the problem of interaction a deep appreciation of personal history. Thus, the archaeological model of transference in the patient has been applied, by writers like Theodore Jacobs, to the historical depths of countertransference in the analyst. I compare Jacob's exploration of ghosts from the past with Darlene Ehrenberg's interpersonal emphasis on here-and-now encounters and with Thomas Ogden's recent formulation of the "analytic third" from contemporary Kleinian notions of projective identification and Winnicottian concepts of "potential space."

Chapter 6 begins with the observation that the movement toward a fully two-person, interactional framework renders obsolete all traditional notions of the analyst's intentions. If meaning is cocreated in the analytic situation, if the analyst's ideas about his own participation are not considered definitive with regard to their significance to the patient, traditional aspirations to analytic stances like "neutrality," "empathy," and "authenticity" are all called into question. In fact, the recent literature seems to demonstrate over and over that whatever analysts thought they were doing, they really cannot possibly actually do. Recent authors have emphasized that what the analyst does is less important than the ways in which analyst and patient process their interaction. Nevertheless, analytic clinicians have to do something and in fact are making continual clinical choices all the time. How ought those choices be made?

Chapter 7 explores the recent controversies surrounding the nature of the analyst's knowledge and authority, a crisis created both by two-person, interactional revolutions within psychoanalysis and by the crisis in authority and other postmodern developments in the culture at large. I suggest that both the kind of knowledge the analyst offers and the kind of authority the analyst can legitimately claim are in need of radical revision to fit with contemporary clinical theorizing and practice.

Chapter 8 brings together many of the themes of the previous chapters in the crucible of clinical work in two of the most hotly contested and controversial areas of contemporary life—gender and sexual orientation.

Mitchell, SA (1997). Influence and Autonomy in Psychoanalysis. Hillsdale, NJ: Analytic Press.

CHAPTER 2

THE THERAPEUTIC ACTION

A New Look

One of the most distinctive and fascinating features of psychoanalysis as a field is the centrality and perpetual presence of its founder. There are few intellectual, empirical, or clinical disciplines in which the ideas of one person have held sway for so long. Freud's position vis-à-vis psychoanalysis in some sense surpasses Newton's in physics or Darwin's in biology. They made extraordinary, but more circumscribed contributions; physics and biology have absorbed their impact and moved on. Their disciplines have grown past them.

The relationship between Freud and psychoanalysis has been different. Freud's ideas, his vision, the entire package of theory, technique, and understanding that constituted Freud's psychoanalysis has had remarkable staying power—inspiring generations of analysts, serving as a perpetual take-off point and frame of reference for virtually every dimension of the subsequent history of psychoanalytic ideas. One has only to look at the photographs of Freud and his contemporaries to be aware of how much time has passed, how much else has changed from Freud's day to ours. Yet his concepts are very much alive. Why has the relationship between Freud and

the discipline he founded been so totalistic?

Surely, one reason for Freud's durability is precisely that, unlike Newton or Darwin, he founded his discipline. Physics existed prior to Newton; biology existed prior to Darwin. There was no psychoanalysis before Freud. There had been protopsychoanalytic forays into unconscious phenomena, expanded notions of sexuality, symbolic processes, and so on. But until Freud put it all together, nothing remotely like psychoanalysis existed as a system of ideas, a methodology for psychological exploration, a technique for treating mental disorders. And, because psychoanalysis, in its early decades, was so distinctively and thoroughly "Freudian," it is difficult to imagine a psychoanalysis that is wholly post-Freudian.

But there is more to it than that. Systems of thought, even the richest and most powerful, ordinarily have a life span. Think of the intellectual fashions that have illuminated and then faded from recent Western culture: Marxism, existentialism, structuralism, deconstructionism. What is different about psychoanalysis is that, in addition to being a system of thought, it is a treatment, a powerful treatment. Of course, there had been other treatments for so-called nervous disorders; but psychoanalysis was something different—a sustained, in-depth, intensive exploration of the structure of the patient's mind, the complex tapestry of the psyche.

By inventing psychoanalysis, Freud created not just a treatment, but *a kind of experience* that had never existed before. Symptomatic treatments, like hypnosis, were highly focal and time limited. A more radical cure required that the understructure of symptomatic outcroppings be traced and delineated, and that exploration led Freud into the depths of unconscious motivation and the residues of childhood.

It does not diminish Freud's achievement to suggest that he stumbled into something the power of which he had scarcely imagined. In his necessarily naive early associative tracing of symptoms to their original contexts, Freud soon encountered the phenomena of transference and resistance in all their passionate intensity. The tracing of neurotic symptoms led step-by-step into the deepest recesses of personal experience, into the remote past, the most horrifying impulses and fantasies, the most dreaded fears, the most poignant and delicate hopes and longings. Like a river explorer sucked into a whirlpool,

Freud repeatedly found himself in the grip of forces beyond his comprehension, and classical psychoanalytic theory, as a system of thought, carried him through. The theory of infantile sexuality, drive theory, technical recommendations regarding interpretation—these all became crucial parts of the conceptual craft that Freud developed to navigate the treacherous waters of the psychoanalytic experience.

The widespread interest in psychoanalysis today, so many years after Freud's original efforts, suggests that clinical psychoanalysis works, both for analysands and for analysts. Patients' lives often get better; under the best of circumstances, they get better in ways more remarkable than Freud could possibly have envisioned. They get better in ways the patients themselves could scarcely have envisioned. At its best, psychoanalysis can assuage painful residues of childhood, release thwarted creative potentials, heal fragmentation, and bridge islands of isolation and despair. And not only is psychoanalysis a powerful, transformative experience for the patient, it also provides an extraordinary experience for the analyst. It is only in recent years, with the increasing openness in writing about countertransference, that it has been possible to acknowledge how absorbing, personally touching, and potentially transformative the practice of psychoanalysis can often be for the analyst.

Thus, perhaps the most distinctive feature of psychoanalysis as a field is not just that Freud created a set of ideas or a treatment, but that Freud invented a unique, extremely powerful, personally transformative experience for both parties. Since many of us have been both analysand and analyst, we have lived that experience from both sides, and it has been compelling enough to want more and to want to offer more to other people.

To return to our original question, I would argue that one of the most important reasons for the durability of Freud's ideas over the history of psychoanalysis is that his system has made it possible for us to think that we really understand what happens in the analytic process, really understand why people change in the often profound ways that they do. It is the central purpose of this chapter to demonstrate that, whereas Freud's explanation worked persuasively in his day, it can no longer work for us and that we have had great difficulty fully coming to terms with this.

The Traditional Model: Interpretation and Insight

Freud's explanation, stripped down to its bare essentials, goes something like this: Psychopathology results from repression, a blocking from awareness of disturbing impulses, memories, thoughts, and feelings. Repression is undone through insight, which opens up a linkage between conscious ideas and the unconscious impulses, memories, thoughts, and feelings. The analyst's correct and well-timed interpretations generate insight by creating the necessary bridges. Transferences and resistances, correctly understood, express the central unconscious conflicts with great intensity, so the competent analyst can always find just the right material to interpret.

This is a wonderful model—interpretation leads to insight and insight changes psychic structures. It must have been extraordinarily persuasive for analysts of Freud's day. The whole feel of it was so consistent with the stunning developments and new technologies in the rest of science. Microscopy was enabling scientists to look into the subvisual world and view the underlying structure of both organic and inorganic matter. (It was only shortly before Freud entered neurology that the neuron had been isolated in the study of brain function.) Telescopes were enabling scientists look into outer space and see planets, moons, stars never viewed before. Freud too had invented a methodology for entering a previously invisible realm—the psychological structure of the human mind. Free association and the other features of the analytic setting revealed the underlying patterning and fragmentation of psychic life, and interpretation seemed to be a wonderfully precise tool for excising and reworking faulty patterns and rejoining fragments.

Many things have changed since Freud's day, and these changes have rendered this model no longer very workable for us. For our purposes here, I would like to note a few salient, quite profound shifts. (For a fuller discussion of cultural changes from Freud's day to our's and their implications for psychoanalysis, see Mitchell, 1993.)

1. Scientists of Freud's time could well believe that they stood outside of what they were studying, observing its nature. Scientists of our time believe that to study something is to interact with it, that one's methodology partly creates the object of study. So, any analytic theory today—drive theory, object relations theories, self psychology—needs to be regarded as offering not a blueprint of mind but a framework partially imposed by the analyst to order data that could be organized in many other ways.

2. The hopes of scientists of Freud's time that they would soon be able to grasp the smallest particles of matter or chart the broadest patterns of the universe seem, from our perspective, understandably naive. Considering the ever-expanding complexities of particle physics, astronomy, and cosmology, and considering that the human brain is the most complex natural phenomenon we have yet encountered, the confidence of Freud and his contemporaries that psychoanalytic theory provided a comprehensive, ultimate blueprint of mind seems wildly overoptimistic, if not fundamentally misguided.

3. An analyst's giving an interpretation to a patient in Freud's day was a very different event from an analyst's giving a patient the same interpretation in our day because the whole social context of our experience of authority is so different. In Freud's day, everyone invested the analyst with considerable authority; it made sense to do so. Thus, Freud regarded what he termed the "unobjectionable positive transference" based on childhood belief in authority as a basic ingredient in the power of the analyst's interpretations. The patient grants the analyst a certain expertise, a certain power, even a kind of magic—but that's OK, because it helps the patient really to consider the interpretation, creating the bridges that release repressions from their internal exile.

In our day, anyone who initially invests the analyst with that kind of authority has a serious problem. In our post-Watergate, post-Iran/Contra world, with all we know about the abuse of authority by political leaders, doctors, lawyers, priests, and so on, it makes no sense to grant the analyst the kind of authority Freud was granted by his patients. Or, rather, it makes a different kind of sense. The same behavior means something different in our time than it did then. Anyone approaching me with that kind of deference at the beginning of a treatment starts me thinking about the possible reasons for a brittle idealization, or a kind of obsequious handling, or perhaps both.

That sort of transference today *is* "objectionable," not in a moral sense, but in that it requires one to object, or to raise questions, because an interpretation accepted in such a mode is an act of submission. It is less likely to lead to insight than to the perpetuation of sadomasochistic object relations.

4. Since Freud's day there has developed a hefty literature on outcome of analytic and other treatments. This literature is complex, confusing, and hotly contested. But I think any fair overview would have to take account of two predictably recurrent findings that pose difficulties for the traditional model of therapeutic action—interpretation leading to insight: 1) patients, even in highly successful analyses, tend not to remember or put much weight on interpretations given to them, and 2) the particular theory or ideology of the therapist, his or her repertoire of interpretations, has little impact on outcome, whereas his or her personality or emotional presence has great impact. Now, I know that such findings can be explained. But what we do when we do this is explain away, rather than really explain, because it is bothersome, very bothersome, to think that analysis may not work on the basis of interpretation leading to intrapsychic insight.

Because of these developments since Freud's time, it is no longer compelling to think of the analyst as standing outside the patient's material, organizing it in some neutral, objective way. It is understandable that Freud and his patients saw it that way; it is no longer possible for us. Patients who today accept and internalize analytic interpretations the way Freud's patients did are not helping themselves get better; they are enacting their pathology. No matter how fond we are of our theories and interpretations—and I, for one, am exceedingly fond of mine—we must deal with the fact that something else is going on.

There is a strong tradition in psychoanalytic thinking and writing that makes it very difficult to deal directly with this problem—a tradition that enshrines Freud's model of therapeutic action as a kind of holy relic, a relic that needs to be preserved untouched, rather than reworked and revitalized. Even some of the most progressive thinkers of our time add their contributions around the traditional model of therapeutic action as a credo. Thus, Fred Pine (1993) begins an article

by proclaiming, "Arlow and Brenner see analyzing as the essence of the psychoanalytic process, and I certainly concur" (p. 186). Despite Pine's recent assimilation of the contributions of object relations theories and self psychology, he makes a point of distinguishing his approach from the work of more radical thinkers like Kohut on the basis of his loyalty to the credo. The doctrinal allegiance is particularly striking in statements like this, because Pine repeats words like analyzing as if contributions from object relations theories and self psychology had not added new dimensions to and greatly enriched our understanding of what happens when the analyst makes an interpretation to a patient, as if the word analyzing today had the same meaning that it did in Freud's day.

> Although Kohut has quite a different view of the change process, in principle, I believe, one need not shift the view of the process even if one were to shift or expand the view of the significant mental contents that analysis addresses [p. 187].

Otto Kernberg, who has broadened the content about which interpretations should be made to include early object relations, also preserves the traditional model of the therapeutic action—interpretation leading to insight—as if it were still serviceable in its pristine form. Thus, Kernberg (1992) has reaffirmed interpretation as "the basic instrument of psychoanalytic technique . . . the concept and testing of changes in conflictual equilibrium is central to psychoanalytic technique as well as to its theory of outcome" (p. 121).

The Transference-Countertransference Web

As an illustration of why I believe the classical model of therapeutic action, interpretation leading to insight, can no longer serve us well in its original form, consider a moment in the beginning of the treatment of a very disturbed young man. George had been in several nonanalytic treatments before, mostly centered around problems with drug addiction. He was the son of an emotionally absent, workaholic, celebrity father who had an almost unimaginable amount of money.

George's sense of self was remarkably merged, first with his father and secondarily with his wife, whom he had married as an antidote to the power his father had over him, but with whom he had a similar, merged relationship, a blend of adoration and submission. He would recite aphorisms from both his father and wife (who were, incidentally, both devotees of psychoanalysis), as if they had been handed down on Mt. Sinai. The father had for many years been the patient of a famous analytic researcher to whose research efforts he had donated great amounts of money. I do not know if the father's analysis did him any good, but there was no evidence of it in terms of his relationship with his son.

After several weeks of his not being sure what to talk about and my not being sure what to say to him, George began filling me in on characteristic details of his problematic negotiations with his wife. He liked to spend one or two evenings a week out with his male friends, at sporting events or playing poker, but that meant leaving her alone with their two children, because she was a devout believer in the ideological principle that small children should never be left without a parent. He felt he was never in any position to decide what would be fair, because he had demonstrated his unreliability in earlier years by his drug excesses. Further, he did not want to be the kind of absentee father and husband that his own father had been. So he had to leave it up to his wife to decide when he had the right to spend an evening out. When he did go out, however, he tended to stay out longer than she was comfortable with, drink too much, and arrive home in a state that seemed to confirm his judgment that he was unable to make these kinds of decisions for himself.

I felt I might be able to say something useful here and commented on his turning over to her a great deal of power over him in a way that, I imagined, might have made him angry and resentful; I could understand how he might defiantly abuse his privileges on his evening pass. He acknowledged that this was precisely how he often felt. I tried to get him interested in the vicious-circle aspect of this interaction, how his submission made him angry, his anger made him self-destructively defiant, and his self-destructiveness convinced him further of his need for submission (Wachtel, 1987). I did not say this all at once; I felt he was with me point by point. At the end of the session, however, he asked me to summarize everything I had said. He felt that, being lazy and forgetful, he had a tendency to misuse therapy, and this seemed important. He wanted to get it clear. I repeated what I had said. Then he wanted to repeat it back to me so he could repeat it again to his wife when he returned home.

I had a progressively sinking feeling, as I imagined my interpretive description hanging, embroidered, on their wall, with little flowers around it. I tried to say something to him about his doing with me precisely what we had been talking about his doing with his wife—treating my ideas as if they were some kind of precious, supernatural guide to living rather than something he and I were working on together. He became confused and obviously felt I was both criticizing and abandoning him. I backpedaled and, I think, was able to regain the sense that we had understood something important, although clearly on his adorational terms. I reflected on his need to believe that I had all the answers but decided not to challenge that belief now and expressed instead a curiosity about his need for that belief and the lengths he seemed prepared to go to maintain it. It seemed to me that my choice was between repeating one or the other feature of his relationship with his father: sticking to my interpretation of the transference and thereby abandoning him like the "bad" father, or allowing him, with a gentle invitation to self-reflection, to use me as the overly idealized magical father. The latter, I thought, might eventually offer more opportunities for growth.

What is happening in this interaction? I think I see something in the material the patient provides that is worth commenting on interpretively. This is what I have been taught to do. The same material surely could be described interpretively in other ways—as a wish and a defense, a developmental longing, and so on. I don't really think it would have mattered. Because what happened was that George did not really hear the interpretation as an interpretation; he heard it as something else, something familiar, something recognizable within the basic categories of his own frame of reference. I might have thought I was offering an interpretation; George thought I was handing down the 11th commandment.

Is this transference of George's "unobjectionable"? In Freud's day, it might have been defensible to think of it that way, but I do not

think we can really get away with that now. It seems fairly clear that George is relating to my interpretation much as to one of his father's aphorisms rather than to my idea of what an interpretation is supposed to be about.

The contemporary Kleinians (e.g., Betty Joseph, 1989) have a solution to this problem, which concerns what they call the patient's "relationship to the interpretation."[1] Make another interpretation, this time of the patient's relationship to the interpretation. This is, in effect, what I did, calling George's attention to the way in which he was doing with me what I was describing his doing with his father and wife. The content of all other possible interpretations is irrelevant, the Kleinians argue, because of the way the patient relates to interpretations. *Interpreting this mode of processing interpretations* is the only way to get through. I find this a useful way of thinking, and it sometimes works. But most often it does not really solve the problem. You will remember that when I made such a second-level interpretation to George, he became confused and disoriented. I think it was clear that he was unable to reflect on the way in which he attributed oracular status to my statements and instead felt that I was delivering yet another, a 12th, commandment, raising questions, in an obscure and critical fashion, about his failure to defer properly to the previous commandment. Trying to interpret the patient's relationship to each interpretation can create an infinite regress from which the analyst can never disentangle himself.

Because Freud could assume that the analyst, when making interpretations, stood outside the web of these kinds of sticky, repetitive transference–countertransference configurations, he never had to deal with this problem as such. Whatever other transference there was to the analyst's interpretations, the dimension of the "unobjectionable positive transference" was, as I noted earlier, considered an aid. The closest Freud came to dealing with the kinds of problems we are faced with today was when he discovered the importance of time, long periods of time, in effecting analytic change. Recall that Freud's early analyses lasted only several months. It seemed reasonable to assume that for curative insight to occur, the analyst needed merely to arrive at

1. This strategy is explored at length in Chapter 4.

the correct interpretive understanding and convince the patient of its correctness. Freud and subsequent analysts discovered that useful interpretations were not a one-shot deal. They take time, lots of time. One makes the same or closely related interpretations over and over again. How can this be understood within the traditional model of therapeutic action? If the conflictual material is released from repression by the interpretation, why does it have to happen over and over?

Freud developed the notion of "working through" to try to account for the temporal dimension of the analytic process—the work takes time. I have always found this the most elusive, the murkiest of all Freud's major technical concepts. Laplanche and Pontalis (1973) noted that working through takes place "especially during certain phases where progress seems to have come to a halt and where a resistance persists despite its having been interpreted" (p. 488). What does the analyst do to facilitate working through? Laplanche and Pontalis say that "working through is expedited by interpretations from the analyst which consist chiefly in showing how the meanings in question may be recognised in different contexts" (p. 488). This seems to amount to saying that during stagnant times, when interpretations seem to fail, something useful sometimes happens when the analyst continues to make them. Can this be persuasively explained in the classical model?

Picture working through in terms of the spatial metaphors Freud relied on. Even after the original conflict is uncovered through interpretation, its derivatives need to be traced and eradicated, like the troublesome shoots of a complex weed system in a garden. Once the central roots are pulled up, one needs to follow the many shoots to prevent a reemergence of the plant. But this way of thinking about working through over time does not really explain how patients like George change. George could not really use more interpretations; George seems to need some different way of grasping and internalizing interpretations. My interpretation seemed to compound the problem, not to cure it. In pulling up each root, the analyst is scattering seeds of the same weed; the very activity designed to deal with the problem perpetuates the problem. From our contemporary point of view, the analyst seems less like the surgeon Freud asked us to imagine and more like the Sorcerer's Apprentice.

Is this just a problem that comes up in the beginning of analyses? Or in especially difficult cases? I don't think so. We become most aware of the limitations of the therapeutic impact of interpretations when they fail dramatically, as with George, but the very same processes may be operating even when things seem to be going well.

Bootstraps and a Missing Platform

A vivid demonstration of the limits of interpretation in everyday analytic work and therefore of the explanatory insufficiency of the traditional model of therapeutic action is to be found in an excellent paper by William Grossman and Walter Stewart (1976). This paper points to the way in which the common (perhaps it would be fair to say the traditional) interpretation of penis envy presumes, following Freud, that penis envy is a concrete, biologically based fact rather than a metaphor to be interpreted like any other piece of manifest content. The authors thoughtfully demonstrate that, for two women who sought a second analysis, the penis envy interpretation from the first analysis had an antitherapeutic effect of gratifying various masochistic and narcissistic dynamics. In discussing one patient, they note that

> since admiration always led to rivalry and envy, and sexual interest to aggression, the only permanent tie to the object was of a sado-masochistic nature. She chose the masochistic role and the defense of a mild paranoid attitude. Indeed, the "helpless acceptance" of the penis envy interpretation in the first analysis seemed masochistically gratifying [pp. 197–198].

Here is a very interesting situation. Grossman and Stewart are suggesting that, while the content of the analyst's interpretation may or may not have been correct or relevant in one sense or another, what was most important was the way in which the patient experienced and internalized the interpretation (the patient's relationship to the interpretation). While the analyst thought he was offering an interpretation, the patient experienced it as a kind of sadistic attack or beating to which she was submitting, thereby enacting her central dynamics. While it looked as

though something new was happening—an interpretation that should create insight and effect psychic change—actually the patient was reenacting her same old masochistic surrender to men, this time by submitting to the analyst and his interpretation.

Second analyses are always wonderfully privileged vantage points to observe what went wrong in the previous analysis. But in this case, the realization Grossman and Stewart arrived at, that the first analyst's interpretations had had no real analytic impact because they had been processed through the patient's masochistic dynamics, did not help the second analyst very much.

> Even to interpret her masochism posed the threat that the interpretation would be experienced as a "put down" and gratify her masochistic impulse; all interpretations, if not narcissistically gratifying, gratified masochistic wishes. They were felt as attacks in which her worthlessness, her defectiveness, and her aggression were unmasked. The analysis threatened to become interminable, one in which the relationship to the analyst was maintained, but only at the price of an analytic stalemate [p. 198].

This is a wonderful example of the central problem at the heart of every analysis. The analyst arrives at a way of understanding the patterns through which the patient organizes her subjective world and perpetuates her central dynamic conflicts. The analyst delivers this understanding in the form of an interpretation. But the patient can hear the interpretation only as something else—it is slotted into the very categories the analyst is trying to get the patient to think about and understand. The analyst makes an interpretation about the way in which the patient eroticizes interactions, and the patient experiences the interpretation itself as a seduction. The analyst makes an interpretation about the way in which the patient transforms every interaction into a battle, and the patient experiences the interpretation itself as a power operation. Or, in this case, the analyst makes an interpretation about the patient's masochism, and the patient experiences the interpretation as a put-down to be agreed to and feel humiliated by.

It is very common for the analyst not to realize that this is happening, but, as in the cases discussed by Grossman and Stewart, it often

becomes quite apparent to the next analyst. Why? The patient and the analyst, as long as the analysis is ongoing, both have a great investment in thinking that the analyst's interpretations are something different, something new, part of the solution and not part of the problem. It is very easy for the patient unconsciously to organize her experience in analysis in her familiar, characteristic fashion while hoping and believing that something quite new and transformative is happening. It is often very difficult for patients to let their analysts know that they are beginning to feel that the analyst, even in offering interpretations, is only the latest in a long line of those from whom they have suffered seduction, betrayal, abandonment, torture, pathetic disappointments.

It is also very difficult for the analyst to pick up and hear the patient's hints in these directions, because the analyst wants so much to feel that the analysis is going well and that interpretations are truly analytic events rather than reenactments of chronic disasters. But it is often more complicated still. Generally speaking, the analyst, despite his best intentions, is likely to become entangled in the very same web he is trying to get the patient to explore. So, the analyst making an interpretation of the patient's tendency to erotize interactions is likely to be speaking from an erotized countertransferential position in his own experience. The analyst making an interpretation of the patient's tendency to transform all encounters into battles is likely to be feeling embattled himself and trying to use interpretations as a potent weapon in his arsenal. And the analyst making an interpretation about the patient's masochism is likely himself to have felt victimized by the patient's long-suffering misery and is speaking in a voice laced with exasperation. Thus, the analyst's experience is likely to be infused with the very same affects, dynamics, and conflicts he is trying to help the patient understand. Because analysts make their living as helpers, there is a built-in, chronic counterresistance to becoming aware themselves of precisely what they need to help their patients locate and understand in themselves. Because they try so hard to be part of the solution, it is very difficult to grasp the subtle but profound ways in which they have, in fact, become part of the problem.

When a patient, with or without the analyst's help, finally makes it unmistakably clear that he is experiencing the analyst's interpretations

not as something new but as something old, there is usually a sense of great crisis in the analysis, and its value is called into question. Most often, the patient's experience of the interpretation is not fully revealed and investigated until the patient is already working with the next analyst and the new analytic pair can operate under the illusion that this problem does not really pertain to them.

Because Grossman and Stewart (1976) had laid out the issues so clearly, I was very interested to see what they would say next. Did they find a way out of this central dilemma? The next paragraph begins: "Over many years the patient was able to recognize her need to be a mistreated little girl, rather than to face her disappointments as a grown woman" (p. 198).

The first time I read this passage I was convinced that my mind must have wandered and that I had missed a paragraph. No. Perhaps the typesetter dropped the paragraph. What had happened here? The authors lay out the problem so lucidly. They show that interpretations, in themselves, can't possibly solve the problem, because the patient organizes the interpretations into another manifestation of the problem. Yet, they say that "over many years" something changed. But how? The implication is that the interpretations themselves eventually did the trick, that the traditional model of therapeutic action somehow prevailed. Yet Grossman and Stewart have shown that in itself interpretation cannot possibly have effected analytic change. There is a major bootstrapping problem here at the heart of the traditional model of therapeutic action. Something else must have happened.

Webster's says that when we describe someone as pulling oneself up by one's own bootstraps we mean that one has helped "oneself without the aid of others; use(d) one's own resources." But this definition leaves out the paradox implied by that phrase. You cannot pull yourself up by your bootstraps; try it. You are standing in them. To pull yourself up by your bootstraps, you would have to find somewhere else to rest your weight. You cannot be in them and pull yourself up by them at the same time. This seems to be precisely the problem that we have been tracing with the traditional model of the therapeutic action. Interpretations are credited with pulling patients out of their psychopathology; yet interpretations are deeply mired in

the very pathology we use them to cure. There must be something else on which the analyst can rest his weight while he is tugging on his interpretive bootstraps. There is a missing platform somewhere.

When astronomers were studying the orbit of the planet Uranus, they noticed small deviations from the elliptical course they would have predicted. Even though the telescopes available at that time did not make it possible to see other planets, the astronomers realized that there must be something else out there pulling Uranus out of its predictable orbit. This reasoning made it possible for them to locate and eventually see Neptune.

We are at an analogous point in the history of psychoanalytic ideas. There is something else, some other force, that must help the analyst to pull patients out of their customary psychodynamic orbits—simply making interpretations cannot possibly be doing the job. But whatever else is out there, in the analytic situation, has been generally invisible to our available conceptual repertoire, and the preservation of Freud's now anachronistic model of therapeutic action, of interpretation leading to insight as the basic mechanism of change, lulls us into not really looking. Recent versions of this model of therapeutic action, for example, the sort of ego and defense analysis systematically and elegantly developed by Paul Gray (1994; see also Bosch, 1996), suffer from the same basic problem as earlier versions. Thus Gray stresses "an observing, listening, focus which tries to perceive, primarily via the spoken material, evidence of drive derivatives that *have reached the patient's awareness* and that have *then* developed enough conflict to stimulate the ego to a defensive/resistive solution, the outcome of which is the removal of the drive element from consciousness. At appropriate moments and with acceptable words, I invite the patient to share in observing what has taken place" (pp. 100–101). Gray maintains the traditional presumption that the observing, interpreting analyst stands outside the transference–countertransference matrix. But who is offering the invitation to share? And to whom? For Gray, the answers to these questions are simple and obvious. For me, they are complex and continually shifting, and the collaborative exploration of their intricacies are, in fact, the heart of the analytic process.

There have been several important strategies for shoring up

Freud's model, and the concept of the "working alliance," developed within American ego psychology, has been the most popular of these, particularly in this country. When interpretations fail, it is because there is no working alliance. Thus, Freud was right about how analysis works, but we have come to understand the preconditions of an effective analytic process. With more disturbed patients, rather than making interpretations, the analyst builds a working alliance. With patients who are working well, a closer look reveals an underlying working alliance. Thus, the working alliance becomes the missing platform that makes interpretive leverage possible, a place for the analyst to rest her weight when making interpretations.

But the concept of the working alliance begs all the most interesting questions of the bootstrapping problem we have been considering. Interpretations won't work unless the analyst is experienced as being outside the dynamic web of the patient's transferences. You need to have a working alliance. But how in the world does one establish a working alliance? A close reading of Greenson (1967), for example, reveals that one actually establishes the working alliance largely by interpreting the transference. But how can the patient "hear" interpretations of the transference if there is no preexisting working alliance? This concept has merely shifted the problem with the traditional model of interpretation to an earlier precondition for interpretation. (See Friedman, 1988, Chapter 2, for an extensive and extremely incisive critique of the concept of the working alliance.)

Parallel use has recently been made of many concepts borrowed from object relations theories and self psychology by writers like Pine, Kernberg, and Modell. Interpretation leading to insight is still the key process, but, in order for interpretations to work, patients must experience the analytic setting as a "holding environment" or experience the analyst as truly "empathic." When interpretations fail, holding or empathy is needed; when interpretations work, holding or empathy is presumed.

But for holding or empathy to be genuinely analytic, the patient must experience it as something quite different from anything found in her customary object relations. How is the analyst able to establish something different? To presume holding and empathy is, once again, to beg the most central questions. For the patient who has grown up in a world of dangerous and deceitful others, the analyst's offer of

empathy is likely to be experienced as dangerous and deceitful, and what the analyst might feel is an empathic understanding of this problem doesn't solve the problem because the analyst's gesture, for the patient, is still embedded in a dangerous and deceitful world. Rather, it is in the long and hard struggle to establish an empathic connection that a particular patient can recognize as such and really use that the most fundamental analytic work is done, not in the effective interpretations that presuppose its achievement.

Several lines of analytic thinking have engaged the bootstrapping problem directly. Fairbairn (1952) anticipated our current struggles with this problem almost 50 years ago, when he argued that the relinquishment of the tie to the bad object is the central transformative dimension in psychoanalysis. He suggested that in order for the patient to give up, to use Freud's wonderful descriptive adjective, the "adhesive" tie to the bad object, he had to believe, through the relationship with the analyst, in the possibility of a good object relationship. Fairbairn, however, left obscure and ambiguous the questions of exactly what a good object relationship is and how one struggles through transferences to achieve it.

Important progress has been made on this problem by the interpersonalists, particularly those most influenced by Fromm. (Sullivan, although radically innovative in many areas, was quite conservative regarding therapeutic action and the analytic relationship; he considered analytic traction to rest on insight, delivered not through interpretations but through questions, from a therapist located outside the push and pull of transference and countertransference.) Fromm (1960) saw the analyst's role as more personal, and contemporary interpersonalists (e.g., Levenson, Wolstein, and Ehrenberg) locate the therapeutic action in the struggle of the analyst to find an authentic way of engaging the patient. (The decades-long struggle of interpersonal theorists with the complexities of analytic interaction are considered at length in the next chapter.)

Self psychology also has made important contributions to the bootstrap problem. Whereas Fairbairn (1952) understood the adhesiveness underlying psychopathology in terms of ties to bad objects warding off unimaginable object loss and isolation, Kohut understood adhesiveness as the need for selfobjects to ward off the experience of

annihilation and disintegration of the self. In my view, Fairbairn's depiction of the untenable loss of all objects and Kohut's depiction of annihilation anxiety are two different ways of describing the same phenomenon.

Whereas Fairbairn was sketchy, Kohut was messianic; he often depicted empathy as if it were generic and easily achieved, a basic posture on the analyst's part that works for all patients. Kohut also seemed to suggest that selfobject needs are primed in the patient all the time, waiting and eager to emerge. This view (like Winnicott's notion of a prefigured "true self") is problematic, because it once again presupposes rather than explains how the analyst finds, differently with each patient, how to be that patient's analyst. The classical model circumvented the bootstrap problem by assuming that interpretations provide a direct channel between the analyst and the patient that bypass the patient's dynamics. Contemporary Kleinians (see Chapter 4) assume that only interpretations of the patient's relation to interpretations provided a direct channel. What might be called the classical self psychology of Kohut assumed that the analyst's empathic stance provides a direct channel to the patient, bypassing the patient's conflicts and reaching developmental longings poised for growth if only provided the requisite environment.

The futile search for the direct channel that has characterized so much theorizing within the various traditions of the psychoanalytic literature has been motivated partly by the hope of circumventing the messy, knotty problems of influence in analytic interaction. If the analyst has available some mode of participation for reaching the patient directly—neutral interpretations, empathic reflections, meta-interpretations of relations to interpretations—then something new can be assumed, a point of leverage taken for granted. Just as early explorers of North America were searching for a Northwest Passage linking the Atlantic and Pacific oceans to make unnecessary the endless trip around the southern tip of South America, so have psychoanalytic theorists searched for a direct passageway between analyst and patient to make unnecessary the arduous task of examining and interpreting their mutual influence on each other in the service of the patient's personal growth and development.

I am arguing that it is not useful to assume such a direct channel,

but rather to understand the interactions generated between the patient and analyst in terms of the patient's dynamics as manifestations of old patterns. Meaningful analytic change, in this view, comes not from bypassing old object relations, but from expanding them from the inside out (Bromberg, 1991.) This entails new understandings and transformations of the patient's old relational patterns in the transference, as well as new understandings and transformations of the analyst's customary relational patterns in the countertransferences, including the analyst's capacity to think about analytic interactions in new and different ways. Recent developments in self psychology more directly address the bootstrap problem in their exploration of the repetitive dimensions of the transference (Lachmann and Beebe), the "dread to repeat" (Ornstein), the inevitability and utility of "empathic failures," and the fundamentally intersubjective nature of the analytic situation (Stolorow).

The point of convergence of these various lines of innovative thinking about therapeutic action, the missing planet of the analytic process, is to be found in the emotional transformation of the relationship with the analyst (Racker, Levenson, Gill, Hoffman, Greenberg, Spezzano). Interpretations fail because the patient experiences them as old and familiar modes of interaction. The reason interpretations work, when they do, is that the patient experiences them as something new and different, something not encountered before. The effective interpretation is the expression of, and sometimes the vehicle for, something deeper and more significant. The central locus of analytic change is in the analyst's struggle to find a new way to participate, both within his own experience and then with the patient. There is an enormous difference between false empathy, facile and postured, and authentic empathy, struggled toward through miscues, misunderstanding, and deeply personal work on the part of both analyst and patient.

Thus, although I find enormous value in the developmental concepts of writers like Winnicott and Kohut, I think there is a danger in the developmental perspective of assuming new growth where subtle forms of repetition may be occurring. Of course, neither of these two different interpretative approaches can be considered simply right or wrong—they are ways of organizing ambiguous data that can be organized in many ways. The more relevant question concerns not correctness, but the consequences of holding one view or the other. Looking for repetitions, if done with sensitivity and tact, has two major advantages.

First, it helps the patient appreciate how deftly old patterns can be resurrected. Since none of us ever completely outgrows such patterns, and relative mental health entails an increased capacity to refind and emerge from them, this effort serves the patient well. It conveys to the analysand the sense that authentic living is never achieved without struggle.

Second, an alertness to repetitions shapes the analytic relationship in a way that is likely to be highly beneficial. It conveys a willingness on the part of the analyst continually to question his or her own participation, an openness to criticism and self-reflection, and a dedication to patients' getting the most possible out of their analyses and, consequently, their lives.

Impasses and Outbursts

Consider a point in the second analysis of a woman named Carla, whose first analysis had come to an anguished stalemate. I use this material here because it involves a later point in work with a patient whose issues were similar to George's. I will elaborate my own struggles in the countertransference, because that is where I think a lot of the work was done.

Carla was the daughter of a brilliant, crackpot, would-be inventor who had lived in paranoid isolation, working on what he considered to be ground-breaking innovations. Carla and her siblings were forced to choose between their parents in the years preceding as well as following their divorce, and Carla felt deeply loyal to her father. She felt that she was like her father in many ways and had cultivated a deep isolation from her own peers, which was a sign of her feelings of superiority and her internal merger with her father. She was torn between her sense that her father's self-absorbed estimation of his own importance was wildly inflated and her deep need to believe in her father and her link with him. Very little ever actually happened between

Carla and her father, but, through her identification and loyalty to him, Carla felt a precious, but very shaky, fantasied sense that she was following in her father's footsteps and that her father was taking care of her.

Central to Carla's resentments against her first analyst was her feeling that she had been kind of snookered into treatment from the very beginning. She had been sent to consult with this man by a friend and really did not know what sort of treatment would be preferable. Following an extended consultation, the analyst informed her that she would be suitable for analysis and offered to see her five days a week for a token fee. (Carla later suspected, of course, that the analyst was a candidate at an institute and that she had become a training case, although this was never explicitly acknowledged.) In a certain sense, the die was cast from that initial moment, because a central feature of the transference was organized around the idea that the analyst had lured her into their analytic arrangement for the analyst's own needs.

The analyst seemed blindly devoted to psychoanalysis as a quasi-religion. Carla experienced her own devoted daily attendance as an effort to worship at the analyst/father's altar, even though she had profound doubts both about the analyst and about psychoanalysis. In return, she longed to be helped, perhaps rescued, at least talked to. Over the years, she developed a deepening sense of betrayal, abandonment, and outrage.

Carla came to see me for help in understanding what had happened in this treatment that had left her feeling so embittered. After several consultations, I had gotten enough of a sense of the features of the transference I have just recounted that I recommended that she begin a kind of trial analytic treatment with a new analyst, the purpose of which would be partly to explore what happened the first time around. We agreed it would be best for her to work with someone experienced. This meant higher fees, and, since her income was limited, only one or two sessions a week. I told her that, in my experience, working at that frequency was difficult but often quite constructive. After thinking about it a while, she asked if it would be possible to work with me, and we set up an arrangement by which I saw her once a week at a somewhat reduced fee.

Many things happened over the course of the first six months

which I will not recount here, since I will follow only the threads leading to the moment I want to describe. Generally, I felt that the work was going quite well. She seemed deeply mired in her masochistic, narcissistic identification with her father, but we were working well together and I felt cautiously optimistic. Then she told me she had found out that she actually had an insurance policy that would pay a considerable amount toward her treatment, with a $20,000 lifetime limit.

Given the retrenchment in third-party payments these days, I regarded this news as roughly equivalent to a report that she had won the lottery. I envisioned expanding to three or four times a week. I found working with her very absorbing, but also frustrating, at once a week. Her announcement seemed like great news. I restrained my enthusiasm, and she herself wondered whether this meant she might come more often. What did I think? Being well trained, I dodged the question and asked what she thought.

Because so much reciprocal dodging ensued, I don't remember exactly who said what, but the basic outlines were something like this: Being a lot more frugal than I, she felt that this newly available money needed to be spent carefully. After all, the $20,000 would last only for several years; then it would be gone. So she really needed to be sure that this work with me was *the* treatment for her; perhaps she would be able to afford only one such treatment in her lifetime, and she needed to know that this was it. And she had all kinds of doubts. Her life certainly hadn't improved noticeably over the six months. What did I think?

I felt increasingly uncomfortable. At first I thought that I was doing a good job as an analyst by dodging her question and solemnly taking the position that the decision was hers. We needed to explore what she thought. This position did not wear well, though. As we explored her sense that she needed to hear from me, my somewhat righteous analytic conviction that I was not called on to venture an opinion began to feel too easy, even a bit irresponsible. We explored her experience of my position that my opinion was not important. Why wasn't it, she wanted to know? After all, I was an expert to whom she was coming for professional help. I must have an opinion; it must be more informed than hers, or at least of some potential value

in helping her make up her mind. My withholding my thoughts from her seemed deliberately hoarding and sadistic, like her first analyst's laconic style. To ask her to believe that it was really in her best interest seemed like asking her to defer to a principle that seemed to her exceedingly abstract and dubious, and probably self-serving on my part. The more we explored her experience of my abstention, the more unfeasible it seemed to be.

Well, I thought further, what do I really think? I could imagine going two ways.

One line of association about the question of whether or not this was the best treatment for her led to the thought: "Beats the hell out of me." Most of the people I've worked with have gotten a great deal out of the work and feel it was worth it, but not all. Would it work for her? I really didn't know. She would have to decide one way or the other and take her chances: "You pays your money and you takes your choice." But that didn't feel right. It felt too facile. Did I really feel so casual about this decision? No. Maybe I should tell her to go ahead and use the money on our analytic work. That was certainly what I would do. She was in serious danger of living an enormously compromised life. If our work took, it could make a great difference in the quality of her life, much more than having the money in reserve. She should go ahead, and I should tell her so.

But that didn't feel very comfortable either. For one thing, I tend to spend money impulsively. The next $20,000 I stumble across will surely pay for the tennis court I've spent years fantasizing about. Perhaps Carla's cautiousness was valid, particularly for her. Was I so sure our work would help her? How much was that belief an extension of my narcissism? Easy for me to say. Perhaps my very passion for the work was itself dangerous to her. Further, I could imagine my clear stand on the desirability of analysis for her leading us into precisely the same sort of transference–countertransference impasse that destroyed the first analysis. Would I need to keep convincing her that the work was going well? Would I need increasingly to see it that way myself? The more confident I was that this would be good for her, the more she might need to defeat me by destroying the analysis. It began to feel as though the alternatives were either to bail out on her or to snooker her into the greater frequency of sessions by selling a product with a greater certainty than I, in fact, had.

I began to feel suffocated, a feeling I have come to regard as an invariable sign that something important is happening. This situation is set up so that there is no way for me to be my idea of an analyst. If I abstain, she feels it as an abandonment. If I encourage her, she feels it as a seduction; and there *is* something in the way our interaction develops that draws me into wanting to make claims and implied promises I have no business making. We seemed to be at an impasse.

The term impasse has been used with growing frequency in the recent literature, generally with some prescribed route out. As I suggested earlier, the contemporary Kleinians regard interpretation of the patient's relationship to the interpretation as the solution. Some interpersonalists (Cooper and Witenberg) recommend detailed inquiry into the patient's history. Other interpersonalists (Ehrenberg, 1992) regard self-disclosure of countertransferential feelings as the key. Self psychologists favor the reestablishment of an empathic stance. When things get difficult, everyone relies on what they do best.

I have not discovered any general solution to situations like these; in fact, I don't believe there are any general solutions, for reasons I will explain in a moment. But one reaction to impasses that I have found helpful sometimes is an outburst. I do not mean a countertransferential temper tantrum or a retaliatory attack. I mean a reaction that conveys a sense that I feel somehow trapped and constrained, that I feel that the analysand and I are both trapped and constrained, and that I want to burst out of the confines of options that all seem unacceptable to me.[2] So I told Carla about my sense of being stymied: I agreed with her that it did not seem fair not to say what I thought, but I could think of only two ways to respond, and neither seemed quite right. To say that I really didn't know if our work would be right for her left out my good feelings about what we had been doing and my sense of its possibilities. Yet for me to say that she ought simply to go ahead seemed to imply a certainty and a

2. See Symmington (1983) for a vivid account of the analyst's necessary enmeshment in the closed world of the patient's neurosis and the break for freedom that is required for the analyst to have a therapeutic impact.

promise that I couldn't make, a promise that I felt quite sure she would feel the need to defeat and feel betrayed by. As we spoke of these various options[3] I told her what I thought I would be asking myself if I were her: Did she feel the things we were talking about were at the center of what mattered to her in her life? Did she feel we were grappling with them in a way that seemed meaningful? What seemed to her to be a reasonable trial period for our efforts to bear fruit? As I spoke and she engaged some of the questions I was framing, the whole emotional tone between us shifted. I no longer felt that I was dodging her questions, stranded between unacceptable postures. She no longer felt frustrated and subtly abandoned. The treatment went on, and what seemed important was that we had found a way to work together that allowed me to function in good faith as my idea of an analyst and allowed her to begin to conceive of a way of getting something important from me that did not require a self-betraying devotion.

The way constructive analyses overcome the bootstrap problem is that the analysand and analyst struggle together to find a different kind of emotional connection. There is no general solution or technique, because each resolution, by its very nature, must be custom designed. If the patient feels that the analyst is applying a technique or displaying a generic attitude or stance, the analysis cannot possibly work. Sometimes making interpretations works analytically, not simply because of the content of the interpretation, but because the patient experiences the interpreting analyst as alive, as caring, as providing fresh ways of thinking about things, as grappling deeply with what is bothering him. Sometimes refraining from interpreting works analytically, because the patient experiences the quiet analyst as alive, as caring, as providing fresh ways to be together that don't demand what may have come to feel like the inescapable corruptions of language. Sometimes patience seems called for: a sustained involvement over time that is evidence of a kind of relationship different from past abandonments. Sometimes impatience is required: an exasperation that conveys a sense that the analyst can envision something better than the patient's perseverative patterns and cares enough not to take

3. See Hoffman (1992) for a discussion of a similar clinical strategy.

the easy way out and passively go along. What I am suggesting is that the central feature of the therapeutic action of psychoanalysis is the emergence of something new from something old. It cannot be there in the beginning, because you have to find yourself in the old to create the proper context for the emergence of something new. It cannot be in the application of a standard technique or posture, because then it would not really be something new and would never strike the analysand that way.

In the classical psychoanalytic literature, the concept of the "transference neurosis" referred to the central, most difficult phase of the analysis, in which the infantile neurosis reappeared in the analytic relationship itself. Whatever the patient's problems were on entering analysis, the problem had now become the analyst, who was driving the patient crazy. But, in the classical framework, the transference neurosis, like all lesser problems, could always be dealt with—through interpretation. The analyst was portrayed as *outside* the problem, and from his clear vantage point he could offer the patient illumination.

The thematic frequency of concepts like impasses and stalemates in the recent psychoanalytic literature represents an effort to describe this same central feature of the analytic process in contemporary terms. The patient is stuck; the analysis has been transformed from the solution to the problem. The patient who was imprisoned in his neurosis (see Schafer, 1983) has now become imprisoned in the analysis itself. Whatever the patient imagined were the obstacles to a more satisfying life before the analysis, those obstacles have now become the analysis and the analyst himself.

What distinguishes psychoanalysis from most other forms of psychotherapy is precisely this valuing of impasses and obstacles. As Adam Phillips (1993) has put it, "One of the aims of psychoanalytic treatment may be to enable the patient to find, or be able to tolerate, more satisfying obstacles to contend with. Poor obstacles impoverish us" (p. 86). In other forms of treatment, there is a shared agreement on getting somewhere, removing some symptom, overcoming some inhibition. In psychoanalysis, there is a similar initial contract, but the analyst knows, in a way that the patient simply cannot, that the final destination will be very different from whatever was envisioned at the