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The Problem of Analytic Neutrality

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SINCE THE FIRST, RUDIMENTARY, psychoanalytic treatment, Breuer's attempt at achieving a "talking cure" with Anna O., the relationship between analyst and analysand has been at the center of clinical and theoretical interest. The relationship is central clinically because technical interventions—what the analyst actually *does* or thinks he does—depend upon how he construes it. Theoretically, because the clinical setting generates the bulk of our data, our ways of understanding the relationship between patient and analyst cannot be overemphasized, since they define the position of the observer in the observational field.

The postulate that "objective" data can be extrapolated from the psychoanalytic setting raises questions that concerned Sullivan throughout his career and that have been addressed provocatively in Spence's (1982) work on narrative and historical truth. Freud's concern with the issue is implicit, but it is an important aspect of many of his most famous statements about the analytic relationship. The blank screen, the reflecting mirror, the attitude of surgical detachment, etc., when read in context turn out to be responses to the anti-psychoanalytic criticism that suggestion by the analyst is responsible not only for therapeutic change but also for the data on which analytic theory and practice is based.

Freud's concern was justified. Spence, who seems to have rediscovered the principle of participant observation, argues convincingly that the analyst's creative contribution to the analytic process raises doubts about how easily clinical data can be generalized. While it is not terribly difficult to develop a theory of cure around this sort of interactive model of the psychoanalytic situation, it is much more difficult to claim universality for its dynamic and genetic findings. I do not think that in this respect psychoanalysis is tremendously different than any other field of investigation. However, its content—the personal and not always palatable nature of its findings—makes it unusually sensitive to this type of critique.

Because an important aspect of the aim of his writing was to establish the legitimacy of psychoanalysis, Freud was continually at pains to place the observer in the same position vis à vis his data as was any investigator in any science, as science was construed in the 19th century. His rare uses of the term "neutrality" itself were narrow in their scope, and his depiction of the analyst's observational position is best summarized in the concept of "evenly-hovering attention" (1912). Neutrality was first formally defined by Anna Freud (1936, p. 28), who said that in doing his work the analyst "takes his stand at a point equidistant from the id, the ego, and the superego." Despite its centrality to the clinical and scientific purposes of psychoanalysis, the definition of neutrality is rarely given consideration by those who employ it. It is not listed by itself in either of the major psychoanalytic indices, nor is it to be found as a separate entry in the important textbooks on technique.

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The origin of the neutrality concept in Freud's research setting provides an important clue to the source of the difficulty in defining it. It has often been noted that the neutrality of the researcher is bound to be something very different than the neutrality of the healer. The researcher is, by the nature of his task, indifferent to the well-being of his subject, which frequently is not even animate. This attitude translates poorly if at all into the clinical setting within which analytic inquiry is conducted. The analyst's decision to treat his patient, as well as to observe him, decisively colors the nature of their relationship. Schafer, who in his recent work has stressed the role of the analyst's philosophical and even aesthetic preferences in shaping the analytic process, argues that "… viewing psychoanalysis as a therapy itself manifests a narrative choice" (1983, p. 223). Whatever clinicians may think about their position vis à vis their patients, it is nothing that an outside observer with no commitment beyond scientific inquiry would even think of calling neutral.

In recent years, the neutrality concept has come under considerable fire from analysts whose primary allegiance, clinically and theoretically, lies outside the Freudian tradition. Adherents of various relational models—the American interpersonalists and most of the British object relations theorists—believe that neutrality carries the implication that the analyst can be outside of the analytic process, that he can be an observer without being a participant. Theorists who disagree on many other issues unite in rejecting this idea. They argue that the analyst inevitably influences the course of treatment and the evolution of the transference. This perspective is so stated by Wachtel, who comments that, "So-called neutrality is but one more way of participating in the events of the therapeutic process, and is no less likely to influence ensuing events than any other way of participating" (1982, p. 263).

It seems to me that arguments stressing the inevitability of the analyst's participation—what Hoffman (1983) and Gill (1983) have called the radical critique of the blank screen position—rest on unassailable grounds. There are, demonstrably, two people in the room during every analytic session. Anybody who has been supervised, or has analyzed a patient who has had previous treatment, or has himself undergone more than one analysis knows that. Storytellers, historians, anthropologists, sociologists, and contemporary physicists and zoologists are fully aware that no data gathering enterprise is free from the influence of the data gatherer. However, I am unwilling to relinquish the neutrality concept entirely, because I believe there is too much wisdom in it for the practicing psychoanalyst. I do, however, believe that we must come up with a somewhat different approach to the concept than that which has typically been taken by either its supporters or by its critics.

The title of our panel, "From Neutrality to Personal Revelation, " embodies the traditional approach, because it implies that neutrality and personal revelation are points on a continuum. I suggest, however, that it can be more useful to think of them as concepts from very different logical domains. The advantage of this perspective becomes clear when we try to define the two terms. Personal revelation is easy to define. It refers to telling patients about ourselves—facts about our lives, our values and judgments, our countertransference feelings and so forth. Observing an analytic session, we could judge with considerable agreement whether the analyst was being personally revealing or not. Neutrality, on the other hand, is virtually impossible to define in behavioral terms (see Myerson, 1981). Observing a session, we would find very little consensus about whether the analyst was being neutral; any agreement would depend not only on our direct observations but also on our shared assumptions about broad issues of theoretical perspective.

On the basis of these conditions, let me suggest that, unlike personal revelation, neutrality should not be thought of as behavioral concept at all. Silence, anonymity, advice-giving and other terms refer to possible behaviors of the analyst. Neutrality, on the other hand, is a way of talking about a particular therapeutic form. To put it differently, it is a way of understanding the goal of the analyst's behavior. It is a word like "democracy, " which refers to a kind of government rather than to the particular laws which implement it. Once we have consensus about what a word like "democracy" means, we can debate how desirable it is compared with other kinds of government. The logical status of the neutrality concept is similar. When we have achieved some sort of agreement about what neutrality is, we will be free to discuss when and whether it is an appropriate goal, and consensus as to its desirability still leaves open the question of the specificsteps to be taken in effecting it.

The difficulties inherent in any attempt to treat neutrality as a behavioral concept are apparent in the recent work of Schafer (1983). Offering what is perhaps the most comprehensive formulation of neutrality that has appeared to date, Schafer lists six characteristics of the neutral position:

1. The analyst allows all conflictual material to be represented, interpreted and worked through. He takes no sides in the consideration of these conflicts.
2. The analyst avoids both the imposition of his own values on the patient and an unquestioning acceptance of the patient's values.
3. The analyst is unpresumptuous as to the desirability of alternative courses of action which the patient is considering. He does not unilaterally try to make anything happen and does not try to bring about a certain kind of change because he believes in it in principle.
4. The analyst is non-judgmental not only with respect to the patient, but also with respect to others in the patient's life.
5. The analyst subordinates his personality to the analytic task.
6. The analyst totally repudiates any adversarial conception of the analytic relationship.

Although several of these criteria are couched in prescriptive terms—as injunctions about what the analyst ought to do—they do not hold up well as statements about manifest behaviors. Schafer himself hedges several of his suggestions. For example, subordination of personality does not mean non-expressiveness, and "total opaqueness is impossible to achieve and, owing to its artificiality, technically undesirable as a goal" (p. 23). Unpresumptuousness with respect to alternative courses of action does not apply to absences from sessions, non-payment, suicide or schizophrenic regression. The attempt to bring about certain kinds of change is permissible when the change has been discussed with the patient and it has been determined that "it makes analytic sense" (p. 169). The non-judgmental attitude toward others in the patient's life does not exclude the fact that "It is not a departure from neutrality to call a spade a spade" (p. 4).

Approached with the idea that neutrality is a form or a goal, however, Schafer's list is compelling. The optimal atmosphere in his vision is one in which the analyst is distinctly on the side of the patient, but he is not on the side of one aspect of the patient's personality at the expense of others (shades of Anna Freud, 1936). There is no pretense that the patient's associations can unfold as if he were the only person in the consulting room but, realizing this, the analyst can attempt to be a benign and affirmative presence. This affirmation must extend to all of the patient's motives. Schafer accepts the inevitability of the analyst's influence on the patient, but argues that this influence should be directed toward helping the patient to acknowledge the various aspects of his personality—his impulses as much as his defenses, his kindness as much as his hatred, his regressive as well as his progressive tendencies. Only within this kind of atmosphere can the patient gain the freedom to know himself.

Because self-knowledge is not the goal of every therapeutic modality, neutrality is not identical with "good therapy, " or even with "good analysis." Rather, it is the ideal atmosphere within the context of a particular understanding of the analytic process, one in which self-knowledge is the goal. This goal, in turn, is embedded in a particular, theory-bound vision of human growth and development—Freud's idea that knowledge cures and that change follows from making the unconscious conscious. There are some effective therapies that advocate and even require non-neutrality, of which behavioral approaches constitute particularly apt examples. These are necessarily non-neutral from an analytic perspective, because they embrace a clear-cut preference for symptomatic improvement, which constitutes an alternative vision of what it means for the patient to become "better."

Behavioral approaches have infiltrated analytic thinking, particularly in our pragmatically oriented nation. One residue of this has been that for some analysts the attitude of neutrality has given way to a kind of therapeutic "zeal." I think that therapeutic "zeal" is detrimental to the analytic process because it encourages the dissociation of crucial aspects of the patient's personality—aspects that may be regressive, masochistic, destructive or rebellious. If the analyst clearly values a particular sort of change, the patient can come to feel that acceptance by the analyst is contingent upon the patient being collaborative and making progress, an atmosphere in which critical aspects of the transference canbecome irreparably lost.

On the basis of these considerations, I cannot accept the two-pronged argument that Wachtel (1982) has recently made with respect to neutrality and active therapeutic intervention. He says, first, that from the perspective of interpersonal theory neutrality is impossible; that it is simply a way of participating in the therapeutic interaction. Given this, he continues, active techniques, which are themselves simply proven, therapeutically effective ways of participating, are no less neutral than neutrality, and can aspire to equal legitimacy within the scope of clinical analytic method.

My disagreement with Wachtel will serve to summarize my argument to this point. First, neutrality is not best thought of as a way of participating, because ways of participating are behaviors and neutrality is not a behavior. Rather, neutrality should be considered the goal of behavior. Secondly, the implication of neutrality as a goal is that the analyst should try to create an atmosphere in which respect for all aspects of the patient's personality, including those aspects which oppose the work of the analysis, predominates. This means that respect for the patient's autonomy takes precedence over interest in any *a priori* notion of what improvement should be. If neutrality has any use to analysts, it is as a way of affirming our own commitment to exploration and self-knowledge in contrast to other therapeutic aims. Let me underscore that nothing I have said should be taken to deny that the analyst inevitably influences the analytic process. However, like personal revelation, the concept of influence is not opposed to the concept of neutrality; neutrality is simply one form of influence. As with personal revelation, the logical difference between neutrality and influence is clear from the fact that while neutrality cannot be measured, influence can. With this in mind, we may productively debate whether neutrality is the most beneficial mode of influence in analytic work. By blurring the distinction between the kind of influence which is typical in a well conducted analysis and the kind which is exerted in other therapies, Wachtel deprives us of the opportunity to enter this critical debate.

In my discussion so far I have confined myself to considering the first of the two concepts in the title of our panel. Let me turn now to some thoughts on the second of the concepts—personal revelation. Having shown that personal revelation is not on the same logical plane as neutrality, I can ask twoquestions which I think are more interesting than the original, namely: Is it possible that at times personalrevelation may actually contribute to neutrality? And if this is so, under what circumstances does it enhanceneutrality and under what circumstances may it detract?

Clearly, the dangers to the goal of neutrality of personal revelation are more apparent and have been more generally noted in the literature. Poland has expressed this well. He points out that analysts often avoid the brunt of their patients' transferential rage by hastening to repair a presumed disappointment. Personal revelations may serve this reparative function, but they often detract from the goal of neutrality. Poland suggests that "Too often this supposedly humane response is a failure of empathic perceptive accuracy. An atmosphere of acceptance implies full openness; it does not provide a selective filter for the comfort of the analyst" (1984, p. 290).

A related point deserves mention. Frequently, when personal information is given to the patient, unless it the result of a countertransferential discharge, it is given in the interest of promoting either trust or some kind of identification. These goals are generally incompatible with the establishment of a neutral atmosphere, because they embody the analyst's decision that he should support or bolster one aspect of the patient's tendencies at the expense of another. Unsurprisingly, the effect of many personal revelations is to stifle feelings. The analyst who has told his patient that he, like the patient, becomes anxious when doing creative work like writing may intend to promote, via identification, the patient's tolerance for his own anxiety in similar situations—but he will run the risk of making it difficult for the patient to express his contempt for the analyst's non-productivity. The analyst who has told the patient that he has children to whom he is devoted may well have deprived the patient the freedom to express his hatred for the children who, until that moment, had existed for him only in fantasy.

There are, however, any number of circumstances in which I believe that personal revelation may contribute to the establishment, consolidation or restoration of the neutral atmosphere. There are situations even in otherwise smoothly running analyses when the analyst's non-analytic countertransference around a particular issue temporarily dominates the situation. For example, he may have gotten particularly involved in the patient's ruminations over aspects of life—should he take the job, marry the woman, continue in treatment. The analyst has come to a clear, although not necessarily objective point of view on the issue, but in the interest of anonymity is withholding it. What develops is a kind of analytic nagging—when the patient expresses feelings different from the analyst's own, the analyst questions relentlessly but hears nothing. The patient digs in, feels a certain amount of despair and disqualifies an otherwise respected analyst from being of any particular help with the matter in question.

At these points it can be useful for the analyst to reveal something about himself—his feelings about the issue and, perhaps, whatever he can figure out about the reasons for those feelings, and why they have led to the passive confrontation with the patient. This kind of revelation, which often leads to the discovery of disclaimed aspects of the patient's own feelings, can get the treatment back on an even—that is, from my perspective, neutral—keel.

This example suggests an analysis gone awry—there has been a temporary failure, although I don't think that it is either an uncommon or a fatal sort of thing. In other circumstances, and with certain patients, though, I believe that self revelation is necessary from the outset if the neutral atmosphere is to be achieved. For many patients, for example, the modal analytic posture of quiet attentiveness is too close to hated and feared characteristics of the parents. Even relative silence can be experienced by these patients as withdrawal, rejection, depression or homicidal rage. Interpretation of these transference reactions—and I am thinking even of some quite sophisticated patients who are otherwise prepared for and accepting of the interpretive process—is simply not enough. For these patients, who, I believe can be found in all diagnostic categories, the analyst's quiet attentiveness cannot be experienced as neutral. (I have expanded these ideas in Greenberg, 1986, see pages 87–106.)

In these circumstances, self revelations of various kinds can serve the establishment of a neutral analytic atmosphere. The analyst can correct the patient's perception of him as rejecting or critical by sharing his actual responses. For example, most analysts are much more often interested in or even admiring of such patients than the patients let themselves know. It can help to say this, although there should be no expectation that the information will be easily, or unambivalently assimilated: In sharingpersonal feelings, one steps into a complex, internal object world and into a world of long-standing and tenaciously held defenses. However, as the patient struggles to re-establish his internal world at the expenses of what he knows—as he struggles to undo the atmosphere of benign and attentive neutrality that could be available to him—the nature and also the importance of his transference reactions slowly becomes clearer to him. Over time, that is, such patients learn to accept and even to embrace the new experience of neutrality that the analyst has to offer—a learning which can be one of the most difficult parts of analysis and which can be facilitated by self revelation. By contrast, the analyst who maintains a posture of aloofness—that is the analyst who has confused the behavior of anonymity with the goal of neutrality—offers the patient no context within which to appreciate the nature of his transference.

I don't think what I am saying is startling from the perspective of what analysts actually do. Nothing that we know of what Freud did with his patients suggests that he was anything other than a vibrant and forceful presence in the room. More recently, Greenson's (1967) concept of the working alliance has pointed to behaviors which aim at encouraging a positive relationship between patient and analyst. However, the working alliance is explicitly construed as a departure from neutrality, because it represents a collaboration with one part of the patient's psychic structure, his observing ego, at the expense of the other systems. Freud himself made no effort to integrate his frequent personal revelations into this theory of technique. The approach to the problem of neutrality that I am suggesting, however, does make it possible to encompass what Freud and Greenson did, and many other analysts actually do, into a framework which maintains the unique benefits of psychoanalysis as a therapeutic modality.

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