The Real Person of the Analyst and his Role in the Process of Psychoanalytic Cure

Milton Viederman, M.D.

ABSTRACT

This paper focuses on the real relationship with the analyst in the psychoanalytic situation as an aspect of the therapeutic process that leads to change. The role of free association, clarification, and interpretation of the transference are taken for granted as major activities of the analyst, and the real relationship with him is seen as a complementary but important ingredient for change. In particular, his emotional availability determines the climate of analysis. The concepts of neutrality, anonymity, and abstinence, though of importance as guideposts in the conduct of an analysis, have conceptual limitations that not infrequently bind the analyst in a stance that is not useful for the progress of the analysis. On occasion, confirmation by the analyst of the verity of an experience in the patient's early life facilitates the analytic process. This occurs particularly in situations of early trauma, but at times may include chronically traumatic early life experiences. An important motivating force in analysis is the patient's unconscious wish to find the ideal parent absent in early life experience, a wish that is experienced and ultimately analyzed. This is to be distinguished from a defensive idealized transference. Psychoanalytic developmental psychology contributes to our understanding of how the real person of the analyst, his emotional availability, his responsiveness at particular times, his attitude toward action and progressive change in the patient, affect the therapeutic process that leads to change.

The knower is not simply a mirror … passively reflecting an order that he comes upon and simply finds existing. The knower is an actor … he registers the truth.

Professor of Clinical Psychiatry, Cornell University Medical College; Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research.
Accepted for publication November 2, 1989. I gratefully acknowledge the stimulation and helpful criticism of Drs. Michael Beldoch, Richard Druss, Roger McKinnon, Robert Michels, and Samuel Perry.
which he helps to create. Mental interests … helped to make the truth which they declare. In other words, there belongs to mind, from its birth upward, a spontaneity, of vote—William James [in Meyers, 1986 p. 8].

And there is something else that I would like to note about Toynbee's work—not in the way of a criticism of it, but as a feature that helps to explain it; and that is its extraordinary personality. No one could leaf through the volumes of his principal works without being struck by the seldomness with which individuals make their appearance in this material [yet one cannot deny that] … at the bottom of all human experience, there lay, after all, the mystery of the individual personality—its ultimate autonomy of decision—its interaction with the mass [Kennan, 1989 p. 21].

THE INFLUENCE OF THE REAL PERSON of the analyst on "psychoanalytic cure" has, with few exceptions, been treated cautiously in the psychoanalytic literature. My intent in this paper is to place the relationship at center stage as an aspect of the therapeutic process that leads to change, to examine the reluctance of analysts to acknowledge its role, and to explore the manner in which it manifests itself in the psychoanalytic process that leads to change. The role of free association, of clarification and interpretation, particularly of the transference, is taken for granted as a major activity of the analyst; what I describe is to be understood as complementary. By "real" person of the analyst I refer not only to his outward traits, but to his unique characteristics as a person and to his behavior in the analytic situation which goes beyond interpretation and clarification. The analyst's presence is rooted in the revelation of his personality and at times certain aspects of his experience, and in the idiosyncratic ways that two people develop a relationship and establish a dialogue with characteristics unique to that
dyad. Each analytic relationship has qualities that reflect the uniqueness of the relationship and that make it different from any other analytic relationship. Beyond the special qualities that develop spontaneously and are reflections of the unique characteristics of the two individuals, are a wide array of behaviors, often conscious although spontaneous and not contrived on the part of the analyst, which are directed toward the mutual goal of change. In a successful analysis, the analyst is felt as a presence in this regard.

I distinguish between the climate of analysis, which is the prevailing emotional tone of the relationship in part created by the analyst, and the weather, which more closely approximates the usual transference vicissitudes. For example, an analytic stance dominated by strict adherence to the rules of anonymity and abstinence creates an analytic climate not of neutrality (speaking here in the broadest nontechnical sense), but of deprivation, which necessarily will generate an aggressive response, or a submissive or avoidant response as a persistent mode in the patient, a mode that ultimately may be responded to by the analyst with countertransference counteraggression in the face of frustration. Coldness experienced as sadism may silently gratify a masochistic patient. Often the patient will recognize the artificiality of the analytic stance. A colleague recounted that his patient challenged him on his analytic "costume," which she experienced as a cover, recognizing his reluctance to reveal his natural warmth. This countenance affects the analytic climate and sets a tone to which the patient inevitably responds. It is impossible not to be seen. One must be seen in one way or another. I contend that in many situations (not all, as with a paranoid patient fearful of closeness and intrusion) a climate of warmth that the patient experiences as supportive offers the possibility of an easier examination of issues pertaining to intimacy, closeness, and in itself does not prevent the development of angry negative transferences that require analysis. Moreover this stance may facilitate the expression of anger in a patient less fearful of destroying the analyst. Interpretation
is, of course, a vehicle for the special status with which the patient endows
the analyst as he helps to create a new and unique perspective on the patient's
experience, a perspective that alters the patient's self-perception and his view
of himself in relation to the world. The analyst's status as a special person
involved in the patient's growth through understanding gives him centrality in
the patient's life as a participant, as an agent of change in the achievement of
desired goals. But it is not only through interpretation that this is established.
The analyst's particular stance in relation to change encourages the patient to
overcome inhibitions and to confront the world in a new way. This
encouragement may involve suggestion as the analyst questions inhibitions
with implicit valuation and support for new behaviors. The analyst who
interacts with the patient with spontaneity and humor emerges in a different
way for the patient in his struggle for understanding and self-fulfillment than
the analyst who is primarily constrained and controlled.

The affective presence of the analyst, namely his self-expression with
feeling and conviction, when indicated, acts as a stimulus for an affective
interchange and the development of transference which has a different quality
from transference evoked by an analyst who insists on absolute abstinence
and interpretation as the only vehicle for communication with the patient.
Many analyses become sterile by virtue of the apparent detachment of the
analyst, and anxiety generated by fears of intimacy in the patient remain
unanalyzed as both patient and analyst sink into a comfortable but distant and
nonproductive *modus vivendi* that not infrequently characterizes some
particularly long analyses. This conclusion is a product of considerable
experience in consultation with patients who had had previous analyses and in
reanalyzing some of them, and reflects observations of my own earlier
analytic work and the changes in behavior I have noted in myself as I have
become experienced in the analytic role. The affective presence of the analyst
often generates anxious states in the patient that are then available.
Anxiety generated by sexual tension similarly is more available for analysis in an affectively charged interaction than in one characterized by excessive distance and careful control, often engendered by the view that appropriate responsiveness is nonanalytic. The analyst does not reveal his sexual feelings explicitly to the patient. However, his awareness of such feelings and his comfort with them will permit an interpretive approach that has an affective quality and will further analytic scrutiny of something experienced rather than something viewed as a theoretical possibility. Clearly, timing, titration of anxiety, and awareness of the patient's capacity to tolerate intimacy or sexual feelings or wishes at any single moment will guide the behavior of the analyst. However, to recognize that there are degrees of mutuality related to sexual attraction between a man and a woman and that the analyst experiences this is not to act upon it but to bring this theme clearly into focus as a subject of analysis. Similarly, the analyst who permits himself to experience closeness and affection for a patient, will inevitably communicate this in a way that evokes a response in the patient, a response that is then subject to analysis.

A psychoanalysis is an intense personal relationship for both patient and analyst. Although the analyst operates with a degree of control and deliberation, affective responsiveness on his part evokes behavior in the patient that should become the material of analysis. We like patients more or less, we find them more or less attractive and interesting, and are more or less fascinated by the stories they tell. As analysts, we work better with patients with whom we can become more involved, and these analyses are more successful for they facilitate the ease and responsiveness of the analyst to his patient in many ways that go beyond interpretation and stimulate an analytic dialogue. By dialogue I do not mean a mutual recounting of histories or major self-revelations by the analyst, although at times when the patient is confronted by a particularly painful reality experience, the analyst's willingness to recognize such an experience as familiar to himself can effect a powerful bond. Although the patient is the primary spokesman in this dialogue,
he is talking to two people: to himself and to the analyst. The quality of a shared experience should dominate in spite of the asymmetric roles of the two parties.

The idiosyncratic aspects of the relationship between analyst and patient are revealed commonly as one examines anecdotes from case histories. Poland (1988) and McLaughlin (1988) richly describe the subtle reciprocal communication that develops between patient and analyst as it leads to special understanding on the part of the analyst about the patient's unconscious fantasies. It is commonplace to recognize how the analyst's emotional responses and fantasies generated by the patient lead to further understanding of the patient. This results in a unique relationship between analyst and patient. What is evoked in the analyst will affect the nuances of the analyst's actual behavior with the patient as it influences the patient in his view of himself, his actions in the world, and his ultimate understanding. I refer here to authentic and conscious as well as unconscious behavior by the analyst, which includes spontaneity and use of his own resources. I am not speaking here of a deliberately contrived therapeutic stance with the patient to contradict transference projections, i.e., the corrective emotional experience (Alexander 1958), nor of affirmation of a patient's need for approbation.

The following is an illustration of the role the analyst may play in facilitating the patient's engagement in life in a new way which then becomes the subject of analysis.

**Case 1**

The patient was a young lawyer, who was unassertive, especially in his professional life, and markedly inhibited sexually. His anxious and hesitant self-presentation, careful and controlled speech were generated by oedipal conflicts that markedly inhibited his capacity to function effectively. During the first year and a half of analysis, interpretations seemed to evoke little meaningful response as the patient seemed mired in inhibitions.
in both personal and professional areas. He continued the only heterosexual relationship he had ever had with a woman who was equally inhibited and who lived in another city. Interpretations seemed to evoke little in the way of associations, but the patient became increasingly comfortable in the analytic relationship. I experienced him as an appealing person as he revealed a sense of humor, a capacity to laugh gently at his own inhibitions, and I felt warmly disposed to him. This was communicated with occasional shared humor, often about the patient's inhibitions, which generated an awareness in him of my involvement and interest in his life and progress. During this first year it was the tone and quality of the relationship that was most important. In the context of the patient's experience of me as a person who encouraged him in his exploration of the world, and with the support of a pleasant comfort that had developed in our relationship that contrasted markedly with the hostile and denigrating behavior of his mother, he developed a passionate attachment to a woman (consolidated and validated in part by his discovery of an article I had written about passionate attachments). Protected by this developing relationship with the woman, significant analytic work began. The positive attitudes and experience of safety generated early in the analysis gradually permitted him to bring out what was inhibited in him. This in no way prevented the patient from moving into an analyzable transference that included a powerful negative maternal transference and later competitive feelings, rage, and resentment about deprivation. The transference deepened, was analyzed, and its genetic roots explored. The patient married, had a family, and achieved a successful termination of analysis. During the termination phase, he spoke with intense feeling of the essential role that my valuation of him had played in permitting him to engage the world. "Over time with you—that is how I developed the trust. I would never have developed the relationship with Ellen were it not for you. It was when you and I were in this trusting relationship where I saw myself as good and you as good that this happened—though this would
be interrupted at times as if my mother was intruding and I began to feel you were humoring me, not taking me seriously, only to regain the trust once again."

The first phase of the analysis offered an environment of safety and trust in the relationship with me, which permitted the patient to establish an intense and intimate relationship with a woman. This connection was not interpreted as the relationship with the woman developed. However, once the heterosexual relationship was established, there was full development of a transference that permitted examination of the roots of homosexual anxiety, competitive struggles and fear of destroying the father, and of the profoundly negative conflictual relationship he had with his mother. The regressive thrust of the analysis during the early phase evoked for the patient a wishful fantasy of the analyst as the protective and nurturant good mother, an unconscious fantasy that pervaded the early phase of the analysis and was later interpreted. This early "holding environment" differs markedly from what Modell (1976) has described as a phase of analysis characteristic of work with narcissistic patients who, by virtue of a defensive self-sufficiency that he calls the cocoon transference, have no need for the analyst as a person and operate with the illusion of his presence as a safe object. My experience with this patient was quite different. His experience of me as an encouraging and supportive figure was generated in part by my emotional response in the way I communicated with him. This was true although I did not offer advice, press the patient to behave in any specific way, or explicitly state my positive feelings. My attitude conveyed my valuation of the patient and an optimistic attitude about his difficulties. There was nothing contrived or unauthentic in my responsiveness, which created a climate of safety for the patient.

**Views of the Influence of the Real Person of the Analyst on the Therapeutic Action of Analysis**

Freud's (1912) surgical metaphor coupled with the notions of neutrality, anonymity, and abstinence to create a field for transference in which conflict is played out and interpreted has
clarity, conceptual elegance, and a purity that identifies its origins in
tenineteenth-century positivism. To give theoretical status to the personal
attributes and responses of the analyst understandably generates concern that
the definition of the analytic process will be clouded and its scientific status
compromised. Emphasis on the personal element in the analytic process
threatens to blur the boundary between psychoanalysis and psychotherapy
and particularly the myriad other therapies, some without theoretical foundation or
intellectual substance. Psychoanalysts therefore have been hesitant to
recognize the importance of personal influence lest it cloud the definition of
transference, countertransference, resistance, defense, interpretation.

The classical position of the analyst in the psychoanalytic situation is
described by Eissler (1953). He states that interpretation is the sole
therapeutic modality of psychoanalysis and that the utilization of other
techniques or interventions are to be considered parameters or deviations
from classical technique, to be analyzed later. Stone (1961) in his ground-
breaking monograph, The Psychoanalytic Situation, touches on many of the
issues addressed in this paper. He speaks of the "mature" (and by implication
reasonable) wish of childhood for tolerance and sympathetic understanding,
and indicates that the analyst's failure to respond to such wishes interferes
with the inevitably painful evolution of the analysis. He alludes also to
superficially remote and depriving attitudes which engender "awe and
detachment [but] promote an artifact … in the transference neurosis" (p. 54).
Stone refers to the inevitability of the influence of the real person of the
analyst on the analytic situation. Loewald (1960) developed a theoretical
model of the psychoanalyst's effect on therapeutic change that lends itself to
the point of view being expressed in this paper. He views the analytic process
as analogous to the developmental process and, like Emde (1988),
emphasizes the interpersonal experience of the patient in the analytic
relationship. Internalization implies the integration in the analysand of a new
mode of interaction with an object and not simply the taking in of a new
object.
The parent/child relationship can serve as a model here. The parent ideally is in an empathetic relationship of understanding the child's particular stage and development, yet ahead in his vision of the child's future and mediating this vision of the child in his dealing with him. This vision, informed by the parent's own experience and knowledge of growth and future, is, ideally, a more articulate and more integrated version of the core of being that the child presents to the parent. This "more" that the parent sees and knows, he mediates to the child so that the child in identification with it can grow. The child, by internalizing aspects of the parent, also internalizes the parent's image of the child—an image that is mediated to the child in the thousand different ways of being handled, bodily and emotionally ... the bodily handling of and concern with the child, the manner in which the child is fed, touched, cleaned, the way it is looked at, talked to, called by name, recognized and re-recognized—all these and many other ways of communicating with the child, and communicating to him his identity, sameness, unity and individuality, shape and mold him so that he can begin to identify himself, to feel and recognize himself as one and as separate from others yet with others... In analysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place [Loewald, 1960 pp. 229–230].

Cooper (1987) elaborates and further develops some of Leowald's ideas in a paper on transference interpretation. He takes note of the impact of the analyst in what is an interpersonal situation, but he does not make it a central feature of change.

The range of personal behaviors available to the analyst before we need be concerned that the analyst is engaging in activities that are excessively self-revelatory or that force the patient into a social relationship is probably much
broader than we thought a few years ago. But we also know that almost any behavior of the analyst, including restraint or silence, immediately influences the patient's responses. In these newer views of the analytic situation it is not easy to know what in the transference are the iatrogenic consequences of analyst behaviors rather than intrapsychically derived patient behaviors [p. 87].

Cooper remains vague as to the acceptable limits of the analyst's behavior in the psychoanalytic situation. He is, however, quite aware of the influence of the analyst as a background figure:

In one important aspect, the analytic situation acts as a Proustian madeleine. It awakens sweet resonances of the sense of childhood security and safety, whether actual or fantasy, and this allows the release of memories, even painful memories. This portion of the transference is usually interpretable only in retrospect… While the analyst was, of course, often the object of representations in the past, I played an equally important role as the necessary background of safety for the patient's experimentation with new self- and object representations [pp. 90–91].

Cooper reveals his hesitancy in the last sentence by referring to himself in both the third and first person, and does not describe how he achieves the special status of trust that is the substrate for the analytic relationship. His statement of the childhood safety and security generated in the psychoanalytic relationship touches on my view of the ideal wishful parental transference to be described below.

Chused (1987) addresses the special idealized role of the analyst as a mentor for the young adult. She views this idealization and identification with the idealized mentor as a useful process in analysis, but she emphasizes that it is not based on the real characteristics of the analyst, but rather is a product of the patient's developmentally determined longing for an ideal object, what I refer to below as the wishful transference. Grunes
(1984) describes a special relationship that must evolve between analyst and patient in the treatment of highly regressed patients with severe and primitive psychopathology. He emphasizes that 'although from the perspective advanced here, therapeutic change is crucially influenced by interpretation and the analysis of transference, the therapeutic object relationship is a primary matrix of change, particularly in the more regressive patient' (p. 131). He is reluctant to generalize this view to the usual psychoanalytic situation. Thomä and Kächele (1987) discuss this problem at length, emphasizing the dependence of transference, including transference resistance, on the analytic situation and its shaping by the analyst, beginning with his physical appearance and including his personal equation, his theory, his image of man, his Weltanschauung. They speak of transference as something evoked which draws upon transference readiness or disposition in the patient, activated by various aspects of the analyst and his behavior.

The issues that I address in this paper have recently become the subject of discussions of psychoanalytic technique. In a workshop of the American Psychoanalytic Association on "The Psychology of the Analyst" (1988, unpublished) analysts presented their own fantasies, memories, and associative material evoked by patients' transferences, and demonstrated how self-analysis of these responses clarified the transference and led to fruitful understanding. In another presentation Shane (Abend and Shane, 1988) spoke of the holding environment (Modell, 1976); (Winnicott, 1965) and the utilization by the patient of the analyst for self-regulatory function. Shane emphasized that in the analytic relationship the analyst took on a new object function, and referred to the ideal relationship with parents, generated by trustworthiness, and attunement. However, he maintained caution in emphasizing that the analytic stance was not altered by this conceptualization, a point of view I shall dispute below. Skolnikoff (1988) emphasized how shame about deviation from certain inculcated norms often operates to create guilt in the analyst, in particular when he admits the
intense emotional involvement generated by the analytic situation. Abend (Abend and Shane, 1988) presented the classical point of view, emphasizing neutrality in such a way as to suggest that it is a basic, untainted, value-free stance.

**Abstinence, Anonymity, Neutrality, and the Question of Cure**

What is the proper climate for the conduct of an analysis? Although it is well known that Freud often behaved in remarkably interactive and gratifying ways with his patients, which today would be viewed as deviations from usual technique, the classical view affirms strict abstinence, anonymity, and neutrality as a required stance for analysis (Freud, 1915).

Abstinence generally implies that the analyst not gratify the patient's wishes or demands or fulfill a role the patient desires or tries to impose on him (LaPlanche and Pontalis, 1973). Anonymity implies that the analyst not reveal himself personally, so as to create an untainted field for the patient's transference projections and fantasies.

These rules of analytic conduct have a logical basis in the traditional view of cure, for by maintaining this attitude, the analyst constructs a neutral field for the projection of the patient's wishes, fears, and expectations in such a way as to facilitate what might be viewed as pure transference phenomena. Abstinence was closely tied to Freud's dictum that an aim of analysis was to change action into words. This was based on the economic hypothesis that viewed action as a discharge phenomenon. Hence frustration of the patient's wish should lead to rechanneling of drive into fantasy production. Yet it is evident that gratified wishes are subject to analysis as are ungratified ones and systematic frustration is not only unnecessary, but has its own influence in changing the field. The important requirement is that one analyze what is happening between analyst and patient and not attempt to create a one person field.
Recent contributions contradict the view that transference can be viewed as independent of the context in which it develops (Thomä and Kächele, 1987). Strict abstinence and anonymity are neither possible nor desirable. The rigid application of this stance creates an artificial climate, deceptively viewed as neutral (in the common sense of the term), which distorts the relationship and generates inevitable and unnecessary hostility, whereas appropriate responsiveness facilitates the analytic process. Gill (1982) argues that to properly interpret transference, one is forced to take note of the nidus of reality, inevitably present, which generates the transference reactions of the patient. I would go further in suggesting that in a properly conducted analysis, strict abstinence and anonymity as a goal do not adequately describe the most effective analytic stance. As a model of analytic behavior it constricts the analyst in such a way as to encourage formality and rigidity in his work. Deviation from anonymity begins with the physical appearance and surround of the analyst, highly reflective of his world and his tastes, though obviously limits and discretion are indicated and it would be entirely inappropriate to display a picture of his family, for example. Even more striking is the expression of his personality and temperament in his mode of expression, the tempo of his words, the affect with which he expresses himself. To pretend that these factors do not powerfully influence the interaction with patients is not only to ignore the obvious, but more important to ignore something positive that facilitates the analytic process. The patient's engagement will be a product of the experience with the analyst that goes beyond intellectual analysis of defense and other content. The issue merges with the principle of abstinence. The analyst's response to a sudden and unpredicted painful event is important in this respect. To convey this comprehension of the patient's pain encourages the development of an affective bond of shared experience that enriches the analytic process. Abstinence and a certain anonymity remain important elements of an analytic stance but should be conceptualized in such a manner as to permit the type of
responsiveness that will facilitate the analytic process. This point of view should not be interpreted as a new and rigid formula, for patients vary in the degree to which they tolerate closeness and the emotional availability of the analyst.

The concept of neutrality has been the subject of extensive recent discussion in the literature. There is general agreement about the value of such a stance, though definitions vary and actual behavior by the analyst as it pertains to the concept is rarely described. Freud's (1915) initial comment on the subject, in which he refers to neutrality as "acquired through keeping the countertransference in check" (p. 164), cannot be disputed, although the wide-ranging definitions of countertransference blur this definition. Shapiro (1984) takes the traditional and classical stance: "Thus, the analyst is not a non-person or a neutral icy being, a disembodied voice, but part of a setting where unconscious wishes are permitted to emerge—to be considered and used with conviction as an instrument for change. The controversies about his personal being and actions and their expressions become trivial against the need for neutrality as a means of achieving the aim of understanding the unconscious" (p. 281). Shapiro views Freud's (1909) obvious deviation from neutrality in the Rat Man case as a human failing rather than as a recommendation on technique. Hoffer (1985) develops Anna Freud's (1936) classical definition of neutrality as the maintenance by the analyst of a position of equidistance from id, superego, and ego, by adding the explicit concept of external reality. He therefore broadens the idea of equidistance to include interpersonal conflict within the psychoanalytic relationship and conflict within the analyst. Hoffer does not include the external reality of the patient, admittedly a construct of the patient. This is an area of major debate as reflected in the recent literature (Panel, 1988); (Arlow, 1985); (Schafer, 1985); (Wallerstein, 1985); (Michels, 1985). Poland (1984) focuses on the neutralization and mastery of the analyst's own internal processes and returns to Freud's original view of neutrality as protection against countertransference. He emphasizes the
importance of the analyst's self-examination to prevent rationalized, unmastered action or the development of two-party blind spots, a cautionary note with which all would agree. However, the difficulty with what is meant by countertransference remains. It is compounded by Poland's statement that abstinence is not absolute, but requires a titration of transference gratification to promote psychological work, a point with which I agree wholeheartedly. Poland goes on to indicate that the analyst need not hide his interest in analytic work. He is properly cautious about the analyst imposing his own values on the patient.

The intensity of the interest in the concept of neutrality is well deserved. The implications of this stance and its undisputed value lie in the enormous freedom its application offers to the patient—the luxury of a unique situation in which the most painful revelations may emerge in a value-free environment that facilitates free association. Yet implicit contradictions reside in the concept.

Although our interpretive stance is designed to address what we perceive as the primary emerging conflict at any moment during the analysis, at times we direct the patient's attention to defensiveness, guilt, perception of reality, reflective of our evaluation of the current field. In questioning the motivations for certain ego-syntonic behaviors we imply there are alternate behaviors that are less defensive, less guilty, less hostile. Our interventions at times reflect normative values which have to do with adaptation. Interventions alert the patient to areas of our particular interest and concern. It is for this reason that the presentation of material even by individuals of similar theoretical persuasions is so different, and why it is appropriate that we be concerned about the norms of analytic conduct. Our personal responses, our conceptualization, our theoretical strategies are quite individual. No two analysts are likely to conduct an analysis in the same way even though there may be consensus on the broad conceptual issues as they pertain to the
theory of treatment. This is not to suggest that the understanding of analytic material is arbitrary or relativistic, but rather to emphasize that the concept of neutrality, though theoretically useful and to be valued, is not an absolute and varies in its application at different moments during an analysis. There are no pure observers as there are no perfectly abstinent physicians.

The following cases illustrate particular deviations from abstinence, anonymity, and neutrality that I believe facilitated the analytic process.

**Case 2**

The material generated by a spontaneous interaction with this patient in a social situation was of particular value in furthering the analytic process by rendering material accessible that otherwise would have remained hidden. The cited material was recorded in notes during the session and filled in in greater detail immediately after.

The patient was a forty-year-old professional in his fifth year of psychoanalysis. As a child he had experienced considerable deprivation in the form of an isolated, depressed, and masochistic mother, a father, unknown to him who had died while the patient was an infant, and a stepfather who was alcoholic and rejecting. His older sibling was psychotic and ultimately died in an accident. The patient was highly literate, poetic, capable of intense feeling, and worked very well in analysis. His psychological mindedness and emotional expressiveness facilitated communication between us and I found the analytic process intriguing as well as very moving at certain moments. In spite of the intimacy that appeared to characterize our relationship, the patient maintained a discreet formality and distance of which he was partially aware and which he related to early experiences of emotional injury. This had been a theme in the sessions immediately preceding the intervention to be described. The patient had been discussing a low-grade, chronic depression and disconnection from people and from
me. He revealed that he was starved for connection, which he concealed.

Before one session we met in the elevator of my office building and had a brief conversation. I asked him whether he continued to spend weekends in the country over the winter, and he replied that the house had been closed because he went so infrequently. It was costly to heat. I revealed to him that I too had a house in the country which I had recently insulated in such a way as to make it possible to heat efficiently. In response to his show of interest, I offered the name of the contractor who had insulated the house.

He began this session by acting as if the conversation had not taken place, and continued in the theme of unconnectedness. He dutifully indicated that my distance was a proper analytic stance (although our relationship had not been characterized by distance). He then contradicted his previous contention by alluding to the sense that he was available for a closer connection, but that I had refused. At this point, now about ten minutes into the session, I brought up that he had not commented on our exchange in the elevator. He responded by saying, "I had been talking about a type of intimacy that you haven't given and I haven't admitted that I want." It was much easier for him to identify vicariously with the intimacy of characters in old films than it was to experience it with me. He continued on an old theme of wanting me to confirm the story of his life in such a way as to exculpate him from some sort of original sin. "Give me a bible, a gilt bible, that I can believe in, in a way that I can't believe in my own oral tradition." I repeated, "guilt?" and we laughed. He began the next session by revealing that he had been thinking about our interchange in the elevator and that "less clinical, human encounter." He had had a dream.

I came to your office and you knew that I was moving into a new residence. As a gift you gave me some carpet scraps, remnants that you used to block some holes on the side of your wall. Just outside was hanging a suit of mine
that had just been returned from the cleaners. You used crumpled newspaper to block up the holes that had previously been covered by the carpet.

His associations had to do with giving up remnants from the past, transforming scraps into brilliant colored rectangles as Mondrian had done to change junk into beauty. He saw holes in the wall as his access to me and he once again dutifully excused me for my previous distance. I challenged him on his indulgence with me and reminded him that he had never felt entitled to the attention and care of others. This theme continued for the rest of the session.

The next day he started by indicating that "these bunches of conversations about you and me have been strangely liberating. It is strange to talk about something forever and then suddenly to see it in a new way. I set my expectations so low that I missed a great deal, yet I had no sense that they had been set so low. You, on the other hand, had frequently commented on my calm standoffish unwillingness to engage in fights with you. It surprised me, but it is so consistent with the low standards that I have set for anyone about giving me anything." He then spoke of his avoidance of conflict with me and of a previous situation in which he had made a request that I had refused. His feelings about this had been pushed underground. "I can say my lack of fulfillment, my frustration of intimacy, gets swept under the carpet because my expectation is only of disappointment and lack of fulfillment." He had maintained the method of being self-sufficient and working to rescue the family as a good boy while he was slowly "being destroyed." "It's funny how this came out after you and I had this conversation in the elevator. This was the triggering event for these thoughts. It is close to impossible for me to be aware of the fact that we have had a human relationship. It must sound weird." I commented on the strangeness of this perception in view of my experience of the frequency of intimacy in the relationship. "I can never keep this in mind. It is like color-blindness or
dyslexia. I notice it and it disappears. It is like this phenomenon of denial, what we call in psychiatry, a defense mechanism [we laughed]. As a child the voice was constantly saying that this isn't happening to me. I want to go back and experience the pain to expiate." "Expiate?" I said. I related this to his comment about guilt in the previous session.

In the next session the patient recounted a "weird dream" about his mother.

I am with a woman and having a romantic attachment which leads to sex. It was the first of a kind. In the middle of the dream I discovered that it is my mother, and yet I am so struck that it was liberating and not shameful.

The patient commented on his mother's early beauty, her talent, and how much she resembled a movie star when he was a child. His dream was a watershed event and had been stimulated by the discussion in the elevator, he said. It is the sign of the rite of passage. He had the sense that he was working something out with his mother and instead of loathing, he imagined the experience as a lovely and positive interaction. "My distrust and self-loathing in the past was associated with the fear of losing the person I wanted." He was now in tears as he spoke of being at peace with powerful forces within him. He spoke of possibilities that I had been trying to point out to him all along only now to discover them. "The analytic situation seemed to take away your humanity, but this has clarified it."

The following session began with his presentation of another version of a recurrent dream in which he was embattled with intruders whom he repelled. His associations led him back to the family about the time he was born when his father was still living with the family, shortly before he abandoned them. He had the sense that some horrendous event had occurred between mother and father. I interpreted that horrendous event as one that coincided with her pregnancy with him. He was very taken aback by this interpretation. He had never considered the possibility that he, by his birth, had driven his father
away and thus ultimately was responsible for his father's death. He realized that the repeated battles he had with men in his dream were related to this and that he had a score to settle with someone who was not there. He was awed and taken aback by this new awareness.

The patient entered the next session angry, complaining that I had never told him this before. He was there to be educated and be understood; I could have told him this years ago. The anger continued in the next session. He said it was a new type of "being pissed" off; for the first time he had a feeling of entitlement about his anger at my having failed him. "For a long time I have been saying I can't put this together, and you come up with this obvious inference so easily." He might have missed the point or argued with me, but he was never irrational in his arguments. "Maybe there has to be some truth and fighting to get there." I responded, "What makes you angry is that I haven't been here to fight with you just as your father has never been there." The patient began to cry. "What set this battle in motion was your presence and not your absence. This is one of my frustrations for the entire history of the relationship." He had never felt entitled to complain until now. "Here is something interesting, something that qualifies as real and not out of the book. We are demonstrating how one of my life problems derives from the man who wasn't there. This is so different from how I dealt with my stepfather, or G. [his boss—areas of conflict that had been examined extensively]. I had written them off. The problem with you is how to deal with someone who is the kind of person that one would want to have as a father. Yet we haven't had anything like a father-and-son relationship, and the primary reason was that there was no fighting. I guess I was in control of whether we'd fight, which is to say that I was in control of whether it would be a father-son relationship. I had established you as a nonfather and I did what I had to do to keep you at a distance." I replied, "All the more striking, given the intensity of your feeling and the fact that you haven't been a removed or obsessionally distant person
with me." The patient continued: "Yet I ask myself if the *pater absconditus* was necessary. It really is a type of self-flagellation. This is where it all began, with guilt for the original sin. I've had to repair it all, to be the good son to make up for my fault." The following week began with a dream in which he was trying to hold back a violent prisoner breaking out of an open cell. In so doing he injured his hand as the cell door was flung open. Security had been lax. His associations led to the feeling of emasculation engendered by compliance, in a defense against rage, a theme further developed in the examination of a dream the following day involving an operation on his penis.

The above is a highly condensed account of material generated by a social interchange in an elevator. The patient's profound guilt resided in the fantasy of a victory over and destruction of the oedipal object, which had left him with the need to make amends, to repair the family, to be the good boy—a stance that also protected him against the expression of violent rage toward the father who had failed him. Moreover it generated a sense of lack of entitlement to a father-son relationship, to closeness with a man, or to the expectation of attention and love from others. For the first time, he was able to experience his hatred toward the absent father, in the transference. It is important to note that the disconnectedness related to his fear, his guilt, and expiation was a subtle one. There has been much connectedness in his life and in the analytic situation before the interchange. Although this theme had been the subject of considerable previous interpretation in the transference and outside of it, it was now experienced by him with greater intensity of feeling and conviction.

This felicitous interchange in an unexpected social situation was not contrived, and therefore not a manipulation. I was aware of a conscious desire to reach out to the patient, felt comfortable in so doing, and would not have done it early in the treatment. Given the transference configuration at the time, one might argue that I was acting on a countertransference wish to breach the patient's distance, but I did not experience the distance as burdensome.
Case 3

The patient was a middle-aged woman who had entered analysis in a depressed state. After two years, material began to emerge in dreams and fragmented memories that ultimately were consolidated into an awareness that she had been seduced and molested on two occasions by a beloved uncle. Memories of this event had been totally repressed, and great anxiety accompanied the emergence of this material. Her capacity to tolerate the pain of this experience resided in the trusting relationship that had developed between us as her fears and inhibitions in feeling closeness and establishing trust in me were analyzed to their roots in her conflicted relationship with a highly controlling and devaluing father.

One day, with considerable agitation and in a fashion quite uncharacteristic of her, she challenged me to reveal whether I believed as she did that the seduction had occurred. I was somewhat taken aback, but responded that although there was no way I could know for certain, I did believe her. The patient was much relieved. She went on to express her rage at the grandmother whose son had been the seductor and who had failed to give credence to her story. This grandmother had been a beloved and special person in her life, a constant source of support, a model and an ideal for her. When she died, she left her highly valued home to the patient, although it would have been more natural for the inheritance to have been divided among all of the grandchildren. This had been a subject of considerable puzzlement to the patient and her family. Now it seemed likely that in this act the grandmother had atoned for her uncharacteristic stony silence in the face of the patient's distress as she denied the incident and protected her son. This dramatic incident and the terrible disappointment and anger directed at the grandmother had been repressed by the patient for almost fifty years, so as to permit her to maintain the idealized and ideal relationship which continued until her death. My intervention was remembered by her some years later as
event of great importance. "Had you responded differently," she said, "it all would have gone underground again, as had been the case with my husband."

By supporting an element of reality, I had deviated from a neutral stance and a stance of abstinence. One might argue that in confirming the patient's view of an actual event, I was actualizing the good grandmother role and maintaining an idealization of myself. The patient was aware that I could not know whether the event had occurred or not, although my confirmation of the patient's perception was based on an authentic belief. I might have questioned the patient's need for confirmation, but at that moment of great distress I believe this approach would have been experienced as an awkward adherence to rules. What I did facilitated the continuing analytic process with the development of negative transferences related to disappointments with both father and mother and grandmother herself.

The question arises as to the special circumstances that determine when such confirmation is indicated, for generally it is not the role of the analyst to establish the verity of the patient's memories which of course change through the course of analysis as conflicts are analyzed. This confirmation is most useful in response to traumatic events that have been uncovered, perhaps particularly as they relate to childhood seductions in which one of the most important aspects of the trauma is the disbelief of people important to the patient. It may be also of special value for patients with severe psychopathology and chronic early trauma as Grunes (1984) points out.

What of the relationship between abstinence and the question of cure? Traditionally, the analyst took the stance that his goal was to understand and not to cure. To cure was to expect something of the patient, to be vulnerable to the patient's resistances, to be hostage to his neurosis. Yet the patient accepts treatment with the expectation of and wish for cure, which is implicit in the decision to undertake analysis. The role of the analyst is to affect the patient and to catalyze change, though
his primary tool is that of interpretation. One major indication for analysis is a situation in which the patient feels a need for important life change; it is to this goal that the analyst commits himself. Movement toward the achievement of this goal of change through successful analytic work is an inevitable source of pleasure to the analyst as well as a satisfaction to the patient. To disguise this is to deny the obvious. I am not suggesting that the analyst consistently celebrate every movement in analysis whether it be insight or manifest change, but I believe that the mutuality of shared work and the enthusiasm generated by it will be and should be appropriately expressed, though it may not be manifestly stated. This includes enthusiasm for the process of analysis itself and for the value that he attaches to it. Recognition of and an enthusiastic response to the patient's overcoming of an inhibition or taking an important new step in his life gives the process a sense of mutuality. This is frequently experienced as supportive and facilitating by the patient, but his response may require analytic attention. He may feel that the analyst is taking credit for his success, or he may view the analyst as self-aggrandizing, or patronizing. Hence, conflicting wishes to competitively defeat the analyst, or negative therapeutic reactions based on guilt, may be usefully evoked to become the subject of analysis.

Patients often remember moments in their analyses when the analyst shows great feeling or deviates from a more usual abstinent approach. These events tend to be discounted as part of the folklore of analysis. Little significance is attributed to them, particularly when the analysis proceeds in a traditional way. I suggest that these uncontrived moments have special significance for the patient because they reflect his awareness that he has had an influence on the analyst and that the analyst is involved in the relationship. Although these are the more dramatic moments of "presence" in the analysis, I contend that the ongoing background of analytic work optimally includes interventions that evoke the presence of the analyst which acts as a background for more complete analysis of conflict.
The Wishful Good-Parent Transference

Patients approach psychoanalysis with unconscious transference wishes and hopes. Among them is the unconscious desire to find the wished-for, ideal parent who eluded them in childhood. This is in part the nature of "the curative fantasy" in the therapeutic or analytic situation (Ornstein and Ornstein, 1977). In my view, although the intensity of and need for such a figure varies considerably from person to person, it develops in all analyses and acts as a background and a facilitator of the analytic process. I separate this transference phenomenon from ordinary transference that involves the reenactment of experienced old self-and object constellations, the everyday substance of psychoanalytic process.

This is to be distinguished from the primal or primary transference (Stone, 1961); (Greenacre, 1975). This primary trusting relationship is built early in development during the preverbal phase and is the bedrock for psychoanalysis. People who have not had the experience of this primary trust are incapable of entering the analytic situation. It is to be emphasized that this primary or primal transference, by virtue of its preverbal and profoundly unconscious nature, is minimally experienced in the analytic process and hence is not subject to interpretation. Stone (1961), for example, speaks of "the basic attachment and unrenounced craving [for fusion with the primal maternal object] … which play little or no important role in the empirical realities of a given analysis" (pp. 76–77). What I call the wishful good-parent transference is both experienced and interpreted in the terminal phase.

The wishful ideal parental transference, though unconscious throughout long periods of the analysis, is stimulated and encouraged by what I have described above as the presence of the analyst, the impact of his real person revealed in the analysis in interventions that go beyond interpretations. Although it is experienced by the patient as benevolent and trusting, the usual transference evolves with the reenactment of
what the patient has experienced in fantasy and in life. The ideal transference complements this by what has been missing in the child's life and develops to a greater or lesser extent in response to the personality of the analyst as revealed in his emotional expression and behavior. Although it may be more intense in patients who have experienced severe parental deprivation, it is ubiquitous, and its presence facilitates the undoing of negative aspects of the relationship with parental and other primary figures as they are analyzed. This aspect of the therapeutic process has been described by Loewald (1960) as analogous to good parenting. I would add that this is generated not only by the interpretive stance of the analyst, but that it represents the coming together of the patient's wish and the real behavior of the analyst as a benevolent and growth-promoting figure in the analytic situation, and as such represents the analytic response to developmental failure.

It is important in this regard to make a distinction between what I have described and the actualization of transference wishes. In commenting on the presence and emotional availability to the analyst I speak about a background phenomenon that operates unconsciously and, although it involves some gratification, is a support for the analysis, ultimately to be analyzed (Case 1). This is quite distinct from the immediate clamor and demand for gratification implicit in the everyday behavior of the analytic patient as manifested in usual transference. It is important to distinguish between an ideal transference (the wished-for good parent) and an idealized one rooted in defense and conflict, subject to ongoing interpretation or awareness by the patient as the analysis proceeds.

The following vignette illustrates this theme. It describes the experience of the patient in Case 2 when he was in the terminal phase of analysis. The session had been preceded by one in which he had made the moving discovery that his reluctance to have children had been strongly conditioned by a traumatic experience he had had with a nephew who had a severe
developmental failure and to whom he had been profoundly attached.

"I was moved and uplifted by our talk last time and had been quite surprised that an experience I had in my twenties could have been traumatic that way. I had learned Freud too well, thinking all occurred in childhood. It's the difference between me preanalysis and now. I used to think people older than I were unwilling to grow and to learn, that they were ignorant and hostile. I am touched and surprised to find so many people who are learning and growing, even assholes like me who at twenty didn't know it. You played a special role in this. I never thought that anyone could be sensitive, interested in feelings and exploring them. After a very long period of having a chip on my shoulder about you, I began to see the degree of intellectual curiosity you had about a life history that happened to be mine. Who would have thought it? I was convinced that everyone was mean-spirited or with mixed motives or with a secret agenda. It's been quite a change now when I deal with people who actually are that way. I just kind of feel sorry for them in a condescending way. I've come a hell of a lot of distance from the hatred that I felt, the hatred that only one who sees himself as a victim or a potential victim of any of these creeps can experience. It has been a tremendous tribute to my willpower and blind faith to be able to withstand the period of figuring this thing out." I commented, "But yet you did it; something sustained you." He continued, "Blind faith. Only the other thing was that somehow I believed that you were doing what you are doing. I believed what you turned out to be. In some way I had a blind faith because I believed it even when the dominant feeling was hostile." I asked, "Was there something that enlisted this belief?" He then referred to the simplicity of the referral from his friend, a colleague of mine, who had said, "this referral is right." "He gave me the nononsense factor. And yet I was able to withstand analysis. You appeared not to make mistakes, and since I was so hostile and angry and ready to find fault, the fact that I wasn't finding
fault and had no false counsel sustained me. Your stringency was good."

He continued in the following session: "I was talking about my perception of you, but what was so important was the growing sense that certain people had real integrity. My life was much more chaotic by virtue of not having any sense of the personification of integrity. I found it in you and with it a sophistication that ran deep. And it was only by knowing that such things are personified that I realized that what I was struggling for was not simply what I want to be, but what I was. It was a question of fine tuning. The issue of how I could stand up, or perceive myself as different from the person I thought I had been two seconds before could take place because of the presence of this person that you were. One related thing has to do with the reasons that I stuck with the process and which have to do with you. As much as I bristled at the idea of having any older person as an advisor, a counselor or a critic [the patient was speaking metaphorically], I was convinced that I was neurotic, that I was goofing up—in fact I was overstating the degree to which I was goofing up. What kind of person could exercise authority over the long term and have me stand it? It was not a consciously stated question then. It is now. There are a number of aspects of you that fit the bill. Things that I look for and serendipitous things at the same time. You came off as wise and seasoned. One looks for these things in lawyers and automobile mechanics. Also you had some appreciation of metaphysical things and you appreciated the esthetic experience. I had been aware that I had a big metaphysical life and yet I had never been aware of how much I could go on with such feelings. It is fair to say that not infrequently you didn't know the fuck what I was saying, but you stuck with it and we saw it together. I don't know if it is unique to me to think and feel this way or everyone does it when they start to poke around." I commented that he had his own special way. He continued: "It's like discovering that I speak prose. The esthetic element was especially profound and I could see it in you. I
had never been aware of how the appreciation of beauty in art and nature all can be a well integrated part of a personality and that having these experiences helps you to function with a larger psyche... You, the profession, have pretended you are empirical scientists who leave the spirit to the artist and the poet. That is not what had happened here. We could have come along much more rapidly if before I came I had inculcated in me the sense of freedom that both of us would have together. Yet many times early on you conveyed to me as I talked on about life 'why are you going on about this?' I had been shocked that you had turned away my words that were metaphysical. You had to overcome your resistance, and you did, and after a while you listened and heard and realized that I was not talking about world politics, but about myself." I acknowledged my uncertainty about what had seemed intellectual, and the session ended with his comment on how analysis had led him to appreciate beauty and life, to see the gothic cathedral in a new light.

The patient described vividly the role I had played in helping him discover his sense of personal value and in changing his perception of people, in particular, older men. This change, fueled by interpretation, also reflected in part the individual special communication that had evolved between us. For a long time he had not been aware of how his developing view of me had modified his stereotype of older men. In speaking of serendipity he was commenting on a chance encounter of two individuals who resonated in a special way. What was operative in this treatment was a new, powerful personal experience generated by our interaction and only later to be observed as important when the extra baggage of transference fears and projections had been worked through and modified. His description of our relationship was particularly meaningful in the light of his early experience of the absence of older male figures (fathers) as guides or objects of identification, and his struggle early in the analysis to avoid acknowledging me as such a figure. I emphasize that this patient did not meet the criteria
defined by Stein (1981) in his paper on the unobjectional transference in that my patient's resistance to transference was an important early focus in analysis, and his experience of the past was quite different from the relatively benign early life histories of Stein's patients. In a similar sense, he did not manifest the transference readiness described by Frosch (1959), in which the patient attaches family romance fantasies to the analyst as they begin analysis.

Although the analyst does not achieve perfection in this role, he does, as an ideal object, guide, direct, and administer. It is in this guiding role of the ideal parent, initially experienced unconsciously by the patient, that the analyst functions as a significant force directed toward change.

**Attitude of the Analyst Toward Action, Acting Out, and Insight**

Freud's view that the task of analysis is to convert action and repetition into remembering and into words has led to considerable wariness on the part of analysts in their attitude to the actions of patients often viewed as a resistance to analysis. Traditional psychoanalytic theory maintains that insight leads to change resulting in action. Action in the world often consolidates change and would appear to be necessary to maintain change. Sterba (1944) speaks of the formative activity and educational function of the analyst required to consolidate the gains of insight by encouraging the patient to utilize insights through changed behavior in the world. Although this continues to be a useful concept, there are important exceptions. A useful role of the analyst may be to facilitate action in certain circumstances, for actions often precede insight, and insight sometimes does not occur until a real change in the behavior of the patient has taken place. Freud's recommendation for the treatment of phobias follows this principle. The phobic patient frequently must be confronted with a phobic situation before the unconscious conflict can emerge and be available for interpretation.
This principle operates in other situations as well. The useful role of the analyst may be to facilitate action in certain situations in order to make the conflict accessible to analytic scrutiny. This may well be viewed as a tactical deviation from neutrality. This is exemplified in the following case.

**Case 4**

The patient was a severely inhibited young man with serious doubts about his masculinity. He felt enslaved in a long-standing marriage that had taken place at a moment of great anxiety and need. He had difficulty in viewing himself as an attractive and potent masculine figure. His premarital sexual relationships had been few, and each had been tentative and uncertain. Early in the analysis he was challenged in this view of himself in a warm and responsive manner not unmixed with lighthearted humor. The patient began to question his presumption of inadequacy. In this context he developed a passionate attachment to a female colleague at his law firm, for the first time experiencing himself as masculine and potent in this new relationship. This occurred early in the analysis, before significant interpretive work had been done, but the experience led to a change in his view of himself that became the basis for further work in analysis. It appeared to facilitate an examination of homosexual anxiety in the transference that would have taken much longer to emerge without the reassuring support of the new relationship that had solidified his masculine awareness. Moreover it confronted him with the difficult dilemma as to whether he should remain in a marriage that offered little possibility for fulfillment and gratification. This behavior early in the analysis was on one level an acting-out of transference fears related to homosexual anxiety generated by my warm, generally supportive attitude. Although I did not encourage the new relationship directly, I did support it by challenging fears and inhibitions about engaging in it, and I did not inhibit it by what I would
consider to be premature interpretations of its defensive transference implications of which I was quite aware. Privately, I did believe that it was in the service of the patient's analysis and growth, and this was communicated indirectly. Admittedly the issue of when to take this stance is a difficult one, and the analyst must be wary of countertransference acting out.

Early interpretation of this behavior as acting out might well have undercut the relationship with the woman. The analysis would have proceeded differently, as had been the case in the patient's previous analysis. By virtue of my having chosen another path, the patient was able to engage in a new experience. In the context of recognizing himself in a new way, multiple conflicts emerged about competition, homosexuality, masculinity, which then became available for analysis. This illustrates how the analyst's perception of the nature and implications of the patient's behavior and his description of his world strongly influences his interpretive stance.

**Affective Interchange as Part of the Real Relationship with the Analyst**

Much of the psychoanalyst's attitude toward the patient is conveyed in the affective tone that accompanies his words, in the timing and appropriateness of his interventions, in the distance or closeness that his stance generates. Patients vary in the degree to which they can tolerate closeness. However, the affective tone may be a critical ingredient of the effectiveness of interpretations and, in its own right, contributes to the picture the patient has of the analyst as a person with his, the patient's, preoccupations and future.

This was graphically revealed in a sequence of supervisory sessions with a candidate who had been working very effectively with an analytic patient. In general, the candidate had been in good emotional contact with the patient, had understood and interpreted appropriately. At a particular moment she had
been distressed by a crisis in her own family involving the impending death of someone close to her. In the supervisory session, she presented the patient's material as it pertained to the patient's experience of their impending separation due to her vacation. She had properly interpreted the patient's experience of loss and abandonment, but her interpretations were devoid of the subtle but definite affective quality that had been present in her previous interpretive interaction with the patient. Oblivious to the interpretations, the patient continued to speak of her sense of being isolated, alone and confronted with a painful solitude even in the presence of the analyst. She spoke poignantly of the lack of involvement of those around.

During the supervisory session that followed these sessions, it became clear that the patient had been responding in part to her changed experience of the analyst, now emotionally removed though technically accurate in her interventions. In the session after the recognition of her isolation, the analyst acknowledged the patient's experience of her as distant and removed in the context of a preoccupation in her own life. The patient burst into tears and revealed that she had always experienced isolation, distance, and a sense of solitude in her relationship to parents and to those around her. It was as if there were a layer between herself and the outside world. "I think it is very difficult to be real, to be who you are, to be open and not to hide, to see someone not covered up and to enjoy being with them. I am amazed at the openness of some of my friends and find myself so unable to respond in a similar way. I appreciate your honesty and I need it, kind of not like having enough of it of my own. I want to be the kind of person to say what I think like you just did." In the following session the patient described how on the way to her analytic session she had found herself thinking and emotionally experiencing things, not just looking at them as an observer as she had always done. "Somehow I felt connected with my inner self." During the night before the session that was to be the last before the vacation, the patient had been restless and had the sense of alternating

- 484 -
between being hot and cold. She had become aware of her fear that things could be too hot or too cold between herself and the analyst, but ended the last session by stating she felt better and more centered.

It is to be noted that the patient's awareness of her own transference distortion emerged when the analyst confirmed her participation (Gill, 1982). This had to do with the specific state of the analyst, unrelated to her character or to countertransference. However, it highlights the importance of prevailing emotional availability. There is little question that an analyst, detached by virtue of character, would have had a very different relationship with this patient that would have muted the patient's capacity to recognize her own isolation.

Much has been written about the impact of countertransference responses, errors in the analytic situation, and modes of dealing with them (see Gill, 1982, for example). Skolnikoff (1988) emphasizes that rare moments of unanticipated emotional expression by the analyst in response to pressures by the patient are remembered as having special meaning to the patient, and by virtue of the analyst's acknowledgment of his role become subject to scrutiny as repetitions of interactions with important figures from the past. In the above anecdote what was disrupted was the emotional engagement of the analyst that characterized the relationship. It may be by its disruption that the availability of the analyst in the relationship is revealed. This availability tends to be largely ignored by those who view neutrality as emotional distance. Also revealed in this anecdote is the patient's wish to identify with the analyst as someone who is open, emotionally available, and honest in her lapses. Although I do not dispute that the wish for identification may in itself have conflictual elements, I disagree with Abend (Abend and Shane, 1988) who states that these identifications must be uniquely viewed from the standpoint of conflict and must be dissolved by the end of the analysis. These identifications appear in important aspects of growth and must be noted as important aspects of change (Viederman, 1976).
In summary, the disruption of the experience of the analyst's engagement and his admission of it revealed to the patient her transference distortion of the analyst as removed and abandoning and permitted analysis of its genetic roots. Had the analyst maintained a distance and unemotional stance (or had she always been distant), the patient would have continued in an essentially constricted, complaining, masochistic way, unable to obtain a perspective on her own distortion. Not only did acknowledgment facilitate the analysis, but the consistent emotional availability was an essential ingredient in a productive analytic process.

**Developmental Theory and the Role of the Real Person of the Analyst**

I close with a brief comment about developmental theory as it applies to psychoanalytic process and the real person of the analyst. Emde (1988) emphasizes that internalization pertains not only to values and attitudes, but to internalization of transactions, a view that must also apply to the experience of psychoanalysis. Patients who work with different analysts will have different experiences, and different patients seen by the same analyst will in some measure evoke different responses in the analyst, just as different siblings evolve different relationships with their parents given the uniqueness of their sex and temperaments. Fortunately or unfortunately, these factors affect the course of analysis. I am speaking here of subtle differences, not gross overreactions by the analyst.

I have argued that change occurs not only by analysis of the transference or by analysis of conflict as it relates to experiences in the outside world, but also in the context of transactions between analyst and patient as they pertain to dialogue about the patient's life. That successful outcomes in analysis may occur with analysts of widely differing theoretical persuasions can be understood as related to the internalization of the
dialogue between analyst and patient which, though guided by a theoretical model, is powerfully influenced by the special quality of their relationship. Emde (1988) speaks as well of "social referencing as a central developmental motivational system." This refers to the process by which the developing child obtains signals from the parents that direct action or avoidance, the designation of positive goals and negative prohibitions. I suggest that the nature of the analyst's interventions, his timing, what he chooses to select for scrutiny and what he ignores, act as points of social referencing that powerfully influence the patient, even though their intent may be to focus on areas for examination and are experienced by the analyst as neutral. This will also be affected by the noninterpretive interventions I have described.

**Conclusion**

My intent in this paper has been to place the real person of the analyst at center-stage as it relates to the curative process of psychoanalysis, and to focus on the analyst as a presence in the psychoanalytic situation. This view is not to be seen as a substitute for the traditional techniques of psychoanalysis, but as complimentary with an eye to facilitating the understanding of the psychoanalytic process. Moreover, it is intended to encourage a freedom that has been too often stifled by strict interpretation of the rules of psychoanalytic technique. It is not my intent to espouse wild analysis, to propose that analysis is a cure by love, or to view it as a manipulative process designed by the analyst to change the patient's behavior. However, one must take seriously the powerful effect of the real person of the analyst, the intensity of his emotional involvement with the patient over many years, the special qualities that inevitably evolve in each individual analytic situation, and the use of noninterpretive interventions. A unique language evolves between each
analyst and each of his patients, and the analyst's commitment to change facilitates the process of analysis.

REFERENCES

to liberate growth or to stimulate growth Presented at the Fall Meeting of the American Psychoanalytic Association. [→]
ALEXANDER, F. 1958 Unexplored areas in psychoanalytic theory and
treatment In Scope of Psychoanalysis New York: Basic Books, 1961 pp. 319-335
ARLOW, J. A. 1985 The concept of psychic reality and related problems J. Am. Psychoanal. Assoc. 35:521-536 [→]
CHUSED, J. F. 1987 Idealization of the analyst by the young adult J. Am. Psychoanal. Assoc. 35:839-861 [→]
EISSLER, K. R. 1953 The effect of the structure of the ego on psychoanalytic technique J. Am. Psychoanal. Assoc. 1:104-143 [→]
EMDE, R. N. 1988 Development terminable and interminable: I. Innate and motivation factors during infancy Int. J. Psychoanal. 69:23-42 [→]
FREUD, A. 1936 The ego and the mechanisms of defense Writings 2 New York: Int. Univ. Press, 1966
FREUD, S. 1909 Notes upon a case of obsessional neurosis S.E. 10 [→]
FREUD, S. 1912 Recommendation to physicians practicing psychoanalysis S.E. 12 [→]
FREUD, S. 1915 Observations on transference love S.E. 12 [→]
FROSCH, J. 1959 Transference derivatives of the family romance J. Am. Psychoanal. Assoc. 7:503-522 [→]
GREENACRE, P. 1975 On reconstruction J. Am. Psychoanal. Assoc. 23:693-712 [→]
GRUNES, M. 1984 The therapeutic object relationship Psychoanal. Rev. 71 123-143 [→]
HOFFER, A. 1985 Toward a definition of psychoanalytic neutrality J. Am. Psychoanal. Assoc. 33:771-795 [→]
LAPLANCHE, J. & PONTALIS, J. B. 1973 The Language of Psychoanalysis New York: Norton. [→]
LOEWALD, H. 1960 On the therapeutic action of psychoanalysis Int. J. Psychoanal. 41:16-33 [→]
MEYERS, G. E. 1986 William JamesHis Life and Thought New Haven, Conn.: Yale Univ. Press.
MCLAUGHLIN, J. T. 1988 The analyst's insights Psychoanal. Q. 57:370-389 [→]
MICHELS, R. 1985 Perspectives on the nature of psychic reality J. Am. Psychoanal. Assoc. 35:515-520 [→]

- 488 -

ORNSTEIN, P. & ORNSTEIN, A. 1977 On the continuing evolution of psychoanalytic psychotherapy: reflections and predictions Annual Psychoanal. 5 329-700


POLAN, W. S. 1988 Insight and the analytic dyad Psychoanal. Q. 57:341-369


STERBA, R. F. 1944 The formative activity of the analyst Int. J. Psychoanal. 25:146-150


VIEDERMAN, M. 1976 the influence of the person of the analyst on structural change Psychoanal. Q. 45:231-249

WALLERSTEIN, R. S. 1985 The concept of psychic reality: its meaning and value J. Am. Psychoanal. Assoc. 33:555-570

Article Citation [Who Cited This?]