Roles in the Psychoanalytic Relationship

Who we are depends on the situation we are in. Psychoanalysis, like any other recurrent social activity, is conducted under the influence of implicit social roles. Our technical emphasis on free association and other unstructured aspects of the analytic setup tends to minimize awareness of the degree to which both analyst and patient orient around role expectations. The analyst's role is the result of enculturation during training and after; the patient's role is a product of character, transference, and analytic influence. This paper explores the way in which the alternation and tension between role and nonrole aspects of the psychoanalytic relationship is at the center of therapeutic process and change. The author illustrates the way in which role and nonrole aspects of process appear in a case study, both over longer stretches of time and in particular moments. Understanding the importance of analytic roles clarifies some dilemmas and contradictions in older discussions of technique and modern relational theory.

The central point of this paper can be derived from the following comment attributed by Brian Bird (1972) to Fairbairn: “You can go on analyzing for ever and ever and get nowhere; it's the personal relation that's therapeutic.” If Fairbairn felt this way—and if in our heart of hearts many of us do—what does it mean? What are all the years of training about? All the reading, the study groups, the mulling and consulting? This paper answers the question by arguing that “analyzing” provides a special social structure for the personal relation. The analyst and the patient operate within a specialized role framework. The contribution...
I am indebted to Jane Kite, Ph.D. (2006) for drawing my attention to this statement.

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here is to emphasize an interface in the relationship between its prescribed elements, what we call on our side “analyzing,” and its more spontaneous elements, based on character and on impulses stimulated in the moment. We tend to garb analyzing in formal terms like interpreting, empathizing, or listening—but these may also be seen as aspects of the role behavior peculiar to the person working in the analytic role. Similarly, transference, regression, and resistance can be understood as role behaviors of the patient. This view of analytic therapies as processes conducted within a role framework can help deepen our understanding of mutative process, including discussions of one- versus two-person psychologies, enactments, moments of meeting, and dynamic systems.

The history of the role relations in psychoanalysis derives from the origins of clinical analysis in Freud's background as a neurologist, treating individual patients, while seeking to develop a general theory of mind. As a by-product he created a therapeutic/investigative technique that is dyadic, hence social and interactive. Freud was not a social psychologist interested in conceptualizing two-person phenomena. You may immediately ask, “What about resistance, transference, and countertransference—are they not implicitly dyadic?” Yes, but each of these is intrinsically an intrapsychic concept related to distortions in perceiving or reacting to others. In each case, Freud was concerned initially with the phenomenon as an impediment to psychoanalytic progress. His genius was to recognize—assertively in the instances of transference and resistance, and tacitly in the
case of countertransference—that what was getting in the way could become a therapeutic opportunity (Freud, 1905, 1912a, 1912b). Freud stuck to analyzing as the way to exploit the opportunity. That is, he thought about transference and resistance in one-person terms, with the analyst remaining in a role on the sideline, interpreting.2 A century later we can recognize not only that psychoanalytic treatments involve a relationship but that any relationship that becomes professional implies a social role structure that will have an important impact on what transpires in that relationship.3

2 It is worth noting that Freud as a clinician was liberal in his use of the relationship to establish trust and authority with his patients (Lohser & Newton, 1996). The “classical” technique that has come to be seen as his creation reflects certain of his technical recommendations, combined with a greater stringency of the second generation of psychoanalytic leaders.  

3 There is a voluminous literature in sociology and social psychology on the subject of social roles and role theory, including its application to physician-patient relationships (Parsons, 1953). A simple definition of role theory states that “it addresses the manner in which social situations are structured by extensive sets of rules or expectations” (Almond, 1995)

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The Analytic Role

The reader is familiar with the history of emerging recognition of the relational quality of analytic process, beginning with the Kleinians' emphasis on countertransference (e.g., Racker, 1957);
Sullivan's (1953) interpersonal psychology; and, over the intervening years, a growing variety of conceptions about how the dyad works (e.g., Aron, 1996; Beebe & Lachmann, 1998; Davies, 1994; Ehrenberg, 1992; Greenberg & Mitchell, 1983; Moroda, 1991; Pizer, 1992; Stern et al., 1998). The thrust of these conceptions has been to relocate the center of mutative action from impulse/defense processes in the individual, to patterns of interaction taking place in the therapeutic relation. One of the challenges in taking a relational position has been to define what differentiates the psychoanalytic bond from another sort of relationship. If the analyst uses techniques that are more responsive to the patient's affective press, what are the consequences? For example, Renik (1993) writes about the analyst's “irreducible subjectivity,” stating that we cannot control the unconscious contribution we make to the relationship, that we can only analyze it after the event. Does this mean, then, that psychoanalysis is an alternation of wild, subjectively driven moments and dispassionate rehashes? This hardly describes most analysts' experience.

Hoffman (1998) also framed the issue in a binary way—as one of “ritual and spontaneity.” That is, the analytic relationship has a format with a number of predictable, characteristic features. These tend, Hoffman argued, to create a sense of authority for the analyst, through his anonymity, and other aspects of control of the frame and discourse. In return, the patient receives a “scaffolding of protection,” a “safe environment,” “rules of the game” (p. 220). He contrasted this vertical authority relation with a horizontal one—using a term borrowed from anthropologist Victor Turner, communitas—in which the members of a group or, here, a dyad are in a state of essential equality of status.4

What is transformative, however, is not this action alone [the analyst's recognition and affirmation], but a continual struggle with the tension between spontaneous responsiveness and adherence to psychoanalytic ritual and a continual effort in Turner's (1969)
word's “to accept each modality when it is paramount without rejecting the other.” (p. 235)

4 For a more extensive discussion of the concept of communitas in therapeutic situations, see Almond (1974).

The point I introduce and illustrate is that these seemingly extreme statements (“irreducible subjectivity”) and dilemmas (analytic authority vs. communitas) are mediated by an important aspect of the psychoanalytic situation—its role structure. All the phenomena that analysts speak of in trying to conceptualize process occur in a social-psychological context where the internal motives that lead to behaviors are modified en route by highly complex role experiences. When we state, for example, that “the analyst contained the patient's rage,” we are using a metaphor to express that the analyst understood his role to involve inhibiting counteraggression to the patient's attack—or, perhaps, gently but firmly setting limits on the patient's violation of the frame of treatment. In a more general sense, what I am saying is closely related to Sandler's (1986) point about the analyst's avoidance of “role-responsive” reactions—although my use of “role” is quite different from his. Sandler referred to the tendency to automatic, affect-driven reactions to moves on the patient's part, much like Racker's (1957) “complementary countertransferences.” In my usage, “role”—here as an internalized, specialized ego function of the analyst—enables him to restrain automatic, countertransference-prompted responses.5

Adult social relationships are framed by role definitions of the parties involved. These role definitions are not hard and fast rules such as those for being presented at court but more general
collections of attitudes and mental guidelines. Freud's (1912b, 1913) two papers on “recommendations to physicians practicing psychoanalysis” represent the earliest formal statements of the analytic role. There have been others since, although, like Freud's, not couched in terms of role but of technique. Schafer's (1983) volume, The Analytic Attitude, spoke to the internal psychic position that conditions the analyst's role. Kantrowitz's (1993) work on “fit” in the analytic dyad has raised the issue of the analyst's role. In a paper titled, “The Analytic Role,” I delineated a number of elemental role components and argued that having an internalized role enables the analyst to mediate powerful transference input from the patient and countertransference action pressures in himself (Almond, 1995). I categorized “attitudinal guidelines” like professionalism, neutrality, curiosity, affirmation, and helpfulness; “interactional guidelines” like selflessness, anonymity, and abstinence; and “communicative guidelines” like minimizing automatic responses, controlling affective intensity, maintaining receptivity through silence and other means, forthrightness in expression, avoiding either/or thinking, making connections, and

5 For convenience, I use male pronouns in talking about both patients and analysts generally.

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drawing attention to sources of anxiety. I also alluded to tactics, which tend to vary more among theoretical schools. All of these add up to the role, which is not one fixed set of behaviors but, like most social roles, a group of guidelines for how to function in a given social situation.

The analytic role is a complex psychic structure, an aspect of adult
identity (Erikson, 1950). Its development is the result of a long, arduous process of learning, including cognitive, individual, and group identifications and conviction elements (Grusky, 1999). Theory, and affiliation to like-minded theory groups, supports the analytic role in an ongoing way (Almond, 2003). My aim here is not to describe the role in further detail but to emphasize that one way of viewing the analyst is as containing within himself a continuing tension between role and nonrole potentialities.

The Patient Role

The patient is also affected by role—in two ways. The patient enters the analytic situation with an idiosyncratic conception of what is expected of him, what he wants, and how he is expected to act. We are accustomed to thinking of the more object-related, fixed, repetitive aspects of these expectations as transference. However, the patient will almost always disguise the transference within a more socially appropriate role-conception—something like, “I am here to tell the story of my symptoms—or complaints about my parents—or guilty feelings.” As analysts, we usually regard this patient role behavior as resistance, or a manifestation of anxiety, because it obscures deeper sources of conflict and stasis. We intervene over time in ways that in one language can be called “interpreting the resistance” and in role language can be called “inducing a new role.” I explored this in “The Patient's Part in Analytic Process” (Almond, 1999), where I proposed that the analyst has in mind a series of role expectations for the patient and, overall, seeks that the patient learn to become more flexible in moving between different positions. For example, a patient who provides only narrative is helped to edit (i.e., to self-observe) more, whereas a patient who can only self-scrutinize is encouraged to associate more freely.

To summarize the role situation of psychoanalysis: The analyst
begins with a fairly well-defined idea of his role, although it will change somewhat over the course of an analysis, while the patient enters with a more idiosyncratic interpretation of his role and gradually adds patient role capacities. We know, of course, that in practice analysts tend to be more role-bound early in analysis and less so in the later phases. Similarly, a patient may be

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“too good” at the analytic patient role (Fogel, 1995) at the outset, so that what seems like desirable role behavior is actually being used to hide the spontaneous and impulsive aspects of their potential completely from view. But my point is not to make a simple, universal claim about the arc of role-nonrole interface over the course of analysis. It is rather to emphasize that this interface is present at almost every moment and that there is value in taking it into account.

What Is Role and What Isn't

When I open the door and welcome the patient with a practiced “Hi!” or “’Morning!” I am largely role occupying. When I open the office door, just after an hour, and find my previous patient shoving aside the six free copies of TV Guide that have just fallen through the mail slot so that she can get the exit door open, and we both burst into laughter, we are suddenly both outside of our roles. More accurately, every moment of human interaction contains aspects of both—unmediated impulses and traits on one hand and role influences on the other. Most moments, especially for us as analysts, are admixtures in which our role protects us from taking action more passionately or violently than would be safe for the relationship. Pizer (1992) and others have pointed out that many people remember most vividly from their analyses those moments when their analyst was “real” by responding directly, affectively,
or with a personal anecdote, often at a moment of intensity or personal crisis. Stern et al. (1998) suggested that “now moments” are the pivotal points of treatment when the independent, nontransferential internal processes of the two persons in the treatment relationship meet irrevocably and alter both. These are only two examples of many from the current literature that suggest what is mutative occurs in the tension between, or the shifting between, the everyday state of relatedness in the analytic relationship—which I would suggest is the heavily role-related aspect—and a more spontaneous state. Further, many propose that it is the sequel (i.e., the return to the analyzing role relationship) where the moment of spontaneity is then “understood,” that stabilizes change made possible by an enactment, moment of meeting, affective exchange (Jones, 2000; Kohut, 1984; Renik, 1993).

A Clinical Example

In the following case study, I focus on the ebb and flow of role versus nonrole dominated aspects of the relationship at selected phases of an analysis.

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My patient, Mr. G, first came to see me amidst an acute crisis characterized by great anxiety, indecision, and secondary depression. He had just accepted an executive position locally, a prestigious one, in a nationally known company. His decision to move from his prior company had been agonizing, as it involved leaving an influential group he had been instrumental in forming. Mr. G felt guilty about abandoning his former coworkers. In addition, his move had the internal meanings of an act of revenge and competitive triumph over one of his former colleagues. His decision to move had become so difficult that Mr. G had changed
his mind several times, exasperating all concerned. He had become increasingly anxious, desperate, and unable to act until forced to by those around him.

When Mr. G began treatment he was in a highly agitated state, and he created interpersonal pressure to join him in the subjective reality of this agitation. However, I found it relatively easy not to become caught up in his anxiety and to direct his attention steadily to internal sources of his anxiety—his guilt and anxiety about the aggressive meanings of his recent move. Mr. G calmed down relatively quickly during the early, more psychotherapeutic phase of his treatment during which I saw him four times a week, sitting up. Although in a single case we can never know what brings about change, I believe that an important element was this last aspect of my calm in the face of his anxiety. Yes, I made interpretations about the sources of his anxiety and got him working on looking at them. But Mr. G had had a good bit of treatment before, and I suspect that I wasn't telling him that much new. What I believe was new was the persistence of my inquiry, my conveying along with my words that I believed he was—behind the anxiety—capable of working and of mastering the affects and impulses that now seemed overwhelming. My persistence, in turn, we can trace to an interesting combination: my role as analyst, and my more idiosyncratic personal reaction to Mr. G. These two were acting in tandem here, so that despite day-to-day threats of his moving back to his old job, becoming paralyzed with anxiety, I was relatively unperturbed. On Mr. G's side, his interpretation of the patient role included a passive surrender, following his aggressive break with the old company, so submitting to my calmness was reassuring. The “fit” here is one often seen in the “honeymoon phase” of analysis—some aspect of the patient's needs and character translate into the role of patient in a way that works smoothly with the analyst's role. The improvement that results is an outcome of the role relations, but temporary, as there has been no full engagement with nonrole
aspects of either party. In the older language of psychoanalysis, the transference neurosis had not been established.

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Once the treatment was converted to the couch and an open-ended psychoanalytic commitment, things became more complicated. Now Mr. G, although much calmer and engaged with the more routine aspects of his work, became irritated when I tried to introduce his feelings about me into the analytic discussion, saying, “It's just what analysts always want to do—talk about themselves.” He insisted on talking only about the growing deterioration of his relationship with his girlfriend. There are various ways to describe this resistance to acknowledging the transference (Gill, 1982). What I want to emphasize is how I was forced, in effect, out of my preferred analytic position, one Mr. G was sophisticated enough to recognize. He was saying, “No, we aren't going to talk about my feelings about you, we are going to talk about my feelings about my girlfriend, how she treats me, how I worry about her, what I have done to her—and you will have to talk with me about that.” Of course, it could be argued that Mr. G was invoking simply a different transference, a paternal one, in which he made me the withdrawn father who let Mother and him play out an exciting fantasy of being Mother's phallic-narcissistic extension. Or Mr. G could be seen as projecting his narcissism onto me, and attacking me for it. We know that transference is present when the patient denies it, or refuses to discuss it, as here. I am addressing, however, what I think may have been the salient aspect of the situation of treatment during this time.

For more than 2 years Mr. G's relationship with his girlfriend deteriorated, a direction that was clear to me and others but one that he could not accept—despite his worrying. Finally, she left him and moved to another part of the country. Desperate now to save the relationship, he arranged a work assignment for several
months in her area of relocation. He continued the analysis by phone during this pursuit, which was unsuccessful in bringing about a reconciliation. But the separation had an effect on the analytic process: Mr. G gradually began to be able to consider his transference feelings and think about his dislike of my pointing them out, as well as other transference feelings—about separations, feeling criticized, and so on. Increasingly, Mr. G also became able to feel positive affects in sessions, noting that he would enter in a state of agitation and gradually calm down, and even at times have a warm, relaxed feeling. It became clear to both of us—implicitly at first, but then openly acknowledged—that these feelings had to do with me and our relationship. In his external life, Mr. G progressed to successively more appropriate and satisfying relationships, and he began to be productive once more. All of this could be described in a number of ways having to do with the working through of narcissistic defenses.

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In terms of role-nonrole action, I think that Mr. G experienced my willingness to continue the analysis by phone as a major nonrole event. I was willing to hang with him through his anxiety-driven action. More specifically, unlike his father, who remained uninvolved in Mr. G's childhood struggles to separate from his mother, I was willing to go through his enacting a double separation—passively from his girlfriend, actively from me. I want to make clear that all of these events and positions had significant transference meanings, some of which were analyzed at the time. By emphasizing the nonrole aspects I refer to the significance of the role relation-ship—whether we continued the analysis by phone at this time—and that I believe that it was the role situation that made the transferences particularly salient at this point. Of course, my behavior remained relatively steady during all this action. What I am getting at when I refer to its “nonrole” quality is that in the context of internal meanings of transferences and
previous therapeutic experiences, Mr. G was having a significant experience with me that had to do with the meanings of how he enacted the patient role and I the analytic role.

During the midphase of the analysis, Mr. G's sessions became litanies of his lamenting to me his lack of promotion and invitations to give important presentations. Mr. G filled hours with reports of his preoccupation with feelings of envy and rejection. Although there were a variety of transference meanings contained in Mr. G's repetitive pattern of complaining, a central one being enacted was the fantasy that he would eventually passively and magically triumph, sidestepping the preoedipal and oedipal anxieties around taking action. The latter included a fear that his mother would humiliate him by exposing his inadequacy.

Ultimately, the interactions around Mr. G's complaining became more complex, subtle, and interesting. I was silent more often; he “came out of it” on his own more. Finally, he engaged in a piece of acting out in the form of extra-analytic research: He Googled me. Now he found out about my family, my analytic credentials, and my publications. Of great interest to him was that my father had been an eminent academic. This led him to think about what I might have had to deal with, that I might be familiar firsthand with accepting the greater reputation of a competitor, something he found so difficult with more successful colleagues. I had to press Mr. G to look at these speculations, but when he did, I was quite aware that we were talking about something very palpable.

Although I was not going to tell him my history, I acknowledged, in referring to the presence of these interests and issues, that there was a story. In one hour I made a slip in phrasing: I noted his “interest in my struggle with a famous father” (italics added). Although neither of us commented directly on this phrasing, in the following hour, Mr. G found himself for
the first time briefly feeling at peace with his life as it was, its satisfactions, and accomplishments.

From the point of view I am taking, what is striking is that Mr. G had found a way to both be a patient—in his role (he has a complaint to bring me)—while being himself in certain crucial respects. He wanted to be prominent in a magical way through his earlier smartness recognized by mother, and by being prominent never to have to worry about “recognition” again. But such wishes induced fears of castration by one or another parent. He wanted me, I would venture, to bring this about in some magical way, as his mother once could, but perhaps in an even better version, without my appropriating his accomplishments for my needs. At the same time, he wanted me to step in and recognize that the demand for greatness is excessive, that it places a strain on his capacities and denies him real selfhood and love.

On my side, I was recognizing him through his impact on me and my impulse to react in a complementary way, that is, a manner that corresponds to his internal object relationships (Racker, 1957). Mr. G expected that his distress about feeling over his head would be that his object would not understand, and would continue to need him to succeed, or would withdraw. My initial reactions of “But you haven't been productive” probably had this meaning for him, that is, that I was withdrawing in the face of his insistence. When I later said, “I have the feeling you want something from me,” I may have been getting closer to recognizing and acknowledging his inner situation, that beneath the complaining was real conflict that he could not deal with by himself. Here, Mr. G could hear me describing how I was working to function in my role, struggling with it, admitting limitations openly, as I was not able to identify what he wanted from me.6

I also believe that Mr. G's Web search—something that he could have done at any point in the analysis—occurred at this point as an
active version of the same process. That is, in searching for information about me, he knew he would learn something about the “real” Dr. Almond, and then, whatever he learned, that could be put in contrast to Dr. Almond in-role, who evoked a variety of meanings for him. I am avoiding the word transference here because both of the guises in which I appear are capable of transference

6 I was not unaware of the numerous possible transference meanings of Mr. G's complaining, including his envy of my nurturing function, his need to display himself in a position of masochistic surrender, and so on. What is presented here is the interpretive level that I felt he could hear at this point.

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meanings for him, and what is important is that he could use the discrepancy between the person he found out about and the person he experienced in the office to create a new experience. In this new experience he could momentarily see someone dealing with the problem of a famous father and therefore having to come to terms with compromises of infantile grandiosity and oedipal anxiety. If I had had to accept set downs, perhaps he could. In his mind he could simultaneously experience the transference version of me—as larger-than-life father/mother—and the life-size person he had discovered through his research.

What I am trying to bring out is the continuous shifting between the real people of the dyad and the roles they play as patient and analyst. This shifting between role and nonrole aspects of the relationship—driven by characterological and reactive forces in both parties, reverberating within the framework of the role structure—makes for psychoanalytic process (Friedman, 2005;
Hoffman, 1998). This view does not insist we choose between models in which the impetus for change begins with the patient (Weiss & Sampson, 1986), or ones in which it begins with the analyst (Raphling, 2002). It allows for a variety of analytic processes, unique because of the histories and temperaments of the two parties but sharing the commonality of a more-or-less similar role framework.

## Discussion

In The Dynamics of Transference, Freud (1912a) depicted a significant challenge in analysis: The “cause” of symptoms exists far in the patient's past, but therapeutic work can only be done in the present. By 1912 he had recognized that intellectual understanding—interpretation of these past events alone—was not sufficient for mutative influence. Freud now suggested that under the conditions of psychoanalysis the patient engaged the residue of the past in a new relationship—the transference neurosis, a creation with the analyst. His paper ends with the well-known reminder that the dragon cannot be slain in effigy. Although this observation provided the basis for all of modern psychoanalytic clinical theory, it can also be argued that Freud's introduction of the concept of transference paradoxically also created a certain distance from the immediacy he was identifying (Szasz, 1963). The analytic setup does facilitate affectively intense states of mind in both patient and analyst in a relatively unprotected situation. Szasz pointed out that Freud's introduction of the idea of transference provided a way to create emotional protection for the analyst in the heat of this situation.

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By having a label for the patient's subjectively based behavior, the analyst could protect himself from becoming swept up in reacting
My way of putting this would be that the two parties can deal with this potentially confusing and chaotic situation because it is framed in the social role structure of analysis. When the constraints of this structure break down we speak of a “psychotic transference” if it is the patient who loses track and of “boundary violations” if it is the analyst who does so. For the patient, the situation is structured, as Freud observed, by both desires and resistances organized around the person of the analyst. We can add that the patient has role expectations that he brings along about the situation. Another way to appreciate what is at the core of the analytic situation in this real/role tension is by considering it as a rite de passage (Turner, 1969), in which dramatic personal psychological changes occur in a social context (Frank, 1974).

I think in psychoanalytic technique Freud happened upon a method the mutative essence of which captures the same elements within the simple framework of the office and the couch. The free associational request serves as a disconnecting pressure/invitation to the patient who, against resistive constraints, will begin to let his mind wander. As this happens, nonrole elements will increasingly pervade the interaction with the analyst. One of the reasons that the patient role is so little defined in psychoanalysis is to facilitate the “stripping away” of the garb of familiar, protective social roles as is often done more literally in the rite de passage. In these ceremonies, the initiate is often exposed to secret rituals and required to pass tests that speak to learning the values of the group. Although we abjure indoctrinating patients, we do want them to become “good patients,” capable of self-reflection, “good” hours, and working through.

Mr. G's active forays into action, as I have depicted them, were complex, occurring well into his analysis. They can be understood as involving his difficulty relinquishing a subjective gratification.
stemming from maternal excitement about his mind in favor of a wish for different sorts of gratification—real dependencies involving mutuality, and real work involving limitations and risk. Both were part of his relation to me. To get

7 The link between Freud's development of psychoanalytic technique and rites de passage is not as unlikely as it might seem: Many writers have noted Freud's heritage from Jewish tradition, and Bakan (1965) specifically links psychoanalytic technique to the mystical aspects of this part of his experience. Hoffman (1998), as previously noted, picks up on this in his use of Turner's concept of communitas to characterize the leveling state that I would suggest is created in nonrole moments, that are part of rites de passage.

from the former to the latter required a shift that exposed him to painful amounts of shame and humiliation. He did not want to be the only one undressed during his rite of passage, so he arranged to undress me. I cooperated by having a noteworthy father whom he could discover and by being willing to acknowledge at one moment that this had presented me with a psychological challenge. These face-saving real moments offset the shame that was associated with our analytic roles. Once the shame was tolerable, he could accept the closeness, dependence, and paternal authority that he so longed for. Of course, all of this occurred not just this once but in repetitions and in varied forms—working through, but in a form that involved a crucial shifting in our relationship from anxious submission to real assertion. What I believe made this process effective in particular was that both Mr. G and I were intensely engaged but also protected by the fact that we had roles in the psychoanalytic situation. I knew I could let Mr. G “see” a bit
of me when I (preconsciously) chose to admit to a struggle of my own with my father, because I also knew that I could maintain my standing with him in a psychoanalytic role. He, on his side, could “discover” my vulnerabilities knowing that I was protected from complete devaluation by my analytic role.

One of the features of the analytic role I have noted elsewhere is the attenuation of affective intensity (Almond, 1995). Hoffman (1998) made the same point in a more relational, co-constructive form: “At the very moment that I transgress I am aware, implicitly, that the patient and I are also trying to construct a noncatastrophic transgression, a nonincestuous, nonsuicidal, nonhomocidal violation of the rules” (p. 234).

**Where the Role Concepts Fit in Current Psychoanalytic Thinking**

Over the past 20 years, all major schools of psychoanalytic thought have moved—in different ways—toward recognition of the importance of the relationship. I would like to suggest that the real/role tension plays a significant part in therapeutic action and that we can see this by looking at some of the concepts and models that have emerged as the relationship has been explored as the scene of mutative action. Common to all has been recognition of the importance of countertransference affects, of the here-and-now, and of the nitty-gritty of mutual influence on a microscopic level (Gabbard & Westen, 2003; Jones, 2000; Kernberg, 2001). In particular, I want to highlight the way in which role plays an important

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part in translating our understanding of the more static qualities of the analytic situation—personality and interactive constellations—
into understanding of action.

Transference. Bird (1972) pointed out that the capacity for transference is a remarkable ego skill. I believe that this transference capacity rests on the ability to move between real-and role-dominated states in the analytic situation. The analyst's fundamental rule is in fact a role invitation for a particular sort of role behavior, one we label regression because the role involved often is characterized by the sorts of feelings and impulses that are openly expressed by children. Here things become complex, because the patient who is “in-role,” feeling deeply involved with the analyst, is in part not “in-role” if we think of the sort of motives that generate the transference. The way I would clarify this is to say that the patient's role (along with the analyst's role) provides a containing structure for the nonrole affects and motives. There is a tension between the two. For example, late in his analysis, Mr. G wanted to challenge me effectively (he had nonrole oedipal motives to defeat and destroy me), but he knew that we would both limit the extent of his wishes to hurt or destroy me (he knew that his aggression was contained by our roles).

The patient is accustomed to acting in response to role cues. So in the analytic situation, despite its initial ambiguity, when the patient begins acting, the analyst responds in one way or another out of a mix of subjectivity and his analytically trained role. I have described how I felt Mr. G needed to substitute object related satisfactions for narcissistic ones but that he encountered shame and humiliation en route. I not only interpreted this to Mr. G, but I also reacted to it affectively (nonrole), and he sensed this. But for him to shift toward enjoying the more object-related aspects of his life meant experiencing real humiliation with me, given whom he felt me to be. We unconsciously found a way to process this impasse through his getting around the mask of my role, and my acknowledging my humanness—while still keeping the whole encounter within the analytic frame of our roles. We can view this
event in terms of its transforming aspects—the ways in which Mr. G was modulating his narcissistic defenses through acting out and working through, or in terms of its relational aspects—my availability as a nonshaming object for him to compare himself to. In either case my analytic role aided me in both letting me “be human” and “be analytic” at different moments in the process, thus actually being analytic all through it, in a wider sense.

Various theorists have conceptualized this sort of situation in different ways: in terms of the idea of multiple selves—that there is not a single, unitary

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“self” but a series of selves that the individual moves between (Bromberg, 1996), or multiple internal self-and-object representations linked by affective states (Kernberg, 1983), or role-relational states (Horowitz, 1993). Each of these captures in a different way the capacity to have different states of mind at different points. What role introduces is the element of action (Schafer, 1976), in the sense that in the analytic situation there is a continuous pull to act either according to some sort of conception of the roles expected or according to more idiosyncratic subjective pressures. Roles, as I have said, are learned repertoires of responses to various social situations and are continuously added and attuned through the course of development. Certainly there is a different “self” in operation when the analyst or patient is “in-role” or more spontaneously responding to impulses in the relationship. That is, my role-defined states are closer to what Hoffman refers to as the ritualized aspect of the analytic relationship, whereas my “nonrole” states are akin to Hoffman's (or Turner's) communitas relatedness. But another way to look at this is that the self-state is a content, and a role is a means of playing out that content, once one is in a social situation. My central point about role-nonrole experience is that it is in constant tension and that particular
moments or phases of analysis involve the juxtaposition of the two in unique ways.

Enactments. These are moments or periods in treatment when the analyst joins the patient in activity that is driven by a combination of responses to the patient and internal motives. I understand enactments as episodes in which nonrole motives predominate. For Mr. G, his period of phone analysis could be seen as a “low-key” enactment, in the sense that I was willing to participate in his subjectively driven pursuit of his retreating girlfriend—in this case to “bend” the rules of analysis that we meet in person. The enactment involved my accompanying him during a loss he had helped bring about, and then felt anxious and guilty about. I sensed that an attempt to interpret his pursuit as a flight from the analysis would have been ineffective, and likely inaccurate. More important, I felt that “going with him” by phone was a way of recognizing nonverbally that I understood the intensity of his anxiety.

In a more vivid and momentary example, my inadvertent self-revelation in phrasing—the comment about his interest in “my struggle with a famous father”—was a bit of countertransference-based enactment in reaction to his Googling me and the resonances that it stirred up for me. It provided Mr. G with an opportunity to see me “out of role”—or, more pertinently, to feel that he could take an active part in our relationship in a way that would noticeably get me off balance the way he felt so much of the time with powerful others.

In discussions of enactment and mutative action, change is seen as stemming from the analysis of what has occurred between patient and analyst (Chused, 1991; Levine, 1994; Renick, 1993). I see this
as a transition in the relationship back to a role-dominated condition, but at a new level. Mr. G, for example, after his period of phone analysis, was more open to experiencing and discussing feelings directly in the relationship with me, exploring various transference meanings and feelings. Similarly, interactions like that around the Googling contributed to a change in the relationship that Mr. G noted and appreciated, commenting, “This feels more real than most of the time we have spent together.” In a more recent situation, Mr. G. was describing my office as filled with the ritual objects from Freud's tradition, listing my small art objects and Oriental rug. Without much reflection I said, “Actually, the rug came from my grandmother.” Again, Mr. G experienced my revelation as a positive, warm move, not—as I had some apprehension he might—as a one-upping of his stereotyping me. Here the enactment was at my initiation, moving from a more role-dominated state the patient was using to a more personal out-of-role state. Sudden shifts to a state of understanding from subjectivity, or the opposite, a shift from abstractness to a feeling of real contact—require that there be role structures for the transaction of each.

Systems theories. There is a growing consensus that mutative process involves a sequence of disturbances and re-equilibria in the relationship. Kohut (1984) described them as empathic failures and the understanding of them by the analyst, or patient and analyst together. Beebe and Lachmann (1998) used the language of systems theory to capture the way in which changes occur in both parties through events in the relationship, much as mother and child mutually regulate during development. Stern et al. (1998) similarly elaborated an extensive systems model describing mutual cueing, fuzziness of communication, and disorganization/reorganization of the separate psychologies after connection. I believe that these patterns of mutual influence often play on the social role structure of the analytic relationship for their salience, their cognitive and affective meaningfulness to the
two people involved. To put it another way, coming late can be called a resistance and suggests something going on in the patient. When we recognize that it is a way of getting our attention because it disturbs the role relations, then we can ask, “What is going on in the relationship?”

Intersubjectivity. Similarly, the idea of intersubjectivity becomes less of a conceptual dilemma if we include the role-nonrole shifts that the relationship goes through. For example, if the analyst's subjectivity is “irreducible” as Renik (1993) suggested, then there would seem to be no way out of his unconscious response to the patient. But Renik also posited a post hoc examination by the analytic couple in which the analyst's involvement can be studied and brought into useful play for the analytic work. Without saying so, Renik assumes the existence of an analytic role, with an intrapsychic component that can free itself of the “irreducible” subjectivity enough to conduct reflection on what is going on. This is essentially the enactment situation from another viewpoint.

**Summary**

Psychoanalysis combines a complex social situation with the special roles of the patient and analyst. The situation is one that lends itself to the expression of inner states and motives on the parts of both members. These states are mediated by the roles developed through socialization. For the analyst, the role is established over years of training and practice, although it is expressed differently by every analyst in every clinical situation. For the patient, the process of analysis is a gradual transmutation from an initial idiosyncratic interpretation of how to act, to a set of additional role behaviors that are learned in analysis. Most important is that the roles help both stimulate and contain the
powerful impulses and motives that develop in the analytic situation. I have tried to show here how the current discussion of mutative action can be framed with an appreciation of these factors. Concepts ranging from transference and countertransference, with their allusion to two coexisting levels of meaning, to relational ideas of enactment, mutual influence and intersubjectivity become less contradictory in the context of a view of the analytic situation as one involving intersecting social roles and unique individual characters and momentary motives. Roles can be seen as the individual/social element stimulating and regulating analytic activity.

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