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The Patient as Interpreter of the Analyst's Experience

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Introduction

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

The Resilience of the Blank Screen Concept

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

> *It can no longer be maintained that the analysand's reactions in analysis occur spontaneously. His behavior is a response to the rigid infantile setting to which he is exposed. This poses many problems for further investigation. One of them is how does it react upon thepatient? He must know it, consciously or unconsciously (p. 526, italics added).*

Theresa Benedek said in 1953:

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

In 1956 Lucia Tower wrote:

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

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In the sixties Loewald (1960), Stone (1961), and Greenson (1965) added their voices to the already large chorus of protest against this remarkably resilient concept. From varying theoretical perspectives, the critiques continued into the seventies and eighties as represented, for example, in the writings of Gill (1979) ; (1982a) ; (1982b) ; (1983) ; (Gill and Hoffman, 1982a) ; (1982b) ; Sandler (1976) ; (1981) and Kohut (1977), among many others. In fact, the blank screen idea is probably not articulated as often or even as well by its proponents as it is by its opponents, a situation which leads inevitably to the suspicion that the proponents are straw men and that shooting them down has become a kind of popular psychoanalytic sport.1

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

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

In psychoanalysis, the blank screen idea persists in more or less qualified and more or less openly acknowledged forms.2 The counterpart of the notion that the analyst functions like a screen is the definition of transference as a distortion of current reality. As Szasz (1963) has pointed out, this definition of transference can serve a very important defensive function for the analyst. This function may partly account for the persistence of the concept. I believe that another factor that has kept it alive has been the confusion of two issues. One has to do with the optimal level of spontaneity and personal involvement that the analyst should express in the analytic situation. The other has to do with the kind of credibility that is attributed to the patient's ideas about the analyst's experience. A theorist may repudiate the notion that the analyst should behave in an aloof, impersonal manner without addressing the question of the tenability of the patient's transference based speculations about the analyst's experience. To anticipate what follows, such speculations may touch upon aspects of theanalyst's response to the patient which the analyst thinks are well-concealed or of which he himself is unaware. Ingeneral, recommendations pertaining to the analyst's personal conduct in the analytic situation may very well leaveintact the basic model according to which the transference is understood and interpreted.

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[1]It is interesting that critics of the blank screen concept have frequently been concerned that others would think they were beating a dead horse (see, for example, Sterba, 1934, p. 117) ; (Stone, 1961, pp. 18–19) ; (and Kohut, 1977, pp. 253–255).

[2]Dewald's (1972) depiction of his conduct of an analysis exemplifies, as Lipton (1982) has shown, a relatively pure, if implicit, blank screen position.

Standard Qualifications of the Blank Screen Concept

The notion that ideally the analyst functions like a screen is always qualified in the sense that it applies to only a part of the patient's total experience of the therapist, the part which is conventionally regarded as neurotic transference. This is the aspect of the patient's experience which, allegedly, distorts reality because of the persisting influence of childhood events, wishes, conflicts, and adaptations. There are two kinds of experience which even the staunchest proponents of the screen or mirror function of the analyst recognize as likely to be responsive to something in the analyst's actual behavior rather than as expressions of pure fantasy. One is the patient's perception of the analyst as essentially trustworthy and competent, a part of the patient's experience which Freud (1912) subsumed under the rubric of the unobjectionable positive transference but which others, most notably Sterba (1934), Greenson (1965), and Zetzel (1956) have chosen to exclude from the realm of transference, designating it as the experience of the working or therapeutic alliance.3 The second is the patient's recognition of and response to relatively blatant expressions of the therapist's neurotic and antitherapeutic countertransference. Both categories of experience lie outside the realm of transference proper which is where we find the patient's unfounded ideas, his neurotic, intrapsychically determined fantasies about the therapist. The point is well represented in the following statements (quoted here in reverse order) which are part of a classical definition of transference (Moore and Fine, 1968):

1. Transference should be carefully differentiated from the therapeutic alliance, a conscious aspect of the relationship between analyst and patient. In this, each implicitly agrees and understands their working together to help the analysand to mature through *insight*, progressive understanding, and control.

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

Two Types of Paradigms and Critiques

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

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[3]For discussions of the implications of Freud's position on this matter see Lipton (1977a) and Gill (1982, pp. 9–15).

In contrast to conservative critiques, radical critiques reject the dichotomy between transference as distortion and non-transference as reality based. They argue instead that transference itself always has a significant plausible basis in the here-and-now. The radical critic of the blank screen model denies that there is any aspect of the patient's experience that pertains to the therapist's inner motives that can be unequivocally designated as distorting of reality. Similarly, he denies that there is any aspect of this experience that can be unequivocally designated as faithful to reality. The radical critic is a relativist. From his point of view the perspective that the patient brings to bear in interpreting the therapist's inner attitudes is regarded as one among many perspectives that are relevant, each of which highlights different facets of the analyst's involvement. This amounts to a different paradigm, not simply an elaboration of the standard paradigm which is what the conservative critics propose.

In rejecting the proposition that transference dominated experience and non-transference dominated experience can be differentiated on the grounds that the former is represented by fantasy which is divorced from reality whereas the latter is reality based, the radical critic does not imply that the two types of experience cannot be distinguished. Indeed, having rejected the criterion of distorted versus realistic perception, he is obliged to offer other criteria according to which this distinction can be made. For the radical critic the distinguishing features of the neurotic transference have to do with the fact that the patient is selectively attentive to certain facets of the therapist's behavior and personality; that he is compelled to choose one set of interpretations rather than others; that his emotional life and adaptation are unconsciously governed by and governing of the particular viewpoint he has adopted; and, perhaps most importantly, that he has behaved in such a way as to actually elicit overt and covert responses that are consistent with his viewpoint and expectations. The transference represents a way not only of construing but also of constructing or shaping interpersonal relations in general and the relationship with the analyst in particular. One could retain the term "distortion" only if it is defined in terms of the sense of necessity that the patient attaches to what he makes happen and to what he sees as happening between himself and the analyst.

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

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

Conservative Critiques: Transference in the Asocial Paradigm

Overview: Types of Conservative Critiques

Conservative critiques, as I said earlier, retain the dichotomy of transference and realistic perception, but argue that the standard qualifications of the screen function of the analyst require amplification. Some conservative critics like Strachey (1934) and Loewald (1960) offer reconceptualizations of the real, benign interpersonal influence of the analyst in the process without any recommendations for changes in prevailing practice. Others, like Stone (1961) and Kohut (1977) combine such reconceptualization with advocacy of less restraint and more friendly, spontaneous involvement than is customary. In this context, Freud is often cited as a practitioner who was extraordinarily free in his manner of relating to his patients.

Strachey, Loewald, Stone and Kohut have in common some kind of amplification of the realistically benign and facilitating aspects of the therapist's influence, although, to be sure, what is benign and facilitating in Stone and Kohut includes a certain optimal element of frustration or disappointment. The other major subdivision of conservative critiques are those which emphasize the importance and prevalence of objective perceptions of countertransference which, it is argued, fall outside the province of transference. Langs (1978) mounts the most systematic and thorough critique of this kind. Perhaps the clearest example of all the conservative critics is Greenson (1971) whose "real relationship" includes the patient's experience of both the working alliance and of countertransference and unequivocally excludes the experience of the transference.

Hans Loewald and James Strachey

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

> *The theoretical bias is the view of the psychic apparatus as a closed system. Thus, the analyst is seen, not as a co-actor on the analytic stage on which the childhood development, culminating in the infantile neurosis, is restaged and reactivated in the development, crystallization and resolution of the transference neurosis, but as a reflecting mirror, albeit of the unconscious, and characterized by scrupulous neutrality.*
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> *This neutrality of the analyst appears to be required (i) in the interest of scientific objectivity, in order to keep the field of observation from being contaminated by the analyst's own emotional intrusions; and (ii) to guarantee a tabula rasa for the patient's transferences … the analyst is supposed to function not only as an observer of certain processes, but as a mirror which actively reflects back to the patient the latter's conscious and partially his unconscious processes through verbal communication. A specific aspect of this neutrality is that the analyst must avoid falling into the role of the environmental figure (or of his opposite) the relationship to whom the patient is transferring to the analyst (p. 17).*

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

> *[The analyst's] objectivity cannot mean the avoidance of being available to the patient as an object. The objectivity of the analyst has reference to the patient's transference distortions. Increasingly, through the objective analysis of them, the analyst becomes not only potentially but actually available as a new object, by eliminating step by step impediments, represented by these transferences, to a new object-relationship. There is a tendency to consider the analyst's availability as an object merely as a device on his part to attract transferences onto himself. His availability is seen in terms of his being a screen or mirror onto which the patient projects his transferences, and which reflect them back to him in the form of interpretations. …*
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> *This is only a half truth. The analyst in actuality does not only reflect the transference distortions. In his interpretations he implies aspects of undistorted reality which the patient begins to grasp step by step as transferences are interpreted. This undistorted reality is mediated to the patient by the analyst, mostly by the process of chiseling away the transference distortions … (p. 18)*

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

Loewald's position has a forerunner in Strachey (1934) in that Strachey too emphasized the new, real interpersonal influence of the analyst in the analytic situation. Loewald sees this new real influence in terms of the patient's identification with the analyst's higher level of ego functioning, particularly with his rational perspective as it is brought to bear upon the patient's own neurotic tendencies. Strachey saw a new real influence more in terms of the patient's identification with the analyst's acceptance of the patient's hitherto repressed impulses, so that the modification that occurs involves a softening of the punitive tendencies of the patient's superego, rather than, as in Loewald, a strengthening of the reflective integrating capacities of his ego.

Leo Stone and Heinz Kohut

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

Stone is clear in his rejection of the notion that transference fantasies will crop up spontaneously if the analyst manages to keep his personal human qualities or reactions out of the patient's purview in keeping with what Stone believes is the prevailing understanding of proper analytic conduct. But what is Stone's view of the relationship between transference and reality when the analytic situation is modified in accord with his recommendations? In this respect, Stone (1961) is more ambiguous. At times he seems to be saying that the transference will, under those circumstances, include realistic perceptions of the analyst and that this is not only not regrettable but actually desirable:

> *For all patients, to the degree that they are removed from the psychotic, have an important investment in their real and objective perceptions; and the interplay between these and the transference requires a certain minimal if variable resemblance, if the latter is to be effectively mobilized. When mobilized, it is in operational fact of experience, always an integrated phenomenon, in which actual perceptions, to varying degree, must participate (p. 41).*

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

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

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

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

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

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

In the case of transferences associated with the disorders of the self, which Kohut increasingly viewed as the underlying disturbance even in the classical neuroses, the analyst as a real person is implicated more directly insofar as his empathy facilitates the self-selfobject tie that the patient's development requires. More precisely, the sequence of empathy, minor failures in empathy, and rectification of such failures promotes the "transmuting internalizations" which result in repair of the deficits in the development of the self which the patient brings to the analysis. However, it would seem that the whole complexity of the analyst's personal response to the patient is not something the patient would attend to in a way that was associated with any special psychological importance. To the extent that the patient is suffering from a disorder of the self, or a narcissistic disorder, he presumably does not experience the analyst as a separate person with needs, motives, defenses, and interests of his own. One might say that the patient is concerned about breaches in empathy and that he reacts strongly to them, but that he does not necessarily account for such failures or explain them to himself by attributing particular countertransference difficulties to the analyst which then become incorporated into the transference. In fact, to the degree that the patient is suffering from a disorder of the self, and therefore is experiencing the analyst as a selfobject, he is, by definition, a naive observer of the analyst as a separate, differentiated object. Thus, I believe I am justified in classifying Kohut as a conservative critic of the screen function of the analyst even taking into consideration his ideas about the narcissistic transferences.[4]

Robert Langs

Whereas Loewald, Strachey, Stone and Kohut are concerned with the fact that the screen concept lends itself to a deemphasis of the "real" therapeutic, interpersonal influence of the analyst, others have been concerned more with its tendency to obscure the importance and prevalence of real neurotogenic influences that the therapist exerts via his countertransference. Here again, the critique is conservative in form insofar as it merely expands upon one of the standard qualifications of the blank screen concept. A carefully elaborated critique of this kind is that of Robert Langs. No psychoanalytic theorist has written more extensively about the implications of the patient's ability to interpret theanalyst's manifest behavior as betraying latent countertransference. In Langs' view, the patient is constantlymonitoring the analyst's countertransference attitudes and his associations can often be understood as "commentaries" on them (1978, p. 509).

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

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[4]The self psychology literature certainly includes discussion of likely countertransference reactions to particular kinds of narcissistic transferences (e.g., Kohut, 1971) ; (Wolf, 1979), but these discussions omit consideration of the patient's specific ideas about the nature of the countertransference.

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

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

Langs' position is based upon the same absolute view of reality which is implicit in any position which retains the dichotomy between distorted and undistorted perception of interpersonal events. Langs believes, for example, that strict adherence to a prescribed set of rules constituting what he calls the "basic frame" *will not* be interpreted—at least not accurately—as any kind of expression of countertransference which could endanger the kind of communication he wants to foster. By the same token, violations of the frame *will* be perceived and responded to in this way by virtually all patients.[5]

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

The conservativism of Langs' critique of the screen model in psychoanalysis is particularly ironic given the enthusiasm with which he champions the more radical positions of other theorists such as Searles (1978–1979) and Racker (1968). Langsfeels that these theorists (especially Searles) inspired many of his own ideas and he conveys the impression that insome sense he is taking up where they left off. However, because Langs actually retreats to the standard dichotomyof transference and non-transference experience on the basis of distorting and non-distorting perceptions of thereality of the analyst's attitudes, I believe he actually takes a step back from his own sources of inspiration ratherthan a step forward.

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[5]According to Langs, by maintaining the frame and intervening in an optimal manner, the therapist provides the patient with a secure holding environment. Langs' account of the nature and importance of this kind of environment in the analytic process complements his account of the importance of countertransference errors, so that he, like Greenson, actually elaborates on both of the standard qualifications of the screen concept.

Ralph Greenson

Perhaps the theorist who best exemplifies a conservative critique of the blank screen fallacy is Greenson (1965) ; (1971). Greenson's "real relationship" encompasses both the patient's accurate perceptions of the benign aspects of the analyst and his perceptions of the analyst's countertransference expressions, and Greenson's position is an emphatic objection to the tendency he sees to underestimate the inevitably important role of the real relationship in the analytic process. There is nothing in Greenson which alters in the slightest the standard understanding of transference as distortion and the standard dichotomy of transference and undistorted perception of the analyst. He writes (1971):

> *The two outstanding characteristics of a transference reaction are: (1) It is an undiscriminating, non-selective repetition of the past, and (2) It is inappropriate, it ignores or distorts reality (p. 217).*

In contrast to the transference, Greenson states:

> *The meaning of "real" in real relationship implies (1) the sense of being genuine and not synthetic or artificial and (2) it also means realistic and not inappropriate or fantastic (p. 218).*

The extent to which Greenson is wedded to this dichotomy is betrayed by the fact that he cannot find his way out of it, even when it seems like he is trying to. Thus, for example, he says:

> *I must add that in all transference reactions there is some germ of reality, and in all real relationships there is some element of transference (p. 218).*

Here he seems to be saying that transference *itself* is not completely lacking in some sort of realistic basis, although the word "germ" suggests a very common kind of lip-service to this idea: the element of reality is considered to be so slight as to be hardly worth mentioning much less making an issue of in one's interpretive work. But even this concession is lost immediately in Greenson's very next sentence which he has in italics and which is clearly intended as a restatement or paraphrase of the first:

> *All object relations consist of different admixtures and blendings of real and transference components (p. 218).*

Now the idea that transference includes something real is superseded by the much blander notion that all relationships include something real as well as transference. In other words, the dichotomy of transference and realistic perception is retained.

Radical Critiques: Transference in the Social or Interpersonal Paradigm

Overview

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

To digress for a moment, although I have counted Gill among the radical critics, within his recent work there is actually a *movement* from a somewhat inconsistent but generally conservative position to a more consistently radical one. Thus, in his 1982 monograph, Gill (1982a) criticizes those, like Anna Freud and Greenson who define transference in terms of distortion of reality (p. 12). However, his objection is tied specifically to what he describes as "a lack of recognition that Freud's inclusion of the conscious, unobjectionable positive transference in his concept of transference is not an unfortunate lapse but an integral aspect of the concept" (p. 12). Throughout his discussion of the distinction between the unobjectionable "facilitating" transferences and the "obstructing" transferences (pp. 9–15), it is only the former which is considered to have realistic features. There is nothing about realistic elements in the "obstructing" transferences, not to mention any question being raised about the dimension "realistic-unrealistic" itself. Overall, in the first six chapters of the monograph, Gill apparently had not yet extricated himself from the traditional asocial paradigm for understanding transference (that is, neurotic or obstructing transference) although he was struggling to do so. His transitional, but still essentially conservative stand is exemplified by the following:

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

There is a noticeable shift in the book beginning with chapter seven to a fully social and relativistic position (see, for example, p. 118). Moreover, in subsequent writing Gill has been unequivocal in his adoption of the social paradigm for understanding all aspects of transference (Gill, 1982b) ; (Gill, 1983) ; (Gill and Hoffman, 1982a) ; (1982b).

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

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

1. The patient senses that the analyst's interpersonal *conduct* in the analytic situation, like all interpersonal conduct, is always ambiguous as an indicator of the full nature of the analyst's experience and is always amenable to a variety of plausible interpretations.

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

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

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

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

> *The first distortion of truth in "the myth of the analytic situation" is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities—that of the analysand and that of the analyst—responds to every event in the analytic situation (p. 132).*

And in another paper Racker (1968) says:

> *The analyst's relation to his patient is a libidinal one and is a constant emotional experience (p. 31).*

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

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

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

> *To be sure, each patient's experience of the analyst is highly individual and shaped by personal needs and fantasies. But consider the enormous variation in perception of the analyst by those other than his patients—the differences in how he is experienced by his spouse, his children, his teachers, his students, his friends, his rivals. Which is the "undistorted" standard from which the transference distortion varies? (pp. 66–67)*[6]

There is no perception free of some kind of pre-existing set or bias or expectation, or, to borrow from Piaget's framework, no perception independent of "assimilation" to some preexisting schema. Such assimilation does not twist an absolute external reality into something it is not. Rather it gives meaning or shape to something "out there" that has among its "objective" properties a kind of amenability to being assimilated in just this way. Moreover, the schema itself is flexible and tends to "accommodate" to what is in the environment even while it makes what is in the environment fit itself. Thus, turning to the clinical situation which concerns us, a patient who, for example, has a readiness to feel used, may detect and be selectively attentive and sensitive to whatever qualifies as a plausible

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[6] In what seems to me to be a non-sequitur, Wachtel retreats from the implications of this position at the end of his paper (p. 74) and accepts the term distortion in a manner which contradicts the heart of his argument.

indication of an exploitative motive on the part of the particular analyst he is seeing. With one analyst it might be his high fee, with another his use of a tape recorder for research purposes, with another his use of the therapy for his own training, with another his (allegedly) sadistic use of silence, with another his (allegedly) sadistic use of active interpretation.

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

> *In some instances, a group of judges may agree that the therapist has behaved in a particular way, one which could be construed as seductive, or disapproving or whatever, only after some subtle aspect of his behavior is called to their attention by another single observer. This observer, might of course, be none other than the patient (p. 140).*

Not despite the influence of the transference but because of it:

> *[The patient] may notice something about the therapist's behavior or suggest a possible interpretation of it that most judges would overlook. Nevertheless, once it is called to their attention, they may all agree that the patient's perceptions and inferences were quite plausible (p. 140).*

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

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

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

Sandler (1976) puts it this way:

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

Sandler's emphasis on the analyst's behavior as a basis upon which the patient concludes (pre-consciously) that he has elicited the response he is looking for underestimates the extent to which the patient's ideas about the countertransference can flow directly and plausibly from what he knows about the evocative nature of his own behavior. However the analyst believes he has behaved, if the patient thinks he has been continually depreciating, or harshly critical, he has reason to believe that the analyst may feel somewhat hurt, or that he may experience a measure of irritation and a wish to retaliate. Such ideas do not require perceptual confirmation in order for the patient to believe, with reason, that they are plausible. The perceptual confirmation might follow in any number of ways. For example, if the analyst keeps his cool and shows not the slightest bit of irritation, the patient might well imagine that this is precisely the expression of the analyst's revenge, i.e., that the analyst will not give the patient the satisfaction of thinking he can affect him in a personal way. And, undoubtedly, ostensible adherence to the more

more austere canons of "proper" analytic conduct can sometimes function as a disguised vehicle for the expression of intense countertransference attitudes on the part of the analyst. However, the perceptual confirmation may be secondary, since from the patient's point of view the die is cast and the outcome is highly likely given his own evocative behavior.

For a theorist like Racker the countertransference is inevitable and his discussion of it carries none of the opprobrium that comes across so heavily and oppressively in the work of Langs. Racker and Heimann take the same step forward with respect to countertransference that Freud took when he moved from thinking of the transference as an obstacle to thinking of transference as the principal vehicle of the analytic process. The countertransference in the social paradigm of the radical critics is likely to embody something resembling aspects of the patient's internal objects or aspects of the patient's self-representation. Heimann (1950) goes so far as to say:

> *The analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is part of the patient's personality (p. 83).*

The element of hyperbole in Heimann's position illustrates an error that often appears in discussions of the mechanism of projective identification. Instead of being a blank screen, the analyst becomes an empty "container" (Bion, 1962) into which the patient deposits various parts of himself. Although the emphasis is on interaction, the metaphor of the container lends itself, ironically, to yet another asocial conception of the situation since somehow the analyst's personality has once again been extricated from the process (cf. Levenson, 1981, p. 492). Nevertheless, the concept of projective identification, with the hyperbolic metaphor removed, does help bridge the alleged gap between the intrapsychic and the interpersonal (Ogden, 1979). It should be evident that in this paper the terms "social" and "interpersonal" do not connote something superficial or readily observable from "outside" or something non-intrapsychic, the pejorative connotations that these terms have unfortunately acquired for many classical analysts. Experience that is conceptualized in the terms of the social paradigm is experience that is layered by reciprocal conscious, preconscious, and unconscious responses in each of the participants.[7] What is more, something can "unfold" in the course of the analysis which bears the stamp of the patient's transference predispositions. What is intrapsychic is realized in the patient's idea of the interaction of the transference and the countertransference which is likely to include a rough approximation of the quality if not the quantity of the actual countertransference. It is in this element of correspondence between the patient's idea of the countertransference and the actual countertransference that the elusive interface of the intrapsychic and the interpersonal lies.

Implications of the Social Paradigm for Technique

The Impact of the Countertransference on the Fate of the Relationship

Because the analyst is human, he is likely to have in his repertoire a blueprint for approximately the emotional response that the patient's transference dictates and that response is likely to be elicited, whether consciously or unconsciously (Searles, 1978–1979, pp. 172–173). Ideally this response serves as a key—perhaps the best key the analyst has—to the nature of the interpersonal scene that the patient is driven by transference to create. The patient as interpreter of the analyst's experience suspects that he has created something, the complement of the transference, in the analyst; that is, he suspects it at some level. What he does not know and what remains to be decided, is what role the countertransference experience of the analyst will have in determining the total nature of the analyst's response to the patient. In other words he does not know the extent to which the countertransference will combine with the transference to determine the destiny of the relationship. The extent to which the analyst's "objectivity, " the tendency which is inclined towards understanding more than enacting, the extent to which this tendency will prevail and successfully resist the pull of the transference and the countertransference is unknown at any given moment not only to the patient but also to the analyst.

Within the transference itself, there is a kind of self-fulfilling prophecy, and with it, a kind of fatalism; a sense that the outcome is inevitable. The transference includes not just a sense of what has happened or is happening

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[7] See Fourcher (1975) for a discussion of human experience as the expression of social reciprocity on multiple levels of psychological organization and consciousness.

but also a prediction, a conviction even, about what will happen. The attempt to disprove this prediction is an active, ongoing, mutual effort, which is always accompanied by a real element of uncertainty. The analyst's uncertainty has as much if not more to do with his inability to know, in advance, how much his own countertransference will govern his response to his patient, as it has to do with his inability to measure, precisely, the patient's resistance and motivation for change. Moreover, the patient, as interpreter of the therapist's experience, has good reason to think and fear that the countertransference-evoking power of his transferences may be the decisive factor in determining the course of the relationship. Or, to say the same thing in another way, he has good reason to fear that the analyst's constant susceptibility to countertransference will doom the relationship to repeat, covertly if not overtly, the very patterns of interpersonal interaction which he came to analysis to change.

Pitted against the powerful alignment of transference and countertransference is the interest that the patient and the analyst share in making something happen that will be new for the patient and that will promote his ability to develop new kinds of interpersonal relationships. This is where the "objectivity" of the analyst enters and plays such an important role. It is not an objectivity that enables the analyst to demonstrate to the patient how his transference ideas and expectations distort reality. Instead it is an objectivity that enables the analyst to work to create another kind of interpersonal experience which diverges from the one towards which the transference-countertransference interaction pulls. In this other experience, the patient comes to know that the analyst is not so consumed or threatened by the countertransference that he is no longer able to interpret the transference. For to be able to interpret the transference fully means interpreting, and in some measure being receptive to the patient's interpretations of the countertransference (Racker, 1968, p. 131). What ensues is a subtle kind of rectification. The patient is, in some measure, freed of an unconscious sense of obligation to resist interpreting the analyst's experience in order to accommodate a reciprocal resistance in the analyst. Ironically, the resistance in the patient sometimes takes the form of an apparently fervent belief that, objectively speaking, the analyst must be the very neutral screen that, according to the standard model he aspires to be (see Racker, 1968, p. 67). The patient takes the position, in effect, that his ideas about the analyst are nothing but fantasy, derived entirely from his childhood experiences; nothing but transference in the standard sense of the term. In such a case, the analyst must interpret this denial; he must combat this resistance not collude with it. To the extent that the analyst is objective, to the extent that he keeps himself from "drowning in the countertransference" (Racker, 1968, p. 132), which, of course, could take the form of repressing it, to that very extent is he able to actively elicit the patient's preconscious and resisted interpretations of the countertransference and take them in stride.

Interpretation as Rectification

Whether the therapist's response will be dominated by countertransference or not is a question that is raised again and again throughout the course of the therapy, probably in each hour with varying degrees of urgency. Also, it is a question that in many instances cannot begin to be resolved in a favorable direction unless or until a timely interpretation is offered by the therapist. At the very moment that he interprets, the analyst often extricates himself as much as he extricates the patient from transference-countertransference enactment. When the therapist who is experiencing the quality, if not the quantity, of the countertransference reaction that the patient is attributing to him says to the patient: "I think you think I am feeling vulnerable, " or "I think you have the impression that I am hiding or denying my hostility towards you" or "my attraction to you, " at that moment, at least, he manages to cast doubt on the transference-based expectation that the countertransference will be consuming and will result in defensive adaptations in the analyst complementary to those in the transference. The interpretation is "mutative" (Strachey, 1934) partly because it has a certain reflexive impact on the analyst himself which the patient senses. Because it is implicitly self-interpretive it modifies something in the analyst's own experience of the patient. By making it apparent that the countertransference experience that the patient has attributed to the analyst occupies only a part of his response to the patient, the analyst also makes it apparent that he is finding something more in the patient to respond to than the transference-driven provocateur. Not to be minimized as a significant part of this "something more" that the analyst now is implicitly showing a kind of appreciation for is the patient's capacity to understand, empathize with, and interpret the analyst'sexperience, especially his experience of the patient (cf. Searles, 1975).

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

Systematic use of the patient's associations as a guide to understanding the patient's resisted ideas about the countertransference is a critical element of the interpretive process in the social paradigm. Without it, there is a danger that the analyst will rely excessively on his own subjective experience in constructing interpretations. The analyst then risks making the error of automatically assuming that what he feels corresponds with what the patient attributes to him. In fact, Racker (1968), whom I have cited so liberally, seems to invite this criticism at times, although he also warns against regarding the experience of the countertransference as oracular (p. 170). It is true that in many cases the most powerful interpretations are constructed out of a convergence of something in the analyst's personal response and a theme in the patient's associations. However there are other instances when the associations suggest a latent interpretation of the analyst's experience which comes as a surprise to the analyst and which overrides what he might have guessed based upon his awareness of his internal state. Thus, continually reading the patient's associations for their allusions to the countertransference via the mechanisms of displacement and identification (Lipton, 1977b) ; (Gill, 1979) ; (1982a) ; (Gill and Hoffman, 1982a) ; (1982b) is a necessary complement to the analyst's countertransference experience in constructing interpretations and ensures that the patient's perspective, as reflected in the content of his communications, is not overshadowed bywhat the analyst is aware of in himself.

The Role of Enactment and Confession of Countertransference

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

I want to be clear that nothing I have said requires admission on the part of the analyst of actual countertransference experiences. On the contrary, I think the extra factor of "objectivity" that the analyst has to help combat the pull of the transference and the countertransference usually rests precisely on the fact that the nature of his participation in the interaction is different than that of the patient. This is what increases the likelihood that he will be able to subordinate his countertransference reactions to the purposes of the analysis. What Racker (1968) speaks of as "the myth of the analytic situation, " namely that it is an interaction "between a sick person and a healthy one" (p. 132), is, ironically, perpetuated by those who argue that regular countertransference confessions should be incorporated as part of psychoanalytic technique.[8] Such regular self-disclosure is likely to pull the therapist's total personality into the exchange in the same manner that it would be involved in other intimate social relationships. To think that the analyst will have any special capability in such circumstances to resist neurotic forms of reciprocal reenactment would have to be based on an assumption that his mental health is vastly superior to that of the patient. Admissions of countertransference responses also

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[8]Bollas (1983) has recently discussed and illustrated the usefulness of *occasional* judicious disclosures by the analyst of his countertransference predicament.

tend to imply an overestimation of the therapist's conscious experience at the expense of what is resisted and is preconscious or unconscious. Similarly it implies an extraordinary ability on the part of the analyst to capture the essence of his experience of the patient in a few words whereas the patient may grope for hours in his free association before he reaches a verbalization that fully captures something in his experience of the analyst. Another way of saying this is to say that countertransference confessions encourage an illusion that the participants may share that the element of ambiguity that is associated with the analyst's conduct and that leaves it open to a variety of plausible interpretations has now been virtually eliminated. Once the analyst says what he feels there is likely to be an increment of investment on his part in being taken at his word. This is an increment of investment that the patient will sense and try to accommodate so that the reciprocal resistance to the patient's continuing interpretation of the therapist's inner experience can become very powerful.

Although countertransference confessions are usually ill-advised, there are times when a degree of personal, self-revealing expressiveness is not only inescapable but desirable (Ehrenberg, 1982; Bollas, 1983). In fact, there are times when the only choices available to the analyst are a variety of emotionally expressive responses. Neither attentive listening nor interpretation of any kind is necessarily a way out of this predicament because the patient may have created an atmosphere in which customary analytic distance is likely to be experienced by both participants as inordinately withholding, compulsive, or phony. As long as the ambiance is such that the patient and the analyst both know that whatever is going on more than likely has meaning that is not yet being spoken of or explored but eventually will be, openly expressive interpersonal interactions may do more good than harm and may continue for some time before it becomes possible to interpret them retrospectively in a spirit that holds any hope of benefit for the patient. In other words, it may be some time before the act of interpreting will become sufficiently free of destructive countertransference meaning so that the patient can hear and make use of the content of the intervention.

Again, it is not that instead of interpreting in such circumstances one should merely wait silently, but rather that a certain specific kind of spontaneous interpersonal interaction may be the least of the various evils that the participants have to choose from, or, more positively, the healthiest of the various transference-countertransference possibilities that are in the air at a certain time. It may be that such "healthier" types of interpersonal interaction actually do have something relatively new in them or maybe something with weak precursors in the patient's history that were not pathogenic but rather growth promoting. However it is crucial that the therapist not assume this and that he be guided by the patient's subsequent associations in determining how the patient experienced the interaction and what it repeated or continued from the past.

Exploration of History in the Social Paradigm

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

The Patient's Perception of Conflict in the Analyst

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

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