PSYCHOANALYTIC THEORY AND ITS RELATION TO CLINICAL WORK

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Freud's shift to the fantasy theory of neurosogenesis defined the investigation of intrapsychic life as our fundamental theoretical purview. In assigning to inner experience a data base for scientific exploration, there is reflected a central epistemological innovation which must profoundly alter the way we view what is real. This paper considers some of the continuing clinical challenges and far-reaching implications posed by this shift to "psychic reality" as our core psychoanalytic theory.

> Science is the attempt to make the chaotic diversity of our sense experience correspond to a logically uniform system of thought [Einstein, 1936].
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> Everything factual is, in a sense, theory. . . . There is no sense in looking for something behind phenomena. They are theory [Goethe, 1829, p. 94].

IN PSYCHOANALYSIS, AS IN OTHER sciences, there is no fact without theory. All that we observe is theory-laden, and any effort to locate a theory-free datum would in itself be endowed with theory. The question arises, when we speak of theory as it relates to our clinical work, what sort of theory do we mean? Do we refer to a theory of the mind's topography, a theory

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of development, of instincts, affects, object relations, conflict, trauma; perhaps a theory of meaning, and its interpretation—one experience-near or more removed, metapsychology? Do we have in mind a theory of causes or effects—etiology, pathology; a theory of technique, or one of therapeutic action? All are theories having to do with our chosen terrain—a study of the inner psychic life.

The psychoanalytic vantage point is that of the intrapsychic; and *this very purview is itself a theory*. It is this theory, that it is "psychic" reality that is the "decisive kind" (Freud, 1917, p. 368), which I underscore as *our bedrock*. In its paradigmatic significance, it has changed the way we see the world. I would like here to reflect further on the profound implications in this core theory for our listening, our clinical data-gathering, and our interpretive processes. I have, in past years, attempted to delineate some methodological and conceptual aspects in our mode of analytic listening. My effort in this paper will be to extend this focus to a more specific consideration of these conceptual and epistemological ramifications deriving from psychoanalytic theory, as a theory of the intrapsychic, and their relation to our clinical work. Consider the following examples:

A student told me her patient complained that she had not said "happy birthday" to her on the designated day. She asked me, should she, the analyst, have said it, or not? Are there circumstances, she wondered, in which one might? Would such a response constitute a parameter? What did I think she should have done? I replied by asking her, from what she knew about her patient, what did she think was her inner experience? What conflicts were stirred within her? What may the patient have been seeking from the analyst that troubled her when it was not met? Posed this way, keeping the investigation on psychic reality, the question—should one or not say "happy birthday"—will shift. The analyst's response to this patient might then be, I suggested, as she now shared further reflections about how unwanted the patient has felt, "What you wished for me to convey, and what hurt you that I did not, is that I am happy you were born." When I said this to the analyst, she recalled, with an immediate sense of its poignancy, that the patient had in the past said she did not feel her mother was happy she was born.

A patient, fairly new to analysis, asks me if I have seen a certain play in town—not an unusual kind of question for him. I do not answer; he waits, becoming upset that I do not respond. "What can be the harm in it?" he asks, as he makes a compelling case for my simply telling him. (It seems easy to be drawn into that.) If I were just to tell him I saw it, he suggests, it would save him the time of recounting it; if I did not see it, then he would tell me about it. What can possibly be "served," he goes on, by my not saying? "It feels so impersonal." "Impersonal?" I wonder. Contemplating his words in expressing his feelings, I then say, "You mean it feels like it doesn't serve anything for you; it's not for you, personally—like uncaring—that I don't tell you about my life outside here?" "Yes," he says, "that's right." His tone is calmer as he becomes more reflective. "But I see now," he continues, "where would it stop? I'd want to know where you're going when you go away and all sorts of other things about you. But you know, with my former analyst, he wound up sharing all sorts of things about his life with me, and it didn't feel like it was for me." "Still impersonal," I say, "not serving anything for you." He then elaborates on the seemingly contradictory ways he has felt not personally responded to, not cared about—for him. He wipes his eyes, "Now I'm feeling teary," he said. "I know I've cried here when I've felt understood by you."

Freud (1915) wrote: ". . . a psycho-analyst must look at things from a different point of view [p. 160]. It is . . . just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these . . ." (p. 166). Thus, while we may not say "happy birthday" or tell if we saw the play, we do not suppress the "craving" to be told. We are to look at these wishes "from a different point of view."

There is here a fundamental epistemological innovation. Heralded by Freud's shift to the fantasy theory of neurosogenesis, the concept, psychic reality, alters the way we view what is real, assigning to inner experience a data base for scientific exploration (Schwaber, 1990a). Spruiell (1983) notes, "Sigmund Freud opened a way to a revolution when he forever redefined 'reality,' at least as far as psychology is concerned" (p. 4). "Real is how things are felt to be, and how they are perceived—how feelings, wishes, defenses, and perceptions interdigitate. Real is what each of us experiences as true, and the correctness of which no other one of us can be the arbiter. Real, as it is felt by another, must include ourselves, the observers, as its particicpants" (Schwaber, 1990a, p. 232). Understood in this way, the patient's psychic reality is neither simply one among other plausible narratives woven together by a particular analyst and patient, nor is it a relative or subjective truth contrasting with one more objective. As Bucci (1985) states (in her disagreement with R. Schafer and D. P. Spence), we do not construct the patient's reality, we discover it. It is the patient's truth, our domain to be explored and learned—drawing on all the skills we have, all the verbal and nonverbal cues we can discern, to recognize it. This is our theoretical base.

It should be noted that there is here no suggestion of the absence of a measurable or otherwise validatable reality. We utilize information about life events and chronology, and surely employ our own sensory apparatus in our clinical investigations. If, for example, a patient (with no organic visual abnormality) sees a red dress where the analyst is wearing beige, we may assess the *in*accuracy in the specification of the color. But this is a matter different from a judgment about the correctness in the *experienced* reality—in this case, the *experience* of perceived redness. Thus, the analyst need not surrender her or his own view of reality in order to locate that of the patient, but may draw on the discrepancy between them as an indication of something in the patient's perspective, which may be conveyed metaphorically, bearing a truth still to be learned.

I have elsewhere expressed my view (Schwaber, 1985) that the discovery of the transference, beautifully reflected in the Dora Postscript (Freud, 1905), with its temporal and spatial dimensions—the continuity of the past within the present, and the participation of the observer within the field observed—marked the entry of depth-psychological observation into the scientific era of relativity. "What we experience in another is a representation of the meaning we give to it; what we see and feel is a product of what we bring to it" (p. 3). McLaughlin (1981) writes, "From this [Freud's original] sweeping view of transference [as a central organizing mode] it is possible, indeed inevitable . . . to assert that all we feel we know or can ever come to know about ourselves and the reality in which we exist can be ours only through psychic structuring shaped by transference; that this psychic reality is what we live with" (p. 642).

As in other sciences, the revolutionary allusions in this paradigm stir great difficulty and controversy. "What is so hard," writes the physicist, John Archibald Wheeler (1981, unpublished): "is to give up thinking of nature as a machine that goes on independent of the observer . . . We are inescapably involved in bringing about that which appears to be happening . . . In some strange sense this is a participatory universe . . . What we conceive of as reality is a few iron posts of observation with *papier-maché* construction between them that is but the elaborate work of our imagination . . . For our picture of the world, this is the most revolutionary thing discovered. We still have not come to terms with it." *It is then this core theory of psychoanalysis—of psychic reality with the transference at its helm—in which this fundamental shift in our understanding of what is real took place, with which it is so hard for us to come to terms.* In the Dora Postscript, Freud (1915) wrote as though warning us lest something "in our relations or in [our] person or circumstances," some "unknown quantity" in our participation in the experience of another, take us too "unaware" of the transference, as it had him (p. 118). And we know of the tension and

controversy that linger in the aftermath of Freud's abandonment of the seduction hypothesis: Is the contribution of the outer world, are traumas bypassed in favor of inner forces, wishes, and fantasies? Did a seduction occur that is overlooked? Alternatively, is the intrapsychic life, what is unconscious, once again being resisted in a focus that has shifted back to the "outside" (as it has with an interpersonal position)? In this debate, we have yet to reckon with the implications in the notion of an external world to be discerned and understood as real, *as it is perceived and experienced*—an outer world, the individual perception of which expresses an intrinsic aspect of one's inner reality.

When we speak of the patient's "misperceptions," "misapprehensions," "distortions," or of "real" events, the analyst's "actual" participation, the "real" relationship, we cloud the distinction between what are differing vantage points—patient's and ours, assuming a view of the patient's reality from which we, as analysts, can stand apart to judge its "correctness." As long as the question—"from whose point of view?"—is not clearly delineated, the focus on that of the patient, the reality of the patient's inner life, remains blurred. Whether we argue that by virtue of his or her fantasies, wishes, or defenses, the patient misperceives what has taken place, or that by giving such priority to inner stirrings we overlook the real experiences, the actual traumas and seductions—in either case, we circumvent the fundamental implications in our basic theory. Reverting thereby to an earlier scientific *Weltanschauung*, we elude the central scientific breakthrough heralded with Freud's discovery of the fantasy theory and of the transference. If, however, we sustain the position that the reality we seek lies within the patient's experience, with its conscious and unconscious conflictual, defensive, verbal and nonverbal expressions, then the dialectic we pose and the questions we raise will assume, in Kuhn's (1962) sense, a profoundly changed order.

What then about our models of the mind, our theories of structure and affect and development? Our guideposts, as we

follow the ebbs and flows in the patient's associative stream, they are to bring clarity to what may appear as random or chaotic—what Einstein (1936) called "the chaotic diversity of our sense experience" (p. 323). They broaden our perceptual scope, enabling us to see what may otherwise be overlooked, or seem an unyielding maze. Bernardi (1989) writes, "[Our] paradigms . . . represent a way of solving problems in a field, which before their arrival seemed opaque and unapproachable" (p. 343). And they allow us to talk to one another as colleagues, with an effort at common language. In this way, as we draw on our theories—as they shape and become shaped by our assumptions, our clinical and life experience, our values and our perceptions—we introduce what is our vantage point, the place from which we must begin. As Havel (1990) observes, writing in another sphere, "We always take off—regardless of how far we wish to fly—from the ground we know" (p. 66).

But here again we tend toward difficulty. We seek to learn, to recognize another's way of experiencing and organizing the world, but then we are in continuing risk of trying to change that way, foreclosing our inquiry. In a sweeping indictment, the eighteenth-century Italian philosopher, Giambattista Vico (1744) asserted: "It is another property of the human mind that whenever men can form no idea of distant and unknown things, they judge them by what is familiar and at hand. This axiom points to the inexhaustible source of all the errors about the principles of humanity that have been adopted by entire nations and by all the scholars" (cited by Corradi Fiumara, 1990, p. 9).

Whether it is the remote or the seemingly proverbial that we are attempting to investigate, it remains a singular struggle for us to not regard our own vantage point as holding the more real, the more correct version of what is true. Despite our best intentions, we may recognize a fundamental disinclination to shift our own perspective, particularly our view about ourselves, in order to locate that of the patient. Rothstein (1980) writes of our narcissistic investment in our theories. However we may

understand this investment, I believe it extends to our own "grounding," or as a student reflected, to what may feel to be our center of gravity.

There are no theory-free data. As Wheeler has said, "we are participants" in creating the reality we observe. This is our twentieth-century vision of science, and it is a view that finds expression in other domains as well. The novelist Milan Kundera (1986) wrote while in exile, "Man does not relate to the world as subject to object, as eye to painting; not even as actor to stage set. Man and the world are bound together like the snail to its shell: the world is part of man, it is his dimension, and as the world changes, existence (*in-der-Welt-sein*) changes as well" (p. 35).

That we are participant observers does not make psychoanalysis a two-person psychology. To be sure, the impact of our participation, as may be conveyed by the way in which we use our model, must be a fundamental aspect of our inquiry—*but as seen from and as data about the patient's point of view*. This position contrasts with those that argue for an interpersonal framework in elucidating the analyst's participation in the transference, as, for example, in the work of Gill (1982). I highlight that it is the patient's vantage point, not that of the analyst or any other outside observer, that defines our investigative terrain. However similarly or differently we may perceive our own contribution, such a determination offers us only our perspective, and does not yet tell us how we are being experienced by the patient. We may believe we are not imposing our model, but the patient, in his or her own mode of expression, may suggest otherwise, and lead us in still uncharted directions.

A patient came in one day, sharing his associations with apparent spontaneity, but seeming to be weighted down in his tone; there was a heaviness to it, different from its lighter, more buoyant quality in the preceding session. Whatever else emerged in his verbal commentary, there was this tone. I asked him about it, and he reflected, remembering that when yesterday he had spoken of a recent event in his life, I did something

that felt a bit familiar and painful. I had gone on to search, however unassumingly, for its connection to his relationship with me, leaving aside his emphasis on what he was trying to convey. It felt to him, he said, that though my perspective may otherwise be helpful, I had not left him room to have an autonomous experience, all his own. We talked about it; of course, we had yet to understand why he had this particular response at this time, and how it may have linked to something in his past. But I had to learn again what here may seem a paradox: even a model so basic as the centrality of the analyst's participation within the patient's experience, can become a truth "with a big T."

Bertrand Russell (1927) states, ". . . there is a tendency to use 'truth' with a big T in the grand sense, as something noble and splendid and worthy of adoration. This gets people into a frame of mind in which they become unable to think" (p. 265). Again, Havel (1989) cautions us, "How easy it is for a well-intentioned cause to be transformed into the betrayal of its own good intentions . . ." (p. 6).

As may happen with our formal theoretical systems, so too with our personal and world views. Often and unwittingly, we skip over questions which do not occur to us because we assume we already know.

A student analyst told of his patient's having spoken of his trip to his parents' gravesites for the first time since his father died, when he was a small child. The patient's mother had died just recently; that's why he now went. The analyst said to me, "It felt sad." "To whom?" I asked. He seemed startled by my question; "It just felt sad," he said. "To the patient, to you? How was it conveyed?" I wondered. The analyst realized he did not have the answers. He had not thought of it that way. It seemed a commonplace that it is sad to visit the gravesites of two dead parents, particularly with the recent death evoking a childhood loss. Taking his own assumptions as shared truth, he blurred the distinction between the two vantage points—his and his patient's, and did not think to ask the question.

Another student told me of her patient saying the analysis was painful. I asked why, in what way? It had not occurred to the analyst to wonder about this; she had simply thought, "That is what analysis must be." Then, when the complaint recurred, she asked her patient, "What about the pain? What may have evoked it?" To her surprise, an unforeseen pathway was opened. As other options for the patient's experience of the analysis now came to view, the analyst also learned from the patient something she had not quite recognized, about herself.

Both of these students subsequently noted that with the impact of the realization of their own unexamined assumptions, they came to feel a powerful shift in their mode of listening and responding.

It may be especially hard to relinquish the notion that ours is the more "correct" truth when there is a difference between us and the patient about how we are perceived. Herein lies the essential epistemological implication in the theory of transference. Another's view—even of us—has a reality as real, as true as our own. Let me share a clinical example at greater length to convey some of my own struggle with this effort to sustain the focus on the patient's psychic reality (see also Schwaber, 1992).

Two sessions before the summer break, Ms. T. (given to recurrent periods of silence) was quiet much of the time. She began the next hour again, silently. When she spoke, she said she worried that something might happen to me and I would not return, and she stopped. Then she said, "You're always more quiet before you go away. I want you to talk to me and you don't and I get angry. Before you go away, I want to establish a stronger connection, and I feel you want to establish more distance."

"I want [to establish] more distance?" I thought to myself. But she has become quiet; she seems to be distancing herself. I did not feel particularly quiet or distant, but responding just as I always do, to her. My sense of myself was jarred. I was certain I was not the one retreating. Perhaps she is placing her

feelings onto me so she will not have to bear them; or perhaps she is trying to get me to feel what she feels—angry and unresponded to, so I might know it that way. It would be easy now to find an explanation; after all, I was going away. That could be reason enough, I thought, for her to experience what I saw as my attentive response in this "distorted" fashion—a projection of her own withholding feelings, and for her to focus her anger on some other injury to deflect from the pain of our imminent separation.

Then I recognized that I was feeling a sense of certainty about what was only my supposition, as though I had already understood the meaning of her experience, and maybe I had not. I was responding as though her perception of me must be predetermined rather than arising in the wake of my particular contribution in the session, and then I sought a theory to explain that presumption. My view, I believed, particularly about myself, held the truer version. Observing this temptation for closure, I shifted my position to try to listen more attentively to what she was telling me—about me, and to see what I might yet learn—about her reality. It was striking; in this mode, my sense of struggle with her eased, for I was no longer trying to change her view. (Indeed, I have observed more generally that a feeling of struggle with a patient, however scarcely and subtly perceived within ourselves, may be a salient indicator that we are trying to guide the patient to see it *our* way.) I could now begin to appreciate that though I had believed myself to have been respectfully and appropriately waiting for her associations, my wait alone might make me seem quiet, certainly not as reaching out. In reviewing my notes in order to share this material, I could see the sequence even more clearly; her first words after she was quiet were that she was worried that I might not return, and I still said nothing. At this point, perhaps even a moment of my quiet, continuing after she had finally ventured her frightened concern, might understandably be felt as distant. It was then her tone became angry.

I had not yet recognized these nuances at the time—only that I was going to try to find the logic in her perception that I seemed too quiet and distant, however quiet I perceived her to be. And so when she said that what she sought was a "stronger connection" before I went away, I responded simply, "It seems you're wanting me to reach *more* actively to you [than I am]."

"Yes," she said, unhesitatingly, her tone seeming now to sound more relaxed.

"Why then do you become [what appears] more quiet at this time?" I asked. "Do you feel that, too?"

"Yes."

"Why do you think that is?" I asked, "As you say, it's not to establish more distance."

"Maybe it's just if I talk," she reflected, "then I wouldn't know if you really mean it when you respond."

"Oh, so you look for something *more* from me," I now could see, "especially at this time before we separate, for me to show my continued involvement."

"Yes," she said, as she spontaneously began to note parallel experiences that she had not quite seen in this light before; "I feel the same way about George [a friend], before he goes away. It's also hard for me to reach out; I only do that in desperation really. . . ."

A new direction was then opened as she recounted her feeling of not existing in the other's absence and her sense of increased risk before a separation; in later hours, she elaborated resonant memories from the recent and more distant past. As she felt her perceptions and her experience of them recognized, she came to distinguish and acknowledge on her own, additional nuances in the meaning of her defensive stance—her uses of quiet and retreat, and their interdigitation with her conflictual issues.

It is of course quite possible that in my taking the approach I did, she may have felt me as reaching more to her, the very thing she had sought in the first place. But it was yet uncertain whether it was the quantity of my words or the position from

which they were spoken—that is, the active search for her perspective, that had the decided impact on what ensued. Whichever it may have been, or both, was still to be learned. We could, in either case, observe that there was clearly at the time some relation between my response—silent or verbal—and her ensuing one, the meaning of which warranted further elucidation.

It was hard for me to come to terms with the "unknown quantity" (Freud, 1905) in me, which had led the patient to perceive me as she had. My temptation was to override her reality, drawing on theory-based inferences to explain her stance, and thereby to maintain my own sense of myself. Perhaps this proclivity to teach her something was heightened particularly at this time, for reasons of my own, associated with my imminent vacation. I have elsewhere (1992) described such an inclination as marking the countertransference—that is, countertransference reflecting a retreat from the patient's vantage point toward an added certainty in the correctness of one's own. I have suggested such a definition of the concept of countertransference with its related potential for enactment, in keeping with the theoretical views expressed here about the centrality of focus on the patient's psychic reality.

My struggle to sustain the inquiry from Ms. T.'s vantage point was intensified on other occasions as well. She came in one day, lay down, seemed to be sniffling, but said nothing. "You don't want to say anything?" I asked. "It's so silly," she replied; "it's just . . . I'm feeling tired and wanting someone to take care of me. Joe [my husband] is away and my partner is away; George also didn't come through. I wanted him to go with me to dinner tonight so I wouldn't have to go home to fix it, and he said no. I can't stand the thought of going home to take care of the kids when I want someone to take care of me."

The patient was a professional woman, glamorously and painstakingly dressed, with a husband who, despite his own work commitments, usually did most of the domestic chores while she often delayed going home, for her flirtation with George. Her resentment of Joe's occasional business trips was

expressed around the extra burden of responsibility imposed on her in having to care for her children, both under the age of nine, and in taking her time away from George. It was hard for me at first, to resonate with her tears about that; I felt in a conflict of values. But I recognized that were I not to get past my predicament, or deny it to myself, my interventions could in some way express a well-rationalized effort to shift her position—perhaps to help her reflect on her sense of "entitlement," and so to go home and take care of her children. I could find a theoretical argument to bolster an interpretation, subtly in keeping with such an agenda. This time, catching hold of my predilection in a way that I may not have before, I could see that listening in this way from within my vantage point, to how she lives her life "out there," would reflect a perspective other than her own—a focus elsewhere than on her psychic reality.

And so, I thought to myself, Ms. T. is telling me she feels left, having to do the feeding and caretaking when she wanted that for herself. She is the oldest of six children, the next one in line only fourteen months younger. Though I had not before heard it expressed in quite this way, there may be still a feeling of some missing caretaking for her. "Perhaps," I said, "it feels like when, as a child, your mother was away and you had to take care of the little ones." "Yes!" she rejoined, then acknowledged for the first time what she had previously been ashamed to say, how Joe does the cooking and serving, for her as well as for the children. Though she has accepted that arrangement for its convenience, he seems very controlling with it—like her mother had been. She remembered her dread of mealtime while growing up, and how critical or mocking mother was, chiding her for thinking only about herself, or for making a "big fuss about nonsense." She felt estranged from mother. We may recall that when she first spoke in this hour she said, "It's so silly," as though expressing a sense of shame or a concern that I too might respond to her complaint in some disparaging way; perhaps she has felt I had. Perhaps her quiet reflects the potential, here too, for a sense of estrangement.

This was a Thursday session, the last of the week. Mondays were especially difficult for her to resume her associations; there was always a beginning delay. Her feelings of detachment and ambivalence about analysis were heightened with the weekend interruption. But she had not at any time directly expressed a wish to be here. It was hard for her, as she had said earlier, to reach out. On this following Monday, she came in and talked immediately: "I thought of calling you just because I wanted to see you again . . . All weekend I felt I wanted to come back. The last session here, I didn't want to leave. I had a dream last night that I was pregnant. I'm ashamed to say I didn't want to do it because I didn't want to get fat and misshapen again. In the dream, I wanted to talk to my mother about it. I did and she was understanding and listened and told me to do what I thought was best. I was so surprised, but then I turned around and she didn't look like my mother; she looked like you. Then I woke up and wanted to get back to the dream." She spoke tearfully, revealing for the first time how she wanted to be closer to me, and went on to tell of her lost and buried love for her children. In later hours, she observed how she had somehow felt she had lost her husband to the children. As he had taken over their care, which she permitted—the more so as he criticized the way she mothered them—she disengaged from him as well. Now recognizing the familiarity of this old conflict about caretaking and control, and the sense of loss reevoked, a newly emerging warmth for her husband began to appear.

It was in this context that she pursued a deepened exploration of her sexual conflicts, which we may see coursing through this affectively vivid material. Ms. T. came to observe—outside, and within the analytic moment—her defensive efforts to protect against profound feelings of inadequacy about herself and as a woman; she could see how these feelings also oscillated with her experience of me, of my participation in the transference. Herein too, as she felt me trying to learn, not to change the

internal logic in her perspective, she dared to expose even to herself its more shame-inducing dimensions.

Although our models and conceptualizations are to enlarge our perceptual scope, "often and unwittingly, we draw upon them to make leaps of inference about unconscious meaning and bypass untold paths for which the theory may not fit. Hard as we may try to do otherwise, we are vulnerable—more or less in different moments, each of us in accord with one's own threshold and proclivities, one's own capacities to tolerate helplessness, uncertainty, culpability, or affective closeness—to using our theories to rationalize [what may be] hidden assumptions and agendas [and values]" (Schwaber, 1990b, pp. 31–32). But we can address these occurrences and their aftermath, and the history they may awaken, by learning of them from the patient, however that may be communicated. In this way, we encompass our fundamental theoretical stance—that *we are participant observers, as understood from the patient's point of view*—within our basic methodology.

With this sharpened attunement we can bring forward questions about the nature of our clinical evidence: How do we know what we believe we know? How do we learn it? What allows us to discover something we had not before known, or to change our minds? Bernardi (1989) asks another question: "How can we arrange that [our 'paradigms'] should grow as instruments of knowledge instead of as means of identifications and power?" He answers, ". . . it is necessary that something coming from the material should in turn have an effect on them" (p. 355)—and surely, I would add, on how we use them.

In summarizing, I shall underscore: I am not addressing technical considerations in their own right; nor am I addressing such concepts as empathy—a word that has become burdened with ambiguity—or subjectivity, or the merits and doubts in the uses of confrontation—surely, at times, an indicated option. I do not question that there may be circumstances that necessitate our having to assume a position other than that of sustained intrapsychic inquiry, as when there is a risk of loss of control,

dangerous behavior, or overwhelming anxiety, or when in our clinical judgment something in the particular instance warrants a departure from the analytic mode.

That we are to hear the patient's vantage point does not mean we must relinquish our own. That we are to ask because we recognize we do not know does not mean we become more interactive, or lace our interventions with questions. That we are to augment our focus on verbal and nonverbal nuances in the immediacy of the moment does not mean we bypass what is latent, or what is past. We do not circumvent expressions of anger or other conflictual themes, but can more closely discern their subtle and manifold elaborations. We do not evade exploration of defenses or their interpretation, but can more rigorously observe them as they take place. It is precisely in raising the magnification on shifts in affect and state and content, and on the defensive allusions these may convey, that we can find our way, with narrowed leaps of inference, to pathways hitherto unconscious. Further, it is such profoundly, if subtly expanded and articulated shared recognition that underlies the mutative power of psychoanalysis. "By this rigorous approach to psychic reality . . . the patient may attain a sense of discovery and recognition of his or her inner world, of what feels real and old and familiar or new. This is the mode of therapeutic action" (Schwaber, 1990a, p. 238).

It is an outlook I am addressing, one implicit in this sustained investigation of the intrapsychic as our theoretical base. Central to this position is that our participation, as may be expressed in the ways in which we use our varying models, is intrinsic to the reality we are to discern and to articulate; further, this participatory dimension, *as delineated from within the patient's point of view*, underlies our understanding of the transference. The concept of transference, thereby, may be seen as designating the representation of psychoanalysis within our modern scientific era.

Such questions as: "Should one or not say 'happy birthday?' " "Did I or not impose my transference model, intrude

on my patient's autonomy?" "Was the student's patient sad, or not?" "Was I too quiet or not?" "Was Ms. T. misperceiving or was she not?" "Was she unrealistic, 'entitled' in her response, or was she not?" reflect the difficulty in coming to terms with the paradigmatic shift in our view of reality, in which no one of us can be the arbiter of the correctness in the meaning seen from another's perspective. As we struggle to listen, as Freud said, "from a different point of view," these questions fade and others, sharply repositioned to illuminate the patient's as yet unrevealed vantage point, come forward. It is the outlook inherent in this "different point of view," our bedrock psychoanalytic theory, which, I believe, presents a continuing and far-reaching clinical challenge, the full impact of which has still to be realized.

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