Few would dispute that the establishment of a bond between analyst and patient that permits the work of analysis to unfold is a sine qua non of our work. Yet serious differences exist regarding the essential nature of this bond, and the clinical implications of these differences are profound. The problem of resistances has thwarted psychoanalysts in their efforts to bring about more predictable structural change, leading to criteria for analyzability that increasingly exclude large numbers of persons seeking analysis. (Waelder, 1960; Greenson, 1967). Freud's (1937) final work, “Analysis Terminable and Interminable,” reflected his preoccupation with the severe limitations posed by resistances on the therapeutic efficacy of psychoanalysis. In this summary he held a large number of factors, all intrapsychic, to account. If Freud's conclusions were to be accepted as final, psychoanalysts were faced with either an analytic procedure severely restricted in its scope or with the necessity of having to alter significantly the basic principles and techniques of psychoanalysis in the hope of increasing its therapeutic effectiveness. This dilemma provided a powerful stimulus for the reexamination of the nature of the therapeutic bond. And so the concept of a therapeutic alliance, already implicit in much of Freud's writings, became the focus of great interest in the 1950s.

In retrospect, it is clear that in the United States the interest in the therapeutic alliance, a particular object relationship between patient and analyst (Sterba, 1934; Bibring, 1937; Fenichel, 1941; Greenson, 1954; Zetzel, 1956; Stone, 1961), was stimulated by the development of ego psychology and paralleled the burgeoning interest in the more general
subject of object relations in Great Britain, as exemplified in the work of
Klein, as well as that of Winnicott, Balint, and Fairbairn. Both developments
were rooted in the recognition that breakdowns of the therapeutic process
came about because of disruptions within the analytic dyad, and so it was to
these subjects that analysts turned their attention in attempts to extend the
scope of analytic influence.

The ego psychologists, focusing on the central role of the ego in
development and pathogenesis, visualized the analytic relationship as having
two dimensions. One was rooted in the patient's identification with the analyst
and especially with his understanding of the patient's unconscious. This, they
held, was the basis for the therapeutic alliance. The other part of the patient's
ego was engaged in resistance to the unfolding of the unconscious regressive
instinctual forces and the structural conflicts that constituted the pathogenic
oedipal complex of the transference neurosis. The maintenance of the
therapeutic alliance was dependent on bringing about a split between an
experiencing ego and a more reasonable, detached, and observing ego
(Zetzel, 1956; Greenson, 1967) in order to deal with the resistance. This
was to be facilitated by the patient's rational wish to cooperate with the
analyst in order to overcome his suffering and by “his ability to follow the
instructions and insights of the analyst” (Greenson, 1967, p. 192). Greenson
(1967) emphasized the patient's identification with the analyst's interpretive
approach as the specific goal of the therapeutic alliance. He took a step away
from the traditional view when he considered the establishment of this
relationship between patient and analyst, the “ingredient which is vital for the
success or failure of psychoanalytic treatment,” as “relatively nonneurotic,
rational”—in other words, nontransference (Greenson, 1967, p. 46).

It is to be emphasized that in describing the establishment of a therapeutic
alliance the ego psychologists were not only claiming that the patient must
identify with the analyst's basic investigative methods and with such general
principles as transference, resistance, and unconscious forces shaping
subjective experience. The process of identification also had to include the
analyst's theory-rooted assumptions about the patient's basic motivations and
about the contents of the patient's mind. Thus, if the patient rejected or failed
to recognize the correctness of the analyst's view that drive-related conflicts,
particularly the oedipal conflict, were central in his symptoms and in his
development, this continued to be regarded as the ultimate expression of the
rivalry belonging to the very oedipal complex that the analyst had been
seeking to uncover, now inevitably working its way into the transference
(Abraham, 1919).

Understanding the resistance as deriving from conflicts arising solely from
within the patient, the ego psychologists also required the patient to
identify with the analyst's view of himself as essentially neutral in relation to
the patient's conflicts, a blank screen upon which these were played out.
Accordingly, transference was to be seen as the result of the patient's
displacements or distortions, except where it might be influenced by those
countertransference intrusions that the analyst was able to recognize. Chronic
and intractable resistances were believed to be signs of negative therapeutic
reactions or unanalyzability and were ascribed to ego weakness or a
masochistic need to fail.

The dominant school of object relations in Great Britain, that of Melanie
Klein, on the other hand, held that the therapeutic alliance was embedded in
the transference, which itself was a complex object relation. The attachment
of a “normal” dependent part of the self to a “good” part-object, the breast,
was revived in the analysis, and the identification with it formed the nucleus
of the therapeutic alliance. Disruptions in this bond were attributed to the
operation of primitive defensive measures of the ego, which shaped and
distorted the patient's perception of “real objects,” including the analyst, and
resulted in pathogenic introjections of cruel objects or objects damaged in
omnipotent fantasy by the patient's destructiveness. The reestablishment of the
therapeutic bond, and with it a secure tie with good, protecting, and protected
internal objects, was thought to be the foundation of growth and creativity.
This was brought about by the interpretation of the unconscious archaic
defense mechanisms, by the working through of the infantile conflicts of
ambivalence and pathological envy that the patient was defending against, and
by the patient's developing trust in the analyst and his explanations of the
nature of the patient's subjective experience, anxieties, and depressive
feelings.

Klein (1950), unlike the ego psychologists, believed that the functioning of
the ego was at all times determined by its relationships to its external and
internal objects. Archaic ties between the ego and primitive objects or part-
objects existed from the beginning, she insisted, and thus the history of any
individual's development could be found in the record of the complex
relationship between ego and objects. As a consequence of this view, the
scope of psychoanalysis was for her automatically extended. The
constitutional strengths or adaptability of the patient's ego were not stressed
as a prerequisite, and consequently, children and psychotics were accepted,
in principle, as being suitable for analysis. This remained a point of
contention between the two schools.

Strachey’ (1934) conceptualization of the “mutative interpretation”
illustrates the Kleinian view of the therapeutic process. Strachey believed, as
did the ego psychologists, that identification with the analyst occupied a
central role. For him the operative mechanism was that of introjection,
whereby the analyst's interpretations enabled him to be

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installed as a less severe and more benign influence than the patient's existing internal objects or superego. However, in Strachey's formulation the mutative value of the object relation to the analyst lay not only in an analytic attitude or stance that might open the possibility of a transforming introjection. It was essential that the identificatory process extend to the analyst's interpretations of the impulses and defenses that characterize the paranoid-schizoid and depressive positions postulated by Klein, since these were assumed to reappear in the transference. These “mutative interpretations” would have to be accepted as “true,” so that the patient's view of himself and his history would come to conform to what the analyst had reflected to him.

Klein's followers adhered to a stance whose basic principles she (1961) described as follows:

The psychoanalytic procedure consists in selecting the most urgent aspects of the material and interpreting them with precision. *The patient's reactions and subsequent associations amount to further material which has to be analyzed in the same way ...* I was determined not to modify my technique and to interpret in the usual way even deep anxiety situations as they came up and the corresponding defenses [pp. 12–13; emphasis added].

The interpretive principles derive from Klein's view of the central importance of primitive defense mechanisms, especially splitting and projective identification, directed against internal instinctual forces or internal objects distorted by projected contents. Within this system intense and prolonged resistances leading to negative therapeutic reactions were and continue to be ascribed to the workings of pathological destructive envy, a vicissitude of the death instinct (Klein, 1957; Joseph, 1982; Rosenfeld, 1987). This clinical formulation is hardly surprising in view of the primary etiologic role Klein's metapsychology attributed to the innate conflict between life and death instincts. Here also, as in the case of the ego psychologists, the unsuccessful therapeutic result was assumed to demonstrate the correctness of the theory no less than the successful one. Despite their profound differences, in this crucial aspect these two divergent theoretical schools were in accord. The therapeutic alliance and the success of the analysis were held to depend on the ability of the patient ultimately to see the events of the analysis according to the basic concepts that organized and informed the analyst's observations and interpretations. This is a requirement with which patients often felt compelled to comply, as the price for maintaining the vitally needed tie to the analyst.

We have chosen to discuss the concepts and practices of these two dominant schools not only because of their leading position and continuing
influence on psychoanalytic thought, but also because, in their approach to a therapeutic bond, they illustrate a basic and largely unchallenged philosophical assumption that has pervaded psychoanalytic thought since its inception, namely, the existence of an “objective reality” that is known by the analyst and distorted by the patient (Atwood and Stolorow, 1984; Stolorow, Brandchaft, and Atwood, 1987). This assumption lies at the heart of the traditional view of transference and its insistence on the dichotomy between the patient's experience of the analyst as distortion and the analyst's experience of himself as real. This dichotomy is one of the foundation stones on which the more elaborate and experience-distant theoretical scaffoldings of the two divergent psychoanalytic schools have been built. It is not the philosophical assumption with which we are here concerned, but the serious and insufficiently acknowledged consequences of its clinical application.

In agreement with Schwaber (1983), we contend that the only reality relevant and accessible to psychoanalytic inquiry (that is, to empathy and introspection) is subjective reality—that of the patient, that of the analyst, and the psychological field created by the interplay between the two. The belief that one's personal reality is objective is an instance of the psychological process of “concretization,” the symbolic transformation of configurations of subjective experience into events and entities that are believed to be objectively perceived and known (Atwood and Stolorow, 1984). Attributions of objective reality, in other words, are concretizations of subjective truth. As we have observed this process in ourselves and others, we have become aware that it operates automatically and beyond conscious awareness. It belongs to a relatively uncharted area of the unconscious termed the “prereflective” unconscious (Atwood and Stolorow, 1984) and involves the shaping of experience by invariant organizing principles that operate outside a person's awareness.

Adherence to the doctrine of objective reality and its corollary concept of distortion has led both psychoanalytic schools to view pathology in terms of processes and mechanisms located solely within the patient. This emphasis blinds the clinician to the impact of the observer on the observed as an intrinsic, ever-present factor in the psychoanalytic situation, and it obscures the profound ways in which the analyst himself and his theories are implicated in the phenomena he observes and seeks

1 Although concrete symbolization may serve multiple purposes, its suprareal function is to cast subjective reality in a reified and material form in order to articulate and consolidate it and buttress one's belief in its validity. The concretization of experience is a ubiquitous process in human psychological life, underlying such phenomena as neurotic symptoms, sexual and other enactments, dreams, fantasies, and psychotic delusions (See Atwood and Stolorow, 1984; Stolorow et al., 1987).
to treat. When the concept of distortion is imposed, a *cordon sanitaire* is established, which forecloses the investigation of the analyst's contribution in depth. The invitation that the patient identify with the analyst's concepts as a condition for a therapeutic alliance is an invitation to cure by compliance. Alternatively, it can trigger the appearance of what seems to be a resistance. Investigation of the patient's experience may reveal, however, an important attempt at self-differentiation, an attempt to protect an independent center of perception and affectivity from usurpation. When the patient reacts adversely to the analyst's explanations, the idea that these disruptive reactions arise from purely intrapsychic causes and are to be explained by the same concepts that are producing the reactions sets the stage for those chronic disjunctions that have been described as negative transference resistances or negative therapeutic reactions (*Brandchaft, 1983; Atwood and Stolorow, 1984*).

When analysts invoke the concept of objective reality along with its corollary concept of distortion, this forecloses and diverts the investigation of the subjective reality encoded in the patient's communications, a reality that is precisely what the psychoanalytic method is uniquely equipped to illuminate.

Considerations of this kind have led us to formulate an intersubjective approach to psychoanalytic treatment:

*In its most general form, our thesis … is that psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities—that of the patient and that of the analyst … psychoanalysis is pictured here as a science of the intersubjective, focused on the interplay between the differently organized subjective worlds of the observer and the observed. The observational stance is always one within, rather than outside, the intersubjective field … being observed, a fact that guarantees the centrality of introspection and empathy as the methods of observation … Psychoanalysis is unique among the sciences in that the observer is also the observed … [Stolorow et al., 1987p. 1].*

The intersubjectivity principle was applied to the developmental system as well:

*Both psychological development and pathogenesis are best conceptualized in terms of the specific intersubjective contexts that shape the developmental process and that facilitate or obstruct the child's negotiation of critical developmental tasks and successful passage through developmental phases. The observational focus is the evolving psychological field constituted by the interplay between the differently organized subjectivities of child and caretakers … [Stolorow et al., 1987p. 2]*
The intersubjectivity concept is in direct contradistinction to the constricting tendency to view pathology in terms of mechanisms and processes located solely within the patient.

What, from our intersubjective perspective, constitutes the essence of a therapeutic alliance? It is surely not the bond formed by the patient's commitment to follow the insights of the analyst. In our view the foundations of a therapeutic alliance are established by the analyst's commitment to seek consistently to comprehend the meaning of the patient's expressions, his affect states, and, most centrally, the impact of the analyst from a perspective within rather than outside the patient's subjective frame of reference (Kohut, 1959). We have referred to this positioning as the stance of “sustained empathic inquiry.” Let no one believe that this commitment is an easy one to fulfill—it is frequently like feeling the sand giving way under one's psychological footing. Seeing himself and the world consistently through the eyes of another can pose serious threats to the analyst's personal reality and sense of self, much as the patient must feel threatened when his experience is treated as a distortion of reality.

What are the advantages of this stance? It opens for further psycho-analytic illumination those disruptions of the analytic bond that produce stubborn resistances that threaten to become entrenched. Disjunctions arising from frustration, disappointment, and experiences of misattunement are the inevitable consequence of the profoundly intersubjective nature of the analytic dialogue, the colliding of differently organized subjective galaxies. They are not to be regarded as errors in an “objective” sense. They are, however, evidence that the impact of the analyst and his understanding, or lack thereof, is central to the patient's subjective reality, and thus they provide access to crucial areas of the patient's inner world. The commitment to extend empathic inquiry to these experiences of disruption and to view them from within the patient's subjective framework, with the observer as an immanent part of the experience, repeatedly reestablishes and mends the therapeutic bond. Access is then provided to the specific and idiosyncratic ways in which the patient is organizing his experience of the analyst and to the meanings that this experience has come to encode. A window is thrown open for a fresh look into the area of discrepant and conflictful experience, into a room in which are locked the most intimate of secrets and longings and the most personal of happenings. It is from this space that a “new beginning” may take root.

What are the goals that join the participants in the therapeutic alliance? They are the progressive unfolding, illumination, and transformation of the patient's subjective universe. When the analyst and the patient are
freed of the need to justify their respective realities, the process of self-reflection is encouraged and vitalized for both. Inevitably, it emerges that the central motivational configurations mobilized in analysis are derailed developmental strivings, and the course of the developmental processes activated by the analysis becomes the focus of inquiry. The experiences of vitality and devitalization, of buoyant aliveness and apathy, which are clues to the unfolding developmental processes and their derailment, can be followed, while the effect of the analyst as he is experienced in this ebb and flow is always kept in view.

It cannot be emphasized too strongly that the analyst's acceptance of the validity of the patient's perceptual reality in the ongoing delineation of intrapsychic experience is of inestimable importance in establishing the therapeutic alliance. Any threat to the validity of perceptual reality constitutes a deadly threat to the self and to the organization of experience itself. When the analyst insists that the patient's perception is a secondary phenomenon distorted by primary forces, this, more than any other single factor, ushers in the conflictful transference-countertransference spirals that are so commonly described as resistances to analysis or negative transferences. These can be recognized as crises or impasses in which each partner in the erstwhile therapeutic alliance becomes engaged in desperately attempting to maintain his own organization of experience against the threat to it posed by the other. Schwaber (1984) has also pointed out that many of our patients suffer from a primary sense of uncertainty about the reality of inner experience. For them the recognition and articulation of vaguely felt affect states or perceptions is especially meaningful (Schwaber, 1984, p. 161). For others the development of the ability to sustain a belief in their own subjective reality was derailed because their perceptions contained information that was threatening to caregivers. The perceptions thereby became the source of continuing conflict and had to be repudiated. This familiar core experience has been dramatized in the “gaslight” genre. We have presented three cases (Stolorow, Brandchaft, and Atwood, 1987) in which the inability to maintain one's own perceptual reality appeared to be a factor predisposing to psychotic states. In these cases delusion formation represented a desperate attempt to substantialize and preserve a perceptual reality that had come under assault and begun to crumble. We stressed particularly the noxious role unwittingly played in therapeutic situations by failures of the analyst to recognize the core of subjective truth encoded in the patient's communications.

The specific attunement to “the role of the analyst and of the surround, as perceived and experienced by the patient … as intrinsic to [his] reality … draws upon modalities which are significant components of
the essentials of parental empathy—attunement to and recognition of the perceptions and experiential states of another” (Schwaber, 1984, p. 160). In the transference such attunement is a constituent of a quintessential selfobject experience serving to reinstat aborted developmental processes of articulating and consolidating self-experience. No more active mirroring is ordinarily required than the analyst's continuing, active interest in, and acceptance of, the perceptual validity of his patient's experience, together with his alertness to cues of disavowed affect states that signal perceptions the patient cannot as yet admit into his subjective world. However, as Schwaber (1984) also points out, “It would be misleading to employ these terms (i.e., the analyst's and the parent's empathy) synonymously, or to suggest that the one ‘corrects for’ the failure of the other, for they speak to two very different contexts” (p. 160). It is the failure to understand this point that forms the basis of the criticisms of self psychology as being reparenting and psychotherapeutic but not psychoanalytic.

The stance of sustained empathic inquiry consolidates the therapeutic alliance as it enhances and extends the domain of safety and harmony within the intersubjective field. The continuing articulation and consolidation of subjective reality is, however, only a part of the therapeutic experience. The additional goal of the therapeutic alliance is the transformation of subjective experience. We will not focus here on the transformational prospects for the analyst in discovering his impact and that of his inferences on the patient or in reflecting on the invariant principles that organize his experience of himself and his patient. Instead we wish to emphasize that a milieu in which the patient's perceptual reality is not threatened encourages the patient to develop and expand his own capacity for self-reflection. Access is thereby gained into unfolding patterns of experience reflecting structural weakness, psychological constriction, early developmental derailment, and archaic defensive activity—that is, the specific patterns that await transformation.

Often analysts fear that the commitment to understanding from within the patient's own subjective framework, and especially to recognizing and investigating the analyst's contribution to the patient's experience, will result in an obfuscation of the patient's contribution to his own circumstances. We find this fear to be unwarranted. Central to the process of transformation is the understanding of the ways in which the patient's experience of the analytic dialogue is codetermined throughout by the organizing activities of both participants. The patient's unconscious structuring activity is discernible in the distinctively personal meanings that the analyst's activities—and especially his interpretive activity—repeatedly and invariantly come to acquire for the patient.
Self psychology has been mistakenly characterized as a “psychology of the conscious,” because of the erroneous impression that the domain of empathic inquiry extends only to the conscious elements of subjective experience. On the contrary, an indispensable part of the work of analysis involves the investigation of how conscious experience is organized according to hierarchies of unconscious principles. These determine the ways in which the patient's experiences are recurrently patterned according to developmentally preformed themes and meanings. It is in the illumination of these meanings, and of the subjective truths they encode, that the therapeutic alliance and psychoanalysis itself finds its most generative purpose.

Consider, for example, the difficulties regularly encountered when attempting to treat patients whose severe developmental deprivations have predisposed them to intense distrust, violent affective reactions, or stubborn defensiveness. In such patients we have become aware of underlying unconscious and invariant organizing principles into which all experience tends to be assimilated. From their early history has crystallized a certain conviction that nothing good could happen to them in relation to another person, that no one could possibly care for them, that they are doomed ultimately to live and die alone, and that any hope for a meaningful life based on an inner design of their own is an illusion and a certain invitation to disaster. Every experience of disappointment or limitation tends to confirm one or another of these principles. The impact of such experiences is not felt to be delimited and temporary, but global and eternal. Consequently, such inevitable experiences lead inexorably to resignation and walling off or to violent affective reactions. The subsequent trajectory of self-experience is codetermined both by the impact of external events and by the invariant ordering principles into which these events are assimilated and from which they derive their meaning. Developmental traumata derive their lasting significance from the establishment of invariant and relentless principles of organization that remain beyond the accommodative influence of reflective self-awareness or of subsequent experience.

Our emphasis on investigating the unconscious principles organizing the interacting subjectivities of patient and analyst is an answer to the criticism of self psychology that it involves reparenting or an abdication of the analytic stance. At the same time, we are not unmindful of certain dangers posed by the therapeutic alliance as we have conceptualized it. When the stance of empathic inquiry, for example, facilitates the appearance of archaic longings expressed in concrete demands to occupy a special place or to be given special consideration, there is a tendency for the analyst to be catapulted into a concreteness of his own and to react in either of two ways. On one hand, reacting defensively, he may insist that
his patient recognize the unrealistic nature of these demands. On the other hand, he may react from a feeling of responsibility for the patient's disappointment and give covert encouragement to the patient's underlying hope for a relationship purified of any repetition of childhood traumata. Either course diminishes the likelihood of thoroughgoing change through the transformation of existing structures. Only the consistent working through in the analysis of the developmentally determined, invariant organizing principles can achieve the structural change so hopefully envisioned by the pioneers of our calling.

In order to illustrate our view of the therapeutic alliance, we offer some critical commentary on a case report by a well-known and respected psychoanalytic clinician and theoretician that appeared in a recent publication. Kernberg (1987) writes of a woman who “started her psychoanalysis suffering from a hysterical personality, consistent inhibition of orgasm in intercourse with her husband, and romantic attachments in fantasy to unavailable men” (p. 802). After the patient, with the help of the analyst, had overcome her reluctance to speak about her fears of him, she expressed the fantasy that he “was particularly sensual, in fact, ‘lecherous,’ and might be attempting to arouse her sexual feelings … so as to obtain sexual gratification from her” (p. 802). She said that the basis for her fears was that she had heard he came from a Latin American country and had written about erotic love relations. Furthermore, the analyst writes,

She thought I had a particularly seductive attitude toward the women working in the office area where I saw her. All this, she considered, justified her fears. She expressed the fantasy that I was looking at her in peculiar ways as she came to sessions, and that I probably was trying to guess the shape of her body underneath her clothes as she lay on the couch [p. 802, emphasis added].

Her attitude was not seductive. On the contrary, she was “inhibited, rigid, almost asexual in her behavior” (p. 802), and there was very little eroticism in her nonverbal communications. The analyst took notice of all this and noticed also, on reflection, that his own emotional reactions and fantasies about her had a subdued quality and contained no conscious erotic element. On the basis of these observations he concluded “that she was attributing to me her own repressed sexual fantasies and wishes” (p. 802) and that “this typical example of a neurotic transference illustrates the operation of projection,2 with little activation of

2 The assumption that transference experiences are to be explained by the operation of defensive measures is undoubtedly shared by a majority of analysts. It is precisely for this reason that we are urging a reexamination of the clinical evidence. We wish to emphasize that it is not the particular theory-rooted content of Kernberg's interpretations that we are questioning here. What we are calling into question is the epistemological stance according to which the analyst, through his acts of self-reflection, is presumed to have gained privileged access to the objective truth about himself that the patient's discrepant perceptions are then said to distort. This stance does not have to be inferred from Kernberg's clinical material; it is readily demonstrated in his descriptions of how he arrived at transference interpretations. Our growing awareness of the unintended and unexamined impact of this epistemological stance on the course of the therapeutic process was one of the central concerns that motivated us to write this article.
countertransference material either in a broad … or in the restricted sense” (p. 802).

The report goes on to describe changes that took place during the ensuing year. The patient's fear of the analyst's sexual interest in her was succeeded by expressions of her disgust for the sexual interest older men have for younger women, and she discovered features of her father in these lecherous old men. Her own romantic fantasies, meanwhile, remained fixed on unavailable men, while she was terrified of sexual engagements with men, including her husband, who were available to her. As she became aware, the analyst writes, that her sexual excitement was associated with forbidden sexual relations, there was a decrease in her “repression and projection of sexual feelings in the transference” (p. 803). She stopped feeling that the analyst was interested in her sexually and, as he had anticipated and interpreted from the beginning, she began to have “direct oedipal” sexual fantasies about him.

At one point, in response to her fantasies, the analyst found himself responding erotically and with a fantasy of his own that he in turn would enjoy a sexual relation with her, “breaking all conventional barriers” and providing her “with a gift of the fullest acknowledgment of her specialness and attractiveness” (p. 803). The analyst describes this as a transitory emotional response to her seduction in the transference, which had activated in him “the complementary attitude of a fantasied, seductive oedipal father” (p. 803). Subsequently the patient once more accused the analyst of teasing and humiliating her and, finding no indication of what the patient perceived, the analyst concluded that the patient was projecting onto him experiences with her father from the past.

In this latter series of associations and interpretations, as in the others cited, there is no indication of an attempt to explore fully the basis of the patient's experience from within the perspective of her own subjective frame of reference. Perhaps she perceived something in his tone or his manner that he had not intended or even been aware of. Did his initial scrutiny of her for signs of “eroticism” mean something else for her? Did his fantasy of a sexual affair with her, which he believed was reactive, communicate itself to her in some way and stimulate concerns in her?
The point here is not that the analyst “objectively” did anything wrong; he clearly kept well within the boundaries of professional behavior. The point is that whatever singular meanings these or other cues from the analyst might have had for the patient are left unexplored. Only what conformed to the theory being employed was attended to. The analyst in this case used as primary data his own self-reflections, and these persuaded him that the patient's experience was the consequence of distorting mechanisms. Here the analyst's subjective frame of reference is elevated to the status of objective fact, and the patient must accept the analyst's view as objective as part of the working alliance. Otherwise, as the report describes, the resistance has to be worked through so that she can come to recognize her defenses against accepting the analyst's perceptions, presumably because she is afraid to face her own impulses. One reality, the analyst's, is apparently real; the other, the patient's, is false! The therapeutic task is to account for the “distortion.”

However, a crucial source of data is left unexplored. Access to that source, that is, an investigation in depth of the elements of the patient's experience from within her subjective framework, is bypassed when the stance of empathic inquiry is abandoned in favor of doctrinal inference. A process is derailed that might have disclosed how seduction was being signaled for this patient. Acceptance of the perceptual (not objective) validity of the patient's experience might have made possible a therapeutic alliance committed to an investigation of the exquisitely personal meanings of seduction and humiliation into which the various cues from the side of the analyst were being assimilated.

It is also possible that such investigation might have provided a safer milieu wherein elements of the patient's experience of her husband that would have illuminated her aversion to his sexual advances could have been articulated. Her extramarital sexual fantasies might then have disclosed, not an oedipal fixation, but sequestered hopes for acceptance, responsiveness, and enrichment not otherwise available to her.

The patient, it is reported, gradually came to realize her defenses against her sexual feelings and produced oedipal wishes toward the analyst. Such expressions are commonly taken as proof of the correctness of the theory of drive and defense. However, nothing illustrates more clearly the need for the analyst to investigate from within the patient's subjective framework the impact of his own theories on the direction and course of the analysis. In the establishment of a therapeutic alliance, two heads are surely better than one. Only this can enable patient and analyst to distinguish between a “pseudoalliance” based on compliance with the analyst's viewpoint and a therapeutically mutative alliance based on empathic inquiry into the patient's subjective world.
There is more than an echo here of the quandary Freud encountered that changed the whole course of the evolution of psychoanalysis. Freud found evidence that some of the childhood sexual seductions his patients complained of could not have happened and, it is reported, he felt betrayed. He concluded that these must have been fantasies that expressed the childhood wishes of his female patients, and he built his subsequent theories of psychosexual development and of transference on that foundation. For Freud these fantasies were mental representations of instincts. However, sustained empathic inquiry reveals that such fantasies often encode experiences of traumatic developmental derailment and that Freud's dilemma was a false one. It is common for experiences of abuse and seduction of a nonsexual or covertly sexual nature to be concretized and preserved in sexual symbolism. This insight into the kernel of truth encoded in a patient's fantasies opens up a whole new pathway for exploration, one that remains foreclosed when a patient's perceptions are dismissed as distortion.

**Summary**

We have offered a critique of the concept of the therapeutic alliance implicit in both traditional ego psychology and Kleinian psychoanalysis. Specifically, we have objected to the notion that the therapeutic alliance requires that the patient identify not only with the analyst's analytic stance of empathic inquiry, but also with his theoretical presuppositions as well. We hold that such an alliance is actually a form of transference compliance, which the patient may believe is necessary in order to maintain the therapeutic bond on which all hopes for his future have come to depend. We have contrasted this “pseudoalliance” with a therapeutic alliance established through sustained empathic inquiry into the patient's subjective world. This latter alliance, in which the perceptual validity of the patient's transference experience is accepted, promotes the illumination and transformation of the invariant principles that unconsciously organize the patient's inner life. Material from a recently published case report is examined in order to illustrate the differing clinical consequences of fostering one or another of these two varieties of therapeutic alliance.

We are aware that analysts of all persuasions approach their patients with preconceived ideas and that any theoretical framework, including our own, can be perceived by patients as something with which they must compliantly identify. What we are emphasizing is that the commitment to investigating the impact of the analyst, of his interpretive activity, and of
his theoretical preconceptions, whatever they may be, from within the perspective of the patient's own subjective reality is central to the establishment of a therapeutic context in which the patient's unconscious organizing principles can be most sharply illuminated and thereby become accessible to therapeutic transformation.

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