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# DIALECTICAL THINKING AND THERAPEUTIC ACTION IN THE PSYCHOANALYTIC PROCESS

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*The therapeutic action of the psychoanalytic process depends upon a special kind of power with which the analyst is invested by the patient and by society, a power that is enhanced by adherence to psychoanalytic rituals, including the asymmetrical aspects of the arrangement. It is important, however, that the analyst also engage with the patient in a way that is sufficiently self-expressive and spontaneous so that a bond of mutual identification can develop between the participants. At the core of the generic "good object" is an element of uncertainty as the analyst struggles to find an optimal position relative to this dialectic between formal psychoanalytic authority and personal responsivity and self-expression. At the core of the generic "bad object" is an uncritical commitment to one side of the dialectic at the expense of the other. An extended clinical vignette illustrates how the analyst's struggle with this dialectic has great therapeutic potential.*

## ON THROWING AWAY "THE BOOK"

The movement toward full appreciation of the inevitability and usefulness of the personal involvement of the analyst in the analytic process has accumulated a lot of momentum. Sometimes knowing of each other's work, sometimes not, many analysts, going back to Racker and others in the fifties, have been reporting the ways in which they have been able to use their emotional experience or countertransference, broadly defined, to enhance their understanding of their patients and to open up new therapeutic potentials in the process. It is important to

recognize that the contributions to this movement have come from analysts with diverse backgrounds cutting across many of the major psychoanalytic schools: classical Freudian, Kleinian, object relations, and interpersonal. To be sure, there are many important and interesting differences among the authors contributing to this current of thought. But one of the commonalities among them that has struck me is the extent to which the clinical experiences that they report include, at some juncture, implicitly or explicitly, a *feeling of deviation* from a way of working which they view as more commonly accepted, more a part of their own training, more traditional in one sense or another. There is a feeling of "throwing away the book," one that Jacobs (e.g., 1990, pp. 450-451; 1991), Natterson (1991), Ehrenberg (1992), Mitchell (1991), and others mention or allude to in a number of their papers. Moreover, that feeling is not restricted to the analyst. One gets the impression that patients are often aware that there is a good deal of tension between, on the one hand, the analyst's more customary attitude, or the one the analyst may regard as more acceptable within his or her particular analytic community, and, on the other hand, the moments of deviation from it.

So I began to wonder to what extent a sense of deviation from tradition or from a stance that seemed more "psychoanalytically correct" was an important or even essential part of the therapeutic action of the experience. If it was, it seemed to me that those of us who were part of the movement were in for trouble. After all, how often could we throw away, retrieve, and throw away the same book? One would imagine that over time the vividness if not the credibility of our sense of defiance and liberation would be eroded. After all, it is not as if we are keeping our own iconoclastic ideas hidden. On the contrary, a new composite Book on the process seems to be emerging, made up of such works as *Collected Papers on Schizophrenia and Related Subjects* by Searles (1965), *Transference and Countertransference* by Racker (1968), *Analysis of Transference* by Gill (1982), *The Ambiguity of Change* by Levenson (1983), *The Matrix of the Mind* by Ogden



(1986), *The Shadow of the Object* by Bollas (1987), *Relational Concepts in Psychoanalysis* by Mitchell (1988), *Understanding Countertransference* by Tansey and Burke (1989), *Other Times, Other Realities* by Modell (1990), *The Use of the Self* by Jacobs (1991), *Beyond Countertransference* by Natterson (1991), *The Intimate Edge* by Ehrenberg (1992), and *Contexts of Being* by Stolorow and Atwood (1992). When the general spirit of these books becomes The Book, what Book shall we discard? How can we spontaneously and creatively defy tradition once a new tradition emerges that seems to require at least a modicum of defiance as a matter of principle? Then to defy the old would be to conform to the new, a conformity that might well diminish the flavor of creative rebellion, spontaneity, and discovery that an important sector of our community has managed to sustain for thirty or forty years.

There are good theoretical and common sense reasons, moreover, to think that a sense of spontaneous deviation, shared by patient and analyst, may be a central or even crucial feature of whatever corrective experience may be afforded by the emergence of the analyst's subjectivity in the process. When the patient senses that the analyst, in becoming more personally expressive and involved, is departing from an internalized convention of some kind, the patient has reason to *feel recognized* in a special way. The deviation, whatever its content and whatever the nature of the pressure from the patient, may reflect an emotional engagement on the analyst's part that is responsive in a unique way to this particular patient. It is not that the content is irrelevant. Certainly each instance of use or expression of countertransference would have to be examined individually to weigh the relative contributions of therapeutic, nontherapeutic, and anti-therapeutic factors. But I would argue that there is something about the deviation itself, regardless of content, that has therapeutic potential. Indeed, it is possible that even when the affective reactions of the analyst seem to implicate him or her in the enactment of old, pathogenic object ties, meeting what Ghent (1992) has referred to as malignant as opposed to benign needs, the *context of deviation* from a standard technical

stance, in favor of immediate responsiveness to the patient, can transform one's apparent participation as the "bad object" into that of a "good object" in the current situation. Conversely, when the analyst adheres religiously to a particular stance in order, ostensibly, to ensure *contrast* with the patient's bad objects, the *context of conformity* to the technical stance, at the expense of immediate responsiveness to the patient, can transform one's apparent participation as the good object into that of the bad object in the present.

It is commonplace to recognize the narcissistic, exhibitionistic, and exploitative potential of overtly self-revealing behavior. But any automatic routine might also be viewed, plausibly, by the patient as a resistance on the analyst's part to an individualized engagement with the patient and as a form of self-indulgence of one sort or another. The patient might view the analyst as content to sit back and pat him- or herself on the back for doing "the right thing," according to whatever the Book requires, at the expense of attending in a creative way to the patient's needs. Alternatively, or simultaneously, the patient might view the analyst as fearful of any kind of personal engagement. Thus, for example, if the patient felt overburdened or exploited by needy parents, a line of correspondence might be drawn between that history and an analyst who never openly conveys anything at all about his or her own needs. The common factor in that case could be the patient's sense that the behavior of the parent or the analyst is propelled by fixed, predetermined, internal pressures rather than by responsiveness to the patient's immediate experience and communications. So, again, to be the good-enough object, the analyst sometimes has to show a willingness, on a manifest level, to be pulled somewhat in the direction of the bad object, whereas a determined effort to avoid any behavior that might be similar in its content to that of the bad object might be precisely what constitutes the bad object in the analytic situation.

Regarding adherence to the rituals of classical technique, here is what Searles wrote in 1949 in a paper, twice rejected for



publication, that Robert Langs (1978-1979) finally discovered and published:

> The analyst who attempts to adhere to the classical behavior of unvarying "dispassionate interest" toward his patients regularly finds the patients to be irritated by such behavior which, after all, they have to cope with in everyday life only in so far as they may deal with schizoid other persons. It seems that such dispassionate behavior all too often merely repeats the patient's discouraging childhood relationship with one or another schizoid parent, and lends itself to unconscious employment by the analyst as a way of expressing hostility to the patient. For the analyst to reveal, always in a controlled way, his own feelings toward the patient would thus do away with what is often the source of our patients' strongest resistance: the need to force the analyst to admit that the patient is having an emotional effect on him (Searles, 1978-1979, p. 183).

But classical technique, especially when practiced in a rigid way, is a familiar target of criticism for its seeming coldness. I would say it is actually a scapegoat, a whipping boy, for a problem that cuts across most of the major theoretical positions, sort of like the identified patient in a disturbed family. It is more difficult but equally important to locate the expression of disturbance in points of view that advertise themselves explicitly as warmer or more "human" alternatives to the classical position. Self psychology is one such point of view. The central principle of technique in self psychology is "sustained empathic inquiry." Can conformity to such a "benign" principle cast the shadow of the bad object on the analyst? I think it can. Consider the argument of Slavin and Kriegman (1992):

> . . . it is quite possible for empathy to be practiced with a fair degree of verisimilitude, as a technique, rather than as the genuine intimate act and sign of mutuality that is so profoundly, intrinsically valued. Indeed, patients know, or come to know, that another human being whose only substantial utterances take the form of validating affirmations of the patient's own subjective world and developmental strivings are

> likely, themselves, to be engaged in one or another form of self-deception and deception (p. 250).
>
> The attempt to remain exclusively attuned to what appear to the therapist to be the dominant themes and meanings in the patient's subjective world is, in fact, sensed by many patients as a self-protective strategy on the part of the therapist. . . . Over and above any particular individual defensiveness that we may attribute to the therapist, the overly consistent use of the empathic mode will, for some patients, be sensed as the therapist's hiding some aspect of him- or herself, or pursuit of his or her own interests—interests that, as the patient well knows but therapists are loath to face, indeed, diverge in some significant ways from those of the patient. We must, thus, clearly face the fact that an immersion in the patient's subjective world . . . must be complemented, at times, by what is, in effect, the open expression of the analyst's reality (pp. 252-253).

Some patients more than others are particularly sensitive to and intolerant of anything that smacks of psychoanalytic clichés, or of going by the Book in one way or another, or even of a measured, unvarying psychoanalytic tone of voice, whether it is coolly detached or warmly "empathic." Those patients often have a therapeutic effect on *me* because they do not let me get away with the party line or tone. Instead, they challenge me to think things through in a fresh way, to be myself, and to respond to them as unique individuals. Of course intolerance of stereotypic behavior can sometimes be excessive and defensive. Some acceptance by the patient of the recognizably technical aspects of the analyst's behavior is essential. However, the conspicuously formal, role-related aspects of the analyst's participation, however much they may contribute to a safe analytic environment, can also be powerful magnets for the patient's mistrust. And, of course, for every patient who complains *explicitly* about something artificial in the analyst's behavior there are countless patients who would not say a word about it or who would deny it. With them, one would have to look for disguised references to the issue in dreams and other associations (Hoffman, 1983). In some cases the patient might simply identify with the aggressor (as perceived) and go through the motions for a long time, sometimes years, without feeling touched or reached. In this connection Lipton (1977) has suggested that there may be some patients who are thought to have narcissistic personality disorders who are actually identifying defensively and unconsciously with analysts who do not make themselves available for a personal relationship.



## PSYCHOANALYTIC DISCIPLINE IN A NEW KEY

So the question arises: If we appreciate the dangers inherent in uncritical systematic application of psychoanalytic technical stances and rules of conduct and the potential benefits that can come from spontaneous personal engagement with the patient, why not simply get rid of the former and cultivate the latter to the hilt? Well of course that will not do at all. We would then simply be entering personal relationships with our patients with the arrogant claim, masked as egalitarianism, that to spend time with us will somehow be therapeutic. Also, we would be promoting allegedly "authentic" personal involvement as an encompassing technique, an approach that would be just as suspect in terms of its genuineness as any fanatically ascetic stance. No, clearly there is much wisdom in the requirement that the analyst abstain from the kind of personal involvement with patients that might develop in an ordinary social situation.

How then, in light of the current emphasis on the importance of acknowledging and making constructive use of the analyst's emotional participation, *should* we conceptualize the special sense of analytic restraint that undoubtedly remains indispensable to practice? Perhaps a key abstract principle to which we would all subscribe can be stated as follows: *analysts, assuming adequate monetary (or other) compensation, must try, in a relatively consistent way, to subordinate their own personal responsivity and im-*

*mediate desires to the long-term interests of their patients. Such consistent subordination can be optimized only in the context of the analyst's ongoing critical scrutiny of his or her participation in the process.* Well, even if the money is good, that is a lot to ask, perhaps more than what we would expect of good-enough parents (Slavin and Kriegman, 1992, p. 234). Fortunately, the principle has to be qualified as stated because we now have more conviction about the interdependence of the patient's and the analyst's needs. If the analyst is too abstinent or too self-negating, the patient's healthy need for the analyst to survive, and even to benefit from, the patient's impact (Winnicott, 1971; Searles, 1975) will not be met. So, on the one hand, a sense of psychoanalytic discipline, which includes restrictions on the extent and nature of the analyst's involvement, provides the backdrop for whatever spontaneous, personal interactions the participants engage in. On the other hand, given our current understanding of how important it is that analysts allow themselves to be affected and known to some significant degree by their patients, the restrictions themselves are more qualified than they once were. Thus, the moment in which the analyst allows himself or herself to surface as a desiring subject (Benjamin, 1988) is not experienced with the same sharp edge of deviation that characterized it before. Now, instead of *throwing away* the Book, we place it temporarily in the background while the analyst's distinctive self-expression moves into the foreground. The opposite holds as well. When the analyst's more standard, formal, detached, reflective, and interpretive stance is in the foreground, the aspect of the relationship that reflects his or her more personal engagement can still be sensed in the background.

## DIALECTICAL THINKING

What I have just said amounts to a dialectical way of thinking about the analyst's participation in the process, one that others, including Benjamin (1988), Ghent (1989), Mitchell (1988), Ogden (1986), Pizer (1992), and Stern (1983), have been trying to articulate and develop. The term "dialectic" has a long history in philosophy involving a variety of meanings.[1] For my purposes, the following definition by Ogden (1986) has been useful:

> A dialectic is a process in which each of two opposing concepts creates, informs, preserves, and negates the other, each standing in a dynamic (ever changing) relationship with the other (p. 208).

To think and speak in a dialectical way is difficult and sometimes confusing. Many of our concepts in psychoanalysis imply dichotomous thinking. Fantasy versus reality, repetition versus new experience, self-expression versus responsivity to others, technique versus personal relationship, interpretation versus enactment, individual versus social, intrapsychic versus interpersonal, construction versus discovery, even analyst versus patient. There is a sense that these polarities constitute a series of mutually exclusive opposites. But when we think about the poles within each pairing in dialectical terms, we are challenged not only to recognize their obviously contrasting features, but also to find the effects of each pole on the other, and even aspects of each pole represented within the other. One might think in terms of two mirrors positioned opposite each other so that we can see the endless series of reflections of the two within each. The relationship between psychoanalytic discipline and expressive participation is dialectical in that sense.

On the side of analytic discipline, first, however much it is learned and internalized in a process of professional socialization, such an attitude gets into the analyst's bones so that it expresses a very important aspect of him- or herself. Second, that discipline, to begin with, is not simply imposed from outside



[1] Ghent (1992, p. 156) has decided to eschew the term "dialectic" because of the connotation of a movement toward synthesis in which tensions are dissolved. He prefers the term paradox. I think dialectic has the advantage, however, of implying an interactive dynamic between opposites, whereas paradox seems more static. In any case, I intend the connotation of tension, not resolution.

but represents a special kind of development of the analyst's potential for attention to the experience of others. And third, although the analyst speaks partly in the context of the role of disciplined expert, his or her *voice* can and should remain personally expressive. The effect of the dialectic is to encourage what Schafer in 1974 called "talking to patients," as opposed to the "impersonal diction" that the author found to be so pervasive among analytic therapists following a "pseudoanalytic model."[2] With regard to the other pole in the dialectic, moments of personal self-revelation or spontaneous action on the part of the analyst can be located within, and intuitively guided by, a sense of their place in the process as a whole. The latter involves a complex mosaic of interdependent, overtly interpretive, and overtly noninterpretive interactions (Pizer, 1992). So, on the one hand, psychoanalytic discipline can be self-expressive and, on the other hand, the analyst's self-expression may reflect a complex, intuitive kind of psychoanalytic discipline (Hoffman, 1992a).

The analyst's personal, emotional response to the patient, when expressed, may or may not entail some form of gratification of the patient's needs or wishes. Because of the valuing of abstinence in classical psychoanalytic theory of technique, a withholding attitude tends to be associated with a more "correct" posture, whereas "giving in" to pressures from the patient tends to be associated with the unfortunate intrusion of something from within the analyst. Deficit theories such as those of Kohut and Winnicott have legitimized certain kinds of gratification as an intrinsic part of the psychoanalytic process. At the same time

[2] In the paper cited, republished in Schafer's recent book (1992), no explanation is offered for the prevalence of impersonal diction aside from its conformity to a "pseudoanalytic model." In my view this way of speaking is grounded in an objectivistic, "technically rational" (cf. Schön, 1983) perspective on the process. Conversely, "talking to patients" needs to be anchored in a different model, one that I have referred to as "social constructivist" (Hoffman, 1991, 1992a, 1992b). By "constructivism" I mean something quite different from the perspective Schafer has articulated (see Hoffman, 1992b, for discussion of this difference).



they have introduced a new kind of institutionalized disguise for personal, countertransferential tendencies. Mitchell (1991) has discussed the influence of the analyst's personal attitudes upon the classification of the patient's desires into those that qualify as "needs" for responses that are developmentally necessary and those that amount to "wishes" for gratifications that have forbidden, incestuous meaning. He argues that such assessments are never simply "diagnostic" of what is objectively true of the patient. Instead, they express complex organizations of transference and countertransference that can often be explored usefully only in retrospect, that is, after certain enactments have occurred. Elsewhere, Mitchell (1988) provides us with an excellent example of dialectical thinking in his account of the optimal posture of the analyst dealing with narcissistic issues in the transference. With respect to the patient's invitation to the analyst to participate in a "mutually admiring relationship," Mitchell writes:

> Responding to such an invitation in a way that is analytically constructive is tricky, and difficult to capture in a simple formula. What is most useful frequently is not the words, but the tone in which they are spoken. The most useful response entails a subtle dialectic between joining the analysand in the narcissistic integration and simultaneously questioning the nature and purpose of that integration, both a playful participation in the analysand's illusions and a puzzled curiosity about how and why they came to be so serious, the sine qua non of the analysand's sense of security and involvement with others (p. 205).

It is important to emphasize that my interest in this paper is in the dialectic between the analyst's personal emotional presence and the analyst's role-determined behavior, whatever their respective contents. Either could be ostensibly gratifying or frustrating with respect to the patient's desires. In the broad sense one could think of the tension as that between a pull that both participants are likely to feel, in varying degrees, toward a qual-

ity of interaction akin to what they would experience (or imagine they would experience) outside of the analytic situation and the sense that both may have, in varying degrees, of the need for a special kind of restraint that is peculiar to the analytic situation itself (*cf.* Modell, 1990). To the extent that the patient wants a personal relationship with the analyst, one could think of a pressure from the patient for a generic kind of "gratification" (Searles, 1978-1979, see above p. 191). When I speak of analysts participating in a "self-expressive" or "personally responsive" way, I have in mind their own inclinations to respond to the patient, in part, as they might imagine they would outside of the analytic situation. However, the point of appreciating the dialectic between personal responsivity and analytic discipline is to recognize that, despite the tension between them, each tendency is also reflected in a substantial way in the other. Thus, the analyst who behaves "naturally" would be incorporating in his or her actions the sense of discipline that is intrinsic to his or her sense of identity as an analyst. The possibility of such integrative action does not do away with potential tensions arising from discrepancies between types of reactions that antedate psychoanalytic training (in the broad sense) and those that directly reflect its influence.

## PSYCHOANALYTIC AUTHORITY, MUTUALITY, AND AUTHENTICITY

The analytic situation is a unique setup, a ritual, in which the analyst is invested by society and by the patient with a special kind of power, one that the analyst accepts as part of his or her role. I believe that power has psychological continuity with the power of parents to shape their children's sense of themselves and their worlds. The magical aspect of the analyst's authority is enhanced by his or her relative inaccessibility and anonymity. There is a kind of mystique about the analyst that I doubt we want to dispel completely. It is noteworthy in that regard that



however much we, as analysts, may interpret and attempt to deconstruct our authority through the analysis of transference, we do not generally dismantle the analytic frame during the analysis or even after it. We do not usually invite our patients to our homes for dinner or visit them in theirs. Instead, we take pains to protect the special kind of moral presence that we have in our patients' lives.

With regard to therapeutic action, I think there is something to the simple idea that the analyst is an authority whose regard for the patient matters in a special way, one that, again, we do not try to analyze away, nor could we, perhaps, even if we did try. In some cases it may take a lot of work to get to the point where that regard can be conveyed by the analyst and received and integrated by the patient. But I doubt many of us have felt, as patients or as therapists, that the process, when it has been helpful, has not included that factor of affirmation (Bromberg, 1983; Schafer, 1983, pp. 43-48). I think the likelihood of that happening in an authentic way is increased not only because the analyst is in a position conducive to eliciting a certain quality of regard, but also because the patient is in an analogous position. Regard for the *analyst* is fostered partly by the fact that the patient knows so much *less* about him or her than the analyst knows about the patient. The factor of relative anonymity contributes not only to the irrational aspect of the analyst's power but also to a more rational aspect. The analyst is in a relatively protected position, after all, one that is likely to promote the most tolerant, understanding, and generous aspects of his or her personality. I think of "idealization" partly in interactional terms (as in "making the other more ideal") because the analytic situation and often the patient actually do nourish some of the analyst's more "ideal" qualities as a person—what Schafer (1983) has referred to as the analyst's "second self." Conversely, however, the analyst's regard for *the patient* is fostered by the fact that he or she knows *so much* about the patient, including the origins of the patient's difficulties and his or her struggles to deal with them. Moreover, of course, neither party has to live with the

other or even engage the other outside of the circumscribed analytic situation, so that each is afforded quite a bit of protection from the other's more difficult qualities.

Corresponding with what several authors have discussed in terms of an interplay between the "principle of mutuality" and the "principle of asymmetry" (Aron, 1991; Modell, 1991; Hoffman, 1991; Burke, 1992), there is an ongoing dialectic between the patient's perception of the analyst as *a person like himself or herself* and the patient's perception of the analyst *as a person with superior knowledge, wisdom, judgment, and power*. Each way of viewing the analyst is very much colored by the other. Whichever is in the foreground, the other is always in the background. So, those of us who are interested in developing more mutual and egalitarian relationships with our patients should not deny or forget the extent to which we are drawing upon the ritualized *asymmetry* of the analytic situation to give that mutuality its power. The asymmetry, the hierarchical arrangement, makes our participation in the spirit of mutuality *matter* to our patients in an intensified way, one that helps to build or construct our patients' views of themselves as creative agents and as persons ultimately deserving of their own and other people's love. What the balance should be between asymmetry and mutuality for any particular analytic dyad, at any particular moment or over time, is very difficult to determine or control. Also, it must emerge from an authentic kind of participation by the analyst rather than from adherence to a technical formula. To affect the patient's representations of self and other, what is necessary is that the analyst's authority be sufficiently authentic, on the one hand, and that his or her authenticity be sufficiently authoritative on the other. The fact that analysts cannot know exactly how they should position themselves with respect to the dialectic of overtly expressive participation and relatively standard, authority-enhancing technique is precisely the wellspring for an overarchingly authentic way of being with the patient, one that is marked by a sense of struggle with uncertainty, by a willingness to "play it both ways," and by an openness to consideration



of the unconscious meanings, for the analyst and patient, of whatever course has been taken.

## CLINICAL ILLUSTRATION

Now let's look at these ideas as they bear upon a piece of clinical experience.

I was seeing Diane, a single medical student in her late twenties. We were in the midst of an analysis that I was conducting as a candidate at the local Institute for Psychoanalysis. The Institute was there with us in the process, like a concrete representation (and externalization) of a somewhat forbidding psychoanalytic superego. Since sometime in the second year, Diane had refused to lie on the couch, sitting up on it instead. Ordinarily, I sit in a chair opposite the couch when patients sit up. But in this case, I dutifully sat in the chair behind the couch (actually at a 45° angle), as if to say: "You're the one who is violating the rules, not me. I've got nothing to do with it." I am not sure how it came about that she started sitting up. I remember it being a gradual and insidious change, one that I was against. At least I said I was against it and told her so. I cannot deny, however, that even as I stated my objections, her mischievous smile, when she began turning around, sometimes elicited a slight smile in return. And when she asked me point blank: "Are you sure the couch is necessary for the process? I think the eye contact is more important for me," I bluntly replied, "Well, I don't know about the process, but it might be necessary for me to graduate."[3] My conviction about that was somewhat diminished by the fact that the supervisor, one I had chosen, had a propensity for independent thinking. (The supervisor, of course, does not al-

[3] Over time I conveyed to her the various rationales for the use of the couch. I also admitted that my convictions about it were hardly absolute. Nevertheless, I said that I had a serious interest in gaining experience with that arrangement and that I considered such experience to be one of the benefits of the Institute training program.

ways have the last word on such matters.) Although he thought it was preferable that Diane lie down, he did not think her sitting up was a major problem. The important thing, he thought, was that we try to explore the meaning of whatever was going on. But for reasons that were undoubtedly related to those that accounted for Diane not lying on the couch, she was not always enthused about analyzing things either. She had real troubles in her life, and she wanted to talk about them and have me understand their importance. She did not think of herself as offering associations as grist for my psychoanalytic mill. She thought of herself as talking to me about things that really mattered in their own right, things that she wanted me to take at face value and help her deal with in a direct way.

So maybe she was "unanalyzable," a candidate for psychotherapy at best, not for psychoanalysis. (See Gill [1991] for a discussion of the distinction between psychotherapy and psychoanalysis, and Bromberg [1983], Gill [1991], and Ehrenberg [1992] for challenges to traditional views of "analyzability.") This, however, was not the whole story. What I discovered, and what was so important for the analytic process, was that if I met the patient "halfway" (that is, what seemed to her to be a quarter of the way and to me three quarters of the way), she could do a lot of very hard work in the standard analytic sense. If I showed genuine and extended interest in the manifest issues first, joint exploration of latent meaning would often come later. Not only that, but whatever was learned was always lived out in a very vivid way. Interpretations had to stew with other kinds of interactions or the patient would not chew on them at all, much less swallow or digest them.

About the not lying down, we came gradually to appreciate how much humiliating submission[4] there already was in Diane just getting herself to the office for her appointments. Lying down while I sat up added too much insult to injury. Her father,

[4] Ghent (1990) draws a useful distinction between "surrender" as a benign form of yielding and "submission" as a malignant subjugation of self.



a Holocaust survivor, had been compulsive and tyrannical about all kinds of trivial matters in the home. Things had to be in place, wife and children (two older brothers and a younger sister) had to be on time, the waiter or waitress in the restaurant had to provide quick service or he would get enraged. At times he seemed identified with his Nazi persecutors in his rigid, authoritarian ways. He was also a very charismatic, energetic man, successful in his business and a dedicated athlete and outdoorsman. Diane, seeing him as a powerful and exciting figure, worshiped him in her early years, only to become bitterly disappointed and disillusioned as she came to regard him as extraordinarily self-centered and stingy with his time, his money, and his demonstrations of affection. In my nonverbal acceptance of Diane's sitting up, I was consciously disidentifying with her father. The presence of the Institute made the departure from convention both harder and easier for me to accept and participate in. Harder because of a fear of real consequences for my training, easier because I was able defensively to externalize my own real interest in doing it the conventional way. If I did not really care, I did not have to feel cheated by the patient or angry with her. Instead I could restrict my attention to enjoying being a renegade with the patient's appreciation and approval.

To say that I was disidentifying with the patient's father is not precisely correct, in that, needless to say, there were other aspects to the father's personality. It would be more precise to say that I was disidentifying with the father's persecutory superego, one that governed his behavior and that of the people around him rather mercilessly and also one that was internalized to a significant degree by the patient herself. But there was another side to the father that was also in evidence at times, however faintly. The father had great difficulty, as I said, showing affection. At moments of greeting or parting, for example, he would position himself near the patient in a way that would suggest interest in some contact, but he could not initiate it himself. It was always she who had to take the lead. Sometimes the patient felt that her father had a lot of feeling bottled up inside that he

just could not express. So with her gradual move from lying down to sitting up, in an attenuated way, the patient and I enacted this aspect of the patient's experience with her father: it was her initiative to have face-to-face contact, and I was the one, like her father, complying in an inhibited, ambivalent manner.

When I say the enactment was attenuated, I have in mind subtle but crucial differences between the original scene and the analytic one. In the first place, although these things are impossible to quantify, I am fairly sure (or I like to think) that my conflict was less intense than that of the father and that there was more pleasure than pain and more playfulness than fear in "succumbing" to the patient's will.[5] The fact that we could laugh about it at times, I at the patient for her intolerance of analytic rituals and she at me for my interest in them, was evidence of that. In the second place, the enactment itself was embedded in a context in which it was generally recognized as an object for reflection. Whether we were actually reflecting on it at any given time or not, just the fact that the atmosphere was one in which it was understood that what was going on had more meanings than what we might be seeing or acknowledging, and the fact that I was actively curious about those meanings made the whole situation very different from its prototype in the patient's history. All in all, I would say that there was enough sense of similarity between the patient's psychological situation and my own to foster strong mutual identifications, and enough differences so that subtly new ways of being and relating could be explored.

In saying that I was disidentifying with the father's persecutory superego there is another imprecision that amounts to a kind of shorthand. I could only identify with the father to begin with to the extent that he had qualities akin to some objects of identification in my own life. Similarly, of course, the disidentification could only occur in my own experience relative to those internalized objects. No externalization (Sandler, et al., 1969) of internal object relations in the patient can occur unless it finds a "mate" in the internal object relations of the analyst. I recognize that this is the juncture at which some authors, like Jacobs (1991) or McLaughlin (1981, 1988) might become aware of stories in their lives that dovetail with the patient's story. While I have the conviction, one that I hope I convey to my patients, that my experience in the analytic process reflects directly on my own history even as it may shed light on something in theirs, my attention does not necessarily gravitate toward specific details in my childhood that complement or parallel those in the patient's experience. Instead, my focus, to the extent that it is on myself, often stays on my own immediate experience as it relates to the patient's immediate experience and to the patient's history. Of course my experience outside of the analytic situation is often affected by the patient and that part of my life automatically comes under scrutiny as an aspect of the countertransference (Feinsilver, 1983, 1990). In this instance, the Institute affiliation, whatever its intrapsychic-historical meanings for me, parallels the patient's relationship with her father.

There is a difference here that surely has as much to do with personality as it does with a chosen approach (*cf.*, Jacobs, 1991, p. 44). Nevertheless, whatever its benefits, I would think that attention to the specific historical bases for the countertransference may sometimes detract from struggling with the nuances of the immediate experience with the patient, particularly in a way that involves the patient directly. It is important to remember that within a given psychoanalytic hour the process is continuous and the analyst is continuously called upon to respond without the benefit of being able to call "time out" to reflect on his or her past. The clinical experiences reported by Racker back in the 1950's and in recent years by Gill, Ehrenberg, Donnel Stern, Mitchell, and others illustrate intensive work on the transference and the countertransference with the patient in the here-and-now without reference to particulars in the analyst's

[5] In the background the enactment may well have had the reverse meaning. The patient might have been identified with the father demanding that I, in the position she was in as a child, submit to her will.

personal history. However, over the course of an analysis, an integration of the kind of reflection that these authors describe in their work and the kind described by Jacobs and McLaughlin would probably be ideal.

All that I have said serves partly as introduction to the following episode in my work with Diane. I think the episode illustrates further the way therapeutic action can be born of the dialectical interplay between analytic discipline and personal participation and between formal analytic authority (which operates silently in the background) and an atmosphere of spontaneity and mutuality.

We were in the third year of the analysis. An aspect of the transference that was becoming increasingly prominent was the patient's demand for a kind of maternal preoccupation with her needs, one which the patient felt her mother reserved for the patient's younger sister Louise at the patient's expense. In fact, it was possible to understand some things that happened in the analysis as a demand that I be consumed with anxious worry about the patient's well-being to the point of being frantic, "hysterical," or "crazy," just as the patient's mother seemed to be about Louise from the time of her birth when the patient was about two years old. Allegedly, Louise was an abnormally small, sickly, and vulnerable infant. Implied suggestions by me that Diane could function at a high level without feeling overwhelmed when she was hurt or disappointed about something were often associated in Diane's mind with the mother's underestimation of Diane's difficulties and overestimation of Louise's needs. The problem was compounded by the fact that because Diane felt she had been so intensely jealous of Louise and so hostile toward both her and her mother, she also felt that she herself had been an unlovable, greedy, ungrateful, and even hateful child, and she hated herself for it. The derivative of this in the analysis was that she often felt she was an impossibly difficult patient and that I wanted to be rid of her.

After a recent move to a new apartment, the patient became obsessed with a noise she could hear from a garbage chute adjacent to her new residence. An advanced medical student going through a stressful rotation, Diane suddenly could not sleep or study. She was beside herself with anger and anxiety. In addition to recognizing the manifestly disturbing nature of the noise, we explored various meanings that it may have had within and outside of the transference. Among other things we understood that the patient was reacting to it just the way she thought her father would under similar circumstances, with total, half-crazed preoccupation and furious intolerance.



One morning the patient called asking for an appointment early in the day rather than her regular late afternoon time. I could not arrange it, however. When she came in at her regular time, she announced in the waiting room, as soon as I opened the door: "I'm here for one reason and one reason only, and that is to get some Valium. If you can't help me get some, I might as well leave right now!" Nevertheless, she grudgingly trudged in. She knew, of course, that I am a psychologist, but there must be someone I knew to whom I could refer her for medication if not get it directly from that person myself. She much preferred the latter alternative because she did not want to go through the ordeal of having to see someone for an evaluation, a solution that I also thought would be too burdensome under these circumstances. She was just so agitated she had to have something *now* to help her relax, sleep, etc. We could worry about what it all meant later. In the meantime she had to go to work, she had to attend classes, she had to study. What did I care about more, her well-being or my analytic purity? Was I worried about what people would think, or about what she really needed? I tried to maintain a "proper" analytic attitude toward all this, pointing out, among other things, that even if it were true that some sort of tranquilizer might help right now, the idea that she had to get it from *me* was irrational considering the many other resources she had. So the demand that *I* give it to her must represent something else, something very important, but to get her a pill might obscure more than it would clarify what that need was. She would have none of this, except in the

most intellectual sense, and persisted relentlessly in her demand that I address the issue at face value.

Now let us consider the position of the analyst at this juncture. What kinds of options do I have and how should they be conceptualized? Do we take for granted that as an analyst I am restricted to trying to explore the meaning of the patient's behavior? I think that most of our theories of the process do take this position. If the patient reacts with frustration and anger, so be it. Those are precisely the affects that need to be understood analytically. Those are the states, allegedly, that are most clearly reflective of the patient's internal dynamics without excessive influence from the analyst. If we take the view, however, that the analyst is always implicated in "constructing" whatever the patient experiences, and that insisting on playing it by the rules can be as provocative as deviating from them, the door is opened to consider other ways of interacting. Also, now the analyst has to struggle with a sense of uncertainty, risk, and responsibility for whatever he or she elects to do (Hoffman, 1987, 1991; Mitchell, 1988, 1991; Moraitis, 1981, 1987; Stern, 1983, 1989). I believe that this struggle, one that is located within the dialectic of spontaneous expressiveness and technical rigor, has, in itself, great therapeutic potential. It is at the heart of what it means to be a new, good object because it is the most open to the multiple potentials within the patient and the analyst.

So what ensued with Diane was the following. Under the patient's pressure and out of my own need and, perhaps, intuition, however "implicit" (Gendlin, 1973), "unthought" (Bollas, 1987), or "unformulated" (Donnel Stern, 1983), I asked Diane whether she had an internist whom she could ask for a prescription. She said she did but was not so sure how he would feel about it since she had not been in for a check-up in a long time. I said, "Well, if you give me his number I'll call him right now." She replied, "Really?!" sort of delighted and floored at the same time. She gave me the number, and I called. While I waited for the doctor to come to the phone, Diane began whispering in an animated way, "This is crazy; I could get a friend to do this; I could do this myself." She was smiling but seemed somewhat embarrassed. I thought of hanging up just as her doctor picked up the receiver, but decided to go through with it. I identified myself and said I thought it would be okay if the patient called that she be given some mild tranquilizer. He said, essentially, that it was no problem and that Diane should call him. After I hung up, the patient and I started to talk and she was receptive for the first time to exploring the meaning of the whole transaction.



Now let us stop again and think about what went on. Why is the patient suddenly freed of the grip of her own compulsion to force our interaction into a particular mold? Why is she suddenly able to get out of the prisonhouse of projective identification? Ogden (1986) has described projective identification and the alternative to it in terms of dialectics:

> Interpersonally, projective identification is the negative of playing; it is the coercive enlistment of another person to perform a role in the projector's externalized unconscious fantasy. The effect of this process on the recipient is to threaten his ability to experience his subjective state as psychic reality. Instead, his perceptions are experienced as "reality" as opposed to a personal construction. This process represents a limitation of the recipient's psychological dialectical processes by which symbolic meanings are generated and understood. Neither the projector nor the recipient of the projective identification is able to experience a range of personal meanings. On the contrary, there is only a powerful sense of inevitability. Neither party can conceive of himself or of the other, any differently or less intensely than he does at present (p. 228).

In the work with Diane, I think that the key is to think, again, in terms of reversal of figure and ground. What is in the foreground is the way the patient, as she enters the office, is aggressively and unreflectively shaping the interaction. She is saying, in effect, "This is who I am and this is who you are when you are with me. It's the bottom line and there are no options." What is in the background, however, is a projective identification that

originates with *me*. Because to the extent that I am uncritically committed to exploring the meaning of the patient's experiences at every turn, it is I who am saying to her: "This is who I am and this is who you must be when you are with me. Me analyst, you analysand! Those are the terms. Take them or leave them." It is a case of tyrannical father locking horns with tyrannical father. So when I say, "I'll call your internist right now," I am saying, "Look, there is nothing sacrosanct about this way of being in the relationship. You and I together have other potentials that we can realize." I am also saying; "I may *resist* your demands and I may not be sure what is in your best interests, but I'm confident that for me to yield to *some* of those demands will not kill me. I can find a way to yield that is also expressive of my own will." In this instance my "yielding" involves an initiative on my part that has an aggressive component, a kind of calling the patient's bluff that takes her by surprise. The patient, in turn, is out from under her sense of submission to the requirement that she do it *my* way and can now freely find *within herself* an interest in doing it that very way, that is, in reflecting and analyzing and seeing her role in shaping the interaction. The episode conforms to the formula stated simply by Benjamin (1988), drawing on Winnicott: "When I act upon the other it is vital that he be affected, so that I know that I exist—but not completely destroyed, so that I know that he also exists" (p. 38; see also Fourcher, 1975, p. 417).

All this is happening with the ritually based power of the analyst operating silently in the background to give the moment of mutual recognition and responsiveness the intensified impact that it must have to stand any chance of overcoming the profoundly damaging effects of those early object relations in which domination of the other or masochistic submission seemed like the only alternatives available (Benjamin, 1988; Ghent, 1990). When the patient reacts to my getting on the phone, it matters that it is I, the analyst, who is doing this, a person who occupies a special position in the patient's mental life. Again the asymmetrical and hierarchical aspects of the arrangement provide



the backdrop, the element of idealization, that gives such moments of mutuality, cumulatively, their power to affect deeply entrenched and longstanding patterns of internal and external object relations (*cf.*, Berger and Luckmann, 1967).

When the patient starts whispering while I am waiting for her doctor to come to the phone, "This is crazy, I could do this myself," I go through with the call. Why? Maybe it is a bit of playful tit for tat, as if to say, "You tortured me for a half hour, now it's your turn." The aggression on my part borders on a frame violation, a piece of acting out, perhaps, retaliating for the patient's challenges to the frame, challenges that may have carried particularly aggressive implications in light of Diane's knowledge of my status as a candidate (Perl, 1993). Nevertheless, the playful aspect of the exchange reflects our entry into a new kind of transitional space. Also, the shift that I make reflects my movement from one stance to the other, which, in turn, demonstrates the element of uncertainty and struggle that I am suggesting is a central component of the therapeutic action.

So, to continue with the story in the clinical situation, exploration of the meaning of this episode continued sporadically over several weeks of work, and a number of important insights emerged. In the first place Diane acknowledged that she had been very angry because I could not see her earlier in the day. She said, smiling, "Really, I don't ask for that much. Was that too much to ask?" I said, it was one thing to ask and another to be enraged if I could not arrange it, something she undoubtedly recognized herself; otherwise, I said, she would have come in angry about *that* rather than about my anticipated reluctance to get her Valium. She needed something to help legitimize what she recognized as childish: the demand that I see her whenever she wanted to see me.

This demand was linked to another very important issue, another bit of enactment that we had not sufficiently examined because it had been so emphatically presented as a reality issue. I pointed out that the obsessional preoccupation with the noise in her apartment had, in fact, been associated with quite a few

phone calls, not just the one mentioned. This was interesting in light of the fact that during that month we had been meeting only three times per week because the patient insisted she could not make the fourth hour due to her hectic schedule. I had agreed to this most reluctantly and "under protest," with the understanding that we would continue to search for a mutually agreeable fourth hour. Now the patient admitted, much to my surprise, that she actually felt that I had given in "too easily." She expected me to put up more of a fight. Here, as in the case of the demand for Valium, the sense of necessity that characterized the transference demand (we must cut down to three times per week) is undone when the sense of necessity in the countertransference (we must meet four times per week) is undone. She agreed that it was a no-win situation for me (and her), in that if I had been more rigid about it, she would have thought I was doing merely what was best for *me*, at her expense. But the fact was that now she thought I was just relieved to not have to spend so much time with her. She figured that she was as annoying to me as the garbage noise in her apartment was to her. Or, from another point of view, she felt deserted, left alone to cope with all her miseries, condensed symbolically into the sound of the garbage in the chute. The whole sequence recreated the patient's experience with her mother who, for example, was all *too* ready, the patient felt, to stay home (in a distant suburb) and not come to visit if the patient said that she was busy and that it was not a convenient time. Shortly after this, incidentally (and for the record), we resumed meeting four times per week and continued on that basis to the end of the analysis about three years later.

With regard to my calling the internist, the patient said she really liked that and appreciated it because it meant I had become "a little crazy," which somehow meant I understood something about her own sense of desperation at times. This meant both that I sensed her desperation and wanted to do something for her and that I felt desperate myself and was willing to show it, if only temporarily. The enactment helped me and the patient to begin to see how much she wanted me to be frantic about her in a way similar to how she thought her mother was frantic about Louise, the difference being that my "getting hysterical" was also an object of curiosity and critical reflection. Thus there was reason to believe that the quality of my attention, taken as a whole, was better than what either the patient or Louise got from their mother.



## CONCLUSION: OEDIPAL AND PREOEDIPAL DIALECTICS AND THERAPEUTIC ACTION

When the patient makes her aggressive demands for an earlier session, for Valium, for cutting back the frequency of our meetings, and for direct "help" with her life, one might say that she is threatening to "destroy" the analyst-object, and I am in a position of having to decide how far I should go in defending that part of myself that is under fire. It is, of course, only a part of myself. It is not even the part of myself that I would designate as my "true self," not entirely anyway. In working with this patient some part of my "true self," I would say, wants to abandon the standard analytic position even while another part wants to hold on to it. Conversely, despite her protests to the contrary, there is a part of the patient that does not want to lose me as her analyst, as the person with a unique, encompassing perspective, special expertise, and special power to affect her life.

One could translate this situation into oedipal terms and say that the patient (like any patient?) has an investment in my remaining "wedded" to the Institute, to the Book, and to analytic principles, including the principle of abstinence that helps protect my capacity to subordinate my own personal responsivity and immediate desire to the patient's long-term interests in the course of the work. Even as she attempts to lure me away from that marriage, capitalizing, perhaps, on points of vulnerability in it that she detects, she knows at some level that such

an oedipal triumph would be a pyrrhic victory. In that respect, she would rather that, in the long run, her assaults on that part of me not succeed. She would like to win a few battles, perhaps, but not the war. In the last analysis, the child wants to love and be loved by both parents (or their surrogates) and to feel that the parents love each other. Similarly, the patient's deepest need is for the synergy of my personal involvement and the relatively detached, theoretically informed, and interpretive aspect of my analytic attitude.

Abstracting further, to a level that encompasses preoedipal as well as oedipal issues, the "triangle" consists of the patient, the analyst as one who is preoccupied with responding to the patient's immediately expressed desires, and the analyst as one who has other narcissistic and object-related investments. Just as a parent's investments in other objects of interest are inextricably linked to the parent's abstaining from engulfing emotional or incestuous involvement with the child, so too is the analyst's attachment to other objects, including psychoanalytic theories and the "Book of Abstinence" itself, linked to the analyst's avoidance of excessive, suffocating personal involvement with his or her patients. The patient, in turn, although he or she may seem to try to destroy the analyst as a separate subject—which means forcing a collapse of the analyst's internal dialectic—also has a vital interest in the analyst's survival. Here we return to the *patient's* ambivalence. The tension within the analyst has its counterpart in a similar tension within the patient. The patient, like the analyst, has an aspect of self that is preoccupied with the other and a side that excludes him or her and has other interests, narcissistic and object related. In effect, the patient as a whole person cannot survive, much less grow, unless both of these aspects survive and grow together in a dialectical relationship, one that has its counterpart in a complementary, living dynamic tension within the analyst. The tolerance of the tension within each participant goes hand-in-hand with tolerating and nourishing the creative potentials of the tension in the other (*cf.*, Benjamin, 1988).



As the analyst, I cannot know just what balance I should strike at any given moment between my own conflicting allegiances and inclinations. Indeed, relevant aspects of my own conflicts at any given time are likely to be unconscious. In fact, analytic therapists in general can safely assume that they do not have privileged access to their own motives, nor are they able, despite their advantageous position, to know exactly what is best for their patients. That is why the attitude that is the most integrative and authentic must be an alloy of doubt and openness (Hoffman, 1987). At any given moment the sense of uncertainty might be in the background, as the analyst engages in one or another mode of relating with a good deal of conviction (Hoffman, 1992b). Moreover, whatever the analyst does, we must not forget, in our enthusiasm about "the meanings and uses of countertransference" (Racker, 1968), that his or her influence has real impact in real time. It is not merely a bit of manifest content, like that of a dream, that stands in need of interpretation (although it certainly is that too). There is a dialectic between the analyst's participation understood as figurative (or symbolic) and the same participation understood as literal (or actual) and as consequential in the patient's life (Hoffman, 1992c). In either case, the work requires an underlying tolerance of uncertainty and with it a radical, yet critical kind of openness that is conveyed over time in various ways, including a readiness to soul-search, to negotiate, and to change.

The bad object that is lurking in every analytic situation is the one that pulls either of the participants into absolute commitment to one side of his or her conflict (for example, the side that wants to analyze) with the result that the other side (for example, the side that wants to respond in a more spontaneous, personal way) must be abandoned and repressed. The good-enough parent maintains a balance among investments in each child, in spouse (or others), and in self. He or she recognizes the inevitable tensions among these interdependent yet rivalrous attachments but does not abandon any of them. The quality of the attention to the child (and to each of the others), moreover,