A detailed clinical example is used to illustrate how reality testing can create rather than foreclose opportunities for analytic investigation. It is proposed that effective analysis of transference within the treatment relationship requires close and explicit attention to considerations of reality. The author reconsiders certain conceptions of a special psychoanalytic reality, of regression in clinical analysis, and of the nature of free association, suggesting that they tend to discourage the realism necessary to productive psychoanalytic work. He underlines the importance of ongoing reference to therapeutic outcome as an aspect of reality.

Margaret is a thirty-year-old accountant in analysis because of her chronic depression. It is the day before Passover, and she is feeling terrible about having to be all by herself on the holiday. She has been invited to a friend's Seder, but Margaret is going to cancel out because she has a cold and doesn't want to risk giving it to her friend and her friend's family. In all Margaret's previous descriptions, the friend has sounded to me like a happy-go-lucky type; besides which the friend has two small children, one in preschool and one in grade school, so that full exposure to the San Francisco Bay Area viral pool is likely a fait accompli. It seems to me reasonable that rather than opt for self-abnegation all on her own, Margaret might at least explain the situation to her friend and hear what the friend has to say.

Margaret and I have been talking for a while in analysis about her tendency to regard herself as an obnoxious person and her deep fear that nobody really wants to have her around. This idea about herself appears to have originated, at least in part, from Margaret's sense that her mother, though basically caring and responsible, was not very interested in Margaret and found her an imposition much of the time. I have the impression that Margaret's judgment about how to handle the Passover problem is colored by expectations relating to her childhood experience of her mother.

When I explain my point of view to Margaret, she's aghast. She wouldn't dream of putting her friend on the spot by asking her about coming to the Seder with a cold. What I'm suggesting seems selfish and inconsiderate. Am I partisan on Margaret's behalf because she's my patient, she wonders, or do I just have a basically egoistic world-view? Margaret asserts with some alarm that her attitude about such things seems very different from mine. She almost canceled her analytic hour today, she says, except she feels that as a physician, part of the risk I accept in doing my work is exposure to disease—it comes with the territory. Margaret's associations continue on in this vein for a bit.

Eventually, I say that I understand her thinking about coming in today, but I add a question: does Margaret feel that I should cancel appointments when I have a cold or the flu? Because, I tell her, I don't. Does that seem irresponsible?, I ask. I explain that my attitude is that proximity to people who are ill is part of what we all encounter in stores and restaurants, on airplanes, and elsewhere; so when I've got a virus, I may avoid shaking hands and such, but I don't cancel as long as I think I can work effectively. Margaret considers my policy with mixed feelings: she likes the idea of my remaining available to her, but does not like being put at risk.

Mulling over what I have said, Margaret arrives at the conclusion that she may be a bit more cautious than she needs to be. She thinks that I'm trying to do the right thing, according to my judgment. She knows that some people—responsible and nice people—are less concerned than she about possibly causing one another to catch cold. In the course of these reflections, Margaret mentions that she thinks she is phobic, isolated, and depressed like her mother. This is the first time Margaret has described her mother in this light. Previously she had portrayed her mother as

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Margaret's mother and its implications, including Margaret's recognition that she had been trying to make light of her mother's isolation, chalking it up to bookishness, in order to fend off a sense of her mother's capacity for profound withdrawal from the world. I suggest to Margaret that perhaps feeling phobic, isolated, and depressed like her mother is a state of mind that she actually seeks out because it permits her to feel like her mother, and feeling like her mother is one of the only ways available to Margaret to feel close to her mother.

Margaret cries, silently. After a while, she begins to talk about her pain and confusion about what has always been her mother's unavailability. Sometimes Margaret thinks her mother really loves her, but is just terribly inhibited about expressing it. At other times she thinks her mother just doesn't want to have anything to do with her. It's the same with me, Margaret tells me. Even though I seem to be generally interested and involved, she expects that at any time I might get tired of her and tell her that we have to stop treatment.

On Monday, Margaret begins with an account of how she decided to ask her friend whether it would be all right for her to come to the Seder. Her friend replied that Margaret must have the same cold that her kids already have, not to worry at all! Margaret felt relieved and a little silly. She had a great time with her friend and her friend's family on Passover. Margaret takes most of the hour to report the events of her visit in great detail. She is aware of feeling grateful to me and of wanting to thank me by describing how much fun it was for her to really feel like she belonged somewhere on the holiday. She's really glad that I questioned her assumption that she couldn't go, and also that I didn't insist that she adopt my point of view.

In Tuesday's session, Margaret gets back to thinking about the unpredictable distance she felt from her mother growing up. She remembers and reflects for fifty minutes, and I am silent. It was as if her mother considered being emotionally engaged a burden—the need to have strong feelings threatened and upset her. Margaret recalls that once when she was about eight years old, she lacerated her thumb in a playground accident. The injury turned out to be quite minor, but when it happened there was immediately a great deal of bleeding and it was very scary. Margaret ran home and found her mother, who, as soon as she saw Margaret, began yelling at her angrily for having injured herself.

The threat of an irritable outburst from her mother was always in her mind, Margaret feels, but her more predominant, and in some ways more hurtful, experience was of being out of contact with her mother and left on her own. She had no sense of a connection with her mother around feminine things—how to shop, how to dress, how to flirt, how to behave and value herself as a woman—and as a result she developed into a socially uncomfortable tomboy.

Toward the latter part of the hour, Margaret's father comes into her thoughts. She talks about having been conscious throughout her childhood of depending on him for attention and warmth. If something troubled her, she went to her father rather than her mother. If she had a fight with her parents, it was her father who would reach out to her to make it up.

Of course, he couldn't really help her with the female stuff. As a child, Margaret remembers, she often wished she were a boy so that she could be closer to her father. Puberty increased her discomfort. She was a funny-looking misfit, with hair sticking out in all directions, whose clothes never looked right.

Margaret is quite teary as she talks about how unhappy she was. When her father was pleased with her, it helped her feel better about herself. I remind her of her father in a way, Margaret says, when I seem to believe that she is worthwhile and can expect people to like her. The session ends on that note.

Wednesday's hour begins with Margaret's report of a dream from the night before. She was in a field bounded by a fence on all four sides. In the field was a huge, powerful bull. Margaret was in the field with the bull, very frightened that the bull was going to attack her. She associates immediately to her analysis and to worrying that I might overpower her. The four fenced-in sides of the field are like her four hours every week. Sometimes she feels trapped in here with me. If my voice seems to be coming from closer, so that she has the impression I'm leaning forward, she has the idea I might pounce on her.

I ask Margaret what she thinks happened yesterday to make her particularly concerned about me in this way. She says it was probably what she was talking about when she was here, how dependent on me she's getting, as she was on her father. It makes her feel vulnerable. On one hand, it really makes her feel good to think that she might be okay, that maybe she could fit in with people; but on the other hand she knows I could become too important to her. She doesn't want to go around terrified of losing me; she doesn't want to worry all the time about whether I like her.
That's how it was with her father, she explains, and it was especially difficult for her because her father was pretty self-centered. He always had to be right, to be the big authority. He would hold forth endlessly about something that interested him, and he would get upset if she disagreed with him at all. He was very competitive too. They used to play tennis a lot together, which she loved, but he always had to win. If he started to lose, he could get almost vicious, smashing the ball at her. It reminds her of the bull in the dream.

She knows, too, that there's something exciting about the bull, and that the dream has to do with her confusion about sex. Margaret begins to think over how she has been able to enjoy sex with men at times, but there is always some kind of anxiety lurking, something about getting hurt. Now her father's need to be superior comes to mind again.

On Thursday, Margaret continues to think about how she's always regarded herself as out of it, about knowing how to be a woman. She feels inferior to other women in that way, and isolated from them. Partly, it's that she never bonded with her mother, isn't sure at all how her mother sees herself as a woman; partly, it's that her father needed for her to be submissive and give him his way, which is what her mother did. Growing up, Margaret knew she didn't want to relate to men the way her mother related to her father, but she didn't know what else to do. She wanted to find out how other girls related to boys, but she could never get close enough to them to find out. She remembers three very popular girls who always hung out together, whom she knew from being on the tennis team with them in high school. They teased her, calling her stuck-up, when she was really only shy.

As I listen to Margaret describing various interchanges with these three girls, my thoughts go to how often Margaret anticipates incorrectly that she will be unwelcome, is unnecessarily self-critical and pessimistic in her interpretation of social interactions, and underestimates people's interest in her. I wonder whether something of the sort might have been happening with her teammates. I explain my thinking to her, asking if perhaps those girls might have teased her in an effort to make contact with her and get to know her better.

Unexpectedly, Margaret flares up in anger at me. She knows they didn't like her, she says. They never invited her to do anything. Margaret goes on to present a great deal of very convincing evidence that the possibility I had inquired about was very unlikely. She charges me with being just like her father, attached to my own ideas, unable to respect her point of view, needing to be right. Really?, I say. I thought I was only asking. I didn't think I was insisting on being right. Actually, I consider her the expert on her childhood, I say to her, not me.

That's a lie, Margaret responds. All of our work together has been based on the premise that she's not the expert on her childhood. She reminds me that I've often questioned her way of looking at her past, and very usefully too. I acknowledge to Margaret that she is right, of course. In my eagerness to assert that I was not being a competitive bully like her father, I overstated the case. Yes, Margaret replies, she knows that. But what I need to think about, she says, is why I overreacted. Well, I thought I answered that, I respond. I did not want her to think I was being like her father when I felt I had a very different intention in mind. Obviously,

Margaret comments sarcastically, but doesn't pursue it any further. She falls silent, complaining that she doesn't really feel like talking to me. After a bit, I pick up on Margaret's use of the word "really," and suggest that maybe she doesn't feel like talking to me because she doesn't feel like she can say what she really thinks about me.

Margaret hesitates for a while longer, then says with obvious trepidation, this is what she really thinks about me. She thinks I do believe it's important for an analyst to be open and nonauthoritarian, that I try to be that way with her, and that it's very helpful. But besides that, she thinks I have a personal stake in not being seen as domineering and unfair, so that when she sees me that way—rightly or wrongly—I'm quick to react and to try to sort it out; and that gets in the way of my being able to listen to her sometimes. So, in a way I can wind up doing the very thing I'm trying to avoid. Huh, I grunt, somewhat taken aback. That's very interesting and a little embarrassing, I say to Margaret. I never thought of it that way. Those are certainly my sentiments. I'll try to watch to make sure they don't get in the way. I hope she'll tell me if she thinks that's happening.

That would be good, Margaret says. Then she adds that the funny thing is that she knows I wasn't really unable to listen to her about those girls. Sometimes I can get a little too interested in making my point, but not this time. She knows that I'm basically a nice guy. Even if I am a bit narcissistic, I'm also considerate and caring. She knows she likes me a lot and she's not sure why right now she wants to pick a fight with me. There's something else going on. It makes her nervous to be alone in this room with me, feeling like I'm a nice guy and she likes me. She knows it's about sex, somehow.
Reality Testing

I offer this series of hours to illustrate a productive sequence of analytic events that was set in motion via my doing a bit of what is often called reality testing with Margaret. I encouraged her to consider

whether certain of her expressed ideas were realistic, and I presented her with certain of my own ideas about reality for her consideration.

From my point of view, reality is a construct and reality testing denotes a process in which an individual views his or her way of constructing reality. Reality testing in analysis means that the patient attends to those definitive judgments about his or her perceptions that are necessary for the patient to make his or her way in the world, i.e., that the patient repeatedly defines and reviews his or her operational reality. Reality testing has often been conceptualized in a way that assumes the existence of a single, objectively determinable reality which is discovered by analyst and patient (e.g., Inderbitzin and Levy, 1994); and furthermore, the assumption is often made that certain of an analyst's judgments about reality are to be privileged (because the analyst has professional training, has completed significant personal analytic work, is less embroiled than the patient in the patient's conflicts, etc.). In my view, however, neither of these assumptions need be made when using reality testing as a clinical concept.

As I see it, giving reality testing an important place in analytic technique is quite consistent with awareness of the subjectivity of all perception and of the intersubjectivity of the analytic encounter. Certainly, clinical events are co-authored by analyst and patient. Nonetheless, within the clinical situation, each must make up his or her own mind, individually, about those events, as about the rest of life. Given a cooperative and mutually respectful relationship between analyst and patient, consensus about reality will be sought, and often achieved; but it is by no means required in every instance. The crux of reality testing is that the patient reaches decisions about his or her own view of reality. I like the traditional term “reality testing” because it emphasizes the importance of a patient testing his or her perceptions of reality against continuing experience and refining them accordingly. In the process of reality testing, a patient takes the analyst's view into consideration, but does not defer to it as authoritative.

The concept of reality testing could be misunderstood to be

rooted in a “one-person psychology.” At this point in the development of psychoanalytic theory, however, I think it should be clear to us that so-called “one-person” and “two-person” psychologies are not mutually exclusive conceptualizations; they refer to complementary perspectives (see, e.g., Gill, 1993). For me, the important point is that while every psychoanalytic couple is unique, what the patient learns about his or her participation in one unique relationship is generalizable to other unique relationships—if this were not true, we could make no therapeutic claim for clinical analysis. In other words, a patient learns about his or her own individual (one-person) psychology by studying his or her participation in an intersubjectively constructed (two-person) experience.

I think of reality testing as central to clinical analysis; but analysts have tended to look askance at it. Stein (1966), for example, states explicitly that avoidance of reality testing is the very thing that distinguishes psychoanalysis from other psychotherapies! Focusing on the question of what is real interferes with the patient's observation of his or her mental processes, according to Stein, because it directs the patient's attention outward to the perceptual world instead of inward where it belongs, analytically.

Stein's conception is a commonly held one, but my clinical experience does not accord with it. I find that when a patient carefully identifies and evaluates his or her conscious beliefs about what is real, and compares and contrasts them with other views, including the analyst's, it helps the patient recognize the influence of unconscious convictions formed in the past. In other words, reality testing facilitates the analysis of transference. For example, my asking Margaret to consider whether her assumptions about her friends were realistic and offering my own ideas on the subject put in motion an inquiry that led Margaret to notice the way her identification with her mother weighed upon her current perceptions—both within and outside the treatment relationship. Margaret eventually came to realize that her longstanding conscious picture of her mother as a self-absorbed intellectual had the important defensive function of obscuring Margaret's
awareness of her mother's serious emotional difficulties. Similarly, pursuing with Margaret what she really thought about me opened the door to an investigation of sexual conflicts which pertained to her relationship with her father.

I think we have reason to conclude that my questioning Margaret's view of reality and posing alternatives for her to consider created an opportunity for transference analysis. My impression is that in fact a great deal of reality testing gets done in every successful clinical analysis, precisely because, as my vignette illustrates, it is often through reality testing that manifestations of transference get identified. I think, however, that because many analysts, like Stein, conceptualize reality testing as nonanalytic, they feel obliged to do their reality testing implicitly—less straightforwardly and less often, perhaps, than would be most useful.

Abend (1982), following Stein, notes that most analysts operate on the premise that preoccupation with reality in analysis forecloses useful exploration of fantasy. Abend suggests that the danger of foreclosure is particularly clear when it comes to investigation of a patient's ideas about his or her analyst. Again, I do not find this to be the case, as my vignette illustrates. Margaret's exploration of the unconscious determinants of her experience of me and of our relationship was extended, not curtailed, as a result of her efforts to decide what I was really like. Actually, the bit of transference analysis that took place in the hour I reported was only the beginning of what proved to be an in-depth exploration of Margaret's fear that my interest in her was unreliable, a fear that related to disavowed perceptions of her mother's severe emotional difficulties, as well as to intensely felt oedipal rivalry.

It seems to me that it is when an analyst does not want to hear, or needs to discredit, a patient's transference expressions that they get foreclosed, not when an analyst respectfully offers another point of view. In fact, everything we traditionally say about the "power of transference" indicates that it is quite hardy and not easily suppressed. I recall a psychiatrist I analyzed who, because he was feeling professionally envious of me, needed to console himself with the idea that, busy as I was, I must be neglectful of my family. When the patient and I met at a parents' meeting at the school it turned out both our children were going to attend, he was sure this was only a token gesture on my part—the one evening a year I devoted to being a father. Later, when he heard from mutual friends that I went to all my daughter's soccer games, he thought to himself that of course I was only capable of a narcissistic interest in her athletic achievements. He found out about a special holiday dinner I cooked for the family, and decided I was just showing off. And so on. So much for foreclosure. Transference consists of favoring a particular plausible interpretation of reality among many plausible interpretations (Hoffman, 1983), and a plausible interpretation can always be maintained in the face of being questioned if the patient is motivated to maintain it.

In my experience, an analyst does not increase the opportunity to analyze transference by withholding his or her view of clinical events. It is by establishing ground rules which allow a patient to say what he or she thinks is really going on in treatment, including what the analyst might not want to hear, that transference analysis is facilitated. Only when a patient is able to expose his or her sincerest convictions about who the analyst really is can the patient consider how his or her experience of the analyst may have been affected by the past. Margaret's Thursday hour, it seems to me, is an instance in point.

It is important to distinguish between doubts about reality testing per se and objections based on the principle of analytic anonymity. Of course, I could have simply questioned Margaret's view of the Passover situation without explicitly stating my own opinion, even though my choosing to question her view indicated unmistakably that I at least thought it was possible to see things differently than she did. Those analysts who believe that it is categorically inadvisable to explicitly communicate one's own judgments about life to a patient will certainly disapprove of the way I compared notes with Margaret about the problem of how to socialize when one has a cold, and of how, when Margaret described her perception that I do not like being seen as authoritarian, I acknowledged its accuracy, from my point of view. The question of what kinds of self-disclosure by an analyst are helpful requires extensive discussion in its own right, and has received it elsewhere.

(see Renik, 1994). However, for purposes of the present inquiry, I would like to set aside the problem of self-disclosure. I want to focus instead on the idea that reality testing, i.e., encouraging a patient to decide whether the ideas that come to his or her mind are realistic (regardless of whether the analyst explicitly communicates his or her judgments in the matter) is a crucial analytic activity, despite the fact that it is widely considered to be less than optimal technique.

The extensive debate that has taken place concerning historical truth versus narrative truth in analysis may have contributed to the idea that reality testing is counterproductive. There is good reason to question ex post facto determinations in analysis of the reality of past events. (Witness the problem of so-called "true-false memory syndrome" that has received a great deal of press lately.) However,
what a patient in analysis can do is evaluate the way he or she constructs reality in the present, the way the patient assesses the world-view that informs his or her current attitudes and behaviors—including the symptoms which have necessitated treatment. In clinical analysis, past experiences only become relevant insofar as they bear upon reality testing in the here-and-now; and then construction of past reality is a pragmatic activity—to be judged according to its consequences in the present—rather than a pursuit of truth, narrative or historical, in and for itself. Thus, Margaret came to review and revise her childhood image of her mother in the process of trying to best decide for herself how realistic it was, in the present moment, to be declining an invitation to Passover dinner, and how to regard my attitudes about exposing others to illness. It was when she examined, very carefully, what she really thought about my character that she began to become aware of her conflicted sexual interest in her father.

The Real Analytic Relationship and Free Association

Reality testing, as I have been describing it, is only one feature of a technical approach that follows from considering the psychoanalytic treatment relationship real—real in the ordinary sense of

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the term. If the aim of clinical analysis is to allow a patient the opportunity to investigate how he or she operates in the world, particularly how he or she participates in interpersonal relationships, and if the example par excellence to be investigated is the patient's participation in a relationship with the analyst, then, it seems to me, it makes sense to have that relationship be as much like any other relationship as possible. We want clinical psychoanalysis to be a natural in vivo rather than a contrived in vitro examination. Therefore, in my view, analytic inquiry is best served when both analyst and patient think of their relationship as ordinarily real, and conduct themselves accordingly. Of course, the psychoanalytic treatment relationship has unique attributes; however, I think it is crucial to keep in mind that these unique attributes, and the very unusual sort of intimacy they create, exist within everyday reality.

In this respect, it seems to me that a certain amount of confusion has existed around the concept of free association and the “fundamental rule,” which should not, in my opinion, be construed to suggest that the clinical setting is unreal, or possessed of a special, psychoanalytic form of reality. To me the fundamental rule is that a patient in analysis reports his or her thoughts as freely as possible, no matter whether they seem sensible, relevant, embarrassing, repetitious, etc. This does not mean that the patient suspends judgments about his or her ideas. On the contrary, it means that the patient pushes himself or herself to say whatever comes to mind despite troubling judgments that may arise, i.e., even when the patient would like to censor self-expression because of his or her judgments. Most especially, a patient's free association does not involve the patient's suspending judgment about whether his or her ideas are realistic. A patient's judgments about whether his or her ideas are realistic are extremely important thoughts in themselves and need to be reported like any others. The psychoanalytic situation does not offer the patient a reprieve from constructing reality; it offers the patient a chance to extensively examine his or her constructions of reality and to discuss them with unusual candor.

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If a patient's judgment concerning whether thoughts that are coming to mind are realistic appears to me to remain conspicuously absent, I inquire about the omission. My impression is that when a patient avoids judgment about the reality of his or her ideas, it is a kind of procrastination that impedes analysis. I find a way to ask, somehow or another, “Is that what you really think?” When an analyst has this question in mind but does not voice it, I believe the analyst engages in what Arlow (1995) has aptly termed “stilted listening.”

For example, at one point Margaret decided that I was angry at her for canceling a session. She believed that, for personal reasons of my own, I needed her analysis to be the most important thing in her life. She went on to elaborate this image of me at length without asking herself whether she regarded it as realistic. So long as she did not address that question, Margaret had to deal definitively neither with a judgment that her analyst really was being inappropriately jealous and possessive, which would have raised serious doubts about the advisability of her continuing in treatment with me, nor with a judgment that she was unrealistically imagining me to be inappropriately jealous and possessive, which would have required her to look into her own motivations for producing such an idea. As it turned out, pointing out to Margaret that she seemed unwilling to decide whether she thought her idea about my jealousy and possessiveness was realistic opened the way to analysis of a conviction on her part that she was my special favorite patient, and that our time together each week provided me with a measure of feminine warmth that was missing from my marriage. Ultimately, the reality testing Margaret did about this vision of her position in my emotional life led her to conclude that her belief was not based on evidence, but rather was a consoling belief that she needed to maintain for reasons similar to ones that had motivated her to maintain the same belief about her father in childhood.
In my experience, when a patient is evaluating the reality of an image of the analyst, there are not infrequently a point at which more associations are unlikely to illuminate the issue at hand, when to continue to elaborate more and more associative material begins to constitute an avoidance of a necessary evaluation. At such a juncture, the patient faces the task of considering what he or she knows about the analyst and of deciding, as best he or she can, what the analyst is really like. In the course of trying to decide what the analyst is really like, some patients will sit up and take a good look at the analyst—quite reasonably, in my opinion, whatever the multiple motivations involved. There are times when, as many investigators have suggested (e.g., Goldberger, 1995; Moraitis, 1995), use of the couch is counterproductive. If a patient who is trying to decide what I'm really like does not think of looking at me, I sometimes inquire about why the option has not come to mind. It seems to me that it is important for an analyst to be actively realistic, as well as reactively accepting when the patient is realistic.

**Clinical Reality**

Keeping in mind the mundane reality of the analytic treatment relationship means above all, to me, not losing track of its therapeutic purpose. Arlow (1995) speaks of the “fundamental reality” that is the context of clinical analysis: namely, that a patient hopes to gain relief from emotional distress by changing the way he or she thinks about things, and hopes as well that the analyst will help effect the change. I treat the analytic relationship as part of everyday reality, and I see that reality as Arlow does. I expect my patients to work with me toward the goal of reviewing and revising ways they think so as to improve the quality of their lives, and I communicate this expectation to them explicitly. Furthermore, I expect my patients to evaluate how we are doing as we go along—which is to say, I assume that they will keep in mind the reality that clinical analysis is a therapeutic endeavor, as I do. Although a patient cannot always know exactly where he or she is headed or how much progress is being made at any given moment, the patient should have an overall idea of where he or she wants to get and whether he or she is getting there.

Referring to therapeutic goals locates a clinical analysis within the reality of the rest of the patient's life. Otherwise, there is danger of analysis becoming a sequestered, self-sustaining, escapist exercise—a separate reality, so to speak. The analytic treatment setting is designed to “facilitate regression” (Poland, 1994) and, indeed, a patient’s passive wishes do tend to be elicited by an analyst’s focused attention, interest, and acceptance, willingness to subordinate his or her own emotional interests to the objective of being helpful, etc. This creates a particularly problematic situation for certain patients who are drawn to analytic treatment precisely because it seems to them to promise a kind of idealized mentoring of which they feel they have been deprived and to which they feel entitled. Hope for magical rescue dominates their participation in analysis, and their efforts at self-investigation are a pretense, designed to propitiate an analyst-rescuer.

Such a patient is willing to attend sessions indefinitely, in the absence of therapeutic gain, waiting to be saved. In this kind of treatment, unless the analyst draws attention to the reality of the absence of therapeutic benefit, the patient is all too happy to ignore it, and the underlying expectation of magical rescue remains unexposed. The analyst is experienced as promising not a cure based on understanding, but a kind of love relationship upon which, in fact, the analyst can never really deliver. The patient is led to expect not the real love an analyst can, perhaps must, have for his or her patients, together with the very significant though limited benefits such love can bring, but the kind of love only a parent or life partner can actually provide; and underlying this unrealistic expectation there is an infantile wish for magical, alluring love from an omnipotent figure. Friedman (1985) sees this all-too-common deception, in which an analyst seductively offers impossible love to a patient, as inherent in the reality of the analytic situation; but I think it is maintained only when an unrealistic image of the analyst and the treatment relationship is corroborated because clinical analysis is treated as in some ways separate from the rest of everyday reality.

One way separation between analysis and the rest of reality gets established is when an analyst believes it is possible to initiate an undirected process of inquiry into a patient's mental life without establishing specific therapeutic goals: when the assumption is made that free-floating analytic investigation will necessarily eventually
bear fruit in the form of symptom relief. My own impression, to the contrary, is that without clearly defined goals pertaining to the reality of the patient's distress in his or her life, authentic analytic investigation does not proceed. A free-floating approach requires the patient to be particularly disposed to formulate and keep in mind his or her therapeutic goals; whereas the very problems that bring a patient to treatment often interfere with the patient's motivation to identify and pursue realistic therapeutic goals. Therefore, I find that it is indispensable for the analyst to draw attention at various moments to the question of how analysis is functioning as therapy—how it bears upon the reality of the patient's life as a whole.

For me, clinical analysis is a task-oriented endeavor. I do not aspire to a free-floating analytic stance. From the beginning of the treatment, I try to help a patient define exactly what it is about himself or herself that he or she wants to change through better understanding. If it proves difficult for a patient to specify exactly what it is about himself or herself the patient wants to change, which is not uncommonly the case, then that difficulty itself becomes the phenomenon of primary interest in our work together. A patient's view of his or her symptoms usually evolves as analysis proceeds; but symptom relief remains the goal of analysis, and self-understanding functions as a means to that end. As analytic work unfolds day to day, defining the specific goals of treatment is by no means an exclusive and constant preoccupation (it seems to me that there is a great deal about the direction of a clinical psychoanalysis that need not, perhaps cannot, be spelled out explicitly), but I find it is crucial to remain in touch with the therapeutic purposes of an analytic investigation. If, in the course of analysis, there are times when I cannot understand how what a patient is thinking about has the potential to bring the patient closer to his or her goals, I tend to ask. I have observed that such inquiry can be useful in any number of ways (see Renik, 1995a).

The Reality of Termination

Obviously, the evaluation of progress in relation to therapeutic goals is a conspicuous issue when it comes to termination. Bringing a clinical analysis to a productive conclusion depends upon clarification of the relation between analysis and the rest of a patient's life. My experience is that the circumstances of clinical analysis always constitute an obstacle to the patient's learning to some degree, so that certain aspects of self-investigation become possible for the patient only after termination. There are cases in which this problem predominates. We know how often analysis can be used as a "substitute for life," but the counterproductive effect of the analytic setting is part of every analysis; and it cannot be addressed unless the analyst is willing to ask the patient to assess the reality of his or her life and the place in it of psychoanalytic therapy.

For example, a patient I treated, whose father had died when the patient was six years old, was unable to form a lasting relationship with a woman. The patient had derived many benefits from five years of analysis, including the resolution of troubling sexual symptoms, but he was unwilling to choose a woman, commit to his decision, and live with the consequences, because he believed that proper fathering from his analyst would enable him to choose a wife with a sense of absolute certainty and without having to endure anxiety about making mistakes. The patient was unwilling to go all the way, so to speak, in putting his analytic achievements to use because he was holding out for what, when he was six years old, he thought he had lost—a father who could make life risk-free. Notwithstanding our extensive discussions of how he retained this childish notion of what his father could have done for him had he lived, the patient waited for me to remediate his loss.

In our meetings, we were not turning up anything new about this problem; nor was there anything to suggest that there was more the patient needed to know, beyond what we had already discovered together. However, continuing to meet in the expectation of crucial new insights was corroborating the patient's hope for magical rescue. I suggested to him that he was waiting for Godot. I discussed with the patient his temptation to use the treatment situation to help him avoid dealing with reality, and eventually he decided to terminate. A year after discontinuing his sessions, he began to live with a woman to whom, in time, he became happily married. This young man was one of a number of patients I have known, for whom, similarly, termination was an especially crucial step because they had to leave the reality of the treatment setting behind in order to progress with their analytic learning and to realize, in reality, their therapeutic goals. These were extreme cases in which the analytic work that could take place only after termination was decisive, but it is probably important in virtually every clinical analysis.

Dialectics and Psychoanalytic Reality
I have tried to define at some length a down-to-earth conception of clinical analysis as part of everyday reality, because it contradicts a view prevalent among analysts that our work is extraordinary and takes place within a special domain. Over thirty years ago, for example, Tarachow (1963) designated the therapeutic relationship between analyst and patient a thing apart from the real relationship between them. Subsequently, this differentiation was maintained by separating psychoanalytic activity proper from the mundane therapeutic or working alliance (e.g., Greenson, 1965; Zetzel, 1963) and by conceptualizing psychoanalysis as dealing not simply with reality, but with psychic reality (cf., McLaughlin, 1981).

The notion that clinical analysis occurs within a special kind of reality cuts across theoretical orientations and continues up to the present. Modell (1991) asserts: “Anyone who has experienced a therapeutic relationship, either as a patient or as a therapist knows quite well that it is unlike anything else in ordinary life” (p. 13). Modell goes on to state unequivocally that “the therapeutic process … creates a different level of reality…” (p. 15, italics added), and describes psychoanalytic experience as the “processing of real affect within an ‘unreal’ context” (p. 24, italics added). Similarly, Ogden (1994) states that a “unique subjectivity” is generated in the analytic setting (p. 4, italics added).

The idea of a special, specifically psychoanalytic reality arises from the effort to reconcile certain tensions that have plagued theorizing about the mechanism of action of clinical psychoanalysis. Traditional conceptualizations of the mind divided into an “experiencing” and an “observing” ego, with oscillations between the two, are mechanistic and do not offer much in the way of clinical application, inasmuch as it has not proven easy to develop specific formulations concerning when the oscillation occurs and how it is accomplished. Any number of theorists (e.g., Ghent, 1992; Greenberg, 1991; Loewald, 1982) have continued to struggle with the question: How does a patient both repeat the maladaptive patterns that have brought him or her to treatment and forge new adaptive ones? How does a patient experience an analyst both as an old (transference) object and a new (mutative) object offering new interactions?

Contemporary answers tend to be holistic, leaving behind conceptions of the mind divided into different agencies concerned with observation versus interaction. Instead, the special reality of the psychoanalytic situation is now invoked as a way of resolving the old polarities. Analysis is thought of as taking place in a “potential space,” creating its own “third” subjectivity, different from ordinary temporal reality (e.g., Green, 1975; Ogden, 1994; Viderman, 1979). Some authors invoke the concept of play to explain how a unique product is produced in analysis that integrates old and new realities, pathological repetition and therapeutic reworking. In this regard, Winnicott’s (1953) invaluable work on transitional phenomena has been very influential (though not necessarily as Winnicott intended): the mechanism of action of clinical analysis is often conceptualized along the same lines as the creation of an imaginary companion in childhood—the patient’s experience of the analyst is neither me nor not-me, neither real nor unreal.

Insofar as they encourage analyst and patient to negotiate with one another in expressing their individual viewpoints, the more recent conceptions of special analytic reality constitute an understandable and constructive antidote to the claim that the analyst is the arbiter of reality in the clinical setting (see Pizer, 1992). On the other hand, reality testing and related, clinically crucial activities are discouraged when the events of clinical analysis are thought of as transitional phenomena. If one thinks that there is a special psychoanalytic reality, one does not ask a patient “Is that what you really think?” any more than one would ask it of a child who was talking about an imaginary companion.

The problem with this way of using Winnicott’s ideas is, of course, that establishing an imaginary companion is not always adaptive. In fact, while Winnicott described how transitional phenomena are useful during certain stages of development, he also pointed out that if transitional phenomena persist, they can eventuate in addiction and perversion. That is exactly what we see when a patient in analysis is not asked to assess the reality of his or her thoughts—addiction to the treatment situation and use of the analyst as a fetish (see Renik, 1992).

Increasingly, our clinical experience leads us to the realization that it is what an analyst actually thinks, feels, and does, rather than an analyst’s efforts to be an anonymous, as-if figure, that makes possible a successful analytic investigation (e.g., Sampson, 1992; Slavin and Kriegman, 1992). However, I have the impression that our theoretical formulations have not yet caught up entirely with this realization. For example, Pizer (1992) presents a convincing case example in which an analyst’s decision to confront a patient with his poor personal hygiene and offensive body odor proved to be a crucially productive turning point in the analytic work. What could be more definitively real? Yet Pizer.

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suggests that analysis happens in an “area of illusion where two people may intersect and negotiate paradoxical reality of the analytic process” (p. 238, italics added). To my mind, Pizer’s conceptualization points in a different direction than his compelling clinical observations. I have the impression that some of our most creative and innovative contemporary analytic thinkers pursue theory-building in an academic, philosophical vein that can lose contact with the treatment situation, seen empirically and pragmatically. Various conceptions of a unique psychoanalytic reality continue to be elaborated that, in my opinion, do not capture the conditions under which effective clinical work takes place.

Currently, the special attributes of psychoanalytic reality tend to be characterized by the use of the term dialectic. Hoffman (1996), for example, reviewing the work of Benjamin, Mitchell, Stern, and others, suggests that “dialectical thinking” permits the contemporary analyst to balance various troublesome polarities. Hoffman (1996) recommends Ogden’s usage:

A dialectic is a process in which each of two opposing concepts creates, informs, preserves, and negates the other, each standing in a dynamic (ever changing) relationship with the other (p. 195)

Ogden’s (1986) dialectic denotes an equilibrium: motion is described, but no evolution. Under the heading of dialectic, Ogden portrays what is essentially a conceptual hall of mirrors. An analyst who uses this conception of dialectic to think dialectically will not be disposed to ask a patient “Is that what you really think?” because the question will be seen to pertain to a misconceived dichotomy. Ghent (1992), who prefers paradox to denote the static relationship between apparent opposites that Ogden describes, remarks:

...we are witnessing currently an important development in psychoanalysis. Almost since the beginning, our field has been marked by reductionistic dissection of one sort or another: “It’s not this; it’s that!”... Now, however, I believe there is a chance

for a new outlook, one that is built on the capacity for entertaining paradox (p. 156).

My own emphasis would be somewhat different from Ghent’s, at least so far as the history of psychoanalytic clinical thinking is concerned. It seems to me that analysts have always been and continue to be, if anything, too ready to encourage patients to avoid making crucial either/or judgments—too ready to entertain paradox. There is a reason for the famous old joke in which the patient complains, “I’m going to look for an analyst with only one arm, so he can’t always say, ‘Well, on one hand... but on the other hand...’” In psychoanalysis, I would say, the accepted answer to the question “Is it this or is it that?” is usually “Both.”

For me, the Hegelian concept of progressive dialectical process is more relevant to psychoanalysis: instead of being in an eternal, complementary relationship to one another, contradictory propositions contend with one another until one of them prevails or until their contradiction becomes obsolete in light of a new integration—the well-known juxtaposition of thesis to antithesis, leading to eventual synthesis. This is the way, it seems to me, learning proceeds, either in analysis or elsewhere (see Renik, 1995b). Applied clinically, Hegel’s conception of dialectical process directs an analyst to present alternative views to a patient for consideration, and sometimes to ask the patient “Is that what you really think?,” so that the question, if it really does refer to an obsolete dichotomy in the patient’s thinking, can eventually be transcended. Thus, for example, at my invitation Margaret tried to determine what she really thought about going to the Seder with a cold: she went back and forth between the alternatives, and ultimately came to the conclusion that going versus not going was not the salient issue; it was her need to emulate her phobic, isolated, and depressed mother.

Regression and Progression

My observation is that when analyst and patient treat the clinical analytic encounter as part of everyday reality, the patient tends to spend less time than he or she otherwise would in states of mind characterized by feelings of helplessness, extreme dependence on the analyst, preoccupation with analysis to the relative exclusion of the rest of life, and the like. Some analysts who have made similar observations interpret them to mean that paying attention to the conscious “surface” of reality has prevented sufficient “transference regression” from occurring (e.g., Pazel, 1958). Other analysts, however, have concluded that “transference regression” is a misnomer.
applied to iatrogenic symptomatology induced in the patient when the analyst denies the reality of the treatment setting. Lipton (1977), for example, describes how an analyst's enigmatic and removed stance, dictated by certain conceptions of analytic technique, virtually forces the patient to retreat into childish narcissism. Much of what has been described as regression in clinical analysis, it seems to me, is not regression at all, but the creation of a very contemporary state of disorganization brought about when an analyst denies the reality of the treatment setting. I have pointed out that an analytic stance of would-be anonymity cultivates idealization of the analyst and corresponding infantilization of the patient (Renik, 1995a).

I am very skeptical that transference regression, so-called, characterizes a well-conducted analysis. The idea of the past recaptured and reworked through a special voyage of discovery is a familiar folkloric theme, and a theory of healing that informs any number of mystical practices, hypnotherapies, etc. In psychoanalysis, the conception that transference regression by the patient is a necessary aspect of clinical process arises from the “picket fence” model of the mind Freud (1900) proposed in Chapter VII of The Interpretation of Dreams, according to which impulses on their way to discharge pass through layered memories, giving rise to a process of temporal, formal, and topical regression. This model of the mind, from which the concept of salutary transference regression proceeds, is one which we now have every reason to consider obsolete (Palombo, 1978; Reiser, 1990).

I think Brenner (1982) is right when he says:

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Analysts are generally agreed that transference can develop fully only in the setting of an analysis.... that transference as a phenomenon in psychic life stands in a special relation to psychoanalysis as therapy and to the psychoanalytic situation. The fact is otherwise.... It is true that in an analytic situation the wishes and conflicts of early childhood are transferred to the analyst. It is not true, however, that there is anything unique or special about such a transference.... It is not even true that in the relation of patient to analyst the importance of childhood wishes and conflicts is ... greater ... than it is in other human relations (pp. 194-195).

My own experience has been that when the past weighs upon the present, it can be found in the present. The childhood attitudes and expectations that come into focus in analysis are ones that operate in the patient's life all the time. Again, I'm in accord with Brenner (1982), who puts it this way:

When a patient's analysis proceeds satisfactorily, the patient becomes more and more able to tolerate childhood ... derivatives and, indeed, to enjoy the gratification of many of them. Thus, as analysis progresses, childhood ... derivatives appear at less disguise than formerly in the patient's thought and behavior and, at the same time, the patient's associations to them ... indicate more clearly what role those ... derivatives played in the ... patient's ... psychic development and subsequent functioning. It is primarily for this reason that the infantile determinants of the patient's transference manifestations are increasingly identifiable or detectable as analysis progresses (p. 207).

No special, regressive state of mind is needed to identify and explore transference, only a redistribution of attention that comes from the commitment of analyst and patient to thorough and honest investigation; nor is a special, regressive state of mind produced by the discovery of transference, only an unaccustomed acknowledgment by the patient of experiences—sometimes dramatically vivid or upsetting or even disorienting—that have usually been kept out of awareness. In analysis, certain of a patient's shameful, anxiety-provoking, often infantile thoughts and feelings

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that usually occur privately are experienced in the presence of another, which places them in a very different perspective. Customary denials and disavowals become impossible. The concept of transference regression assumes that a patient must become more childish, at least for a time, in order for analytic work to proceed; whereas I find that what is needed is that the patient recognize and review the ways in which he or she is already childish. In my view, the most effective way to make possible the identification and review of unconscious, maladaptive coping strategies left over from the past is to meticulously examine conscious, current experience—including judgments about what is true and actual, in the treatment setting and elsewhere. In other words, the best way for an analyst and a patient to facilitate analysis of the patient's transference is for both to get real.

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