the classical and participant-observation paradigms have been, respectively, on the impersonal and the interpersonal, coparticipant inquiry focuses on the personal.

This book traces the evolution of coparticipant practice in psychoanalysis, clarifies its singular properties, delineates its core principles, and explores its clinical implications. This necessitates a fresh look at the concept of the self. In particular, I address the clinical and theoretical implications of a dialectical relationship between various aspects of a proposed five-dimensional self. This multidimensional concept of the self is an attempt to reconcile the antinomy or paradox that mankind is simultaneously communal and individual--both embedded in a series of social fields of experience and behavior and yet also always uniquely individual. All of us are both part of others and yet also apart. Coparticipant inquiry deals with the dialectic and paradoxical nature of the self in a more comprehensive fashion than either classical theory or participant-observation. This question of the self and its clinical dialectics is examined in part 2 (chapters 4–5).

Narcissism, or the perversion of the self, is explored in part 3 (chapters 6–9). I define narcissism in the broadest sense as a complex of dynamic processes that characteristically involve or impact upon some aspect of selfhood. In my opinion, the dynamism of narcissism represents a core dimension of all psychological disorders—a kind of master neurosis—rather than a discrete diagnostic entity. As the clinical expression of self-pathology, narcissism is, in a sense, the self gone wrong. The study of narcissism thus gives us a particularly advantageous way to examine the coparticipant analysis of the self, particularly of those dimensions of the self I call the personal and interpersonal selves. The study of the clinical dialectics and coparticipant treatment of these opposed aspects of the self forms one of the central themes of the book. I see the study of narcissism, arguably today's dominant psychopathology, as integral to the central concern of the book: the study of the self and its coparticipant inquiry.

The last and largest section of the book represents some of my ideas about the nature and problems of psychoanalytic therapy. Part 4 (chapters

10–13) covers a range of clinical subjects, many of which touch upon current controversies in psychoanalytic praxis. In this part of the book, I examine the interpretation-relationship controversy as to how psychoanalysis works, and I propose that a "living through" process is essential to psychoanalytic growth. I also discuss what I call "openness to singularity," a set of attitudes and abilities that are essential in promoting analytic vitality and viability. There is also a chapter on transference analysis and one on the "analytic work space."

Various questions and controversies are visited in the chapter on transference, including questions of the nature of psychoanalytic knowledge, analytic authority, the place of authenticity in analysis, the role of unconscious communication, the question of transference as an interpersonal phenomenon, modes of listening in psychoanalysis, the question of truth, and working with human uniqueness.

The notion of an active, spontaneous coparticipant inquiry has long appealed to me. In my analytic training I found myself drawn to the freedom of interpersonal psychoanalysis rather than to the Freudian clinical model with its narrow strictures (though I was drawn to Freud's own, freer, way of working). At the same time, I was also aware of a division in interpersonal thinking between those analysts who, like Fromm, focused clinically on individual will and responsibility and defined the analytic process as a human encounter and those interpersonal analysts, who, like Sullivan, saw themselves as experts in interpersonal relations and whose clinical mandate was to carefully attend to the vicissitudes of the individual's socially determined anxiety and psychopathology. Both of these forms of participant-observation have much to recommend them. Both are in many ways compelling; yet each is seriously flawed. Fromm's approach runs the risk of becoming an authoritarian therapy that is exhortatory and blaming, that asks too much of the patient. On the other hand, Sullivan's negation of unique individuality leads to a clinical denial of the therapeutic role of personal agency, will, choice, and similar aspects of free will.

This antinomy is in some ways echoed in the debate between the followers of Kohut and those analysts who advocate a more confronting approach, as does Kernberg. These therapeutic antinomies, at the time, seemed irreconcilable, except in reductive terms. Yet I found both approaches compelling, both of them truthful and helpful. Similarly, I found obvious merit in Freud's counsel of analytic reserve, but at the same time, I was inexorably drawn to the spontaneity, aliveness, egalitarianism, and openness to self-exploration of Ferenczi's radical analytic experiments.

Coparticipant inquiry accepts this paradox and acknowledges the therapeutic potentials of both perspectives. Not unlike contemporary physicists' acceptance of the paradox of light being both wave and particle

(photon), one can, from a pragmatic perspective, enjoy the practical benefits of accepting both clinical approaches, Frommian and Sullivanian, as offering clinical truth and benefits.

The concept of coparticipant inquiry, with its dialectical focus on both the personally unique and the interpersonal, has affirmed and informed my clinical experience. The principles of coparticipant analysis (outlined in chapter 2) represent the ideals and concepts informing my own practice. I find the following clinical emphases or features of coparticipant inquiry particularly helpful and instructive:

1. the egalitarian emphasis on the analytic equality of patient and analyst—the nonauthoritarian acceptance of the patient as a true partner;

2. the acceptance of the patient as both a communal and a uniquely individual being. Both the reality of personal responsibility and the need for interpersonal responsivity are taken into clinical account. The patient is neither seen reductively solely in terms of his or her social surround nor studied without reference to the interpersonal context of his or her experience.

3. the bidirectionality of coparticipant inquiry, which makes possible a freer and wider range of acceptable analytic behavior;

4. the call for greater freedom in analytic technique allows for and, in fact, demands that as analyst I be in touch with my immediate experience;

5. the notion of the therapeutic process as a personal encounter, which encourages greater authenticity in analytic relatedness;

6. the emphasis on there being no one "right" answer to clinical questions is a relief to us since we are so often burdened by notions of the proper or "correct" understanding of clinical events.

These are some of the therapeutic benefits to be found in coparticipant inquiry. This, then, takes us directly to the study of this clinical paradigm and its evolution in psychoanalytic praxis.