

AN UPDATED PSYCHOANALYTIC PERSPECTIVE
ON THE DOCTOR-PATIENT RELATIONSHIP

Richard Tuch, MD

"Our medical training hardly ever . . . emphasize[s] the significance of our subjective reactions to our patients and what we can learn from them. When I take notes during a diagnostic interview I not only write down what the patient tells me but also what I feel at certain moments, e.g., when I feel sad or sympathetic; or bored frustrated and angry"

---Wolff 1977, p. 385

A keen observer will surely note the field of psychoanalysis is indeed evolving. Evidence abounds: the burgeoning field of mentalization, which provides clues about the psychological tools people need to understand one another; intersubjectivity, in all its varied versions, which contributes a two-person psychological perspective from which to view clinical events; an emphasis on the utility of considering the analyst's countertransference reactions and enactments as commentary about the patient's intrapsychic dynamics; the "analytic third" as a model for understanding the creation of something "other" than either analyst or analysand; etc. Clearly psychoanalysis is on the move, leading me—as Rangell (2008) urged—"to present the case for the continued role of psychoanalytic theory with a bang, not with a whimper" (p. 218).

Applying all that's new in psychoanalysis to the larger field of medicine is the subject of this paper. One of the most significant changes to have taken place in psychoanalysis over the last quarter century is a shift from a more exclusive focus on the inner workings of the patient's mind (the "one-person perspective") to greater consideration of doctor-patient interactions as an added field of observation (the "two-person perspective"--Greenberg and Mitchell 1983, Ghent 1989, Gill 1994, Spezzano 1996, Litowitz, 2007; alternately referred to as "intersubjectivity"--Aron 1991, Atwood & Stolorow 1994, Westin 2002, Benjamin 2005). Increasingly

psychoanalysts study the ways in which they and their patients end up relating to one another. This heightened focus on the *interacting dyad*, with special attention paid to the analyst's contribution (Jacobs 1986, 1991, 1993, Aron 1991, Hoffman 1991, Renik 1993, Wilson 2013), has propelled the on-going development of an implicit *psychoanalytic theory of interaction* that can be explicated (Sandler 1991, Bebee et al 2003, Ablon & Jones 2005; Baranger & Baranger 2008; Bohleber et al., 2013) though it has yet to be officially designated as such. This theory addresses the subliminal ways doctor and patient act upon one another--to varying degrees, often outside either's awareness--triggering subjective reactions in each that help shape the particular configuration their relationship ultimately assumes (Aron 1996). Applying what psychoanalysts have come to learn about their interactions with patients to the topic of the doctor-patient relationship in general can help assist clinicians who've found themselves embroiled in malfunctioning relationship with a particular patient.

Earlier psychoanalytic contributions to the field of medicine

This paper strives to offer psychoanalytically-informed guidance to the medical profession. It follows in the footsteps of previous generations of psychoanalysts who strived to apply psychoanalytic principles to the treatment of psychosomatic patients. Early psychoanalytic thinking about medical ailments consisted chiefly in the identification of metapsychological constructs thought to account for the psychogenesis of psychosomatic disorders. Alexander et al.'s (1968) "specificity theory" identified seven particular medical conditions deemed to have developed as a result of specific intrapsychic conflicts: for example, a patient with peptic ulcers was thought to be struggling with conflict over powerful dependent strivings (Alexander 1934, 1936) while one suffering from essential hypertension "fears his own aggressive assertiveness, which he inhibits or represses, often for fear of retaliation" (Weiner 1982, p. 29). In the final

analysis, specificity theory did not stand the test of time and has now fallen into disrepute (Lipowski, Lipsitt & Whybrow 1977; Whitaker and Warnes 1977; Deutsch 1980). After reviewing four major volumes on the subject of psychosomatic medicine published in the late 1970s, Deutsch (1980) observed that a failure to scientifically substantiate specificity theory had resulted in "a questioning, which borders on renunciation, of the applicability of psychoanalysis as an explanation of, or therapy for, all physical and mental disease. . . [which left many] disenchanted with psychoanalysis" (p. 658)--a clear setback for the field. Two decades later, Rangell (2000) reviewed email correspondences sent between members of the American Psychoanalytic Association in the late 1990s and concluded: "the once-flourishing field of psychosomatic medicine seems to have vanished" (p. 175).

Beyond Alexander's specificity theory, the other major psychoanalytic contribution made in the last half century to the understanding and treatment of psychosomatic conditions involved the introduction of a condition known as *alexithymia* (Sifneos 1967), a Greek term meaning "no words for feelings," which was found to be *associated* with, and theorized by some to be the *cause* of psychosomatic symptoms¹. Patients exhibiting alexithymia are thought to be suffering from specific ego defects: their speech exhibits a paucity of affect-laden words (Rad and Lolas 1977), their fantasy life is nearly nonexistent (Vogt et al. 1977), their capacity to symbolize is markedly deficient (Taylor et al. 2003), and their thinking tends to be concretely focused on minutia rather than attending to meaningful, emotionally relevant issues (Marty and de M'Uzan 1963). Rather than processing their emotions through the typical channels employed by others, alexithymic patients tend to somaticize--to convert their feelings into somatic sensations rather than processing them with the help of symbolizing fantasy.

¹ The link between alexithymia and somatic symptoms is irrefutable, the causal relationship speculative.

One major problem with both specificity theory and the concept of alexithymia is that neither offers much in the way of useful guidance to physicians medically caring for such patients. Had psychoanalysts provided helpful hints about how physicians might go about treating such conditions that would have gone a ways towards establishing the applicability and utility of psychoanalytic thinking to general medicine, which--in turn--might have brought the fields of psychoanalysis and medicine into a more meaningful and sustained dialogue. If a psychoanalytic perspective is to benefit general medicine going forward it will need to focus less on the unconscious intrapsychic dynamics of particular medical conditions, about which most physicians care little, and more on topics physicians might find more applicable to their own practices. Such is the aim of this paper—to apply what psychoanalysts have learned over the last quarter century about the dynamics of one-on-one treatment relationships to relationships forged between patients and their physicians.

The Psychoanalytic Theory of Interaction

The currently-evolving psychoanalytic theory of interaction alerts us to the value of attending to the ways in which, and the extent to which doctor and patient reciprocally influence and shape the behavior of the other typically in a circular, back-and-forth, chicken-or-the-egg fashion that makes it nearly impossible to make out whose behavior set the wheels in motion in the first place (Aron 1996). In particular, this clinically-based theory of interaction directs us to attend to the clinicians' subjective reactions to their patients' behaviors, patients' subjective reactions to the clinician's behavior, and the ways in which the *explicit expression* of these subjective reactions contributes to the development of the doctor–patient relationship. These topics outline what psychoanalysis has to say about doctor–patient dynamics from a two-person psychological perspective that, when added to a one-person perspective that emphasizes

transference, rounds out what psychoanalysts have to contribute to the understanding of the doctor–patient relationship.

Transference readiness, in the strictest sense, is defined as the tendency to see the analyst as resembling one's own parent(s) (as one had experienced them during childhood)² and to interact with him/her in accordance with such transference beliefs. Because the medical practitioner undeniably functions as an authority figure, transference inevitably contaminates every doctor–patient relationship for better and for worse. It benefits the treatment relationship when positive parental qualities (e.g., genuine care and concern, possessed knowledge, benevolence) are attributed to the treating clinician, which—in turn—are associated with more ideal types of patient behaviors (trust, respect, gratitude and compliance)³. By contrast, negative transference can manifest, to cite one of many possibilities, in the patient's efforts to defeat the clinician by thwarting his/her wish to heal. To this standard explication of transference we now add the following proposition in line with the psychoanalytic theory of interaction: *How such transference reactions impact the treating clinician--whether his or her emotional response to them proves containable or, instead, are so strong as to move him or her to act--can greatly shape the doctor–patient relationship.*

Returning to the two-person perspective, the patient and his/her treating physician can significantly influence one another to degrees often not recognized or acknowledged by either. Beginning with the patient's influence on the private thoughts, feelings and—most importantly—actions of their physicians, times when the medical practitioner *finds himself/herself* unwittingly

² There are many different sorts of transferences: transference can involve perceiving the analyst as a wished-for parent capable of satisfying one's unfulfilled childhood wishes (including self-object needs); transference can also involve the patients assuming the role of the aggressor (identified with the parent of one's childhood) and unconsciously assigning to the analyst the role the patient had played vis-à-vis his parents during childhood; etc.

³ Naturally, physicians are apt to have transference reactions to their patients, but these are not as likely to be as prevalent or as intense.

reacting to a given patient's "way of relating" can prove most unsettling for practitioners to the extent such behavior may be interpreted by them as representing a breach of their vow to never let a patient "get to the best of them"—to never lose control over the expression of their reactions by becoming drawn into interacting with their patients in ways they'd not consciously intended. Such "enactments" (Jacobs 1986, Renik 1993, Steiner 2007, Ivey 2008, Cassorla 2012) involve instances when clinicians "act out" their feelings before realizing the extent to which a patient had "gotten" to them in whatever way and to whatever extent he or she had. A parallel concept—Sandler's (1976) clinical work on "role responsiveness"—defines analysts' (and, by extension, the medical practitioners') readiness to unconsciously respond to a role unconsciously assigned them by a patient—one that corresponds to how the patient wishes the clinician to act. The potential shame medical practitioners may feel upon realizing they'd become drawn into such an embroilment—seemingly against their will, and assuredly beyond their control—may compound the problem to the extent it makes it that much harder for them to face the fact the patient had ostensibly gotten under their skin, which the medical practitioner may interpret as a breach of his/her responsibility and commitment to act professionally no matter what. Helping medical practitioners accept the inevitability and universality of such developments should go a ways toward helping them sidestep harsh, painful self-recrimination for having succumbed to the patient's attempts to maneuver them in this fashion. This is one aim of any program designed to apply the psychoanalytic theory of interaction to the education of medical students and practicing physicians.

The subtle psychic mechanisms by which individuals subliminally affect one another is a topic of great interest to psychoanalysts beginning with Freud (1912) who claimed the contents of a patient's unconscious can communicate directly with the psychoanalyst's unconscious

bypassing consciousness altogether. While such a claim may strike the scientifically-minded physician as both dubious and mysterious, every practicing psychoanalyst can cite clinical examples to illustrate and back the claim. The sort of unconscious-to-unconscious communication typically thought to account for an analyst's being either drawn into an enactment or induced to adopt an assigned role is that of projective identification (Segal 1973, Ogden 1979, Sandler 1987, Grotstein 1994, 2005), a process whereby a patient's disavowed thoughts and feelings are seemingly transferred to the analyst who then experiences them as his or her own. In the process the patient "rids" himself/herself of psychic content he or she feels the need to "disavow," assigning them to the analyst for "safe keeping" in the hopes the analyst will find a way to psychically process ("metabolize") these thoughts and feelings so they can safely be returned to the patient at a later date in a modified form that makes their reintroduction feasible. Of all the processes outlined in this paper, projective identification is the hardest to grasp and the most challenging to convey to others, some of whom may regard such a process as frankly unbelievable. Regardless, need remains to account for the observed phenomenon of a patient's subliminally influence on his or her physician's thoughts, feelings and actions. Hypothesizing how such feats are unconsciously accomplished is necessary so that one can appreciate just how hard--if not at times, impossible--it can be to break free from its powerful grasp. Understanding as much is necessary to then arrive at a realistic appreciation of just how vulnerable all physicians are to lapsing, from time to time, into reacting unthinkingly in response to patients' ways of being.

The clinician's subjectivity

Just as patients can impact the subjective reactions and actions of their analysts/doctors, the subjective reactions of these clinicians to their patients has become a topic of particular

interest for psychoanalysts (Hoffman 1983, Aron 1991, Kite 2008, Slavin 2010). The varied ways in which the doctor–patient relationship can be influenced by the physician’s personal needs and proclivities has been outlined in a psychoanalytically-informed paper that appeared in the *Journal of Prosthetic Dentistry* (Gamer et al. 2003) which proposes modifications be made to the “House Classification System”—a well-known and widely-accepted system for categorizing edentulous patients (House 1950) based on how they behave as patients and how well they adapt to the use of dentures. Gamer et al. (2003) suggest it would greatly improve the original House classification system, which is solely based on patient behavior, if consideration is equally given to the dentist's behavior, focusing specifically on three of his or her personal needs that exist along a continuum: "The wish to be liked and admired can become a need to be idealized, the wish to be heard and respected as an authority can become a need to have one's words taken as gospel [and to be obeyed], and the wish to feel in control can become a need to dominate" (p. 298). The more extreme the need, the more vulnerable the physician is to having that need frustrated by a particular patient, which—in turn—heightens the chance the physician will be susceptible to being provoked to feel intense feelings that test his capacity to contain (to resist the urge to express outwardly). This paper employs the psychoanalytic theory of interaction, resulting in an illustration of the limits of "typing" either patient or clinician without giving due consideration to the *clinical context* in which each shapes the actions and reactions of the other.

If one charts a patient’s style of relating to the clinician (dentist/analyst/medical practitioner) against the three clinician's needs listed above, a grid is generated that is composed of cells defined by the intersection of patient behavior vs. clinician's need/proclivity. These cells contain guesses about how a given intersection might result in a particular type of doctor–patient relationship as a function of how well the two party’s needs and behaviors mesh or fail to mesh.

For example, a clinician who needs to dominate and have his/her opinion accepted without question might respond poorly to a patient who wishes to be a partner in the treatment process and makes reasonable requests to be fully informed about the doctor's recommendations. Moving in a more extreme direction, if a patient is the sort who wishes to call the shots we'd expect friction to develop if the treating clinician is the type who is pushed to the brink when his/her authority is challenged. Such doctor–patient relationships can eventuate in rancor and may go so far as to trigger litigation. A different type of outcome develops when the particular need being considered is the clinician's need to be liked, which can culminate in his/her inclination to grant a patient's wish, against the physician's better judgment, in order to stay in the patient's good graces. Such a circumstance can regrettably result in a physician's willingness, for example, to overly prescribe scheduled substances. Naturally, there are many such permutations revealed by the intersecting cells.

There is an important point that needs to be made at this juncture. Faulting a clinician for possessing a particular set of needs/proclivities (e.g., needs to dominate) is both unproductive and nonsensical given the fact this is, after all, *who the clinician is*—it's his “way of being,” which constitutes an irreducible factor that helps shape the doctor–patient relationship. Every treating clinician must learn to make the most of his/her particular way of being by realizing which types of patients he or she would be better off treating and which might prove to be the clinician's Waterloo--a critical realization a physician overlooks at his own peril! A consideration of the wide array of needs that clinicians bring with them to the office generates an equally wide array of potential difficulties that can arise in the process of treating every sort of patient—control battles, narcissistic injuries on either party's part, struggles around the theme of

authoritarianism, mutual respect—or the lack thereof, fear of being disliked for denying the other's wish, etc.

Beyond the need to be respected and have one's recommendations obeyed and the need to be liked is a third clinician need that requires special attention: the narcissistic gratification that comes from providing good patient care and having it recognized as such by the patient. Such a need would be deemed reasonable so long as it: 1) doesn't demand the declaration of accolades from the patient, 2) doesn't eventuate in peevishness or retaliatory behavior when the patient is not forthcoming with praise or is critical of the clinician's performance, and 3) doesn't leave the clinician vulnerable to a precipitous drop in his/her professional self-esteem when humbled by the revelation of his/her limits--a failure to live up to self-imposed expectations of excellence. If a clinician's need for narcissistic gratification is overly intense it may render him/her particularly susceptible to reacting strongly whenever that need is frustrated. A patient's denigrating remarks, for example, may challenge the clinician's emotional equanimity, particularly when such remarks strike too close to home or are offered by a patient whose positive opinion greatly matters to the clinician--for example, when the patient has stature. Attempting to treat an unrelenting medical condition may also strike some clinicians as a professional failure, while others prove able to take such situations in stride. There's a litany of other ways in which a patient may successfully get under the clinician's skin and it's these collective problems we wish to consider.

Clinical Vignette

Consider the following example. A woman in her mid-fifties, who we'll call Ms. B., presents with extreme foot pain to a well-respected expert in his field. The physician, Dr. F., diagnoses and treats the condition, but the condition persists far beyond the time he believed it

would. Ms. B. grows concerned, but the physician assures her about the accuracy of his diagnosis, adding--with an air of certainty and a straight face: "If my partner and I haven't seen it, *no one* in this city has seen it!" Months pass and Ms. B. goes from doctor to doctor in search of relief, but to no avail. Finally a radiologist at a University teaching hospital sees her films and suggests a completely different diagnosis. He provides the woman with published literature about the condition he believes her to be suffering with and refers her to a physician, Dr. A., who specializes in this area of medicine. Dr. A. was initially skeptical about the diagnosis given its rarity--and the fact she'd never personally seen a patient with the described condition--but after examining the patient's studies and reviewing the published article Ms. B. had brought along with her, Dr. A. concludes Ms. B. may well be suffering from that very condition. Ms. B. is encouraged and plans to begin the treatment Dr. A. has outlined.

Ms. B. returns to Dr. F.'s office to procure his signature on forms he'd initiated on her behalf early in the course of her illness. She drops off the forms along with a copy of the published article believing he might find it of interest. She asks his assistant to be sure to let Dr. F. know she's relieved and encouraged by this turn of events. Within minutes of leaving his office, before enough time had passed for Dr. F. to have read the article, Ms. B. receives a call on her cell phone from Dr. F. who expresses serious doubt about the new diagnosis, discourages her from placing stock in this as the answer, and warns her against using the recommended medication--Fosamax--calling it "dangerous." The woman's faith in this new approach and her hope for recovery is shaken. The depression she'd experienced when she thought her condition might be life-long returns. She's left reeling, not knowing who or what to believe. She's flabbergasted, irritated and confused about why Dr. F. would offer such unsolicited advice, which ostensibly pulled the rug out from under her nascent ray of hope, but she doesn't dare

share her feelings with Dr. F. believing that doing so would only result in his becoming defensive.

Against Dr. F.'s advice, working past the seeds of doubt he'd planted, Ms. B. decides to follow Dr. A.'s treatment plan and within weeks is on the mend after months of unremitting pain. Since then her symptoms have by and large abated. This clinical vignette is offered to illustrate the extent to which a physician's narcissistic need to protect himself from realizing the limits of his knowledge knew no bounds, leading him to conduct himself in a most emotionally injurious fashion--one that seriously affected the psychological well-being of a patient who'd been under his care--with him seemingly none the wiser!

Acknowledging and Utilizing the clinician's participation

One major obstacle to studying the interactive dynamics of the doctor-patient relationship from the perspective outlined herein is the fact it requires the physician take stock of the personal needs he/she brings with him/her to the examining room and realize how such needs may end up contributing to the nature of his/her developing relationship with the patient. Had Dr. F. known the extent to which he could feel shamed when he came face-to-face with the limits of his professional knowledge he might well have responded differently. But herein lies the rub. Some physicians consider it unprofessional for their personal needs or emotional reactions to enter in to, and impinge upon the treatment relationship, believing such a development constitutes an inexcusable breach of their duty to always act "professionally." For this reason, some physicians may feel disinclined to acknowledge psychological vulnerabilities that might cause trouble when treating patients capable of triggering intense reactions either intentionally or inadvertently. Believing a physician must always remain, and can always remain in complete

emotional control conflates lofty aspirations with down-to-earth, realistically achievable objectives. Just because segments of the general population expect such perfectionism from their doctors doesn't mean the medical community should follow suit. Conducting an honest assessment of one's own vulnerabilities stands a physician in good stead insofar as it makes it that much easier for him/her to recognize instances when, and know the reasons why he or she is reacting to a given patient in the way they are, which--in turn--makes it that much easier to keep such feelings in check.

Though psychoanalysts strive to be consciously aware of, and contain whatever becomes aroused in them in the process of relating to patients, they collectively came to the realization such a goal isn't always achievable (Kohut & Wolf 1978, Renik 1993, Benjamin 2009). Analysts have faced the fact such enactments will inevitably, intermittently interfere with their ability to live up to their professional obligation to remain sufficiently aware of their countertransference reactions so as to be able to contain them rather than act them out. Rather than harshly criticize themselves for having failed, psychoanalysts went to work fashioning ways to make the most of such errors, culminating in an outline of technical recommendations about how analysts might make the most of such developments (for a particular useful example, see Renik 1996). No physician or psychoanalyst is so psychologically evolved as to be able to unceasingly contain their emotional reactions to patients. Believing in the existence of such a mythic physician who is capable of staying the course without missing a beat even when caught up in an emotional storm that threatens his equanimity is problematic insofar as it leads physicians to expect more of themselves than is humanly possible.

The psychoanalyst's task and that of the medical practitioner differ markedly insofar as the former considers such emerging interactional difficulties par for the course, treats them as

“grist for the mill,” and expects to make therapeutic headway by addressing and working through such difficulties, whereas the later considers such developments an annoyance that “gums up the works” and impedes the task of diagnosing and treating the patient’s medical condition. In this regard, the two fields couldn't be less alike. Unraveling such enactments can be a painstaking venture--one for which psychoanalysis is singularly well suited. The medical practitioner will likely find such an exercise far too time consuming and might only think to employ such methods when he's become dangerously embroiled in conflict with a particular patient to a degree that threatens to disrupt patient care or eventuate in a law suit—in which case such an exercise might seem worth the bother. Any program aimed at helping physicians work through such difficulties will need to take stock of these differences.

Going into its second century, psychoanalysts are now better equipped to weigh in on the dynamics of the doctor–patient relationship given their evolving understanding of the nuances of one-on-one relationships based on the psychoanalytic theory of interaction. The time seems ripe for psychoanalysis to re-enter the medical field armed with this new perspective. Any program designed to introduce clinicians and clinicians-in-training to the subject matter presented in this paper would need to address the particulars covered herein. There are many creative ways this could be done but space does not permit a more specific proposal. Whatever form that would take would need to be clinically-derived, clinically-relevant and, hence, experiential, rather than being strictly theoretic and didactic.

Educationally operationalizing the principles outlined by the psychoanalytic theory of interaction could be accomplished in a number of different ways. Whichever methods and venues are selected, instruction must touch on the following points that, in turn, should result in the clinician’s enhanced ability to: 1) conduct an honest inventory of his/her personal needs and

proclivities that render him/her vulnerable to reacting strongly when triggered either by unintended circumstances or when treating patients who thwart those needs or trigger those proclivities, 2) accept the fact these needs and proclivities may go on to significantly influence the nature of the doctor–patient relationship, 3) recognize instances when this is, in fact happening and, 4) be reconciled to the inevitability of such developments so as to be able to forgive oneself whenever one's efforts to unceasingly contain one's emotional reactions intermittently falters. We look forward to the development of programs designed to help physicians think realistically about the unavoidable pitfalls of what remains a unique type of human relationship.

Armed with new sorts of theories and empirical data, psychoanalysts are now better positioned to re-engage with general medicine in ways that could prove most productive for all concerned. Psychoanalysis has a second chance to prove its worth by illuminating the obscure and implicit crevices of the doctor–patient relationship and providing clinically-relevant contributions to its study, which should go a ways towards improving patient care. Such are the potential benefits of the theories, perspectives and proposals that have been presented in this paper.

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