THE ANALYST’S PARTICIPATION: A NEW LOOK

Over the past fifteen years or so, advocates of a relational theory of psychoanalytic process have developed a compelling challenge to the classical approach to clinical work. Their critique of a fixed "standard technique," applicable across the board to all analyzable patients, has been particularly effective. The new approach opens the possibility of tailoring technique to individual analysands, negotiating the best way of working within each unique analytic dyad. But despite the openness of relational theory, many of the most influential clinical vignettes in the recent literature emphasize the analyst’s risk-taking, engaging patients in a highly personal way that breaks the traditional analytic frame. Various implications of the tendency of relational analysts to emphasize this sort of intervention are discussed, and questions raised about the way this may affect how relational thinking is received.

Over the years, psychoanalysis has grown as a discipline under the impact of one inspired theoretical excess after another. At one moment, a new vision of what moves the world arises out of the idea that neurosis is invariably and inevitably caused by a persistent if conflicted attachment to the perverse incestuous fantasies of infancy. Not long afterward, adherents of an alternative insight triumphantly proclaim that the root of all psychopathology can be found in the tormented and tormenting experience of the infant at the breast. Still later, another revolutionary idea emerges, locating the source of emotional difficulties in the failure of the sufferer’s parents to provide the psychic supplies needed for healthy development.

Each new theory as it emerges is both wonderful and surprising, the more so for being narrowly focused on a partial truth. Each probes a dimension of our experience that had not previously been investigated.

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or investigated in quite the same way, and each shows us something new about what it means to be human. It is as if a thin beam of light has been directed toward an area that had been dark forever; we see what had never been seen. But a bright light in the darkness can also be blinding, and areas outside the sweep of the beam grow even darker by comparison.

It takes a while to identify psychoanalytic excess, because each new development generates a powerful sense of excitement. It must have begun right at the beginning. I sometimes imagine Freud and his earliest followers mulling over clinical material, finding new meanings in mundane narratives. There is nothing more thrilling than the sense of being onto something, something that opens up surprising ways of understanding the familiar. Maybe today we envy those early analysts for the wonder they must have felt at their insights, a wonder that no psychoanalyst of our generation can experience in exactly the way that they did. And perhaps the insights worked clinically, for a while at least, because they were surprising and wonderful—because they turned people’s attention in a direction it had not been turned before.

But what about the one-sidedness of our insights? What makes it so difficult, even after the rush of discovery has passed, to wonder whether something has gotten lost in all the excitement? Why couldn’t Freud, caught up as he was in what he was learning about the vicissitudes of Dora’s conflicted sexuality, also see that his patient was a pawn in an intricate interpersonal drama that included Freud himself? Why couldn’t Kohut, dazzled though he was by his insights into ways that parents create their children’s oedipal miseries, keep in mind that inner conflict inevitably accompanies growth and even life itself? We psychoanalysts constantly praise ourselves, in print and in informal gatherings, for our ability to tolerate the ambiguity that confronts us in our daily work. But at the same time, we meet that ambiguity with an ironclad commitment to an overarching way of understanding what went wrong for our patients and what it will take to help them change. The commitment, though it sustains us through the ups and downs of clinical work and is necessary if we are to fully develop our theories, can easily become so passionate and so exclusive that it forecloses alternatives.

We might hope that, as new ideas emerge, there would come a point at which their adherents could step back and undertake a cooler assessment of their scope. The new idea could then be seen as supplementing, or productively competing with, but not rendering obsolete everything that had come before. Whether by integration or through a constructive competitive dialogue, new ideas would over time be contextualized and tempered. Unfortunately, this tends not to happen in psychoanalysis. Typically, instead of critical assessment, movements are built that isolate the new idea from other psychoanalytic visions. Adherents of these movements create a culture based on the new theory, complete with organizational structures, historical records, leaders, rituals, moralities, and so on. The goal is to preserve the sense of excitement that attended the new insights. Recall that when Freud faced opinions that differed from his own psychoanalytic vision, his reaction was to create the Committee, to distribute secret rings, and to write his “On the History of the Psychoanalytic Movement” (Freud 1914a). This sad legacy has persisted throughout our history; ideas remain isolated from other ideas that could deepen, enrich, and challenge them, as groups fragment in the face of theoretical disagreement. There are very few psychoanalysts around these days, only Freudians, or Kleinians, or Lacanians, or self psychologists. The schisms feel painful to those committed to making psychoanalysis work as a discipline, and they are laughable to those who observe our battles from without.

Today, I am afraid that relational psychoanalysis is in danger of becoming the latest wonderful idea to coalesce into a movement. This would be especially unfortunate, because the relational perspective developed explicitly as a reaction to two earlier, related excesses. Both excesses grew out of the euphoria of discovery. First, there was the excess of conceptualizing relations with other people as principally a transformation of our instinctually driven fantasy life. This arose out of new insights into the power of our internal worlds to influence our experience of what goes on around us. Second was the excess of seeing the analyst as a dispassionate technician, capable of impartially assessing the analysand’s inner state and intervening in ways that can alter the balance of internal forces without exerting much in the way of personal influence. This excess grew out of the excitement that analysts felt when they realized the therapeutic potential of deepened self-understanding.

My focus here will be on contemporary relational approaches to the nature of the analyst’s participation in the psychoanalytic process. My goal is to begin a process of examining what the relational model is teaching, to express some of my own developing misgivings, and to
raise some warning flags. First I will outline what I see as an emerging theoretical vision of the nature of the psychoanalytic situation and of the analyst's participation in it. Four premises, I think, are largely accepted by all relational analysts.

1. Far more than the early theorists could let themselves know, the analyst influences the analysand's experience in a myriad of ways. Much of what the patient thinks and feels is responsive to what the analyst does and even to who he or she is (Hoffman 1983; Mitchell 1988; Aron 1991, 1996). Everything the analyst says (and a great deal of what is not said) will affect the patient deeply. This bears heavily on the relational view of the analyst's authority, which is seen as even more powerful than previously imagined (Hoffman 1996; Mitchell 1998). Freud's early idea (1937) that incorrect interpretations will simply be ignored by the analysand is widely rejected. Suggestion and personal influence, once the base metal of the despised and disdained psychotherapies, have become both coin of the realm and a prime area of psychoanalytic investigation.

2. Despite its power to affect everything that happens in an analysis, the impact of the analyst's behavior can never be understood while it is happening. In contemporary terms, enactment is ubiquitous (Hoffman 1991; Renik 1993). A great deal of the work in every analysis is to understand, after the fact, what has transpired in an unexamined way. On this last point, different relational analysts hold quite divergent positions. Some claim that enactments can eventually be understood and that the dyadic unconscious can be made conscious. Others believe that one enactment simply folds into the next, with systemic change developing even in the absence of any privileged insight into what was intended or even into what happened.

3. Following on this second point, and contra Freud and his followers, there is no technical posture the analyst can adopt that will guarantee the creation of a predictable atmosphere in the analysis. Neutrality and abstinence, keystones of classical technique, are mythic and therefore empty concepts. More contemporary stances, like empathy, are equally mythic. Effective analysis can be conducted only in fits and starts, as a result of negotiations within each individual dyad. The aim of these negotiations is to find a way of working, unique to the dyad, that will suit both participants (Pizer 1992, 1998; Greenberg 1995).

4. While the first three points address the analyst's role as a participant in the process, a fourth addresses his or her role as an observer. Even as an observer, the analyst's subjectivity is a ubiquitous presence in the consulting room (Aron 1996; Mitchell 1997). Opinions differ on the extent to which the patient brings something—an unconscious—that can be discovered and known, or whether all meanings are constructed within the dyad. But regardless of where the theorist stands on that point, there is a broad consensus that detached objectivity is a myth—for some relational analysts, because there is nothing to be objective about; for others, because the analyst's memory and desire can never be avoided or barred. Our countertransference is the air our patients breathe.

It goes without saying that I believe there is much of value in the critique of both classical epistemology and the attendant theory of technique that is contained in these principles. For too many years, psychoanalysis was burdened by a more or less phobic avoidance of any acknowledgment of the analyst's participation in the treatment process. Each of the relational principles lays out a new observational field and presents us new data to consider. "Look at what you have been ignoring," each principle calls out, "and you will understand what could not have been understood before." In this way, the relational critique does what psychoanalysis at its best has always done, reminding us to attend to the unattended and forcing us to acknowledge that it is always what we don't know that affects us most deeply.

The principles I have outlined underlie and inform my own work. But psychoanalytic perspectives can never be fully expressed in abstractions. Whenever a new model develops, a body of clinical writing accumulates alongside the formal theorizing. These writings embody the insights and elaborate the sensibilities of the model's adherents in a way that theory, by its nature, cannot. I point up here a tension, one I think has not been noted before, between the teachings of formal relational theory and those implied in many of its most widely accepted clinical narratives. It is in these narratives that the excess I want to address is expressed.

Consider the four principles as I have outlined them. The personal influence of each analyst, the uniqueness of each analytic dyad, the inevitable uncertainty about what is happening at any moment in the treatment, and the consequent unpredictability of the effects of any intervention all suggest that there is no one way of working that can...
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be privileged across the board over any other. Each analyst and each analysand must find the mode of engagement that best serves the analytic goals the participants have defined. There is no way, the relational critique reminds us, to assert a priori the benefit of any technical intervention.

And yet, the clinical examples through which relational authors illustrate their perspective seem always to point us in a particular direction. This is probably true of the narratives of all psychoanalytic traditions; Mitchell (1992) has made a similar point with respect to the prototypical case histories written by adherents of the classical Freudian, self psychological, and interpersonal schools. These narratives carry considerable weight because they express the clinical sensibilities of leading thinkers within a given tradition. Consequently, they take their place as important teaching tools that convey what might be called an ethic or an aesthetic of clinical practice.

With this in mind, consider some important and often cited clinical vignettes reported in the relational literature: Samuel Gerson (1996) admits to a patient that he has lied to her, then enlists her collaboration in understanding his reasons for doing so; Jodie Davies (1994) confesses her erotic feelings for her patient; Emmanuel Ghent (1995) recognizes that his patient is cold and brings her a blanket; John Frederickson (1990) puts his face in front of his patient and screams "Shut up!" I have myself contributed to this trend, writing about self-disclosures (Greenberg 1986, 1991) and about bringing some of my own extraclinical personal preferences into conversations with supervisees about technique (Greenberg 1995).

In each of these clinical examples, the analyst takes a risk and puts him-or herself on the line in a highly personal way. In more or less classical terms, the analytic frame is broken. But then the analyst, in a move that has no counterpart in classical descriptions, offers him-or herself, as a person, to contain the tensions and anxieties the patient is experiencing in consequence of being in treatment. This is the moral of so many relational case reports: they focus on periods in the analysis during which tensions around what is happening are becoming unbearable for both participants. Then, when the analyst behaves in some startling, unexpected, and highly personal way—when, in Irwin Hoffman’s terms (1994), he or she “throws away the book”—the tension is broken. In reaction, the patient is able to relinquish some tie to an archaic internal object and to begin, or to resume, the work of analysis.

I hope it is clear, especially since I have included examples of my own work in my list, that I am not—for the moment at least—quarreling with any of the specific interventions I have mentioned. I believe that the experiences that emerge from such interactions can in many instances facilitate the analytic process, and that in some treatments they are turning points. But I believe also that it is time to wonder why the examples in so many of the important relational texts sound so much the same, even as the very idea of a standard or uniform technique is debunked by the relational critique. It seems we are being offered two parallel messages working at cross-purposes. First we are shown the futility of any attempt to develop a fixed psychoanalytic methodology applicable to all analysts, all analysands, all dyads. But then, alongside or perhaps overarching this, is presented what I have come to think of as a morality play, a series of stories highly prescriptive of a way we should all be working, that puts pressure on the reader/analyst to be open enough, flexible enough, and caring enough to respond appropriately.

Clinical examples such as those I have mentioned are drawn typically from moments in which an analysis has become stalled and fraught with tension. Some of this reflects a rhetorical strategy: authors use the examples to illustrate that analytic work can still get done even in the face of the apparent failure of traditional technique. But more than rhetoric is involved; the examples imply a model of treatment and a new way of thinking about a fundamental clinical problem. The problem, which has been around from the beginning, is this: there is apparently very little reason why a person would want to be in analysis. Freud struggled with this early on, but it took him quite a while before he answered it in a way that satisfied him. To provide a backdrop for my discussion of contemporary views, I will take a brief look at the solution he came up with.

A few years after he had started practicing psychoanalysis, Freud noticed that his patients were looking for something he was not prepared to offer. Obviously daunted by his experience, but speaking, characteristically, with the bravado of a conquistador, Freud warned aspiring clinicians of a danger that threatened to undermine their treatments at the very least, and perhaps their professional reputations as well. Hysterics, he wrote, invariably prefer a cure by love to a cure by analysis (1914b, p. 101).

Consider the dilemma Freud came upon so quickly. The commodity he was selling—self-awareness—was something his customers were
not particularly interested in buying. In fact, they had constructed complex and crippling symptoms to avoid the collapse of self-esteem that awareness threatened to bring with it. Freud’s patients in *Studies on Hysteria* suffered paralysis, hallucinations, and debilitating pain, all to avoid knowing what analysis revealed to them—that they were in love, or felt angry, or were frightened. Evidently, the anguish that came with consciousness of these thoughts and feelings hurt even more than the pain caused by the symptoms. If ever a cure was worse than the disease, this was it. That is why the patient had become symptomatic in the first place.

And the problem did not stop there. Not only did patients want to avoid self-awareness; it was also easy for them to assume that their analysts, despite their claims to be mere purveyors of insight, were in fact offering them the love they desired. Freud quickly realized that in the process of requiring that patients disclose their deepest secrets and creating the conditions that make such disclosures possible, the analyst must appear both to demand and to offer a unique form of intimacy. The “special solicitude inherent in the treatment,” Freud wrote as early as 1895, could encourage patients to become “sexually dependent” on their analysts (Breuer and Freud 1895, p. 302). Thus, the stage was set for every treatment to degenerate into a colossal misunderstanding about what was being offered. This happened in the first analysis on record, Breuer’s treatment of Anna O., and caused its disastrous end.

The need for a way out of this predicament was apparent from the beginning. And, setting a pattern he would follow throughout his career, Freud solved the clinical problem with a brilliant theoretical stretch. Inventing the concept of transference, and using it both to guide his own thinking and to influence the way patients might understand their experience, he was able to say that the patient only thought she wanted the analyst’s love. He believed he could demonstrate to the patient that her belief, despite its poignancy and urgency, was ultimately mistaken. It was based on a “false connection” between experience in the present and memories of the past. So far so good. Armed with the conviction that his patient didn’t really want him—and, of course, that he had no interest in and had done nothing to encourage her desire—he was able to dissuade the patient from her ardent pursuit.

But the concept of transference, whatever it revealed and whatever problems it solved, could not address the question of what motivates the patient to undertake and continue an analysis. Consider: the end result of a successful piece of transference analysis—one that relocated the patient’s desire safely in his or her prehistory—would be a patient who could relinquish the claim on the analyst, but not necessarily one who had much interest in pursuing analysis. We might very well be left with little to sustain the patient through the rigors of treatment.

Today, looking back on Freud’s struggles with almost a century’s worth of hindsight, we are able to give shape to the problem as Freud himself, living through them, could not. So it is easy for us to see why it took Freud quite a while to come up with an explanation for why anyone should want to be in psychoanalysis. In fact, it took him almost two decades; it was only in 1912 that he suggested that alongside erotic longings, patients must also experience an “unobjectionable positive transference” that would motivate the work (Freud 1912). The ideas contained in the patient’s “unobjectionable” transference include a belief in the value of treatment, based on widely held views of analysis as a discipline and of the analyst as a professional practitioner. Because the patient is a member of a social group that shares these beliefs, he or she comes to analysis in the expectation of being helped. There is also an expectation that the analyst he or she has chosen is interested in providing that help and is competent to do so. The unobjectionable positive transference was thought to work in two distinct ways: first, it carried for patients the conviction that analysis, however difficult, would help them improve their lives. Second, by empowering the person of the analyst, it would lead to realistically based desires to please, to be a “good” patient. The unobjectionable positive transference is unobjectionable both because it facilitates the work and, perhaps even more important, because it is based on socially validated and therefore presumptively “realistic” beliefs about what analysis and the analyst can provide.

But the unobjectionable positive transference has not fared very well recently. The beliefs on which it was originally based—beliefs in the knowledge and authority of the analyst and in the efficacy of analytic treatment—have themselves come under widespread criticism. We talk most about attacks from outside—from non-analytic therapists, from academics disdainful of the principles on which psychoanalytic treatment is based, and, perhaps most distressing, from managed care companies. But note that the relational critique as I have spelled it out raises many of these same concerns. In fact,
it would be fair to say that the relational critique aims at deconstructing many of the beliefs that lie at the core of the unconditional positive transference.

This deconstruction has been healthy for psychoanalysis as a discipline. It has freed us from some ideas about what we are doing and how we do it that are based on an outmoded philosophical foundation that has isolated us from the intellectual mainstream. At the same time, however, it reminds us of our old dilemma. Today we live in a postmodern culture in which claims to knowledge are easily reduced to overvaluation of personal opinion, in which the distinction between authoritative and authoritarian qualities has narrowed, and in which the offer of expertise is seen as tantamount to the wielding of personal power. In such a culture, the unobjectionable positive transference—traditionally the great motivator of treatment—seems not only objectionable, but nearly delusional as well. A patient's a priori confidence in the efficacy of psychoanalytic treatment, or in the competence of an individual analyst, is likely to be seen as virtually symptomatic in its own right.

So we need a new answer to the old question of why anyone would want an analysis. The roots of a relational answer, like those of so many foundational principles of relational psychoanalysis, can be traced to the views of Sandor Ferenczi. The analyst, Ferenczi argued, gives the patient more than insight into the workings of the patient's unconscious. Aware of it or not, the analyst invariably and inevitably also provides the patient a new and crucial kind of relational experience (Ferenczi and Rank 1924). This powerful experience does more than give depth and meaning to the insights that emerge from psychoanalytic exploration. Even more fundamentally, because the analyst gratifies a wide range of needs and desires, the experience motivates the patient to enter and remain in treatment.

There is much of Ferenczi's sensibility in the clinical teachings embodied in the relational vignettes to which I have alluded. Stated broadly, the idea is that the patient's ability and willingness to participate in the treatment is an aspect of the unique relationship that is forged by every analyst and every analysand. Psychoanalysis may have lost much of the cultural prestige it once had, and its philosophical origins may today make it intellectually suspect, but a far more important reality is created by the participants in each analytic dyad. Within this reality, it is asserted, a range of needs and desires are met. Because of this, it is within the relational matrix created by analyst and analysand that the motivation for treatment evolves. Putting things this way, we can see that in contemporary thinking the analytic relationship has replaced the wider, socially based beliefs out of which Freud saw the unobjectionable positive transference emerging.

But it is more accurate to say that the relational answer accounts for only a part of what Freud had in mind. It is true that both answers invoke reality—the broad reality of social consensus for Freud, the reality of the particular dyad in contemporary thinking. But if Freud had only reality in mind, he would not have called the unobjectionable positive transference a transference; he could have spoken more simply about a judgment that people make that analysis can be a worthwhile project. But he did speak of a transference, and in doing so he emphasized that there must be something within the patient that makes it possible for him or her to embrace the social consensus and to muster sufficient hopefulness and courage to undertake an arduous treatment. Perhaps even more important, invoking transference directs our attention to the intricate ways in which the motivation for analysis interlocks with, shapes and is shaped by, all the other transferences that get evoked in every treatment. This stands in sharp contrast to the sensibility embodied in many relational vignettes, which tend to emphasize ways in which the analyst can negotiate a way of being that meets an actual need of the patient's. In the new model, the analyst's ability to find and to satisfy crucial needs at crucial times makes analysis possible. Relatively little is said about the patient's hope, or trust, or courage—the transferential and therefore private and internal side of the unobjectionable positive transference.

Now let me turn to a clinical vignette that describes a dramatic moment in which the analyst drew his patient back into analysis in a moment when she seemed incapable of going on. He did this by acting in a way that he calculated would meet a specific relational need. The example is drawn from a paper by Irwin Hoffman (1994) that has become extremely influential. I have chosen to discuss it both because of its importance in contemporary relational discourse, and because, as a result of what Hoffman did, he and his patient were able to get beyond an apparent standoff and into an extraordinarily rich conversation about what had gone on between them. But there are also some unexamined assumptions embedded in the description of what happened. My purpose is to isolate and to raise questions about these assumptions, which
are similar to those guiding many clinical narratives presented recently by relational analysts.

The patient, a medical student, has throughout the treatment been ambivalent about following what she considers rigid analytic rules. Recently she has become increasingly angry and anxious about a series of events in her life outside the analysis. One day, she calls to ask for an appointment earlier in the day than usual. Hoffman is unable to arrange the switch, and when the analysand arrives for her regular hour she begins by saying, “I’m here for one reason and one reason only, and that is to get some Valium. If you can’t help me get some, I might as well leave right now!” (p. 206). She winds up staying, however, and Hoffman tries to engage her in a conversation that would give some meaning to her demand.

But the patient continues to insist that all that matters is that she get the Valium and that her analyst (who as a Ph.D. psychologist cannot prescribe) get it for her. Feeling helpless and desperate in the face of the patient’s unwavering insistence, Hoffman finally asks whether she has an internist who might prescribe the medication; when the patient says she does, he says, “Well, if you give me his number, I’ll call him right now” (p. 207). He makes the call, and the physician agrees to give her the prescription. “After I hung up,” Hoffman reports, “the patient and I started to talk and she was receptive for the first time to exploring the meaning of the whole transaction” (p. 208).

Hoffman’s vignette, like many recently, is about a patient who for the moment at least appears to be incapable of being an analysand in any traditional sense of the word. She cannot see that there is any value in trying to talk about, or to understand rather than gratify, what she experiences as an urgent need. Hoffman’s clinical decision was to avoid trying to engage the patient in the kind of conversation she was unwilling to have. Instead, he chose to do something that would bolster her belief in the value of the analytic relationship. Drawing on his sense of his patient’s history and current need, he created a powerful and—for her—unfamiliar type of interpersonal transaction, one that might provide her some reason to believe in the value of participating in the analysis. In Freud’s terms, he gave the patient the material with which she could reestablish an unobjectionable positive transference. And, in an important sense, his understanding of what he did improves on Freud’s idea. For Freud the unobjectionable positive transference is not subject to analysis, while Hoffman argues convincingly that every-

thing about the transaction he created with his patient can and must be subject to intense examination.

The relational experience that Hoffman offered his patient required, he tells us, that he engage the patient personally, not merely as a technician. He needed to demonstrate to the patient that he could forsake his allegiances to analytic orthodoxy, and perhaps even to analytic propriety, in the name of meeting her where she needed to be met. It is in this meeting that he provided the patient both a reason and the means to go on. In Hoffman’s own words, the question for the patient was, “What did I care about more, her well-being or my analytic purity?” (p. 206). Because the patient cannot believe that he cares about her more than about himself, she cannot participate in the analysis in any way other than by blindly asserting her presumed need. She can move away from this mode of engagement only when he does something in a way that drives home to her both that he cares about her and that he intends to behave in a way that will demonstrate this to her. Hoffman accomplished this, he tells us, by “consciously disidentifying with her father” (p. 202), a man who both the patient and the analyst agree is compulsive and tyrannical.

As I read Hoffman’s account, it occurred to me, in the context of my thoughts about psychoanalytic excess, how frequently contemporary clinical vignettes revolve around a similar sequence. In a moment of crisis the analyst creates a transaction that is new and surprising to the patient; the richness of the subsequent conversation about what went on between analyst and analysand is then offered as evidence of the benefits of the intervention. But, in contrast to the elaborate description of what eventually happened, relatively little is offered to convince us that talking about a novel experience with the analyst is the thing that will best serve the patient’s treatment. Hoffman, like many writing today, is notably casual about this. There seems to be no question in his mind that creating a surprising transaction in response to the patient’s transference demand (in this case, consciously disidentifying with the father) and then exploring it is the best way to help his patient learn about herself.

But the assumption raises many questions for me. How can we be sure that exploring a transaction is the best way to do an analysis, with this patient or with any other? Why is exploring a transaction in this moment more important or more useful than exploring a resistance, or a transference, or an affect state? Perhaps most important, why is
exploring anything more important or more useful than allowing whatever is happening to develop further and to deepen?

Hoffman does not raise these questions in his case report, or even acknowledge that they exist. It is this failure that creates the sense of excess that concerns me. His account gives the impression that he is following a long-standing tradition of zealously declaring that one thing or another is a “royal road” to understanding the unconscious, without thinking very much about what else might be involved. Consider some other royal roads that have had their heyday: symptoms, dreams, fantasies, resistance, transference, primitive affect states, the history of interpersonal relations. My point, of course, is to question any reliance on royal roads, not to deny that it can be interesting and illuminating to explore transactions. Let me repeat here that the idea of a “best route” to anything is not supported by the formal relational theory of technique and is in fact contradicted by it. But in the sameness of the clinical examples that many relational analysts use to illustrate their theory, in the morality play of which this vignette is one act, the sense that creating and exploring transactions is a royal road comes across loud and clear.

A more balanced approach would require the analyst to acknowledge that having arrived at a new place by following a particular route does not imply that this is the only or the best route to get there. It would require also that we acknowledge that every route has its dangers and its limitations. In what follows, I will concentrate on two potential sources of difficulty that can arise when the transactions that are inevitably created in an analysis become too much the focus of our inquiry. Neither of these has been discussed enough publicly, although my sense is that both are causing considerable private concern among working analysts. First, there is the danger that in focusing too much on analyzing “transactions” we are limiting our observational field to what the analyst and the analysand have created together, dyadically. When the priority of this focus is asserted and accepted without comment, we risk losing touch with other dimensions, uniquely private and personal, of the patient’s experience. Second, there is the danger that when the analyst’s role in shaping the patient’s experience is emphasized too exclusively, we encourage the analyst to want to provide the patient a particular kind of experience. This can inflame the analyst’s desire to be a good analyst or even to be a good person. The analyst’s desire is always a tricky business, and I will return shortly to ways in which I believe that desire is fanned by contemporary relational vignettes.

First, consider the ways in which the patient’s attention can be directed away from private experience and toward the transaction. In Hoffman’s clinical narrative he describes an exchange that occurred long before the crucial Valium incident, and that I believe bears decisively on the course of the analysis. Beginning sometime in the second year of treatment, the patient refused to use the couch. This caused Hoffman some anxiety, especially since he was a candidate in training at the time and worried about how his institute would view his handling of the situation. Hoffman tells us a great deal about how he reacted to his patient’s refusal, though he tells us nothing about the patient’s experience except that “she was not always enthused about analyzing things” (p. 201).

What Hoffman tells us about himself is that he remained in the chair that he sat in when patients were on the couch, rather than in the one he used when they were sitting up, “as if to say ‘You’re the one violating the rules, not me.’” He “conveyed to her the various rationales for the use of the couch” (p. 200n). He told her he was “against” her sitting in the chair. When they discussed the issue, he responded to the patient’s “mischievous smile” with a “slight smile” of his own. Finally there is this: “When she asked me point blank: ‘Are you sure the couch is necessary for the process: I think the eye contact is more important for me,’ I bluntly replied, ‘Well, I don’t know about the process, but it might be necessary for me to graduate’” (p. 200).

Consider the impact that this is likely to have on the patient. In all that he is saying and doing Hoffman is communicating a powerful message to the patient. “This analysis is about both of us,” he is telling her. “We each have our own motivations for being here, and in understanding what happens it is necessary to take account of my desires and my needs as much as of your own. In fact, we cannot get to the bottom of your experience unless we understand it as significantly reactive to my own.” From my point of view, and I think that this is fully compatible with Hoffman’s formal theorizing about the power of the analyst’s authority and influence (1996), this constitutes an instruction to the patient about where to look in her attempt to make sense of what she thinks and feels in the analysis. So when, years later, she is feeling distraught about events in her life, despairing about getting any help from her analyst, and angry at him for not agreeing to change her hour that
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about her history, or about herself and her own private experience very much at all. Instead, she focuses her gaze on the analyst’s behavior, and on how her own experience is a more or less inevitable reaction to it. But consider the analyst’s contribution to this assumption of the patient’s. Hoffman believes that patients cannot fully explore their part in creating painful feelings until and unless the analyst is willing to acknowledge his or her contribution to those feelings. And a great deal of the way he has conducted the analysis communicates the same lesson to his patient. He has taught her that what she feels is manufactured within the dyad.

From this, it is a small step for the patient to make the analyst responsible for her experience. And when the pressure she feels becomes unbearable, it is a small further step to demanding that the analyst change his behavior in a way that will relieve some of her pain. On Hoffman’s side, it must be difficult to focus on the patient’s inner life, because he agrees with her that he is significantly responsible for her emotional experience. Given that feeling, it would have to be hard for him simply to observe and to explore her experience; his anxiety and guilt about his role in causing her despair must lead him to want to act in ways that will help her feel better. This inclination will be exacerbated when the patient rejects Hoffman’s offer to explore and insists on his meeting her presumed need in a more immediate and concrete way.

So if we go back to the beginnings of the analysis, to the roots of the situation that Hoffman defused by heroically throwing away the book, it seems highly plausible that what happened is to a significant extent an artifact of his particular way of working. At least once before at a tense moment in the analysis, he has called attention to himself and insisted that the patient take him into account before she looks inward to herself and especially to her various transferences. Perhaps this invited the kind of interpersonal crisis that eventually developed, and that led Hoffman to forgo exploration temporarily and to embrace action. And perhaps, too, had the analyst not interpersonalized the treatment from the beginning, the focus might have been less on the “transaction” that involved Hoffman’s rescue and more on the depth of the patient’s cynicism about the intentions of others and on her despair about being helped. In turn, being able to confront her despair more directly might have opened a space within which she could explore her demand on the analyst more freely.

But to have gotten to this, both participants would have had to have been less preoccupied with the quality of their relationship and more willing to dwell in an experience that was becoming grim and even terrifying for both of them. Hoffman believes that in his struggle to decide how to respond to his patient’s demand lies “the heart of what it means to be a new, good object” (p. 207). I largely agree with this formulation, but I am less sure about the assumption that this was a moment in which the patient was best served by an analyst who was struggling to be either a new or a good object. In fact, I am not sure that the patient was best served by the analyst’s struggling with the nature of his participation at all, rather than immersing himself more receptively in an ancient experience of his patient’s that was engulfing the two of them.

It is always, of course, tempting to find a way to take on the role of a new, good object rather than feeling drawn, inexorably, into enacting something old and ugly. This gets us to the second point I have mentioned, the way that clinical examples can inflame the analyst’s desire. Gabbard (1996) has noted that analysts treating patients with a history of sexual abuse are subject to a particular form of desire, which he characterizes as the “wish to avoid identification with the abuser from the patient’s past” (p. 7). The point can be generalized to our work with all patients; note Hoffman’s expressed wish to distinguish himself from his patient’s father. But the issue of the analyst’s desire—what it means to him or her to be an analyst, or to serve the patient in one way or another—is far too rarely discussed. While I agree strongly with the relational premise that the analyst’s desire can never be neutralized, it would be a mistake to minimize the dangers that are inherent in all desire. Bion (1967) said that the therapist should be without desire at all, and this would certainly include the desire to provide a particular quality of experience, or even the desire to help. In a very different arena, Mahatma Gandhi (1927–1929) expressed in his autobiography a similar sensibility, arguing that to be a true leader one must transcend all desire and that the desire he had found most difficult to renounce was the desire to serve. For both Bion and Gandhi, desire corrupts. At its most basic level, I want to look at the difficulties that accompany the analyst’s desire to create and to participate in an analysis.

Analysts working in today’s environment are at special risk of having our desire inflamed. In general, we are operating under conditions that can fairly be described as a state of siege. No working analyst today
can be oblivious to the theoretical, clinical, and economic challenges to what it is we do. The attacks on the analyst's authority and expertise that I have mentioned leave many analysts feeling that they have little to offer their patients except their desire to help. Freud perhaps, because of his unwavering belief in the scientific truths he was discovering, could afford to be a pessimist about psychoanalysis as a therapy. Today, by contrast, the weakening of our belief in analytic theory has intensified our therapeutic zeal. Desire has been further fanned by the economics of the profession and the scarcity of analytic patients. The effects are not only financial; even analysts with thriving psychotherapy practices want to hold on to their analytic patients, because without them the analyst cannot be an analyst at all.

And the teachings of many relational authors, expressed through their clinical examples, add to these forces. These vignettes invariably portray the analyst as bold and courageous, willing to decenter from his or her experience and renounce preferred ways of doing things in order to serve the best interests of the patient. Hoffman, who is adamant that everything the analyst does exercises a suggestive impact on the patient, must realize that everything an admired author does has a similar effect on readers. In setting themselves up as models of flexibility, openness, and the like, relational authors create a desire to emulate them. I believe that many analysts these days are living with the tension of believing that they could revitalize relationships that have been deadened by toxic transferences if only they were braver, more available, or simply more decent.

Recently I had an experience while doing supervision that illustrated how the analyst's desire can burden the treatment. In many ways, the vignette I will offer reminds me of Hoffman's, though this one is clearly about a moment gone awry. The vignette shares several crucial characteristics with Hoffman's. The patients in both cases suffer from cynicism and despair of a sort that poisons their faith in human contact. In both cases the analyst chafed under the burden of living with the weight of the patient's toxic transference. As a result, each analyst got caught up in a desire to create with the patient a kind of experience that had been missing in the patient's life. Both analysts believed, consciously or unconsciously, that they owed this new kind of experience to the analysand and to themselves. Both believed also that providing the experience involved a disidentification with a parent whose character was seen as a major cause of the patient's despair. And so each analyst acted out of a desire to change what was going on in the analysis. In doing so, I suggest, each kept the dyad away from a full confrontation with the depth of the patients' transference.

In my vignette, an experienced and talented supervisee had been treating a young architect for several years. One of the patient's central problems was a chronic inability to be excited about or even to enjoy his accomplishments. Despite quite extraordinary abilities, the patient had always found a way to put off getting as much done as he might have and to minimize what he in fact achieved. In the analysis, this had been discussed frequently, and had been traced to the patient's experience with his depressed father, who always managed to find just the right word to puncture the balloon of anyone who might think life is worth living.

One day the patient arrived at his session in an ebullient mood. He had completed the design of a house for which he was entirely responsible, and had presented it to his difficult and demanding client, who was uncharacteristically enthusiastic. The house would be built, exactly as the patient envisioned it.

The analyst was pleased and happy for the patient; in light of the way the patient had described the project it clearly had come out better than anybody might have expected. The analyst was especially pleased that the patient had recognized his accomplishment and was able to enjoy it so unabashedly. But there were a few flies in the ointment. For one thing, although he knew that the meeting was coming up, the patient had said nothing about its being so imminent, and the analyst felt somewhat taken by surprise. For another, the analyst quickly began to feel "talked at," barraged with a stream of description and commentary that, however enthusiastic, left no way for him to join the patient or to feel included in the session. The patient, he said, seemed to be "celebrating behind glass," and the analyst's presence in the room felt unnecessary at best. Irritated, the analyst soon began to feel sleepy and, of course, guilty about feeling both irritated and sleepy in the face of the patient's newfound ability to describe his success so energetically and excitedly.

As the patient continued to describe the experience, he mentioned that probably the analyst was surprised that the project was finished and that the client meeting had taken place so quickly. At that point the analyst spoke for the first time in the session. "Yes," he said, "I was wondering about your not having told me that the meeting was
coming up." The effect of this comment on the patient was immediate and devastating. He was crestfallen and deflated, the enthusiasm and energy gone from his voice. Far from being able to enjoy a triumph, he was faced with having failed his analyst. Now it was his turn to be angry. The analyst had done to him just what his father had always done; he had introduced his own bitter sense of failure at just the wrong time, and had spoiled any potential that there was to celebrate an important event.

It was at this point that the analyst brought his experience into supervision, feeling guilty and ashamed about what he had done. And I agree that he had acted in a way that got him and the patient away from the experience that was developing in the room. But I am also impressed, despite the different spirit in which the stories got told, with the similarities between his vignette and Hoffman's. As in Hoffman's vignette, what developed between my supervisee and his patient was born out of the meeting of the patient's negative transference and the analyst's desire. Both Hoffman and my supervisee felt excluded by their patients. Hoffman's patient demanded that he not act like an analyst, which he wanted to do, and that he act like a physician, which he could not do. My supervisee's patient refused to allow his analyst to be the benign, appreciative figure that my supervisee wanted to be.

The difference in the two vignettes, of course, is that my supervisee fell into the trap of repeating something old with his patient, while Hoffman came up with something novel to do. But I am not sure that finding something new to do is necessarily less of a trap than repeating something old. What seems most poignant, as well as most similar to me, is that in each case the analyst acted out of a desire to be part of things in a way that could heal a piece of the patient's history. And in each case, doing so enacted a role in a romantic fantasy of the patient's (Schafer 1970). Hoffman took on the role of hero in his patient's fantasy—recall that he consciously decided to be a better, more loving father while my supervisee became the villain. But these roles define and imply each other, so there is less to the difference than meets the eye. The excess in the two examples is the same: it is the excess of wanting to make something happen. And the excess is perpetuated when, in turn, the thing that happens—the transaction—is understood to be what makes analysis possible, and also becomes its subject matter.

It is also important that each vignette captures a moment when the patient's transference attack on the analyst's desire to make something happen—his desire to create an analysis—has made things unbearable. In the face of these attacks, the analyst's desire is likely to be at its most intense, and he or she will feel most vulnerable about it. Both of these situations went the way they did, I believe, because the analyst was unable to submit to and contain his feelings, his reaction to the terrible moment when analyst and analysand were each the tyrannical, stifling, poisonous father and each the suffering, terrified, rageful child of the other. Moments like these are well known to all analysts, but they always feel as if they are happening for the first time. They are moments when we lose our bearings, when any sense of who was doing what to whom seems impossible to come by, when it seems there is nothing and will never be anything to do. Hoffman's vignette, like many in the relational literature, teaches us that there is something to do, that destructiveness can be overcome, and that once the analysand has been rescued, understanding can follow. Like all inspired excess, this is sometimes true. But not always, and it should be taught as one place to look among many, one that has possibilities and pitfalls like all the others. The lesson of Hoffman's vignette and those like it stands as a major contribution of relational theory, but we risk losing something uniquely affecting, and uniquely possible within the process of psychoanalytic treatment, if we turn it into a prescription for meeting all or even most of the difficult moments that arise in every analysis.

Let me conclude by recalling the way that medieval morality plays worked. The plays were designed to inflame the audience's desire to reject evil and do good. I am struck by the similar tone of contemporary relational vignettes. The characters are different, of course. Instead of gluttony, lechery, sloth, hope, and charity, today we have rigidity, authoritarianism, orthodoxy, openness, decentering, and negotiability. But the endings of the plays and of the vignettes are strikingly the same; both end optimistically, with the saving of the protagonist's soul. The message of the vignettes is that saving our psychoanalytic souls depends on finding the right way of being with our patients. But, like the morality plays, there is a great deal of excess in these reports, and like the plays their message can be oppressive. I hope that by taking this beginning look at some of this excess, I have opened the way to a new dialogue that will allow us to realize the
potential of relational thinking while helping us avoid becoming the sort of movement that forecloses possibilities.

REFERENCES


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COMMENTS

Patrick J. Casement

I wish to begin my discussion of this most interesting paper by quoting its author: “It is always . . . tempting,” Greenberg writes, “to find a way to take on the role of a new, good object rather than feeling drawn, inexorably, into enacting something old and ugly.” I believe that this insight lies at the heart of Greenberg's paper.

If we look at the examples cited, in each case the analyst was under considerable pressure: “periods in the analysis during which tensions around what is happening are becoming unbearable for both participants.” As a result, we are told, “when the analyst behaves in some
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REFERENCES


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Margaret Crasnpole

Jay Greenberg performs an extremely important service in challenging pivotal facets of the relational orientation and its literature. With the acuity and scholarship that are his hallmarks, Greenberg delineates many of the issues relationalists struggle with—sometimes privately, sometimes in closeted teaching settings, but not often enough in public forums. I am impressed with his boldness in identifying how the relational perspective sometimes focuses too narrowly on its new vistas, thereby potentially losing sight of the broader landscape. It can only add to the vigor and utility of our theory building when we submit new ideas to steady self-scrutiny. This should indeed become the rule rather than the exception in psychoanalytic theorizing of every persuasion.

Several areas of ambiguity in Greenberg’s paper complicate my efforts to understand and respond to his arguments. The author says that the “excess” of the relational perspective lies in the tension between its formal theoretical precepts regarding the analyst’s mode of participation and their practical realization in the clinical interchange. This excess, according to Greenberg, is expressed primarily in the body of literature that reflects clinical practice, as opposed to its theoretical underpinnings. Yet those underpinnings themselves also seem open to question, at least as they are articulated in this paper. It is unclear whether in Greenberg’s mind he is really aiming his critique of the relational perspective squarely at its clinical applications and their underpinnings. Yet those underpinnings themselves also seem open to questioning tone when he alludes to these specific theoretical matters mingling with and ends up coloring by association his overall view of the relational position. This complicates the task of unraveling the threads of Greenberg’s argument, in order to determine clearly and unambiguously where (from his point of view) the problems lie.

Greenberg’s essay offers some extremely thought-provoking and substantive criticisms of contemporary relational thought. The relational literature is indeed stocked with clinical examples of apparently ad hoc, “personal” interventions in which therapeutic bottlenecks lead to the analyst’s responding directly to the patient’s relational needs or wishes, whether to gratify or violate them. In the aggregate these anecdotes can lead the reader, particularly one relatively new to this perspective, to conclude that such interventions are the sine qua non of relational technique. It might well appear that a specific analytic stance—say, to “break the analytic frame” or “be warm, authentic, and personal” is being prescribed as the optimal means for enabling a patient to substitute new, healthier objects for archaic, disturbed ones. Greenberg feels that the authors of these narratives are endorsing the provision of a caring, highly personal analytic relationship (as opposed to the creation of an analytic environment that can foster new understanding) as the optimal means for promoting psychic growth. Is this what the writers of such anecdotes really intend? What, in fact, do
these types of intervention actually achieve, and what are we trying to demonstrate when we report them?

I submit that these subjective, affectively laden interventions are not, contrary to Greenberg's contention, fundamentally driven by the relational analyst's belief in the primary curative value of establishing a personal relationship with the patient. Instead, the spontaneously responsive analyst engages in such interventions out of the underlying conviction that this approach will progressively allow patient and analyst together to experience and fully recognize aspects of the patient's self that were heretofore unknown or unaccepted. Relational writers, in short, are trying to explore the ways in which the analyst's subjective response to the patient, where responsibly expressed, generates an intense shared experience that can set the stage for a deeper probing of the patient's self.

As Greenberg points out, the classical analysis of yesteryear was (at least on paper) centered around the patient's trust, faith, and dependence on a benign authority and his or her interpretations. By contrast, a contemporary relational analysis is centered around the patient's struggle to be deeply seen by a fellow human being who, while relatively more authoritative than the patient about the vagaries of intrapsychic and interpersonal life, does not purport to be "the" authority. Both approaches offer a certain type of "right" analytic relationship, including but not limited to an unobjectionable positive transference. Though the similarity is not commonly noted, both approaches are in fact geared toward gratifying a patient's needs directly, even if the specific needs they gratify are different. The earlier orientation gratifies the patient's desire to rely on a vested authority with specialized knowledge and understanding about psychic functioning. The more contemporary orientation gratifies the patient's wish to have his or her inner world acknowledged and grappled with by a fellow human being, though worthy of respect, is also admittedly fallible. Both approaches prescribe interventions whose transferential meaning for the patient should be interpreted intrapsychically; they should not be relied on simply as experientially curative. Finally, both approaches, while gratifying, are also likely to frustrate other underlying wishes. The classical approach frustrates the desire to know the analyst as a subject, the relational approach, the desire to idealize the analyst.

Greenberg apparently feels that relational case narratives incorrectly imply that there is primary curative value in the patient's simply experiencing intimacy with (or provision from) a "better" object via the analytic relationship. He reminds us that an analyst's direct personal responsiveness to the patient should be complemented by a careful consideration of the therapeutic impact of such a choice. The transferential and sometimes the countertransferential components of such an action need to be unpacked and interpreted (often overtly in the treatment), so that such interventions are to be maximally therapeutic instead of merely gratifying. New experiences in the analytic relationship can thereby be more than supportive, in that they lead to the patient's internalization of new psychic potentialities.

Relational writers of clinical accounts, in Greenberg's view, should discuss alternative technical possibilities and show where their own approach improves or fails to improve on those others. I agree that this rhetorical tack is "devoutly to be wished," and worthy of being pursued both by relational analysts and those of other persuasions. It behooves relational writers and others to contextualize their analytic posture. They should clarify whether they are promoting a spontaneous, subjective stance as generally preferable, or whether in fact (as I think is more often the case) they believe that a more personally expressive approach should be set against an ongoing background of relative abstinence and a balanced, if not "neutral," investment in the patient's process. It is the contrast between, on the one hand, the analyst's ongoingly conservative analytic stance as a "midwife" to the patient's process and, on the other, a specific act of "personal responsivity" (see Hoffman 1994) that often gives this type of intervention its therapeutic leverage. Ideally a case report would convey the overall pattern of the analyst's manner of participation over time, so that the actual level and degree of the analyst's subjective self-expressiveness (as opposed to greater self-containment) would be evident.

Greenberg suggests—and I agree—that a more personal analytic stance can at times lure analyst and patient into dangerous waters. We err if we interpret the shared sense of pleasure at establishing greater intimacy in the analytic relationship, or the diminution of tension upon meeting a patient's apparent need, as something that will necessarily instantiate or promote therapeutic progress. We err if we interpret post hoc the unfolding of an adventitious analytic avenue as proof that we made the best decision in acting more from intuition than from theory-driven considerations at a given point. We err if we fail to
recognize, with Greenberg, that the virtue of a new therapeutic pathway resides in part in its capacity for "supplementing," not "rendering obsolete," the contributions of the past. We unquestionably err if our own narcissistic or pecuniary needs supersede therapeutic aims in formulating our clinical judgments. Greenberg sounds significant cautionary notes in pointing to these pitfalls, actual and potential.

To my mind, the even more basic and crucial issue Greenberg invites us to consider is the relative efficacy of focusing the analytic inquiry on the nature of the analyst's engagement with the patient in a particular psychoanalytic treatment. To the extent that this is uncritically viewed as the "way to go," we do our patients a disservice. A core question is how to balance analytic work on the dyadic interaction with a thorough and nontendentious elaboration of the patient's internal world. Excessive attention to either the interpersonal or the intrapersonal dimension potentially obscures the significance of the other. Relational analysts must find better ways to assess when concentrating on the dyadic interaction might detract from or otherwise weaken our emphasis on the wealth and breadth of the patient's inner life. We need to spell out the conditions under which a focus on the analytic study will be most intense or have the greatest impact. As a relational perspective would lead us to expect, the patient's own proclivity plays an equal or greater role here.

Another danger is the possibility that an interpersonal exploration can stall the analytic process at the manifest, more rational-seeming level. While this level has its own potency as a reflection of the unconscious, it is nonetheless likely to be colored by our customary ways of interpreting social interaction. As psychological concepts have entered everyday parlance, it has become relatively commonplace for people to "process" problematic interchanges, their aim being to resolve interpersonal conflict. The norms associated with achieving such a mutual understanding can potentially infiltrate a psychoanalysis. The result may be to move the analytic exploration to an interpersonally gratifying resolution that might prematurely close off a fuller articulation of the patient's inner life.

The value of processing an intersubjective experience or enactment is constrained by its dependence on the idiosyncratic nature of the patient's interaction with a particular analyst. An overemphasis on the dyadic experience can potentially limit or skew the development of analytic understanding of the patient's more fundamental self- and interpersonal experience. A further difficulty arises if the analyst becomes zealously overconcerned with considering every aspect of the dyad's intersubjective experience and interpersonal context, as well as of the patient's intrapsychic life. We need to develop better theoretical guideposts for making sound clinical judgments as to where to direct our analytic attention (Aron 1996). These guideposts should be geared toward considering the needs of a particular patient, since not all patients are able to work with equal effectiveness in a given vein, or to move fluidly and productively among multiple levels of exploration. Apropos of this, however, I'd like to emphasize that regardless of the analyst's theoretical bent, she or he is not the only one determining where analytic study will be most intense or have the greatest impact. As a relational perspective would lead us to expect, the patient's own proclivity plays an equal or greater role here.

I find the premises Greenberg describes as "universal" among relational theorists to be problematic and difficult to embrace (though I consider myself a card-carrying relationalist), perhaps because the author articulates them in such radical form that they sound exaggerated. The first premise aptly captures the view that the analyst qua person greatly influences the patient's analytic experience. But then comes the rather hyperbolic idea that "everything the analyst says (and a great deal of what is not said) will affect the patient deeply." This seems to me to overstate the relational claim that certain previously unacknowledged aspects of the analyst might affect the patient deeply.
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(see, e.g., Aron 1996; Crastnopol 1999; Renik 1995). Framing this proposition so absolutely implies a wider disparity than actually exists between the relational view and other perspectives on the analyst’s influence. This works against current efforts to reduce the prejudicial miscalculating of one another’s views, and it complicates our efforts to narrow the schisms among the various orientations.

Greenberg believes that the relational position disingenuously trades on the power of the analyst’s authority, in that “suggestion and personal influence” are now “both coin of the realm and a prime area of psychoanalytic investigation.” I would argue that relational analysts are not intending to lionize these factors, but to make the implicit explicit by acknowledging their existence and spelling out their therapeutic potential. Suggestion and personal influence (not to mention spontaneously expressive interventions) have always been intrinsic to the psychoanalytic process. They were operative when the elderly Freud complained to the poet H.D. (1974) that their work was suffering because his advanced age prevented her from loving him; when Winnicott chided the obsessively workaholic Guntrip for his refusal to turn away new referrals (Hazell 1996); and when Fairbairn traded theoretical formulations with Guntrip in their post-session discussions (Hazell 1996).

Relational theorists certainly would maintain that various aspects of the analyst’s subjectivity, including guidance, identification, and influence, are inherently influential in all forms of therapy. Relationalists are in general more convinced than other theorists of the value of harnessing and also exploring this influence as part of their modus operandi. I would argue, however, that the role of these factors in divergent analytic approaches should be the subject of larger-scale study; we should not simply assert or deny their presence and impact.

In any event, the belief of relational analysts in the effect of their subjectivity does not necessarily make them overweigh it in the treatment. This is not to deny that some do so. If indeed relational analysts are vulnerable to overemphasizing the therapeutic potential of expressing their subjectivity (as classical analysts may be vulnerable to overemphasizing the therapeutic benefits of anonymity), then we still need to distinguish more carefully the excesses of the theory’s implementation from the excesses of its core tenets.

The second premise identified by Greenberg concerns the pervasiveness of enactment. “A great deal of the work in every analysis,” he writes, “is to understand, after the fact, what has transpired in an unexamined way.” Greenberg seems to imply here that relational authors can be read as recommending by example that analyses be conducted in a freer-form, underconceptualized fashion, with what amounts to a pseudojustification that enactments can never be understood while they are in process.

While certain authors might be interpreted this way, this is not in my view their intended message. The analyst interpreting here-and-now analytic interaction is confronted with the human limitation that one cannot fully “participate” and fully “observe” in the same exact moment, which complicates the process of interpreting analytic interplay. This difficulty hampers but should not preclude thoughtful clinical decision making. Rather than countenancing an “anything goes” philosophy, the best relational writing invites other analysts to draw on a fuller range of their human intuition and sensitivity in order to maximize their organismic registering and comprehension of the patient. Most important, these accounts ask analysts to examine alternative possibilities from an expanded repertoire in advance, and often in the privacy of their own internal self-supervision, so that they may approach each decision with a well-informed foundation for making the optimal clinical judgment.

What is the personal motivation behind the analyst’s choice to make a spontaneous, subjectively derived intervention? I would dispute what I understand to be Greenberg’s suggestion that relational theory is being used in the vignettes he cites to support the analyst’s self-interested desire to be a “good person” or a “good analyst.” The value relationalists place on the analyst’s spontaneity is attributable—theoretically, at least—not to its being gratifying (it often isn’t), fun (ditto), or politically correct within a postmodern context, but to the fact that personal responsivity in the analyst can often reflect or access dissociated aspects of the patient’s experience—it “courts surprise,” to borrow Stern’s felicitous phrase (1997). The contradiction dealt with in relational work is that a careful, theoretically grounded accrual of understandings about our patient can be our greatest asset, but can also function inadvertently to create blinders in how we experience (or what we evoke in) the patient. If we remain walled to any theoretically

'It is important to note that much training and prior experience implicitly mediates such “spontaneous” analytic actions.
based conceptualization or interventional style, we may compromise our ability to draw on an intuitive experience of hidden aspects of the patient's self as part of our analytic repertoire. Greenberg is right that this aim can be derailed when relational thinking is poorly conceptualized or misapplied, but such a derailment is not inherent in either its theoretical premises or its technical recommendations.

I argue that relational writing doesn’t mean to portray enactments—that is, behaviors and actions—as the royal road; it means to portray them as at times more expressive of unconscious life than are the other major primary process thoroughfares. Spontaneous interventions and enactments in general are valued because they often embody otherwise inaccessible unconscious currents in the transference-countertransference matrix. Once these repressed or dissociated features are vividly brought to life in the “playground” of the analytic relationship, they can be more fully recognized and acted on therapeutically—sometimes with more immediacy and power than other foci of interpretation (see Friedman and Natterson 1999).

The third relational premise presented by Greenberg is that since the analytic relationship is “uniquely” negotiated, it becomes impossible to formulate recommendations to support a “technical posture ... that will guarantee the creation of a predictable atmosphere in the analysis.” In their deconstruction of such analytic attitudes as neutrality and abstinence, relational writers sometimes do underplay and, in some (but only some) cases, deny the value of these constructs in the psychoanalytic repertoire. If we judge from those deconstructions alone, it would seem that there could never be such a thing as a relational “book,” to pick up on Hoffman’s now infamous phrase (1994). It is true that unambiguous standards for employing these and more personalized modes of intervention have eluded us thus far, and it may also be true that we have not yet pursued them with sufficient tenacity.

Relational writing does challenge the idea that there could be one general analytic stance that will necessarily optimize the clinical endeavor. But this is not tantamount to recommending that we “throw out the book” or that there is none to begin with. It simply says that we need a different kind of book, one that will begin to outline the complex circumstances under which a given analytic posture will facilitate the analytic work. The overall aims of the literature as I read it are to reconstruct and grapple with analytic interchanges as they really happened, and ultimately to create a balance between general technical recommendations and more specialized responses to a given situation.

The overarching relational project is best articulated in the book-length treatises it has given rise to, where underlying issues are more thoroughly engaged and more extended clinical case examples are offered. For a proper grounding and to avoid the misunderstandings that might arise from reading a limited selection of journal articles, I would refer the reader to the influential books of Aron (1996), Benjamin (1995), Bromberg (1998), Hoffman (1998), Mitchell (1988, 1993, 1997), Mitchell and Aron (1999), Pizer (1998), and Siochower (1996), as well as Greenberg himself (1991). These volumes as a body represent a serious effort to begin systematically considering the conditions under which certain approaches will be beneficial and others not. They attempt to create a theoretical infrastructure for arriving at such clinical determinations. I support Greenberg’s calling for a more rigorous attempt to create standards for technique and presumably also appropriate rationales for deviation, but it would be unfair to imply (and perhaps he doesn’t intend to) that this hasn’t been undertaken.

The author suggests that in critiquing the idea of the analyst’s privileged expertise and/or authority, relational theory undermines the idea of the unobjectionable positive transference, which ordinarily underwrites the patient’s motivation for treatment. Bereft of the authoritative mantle, the analyst’s stock in trade becomes that of providing a corrective emotional experience and the direct gratification of the patient’s needs and/or desires. In contrast, I would remind the reader that relational theory clearly retains the idea of a pronounced asymmetrical role differential (Aron 1996), in which the analyst is paid for his or her expertise in setting up and sustaining the conditions for an important maturational experience for the patient. The analyst still has authority, but the nature and cast of that authority has shifted to being expert in one’s general understanding of intrapsychic and interpsychic life, and

Greenberg does not register explicit objections to the fourth premise, regarding the mythic status of the analyst’s detached objectivity. I will therefore not discuss it at length, except to note that he may be pointing to the post-postmodern concern that debunking the belief in objectivity would destabilize our efforts to find or construct an analytically viable psychic reality relatively uninfluenced by the analyst’s subjectivity. The search for an analytic “truth” would then be rendered an empty, if not futile, task. In its place, the analyst’s only recourse might be an overreliance on establishing a need-gratifying analytic relationship to promote psychic growth. Thought-provoking discussions of these issues can be found throughout the relationally oriented literature (see, e.g., Elliot and Spezzano 1996; Stern 1997; Renik 1998).
in various ways of sustaining an analytic process. Nor is the analyst an authority on what a single proper technique is, or on what a single proper interpretive line is, or on any putative psychic truth (see Hoffman 1996, 1998; Mitchell 1997).

I'd like to register my own concern about Greenberg's concern about the analyst's desire. It seems to me that Greenberg's comments could unintentionally "inflame" our desire to stamp out the analyst's desire, just as we may overcontrol id-like urges for fear that once unleashed they will inevitably wreak havoc. We might come to regard the analyst's desire as necessarily libertine, too dangerous, and indeed corruptive, instead of viewing it as "more simply human than otherwise" (after Sullivan) and as capable of being productively harnessed if well understood. This excessively heightened mistrust of the analyst's wishes and needs could spur a countermovement to squelch them, which like most repression and suppression can only compromise the analytic mission.

It takes someone profoundly immersed in a given orientation to be able to examine that position as cogently as Greenberg has. It is crucial that we each be our own "worst"—that is, most conscientious—critic. Greenberg has made every effort to be evenhanded in his comments. Yet I fear that the urgency of his tone—as well as the intensity and, to my mind, the hyperbole of his criticisms—could dissuade newcomers to relational thinking from delving further into its vicissitudes. This could slow our progress in working toward common understandings of the psyche and the psychoanalytic process, the ultimate aim being to advance the field as a whole.

The classical position showcases—sometimes too one-sidedly—the analyst's authority and relative objectivity; the importance of providing cognitive insight along with affective impact; and the sovereignty of the analysand's intrapsychic world and unconscious life. The relational perspective attempts to counterbalance this one-person perspective by highlighting—sometimes too drastically—the analyst's personal responsivity and subjectivity, the influence of the interpersonal context; the importance of emotional (procedural) experience; and the way manifest here-and-now functioning symbolizes and reflects unconscious life. A pendulum is in motion, and Greenberg's argument constructively attempts to narrow its arc. I agree wholeheartedly that relational analysts need to keep a clearer focus on the patient's intrapsychic life and development. The analytic relationship should certainly be pitched first and foremost in such a way as to promote the patient's therapeutic goals; it should not be treated as an end unto itself. Greenberg's probing comments help us expand our self-critical capacities. I look forward to his continued contribution to the painstaking work of writing a different kind of "book"—one that offers meaningful orienting points toward establishing an optimal balance, in each analytic situation, of inter- and intrapsychic emphases.

REFERENCES


