(2000). Contemporary Psychoanalysis, 36:187-232

Interview with Benjamin Wolstein

Irwin Hirsch, Ph.D.

Benjamin Wolstein Was interviewed on two consecutive Saturday afternoons in May 1998, in his office in New York City. The interviews totalled almost six hours and were audio taped and subsequently transcribed. This abridged version represents well less than one-half of the original transcript. Among what is not included is the early part of the interview. This segment dealt with Wolstein's family background and some of his significant personal and educational experiences prior to entering analytic training.

IH: Who would you say were your strongest influences?

BW: My major influence, obviously, was Clara Thompson. I'll always have deep affection and regard for her. She took me on a trip and I took her on a trip. It was a quest for psychic freedom, you know. In that context, anything went. Of course, we had differences of opinion; I mean, about the question of countertransference and how to work with it. This made our differences real. She used to take the established position of the early 1950s—"that belongs in my analysis, not in yours." Of course, I was a bit of a wiseacre. I used to ask her, "if it belongs in your analysis, what is it doing in mine?" She didn't get defensive about it. She laughed. And eventually, something I'll always respect her for, we began to do a certain amount of open analysis. I began to realize how her psychology actually affected some of the work that went on between us. And I thought that was extraordinary for the time. Later, I began to develop the idea about the interlocking of transference and countertransference, and wrote a monograph on countertransference in 1959. There, I also first described the experiential field of therapy. And I got a lot of it from my own experience working both with Clara and with patients. Not all my supervisors went for it. Some appeared to, but really didn't. But I already knew after Transference (1954) that the observations of transference and countertransference were interchangeable, no matter how a particular therapist and patient actually worked with them.

IH: How would you characterize the primary difference in dealing with countertransference between you and her?

BW: From the beginning, I was more prepared to explore countertransference directly.

IH: In terms of disclosing her feelings or in some other way?

BW: Any form. The patient could say whatever about it. The patient isn't

going to be talking in a vacuum. And if I believed in the experiential field, I could only act as though I wasn't responding or as though I wasn't psychically involved. That doesn't mean the patient wasn't getting cues about my awkwardly disguised reactions. So it was only a question finally of whether I was prepared to be open about it or not. In my view of it, in any case, I had already reacted; it was there. The only question is, do I talk about it or not. Then, can I listen to—hear—the patient talk about it? In other words, can I work at any and all unconscious issues in the psychoanalytic setting, which is what this particular patient-therapist relationship is about? And her first position, I think, was a position that you might give beginners: "that belongs in my analysis," when you're doing therapy, or "take that up with your analyst," when you're doing supervision. That used to be part of the stock and trade of 1950s psychoanalysis: "take that up with your analyst." But my question was whether the psychoanalytic situation as a whole was a situation of genuine psychoanalytic inquiry. To what extent, during the psychoanalytic experience, does a therapist get into the unconscious with a patient? Both therapist's and patient's? And I discovered that I dealt differently—and still do—with every patient. So I'm in another place now. At the time, the thing was routinely mythologized. Why I hold Clara in such esteem is she wasn't afraid of knowing herself. She had great therapeutic courage. And, for reasons I never got into with her, she was willing to go with me on it. For all I know, some patients did, still others didn't go there. But I did. I've come to this new mantra, "Wolstein's Law": Every therapist is unique, every patient is unique, every dyad is unique. The wider the range of capacity that a therapist has, or more exactly, capability, the greater the willingness to go into many different strange and secret places with patients. Such things make it possible for a therapist to work with a wider range of people beyond conscious and preconscious experience, in greater personal depth, beyond the borders of intimacy to the threshold of love.

IH: Just to be very concrete, in terms of dealing with your own experience

with countertransference, you're talking about a whole range of possibilities; that is, talking openly to patients about it or dealing privately, right?

BW: Concretely, I deal with it both ways because at some times and places with some patients I have clinical reservations about initially opening myself up. An obvious example is with a patient who's into deeply hostile, even destructive things. There's no point to it then because

the patient is very defended, even obdurate. Or if a patient is very detached, I have reservations. A patient has to arrive at a point of real connectedness with me, so that the analysis of countertransference may mean something to us both. A patient has to be able to use that material constructively, in my opinion. And I have to be able to use it the same way with the patient. In other words, I have to feel free. The critical question to me is, can I go defenseless into relationship with a patient and feel undefended? We hear a lot about vulnerability these days, but I fear vulnerability is always a function of defense. They correlate: the more vulnerable you feel, the more defensive you become; the more defended you are, the more vulnerable you feel. Whether I can be undefended and spontaneous is a basic issue of trust or, in a word we don't use here much, love. You have to feel a kind of love, a kind of what Sullivan might call, in interpersonal relational terms, a basic sense of security doing it. It has to feel right. But to feel right, you know, it's like, just going for it. It's not working through something to dodge or outwit the patient, or to figure out something intricate about the patient that the patient hasn't already. It's not on that level at all. It's a shared inquiry into direct experience.

IH: OK. Did anybody else have significant impact on you as a student during your early days at the White Institute? Any fellow students or colleagues. And what about your analyst? Who was your analyst?

BW: Clara Thompson.

IH: Oh, she was your analyst as well as supervisor.

BW: No, never my supervisor, always my analyst. I learned a lot, I think, the most from her. I don't know if you're aware of this, but in the Budapest School, one's training analyst was one's first supervisor, as well. I want to complete something historically. In 1988, when the Ferenczi Diary came out in English translation, and I came across this phrase of his, "the dialogue of unconsciousness," and this whole new thing about mutual analysis, I suddenly realized that I had already arrived there

in 1959, in my own thinking, my own terminology, my own culture, my own psychoanalytic conception. I later thought, Thompson might have been a kind of conduit, a kind of bridge, because she had worked for years with Ferenczi in Budapest. Thirty years after writing Countertransference, I had to consider the possibility of some sort of generational transmission from Ferenczi's "dialogue of unconscious" to Thompson's "direct psychoanalytic experience" to my "experiential field of therapy."

IH: So who else had an impact on you, other than Thompson?

BW: Thompson was most important. I worked with Fromm-Reichman, but unfortunately found it wearing to travel down to Washington. So, it wasn't as intensive. She tried to get me to do less detailed inquiry and more intuitive activity with my patients. Instead of asking patients questions, she suggested I ask them of myself. But overall, I think she was really working with me in the interpretive mode. Where I was headed was more experiential, more toward direct experience. The actual experience of coparticipation was, I came to believe, where the therapy takes place. Not that the patient doesn't have a rational mind and intellectual interest, but the heart of the psychoanalytic therapy is in the experience. Not in the interpretation.

IH: That's a position—direct experience—that you developed pretty young, pretty early.

BW: I came out of the James-Dewey philosophical tradition of experience, the fluidity of the stream of consciousness and aliveness of direct experience, but I didn't at the time really understand its meaning for the study of unconscious psychology: that unconscious activity continuously persists in the immediate dimension of the experiential field. It's in the immediacy of it, not in its cognitive nor its reflective side. I think reflective detailed inquiry is more about conscious and preconscious experience. That is, things happen in our lives that Sullivan says we selectively inattend, or Freud says we repress. One's descriptive, the other's dynamic, they're both about the [same] sector of experience: security operations or defense mechanisms. The idea is, anything preconscious once happened, we forgot about it, then we bring it back into conscious awareness. Whereas something unconscious may never have happened to us quite that way before, and it brings us to a totally new point in life. I sometimes think preconscious is really reconscious. What was preconscious is made conscious again; that is, for a second time. Literally a reflection of the past, as though in mirror description made conscious, in

some respects modified by the current conditions under which it's now returning to awareness.

But I think that's a distinction that hasn't been sharply enough drawn in our own interpersonal relational positions between what's preconscious and what's unconscious. And you know there's always this standard caveat that the therapist should never intrude into a patient's experience. “Don't be intrusive,” we are told by our supervisors. I was. And I never understood what this meant. I didn't know why, but I knew something about it was wrong. As I got older and more

experienced, I began to realize that the unconscious always intrudes. The unconscious comes from out of the blue, as they say, from out of left field, from alien mysterious places. And if there's no room for such intrusiveness in the therapeutic relationship, there's no room for unconscious experience. No real surprises: it's all worked through history, to be worked through again. It all comes [in] package[d], detailed, and interpretive inquiry. Ignore the incongruous intrusions of unconscious experience, and you gloss over the unrelational side of interpersonal experience. It's not, there it is, how can we assimilate it; but rather, if it's not relational, we can't.

IH: You're making some connection between intrusiveness of the unconscious and intrusiveness of the other?

BW: I'm making a connection between the stark intrusiveness of the unconscious and the unmarked absence of considerations of the unconscious from relational perspectives. Especially the classical relational perspectives. The unconscious is dealt with mostly interpretively, it's not directly detailable. I don't think you get that before Ferenczi and Rank. Until then, the actual therapist-patient experience didn't count. The idea that a therapist could as training use a real therapy and not just a didactic analysis was quite radical seventy-five years ago. It was also a relatively late development. I mean, Freud, a self-defined master analyst, was never analyzed by anyone but himself. He never knew the two-way situation of psychoanalytic therapy. You have to realize that in those years analysis was essentially the interpretation of dreams. Recall the case of Dora. It's very interesting and we often forget that the case of Dora was actually written up to illustrate how his interpretation of three of her dreams constituted his vision of psychoanalysis. He did that work in 1900, and when he published the case in 1905, he added a postscript. "Oh, there must have been a transference going on there." In my opinion, that was his

great clinical discovery. His dawning awareness that psychoanalytic therapy wasn't merely the interpretation of dreams. Transference now became another clinical road to the unconscious, moving in the direction of direct connectedness between therapist and patient.

IH: Just to be clear, what is the distinction you make between interpretation and experience?

BW: Interpretation's not live, lived experience. Psychic events that take place, to drop the term "experience" and define it, are live events that connect therapist and patient with each other.

IH: So those live events, those experiences, as you see it, are not

interpreted? They just are lived without an interpretive intrusion, without postexperience explication?

BW: From my point of view, they are interpretable. For instance, some therapists even believe psychoanalysis is nothing but an interpretive discipline. So they won't pay serious attention to the therapist-patient experience. From my point of view, they prescribe, and, in some respects, even proscribe it. Why not leave the interpretations to the patients who, in final reality, have to bear them?

IH: How might you intervene, in contrast to interpretively?

BW: As opposed to interpreted, for example, they can be identified. They can be referenced, like "What are you feeling now?" or "How did you arrive at that thought?" "What was the previous thought in your mind?" or just leave it be and unfold, and patients will do with it as they will, interpretively.

IH: Is your implication that interpretation is not part of your repertoire, or it just has much more of a recessive role?

BW: I think psychoanalysis is made up of three parts. First, there's the direct experience, about which we make descriptions and inferences. Then, we have a number of transforming postulates like the genetic, the historical, the dynamic, and so on, by which to extend the data toward the basic principle that unifies all psychoanalysis: unconscious psychic experience. The distinctive thing that makes a therapy psychoanalysis, I think, is this quest to enlarge the scope of awareness, so as to reintegrate unconscious, preconscious, conscious experience. It's an overall principle governing the exploration of direct experience. And then, the third dimension of psychoanalysis is interpretive. The real problem with interpretation, as far as I can see, is that it's always the therapist who has the

right interpretive metaphor, and always has the understanding of what's wrong with patients, as though patients don't have a brain in their head and never had a useful though about their problems. That approach comes from the classical psychoanalytic model, or the traditional medical model, where the doctor has to cure the patient. But it seems to me that, in a self-healing therapy like psychoanalysis, patients ought to have the space to interpret themselves. Even if one believes psychoanalysis is an interpretive discipline, that doesn't mean the therapist should always do all the interpreting. I think patients can do their own interpreting as well. And actually, because I believe patients do their own interpreting anyway, when it comes to the therapist's

interpretation, less is more.

IH: Does that imply you encourage the patient to interpret?

BW: All I have to do is listen, I don't have to encourage. I think it's natural. Left alone about it, patients interpret themselves on their own. There's a basic desire to know, like patients are here because they really do want to know something about themselves, have always wanted to know something about themselves, in order to integrate their own interpretive view of themselves. So it's not the interpretation itself that's the objective of our work. It is the increased range of self-aware experience that will help patients go on to rearrange their lives and/or reconstruct their interpretation of themselves. We don't easily accept other people's deep interpretations of ourselves. Raised in the Midwest, I learned an old Midwestern saying early on: "A man don't go his own way, ain't nothin'." And going my own way, I've become a complex mixture of various things: a Western psychoanalyzed mind, an Eastern Yogic body, and a Hasidic Jewish soul. These expansions of my experience presuppose an original psychic ground of self-direction and choice.

IH: So, where is interpersonal psychoanalysis now, in contrast to fifty years ago when you started?

BW: Well, the largest and most obvious change was the move away from Hartmann's emphasis on the ego and its problems of adaptation to the culture, or, in Sullivan's language, the standard of consensual validation. Sullivan was among the first, however, to start using the notion of self systematically in psychoanalysis, and he defined it as made up of reflected appraisals. This self, in older terminology, was introjected, or in later terminology, internalized, or in his, personified. What he and others left out was self as origin. I think that emphasis has changed. It's more about a person's own relationship to that functional self that is introjected,

internalized, or personified. That is, at the point of distinction between the self as origin of psychic resources, and self as acquired through training and tradition, education and adaptation, or consensual validation. There's been a major shift: psychoanalysis has become more deeply personal, closer to the original self.

IH: The term "self" and the concept of self is something that is very strongly associated with you and your work. Do you have a theory of the development of self?

BW: No. For clinical theory and practice, [you] don't need to work out a

developmental theory of self. Besides, Sullivan and others have already done that. In developmental theory, you're really dealing with the notion of the social and interpersonal functioning of self. All the human sciences interest me, but I'm a psychoanalyst therapist. Let me start from there. In addition to self, we have three basic empirical terms of psychoanalysis which, I think, all contemporary psychoanalysts accept: transference, resistance, anxiety. Now, what is the place of these experiences in the stream of consciousness? This, to me, is the critical psychoanalytic question. I would say that when we deal with resistance, for example, and do detailed inquiry, we're always dealing with the past. When we're dealing with anxiety, we're always dealing with the unlived future. When we deal with transference, we're dealing with the here-now of psychoanalytic space-time, the immediacy of experience; therapist and patient, perhaps imperceptibly, literally transfer experience. So mine is a clinical theory of the experiential field of therapy, not a general theory of individual development from birth onward.

What really interests me about psychoanalysis: how people change. What psychic resources do we need? The sense of self was important especially in trying to work with the transference-countertransference complex where therapist and patient are in a rut. I've been there; we all have. How to find a way out? It's an obvious question, and if you're only dealing with self from a rational, reflected point of view, the psychodynamics of unconscious experience do not enter in. Sullivan, I think, treated the reflected "me" pattern far better than he did the "I" process reflecting on them.

IH: Way out of?

BW: Of the transference-countertransference interlock. When one or the other or both get caught up in [being] interlocked, they seek another place to stand within themselves from which to look at this thing. So

they start to work with it. That's where I think the importance of the sense of self developed in psychoanalysis: during clinical inquiry. To ask about a developmental theory is to go back to the traditional evolutionary way psychoanalysts tended to approach things. It's like working from the outside—working at the clinical situation with preestablished theory rather than developing theory and applying from inside the situation. This new importance of the sense of self came out of actual clinical work with transference and countertransference. Even before that, even though psychoanalysts didn't address it, there was this question: How did patients change transference? Was it that the therapist put some sort of cookie cutter on it and said, "This is how you have to adapt it, or consensually validate it"? Or do patients make new choices and enact

their liberated feelings and desires—which, I find, requires a sense of self as origin.

IH: Are you then out of the transference-countertransference interlock or are you placed somewhere else in it? Do you see yourself as getting out of it?

BW: Myself? As soon as I have a point outside it, I'm no longer wholly caught up in it. And then I'm able to understand something about how we got that way. So there we are, beyond it, and the two of us may open up to each other, at least enough to understand how we got that way. Knowing that, we've already changed, no matter what either of us does next.

IH: Is it ever possible to be out of the influence entirely?

BW: Give me a time frame. A minute? Five minutes? Half hour? Hour?

IH: Even for a minute.

BW: Yes. I think a person has a place within that belongs only to one's self. Why not talk about this unreflected, unrelational, autogenerative sense of self in psychoanalytic therapy? If only, indeed, to become aware of it? Well, now we're circling back to our earlier discussion. It's a question of going defenseless into the experiential field of therapy at times like these. That's why I think we usually know it more when we're alone than when we're with another. We more easily drop our relational facade alone. But try it in another's presence….

IH: Would you say that is an analytic aim?

BW: I don't think it's a question of making it an analytic aim. Make it an analytic datum; it's already part of the stream of consciousness. It's

part of human psyche that moves itself. And a thoroughgoing psychoanalytic study of human psyche must include that among all the other things it does. If we were working, I would want you to know it so you could make your choice about staying there, or not. In other words, I would want patients to have that firsthand awareness of selfic resources. And what they do with it—that's their choice. And the reason why I go for it is it's there, like transference, resistance, and anxiety.

IH: When I talk to people and ask, "What do you think I should ask him?" everybody thinks I should question you about the concept of self and how that relates or how that is in synchrony or dissynchrony with constructivism and perspectivism. "Self" in some ways sounds like an absolutist concept, that is, there is a singular self.

BW: A unique self. A unique sense of self is unrelational at its points of

origin—first personal, active, singular. We may name it; we can't construct it.

IH: So, in a way this is very similar to the concept of true self; the true self as being something that is inhibited by one's experience.

BW: Actually, I don't work with it in that conceptual way. I work with it clinically. In relation to transference. A patient talks about a difficult situation he's in, so you say, "What prevents you from doing 'x'?" That's a conditional statement. That's looking to change some attendant conditions as a preventive. But something like "Why not do that?" is a direct appeal to selfic activity.

IH: But how do you know the "Why not do that?" is an appeal to the self [and not] an appeal to following your lead—your liberating "Why not do that?" lead?

BW: If patients wish to follow that lead and, in doing so, operate out of their own inner sense of self, they do not literally follow my lead. Phenomenologically, they're engaging their own psychic sources of activity.

IH: How can you tell which it is?

BW: I don't have to. Look at what's happening between us now. Who asks? Who answers? We each do our own part, respectively, in the first person, active and singular. This original selfic activity, grammar aside, is primary psychic experience. If I own up to mine, does that make me responsible for yours?

IH: What comes from self and what comes from the influence of the

other? And how do you as the analyst, or even the patient, ever know which it is? Am I asking a relevant question?

BW: How do we know anything? When something rings true to us, are we free to know it?

IH: Yeah, but it could be deceptive. It could ring true to me because you're corrupting me and ...

BW: But then, do you have an inner place to stand, your own psychic point of origin? I can't supply it. If you can't supply your own, and if you're so inclined, let's get into the possibilities of self-deception. What's that, if there's no genuine sense of self?

IH: But how do I know I'm really not standing in your place, since you're an important influence in my life?

BW: Well, if you don't know, then there's something to talk about. Here,

the relational facade breaks down therapeutically. If you don't know who you are, and think you're a bundle of influences, then, in an odd sense, you're out of your mind, so to speak.

IH: How is it ever finally determined? Here's the constructivist question.

BW: I think it's an active choice on the part of the patient. The constructivist answers the outsider's question. All the psychoanalytic patient can do is answer from within.

IH: What's the choice?

BW: Wrong question. Who chooses? I know who I am from my own experience. And you don't have my experiences, you don't feel what I feel. Even if I were to use you as influence, that, too, is my choice. It's my experience I'm living, not yours. Do you, in any sense, think we choose our influences? If so, who chooses? If not, why analyze anything? In any case, becoming a patient, becoming a therapist, there are real decisions. To ask the obvious, who makes them?

IH: Is this knowable or do you just think you know it? In some final way, is it knowable that this is myself?

BW: I've been reading Macbeth. Shakespeare calls them "the first links of the heart." Do you know the first things that occur to you in your heart? That's your question. Do I sense what I am, what I feel, what I think? That's mine. And as soon as I start thinking about it, it's overcast. As soon as I start thinking about it, it's no longer there; there's a question

instead. In other words, if patients tell me this is what they think and this is who they are, you know, fine. If they say, this is what I think, this is what I am, but I'm not sure, then I say, okay, let's explore it. In other words, it comes into question because they've put it into question. The self as point of origin, again?

IH: So, you feel, and I guess this is where the constructivist question comes in, that "self" is knowable in some definite way, by the individual or by you as the analyst.

BW: Now I have to ask what you mean by "knowable." If you think of knowable in terms of a constructed entity, obviously you can know that constructed entity only by tracing the factors that are linked to its construction. It's circular and, [in] that sense, knowable. That's the kind of knowledge that comes from the use of constructivist reason. But there's another kind of knowledge that comes from direct experience, immediately had experience, and that's not constructed or constructible. Nor traceable. It's not subject to a factorial or statistical analysis. That's

something a patient presents out of lived experience. What Nietzsche calls "the bloody truth."

IH: You question that you need language to experience it, but how is the experience experienced without language?

BW: As experience. Language is a tool of experience. Language is not experience. Language isn't feeling, thought, imagination. Transference, resistance, anxiety, are not mere linguistic terms: ask anyone who's ever lived through and worked beyond them. Interpreting them doesn't change their experience. New experience does.

IH: How do you know you've experienced it without language to describe it to yourself?

BW: Through direct feeling, through direct experience, through a direct sense of its activity. Without a clear distinction between language and experience—more generally, between ontology and epistemology—I don't know how we can think clearly about psychoanalytic matters.

IH: So, where did you come by the conception of core self?

BW: I don't ordinarily think of it as core self, but I'm willing to go with it here. Clinically. I came by it by working with transference and countertransference locked together. A uniqueness of self is the most direct way to get over and out of that interlocking; it makes possible, it opens up, the love, as distinct from the intimacy, to let it go.

IH: And that is, you believe, an inborn uniqueness in each of us.

BW: Yes. We all have a unique sense of self that's inborn: clinical psychoanalytic inquiry doesn't create it; we find it there. And informing research lends strong support to this notion, as well. So far as current infant research goes now, they trace it back to three months. According to Daniel Stern, there's an incipient sense of self already observable and describable then. I believe that when they develop the tools of observation, they'll find a preincipient sense of self in those first few months, even from birth.

IH: And how does one's environment facilitate the maintenance of that, or the dissolution of it?

BW: That's a good question, but it's not the kind of question I have to answer clinically. The question I usually have to answer is, What kind of leverage do I need in order to get my own self into clinical operation? What kind of leverage do patients need within their own psychology to get their original sense of self into operation? What facilitates its expression in the world? Experiencing therapy carries far more

conviction than any and all interpretation. What makes it possible for a therapist and patient to get into the center of life? To live more fully, experience more richly? This psychic center is not off somewhere, floating around by itself; it's at the center of the interpersonal relational self.

IH: This is a difficult question to answer operationally—how do you do that?

BW: So far, I find, in direct interaction. You know, questions like, Why not say what's on your mind? or, Why not say what's in your heart? Try to live and work through direct experience without spinning it. Which is, by the way, something the clinical psychoanalytic situation is very well suited for—much better than it is for the social and cultural constructivist position. For the immediacy of experience, unspun, is right there at the psychoanalytic center, unconstructed.

IH: How do you get people to truly say what's on their mind?

BW: I can't.

IH: How do you facilitate that?

BW: Only by being open to it. By being interested. And having moments where I can do it myself, here and now in psychoanalytic spacetime, to the best of my given awareness.

IH: Is that the sequence ... Is your ability to say that you feel truly in your heart with a patient the key factor ... ?

BW: It's not what I do with the patient. The patient's own psychic activity makes the differences for the patient. And that frees the patient and me, if we see the difference between experienced connectedness as primary datum, and interpreted relatedness as secondary elaboration.

IH: What facilitates it with you as opposed to someone else, you as opposed to a friend?

BW: The therapeutic focus is consistently the expansion of awareness, searching for what's beyond conscious awareness. What are you keeping out of your shared communication? Out of your thoughts? Your feelings? And why not seek those things? It's a steady self-inquiry pointed toward modifying and enlarging self-knowledge.

IH: Is it through questioning or is it through being ...

BW: It's questioning, it's experience, it's exploration. And I don't see myself as having interpretative answers for patients anytime. When I'm modeled as though I do, that's transference big time, and the psychoanalytic inquiry hits an impasse, a standstill, an interlock; and

then, the therapeutic focus shifts. And whenever I get an inkling of that, I know why it's happening. What am I doing, first of all, that may be evoking it. I believe we're cocreating it. Here, then, my experience with the patient is as good a source of information as is the patient's experience with ...

IH: There's a paradox, I think. I can see Clara Thompson in what you just said, because that was one of her most important contributions: the degree to which transference was a powerful weapon to influence. But if on one hand it's your freedom of expression, speaking from your heart, your center, that is facilitating patients doing the same, then if they do that, there is a transference element, an identification with you element, that's hard to get away from.

BW: It's only a paradox if I make it so. My intention is not to model myself for the patient or offer myself up for interpretative discipline. It's for the patients to finally find what they're looking for in their lives. And if they want to take something over from me, that's their choice. They'll have to outgrow it, anyway. That happened to me. I think it happens to all of us in analysis that we eventually outgrow our therapists as we outgrow our families of origin. In so doing, we see our psychology in action—this time, hopefully, with increasing self-awareness.

IH: Your being as free as you are, to say what you feel like saying: I certainly noticed this with you as a supervisor. Your openness disinhibited me vis-à-vis you. I imagine it's very similar with your patients. If that's not your intention, it sure comes across anyhow.

BW: It happens. Experiment with it. Try it on for size. If the shoe fits, wear it. Or find your own best fit. Find your own way of being in the world. Unique individuality disdains the beaten path. The more important thing is that if I found mine, you may find yours. If I don't have that, I have nothing for the patient or myself. If I don't have some sense of my own being, my own life, then I am nothing in the patient's presence, or anywhere else. A relational fiction doesn't do well with another relational fiction—no psychic life.

IH: All analysts would probably agree that they want their patients to have optimum freedom of expression, to explore the range of what's to be explored. Right? No one would say no to that.

BW: But some would say no to the therapist being free and self-expressive. And that's where I think we differ. In other words, I think it's a two-way inquiry, it starts out as collaboration and it goes where the data take us. It requires discipline; it also requires vision.

IH: Well, what about the question of symmetry and asymmetry. You talk about psychic symmetry. Does that imply you don't believe in symmetry across the board? That is, do you do mutual analysis in the fullest sense—the way Ferenczi tried it?

BW: As far as I can with a patient. It depends on who we are. I think all psychoanalytic therapy is, in a sense, mutual during the transference-countertransference.

IH: Well, total symmetry implies that anything that patients will explore from life history, you might do the same. Do you expose yourself to this extent?

BW: I have an unlimited view of psychic symmetry. Any basic observation of psychoanalysis is as true of the therapist as it is of the patient. To run through them: transference, resistance, anxiety, unconscious experience, and their psychic symmetry in the experiential field of therapy. Everyone in the literature agrees with that. It's a sigh of relief. And any basic discoveries in the analysis of human psyche, qua human psyche, apply as well to therapists as they do to patients.

IH: No, it's not a sigh of relief; I am trying to pin you down here. Do

you imply symmetry is behavioral, as did Ferenczi in his experiment with mutual analysis? Are you as likely to be as open with every aspect of your life and your fantasy life as is the patient? Do you talk about your sex life?

BW: It depends on my work with the patient. In principle, I feel open enough to discuss anything about myself. In practice, it depends who I'm working with, what [the] qualitative situation is, what I had for breakfast, whether I had a good workout the day before, how the stream of consciousness is flowing today, and numerous immediately ponderable factors at the time.

IH: How do you decide?

BW: There's an inner sense, an internal guide. You just do it. What guides you? What drives, as you say, your questions? How do we translate into action? To find out, go directly to your own experience. Not only you, anyone. When you draw a line between thought and action, you have to think twice before you cross it and go into action. You might reflect the thought even more, if you choose, before putting it into action, if ever. But you might also directly translate it into action. Sometimes we all do that. We're all capable of the unguarded, undefensive, even spontaneous interaction; whether we exercise it, that's a matter of temperament, self-knowledge, interest.

IH: The tradition is clearly not to translate thought into action. The tradition is to reflect on all the thoughts and to be cautious about the verbal action.

BW: I'm not speaking from tradition. I'm speaking from the experiential field of therapy. I'm experimental psychoanalytic. I don't expect this view to become widely accepted for a while, anyway; and it may not ever. I mean that it might not happen the way it happened with the changing view of transference and countertransference since the 1950s. It took thirty to forty years—not alone, but a group of us—for these changes to become more widely accepted, too. Interpretative authority may work well in psychoanalytic metapsychology; it has only limited use in certain phases of psychoanalytic inquiry, with certain groups of patients. Traditionally, analysis has always been about the imposition of a frame of reference on the patient. Even today there are colleagues who talk about the frame that we're supposed to have. I don't believe that's how we really work, presenting a lay patient with the expert's interpretation.

IH: You don't believe in the concept of frame?

BW: I don't believe in the frame. The psychoanalytic boundaries are far more porous than, say, the frame of a painting, or if you've ever seen one, the frame of a cookie cutter.

IH: Wait a second ...

BW: No. Let me finish! I believe there's always a particular co-frame; a cooperative frame of reference a therapist and patient cocreate with each other. Nor do any therapists have the same one. There are certain basic concepts of psychoanalysis, certain basic terms of inquiry we all share: experience, things like that. Then there's the question of liberating unconscious experience in order to expand awareness. If you want to call that a frame, that's my frame. But the actual experience that takes place between me and a patient develops out of the co-frame of our direct experience. The way this open-ended interview is going between us.

IH: Well the frame is ... in the simplest, most concrete way, the frame of the session lasting X number of minutes. The frame of no hitting and no sex between two parties. Those are examples of frame issues, no?

BW: I think there's some coconstruction about these things. Years ago there was a cartoon in the New Yorker. Here I'm quoting literature [laughs]. But there was a cartoon in the New Yorker ...

IH: That's the only literature you quoted so far.

BW: Well, you're not asking me about literature, you're asking me for my

thoughts. A guy's running down the street with a couch on his back. And one guy says, "What's that guy doing running down the street with a couch on his back?" "Oh," says the man, "he's an analyst making a house call." I don't make house calls, right? I don't do therapy by telephone. There are certain things I don't do. But they're idiosyncratic to me; they're not intrinsic to the field and the inquiry. I don't charge for sessions automatically. I don't have a policy about money. When we set up a frame in advance, we are saying we don't want to discuss certain issues. We're putting them outside the field of clinical psychoanalytic inquiry. When we're doing psychotherapy, that's a different sort of thing. But I think, analytically, everything's up for grabs. Some patients may even decide they don't want to come to my office, and that's okay; it's their choice. Defining an algorithmic frame has its value. It certainly limits the range of exposure to countertransference.

IH: Well, but if that's coconstructed, are you flexible enough to go to their office?

BW: I don't do that. But that's who I am, that's the way I work. Some therapists do house calls, hospital visits, vacation sessions, phone interview, extra sessions—their decisions.

IH: What if they decide they want to pay only a third of what you're asking to pay?

BW: I've had that happen. I've worked with people who have crazy problems with money. I don't expect patients to be sane before they're sane. I once worked with a patient who gave me paintings. I know I won't do that again. You could say that's part of my frame, but I tried it and found it wasn't right for me. I learn more about a patient's psychology of money, curiously enough, asking for a reduced fee than paying my asking fee right off the bat. Patients who want to pay less get to money issues right away.

IH: Say the frame is coconstructed. Are there limits ... What if they want to sit on your lap, hug you, kiss you, have sex with you? Are you open to that?

BW: My thinking's developed over the years about that. Now, I make a very sharp distinction in psychoanalysis between experience and behavior. I consider psychoanalysis a psychology of experience. It's not a behavior therapy. I don't think I heal anyone through behavior. I don't think anyone sitting on my lap or kissing me will heal from that, or even learn something more about themselves. I'm far more interested in what prompts that behavior, in why the patient thinks of doing that? The

behaviors you mention are not facts to be enacted—they suggest questions to be explored. What's the experience the patient would behave, that the patient still can't communicate in any other way?

IH: How do you—I raised this question before—how do you decide what to say? Are there times when you feel something and don't say it?

BW: Yes, of course. If I've tried something a few times and bumped into a patient's rigidities, I try to learn from that experience. If I sense the patient still isn't open to going there, I'll put that on hold, and go somewhere else—and indicate what I'm doing. Or when I have nothing to say, I'm quiet.

IH: What are those experiences that inhibit your …

BW: I don't consider it an inhibition. It's not a function of counteranxiety.

It's a conscious decision not to go there. When I've been there and the patient isn't moving in that direction, I may say, this thought occurs to me but the conditions aren't ready for it. And maybe another day things will change and we'll be able to explore it. Now we can't. Let's go here instead.

IH: By conditions do you mean… ?

BW: The psychic conditions. The patient's resistant, anxious, obdurate. And so the question is why the resistance rather than to explore my idea. Why this built-in rigidity? And how it loosens up? How do we let go of resistance? We think we do it out of response to the therapist's power, persuasion, or expert interpretation. The therapist can interpret from now to doomsday, however, but it's the patient who has finally to desist from resisting. The patient has to let it go, and no one can do [that] instead [of] the patient. And that's where the unique self comes in, the sense of personal self. And patients do it from their own given resources. We don't change patients. We're agents of change, but we don't actually get in there and change them. Patients change themselves. If, in addition, I'm counterresistant, and don't know its cause, I have to look back at myself, and consider changing.

IH: But do you influence? At least, unwittingly? In the final analysis, is the patient not left with some of our influence, despite the best examination of transference?

BW: With all this talk about influences, then, you're really talking about the transference-countertransference situation, in my opinion. Something in the intimacy of the relationship that is unanalyzed. By unanalyzed, I mean unexplored, unlived through, unworked through: therefore still

preconscious. I can't swear everything between Clara and me is now gone, but to my best knowledge here now, those psychoanalytic influences are part of the cumulative record of my history. I'm not a Hegelian dialectician—once conscious of unwanted influence, I can let it go, and get on with my life.

IH: Do you have a theory of therapeutic action, of mutative action? What makes for change?

BW: It's been implicit in what I've been talking about. I don't think of it as a theory, or aggrandize it as a theory of mutative action, but I think change takes place in and through freeing the self. The freedom to use psychic resources leads to change, if the patient chooses. In fact, the best

way for a therapist to know the patient is freer is the therapist feels freer. When I feel freer I feel the room to move somewhere with or without the patient. And if I feel locked into going a certain place with this patient, I know the patient isn't free yet, either. That, to me, is the interlocking of resistance and counterresistance—to others, perhaps, the interlocking of identification and counteridentification.

IH: So here's, I think, a good question. Does your increased freedom lead to, or [is it] likely to lead to, the patient's increased freedom? Is that how patients become freer, because you become freer?

BW: No, of course not. I think patients become freer because they can do so. You know, there's this special thing about liberation. We all know Abe Lincoln, one of my childhood idols, freed the slaves, didn't he? But the fact is the slaves didn't get free until they freed themselves. And I think the same is true for the therapeutic relationship to influences. I mean, a patient doesn't get free—and free of me, too, that's part of it—before making it to freedom. No outsider finally sets the patient free. Perhaps sets the conditions for it, but it happens when the patient desires it, is open to it, initiates it.

IH: Do you have to do something, or create some kind of particular atmosphere where this can happen?

BW: I've suggested what that is. I seek my own freedom with a patient. I bump into things and we have to explore them. The patient seeks freedom, too, bumps into things and we have to explore them. So our psychoanalytic therapy becomes collaborative.

IH: Then, your seeking your own freedom is the atmosphere under which patients are more likely to do that, right? That's the mutative atmosphere for you?

BW: When they change, I don't think it's essentially because of how I've been, but because of what they've become.

IH: There's something contradictory here. On the one hand, you're conveying what you atmospheric input is, on the other hand, you're saying it has nothing to do with people changing.

BW: Why is there a contradiction? It's a contradiction only if you assume in advance that the atmospheric pressure the therapist creates in the room is what brings about the change. But if you don't assume that in advance, if that's not your preconceived assumption, then you're open to the assumption that the patient energizes something from within, and then moves forward.

IH: You need a particular context. They don't go to the barber and energize it.

BW: The context is, we're open to it, we're looking for it. I mean: we find it, we make it. Maybe, this obviates your contradiction. We're looking for the context of psychological change. We're looking for the reasons why this person is in misery, why that person is locked up, suffering, and in pain. And we try psychoanalysis: We're in pain because we respond to things that are beyond our awareness.

IH: Awareness obviates pain?

BW: That awareness relieves pain? Psychic pain, psychoanalysts believe, indicates limited or absent awareness.

IH: Awareness that we are not in harmony with our true selves?

BW: Not necessarily, but that we're not aware of the conditions of our lives. We're not aware of the reasons why we pattern things the way we do, and we feel compelled to do them. With increased awareness, we get a better understanding of where that comes from.

IH: This puts you on an absolute harmonic plane with every other psychoanalyst. That is, everyone would agree with what you just said.

BW: Listen, I'm a very well trained analyst. I'm not coming out of left field, believe me. It's just that there are some things implicit in psychoanalysis that we don't pay enough attention to—and make explicit—which, if we did, would turn the field around.

IH: To shift to another issue, the word "inquiry" has appeared through all your writings …

BW: Yes, yes a psychoanalytic field of therapeutic inquiry.

IH: You use the term "inquiry" in a somewhat different way, however.

Inquiry usually means, as it meant for Sullivan, asking questions. Not that you don't ask questions. But you also share your experience a great deal. You make observations about the patient and you talk about your experience of the moment. I don't know if you call that inquiry.

BW: I do.

IH: You do. Why do you call that inquiry?

BW: Because it identifies my general approach. Inquiry extends across the therapeutic field. That's what the experience is about: the scope of awareness by means of a wide-ranging [search] for the unconscious, preconscious,

and conscious conditions of transference, resistance, and anxiety.

IH: Why is the word "inquiry"? Inquiry usually means to question, as opposed to express.

BW: The only kind of inquiry that you seem willing to accept is the detailed inquiry that's been accepted in the literature these days. Detailed inquiry refers to what? The descriptive analysis of established patterns of experience and behavior from the past, which in psychoanalytic terms refers to resistance. When we do that sort of detailed inquiry we are working with preconscious resistance and not with unconscious transference. You can't work with transference doing a detailed inquiry. That's a limitation of the operational approach to psychoanalytic inquiry. If detailed inquiry is only asking questions about observable data, actual events, actual facts, what actually happened—that is, conscious and preconscious experience—then I'm extending the notion of psychoanalytic inquiry beyond the patterns of resistance, to include the dynamics of transference, the experience of anxiety, the psychic center of self, and wherever else the inquiry may take a therapist and patient.

IH: You mean the experience of the moment.

BW: Once they go into the experience of the moment, then they're both inquiring into the unconscious present, alongside detailed inquiry into the preconscious past. Hence, inquiry in this larger sense. Once you start interpreting the dynamics of transference, here-now, you don't know where it will lead. Creative imagination has its place.

IH: I would use the word "inquiry" as long as you're asking a question about anything.

BW: You left out a very important area. What about anxiety? How do you explore anxiety? How do you do a detailed inquiry of anxiety? Patients'

actions in the middle of anxiety, how do you explore them? Or inquire into them?

IH: Other than …

BW: Being there. Being there with the patient, going through the experience. That's still part of therapeutic inquiry, in this more general sense. I don't use inquiry to refer only to the study of resistance. I also use it to refer to the study of immediate experience of transference in the present, [and] anxiety about the future.

IH: But what I'm asking is, whose immediate experience? For example:

"Patient, tell me what you experienced about what I just said" versus "Patient, this is what I experienced." The former is an inquiry while the latter is more of a self-expression.

BW: I disagree. Let's distinguish between grammar and psychology. In other words, I may make a grammatical statement, and it's really a psychological question. Or I may ask a grammatical question, and it could really carry an interpretation in it. Psychic interest does not fit a one-to-one correspondence with formal grammar.

IH: Are your statements inevitably questions?

BW: They're always questions in this larger sense, literally questing expanded awareness. The purpose of meeting the patient is psychoanalytic. It's focused toward the expansion of awareness. Whether put in declarative statement or in form interrogatory it's about curiosity, wonderment, exploration, inquiry, and not just about the details. Traditional detailed inquiry, moreover, is a one-way procedure. It glosses over the two-way curiosity, in support of the therapist's expertise, authority, control. Yet, there are instances where the patient becomes at least as curious about the therapist as the therapist is about the patient.

IH: There are other analysts who wouldn't dream for one minute of ever expressing anything that is a reaction or a feeling. And you …

BW: I don't work that way because there's an unconscious connection between therapist and patient. Between them lies a total experiential field of therapy. So your question isn't, as I see it, whether I should experience what I'm experiencing. There it is: I'm having the experience. The difference is rather whether I should verbalize it.

IH: Yes. It's about time I was able to pin you down on this question.

BW: So the practical question is what to do with this experience. Deal with it when and as it happens? Or deal with it later in personal analysis or self-analysis? Even some traditional Freudians these days are

becoming interactive. In fact, someone recently called my attention to the fact that Arnold Cooper's talking about a coparticipant inquiry. We've been about that for years, since Transference in 1954, extending Sullivan's notion of participant observation to include all dimensions of coparticipant inquiry.

IH: How does this differ from other perspectives?

BW: My interest in the psychic self and individualism. Is it merely because I'm American that I highlight this section of experience? Everyone,

these days, is talking far more about projective identification, right? Everyone's concerned about the importance of identification. But I don't hear anything about projective individuation.

IH: Why projective individuation?

BW: To express one's uncreating individuation. I'm not using it pathologically, though it may become so. The capacity to project one's individuality into—to put a personal stamp on—the interpersonal-relational field with significant others, that's what I mean by it. A sense of significant self to supplement Sullivan's significant others.

IH: Back to my question: What is the therapeutic action that the atmosphere you provide creates? What facilitates that kind of projective individuation? Different than other analysts might? Different than good friends might, or lovers might?

BW: Good friends may not tell you what a therapist will or should tell you. You can't expect, as a rule, to end up being friendly with a patient. It may happen, but you can't expect it as an after result of the therapy, because you and your patient will be talking about things that are very private and very difficult; also, if the therapy really succeeds, the two of you will have lived through your insanities once again. And, we all really want to separate from them. To the point of your question: I'm more observant of outer behavior with friends, more observant of inner experience with patients. Friends don't expect therapy; patients don't expect friendship.

IH: You said that good fiends wouldn't tell you what your analyst will tell you. So is part of what creates your mutative atmosphere your freedom? To tell people what their friends wouldn't tell them, so to speak.

BW: To do it, of course, with tact, understanding, sensitivity.

IH: If your freedom and your openness is part of what creates an atmosphere, is there conflict about receiving that? What is the role of

conflict in the willingness to integrate new experience?

BW: Therapists and patients start to experiment, to feel their way to each other. They try to explore their shared experience with a fumbling kind of freedom that's hesitant, unsure, even premature to begin with. It takes time and effort for them to develop a sense of freedom together. The patient willing, I keep nothing in reserve to work out myself—consciously, that is, the abiding continuity of unconscious experience notwithstanding. I think my willingness to work as directly as I can makes

that possible. Did you see Good Will Hunting?1 There's Dr. George Plimpton, and there's Dr. Robin Williams. I don't know why all this concern about therapeutic openness; it's pop culture now. Everyone knows out there how effective therapists work. You know, are therapists willing to connect? That's the world of difference between the open Dr. Williams and the closed Dr. Plimpton. And they couldn't talk to each other either, I think, because they don't inhabit a common world of psychology: they lack a common sensibility, a common experiential pulse, so to speak. Their individual differences create two different universes of experience with Will. My point is, though, that it's already out there; pop culture has caught up with us. The interactive approach is clearly established in the mediated culture now—more clearly, perhaps than in our psychoanalytic forums.

IH: Dr. Williams was being, at least as I see it, what the British school would call a "good object." He was being manifestly warm, loving, and caring. Why would this patient, who has had a history of bad experience, be so receptive to this "good" object?

BW: He knew there was a possibility of openness with Dr. Williams, what I call inquiry in the large sense of the term. He saw the possibility of experiential inquiry, and felt his way into it. But he was dealing with someone who also had a familiar "American" sense of reality about him, and wasn't just [a] formal British object for his transference, like Dr. Plimpton. I think that's the main thing here, that the therapist is not only an object for transference, he's also a subject of countertransference. So I would say, introduce both your subjectivity and your objectivity, as well as the psychic ground that subtends their subject-object construction.

IH: What about the traditional role of valuation of the analyst's ambiguity?

BW: What are you talking about? A phony? Or a therapist who presents a false relational front, trying to outwit the patient? Is the therapist

trying to brainwash the patient, using ambiguity as the method? I think that sucks, as we say. Another name for mystification. You can't be ambiguous in the midst of acting ambiguously; if you're definably ambiguous, that's not ambiguous.

– – – – – – – – – – – – – –

1 Editorial note: In the 1998 film *Good Will Hunting*, Robin Williams and George Plimpton portray two very different psychotherapists working with the protagonist, Will Hunting, a young man struggling to overcome his traumatic history and realize his remarkable potentials.

IH: It would be the analyst who tries to recede.

BW: To recede, well, that's not ambiguity, that's active recession, so to speak, done out in the open. It is clearly observable. It's not ambiguous that the therapist is receding. The therapist is pulling himself out of the center of the clinical picture. I think that's very clear. Perhaps in order to diffuse, deflect, deconstruct the felt meaning of some experience with the patient. Nothing ambiguous, doubtful, or uncertain about the therapist's meaning or intention.

IH: In receding, there are things about you that are harder to determine or to read.

BW: Harder to determine through outward behavior—what you show and tell—and that's if you have a special bias toward the power of words and verbal relations. I think sensitive patients who have some relationship to their own consciousness of self know what's happening, and may even intuit why it's happening. And they may even know, if that's the case, that the therapist happens to be a good guy and doesn't know how else to do it, except recede. A therapist trying to be therapeutic learns that you're supposed to be ambiguous, in order to be therapeutic. But that doesn't create ambiguity in my book, but a learned facade of it. The therapist acting as though it's true, of course, works only when the patient supplies the operant conditions of reinforcement. Don't act that way, and the responsive conditions won't appear.

IH: Of course, the tradition in psychoanalysis requires an effort to reduce cues, so that the patient's mind is the primary object of study.

BW: Where did you get this tradition? Not from Freud, obviously. When he actually worked with a patient, his and only his own metapsychology was all over the therapeutic field. No wonder he encountered frequent and deep resistance, some of it, I believe, rational. Let's use Freud as a model, even—it's clear he wasn't analyzed—as an unanalyzed model. But following his example, what should therapists do? Develop their own

view of life, and bring it into the analysis with their patients. That's precisely what Freud did. Must we be mere conduits for his ideas, or may we create our own? I didn't, for example, find his idealization of Napoleon interesting. Lincoln was far more interesting to me. Does it mean, therefore, that I must get into the military metaphor with my patients because Freud liked Hannibal and Napoleon? I prefer freeing the slaves [laughs]. I'm joking, even digressing a bit, but you understand what I'm driving at. This idea that analysis eliminates all cues from a

good therapist's personality is bull. Do therapists, for example, stop billing patients because that's a source of cue about their countertransference? I never heard of one who wouldn't accept fees for services rendered, in order to remain neutral and incognito.

IH: But there's a strong tradition where there's an effort to do that.

BW: The tradition was created by therapists who thought they needed it for their personal reasons. Can't we also start our own, as well, because we think we need them, for our personal reasons? I don't think it possible, finally, to eliminate all personal cues. In fact, therapists can't work that way. Real analysts use their real experience, their real feeling. Their real thoughts, their real intuitions. And the more psychically real, I'm proposing, the more effective therapeutically. The more generalized, the more impersonal, the more derivative from other metapsychologies, the more detached from their own. But the question about therapists eliminating cues? You know, the joke used to go around: "So what do traditional therapists do when they want to eliminate cues? They stop breathing."

IH: Eliminating cues is one thing, reducing cues is another. I think anyone would agree that eliminating cues is impossible. The question is, how much verbal participation and direct expression of experience is optimal?

BW: That's an unanswerable question. It's not quantifiable. I think that's part of what we learn directly from seeing wide varieties of patients over a number of years: look to the unique dyad. We learn to use ourselves more flexibly—like water, in the James metaphor—in terms of how patients present themselves. So it's not an abstract question of how many cues you reduce. Nor do you become boiled up about them. You work with what the patient presents, and you are what you've got. The idea of reducing cues. Well, that must go back to the idea that the analyst is a shrink. The shrunken head ... [laughs]. So the first person the analyst shrinks is self, and then sets about shrinking others. Why? Because you already know in advance that there's a certain social and psychological

code patients have to live by, and you shrink them to fit the code. But, suppose you think the possibility of psychic curiosity is real, and the desire to know one's unique individuality is real? Then you're in a totally different therapeutic world. You're stretching mind, rather than shrinking it; you want to see your own as well as the patient's stretch! And this process never stops. I've been doing psychoanalysis over fifty years, and

I still don't know how I'm really going to deal with the next patient. I know what I'm capable of, and I know what the psychoanalytic experience can be, but I don't concretely know what the next patient will present or evoke, which is what makes it interesting life work. Even when the most obsessional therapist and patient get locked into each other, how they will finally work through it, if they can, is unpredictable.

IH: What about the term "corrective emotional experience"? It has come back into the literature, but with a very different twist. It's now unwitting corrective emotional experience, as opposed to Alexander's premeditated experience. In the concept of enactment, for instance, or what Levenson has written about when he described transformation. The patient influences us, so to speak, to be somewhat like the significant others in his past. The premise there is that we cannot resist reliving with patients a facsimile of some of the key historical interactions that they've lived through.

BW: I think that depends on the therapist-patient relationship: the individual therapist, the individual patient, the individual dyad. You said it well: it's a premise. To which I add, it's only a premise. Don't worry about being transformed, it may never happen, unless you must counterresist it. I don't get caught counterresisting the patient as a matter of conscious procedure. If I were to counterresist transformation on the part of the patient, in the very act of counterresisting, I'm already transformed. My best approach to the patient is from where I'm really at. Can we patiently wait for the patient to bring up key experiences, and then see what happens between us? You don't have to cross that bridge, unless you get to it.

IH: You don't think that's a universal.

BW: No. But for myself, I do get caught in these things, not as a rule, as a fact. When I do, I think of it as a therapeutic impasse, an interlocking of transference and countertransference, or resistance and counterresistance, and then the issue is for two whole individuals to address this arrested development between them, not in the context of power struggle—may the best man prevail—but in the spirit of curiosity to know what's happening: may the best knowledge prevail. For the

impasse is relational, not psychodynamic.

IH: And you don't think it's necessarily a prerequisite—that is, the old has to be lived through before you get to the new.

BW: I do think the old has to be lived through, has to be transformed.

I don't think it's an inevitable prerequisite, though, for the therapist to fall into its complementary preconscious transformation.

I think [this position] derives from the traditional Sullivanian position of working within the security operations—the resistances and counterresistances—of the relationship. It's really the classical relational therapy of a preconscious history. A thorough going relational perspective—interpersonal or other—doesn't deal with unconscious experience. A relational therapy deals with what I've experienced with you, or with others when I was a kid, and later forgot. Detailed inquiry brings all that relational experience back into consciousness—makes it reconscious, as it were. But unconscious experience, by definition, is unrelational. So we have to introduce a notion of unrelational into the traditional relational perspectives, in order to make room for unconscious experience. Otherwise, we can only—[laughs] psychoanalysis becomes a kind of meat grinder; we keep sending the old hamburger through, over and again. And it may come out looking different, but it's still the same old hamburger.

The thing I find limiting about interpersonal relations is that Sullivan doesn't deal intensively with transference and therefore doesn't deal with the psychodynamics of unconscious experience. He deals with resistance brilliantly, of course, renaming them security operations. Seeing clearly their functional relation to anxiety, he has a good fix on the obduracy of resistance. I think that's the chief value and validity of his contribution, because when you deal with contemporary interpersonal relations, you're dealing with conscious and preconscious resistance, with power struggles, competition, envy, and other things like that. But why ignore all that patients bring to analysis that's unrelational? That has never been related? Literally "un-con-scious," never imagined? That's what I meant earlier about the unique individuality the patient has to self-realize, no less, of course, than the therapist. And they won't get there if they believe interpersonal-relational experience is an endpoint—that anxiety is unanalyzable and interminable.

IH: This is a very complicated issue. What is unrelational?

BW: I've already identified it: unconscious experience. It occurs in relationship, but is not of it.

IH: Now, why is unconscious experience unrelational, if unconscious experience occurs in the context of relationships? If unconscious experience is unconscious because of some good reason, how could

unconscious experience be nonrelational?

BW: That's a very big question. But think it through; unconscious experience, if you parse it, literally means knowledge we have that we don't share with anyone. It's knowledge we've never gotten together with anyone. We can have a relationship of unconsciousness, sense and feel what's happening, and still not get it together as shared knowledge. It's unshared, unrelational. That unconscious experience occurs in relationship only tells us where to find it; we still don't know that it is from direct personal experience. A rough analogy: formulate two parts hydrogen with one part oxygen as H_2O; that hardly indicates the wetness of water in direct experience. The unconscious is unrelational, you know by definition; you know its strangeness in living it.

IH: But how did it get there in the first place? And what's in it?

BW: What's its origin and function? From my point of view, that's metapsychology in the grand manner. The true metapsychology? That's a crap shoot—put down your money. Let all therapists and patients believe their own: it's not the heart of psychoanalytic therapy, in any case.

IH: The unconscious. What is in me? How did it get there? It must have gotten there in some relational way. Right? There had to be …

BW: Not necessarily—unless you believe, a priori, that everything's ultimately relational, in which case you can forget your question, and there's nothing distinctive about the relational denotation. It's a new universalism, of post-Freudian vintage. The origin of it? The Darwinians would find it evolving with the species. Theologians, especially the philosophical idealists, would trace it to God. Breuer never offered anything about it, leaving Anna O free to speculate on her own. You pays your money and takes your choice. What's the origin of individuality? Do we need the answer to do clinical psychoanalytic therapy with patients from day to day? I don't think so. Taking the question in its largest sense, it raises other questions: Where did Mozart come from? Einstein? Or William James?

IH: I know you will disagree with this … maybe not. A fully interpersonal theory suggests that history and self are pretty much indistinguishable. That is, self is a function of internalized historical experience. I think we've gone over this to a degree.

BW: By self as history, you mean self as interpersonal-relational. Sullivan, of course, finds it made up of the reflected appraisals of significant others. So if we define self as being wholly and thoroughly historical,

obviously anything else we may say about it is not interpersonal-relational, by definition. But suppose we expand the definition and introduce some prototaxic, nonreflective, unrelational factors. Then, I think we encompass individuation. Is my individuation merely the reactive working-through of the reflected appraisals I've gotten from others? Or can I actively reflect on them, as well? This active side [of] self is missing in Sullivan. Self made up of reflected appraisals is only reactive. Can self actively reflect on the appraisals, and, in actively reflecting on them, change them? I think if he had moved into that—perhaps he didn't live long enough—he would have gotten into the psychodynamics of transference. Okay, do an interpersonal-relational therapy, and you have a very thorough description. Then, how do patients change? Why do they change? I think Sullivan and his associates got themselves backed into a corner here. Now that they know all this, what can they do? They may step into the unknown future of change, so I find, by means of the self-moving experience of transference, in here and now, in psychoanalytic space-time.

IH: The term "counterprojection," is that Sullivan's term or is that Haven's?

BW: That is, I think, Haven's description of Sullivan's procedure, with the therapists in the role [of] defined expert, so that patients, projecting their problems, can't make them stick to the counterprojective therapist.

IH: Basically, he felt that the expectancies people came to therapy with were not confirmed in the analytic relationship, and so, these old expectancies were replaced by something new, more salubrious. He felt that's what Sullivan really did. That was Sullivan's implicit theory of therapeutic action.

BW: Well, one could put it that way. When I first heard of counterprojection, I thought it clearly tagged the Sullivanian therapist. Anything the patient did, the expert could put back into the patient with his counterprojection. What I miss as a complement to counterprojection is affirmative individuation, because I think it's out of the awareness of striving for individuation that change takes place. And it's interesting that Sullivan, how did he put it in the preface to the third edition of Conceptions?—he inveighed against unique individuality or personal uniqueness. I don't know why he so strenuously opposed it. Indeed, he was the most individual of psychoanalysts. Inhospitable though he was to individuation, who knows what he would have arrived at, had he stuck to his own

psychoanalysis with Thompson and struggled his way through. To my best knowledge, after breaking it off with her, he never completed it with anyone else.

IH: I want to circle back ...

BW: I think it was, finally, his systematic operationism. His unique version of operationism didn't leave any room for the uniqueness of the individual. His participant observation wasn't observable. I didn't go on between people. It comes from them before going on between them. Like the emphasis on interpersonal-relational enactment, it's still what's going on between people, without, however, going to the psychic resources it comes from. We have to open those up, otherwise, I think we lack the psychic means to therapeutic ends. What to do, for example, about transformations when you observe your patient transforming you? What psychic resources does the therapist, deprived of unique individuality, use to work through the transformation? That therapist has to articulate something in that experiential therapy that wasn't there before—and so does the patient. Some new dynamic—a psychodynamic, in fact, so far unrelational—has to be introduced. To circle back to an earlier question, that's why I'm into shared experience: It makes therapy a more experiential level field. So the therapist may be free to open up personal resources, rather than be locked into a done script of how a counterprojective expert is supposed to act. Now, do I counterresist the patient because I'm the expert doing analysis and that's required of me by the prior judgment of the first expert for all later experts, no matter the coparticipant experience in the uniquely individual dyad?

IH: In conceptions where transformation or enactment are given a great deal of weight, the patient is the more powerful figure in the relationship. That is, the patient has this transformative power to shape or to affect the other. Your shared experience notion, or your conception of coparticipation, is much more like two people equally influencing each other. Yes?

BW: It's closer to two people working together, two real, whole psyches in therapeutic engagement with each other. If you see the patient as a transforming power, what becomes of the therapist's capacity to transform? Or, from the other side, what can the counterresistive therapist accomplish with a patient who, in turn, also resists transformation? A mighty struggle? A therapeutic impasse? A stalemated interlocking of transference and countertransference?

IH: The thinking would go this way: The analyst is the more recessive party; a participant observer as opposed to a participant-participant.

The patient is the participant-participant.

BW: Well, that's questionable. It may be a genuine coparticipant inquiry, both ways. In which case, both coparticipate, observe, define, postulate, theorize, interpret, and whatever else they may find in psychic experience, each to his personal best.

IH: Back to unconscious. The prevailing notion, by and large, is that things become unconscious because, in some way or another, it's too dangerous for them to be conscious.

BW: I would consider that preconscious rather than unconscious. Preconscious is about something now being kept out of awareness that once was in awareness. Sometimes I think of preconscious as really being reconscious: something once conscious is then pushed out of awareness because, to use the usual metaphor, it's dangerous, unacceptable, and must be kept out of awareness. Later, in a psychoanalytic inquiry where, we hope, nothing is unspeakable, it can be made conscious again, and that's preconscious. I don't consider that unconscious. A genuine unconscious experience I think of as creative, as uniquely individual, such that I may live something I've never lived that way before.

IH: What you're calling "preconscious" most people would call "unconscious." Most analysts wouldn't make that distinction. Now I understand the distinction you're making. You're using unconscious more as creative experience.

BW: Most people don't make this distinction, but psychoanalysts since Brenner and Freud do, if not always clearly: as a creative source of individuation, as a source of uniqueness, as generating something that was never known before. To make something unconscious conscious, I bring something into consciousness that was never there before. Most people who don't make this distinction are usually relational in one perspective or another. The preconscious is, of course, relational, but the unconscious is unrelational. Without this distinction, psychoanalysis suffers an iatrogenic illness I've diagnosed as "relationitis." [Laughs]

IH: You're describing unconscious not as unconscious based on trouble. Things are not in your unconscious because they are too troublesome and conflict producing. It's unconscious because for some reason or another it hasn't been lived.

BW: Never lived before. This is not an imaginary projection of theory. Unconscious refers to real psychodynamic experience that remains unseen until its effects become conscious.

IH: The reason why it's never been lived before, is that always a troublesome reason? The environment isn't facilitating enough? The environment isn't right enough?

BW: Environmental trouble, generally, evokes security operations, defense mechanisms, character armor, whatever the preferred terminology. They keep it preconscious, or selectively inattended. In contrast, unconscious experience intrudes where it's not always welcome, making trouble from within. From unconscious experience we bring something to bear on these troublesome dangerous situations to transform them actively. We sometimes use unconscious resources to resolve preconscious issues, but the issues are still preconscious in origin, held fast in defense mechanisms or security operations.

IH: Is the reason it's unconscious and remains unconscious because the patient's world isn't ready for it to emerge—that there's a trouble out there? I mean, in the best of all possible worlds, would whatever is unconscious just be readily conscious because of a welcoming environment?

BW: I think of unconscious as a more dynamic factor of personality than that, and bringing things into consciousness can involve great struggle, given the varieties of environing beliefs and values. It's not just a question of being open to it, although I think openness to new possibilities is important. A person can find a place to stand, a dynamic point of origin, in relation to internalizations. It's interesting you know, side-by-side with internalization there should be a dynamic counterpoint of externalization, shouldn't there? Or, when we work with projective identifications, we need the dynamic counterpoint of projective individuations as well. In other words, I think there's the problem, too, of language. It's hard to use static language to describe a dynamic process. I think that's part of the problem. If you try to describe identity and identification without reference to the dynamics of uniqueness and individuality ...

IH: You're talking about the unconscious again?

BW: About unconscious experience becoming conscious, it's something unique that's being lived into shared life, that is, consciousness. And to describe that in flat, rational terms does not include the dynamic, emotional side.

IH: The dynamics refer to what?

BW: Dynamics refer to the psychic activity of bringing something into awareness that never was there. Once I bring it into awareness, that's

already relational; then awareness is conscious, and conscious is shared. "Conscious" is literally a shared knowing—a shared awareness—and there's no way to get the genie back into the bottle. Before I bring something unconscious into awareness, however, that's unrelational.

IH: Why not just shared with yourself?

BW: Okay. Then I have to turn myself into the other and share it with another side of self, me. But that brings us to another question, the psychological difference between loneliness and aloneness. The person, you know, who feels lonely in a crowd because there's no selfic place within to stand alone. A person with a sense of self can be alone, capable of knowing itself from the activity of experiencing it. Otherwise, going with the crowd is a very lonely number.

IH: The question that's still not clear to me is your notion of unconscious as distinguished from preconscious. If the setting is right, why doesn't unconscious just emerge? Does there not have to be tension between the individual and the world to keep unconscious, as you're using it, to keep it unconscious? In a facilitating world, it would not be unconscious anymore, right?

BW: That depends, doesn't it, on the kind of selfic experience one has within. You can work with a patient, you know, get locked into something, and the patient just doesn't move. There's an impasse. Patients sometimes come into analysis—you may not know it until you're in it a while—and they hold some things unanalyzable, which they may tell to you when they're aware of it later. And when you get into that kind of situation, the blockage is not outside. The blockage—although the patient may have received it from the world—that blockage is now that patient's baby. The conditioning hypothesis works, here, only to the point where self-direction must take over. To get my point of view, for example, requires the temporary suspension of others. They block it out.

IH: Blockage persists because, at some other point in the person's life, the environment was not open and this was internalized.

BW: Either that, or certain personal elements. For example, from a psychological point of view, you need to have courage to make the effort. And grit: You have to be willing to fail, get up, and make the effort

all over again. These are important qualities, and there may also be some X-factor in the total personality that we don't understand—I'd say we need more research—but we know it when we see it. Some take off; others can't get started. The Gestalt social psychologist, Kurt Lewin, distinguished between the geographical environment and psychological

environment. In other words, put two, three, five children in the same geographical environment with the same parents, and they each have two, three, five different psychological environments of their own. That's not just based on placement in the family, but on what they each bring to the psychic table, so to speak—what resources, capabilities, strivings they bring. I don't know how these things work at their origins in each case, but I later see they do. That's why I consider them unconscious: I don't know why one patient is aching to take the bull by the horns and go for it, while another will look at the bull and say, "well, I have to back off the risk, and do the best I can with what I've already got." Metapsychologically, I guess, unconscious also means a willingness to gamble on life with unknown odds: a willingness to jump into the pool, in order to learn how to swim.

IH: You mean the release of unconscious.

BW: The willingness to follow one's way, one's inner sense of selfic being. If you wish to find your own path, rather than follow the beaten path. I don't expect the environment to facilitate this. Environmental conditioning facilitates, so to speak, only itself. Psychic experience facilitates psychic experience. They intersect in social relations, but remain distinct in psychoanalytic inquiry.

IH: This may be a hard question to answer, but in terms of the way you work, would you say your focus or your emphasis is on what you describe as preconscious or on unconscious? That is, a focus on preconscious would be in some way an emphasis on historically lived experience that brings trouble in the current and in the transference, of course. Whereas a focus on unconscious as you are explaining—I would see transference being less of a factor, since you're talking about unlived experience. Am I being clear at all?

BW: I don't start with an abstract plan. I spoke earlier about the coframe. If I'm working with patients who are overinterpretive, I may, because I'm interested in the other side, become spontaneous. Without plan or principle, just to try working in direct experience with them—what they feel and think, and why they withhold and get locked up

within themselves. To my capacities, I'm prepared for the whole range of their experience. I emphasize unconscious, which is unrelational, to advance the psychoanalytic tradition I come from. I'm trying to expand interpersonal relations to include direct experience, and stretch out the field of possible therapeutic inquiry. So I don't, of course, deny the importance of detailing the preconscious past. I do that as well as any good interpersonal-relational therapist does. To work with resistance,

you can't do psychoanalytic therapy without it. But I think of transference, on the other hand, as a dynamic experience. It's an active, continuous process. Active and dynamic, self-generative and self-moving, transference doesn't lend itself to detailed inquiry.

IH: Describe what you mean by transference as active and dynamic.

BW: Transference is not passive and static. It's the self-moving psychic activity that bears psychic moves and patterned experience. In that sense it's dynamic; it bumps into things; it goes this way, it goes that way; it moves forward continuously. It's going on within us, generally without awareness, and it's going on all the time. And resistance, for example, is part of the experiential content that's being transferred. Anxiety may also be transferred. Aspects of individuation can be moved around, as well, and reworked again.

IH: Resistance to?

BW: Resistance to parents, to significant authorities, to patterns that are developed with the significant people in our past, which transfer into the experiential field of therapy. But the patterns are not the transference; the transference is the activity of bringing them forward. And before you ask why, because through transference patients hope to resolve them. Do we transform patients? Or do patients transform themselves? Who finally directs whose activity of transference?

IH: Well, when experience is transferred and you see it transferred to you, are you inclined to point out that connection? That history to current connection?

BW: It depends. If the patient is too intellectualized, I won't. That would be a kind of folie à deux. I'd be getting too far off into the cognitive or intellectual side. So it depends on where I am with the patient. Do I understand it that way? Obviously, I use the historio-genetic postulate. It guides one's psychoanalytic approach to preconscious experience, I would say, but how I work into concrete situations depends on

who I'm working with, and where we are in the work. If I'm working with patients who are out of their gourd—you know, they're just doing things without any cogent sense about doing them—I might say something like, "that's your transference, that's the way you're transferring your earlier patterning into our relationship." By doing that here, I'm trying to engage the side of the patient that I think is absent.

IH: Sullivan did everything he could to avoid talking much about unconscious and avoid talk about internal structures. Do you think in terms of internal structures? So much of psychoanalysis has been

conceptualized in terms of a mapping of an internal world. Sullivan was so opposed to the body politic of psychoanalysis in this way especially.

BW: You ask two kinds of questions. The first question about Sullivan—I think he did deal with what the people across the ocean call internal structures, or internal objects, but called them personifications. So a personification is—he didn't use this language—similar to introjection. In this way, I think he referred to this internalized sector of experience. But my problem is how he used it clinically: Why didn't he encounter unique individuality, especially his own? Sullivan distinguished among conscious awareness, selective inattention, and disassociation—and I think, albeit a different frame of reference, they closely parallel Freud's conscious, preconscious, and unconscious. I generally use the old terminology and see no need to change it. When Sullivan changed that terminology, he was, nonetheless, still referring to the same dimensions of personality. And when he went into communicational overdrive, so to speak, then he found the syntaxic, the parataxic, and the prototaxic modes of communication. The prototaxic is, I think, one of the dynamic sources of dissociation. Of course, he never used "dissociation" the way writers are starting to use it these days, as a verb that takes an object. He used it to refer to a dimension of personality, which I think is comparable to Freud's view of ...

IH: Unconscious?

BW: Which wasn't Freud's clinical discovery, by the way. It was Breuer's—Breuer started using it clinically in 1880. And before Breuer, you know, the unconscious had been in the philosophical and psychological literature for years. Some who are interested in its history trace it back to Joseph and Pharoah, Plato's Republic and St. Augustine's Confessions. Spinoza explicitly discusses unconsciousness in his Ethics. The power of psychoanalysis, to me, is that we [have been] redeveloping a

method and defining a field of inquiry by which these wild and strange things can be studied in direct experience. So we study human psyche in vivo, as it lives and grows. And we've coordinated a set of principles and practices that make that kind of experiential inquiry possible. It's not an intellectual endeavor, you know. If you want to study psychoanalytic metapsychologies, you don't need psychoanalytic therapy. It's widely known that Freud had practically given up on psychoanalysis as therapy by the early 1920s. And what he was interested in, finally and only, was psychoanalysis as a research tool to further his metapsychology and support his instinctual theory of personality. But if you'd like to study

theory of personality, there's no need for psychoanalytic therapy. You can get that at any good university these days, in the department of psychology.

IH: Agreed. The concepts of internal structures—how relevant are they, to you?

BW: I don't think in that language, but I certainly deal with preconscious patterns. I call them preconscious patterns. They probably have similar clinical referents as internal structures, yet without the object-relational conceptual scheme, which I, personally, happen to find rather cumbersome in its distance from the therapist-patient experience.

IH: One can say preconscious patterns are internalized?

BW: One could say they're internalized. One could say they're personified. One could say they're introjected. One of the things about psychoanalysis I've noticed recently is we have so much redundant terminology, almost a glut of terminology. One term ought to be enough, but it isn't. I think people like to develop new terms for self-expression. It's a quest for increasing individuation, originality, creativity in terms of self. To go back to that earlier question, I think there's a fundamental distinction in self between its origin and its function. And, of course, you're trying to pin me down about the ingredients of its origin. And wouldn't they, in turn, have origins? Ad infinitum? But I don't think we can know what they are until we observe their function. Origin is always inferential. In other words, you always know it in retrospect—that is, only after becoming consciously aware of it. The matter of ontology preceding epistemology again.

IH: I know this is something I asked you about last week, but I'm still a little bit vague about it. To what extent do you have a theory of human development?

BW: Okay, you raise this very good question again. Perhaps I didn't

make myself clear enough before. I'm going to give two kinds of answers. One is, if you ask me for the professional answer, I say go to the literature, where the various theories of human development are proposed. But I think—now I'm going to the second point—those theories of human development are usually used as built-in mechanisms to defend the therapist's asymmetrical position in relation to the patient. It gives the therapist some sort of expertise to offer the patient, but which, consistently applied, tends to intellectualize the therapy. Third point: I think anyone who thinks about it has a theory of human development, not to say elaborated the way Sullivan did in his Conceptions, or Freud in

his General Introduction. I think everyone has at least the rudiments of a theory of human development, in the sense that they have developed some idea of who they are, why they got that way, where they got into deep trouble, and how they hope to change. And, moreover, psychoanalysis moves from a monarchial to a democratic world, where therapists work with patients on a level experiential field—you see, that's another thing too about doing therapy as shared experience and shared inquiry. It's not the therapist's development interpretation that patients have to accept in order to be cured, which they're not. Patients develop their own metapsychology. Some, for example, have a supreme belief in authenticity; others don't: that's their prerogative, their choice. Patients may believe whatever they come to believe. Everyone has beliefs and values to make sense of their human development; and it's part of the therapy that they become more aware of their own beliefs and values, in the face of the therapist's theories. I mean, they may legitimately hold their own even when they clash with the therapist's. Therapists don't usually set out, not in this country, not at the end of the twentieth century, to convince the patient of the superior value of the therapist's metapsychology, the way classical psychoanalysts once did. When patients left Freud in hostile resistance, and the transference turned negative, he didn't understand what the hell happened. But that's what happened: they felt unheard, became hostile, and left him. Patients didn't have room to say what they believed about themselves because his metapsychology was always there, front and center, getting in the way. We've changed not from a one- to a two-person psychology—we still use both—but to the metapsychologies of the two persons. Psychoanalysis is not the patient accepting the therapist's interpretation; it doesn't happen that way.

IH: So, how do you deal with the fact that everybody has a theory, even if it's not a theory of Sullivan, or Freud, or some other major figure.

Everyone has, at least, a personal theory. How does one not impose this on the patient?

BW: How? Work with the experience, work with your feelings, thoughts, intuitions, and so on. Work with what's happening between you and your patient. Obviously, if I see evidences of psychic abuse that first took place in early childhood, when I hear references to a recurrent history, I pay attention. Or, if I find someone tends to get into a hypnoidal thing and just echoes the ideas of other people, I get into that, too. Why do that? Because I think it represents failed or unrealized individuation. In other words, there's a preconscious pattern that's being presented for

psychoanalytic therapy. I do work with preconscious patterning, but I think the unconscious present is far more important from the standpoint of change, growth, individuation. Now, if this means a developmental rather than a clinical theory, let's consider the difference between experience and value—more generally, between psychology and metapsychology in psychoanalysis—and see how they approach therapy.

IH: When you say that you try to work with experience, how is your experience not affected by your implicit theory? How do you escape yourself?

BW: I don't. I have my belief system, my patients have theirs. But our work is not about them. I'm not value-free. Obviously not. The important thing is, working analytically I'm not implanting values. I'm doing psychological exploration. When I do psychoanalysis, I do psychoanalysis. When I do value theory, I do value theory. Obviously, I have my own values and I bring them to the therapeutic situation. And [patients'] values, I think, are as important to them as mine are to me, and I hope they respect mine the same way.

If patients want to start poking around my values, I'm cool. Anything they want to know about my values—it can be resistance, but not always; it can be transference-countertransference, but not always—as long as we're both clear we're doing psychoanalysis, not axiology. The center of our work is the psychology of our experience, interactions, connectedness. I have my beliefs and values, and my ideas about how people grow up—I don't park all that outside my office when I close the door. I obviously bring them in with me, along with a lot of other things. But that's not what I'm working on. I'm not motivated to advance a particular social and political ideology, nor to extend a particular theory of

human development. They're not matters of immediate psychotherapeutic concern.

IH: It's clearly your emphasis, and I certainly hear Clara Thompson there too, in her warning about strong theory, and how much strong theories tend to dominate the therapeutic interaction. That was probably one of the worst aspects of classical psychoanalysis ...

BW: I'm glad you brought up Clara here, because she said the same thing you do, only about Sullivan. She once remarked that we shouldn't idolize him at the White Institute in the 1950s. I've often wondered, since then, whether she already sensed the one-sidedness of Sullivan's interpersonal relations without psychic uniqueness.

IH: Because of a theory that could be too strong?

BW: That we'd be burdened by theory—Freud's, Sullivan's, or anyone else's—and it could cloud cloud our capacity for new perception, new

observation, new inference, new insight and outlook. There's something alien—sort of un-American—about blindly following leaders down their darkened paths of catch-phrased dogmatism.

IH: So you're burdened by the theories of the icons, but we all have our own humble theories. How does that not dominate your interaction, your whole experiential focus? I mean, how do you hold back your values, or subsume your values?

BW: If I got into that position, I'd be trapped in a self-fulfilling prophecy. Psychoanalysis is not, in my view, a value-centered therapy. My idea is: don't hold values back; don't set them forth. Just leave them be, and stay focused on the distinctly psychoanalytic business at hand. Earlier, I mentioned Wolstein's "law": Every therapist is unique, every patient is unique, every dyad is unique; and I apply this radical uniqueness to the psychoanalytic side of beliefs and values.

IH: If there's anything that should go on your tombstone, I think, that is it.

BW: No. No. "Free at last, free at last, thank God Almighty, I'm free at last" [laughs]. Okay. I understand what you mean.

IH: That notion of uniqueness is a very powerful contribution of yours. Now, in that context, are there any universals at all?

BW: You're asking about my beliefs, again. The belief in individuality; the value of truth; the ideal of self-fulfillment. Having arrived at them

over the years in philosophy and psychoanalysis, I've placed them further and further beyond question. But not completely, because that's a cardinal condition of how I think: nothing is forever.

IH: Would you say that there's something that everybody has?

BW: Yes. Active and reactive sides of experience, or active and passive sides of self. A striving for separateness or individuation; a striving for connectedness or relatedness. I prefer connectedness, by the way, to relatedness. It refers directly to psychic experience, not to the narrative we relate about it.

IH: But you see this as a universal?

BW: I can't say, literally universal. I have to say, very highly generalizable. As someone recently said to me, have you worked with people in the rainforest yet? Or with Eskimos? And, of course, I haven't. So, I have to say, very highly generalizable. There has to be an empirical edge of openness to possible new knowledge. After all, in spite of all the variety, my clinical sample is still rather limited, and though my

expectations for the next patient may be highly probable, nothing's ever certain.

IH: Well, you were describing what your "close-to-universals" are.

BW: And never-to-be universals—now that's a "universal" I can live with. They're clinically generalizable. For example …

IH: You earlier talked about the striving for connections, for connectedness.

BW: When, for example, I'm working with resistance, I know—I won't say it's universal, but as a practical rule—there's always anxiety around the corner. I think that's a very well established psychoanalytic generalization. Or when patients are in the throes of anxiety, and I am patient enough to live through it with them—and without, of course, getting whacked out of shape by counteranxiety—at the other end of that experience of anxiety there will be a clearer sense of individuation, a more secure sense of self. It takes a reasonably clear sense of self to be able to step out of the whirling turbulence of anxiety and into the open space of direct connectedness. For instance, there's a psychic connection taking place between us, too, and that's not reducible to the words we use to relate it. What's going on between us is not just words, spoken and related.

IH: So, "connection" is a much more profound word.

BW: Not more profound, more psychic, and in that sense more to the

point. Recall Magritte's painting of a pipe with the logo spelled out: "This is not a pipe." The same holds true for our connectedness: "This," our relation of it, is not the connectedness. You can't smoke Magritte's painted pipe; you don't experience Sullivan's interpersonal relations. A psychic connection then precedes the relational narrative about it. It's more accurate, I would say, to describe what we're dealing with in the clinical psychoanalytic situation. In other words, we're not just dealing with the secondary relation of stories, we're also dealing with primary experience of direct connection.

IH: Uniqueness and direct connections; you like them.

BW: Yes, but uniqueness makes no sense without shared experience. I became interested in uniqueness in the context of Sullivan's denial of it. I only started working at it seriously in the early 1970s, with a brief report entitled "Interpersonal Relations without Individuality," and I continue this major effort to expand this frame of reference, in order to accommodate our expanding range of clinical psychoanalytic inquiry.

We have to expand the interpersonal-relational field of inquiry. Narrow it down to mere relationalism, and there's no leverage for psychological change. But the keepers of Sullivan's interpersonal relations didn't generally accept my critique then—some still don't now—so I'm in the unwanted position of espousing a unique post-Sullivanian point of view. That's okay: time will tell.

IH: I have said in my published writing that you, more than anyone else following Clara Thompson, are responsible for bringing interpersonal psychoanalysis closer to the analytic mainstream of addressing themes in the transference-countertransference matrix. Prior to Thompson and yourself, for the most part, Sullivan's avoidance of the articulation of the here-and-now interaction characterized the interpersonal perspective and helped isolate it from the body of organized psychoanalysis. Though you may have trouble identifying yourself as anything close to "mainstream," your two pivotal monographs, Transference (1954) and Countertransference (1959), were instrumental in shifting the interpersonal psychoanalytic focus away from the exclusive "there and then," to a focus on the analysis of the analytic interaction. In my mind, no body of work was more significant in the effort to transform interpersonal psychiatry into interpersonal psychoanalysis. Please comment.

BW: I didn't fully realize how mainstream those two 1950s monographs were until I read Ferenczi's Clinical Diary and saw Thompson

as my link. In Transference, I had worked out the interchangeability of transference and countertransference, as well as the space-time centrality of "here-now," where past and future meet in psychoanalysis. And soon after, in Countertransference, I began to see transference and countertransference converging in an "experiential field of therapy." And later, in Theory of Psychoanalytic Therapy (1967), I continued to describe the psychoanalytic inquiry and experience as coparticipant, involving two uniquely individual psyches, their Austrian ego, British object, or American interpersonal relations, as well as everything else in their total personalities.

At the time, to continue the stream metaphor, I think I was riding the waves, and if you've ever done body surfing, you know you can't always tell where you'll end up. The joy of surfing is going all out to where the wave takes you. There I was in the early 1950s: working with patients and in personal analysis, deep into Breuer's and Freud's writing on procedure, and still reading American philosophical psychology. Out of this mix came the realization that traditional psychoanalysts were working only with interpretive metapsychology, and that, in

fact, they believe they should do no more. Left out of this clinical picture was the whole empirical world of direct experience between therapist and patient—the felt and thought experience directly undergone and describably "here-now" in psychoanalytic space-time. To get into this direct experience required no more, or less, than the reconstruction of psychoanalytic theory and practice, especially the traditional view of countertransference and, with that, also transference. Which meant, for psychoanalytic therapy, going into the relativity of transference and countertransference, instead of making them self-enclosed processes that a therapist and patient could live out in each other's presence, without at all impinging on each other in ways they could both explore in order to expand awareness.

So while it's true that my 1950s monographs moved the therapy of interpersonal relations closer to the historical mainstream, you must remember that, in the late 1940s and early 1950s, the mainstream still hadn't reached the point of psychoanalyzing the empirics of transference converging with counter in vivo. Recall Winnicott's late 1940s papers on countertransference. Mainstream psychoanalysis got to the transference-countertransference complex later: for example, Stone's *The Psychoanalytic Situation*. The reconstruction sought in both my 1950s monographs, I now think, pointed in two major directions: first, toward reconstructing

interpersonal relations closer to the psychoanalysis of transference and countertransference; and second, reconstructing psychoanalysis closer to the "here-now" experience of direct coparticipant therapy. Given Sullivan's and Thompson's extraordinary clinical empiricism, the pluralistic culture at White was open to this new freedom in psychoanalytic exploration.

A final word about theoretical compatibility: I think my work is compatible with everyone's work. In other words, what I'm working at is clinical and most clinical psychoanalysts will find my work compatible, whatever they may be doing. Interpretively, no; but then, I'm not building an interpretative system for them to follow. Our predecessors were overly enamored with the magical therapeutics of interpretation, and they counterproject their own belief and values onto their patients.

IH: Okay, I think this is enough. Thank you. This was a rare privilege for me. You've always been one of my psychoanalytic heroes.

BW: Thank you too. In spite of some passing complexities of language and terminology, we've covered a lot of ground. And I'm ready, for better or worse, to let it go now. To separate, as we say, because we connected.