The Patient as Interpreter of the Analyst’s Experience

This chapter presents a point of view on the psychoanalytic situation and on psychoanalytic technique, in part through a selective review of the literature. An important underlying assumption in this essay is that existing theoretical models inevitably influence and reflect practice. This is often true even of models that practitioners claim they do not take seriously or literally. Such models may continue to affect practice adversely as long as their features are not fully appreciated and as long as alternative models are not recognized or integrated. An example of such a lingering model is the one in which the analytic therapist is said to function like a blank screen in the psychoanalytic situation.

THE RESILIENCE OF THE BLANK-SCREEN CONCEPT

The psychoanalytic literature is replete with attacks on the blank-screen concept, the idea that the analyst is not accurately perceived by the patient as a real person, but that he or she serves rather as a mirror to whom various attitudes, feelings, and motives can be attributed, depending upon the patient’s particular neurosis and its transference expression. Critiques of this idea have come from within the ranks of classical Freudian analysts, as well as from...
Kleinians and Sullivanians. Even if one looks only at the classical literature, in one way or another the blank-screen concept seems to have been pronounced dead and laid to rest many times over the years. In 1950, Ida Macalpine, addressing only the implications for the patient's experience of classical psychoanalytic technique as she conceived of it (that is, not considering the analyst's personal contributions), said the following:

It can no longer be maintained that the analysand's reactions in analysis occur spontaneously. His behavior is a response to the rigid infantile setting to which he is exposed. This poses many problems for further investigation. One of them is how does it react upon the patient? He must know it, consciously or unconsciously [p. 326; italics added].

Theresa Benedek said in 1953:

As the history of psychoanalysis shows, the discussion of countertransference usually ended in a retreat to defensive positions. The argument to this end used to be [italics added] that the classical attitude affords the best guarantee that the personality of the therapist (italics in original) would not enter the action-field of the therapeutic process. By that one assumes that as long as the analyst does not reveal himself as a person, does not answer questions regarding his own personality, he remains unknown as if without individuality, that the transference process may unfold and be motivated only by the patient's resistances. The patient—although he is a sensitive, neurotic individual—is not supposed to sense and discern the therapist as a person [p. 202].

In 1956, Lucia Tower wrote:

I have for a very long time speculated that in many—perhaps every—intensive analytic treatment there develops something in the nature of countertransference structures (perhaps even a "neurosis") which are essential and inevitable counterparts of the transference neurosis [p. 232].

In the 1960s, Loewald (1960), Stone (1961), and Greenson (1968) added their voices to the already large chorus of protest against this remarkably resilient concept. From varying theoretical perspectives, the critiques continued into the 1970s and 1980s as represented, for example, in the writings of Gill (1979, 1982a,b, 1983; Gill and Hoffman, 1982a,b), Sandler (1976, 1981), and Kohut (1977)—among many others. In fact, the blank-screen idea has probably not been articulated as often or even as well by its proponents as it has been by its opponents, a situation which leads inevitably to the suspicion that the proponents have been straw men and that shooting them down became, at some point, a kind of popular psychoanalytic sport.

I am persuaded, however, that the issue is a very important one and that it deserves repeated examination and discussion. The blank-screen view in psychoanalysis is only one instance of a much broader phenomenon that might be termed asocial conceptions of the patient's experience in psychotherapy. According to these conceptions, there is a stream of experience going on in the patient that is divorced to a significant extent from the immediate impact of the therapist's personal presence. I say "personal presence" because, generally, certain theoretically prescribed facilitating aspects of the therapist's conduct are recognized fully as affecting the course of the patient's experience. But the paradigm is one in which proper or ideal conduct on the part of the therapist allows for a flow of experience that has an organic-like momentum of its own and that is free to follow a certain "natural" course. An intriguing example of this usual paradigm outside of psychoanalysis can be found in client-centered therapy. Ideally, the classical client-centered therapist is so totally and literally self-effacing that his or her personality as such is effectively removed from the patient's purview. Carl Rogers (1951) stated:

It is surprising how frequently the client uses the word "impersonal" in describing the therapeutic relationship after the conclusion of therapy. This is obviously not intended to mean that the relationship was cold or disinterested. It appears to be the client's attempt to describe the unique experience in which the person of the counselor—the counselor as an evaluating, reacting person with needs of his own—is
so clearly absent. In this sense it is "im"-personal... the whole relationship is composed of the self of the client, the counselor being de-personalized for the purposes of therapy into being "the client's other self" (p. 208).

In psychoanalysis, the blank-screen idea persists in more or less qualified and more or less openly acknowledged forms. The counterpart of the notion that the analyst functions like a screen is the definition of transference as a distortion of current reality. As Szasz (1963) points out, this definition can serve a very important defensive function for the analyst, a function that may partly account for the persistence of the concept. I believe that another factor that has kept it alive has been the confusion of two issues. One has to do with the optimal level of spontaneity and personal involvement that the analyst should express in the analytic situation. The other has to do with the kind of credibility that is attributed to the patient's ideas about the analyst's experience. A theorist may repudiate the notion that the analyst should behave in an aloof, impersonal manner without addressing the question of the tenability of the patient's transference-based speculations about the analyst's experience. To anticipate what follows, such speculations may touch upon aspects of the analyst's response to the patient that are thought to be well concealed or of which the analyst is unaware. In general, recommendations pertaining to the analyst's personal conduct in the analytic situation may very well leave intact the basic model according to which the transference is understood and interpreted.

STANDARD QUALIFICATIONS OF THE BLANK-SCREEN CONCEPT

The notion that ideally the analyst functions like a screen is always qualified in the sense that it applies only to a part of the patient's total experience of the interaction, the part that is conventionally regarded as neurotic transference. This is the aspect of the patient's experience which, allegedly, distorts reality because of the persisting influence of childhood events, wishes, conflicts, and adaptations. There are two kinds of experience that even the staunchest propo-

4. For discussions of the implications of Freud's position on this matter see Lipton (1977a) and Gill (1982a, pp. 9–15). One of the advantages of the notion of the unobjectionable positive transference is that it acknowledges a possible irrational component in the therapeutic action of the process. For Freud, this aspect of transference involves elements of dependency and idealization with origins in early childhood. It is "unobjectionable" not because it is realistic, but because, hopefully, the analyst will employ it to a good end (see Friedman, 1969, for discussion of this paradox). The 1983 article that is essentially republished here is focused on correcting the view of the analyst as a blank screen. Consequently, this chapter fails to give sufficient weight to the importance of the analyst's relative subordination of his or her own personal interest and desire. In certain respects the analyst should be less visible than the patient. That asymmetry promotes both rational and irrational aspects of the analyst's therapeutic authority. In general, the notion of a dialectic between the patient's sense of the analyst as a person like himself or herself and the patient's sense of the analyst as a person with superior, even magical power is not recognized, much less developed, in this chapter (the original version of which was written ten years before the original version of chapter 3 on the analyst's "ironic authority"). What is developed here is precisely one side of that polarity, namely the place of the patient's perception of the symmetrical aspects of the analyst's participation, rather than the asymmetrical aspects. Nevertheless, certain dialectical relationships are in the foreground here, such as those between transference and countertransference, between the patient as interpreter and the analyst as interpreter, and between interpretation and "association" in both parties.

3. Dewald's (1972) depiction of his conduct of an analysis exemplifies, as Lipton (1982) has shown, a relatively pure, if implicit, blank-screen position.
1. Transference should be carefully differentiated from the therapeutic alliance, a conscious aspect of the relationship between analyst and patient. In this, each implicitly agrees and understands their working together to help the analysand to mature through insight, progressive understanding, and control.

2. One of the important reasons for the relative anonymity of the analyst during the treatment process is the fact that a lack of information about his real attributes in personal life facilitates a transfer of the patient's revived early images on to his person. It also lessens the distortion of fantasies from the past by present perceptions. It must be recognized that there are situations or circumstances where the actual behavior or attitudes of the analyst cause reactions in the patient; these are not considered part of the transference reaction (See countertransference) [p. 93].

TWO TYPES OF PARADIGMS AND CRITIQUES

In my view, critiques of the screen concept can be classified into two major categories: conservative and radical. Conservative critiques, in effect, always take the following form: they argue that one or both of the standard qualifications of the blank-screen view noted above have been underemphasized or insufficiently elaborated in terms of their role in the analytic process. I call these critiques conservative because they retain the notion that a crucial aspect of the patient's experience of the analytic therapist has little or no relation to the therapist's actual behavior or actual attitudes. The conservative critic reserves the term transference for this aspect of the patient's experience. At the same time, this critic objects to a failure to recognize sufficiently the importance of another aspect of the patient's experience, which is influenced by the "real" characteristics of the therapist, whether these real characteristics promote or interfere with an ideal analytic process. The dichotomy between realistic and unrealistc perception may be considered less sharp, but it is nevertheless retained. Although the realistic aspects of the patient's experience are now given more careful consideration and weight, in relation to transference proper the therapist is no less a blank screen than before. By not altering the standard paradigm for defining what is or is not realistic in the analytic situation, conservative critiques of the blank-screen fallacy always end up perpetuating that very fallacy.

In contrast to conservative critiques, radical critiques reject the dichotomy between transference as distortion and nontransference as reality based. They argue instead that the transference itself generally has a significant plausible basis in the here and now. Radical critics of the blank-screen model deny that there is any aspect of the patient's experience that pertains to the analyst's inner motives that can be unequivocally designated as distorting of reality. Similarly, they deny that there is any aspect of that experience that can be unequivocally designated as faithful to reality. From the point of view of these critics it is best for the analyst to have as a working assumption that the perspective that the patient brings to bear in interpreting the therapist's inner attitudes is one among many perspectives that are relevant, each of which may highlight a facet of the analyst's involvement. This amounts to a different paradigm, not simply an elaboration of the standard paradigm, which is what the conservative critics propose.

In rejecting the proposition that transference-dominated experience and nontransference-dominated experience can be differentiated on the grounds that the former is represented by fantasy that is divorced from reality whereas the latter is reality based, the radical critics do not imply that the two types of experience cannot be

5. If there have been significant changes in mainstream psychoanalytic thought since 1968 when the Glossary edited by Moore and Fine was originally published, they are not reflected in the definition of transference that appears in the third edition (1990). Although the editors tell us in the Preface that it is "greatly revised" and that many definitions have been "updated" (with the assistance of 195 listed contributors), with regard to the transference we are told that "the relative anonymity of the analyst facilitates the transfer of revived early images onto his or her person. In the absence of information about the analyst's attributes and personal life, the patient generates fantasies relatively uncontaminated by perception of the present." And further: "Not all the patient's reactions to the analyst are transference. Some are based on the analyst's attributes or actual behavior" (p. 197). Clearly, the dichotomy of transference fantasy and the real relationship is as sharp here as it was 22 years earlier.

6. The word "generally" in this sentence replaces the word "always" that appeared in the original article. To say "always" is an overstatement and an understatement. Room has to be left for perceptions and inferences on the patient's part that are very improbable, virtually "off the wall," although as soon as one says that one must immediately become concerned about the analyst's ability to make that judgment. I would stand by the claim of the radical critics, as stated in the next sentence, regarding definitive conclusions about the analyst's inner motives.
distinguished. Indeed, having rejected the criterion of distorted versus realistic perception, they are obliged to offer other criteria according to which this distinction can be made. For such critics, the distinguishing features of the neurotic transference have to do with the fact that the patient is selectively attentive to certain facets of the analyst’s behavior and personality; that he or she is compelled to choose one set of interpretations rather than others; that his or her emotional life and adaptation are unconsciously governed by and governing of the particular viewpoint he or she has adopted; and, perhaps most importantly, that the patient has behaved in such a way as to actually elicit overt and covert responses that are consistent with his or her viewpoint and expectations. The transference represents a way, not only of constraining, but also of constructing or shaping, interpersonal relations in general and the relationship with the analyst in particular. One could retain the term “distortion” only if it is defined in terms of the sense of necessity that patients attach to what they make happen, and to what they see as happening, between themselves and their analysts.

The radical critiques are opposed not merely to the blank-screen idea, but to any model that suggests that the “objective” or “real” impact of the therapist is equivalent to what he or she intends or to what the analyst thinks his or her overt behavior has conveyed or betrayed. What the radical critic refuses to do is to consign the patient’s ideas about the analyst’s hidden motives and attitudes to the realm of unfounded fantasy whenever those ideas depart from the analyst’s judgment of his or her own intentions. In this respect, whether the analyst’s manifest conduct is cold, warm, or even self-disclosing is not the issue. What matters to the radical critic in determining whether a particular model is based on an asocial or truly social conception of the patient’s experience is whether the patient is considered capable of understanding, if only preconsciously, that there is more to the therapist’s experience than what meets the eye, even more than what meets the mind’s eye of the therapist at any given moment. More than challenging the blank-screen fallacy, the radical critic challenges what might be termed the naive patient fallacy, the notion that the patient, insofar as he or she is rational, takes the analyst’s behavior at face value, even while the patient’s own is continually scrutinized for the most subtle indications of unspoken or unconscious meanings.

Although we now have a broad range of literature that embraces some kind of interactive view of the psychoanalytic situation (Ehrenberg, 1982; Greenberg and Mitchell, 1984), emphasis upon interaction per se does not guarantee that any particular theoretical statement or position qualifies as one that views the transference in perspectivistic-social terms. Moreover, emphasis on interaction can obscure the fact that a particular theorist is holding fast, for the most part, to the traditional view of neurotic transference as a distortion of a given and ascertainable external reality.

CONSERVATIVE CRITIQUES: TRANSFERENCE IN THE ASOCIAL PARADIGM

Overview: Types of Conservative Critiques

Conservative critiques, as I said earlier, retain the dichotomy of transference and realistic perception, but argue that the standard qualifications of the screen function of the analyst require amplification. Some conservative critics, like Strachey (1934) and Loewald (1960), offer reconceptualizations of the real, benign interpersonal influence of the analyst in the process, without any recommendations for changes in prevailing practice. Others, like Stone (1961) and Kohut (1977), combine such reconceptualization with advocacy of less restraint and more friendly, spontaneous involvement than is customary. In this context, Freud is often cited as a practitioner who was extraordinarily free in his manner of relating to his patients and who was, in that sense, not “classical” (see Lipton, 1977a).

Strachey, Loewald, Stone, and Kohut have in common some kind of elaboration of the realistically benign and facilitating aspects of the therapist’s influence, although, to be sure, what is benign and facilitating in Stone and Kohut includes a certain optimal element of frustration or disappointment. The other major subdivision of conservative critiques are those that emphasize the importance and prevalence of objective perceptions of countertransference, which, it is argued, fall outside the province of transference. Langs (1978)

7. The term perspectivistic here replaces the term relativistic that appeared in the original version of this paper. The latter term has encouraged the misunderstanding that my position is one of “radical relativism” or even solipsism (see, for example, Orange, 1992; Zucker, 1993). To say that experience is ambiguous, and therefore open to a variety of interpretations, does not mean that it is amorphous and that anything goes. The term perspectivistic foreshadows the emergence of a critical “constructivist” view of the psychoanalytic situation.
mounts the most systematic and thorough critique of this kind. Perhaps the clearest example of all the conservative critics is Greenson (1971), whose "real relationship" includes the patient's experience of both the working alliance and of countertransference and unequivocally excludes the experience of the transference.

Hans Loewald and James Strachey

A good example of a primarily conservative critique of the blank-screen fallacy that advocates a greater emphasis on the benign, facilitating aspects of the analyst as a real person (or object) without any suggestions for changes in technique is that of Loewald (1960). I say primarily conservative because there are ambiguous hints in Loewald's position of a more radical critique that would not dichotomize transference and reality, although I believe the overall thrust of his position is undeniably conservative. Loewald represents the classical position to which he objects as follows (and I quote it at some length because this is one of the clearest statements of the position):

The theoretical bias is the view of the psychic apparatus as a closed system. Thus, the analyst is seen, as a co-actor on the analytic stage on which the childhood development, culminating in the infantile neurosis, is reenacted and reactivated in the development, crystallization and resolution of the transference neurosis, but as a reflecting mirror, albeit of the unconscious, and characterized by scrupulous neutrality.

This neutrality of the analyst appears to be required (i) in the interest of scientific objectivity, in order to keep the field of observation from being contaminated by the analyst's own emotional intrusions; and (ii) to guarantee a tabula rasa for the patient's transferences. The analyst is supposed to function not only as an observer of certain processes, but as a mirror which actively reflects back to the patient the latter's conscious and partially his unconscious processes through verbal communication. A specific aspect of this neutrality is that the analyst must avoid falling into the role of the environmental figure (or of his opposite) the relationship to whom the patient is transferring to the analyst [p. 17].

While not discarding this position entirely, Loewald is concerned about the fact that it leaves something out or lends itself to a lack of sufficient attention to the influence of the analyst as a real object:

[The analyst’s] objectivity cannot mean the avoidance of being available to the patient as an object. The objectivity of the analyst has reference to the patient's transference distortions. Increasingly, through the objective analysis of them, the analyst becomes not only potentially but actually available as a new object, by eliminating step by step impediments, represented by these transferences, to a new object-relationship. There is a tendency to consider the analyst's availability as an object merely as a device on his part to attract transferences onto himself. His availability is seen in terms of his being a screen or mirror onto which the patient projects his transferences, and which reflect them back to him in the form of interpretations...

This is only a half truth. The analyst in actuality does not only reflect the transference distortions. In his interpretations he implies aspects of undistorted reality which the patient begins to grasp step by step as transferences are interpreted. This undistorted reality is mediated to the patient by the analyst, mostly by the process of chiseling away the transference distortions [p. 18].

Here it is clear that Loewald is dichotomizing transference and nontransference experience along the lines of neurotic distortion, on the one hand, and a new appreciation of the real, presumably health-promoting aspects of the analyst, on the other. He goes on to elaborate on the therapeutic effects associated with the experience of collaboration with the real analyst in the process of self-discovery.

Loewald's position has a forerunner in Strachey (1934) in that Strachey too emphasized the new, real interpersonal influence of the analyst in the analytic situation. Loewald sees this new real influence in terms of the patient's identification with the analyst's higher level of ego functioning, particularly with the analyst's mature, rational perspective as it is brought to bear upon the patient's own neurotic tendencies. Strachey saw a new real influence more in terms of the patient's identification with the analyst's acceptance of the patient's hitherto repressed impulses, so that the modification that occurs involves a softening of the punitive tendencies of the patient's super-ego, rather than, as in Loewald, a strengthening of the reflective integrative capacities of the ego. But Strachey (1934) could not be more emphatic about the importance of keeping the "real" analyst separate from, and uncontaminated by, the analyst as transference object:

The analytic situation is all the time threatening to degenerate into a "real" situation. But that actually means the opposite of what it appears to. It means the patient is all the time on the brink of turning the real external object (the analyst) into the archaic one; that is to say, he is on the brink of projecting his primitive introjected images onto him. ... It is important, therefore, not to submit [the patient's sense of reality] to any unnecessary strain; and that is the fundamental reason why the analyst must avoid any real behavior that is likely
to confirm the patient's view of him as a "bad" or a "good" phantasy object [p. 146].

As we shall see, there could not be a starker contrast with the radical critics, according to whom a certain current of transference-countertransference "enactment" is not only likely, but also potentially useful, when combined with critical reflection and interpretation, in contributing to the therapeutic action of the process.

*Leo Stone and Heinz Kohut*

Whereas Strachey and Loewald explicitly disclaim any intent to influence technique, Stone (1961), who also is interested in the patient's perceptions of the real, human qualities of the therapist, is concerned about the excessively impersonal, cold, stiff manner in which he believes many analysts approach their patients, and takes an unequivocal stance in favor of a more natural, friendly, and spontaneous attitude. Stone takes issue with the implication that scrupulous neutrality and nonresponsiveness will allow for the emergence of pure transference ideas uncontaminated by any interpersonal influence. Instead, certain kinds of frustrations associated with mechanically strict adherence to the so-called rule of abstinence, Stone believes, will amount to very powerful stimuli, inducing reactions that, if anything, will be less readily understood in terms of their roots in the individual (see, for example, pp. 45-46).

Stone is clear in his rejection of the notion that transference fantasies will crop up spontaneously if the analyst manages to keep his or her personal, human qualities or reactions out of the patient's purview, in keeping with what Stone believes is the prevailing understanding of proper analytic conduct. But what is Stone's view of the relationship between transference and reality when the analytic situation is modified in accord with his recommendations? In this respect, he is more ambiguous. At times he seems to be saying that the transference will include, under those circumstances, realistic perceptions of the analyst and that this is not only not regrettable but actually desirable:

For all patients, to the degree that they are removed from the psychotic, have an important investment in their real and objective perceptions; and the interplay between these and the transference requires a certain minimal if variable resemblance, if the latter is to be effectively mobilized. When mobilized, it is in operational fact of experi-

ence, always an integrated phenomenon, in which actual perceptions, to varying degrees, must participate [p. 41].

However, in certain of his remarks, and despite many qualifications, Stone seems to adhere to the standard dichotomy of transference and reality. For this reason I believe I am justified in classifying him as a conservative critic of the screen function of the analyst. For example, consider this rather unequivocal stance:

I should like to state that clarity both in principle and in everyday communication, is best served by confining the unqualified term "transference" to that aspect or fraction of a relationship which is motivated by persistent unmodified wishes (or other attitudes) toward an actual important personage of the past, which tend to invest a current individual in a sort of misidentification with the unconscious image of the past personage [p. 66].

Stone is sympathetic to the views advanced by Tower, Racker, and others which point to the uselessness of countertransference in understanding transference and which connote what Stone (1961) terms a "diminution of the rigid status barrier between analyst and analysand" (p. 80). His preoccupation, however, is decidedly with the question: how should the analyst behave? It is very much less with the question: how should the patient's experience of the analyst be understood? Whatever the virtues of Stone's position, what is obscured by his emphasis on the therapist's behavior is the patient's capability to understand that the analyst's manifest verbal and nonverbal behavior can conceal or carry myriad latent, more or less conscious attitudes and motives. I think Stone's position exemplifies a particular variant of those conservative critiques of the screen concept that stress the importance of the benign, human attributes of the analyst. Instead of arguing that in addition to transference, weight should be given to the patient's experience of the analyst's real, benign qualities, this variant argues that the analyst's humanness draws out the transference, especially the positive transference. In a sense, instead of the analyst functioning as a blank screen in relation to the transference, he or she is seen as a kind of magnet for it, albeit a very human one (pp. 108-109). Again, while the idea may not be wrong, it is not the whole story, and the part of the story that it leaves out or obsures is what lies at the core of the radical critiques, namely that the therapist's outward behavior, however it is consciously intended, does not and cannot control the patient's perceptions and interpretations of the analyst's inner experience. As I said earlier,
what the radical critic challenges is the view of the patient as a _major observer of the analyst's behavior_, thus arguing against the expectation that, to the degree that the patient is rational, he or she will take the analyst's outward behavior or conscious intent at face value. It is the taking of the analyst's outward behavior or conscious intention as the basis for defining reality in the analytic situation that is truly the hallmark of the standard view of transference as distortion. And it is in this sense that Stone, with all his emphasis on what is appropriate outward behavior on the part of the analyst, leans toward the standard paradigm and can be categorized as a conservative critic of the notion that, ideally, the analyst should function like a screen.

I believe that Kohut's position on the screen function of the analyst, although it is, of course, embedded in a different theoretical context, can be classed with that of Stone as a special type of conservative critique. Kohut (1977) makes it clear that while it is particularly important in the case of disorders of the self, it is also important in the case of the classical neuroses that the analyst not behave in an excessively cold and unfriendly manner. He believes that “analytic neutrality...should be defined as the responsiveness to be expected, on an average, from persons who have devoted their life to helping others with the aid of insights obtained via the empathic immersion into their inner life” (p. 252). But Kohut, like Stone, conveys the impression that a friendly, naturally responsive attitude on the part of the analyst will promote the unfolding of the transference, whether classical or narcissistic, without specific reference to other aspects of the analyst's personality. For example, he writes:

The essential transference (or the sequence of the essential transferences) is defined by pre-analytically established internal factors in the analysand's personality structure, and the analyst's influence on the course of the analysis is therefore important only insofar as he—through interpretations made on the basis of correct or incorrect empathic closures—either promotes or impedes the patient's progress on his predetermined path [p. 217].

Especially in the case of the classical transference neuroses, Kohut is clear that the analyst does function as a screen for elaboration of transference ideas, although he or she also facilitates change through empathic responsiveness and interpretation. This model follows the line of conservative critics like Stone, because the encouragement that is given to the analyst to express his or her humanness does nothing to alter the notion that the analyst as a real person is not implicated in the unfolding of the neurotic transference proper.

In the case of transferences associated with the disorders of the self, which Kohut increasingly viewed as the underlying disturbance even in the classical neuroses, the analyst as a real person is implicated more directly, insofar as his or her empathy facilitates the self-object tie that the patient's development requires. More precisely, the sequence of empathy, minor failures in empathy, and rectification of such failures promotes the “transmuting internalizations” that can repair deficits in the development of the self. It would seem, however, that the whole complexity of the analyst's personal response to the patient is not something the patient would attend to in a way that is associated with any special psychological importance. To the extent that the patient is suffering from a disorder of the self, or a narcissistic disorder, he or she presumably does not experience the analyst as a separate person with needs, motives, defenses, and interests of his or her own. One might say that the patient, although concerned about breaches in empathy and reacting strongly to them, does not necessarily account for such failures by attributing particular countertransference difficulties to the analyst which then become incorporated into the transference. In fact, to the degree that the patient is suffering from a disorder of the self, and therefore is experiencing the analyst as a self-object, the patient is, by definition, a naive observer of the analyst as a separate, differentiated object. Thus, I believe there is reason to classify Kohut as a conservative critic of the screen function of the analyst, even taking into consideration his ideas about the narcissistic transferences.

Robert Langs

Whereas Loewald, Strachey, Stone, and Kohut are concerned with the fact that the screen concept lends itself to deemphasizing the "real," therapeutic, interpersonal influence of the analyst, others have been concerned more with its tendency to obscure the importance and prevalence of real neurotogenic influences that the therapist exerts via his or her countertransference. Here again, the critique

8. The self psychology literature by the early 1980s certainly included discussion of likely countertransference reactions to particular kinds of narcissistic transferences (e.g., Kohut, 1971; Wolf, 1979), but these discussions omit consideration of the patient's specific ideas about the nature of the countertransference. In the 1990s some self psychologists (e.g. Newman, 1992) have gone further in an attempt to integrate ideas advanced by Racker and, more generally, by object relations theory.
is conservative in form, insofar as it merely expands upon one of the standard qualifications of the blank-screen concept. A carefully elaborated critique of this kind is that of Robert Langs. No psychoanalytic theorist has written more extensively about the implications of the patient's ability to interpret the analyst's manifest behavior as betraying latent countertransference. In Langs's (1978) view, the patient is constantly monitoring the analyst's countertransference attitudes and the patient's associations can often be understood as "commentaries" on those attitudes (p. 509).

Despite his interactional emphasis, however, Langs must be classified as a conservative critic of the blank-screen fallacy because he is unequivocal about reserving the term transference for distorted perceptions of the therapist, whereas accurate perceptions fall outside the realm of the transference. Thus, he writes:

"Within the bipersonal field the patient's relationship with the analyst has both transference and nontransference components. The former are essentially distorted and based on pathological, intrapsychic unconscious fantasies, memories, and introjects, while the latter are essentially non-distorted and based on valid unconscious perceptions and introjections of the analyst, his conscious and unconscious psychic state and communications, and his mode of interacting" (p. 506).

For Langs, what is wrong with the classical position is that it overestimates the prevalence of relatively pure, uncontaminated transference. Because countertransference errors are relatively common in prevailing practice, and because the patient is preconsciously always on the lookout for them, what dominates most psychoanalytic transactions are unconscious attempts by the patient to adapt to this current reality and even to alter it by trying indirectly to "cure" the analyst of his or her interfering psychopathology. To be sure, even the patient's valid perceptions can be points of departure for "intrapsychic elaborations" that bear the stamp of the patient's psychopathology. Nevertheless, the main thrust of all of Langs's writings is that a certain environment can be established that will be relatively free of countertransference and in which the patient will therefore feel safe to engage in a very special kind of communication, one that can take place in this environment and nowhere else. This special kind of communication is, like dreams, a richly symbolic expression of deep unconscious wishes and fantasies that have little relation to the actual person of the analyst. These are the true transference wishes and fantasies. The patient is always on the verge of retreating from this kind of communication because it is experienced as potentially dangerous at a very primitive level to the patient or to the analyst, and betrayals of countertransference (whether seductive, or attacking, or whatever) invariably prevent, interrupt, or severely limit this unique kind of communication.

Langs's position is based upon the same absolute view of reality that is implicit in any position retaining the dichotomy between distorted and undistorted perception of interpersonal events. Langs believes, for example, that strict adherence to a prescribed set of rules constituting what he calls the "basic frame" will not be interpreted—at least not accurately—as any kind of expression of countertransference that could endanger the kind of communication he wants to foster. By the same token, violations of the frame will be perceived and responded to in this way by virtually all patients.9

Langs appears to believe that there is a certain universal language that always carries at least general unconscious meaning. He will not claim to know specifically what it means to a particular patient that the therapist allows him or her to use the phone, or changes the appointment time, or fails to charge for a cancelled appointment, or tape records a session. But he does claim to know that all patients are likely to see such behaviors correctly as reflecting some sort of deep, unresolved, pathological conflict in the analyst. Conversely, he believes it is possible for the analyst to behave in a way that will persuade the patient that no such issues are at work in the analyst to any significant degree, that is, to a degree which, objectively speaking, would warrant anxiety that the analyst's attitudes are dominated by neurotic countertransference. Thus, the analyst, with help perhaps from a supervisor or from his or her own analyst, can decide with some degree of confidence when the patient is reading the analyst's own unconscious motives correctly, which would represent a countertransference response, and when the patient is merely fantasizing and distorting because of the influence of the transference.

The conservatism of Langs's critique of the screen model in psychoanalysis is particularly ironic given the enthusiasm with which he..."
champions the more radical positions of other theorists such as Searles (1978–1979) and Racker (1968). Langs feels that these theorists (especially Searles) inspired many of his own ideas, and he conveys the impression that in some sense he is taking up where they left off; but because he actually retreats to the standard dichotomy of transference and nontransference experience on the basis of distorting and nondistorting perceptions of the reality of the analyst's attitudes, I believe he actually takes a step back from his own sources of inspiration rather than a step forward.

Ralph Greenson

Perhaps the theorist who best exemplifies a conservative critique of the blank-screen fallacy is Greenson (1965, 1971). Greenson's "real relationship" encompasses both the patient's accurate perceptions of the benign aspects of the analyst and his or her perceptions of the analyst's countertransference. Greenson's position is an emphatic objection to the tendency he sees to underestimate the inevitably important role of the real relationship in the analytic process. There is nothing in his view, however, that alters in the slightest the standard understanding of transference as distortion and the standard dichotomy of transference and undistorted perception of the analyst. Thus he writes (1971), "The two outstanding characteristics of a transference reaction are: (1) It is an undiscriminating, non-selective repetition of the past, and (2) It is inappropriate, it ignores or distorts reality" (p. 217). In contrast to the transference, "the meaning of 'real' in real relationship implies (1) the sense of being genuine and not synthetic or artificial and (2) it also means realistic and not inappropriate or fantastic" (p. 218).

The extent to which Greenson is wedded to this dichotomy is betrayed by the fact that he cannot find his way out of it even when it seems like he is trying to. Thus, for example, he says, "I must add that in all transference reactions there is some germ of reality, and in all real relationships there is some element of transference" (p. 218). Here he seems to be saying that transference itself is not completely lacking in some sort of realistic basis, although the word "germ" suggests a very common kind of lip-service to this idea: the element of reality is considered to be so slight as to be hardly worth mentioning, much less making an issue of in one's interpretive work. But even this concession is lost immediately in Greenson's very next sentence, which he has in italics and which is clearly intended as a restatement or paraphrase of the first: "All object relations consist of different admixtures and blendings of real and transference components" (p. 218). Now the idea that transference includes something real is superseded by the much blander, conventional notion that all relationships include something real as well as transference. In other words, the dichotomy of transference and realistic perception is retained.

RADICAL CRITIQUES: TRANSFERENCE IN THE SOCIAL OR INTERPERSONAL PARADIGM

Overview

Whereas conservative critics of the blank-screen concept are relatively abundant, radical critics are relatively scarce. I would number among the foremost of them Merton Gill (1979, 1982a, b; 1983; Gill and Hoffman, 1982a, b), a leading exponent of this perspective coming out of a classical Freudian orientation; Joseph Sandler (1976), another theorist with classical roots, who, however, conceptualizes the psychoanalytic situation in object-relations terms; Heinrich Racker (1968), who takes his cue from a landmark paper on countertransference by a fellow Kleinian, Paula Heimann (1950), but whose rich and detailed account of the inevitable reciprocity of transference and countertransference is unique in the literature; Lucia Tower, if only for her one remarkable paper on countertransference in 1956, the implications of which have never penetrated the mainstream of psychoanalytic thinking about the relationship between transference and reality; Levenson (1972, 1981), Feiner (1979, 1982), and Ehrenberg (1982), who are among the neo-Sullivanians whose work leans heavily in this direction; Harold Searles (1978–1979), a clear and powerful exponent of the radical perspective; and Paul Wachtel (1980), whose Piagetian conceptual framework for understanding transference I will be drawing on myself in what follows. 10

10. Since the original publication of this essay, the number of radical critics has grown. They include Altman, 1995; Aron, 1996; Bromberg, 1994; Davies and Frawley, 1994; Ghent, 1992; Hirsch, 1987, 1993; Mitchell, 1988, 1993; Pizer, 1992; Renik, 1993; Donnel Stern, 1997; and Tansey and Runkle, 1989. Hirsch's (1987) paper is of special interest in that the author takes the criteria proposed here for classifying theorists and extends them to Embaim, Klein, Winnicott, Sullivan, and Schwaber, showing the sense in
To digress for a moment, although I have counted Gill among the radical critics, within his work in the 1980s there is actually a movement from a somewhat inconsistent but generally conservative position to a more consistently radical one. Thus, in his 1982 monograph, Gill (1982a) criticizes those, like Anna Freud and Greenon, who define transference in terms of distortion of reality. His objection, however, is tied specifically to what he describes as “a lack of recognition that Freud’s inclusion of the conscious, unobjectionable positive transference in his concept of transference is not an unfortunate lapse but an integral aspect of the concept” (p. 12). Throughout his discussion of the distinction between the unobjectionable “facilitating” transferences and the “obstructing” transferences (pp. 9–15), it is only the former that is considered to have realistic features. There is nothing about realistic elements in the “obstructing” transferences, not to mention any question being raised about the dimension “realistic-unrealistic” itself. Overall, in the first six chapters of the monograph, Gill apparently had not yet extricated himself from the traditional asocial paradigm for understanding transference (that is, neurotic or obstructing transference) although he was struggling to do so. His transitional, but still essentially conservative stand is exemplified by the following:

Analysts have largely followed Freud in taking it for granted that the analyst’s behavior is such that the patient’s appropriate reaction to it will be cooperation in the joint work. But there are significant interactions between the patient and the analyst which are not transference but to which the patient’s appropriate response would not be cooperation. If the analyst has given the patient cause to be angry, for example, and the patient is angry, at least some aspect of the anger is neither transference nor cooperation—unless the idea of cooperation is confusingly stretched to mean that any forthright appropriate reaction of the patient is cooperative since it is a necessary element in continuing an open and honest relationship. We do conceptualize inappropriate behavior on the analyst’s part as countertransference, but what is our name for an analyst’s realistic response to countertransference? [p. 94; italics added].

There is a noticeable shift in the book, beginning with chapter 7, to a more fully social and perspectivist position (see, for example, p. 118). Moreover, in subsequent writing in this period, Gill continued to develop a view of transference within the social paradigm (1982b, 1983; Gill and Hoffman, 1982a,b; Hoffman and Gill, 1988a,b). 11

I believe that the various proponents of the radical perspective may have more in common with each other than each of them has with what would generally be recognized as their particular school or tradition. In effect, I believe there is a kind of informal “school” of thought which cuts across the standard lines of Freidan, Kleinian, and Sullivanian schools. For example, what Gill (in his later work), Racker, and Levenson have in common may be much more important than how they differ, because what they have in common is a perspective on the fundamental nature of the psychoanalytic situation. 12

Radical critiques of the notion that the patient’s neurotic transference experience is divorced from the actual nature of the analyst’s participation—that is, that it distorts the actual nature of that participation—rest on two basic propositions, with one or the other or both emphasized, depending upon the particular theorist. The two propositions, for which I am partly indebted to Wachtel (1980), are:

1. The patient senses that the analyst’s interpersonal conduct in the analytic situation, like all interpersonal conduct, is always ambiguous as an indicator of the full nature of the analyst’s

11. Over the years, my own views departed, in terms of emphasis, from those of Gill in a number of ways (see Introduction, pp. xiv–xvi). Perhaps most importantly, Gill’s focus was generally upon the analysis of the transference in the context of appreciating the inevitability of the analyst’s continuous interpersonal influence. My focus has been increasingly upon the dialectic of noninterpretive interpersonal interactions and interpretive interactions. Whereas for Gill, like Strachey, the heart of therapeutic action is in the moment of interpretation, for me it is in the dialectic of spontaneous, personal involvement and critical reflection on the process. In my own perspective, the analyst has the responsibility not only to interpret but also to contribute creatively to the development of the relationship in other ways, to wisely exercise his or her inescapable moral authority in the process, and to struggle through the paradox of participating in enactments while trying to understand and transcend them. An overemphasis on analysis of transference gravitates towards objectivism and technical rationality (see notes 9 and 10 in my paper on Gill’s intellectual history [Hoffman, 1996, pp. 48–49]).

12. Although I am grouping Levenson among the radical critics, there is a strong conservative, objectivist bent to his thinking, which I became aware of and took up well after the earlier version of this chapter was published (Hoffman, 1990).
experience and is always amenable to a variety of plausible interpretations.

2. The patient senses that the analyst's personal experience in the analytic situation is continuously affected by and responsive to the way in which the patient relates and participates in the process.

Implications of the Ambiguity of the Analyst's Conduct in the Analytic Situation

There is an underlying view of reality that the radical critics of the screen concept share. This view is simply that reality is not comprised merely of preestablished givens or absolutes. As Wachtel (1980) says, arguing from the perspective of Piaget's theory of cognitive development, "neither as children or as adults do we respond directly to stimuli per se. We are always constructing reality every bit as much as we are perceiving it" (p. 62). Moreover, the realm of interpersonal events is distinguished from that of physical events in that "such events are highly ambiguous, and consensus is much harder to obtain" (p. 69).

Keep in mind that we have as our principal concern one person's ideas (which may or may not be conscious themselves) about another person's experience. The other person's experience can only be inferred; it is never directly visible as such. Although we may believe we recognize signs of it in verbal and nonverbal behavior, the relationship between such signs and actual experience is always uncertain. When we think about patients, we know that there may well be discrepancies between what they say and what they consciously think, as well as discrepancies between what they consciously think and what they vaguely sense but resist facing up to in themselves. We know that the relation between what is manifest and what is latent may be extraordinarily complex. We know this of our patients and in a general way of ourselves. What we are prone to ignore or deny, however, is that this ambiguity and complexity applies to the way in which the therapist participates in the analytic process. As Racker (1968) says:

The first distortion of truth in "the myth of the analytic situation" is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities—that of the analysand and that of the analyst—responds to every event in the analytic situation [p. 137].

In a similar vein, Racker (1968) says, "The analyst's relation to his patient is a libidinal one and is a constant emotional experience" (p. 11).

The safeguards of the analytic situation do not prevent the analyst from having this "constant emotional experience." What is more, every patient senses this, consciously or preconsciously. Also, every patient brings to bear his or her own particular perspective in interpreting the meaning of the analyst's manifest behavior as it communicates, conveys, or inadvertently betrays something in the analyst's personal experience. The fact that a particular perspective may be charged with tremendous significance for the patient does not nullify its plausibility. If anything, the opposite may be the case. The patient's transference predilection acts as a kind of geiger counter, picking up aspects of the analyst's personal response in the analytic situation that might otherwise remain hidden. As Benedek (1953) put it:

Rarely does one realize that the patient, under the pressure of his emotional needs—needs which may be motivated by the frustration of transference—may grope for the therapist as a real person, may sense his reactions and will sometimes almost read his mind. . . . Yes, the patient . . . bores his way into the unconscious mind of the therapist and often emerges with surprising evidences of empathy—of preconscious awareness of the therapist's personality and even of his problems (p. 203).

What the patient's transference accounts for is not a distortion of reality but a selective attention and sensibility to certain facets of the analyst's highly ambiguous response to the patient in the analysis. What one patient notices about the analyst another ignores. What matters to one may not matter to another, or may matter in a different way. One could make a case for using the term 'distortion' for just this kind of selective attention and sensibility, but that is not usually the way the term is used, and I do think it would be misleading. After all, it is not as though one could describe the "real analyst" or the true nature of the analyst's experience independently of any selective attention and sensivity. As Wachtel (1980) says:

To be sure, each patient's experience of the analyst is highly individual and shaped by personal needs and fantasies. But consider the enormous variation in perception of the analyst by those other than his
patients—the differences in how he is experienced by his spouse, his children, his teachers, his students, his friends, his rivals. Which is the “undistorted” standard from which the transference distortion varies? [pp. 66–67].

There is no perception free of some kind of preexisting set, bias, or expectation, or, to borrow from Piaget’s framework, no perception independent of “assimilation” to some preexisting schema. Such assimilation does not twist an absolute external reality into something it is not. Rather it gives meaning or shape to something “out there” that has among its “objective” properties a kind of amenability to being assimilated in just this way. Moreover, the schema itself is flexible and tends to “accommodate” to what is in the environment, even while it makes what is in the environment fit itself. Thus, turning to the clinical situation that concerns us, a patient who, for example, has a readiness to feel used, may detect and be selectively attentive and sensitive to whatever qualifies as a plausible indication of an exploitative motive on the part of the particular analyst he or she is seeing. With one analyst it might be a high fee, with another, use of a tape recorder for research purposes, with another, use of the therapy for training, and with still another use of the therapy for training, and with still another, (allegedly) sadistic use of silence, with another, (allegedly) sadistic use of active interpretation.

The analytic situation is comprised of only two people, both of whom are participating in a charged interpersonal interaction that can result in one of them resisting recognizing something in himself or herself that the other discerns. From the perspective of the radical critic, it behooves the analyst to operate with this skepticism in mind about what he or she knows at a particular moment and to regard the patient as a potentially astute interpreter of the analyst’s own resisted internal motives. In fact, in some cases a patient with a particular “transference predisposition” (a phrase that Racker uses that is comparable to the notion of schema) may guess something about the countertransference that most other independent judges would not have picked up. As Gill and I (1982b) wrote:

In some instances, a group of judges may agree that the therapist has behaved in a particular way, one which could be construed as seduc-

tive, or disapproving or whatever, only after some subtle aspect of his behavior is called to their attention by another single observer. This observer might, of course, be none other than the patient [p. 140].

Not despite the influence of the transference, but because of it, [the patient] may notice something about the therapist’s behavior or suggest a possible interpretation of it that most judges would overlook. Nevertheless, once it is called to their attention, they may all agree that the patient’s perceptions and inferences were quite plausible [p. 140].

Implications of the Responsiveness of the Analyst’s Experience in the Psychoanalytic Situation

In what I have said so far I have deliberately contrived to deemphasize the second major consideration that addresses the implication of the analyst’s personal presence for the transference. I have done this in order to take the argument associated with the ambiguous nature of the analyst’s involvement as far as I could. But it is the second consideration, coupled with the first, that I think clinches the argument of the radical critic that the patient’s plausible interpretations of the analyst’s experience be considered part of the transference and that the transference not be defined in terms of perceptual distortion.

This second consideration is simply that the analyst in the analytic situation is continuously having some sort of personal affective reaction that is a response to the patient’s manner of relating. What is more, every patient knows that he or she is influencing the analyst’s experience and that the freedom the analyst has to resist this influence is limited. Patients create atmospheres in analysis—atmospheres that we sometimes actually speak of as though something were “in the air” between the participants. These atmospheres include the therapist’s personal reaction to the patient, the patient guessing what the reaction is partly on the basis of what the patient thinks his or her own behavior is likely to have elicited, the analyst guessing what the patient is guessing, and so on.

Sandler (1976) puts it this way:

In the transference, in many subtle ways, the patient attempts to prod the analyst into behaving in a particular way and unconsciously tunes and adapts to his perceptions of the analyst’s reaction. The analyst may be able to “hold” his response to this “prodding” in his
consciousness as a reaction of his own which he perceives, and I would make the link between certain countertransference responses and transference via the behavioral (verbal and non-verbal) interaction between the patient and the analyst [p. 44].

Sandler’s emphasis on the analyst’s behavior as a basis upon which patients conclude (preconsciously) that they have elicited the response they are looking for understates the extent to which a patient’s ideas about the countertransference can flow directly and plausibly from what the patient knows about the evocative nature of his or her own behavior. However the analyst believes he or she has behaved, if the patient thinks his or her own attitude has been continually deprecating, or harshly critical, the patient has reason to believe that the analyst may experience a degree of injury, along with a measure of irritation and a wish to retaliate. Such ideas do not require perceptual confirmation in order for the patient to believe, with reason, that they are plausible. The perceptual confirmation might follow, nevertheless, in any number of ways. For example, if the analyst keeps his or her cool and reveals not the slightest bit of upset, the patient might well imagine that this is precisely the analyst’s expression of revenge: to demonstrate imperviousness to the patient’s provocations. And, undoubtedly, ostensible adherence to the more austere canons of “proper” analytic conduct can sometimes function as a disguised vehicle for the expression of intense countertransference attitudes on the part of the analyst. The perceptual confirmation may be secondary, however, since from the patient’s point of view the die is cast and the outcome is highly likely, given his or her own evocative behavior.

For a theorist like Racker the countertransference is inevitable, and his discussion of it carries none of the opprobrium that comes across so heavily and oppressively in the work of Langs. Racker and Heimann take the same step forward with respect to countertransference that Freud took when he moved from thinking of the transference as an obstacle to thinking of transference as the principal vehicle of the analytic process. The countertransference in the social paradigm of the radical critics is likely to embody something resembling aspects of the patient’s internal objects or aspects of the patient’s self-representation. Heimann (1950) goes so far as to say, “The analyst’s countertransference is not only part and parcel of the analytic relationship, but it is the patient’s creation, it is part of the patient’s personality” (p. 83).

The element of hyperbole in Heimann’s position illustrates an error that often appears in discussions of the mechanism of projective identification. Instead of being a blank screen, the analyst becomes an empty “container” (Bion, 1962) into which the patient deposits various parts of himself or herself. Although the emphasis is on interaction, the metaphor of the container lends itself, ironically, to yet another asocial conception of the situation, since somehow the analyst’s personality has once again been eliminated from the field (cf. Levenson, 1981, p. 492). Nevertheless, the concept of projective identification, with the hyperbolic metaphor removed, does help bridge the alleged gap between the intrapsychic and the interpersonal (Ogden, 1979). It should be evident that in this paper the terms “social” and “interpersonal” do not connote something superficial or readily observable from “outside,” or something non-intrapsychic, the pejorative connotations that these terms have unfortunately acquired for many classical analysts. Experience that is conceptualized in the terms of the social paradigm is experience that is layered by reciprocal conscious, preconscious, and unconscious responses in each of the participants. 13 What is more, something can “unfold” in the course of the analysis that bears the stamp of the patient’s transference predispositions. What is intrapsychic is realized in the patient’s idea of the interaction of the transference and the countertransference, an idea that is likely to include a rough approximation of the quality, if not the quantity, of the actual countertransference, however ambiguous, inaccessible, or indeterminate the latter may be. It is in this element of correspondence between the

14. I am in sympathy with Racker’s (1968) use of the term “countertransference” to encompass the totality of the analyst’s experience of the patient, including his or her tendency toward understanding and empathy. Racker refers to the latter as “concordant countertransference” as distinct from “complementary countertransference,” which refers to the analyst’s nonempathic emotional reactions to the transference (pp. 135–136). In this chapter, I sometimes use the general term “countertransference” to refer to what Racker calls “complementary countertransference.” Similarly, the term transference is used to refer to the neurotic or “obstructing” transference rather than to the unobjectionable positive or “facilitating” transference (Gill, 1982a).

15. See Fourcher (1975) for a discussion of human experience as the expression of social reciprocity on multiple levels of psychological organization and consciousness.
Within the transference itself, there is a kind of self-fulfilling prophecy, and with it, a kind of fatalism—a sense that the outcome is inevitable. The transference includes not just a sense of what has happened or is happening, but also a prediction, a conviction even, about what will happen. The attempt to disprove this prediction is an active, ongoing, mutual effort that is always accompanied by a real element of uncertainty. The analyst’s uncertainty has as much, if not more, to do with his or her inability to know, in advance, how much the countertransference will govern his or her response to the patient as it has to do with the analyst’s inability to measure, precisely, the patient’s resistance and motivation for change. Moreover, the patient, as interpreter of the analyst’s experience, has good reason to think and fear that the countertransference-evoking power of the neurotic transference may be the decisive factor in determining the course of the relationship. Or, to say the same thing in another way, the patient has good reason to fear that the analyst’s constant susceptibility to complementary countertransference will doom the relationship to repeat, covertly if not overtly, the very patterns of interpersonal interaction that the patient came to analysis to change.

Pitted against the powerful alignment of neurotic transference and complementary countertransference is the interest that the patient and the analyst share in making something happen that will be new for the patient and will promote his or her ability to develop new kinds of interpersonal relationships. This is where the “objectivity” of the analyst enters and plays such an important role. It is not an objectivity that enables the analyst to demonstrate to the patient how his or her transference ideas and expectations distort reality in any simple sense. Instead it is an objectivity that enables the analyst to work to realize other potentials in the relationship and in the patient’s experience, potentials that are at variance with the reality created by the interplay of the neurotic transference and the complementary countertransference. In this process, the patient comes to know that the analyst is not so consumed or threatened by the countertransference as to no longer be able to interpret the transference. But to be able to interpret the transference means interpreting, and in some measure being receptive to, the patient’s interpretations of the countertransference (Racker, 1968, p. 131). What ensues is a subtle kind of rectification. The patient is, in some measure, freed of an unconscious sense of obligation to resist interpreting the analyst’s experience in order to accommodate a reciprocal resistance in the analyst. Ironically, the resistance in the patient sometimes takes the form of an apparently fervent belief that, objectively speaking, the analyst must be the very neutral screen that, according to the standard

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16. The emphasis here on the tension between deleterious enactments, on the one hand, and interpretation of enactments, on the other, is somewhat misleading in that it fails to consider the subtle blending of old and new within virtually all interactions in the process, whether they are ostensibly interpretive, reflective, and exploratory, or noninterpretive and emotionally expressive. The paradoxical interplay of repetition and new experience, the way in which one can serve as necessary ground for the other, is obscured by the polarization here of regressive enactment and healthy understanding. My own sense of the complexity of the process, conveyed, hopefully, in other chapters, developed more fully some years after this chapter was published in its original form.
model, he or she aspires to be (see Racker, 1968, p. 67). The patient takes the position, in effect, that his or her ideas about the analyst are nothing but fantasy, derived entirely from childhood experiences, nothing but transference, in the standard sense of the term. In such a case, the denial must be interpreted; the analyst must combat the resistance, not collude with it. To the extent that the analyst is objective, to the extent that he or she keeps from “drowning in the countertransference” (Racker, 1968, p. 132), which, of course, could take the form of repressing it, to that very extent is the analyst able actively to elicit the patient’s preconscious and resisted interpretations of the countertransference and take them in stride.

Interpretation as Rectification

Whether the analyst’s response will be dominated by complementary countertransference or not is a question that is raised again and again throughout the course of the therapy, probably in each hour with varying degrees of urgency. Also, it is a question that in many instances cannot begin to be resolved in a favorable direction unless or until a timely interpretation is offered by the analyst. At the very moment that he or she interprets, the analyst often extricates himself or herself as well as the patient from transference-countertransference enactment. When the analyst, who is experiencing something of the quality, if not the quantity, of the countertransference reaction that the patient anticipates, says to the patient, “I think you think I am feeling vulnerable,” or “I think you have the impression that I am hiding or denying my hostility toward you” or “my attraction to you,” at that moment, at least, he or she manages to cast doubt on the transference-based expectation that the countertransference will be consuming and will result in defensive adaptations in the analyst complementary to those in the transference. The interpretation is “mutative” (Strachey, 1934) partly because it has a certain reflexive impact on the analyst that the patient senses. Because it is implicitly self-interpretive it modifies something in the analyst’s own experience of the patient. By making it apparent that the countertransference experience that the patient has attributed to the analyst occupies only a part of the analyst’s response to the patient, the analyst also makes it apparent that he or she is finding something more in the patient to respond to than the transference-driven provocateur. Not to be minimized as a significant part of this “something more,” for which the analyst is now implicitly showing a kind of apprecia-

tion, is the patient’s capacity to understand, empathize with, and interpret the analyst’s experience, especially his or her experience of the patient (cf. Searles, 1975).

As Gill (1979) has pointed out, the patient, through the analysis of the transference, has a new interpersonal experience that is inseparable from the collaborative development of insight into the transference itself. This new experience is most powerful when the insight into the transference includes a new understanding of what the patient has tried to evoke, and what he or she has plausibly construed as actually having been evoked, in the analyst. The rectification, mentioned earlier, of the patient’s unconscious need to accommodate to a resistance that is attributed to the analyst is also more likely when the analyst is able to find the patient’s interpretation of the countertransference in associations that are not manifestly about the psychoanalytic situation at all. In doing so, the analyst demonstrates to the patient that, rather than being defensive about the patient’s ideas about the countertransference, the analyst actually has an appetite for them and is eager to seek them out.

Systematic use of the patient’s associations as a guide to understanding the patient’s resisted ideas about the countertransference is a critical element of the interpretive process in the social paradigm. Without it, there is a danger that the analyst will rely excessively on his or her own subjective experience in constructing interpretations. The analyst then risks making the error of automatically assuming that what he or she feels corresponds with what the patient imagines to be the case. In fact, Racker (1968), whom I have cited so liberally, seems to invite this criticism at times, although he also warns against regarding the experience of the countertransference as oracular (p. 170). It is true that in many cases the most powerful interpretations are constructed out of a convergence of something in the analyst’s personal response and a theme in the patient’s associations. There are other instances, however, when the associations suggest a latent interpretation of the analyst’s internal state that comes as a surprise to the analyst and that overrides what he or she might have guessed based upon his or her conscious experience. Thus, continually reading the patient’s associations for their allusions to the countertransference via the mechanisms of displacement and identification (Lipton, 1977b; Gill, 1979, 1982a; Gill and Hoffman,

17. Encouraging “systematic use of the patient’s associations” may promote an approach that leans too far to the side of the methodical in the dialectic of the methodical and the spontaneously personal.
1982a, b) is a necessary complement to the analyst's countertransference experience in constructing interpretations and ensures that the patient's perspective, as reflected in the content of his or her communications, is not overshadowed by what the analyst is aware of in himself or herself.

The Role of Enactment and Disclosure of Countertransference

The new experience that the patient has is something that the participants make happen and that they are frequently either on the verge of failing to make happen or actually failing to make happen. That is, they are frequently either on the verge of enacting transference-countertransference patterns or actually in the midst of enacting them, even if in muted or disguised ways. Where Gill, Racker, Searles, and Levenson, among others (see fn. 10 for other recent contributors) differ from conservative critics like Strachey and Langs is in their acceptance of a certain thread of transference-countertransference enactment throughout the analysis, which stands in a kind of dialectical relationship with the process by which this enactment, as experienced by the patient, is analyzed.

I want to be clear that nothing I have said requires admission on the part of the analyst of actual countertransference experiences. On the contrary, I think the extra factor of “objectivity” that the analyst has to help combat the pull of the transference and the countertransference often rests precisely on the fact that the nature of his or her participation in the interaction is different from that of the patient. This is what increases the likelihood that the analyst will be able to subordinate his or her countertransference reactions to the purposes of the analysis. What Racker (1968) speaks of as “the myth of the analytic situation,” namely that it is an interaction “between a sick person and a healthy one” (p. 132), may be perpetuated, ironically, by those who argue that regular countertransference confessions should be incorporated as part of psychoanalytic technique.18

Such regular self-disclosure is likely to pull the therapist's total personality into the exchange in the same manner that it would be involved in other intimate social relationships. To think that the analyst will have any special capability in such circumstances to resist neurotic forms of reciprocal reenactment would have to be based on an assumption that his or her mental health is vastly superior to that of the patient. Revealing countertransference reactions also tends to imply an overestimation of the analyst's conscious experience at the expense of what is resisted and is preconscious or unconscious. Similarly, it implies an extraordinary ability on the part of the analyst to capture the essence of his or her experience of the patient in a few words, whereas the patient may grope for hours before finding words that seem to fit something in his or her experience of the analyst. Another way of saying this is that countertransference disclosures may encourage a shared illusion to the effect that the element of ambiguity that is associated with the analyst's conduct and that leaves it open to a variety of plausible interpretations has now been virtually eliminated. Once the analyst says what he or she feels, there is likely to be an increment of investment on the analyst's part in being taken at his or her word. This is an increment of investment that the patient may sense and try to accommodate, so that the reciprocal resistance to the patient's continuing interpretation of the therapist's inner experience can become very powerful.

Although countertransference disclosure may often be ill-advised, there are also times when a degree of personal, self-revealing expressiveness is not only inescapable but desirable (Ehrenberg, 1982; Bollas, 1983).19 In fact, there are times when the only choices available conceal aspects of one's personal experience in the analytic situation. Such an emphasis is less on discrete moments of choice as to whether to disclose or not to disclose and more on an ongoing dialectic between personally expressive and personally restrained behavior.

18. Bollas (1983) has discussed and illustrated the usefulness of occasional judicious disclosures by the analyst of his or her countertransference predicament. See also Burke (1992) for an attempt to spell out the rationale for disclosure. In my view, any approach that is overly specific in terms of technical principles threatens to rob disclosure of the elements of spontaneity and authenticity that are among its main benefits. The principal dialectic, as I see it, is between the inclination to reveal and the inclination to

19. My views on this subject have been gradually changing away from the rather conservative position taken in this paper, published originally in 1983. Although restraint is called for in keeping with the asymmetrical arrangement, I now believe that it is often useful to be open with patients regarding one’s personal reactions in the process. Such openness can facilitate identification and exploration of enactments as they occur; it can help the patient identify and take account of the analyst's biases as they affect his or her participation; and it offers the possibility for a level of spontaneous personal engagement which, in a dialectical relationship with psychoanalytic discipline, has great therapeutic potential. These considerations must be weighed against the reservations articulated in the text above.
to the analyst are a variety of emotionally expressive responses. Neither attentive listening nor interpretation of any kind is necessarily a way out of this predicament, because the patient may have created an atmosphere in which customary analytic distance is likely to be experienced by both participants as inordinately withholding, compulsive, or phony. As long as the ambiance is such that both patient and the analyst know that whatever is going on more than likely has meaning that is not yet being spoken of or explored, but eventually will be, openly expressive interpersonal interactions may do more good than harm and may continue for some time before it becomes possible to interpret them retrospectively in a spirit that holds any hope of benefit for the patient. In other words, it may be some time before the act of interpreting will become sufficiently free of destructive countertransference meaning for the patient to hear and make use of the content of the intervention.

Again, it is not that instead of interpreting in such circumstances one should merely wait silently, but rather that a certain specific kind of spontaneous interpersonal interaction may be the least of the various evils that the participants have to choose from, or, more positively, the healthiest of the various transference-countertransference possibilities that are in the air at a certain time. It may be that such “healthier” types of interpersonal interaction actually do have something relatively new in them, or maybe something with weak precursors in the patient’s history that were not pathogenic but growth promoting. A safe working assumption for the analyst is that the interaction represents a complex alloy of repetition and new experience. It is crucial that the analyst not presume to know the value of his or her contributions and that he or she be guided by the patient’s subsequent associations in determining how the patient experienced the interaction and what it may have repeated or continued from the past.

Exploration of History in the Social Paradigm

An important weapon that the patient and the therapist have against prolonged deleterious forms of transference-countertransference enactment, in addition to the therapist’s relative distance, is an evolving understanding of the patient’s history. This understanding locates the transference-countertransference themes that are enacted in the analysis in a broader context that touches on their origins and helps immeasurably to free the patient and the analyst from the sense of necessity and importance that can become attached to whatever is going on in the here and now. Analysts’ distance and ability to reflect critically on the process is aided by the fact that they, unlike their patients, do not routinely reveal their private associations. The patient’s ability to reflect on the process relies much more heavily on being able to explain what is happening on the basis of what has happened in the past. Such explanation, because it demonstrates how the patient’s way of shaping and perceiving the relationship comes out of his or her particular history, also adds considerably to the patient’s sense of conviction that alternative ways of relating to people are possible. Again, what is corrected is not a simple distortion of reality but the investment that the patient has in shaping and perceiving his or her interpersonal experience in particular ways. Moreover, the past too is not explored either in a spirit of finding out what really happened (as in the trauma theory) or in a spirit of finding out what the patient, for internal reasons only, imagined happened (the past understood as fantasy). The patient as a credible (not accurate necessarily, but credible) interpreter of the analyst’s experience has as its precursor the child as a credible interpreter of his or her parents’ experience, especially the parents’ attitudes toward the child (see Hartmann and Kris, 1945, pp. 21–22; Schimek, 1975, p. 180; Levenson, 1981). The dichotomy of environmentally induced childhood trauma and internally motivated childhood fantasy in etiological theories has its exact parallel in the false dichotomy in the psychoanalytic situation between reactions to actual countertransference errors on the analyst’s part and the unfolding of pure transference that has no basis or only a trivial basis in reality.

The Patient’s Perception of Conflict in the Analyst

The analyst’s participation, involving his or her tendency toward understanding on the one hand, and his or her complementary countertransference reactions on the other, often entails a sense of real conflict as part of the analyst’s total experience of the relationship. I think this conflict is invariably a part of what the patient senses about the analyst’s response. In fact, one subtle type of asocial conception of the patient’s experience in psychoanalysis is one that implies that from the patient’s point of view the analyst’s experience is simple rather than complex, and unidimensional rather than multifaceted. The analyst is considered to be simply objective, or critical, or seductive, or threatened, or nurturant, or empathic. Any truly
social conception of the patient's experience in psychoanalysis grants that the patient can plausibly infer a variety of more or less harmonious or conflictual tendencies in the analyst, some of which the patient would imagine are conscious and some of which he or she would think are unconscious. In such a model, the patient as interpreter understands that, however different it is, the analyst's experience is no less complex than his or her own.

Toward a Social-Constructivist View of the Psychoanalytic Situation

COMMON THEMES: TOWARD A NEW PARADIGM?

A common theme in papers by Aron (1991), Greenberg (1991), and Modell (1991), appearing in the inaugural issue of the journal *Psychoanalytic Dialogues,* is an emphasis on the importance of the personal presence and participation of the analyst in the psychoanalytic process. A real, personal relationship of some kind is thought to develop inevitably. The only options have to do with whether or how the patient and the analyst attend to it, choices that will, in turn, affect the quality of the experience for both participants. These articles suggest that exploring the patient's perceptions of the analyst's immediate experience in the analytic situation, as well as perceptions of the analyst's general attributes, is at least in keeping with the value


1. As stated in the introduction, although it appeared originally as a discussion of these three papers, I believe the chapter can stand on its own. Throughout, unless indicated otherwise, references to Aron, Greenberg, and Modell are to the papers in that inaugural issue, which were followed by this discussion.