uating, in her everyday transference projections. That is where the therapeutic effort needs to be focused. To offer empathic attunement to a patient who is resistant to it or who needs to distort it in some fashion for defensive purposes seems of little value without first undoing just those resistances. I think Dr. Fosshage did just that; what he called the necessary ingredient I would see as understandable and humane lapses in technique, encouraged by his preferred theoretical models, which seems not—at least in what we have seen of the case—to have interfered with their interpretive work together. I do suspect, however, that those lapses in which Dr. Fosshage acted so differently from her first analyst will need to be analyzed at some point in the future, for that reason alone, if for no other.

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Discussion: A Relational View

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I AM DESIGNATING MY PERSPECTIVE “relational” because it is grounded in the traditions of interpersonal psychoanalysis and British school object relations theories. Purists in either of these two schools of thought tend to regard the other as quite foreign. “Classical” interpersonalists, following Sullivan, tend to focus on what people do and largely eschew intrapsychic concepts concerning what is taken to be the latent structure of experience. This approach is at considerable odds with the language and sensibility of the British school and its Kleinian-derived emphasis on fantasy and “primitive” mental processes. On the other hand, various advocates of “object relations theory” tend to value explanations having to do with the earliest relationship between the infant and the mother, a far cry from the “here-and-now,” interactional focus of much interpersonal theory. Nevertheless, I discovered a number of years ago that my own clinical and theoretical perspective had taken shape in the interaction of these influences, along with certain strains from both existential psychoanalysis and revisionist versions of “Freudian” theory (particularly those of Loewald and Schafer). Since such an approach seems to fit into no preexisting category, I am using relational to encompass this mixture of influences (see Mitchell, 1988).

The core issue of the sessions under review have, and perhaps of

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this analysand's treatment as a whole, I see as the issue of betrayal. My central focus in this discussion will be on how both analysand and analyst respond to, manage, and avoid (perhaps inevitably so) dealing with this issue as it unfolds within the transference and countertransference.

P seems to have felt deeply betrayed by both her parents. The mother's paranoia, depression, and egocentricity were characterological problem which, as her daughter experienced them, led her to feed parasitically on the lives of others and rendered her unable to respond to and care for her daughter as a person with needs and interests of her own. The memory of the mother's long absence during her hospitalization as a child vividly crystalizes her chronic sense of abandonment. The dream images in these sessions concerning the "living dead" highlight her sense that the only way to connect with her mother was to offer her mother her own vitality so as to breathe life into her.

The father offered P a powerful, secret, romantic relationship as his "special one." Yet his was a "self-interested love," and she experienced herself more as a vehicle for his own fragile narcissistic needs than cared about in her own right. Her memory of his public disavowal of herpicture captures the pain and humiliation she felt was the price of her tie to him.

The portrayal of both parents thus conveys P's deep sense of having been exploited and ultimately betrayed—used for their own purposes, not valued and protected as an independent person with an inner life and feelings. Her experience of an idealized "God" seems an attempt to compensate for the essential abandonment and exploitation she experienced with her parents. But it is a very tenuous idealization and foreshadows her later experience in analysis. She can't quite hold and trust an experience of another as genuinely caring for her and returns repeatedly to the more familiar although deeply painful experience of having been betrayed.

Not surprisingly, P approaches psychoanalysis with a deep suspicion about the possibility of being truly cared about by her analyst. She feels she "needs" to know whether her analyst really cares, otherwise the analytic relationship becomes a repetition of her experience with both parents—a charade in which self-interest and exploitation masquerade as caring and concern. Her first analysis, after two years of what sounds like very productive work (at least in terms of behavioral changes), floundered in just this problem. The analyst dismissively dodges the question, arguing that any expression of caring would be pointless because P wouldn't believe it anyway. Presumably P's wish was viewed as a conflictual infantile longing, the satisfaction of which would interfere with the development of the transference and short-circuit the analytic process.

Previous analysts, like previous lovers, are always easy targets for current analytic couples, and this account must be taken with more than a grain of salt. I have some sympathy with the previous analyst's view that convincing P she is cared for might be no easy task. The problem seems to have been that the analyst found no way to interest P in exploring what exactly being cared for means, how one goes about finding out whether another cares, and so on. In my view the rupture in the first analysis resulted not so much from the failure to provide assurance or reassurance, but from the failure to engage P in an inquiry into what are in fact very complex and tricky questions. She needed to understand that the analyst's genuine caring about her world not lead to mere statements of caring, either explicit or implicit, but would help her unearth and understand the meaning of her self-sabotaging pursuit of signs of caring and its role in perpetuating her difficulties in living.

Dr. F works with a very different set of premises from those apparently guiding the first analyst, leading him to approach this crucial issue in P's treatment very differently. He combines a developmental-arrest perspective with an analysis of conflict and recurrent relational patterns. What I want to focus on here, however, is his approach to the key transference-countertransference interactions in these sessions, in which Dr. F seems to place primary emphasis on what he regards as P's constructive strivings toward health. I gather his thinking goes something like this:
Not ever feeling truly cared about has left  P with key expericences of having suffered abandonment by a caregiver. P has had to learn to have a clearly demonstrated experience of being cared for, to be deeply empathized with as a person in her own right, in order to mobilize her self-esteem. She is shy, reserved, and protective. Dr. F recognizes the past difficulties in their relationship, and has picked up her message of needing to feel safe. However, it seems that the relationship has become unbalanced, with  P feeling more protective and Dr. F feeling more critical.

The importance of P's existence in her life is reflected in the way she feels Dr. F is always present and available to her. However, this also means that she feels Dr. F is always observing and assessing her, which can be overwhelming. P feels that she is constantly in Dr. F's mind, and that this constant presence is taking a toll on her ability to feel safe and secure in the relationship.

Dr. F's critical comments and her tendency to focus on P's past mistakes and failures can be overwhelming and frustrating for P. These comments can make P feel ashamed and guilty, and can contribute to a sense of hopelessness and despair. P feels that Dr. F is not able to accept her for who she is, and that she is constantly trying to change her.

Despite these challenges, P is determined to continue in the relationship. She is hopeful that Dr. F will be able to change her ways and become more accepting and supportive of P. P is willing to work hard to improve the relationship, and she is committed to making it work.

In conclusion, P's experience in her relationship with Dr. F is marked by a deep sense of abandonment and lack of care. She feels that Dr. F is frequently critical and judgmental, and that this has a negative impact on her ability to feel secure and safe in the relationship. However, P is determined to work through these issues and to continue in the relationship, despite the challenges that it presents.
able, and well-founded skepticism about the motives of others. This doesn't necessarily imply that her earlier trust of Dr. F was phoney and contrived; a lot has taken place between them that strikes me as quite real, substantial, and worthy of generating trust. In her eagerness to believe in Dr. F's righteousness, however, she is inclined to gloss over negative perceptions and feelings. Only now that she feels genuinely more comfortable with him can she begin to risk experiencing and verbalizing this deep and pervasive dimension in her experience of other people. Such an approach differs in subtle but important ways from the one suggested by the language Dr. F uses to describe the negative transference, when he seems to be drawing on Kohut's understanding of aggression as a secondary, reactive, flashlike response to actual or anticipated narcissistic and/or empathic rupture.

Let us consider other facets Dr. F's manner of responding to P's critical thoughts. P becomes interested in the Cadillac in Dr. F's driveway. Does it belong to him? Probably not to his secretary, perhaps his accountant? Perhaps he has "too much money" and doesn't know what to do with it. Perhaps the Cadillac, which she also regards as a frumpy, old person's car, suggests that he is a lot older, frailer, more vulnerable than he appears.

Dr. F responds to these related questions with what appears to be a generally congenial and nondefensive attitude. He conveys that he is unruffled and can take her doubts and criticisms. He responds to her very anxious insistence on knowing if the Cadillac is his by informing her that it is not, to avoid what he feels would be experienced as "a noncaring unauthentic 'technical game.' " After acknowledging her relief that this car is not his, he points to the similarity between her criticisms of him and her "disappointments" with the husband, thus suggesting their generality and, by implication, deemphasizing the importance of their specific content. He seems to implicitly accept her claim that she doesn't know him "very well," once again suggesting that although he can tolerate and empathize with her criticisms, the two of them can agree that there is not much basis for them in fact, and that there is not much point in pursuing and elaborating them. (I shall illustrate below what I think a more active pursuit would be.)

The content of the negative transference is handled respectfully and empathically, but in a way that deflects rather than opens up the full implications of her perceptions and criticisms of Dr. F. Although Dr. F understands her aggression in terms of complex identifications and derivatives from the history of her important relationships, when it comes to explicating the negative transference (at least in these sessions), P's hate and criticism is understood to serve a protective function. It is a defensive posture, protecting her both from anticipated betrayal and from being overwhelmed by the neediness of others.

The perspective I bring to the clinical material overlaps in many ways with Dr. F's, but for the comparative purpose of this discussion, I wish to emphasize some subtle yet crucial differences, which pertain particularly to ways of understanding the nature of the analytic relationship and which derive from the following fundamental premises: (1) The analysand operates within "here-and-now" interpersonal transactions with the analyst in which major characteristic and characterological relational configurations tend to get experienced by both parties (Racker, 1968), often tend to get enacted (Levenson, 1983), and out of which the analysand constructs a set of "plausible" and familiar beliefs about the analyst (Gill, 1982; Hoffman, 1983). (2) The analysand's neurotic constrictions derive from deep loyalties and commitments to old relationship and familiar relational patterns. New forms of relation are not likely to be immediately possible, nor even really sought, but emerge only through reexperience, reexamination, and resolution of old patterns. Countertransference in this framework is not regarded as a contaminant of the treatment but rather as an inevitable, necessary, and useful participation by the analyst with the analysand (Feiner & Epstein, 1979). (3) Hate and aggression often tend to become deeply embedded in character (Fromm, 1973) and play a central role in intimate relationships.
I have found the work of Melanie Klein (1957) very helpful in this respect, not in her understanding of the etiology of aggression in a constitutional drive, but in her depiction of the dynamic functions of aggression and its dialectical interplay with love in what she calls the “depressive position.” (See especially Ogden's [1986] reinterpretation of Klein.)

Let us reconsider the clinical material with these different presuppositions in mind.

Given the centrality of the issue of betrayal in P's early life, questions concerning trust and caring will be extremely important in the analytic relationship and will operate in a complex and subtle fashion, not always apparent. With good reason, she believes that others are apt to be self-absorbed, extremely needy, and exploitative, and that they are very likely to betray her. These beliefs underlie character traits of extreme wariness, skepticism, and hateful minimizing of others, all of which are likely to have been very adaptive strategies for best surviving in her family. I would also assume that the story of the previous analysis and P's manner of presenting herself would generate a powerful countertransference pressure to want to win and maintain her trust, both to keep her in treatment and to avoid the destructiveness of her hatred, which, when activated, seems effective and ruinous.

These assumptions would lead me to view some of the content of these sessions differently, beginning with a different sort of understanding of Dr. F's experience in the countertransference, where I would expect there would inevitably be powerful countertransference resistances, corresponding to P's dread of her own aggression. Dr. F notes that "I found myself at times conveying more directly than is customary to me, through intonations, a word, a smile, my genuine caring for her. Undoubtedly this was in response to her needs for and fragility with maintaining a ‘caring’ connection.” I have no question about the genuineness of the caring described here, but I would be more doubtful about seeing it as a direct and clear response to P's needs. I would at least want to explore the hypothesis that P is not merely looking, unconflictedly, for a “caring” connection, tentatively seeking an empathic response, but that she is, also quite conflictedly, looking for familiar signs that this relationship, despite its initial promise, will fail and betray her, as have all others before. She will therefore, rightfully and understandably, be hypervigilant for signs of betrayal and wavered loyalties. This attitude will create a pressure on the analyst to be stalwart and clear in his devotion, to match her hypervigilance with a redoubled effort to be consistent and clear in his caring. This interaction creates a very complicated situation since, in my view, genuine caring between people is never consistent, clear, and pure, but in the best of relationships is continually lost, clouded, ruined, and restored, in the subtle dialectics of intimacy. The kind of pressure created by this kind of transference inevitably makes it difficult for the analyst to allow himself to experience and to find a way to convey the fullness of his emotional response to P. Further, the coerciveness of the pressure itself may very well create a resentment, which makes it much less likely that P will find the sustained, reassuring emotional involvement that she is longing for.

What is most analytically helpful in working with someone with such dynamics is not only a new experience of what was missed developmentally in childhood, but also an elucidation of the ways in which the characterological adaptation to what was missed in childhood (well described in Dr. F's interpretations), affects others and creates a closed pattern of interpersonal relatedness which precludes different kinds of experiences. Where I differ most with Dr. F is in our views of the way in which that past shapes the current interactions in the here-and-now of the analytic relationship. He tends to regard the key interactions in these sessions as representing a striving for a “new beginning” (Balint, 1968), whereas I would put more weight, at least in terms of generating hypotheses, on the ways in which these interactions also perpetuate, in subtle fashion, old patterns of integration. It is in this context that I would regard the discovery in the countertransference of a tendency to convey caring not necessarily, and certainly not "undoubtedly" as a response to a developmental
need. Rather, I would consider the possibility that this is a useful countertransference resonance to the analysand’s efforts to create a collusive transference-countertransference resistance to the awareness, more mutually aggressive and critical, of other dimensions of their relationship.

The subtle but important difference in viewing these interactions within the analytic relationship derive in part from the preservation in self psychology of what I consider conservative, anachronistic features of the classical theory of technique, particularly as regards transference and countertransference.

In self psychology, neutrality has been replaced by the empathic stance, but the competent analyst is still generally regarded as striving to hold a position outside the patient’s dynamics. The content of the sessions is regarded as largely emerging from what the patient brings to the work. Although he strives to be accepting of the patient’s “subjective experience” of him, the self psychology analyst does not view himself as participating in the creation of that experience. Therefore, although some countertransference is now tolerated as inevitable slippages of the analyst’s empathic capacities (Kohut, 1984), its actual content is regarded as particularly useful as clues to understanding the nature of the analytic relationship.

In my view, this classical remnant in the self psychological model of the analytic situation renders invisible many potentially useful features of the analyst’s experience. When it comes to important moments in their interactions, Dr. F seems to place his major emphasis on such questions as: “What kinds of important developmental experiences have been missing in P’s life? How are they sought in the analytic relationship? How might the analytic experience remedy those traumatic omissions? The alternative approach would lead the analyst to begin with the questions: What is it like for me to be with P? What kinds of feelings and interactions are elicited? What do I find myself protecting us from? The analyst is here viewed as part of the process rather than outside of and empathizing with the process.

An important, closely related difference between Dr. F’s model and mine is that he seems to regard as a shallow, protective, reactive “mode” the very material I would see as outcroppings of key dimensions of the patient’s experience in the transference. Although he accepts these generously, he doesn’t encourage their exploration. For example:

P insists on knowing whether the Cadillac is his. Dr. F feels he has to answer to avoid game-playing, which, it could be argued, would repeat the trauma of unresponsive parenting from her childhood. But is there not also a potential message here, which P might interpret to mean that Dr. F, like herself, is anxious about the implications of the car and that he wants to rescue both of them from exploring them? Why is an answer so urgent? What if it were his car? It is hard to escape the impression that, in the rush to answer, the full meaning of her anxiety was not developed. His response may very well convey the impression that Dr. F feels, as does P, that her continuing to believe that he is a wholly benign figure is more important to both of them than fully confronting the depth of her doubts and fears about him.

There is a tense, brittle, paranoid tone (connected to the emergence of experiences related to a maternal introject?) to P’s urgency at this juncture, particularly striking after two and a half years of productive work together. I see the key issue as not whether to gratify or to frustrate that urgency but to find a way to open up an inquiry into its meaning. “Neediness,” as Dr. F notes, is a central issue for P, and “neediness” inevitably becomes a key part of the analytic ambience as it is played out in the transference and countertransference. Why does Dr. F think that P feels that so much is at stake in his immediately relieving answer? Dr. F understands the relational configurations from which P’s fears with “neediness” arise; yet when it comes to key interactions between them (at least in these sessions) his central concern seems to be to meet quickly and clearly what he understands to be her movements toward health. In the concern about retraumatization, the depth of her fears, both about herself and about him, seem to me to be by-passed.

There may have been other ways to avoid answering the
question that would not have been experienced as game-playing,
including some admission of the seductive yet distracting relief an
answer might provide for both of them because of the other
threatening aspects of their relationship. In the long run, the
patient would probably have experienced such a response as
empathic and reflecting a belief in the durability of their relation-
ship and their joint capacity to emerge from doubts and crises.

One of the most common daily discoveries in analysis is that,
like P, most analysts knew as children much more about their
parents' struggles than the parents were aware of. Almost as
common is a similar discovery about what the analysand knew
about their previous analyst and never spoke about. All of this
suggests that the analysand also knows much more about the
analyst than is usually being articulated, and that it is a
difficult challenge to bring it into the open.

Hoffman (1983) had argued persuasively that despite the fact that
most contemporary analysts eschew the "blank screen" concept of
the analyst's role, most maintain a belief that the analyst is largely
invisible to the analysand, except in ways he thinks he controls
(called "empathy participation," "workingly ego," and so on). These
considerations make the analyst's handling of the transference
"crucial. Let us consider how Gill (1982) has aptly termed the "resistance to the awareness of the
critical perceptions" which might be regarded as the tentative
emergence of significant material that needs to be investigated and
developed.

Following a discussion of the father's vulnerability, Dr. F. said,
"As I have come to realize, as I did when I discussed the project, you are prone
to experiencing me as vulnerable and fragile and in this dead
space. Similarly, in the next session, he noted, "You experienced
intense neediness and suffering around you as you were growing
to see vulnerability and neediness in others, too. This is a way
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through "psychological discussions," to make her feel alive must have strong echoes in P's experience of the analytic situation. Does Dr. F feel that F's theories and obvious conviction that she is not deeply destructive is more important to him than taking a more open-ended look into how destructive she in fact may be? Dr. F's model is one in which trust is believed to emerge through the analyst's empathic response and the patient's experience of the therapist's thwarts developmental needs, poised and ready to be met. In my analysis, trust would be wrestled out of the detailed exploration of the analyst's inevitable analytic age. Because the analyst is not the other major figures in her life, in this model, what will facilitate meaningful change for P is not the offering of a better relationship than she has known, nor an understanding of the way her past relationships have led her to anticipate and look for similar problems in her current relationships. Rather, an analytic change is understood in a close, sustained look at precisely the problems P has found and is finding in this new relationship. The issue is not whether P can trust that Dr. F is not corrupt, narcissistic, greedy, and depressed. These are dimensions of human experience from which we all suffer in one way or another, and P is particularly adept at letting out precisely these wishes he may be. The despair in the last session might be taken to reflect her hesitance about both her own destructiveness and her analyst's potential for helpfulness about the destructive she feels she knows of Dr. F's vulnerability, into exactly how egocentric, materialistic, empty, and pathetic she fears and (perhaps) how impaired and potentially betraying she feels her analyst may.
In my view, both P's love and admiration and her critical destructiveness can be usefully regarded as primary. I have worked with patients who display what Klein calls "pseudo-idealization," where the positive feelings of the analyst are not matched by any genuine admiration for the analyst, and where the patient is not in the analytic situation with some degree of safety and is not being defended against a sense of inevitable and massive mutual malevolence. The pseudo-idealization is often necessary to provide the patient a way of being able to be in the analytic situation with some degree of definitional expression. In the case of P., the caring and protective sense of improvement and enrichment, I feel P. has provided her with a kind of relationship that she has never before experienced. The pseudo-idealization usually contains a defensive facet. I often find it useful to ride with it when it seems primary to be opening things up and creating new kinds of personal and interpersonal experiences. (Although I would try very carefully to help P. see her part of the treatment.)

I differ with Dr. F. in understanding not only the current crisis point in the treatment, but in the face of a striving to deepen the intimacy between them but building up something meaningful, but, as deepening the patient's