The William Alanson White Institute

The William Alanson White Institute of Psychiatry, Psychoanalysis and Psychology, incorporated under the provisions of the New York State Education Law on October 18, 1946, as a nonprofit Educational Corporation, is an association of psychoanalysts and other behavioral scientists, whose primary function is the training of resourceful psychoanalysts. The significant contributions of Sigmund Freud to the understanding of human behavior, and the vital pre- and post-Freudian developments of the study of personality, find a place within the framework of its philosophy.

The curriculum takes note of the psychological, social, and biological factors in human behavior. Taking as its basis the special contributions of two of its co-founders, Harry Stack Sullivan and Erich Fromm, it fosters the study of the human person as a social being, and of human behavior as social communication.

The Institute's program extends beyond the training of psychoanalysts. Its Continued Professional Education Division offers, to a select professional public, courses in recent developments in psychoanalytic theory and the study of behavior. Its clinical therapeutic services provide low-cost therapy to the community. Its Department of Research is concerned with basic studies of behavior within experimental and clinical settings.

In these manifold functions, the Institute expresses its faith that man, through the enhancement of his own capacities, may cope more efficiently with the problems of being human.

ARE INTERPERSONAL AND RELATIONAL PSYCHOANALYSIS THE SAME?

In his thoughtful review of Lewis Aron's (1996) book, *A Meeting of Minds: Mutuality in Psychoanalysis*, Irwin Hirsch (1997) brings up the fascinating question—fascinating at least to those of us in a certain segment of the New York psychoanalytic world—of the difference between the labels *interpersonal* and *relational*. Hirsch sees the terms as essentially identical, at least for the many self-defined relationalists, like Aron, who attempt to integrate a core interpersonal theory with an intersubjective or perspectivist point of view. Current-day interpersonalists, Hirsch says, have generally abandoned the positivistic and the authoritative stance of Sullivan and the early interpersonalists, leaving little or no difference between them and this group of relational psychoanalysts. The label one chooses to describe one's approach, Hirsch suggests, is essentially a political choice, not a theoretical one, based on one's loyalties and professional identifications. But is this really the case?

I think this is to a large degree so—if one looks only at the core theory that each group claims to be guided by. We all accept the proposition that personality and psychopathology are largely shaped through one's interactions with other people. We all, to greater or lesser extents, subscribe to the view that interpersonal history is the primary determinant of personality and psychopathology, and placing the conscious and especially the unconscious relationship between patient and analyst at the heart of the therapeutic effect. The question addressed in this article specifically concerns those relationalists whose core theory is interpersonal, as mine is.

Due to personal and political reasons, these outlooks may correlate quite imperfectly with the groups of analysts that proclaim allegiance to the labels that describe these groups. And due to the fact that interpersonal psychoanalysis is one of the main roots of relational psychoanalysis, some prominent theorists who identify as interpersonal have been instrumental in crafting part of the theoretical underpinning for relational psychoanalysis.
scribe to the idea that interpersonal relations, including the analytic relationship, are mutually constructed and regulated, with substantial unconscious communication between the participants. We are all skeptical of the idea that the analyst has a privileged relationship to objectivity. And we all value the capacity for genuine mutual recognition as a goal of analysis. I could add that some contemporary self-described Freuds would disagree with none of this. Moreover, psychoanalytic schools in the United States seem to be in a period of dislocation. As both Aron (1996) and Hirsch (1996) have pointed out, writers from other psychoanalytic schools generally do not acknowledge the priority of ideas when it belongs to the interpersonal school, but the ideas of many schools do seem to be converging, and they seem to be converging on areas that first were the focus of interpersonal psychoanalysis.

And yet, coming of age as a psychoanalyst at the New York University Postdoctoral Program during the years when relational psychoanalysis was only an infant—at that point not even a recognized "track" within the Program—there seemed to be many people whose outlook was essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?

**Interpersonal Psychoanalysis**

It seemed to me then, as it does now, that the label interpersonal often carries a characteristic aesthetic, a certain attitude in one's approach to working with patients. As Hirsch (1997) notes, Aron (1996) sees the interpersonal school as an oppositional school, developing, as it did, in opposition to certain problematic trends within the mainstream of psychoanalytic theorizing. I think the word "oppositional," in a sense, also characterizes the approach of many self-defined interpersonalists to their patients. Interpersonalists tend to rely on confronting patients with the impact they make upon others (including the analyst) as the primary essentially interpersonal, yet who did not feel they had a place among the interpersonalists at N.Y.U. Why did they not?
that patients are ready. This approach may result in a higher anxiety level in the patient.

Consistent with confronting patients with their impact on others, interpersonalists may tend to focus their interpretive comments more on patients' interpersonal acts rather than on their experience, in contrast to most other analysts. In the language of self- and mutual-regulation, interpersonalists, in their confrontation of what the patient is doing with the therapist, focus on the patient's attempt to regulate the other, and less on the patient's attempt to regulate himself, compared with relationalists (though, of course, these are two aspects of the same act). Along with this focus on acts, I think there is a certain attitude toward the patient's will among some interpersonalists, with a bias even toward seeing the patient's "resistance" as willful.

Developmental Approaches

The developmental approach, which is generally somewhat influential on relationalists, even if not their core theory, is quite the opposite of the interpersonal approach. Proponents of this point of view, including British object-relationalists, such as Winnicott and Balint, self psychologists, and even to some extent classical ego psychologists, have uppermost in their minds the patient's state of readiness to hear an observation or interpretation from the therapist. For them, the patient is, in a very real way, a child, and must be approached as such. Their approach to the "regressed" patient, based on their ideas about child development and the causes of psychopathology, is much less likely to be challenging and confronting. Balint (1968) talked about allowing certain patients the experience of a "harmonious interpenetrating mixup" (p. 136) between patient and analyst, with the analyst taking pains to be "unobtrusive" (p. 173) and to avoid being experienced by the patient as a "separate, sharply-contoured object" (p. 167). Similarly, Winnicott's (1960a, 1971) ideas about the emergence of true self, transitional space, and play also support an approach that does not challenge the patient or quickly move to clarify what is real and who is whom. Mitchell (1993) notes that for developmental analysts, depending on their particular school of analysis, a different role than the patient. Hoffman (e.g., 1991), despite his commitment to the ideas that the analytic relationship is mutually constructed and that the analyst is inherently transparent to the patient, nevertheless asymmetrical. The analyst has responsibilities toward the patient that the patient does not have toward the analyst, and so assumes the function of language is either "to convey a sense of accompaniment, an 'attunement,'" or else "to establish and embellish a resonance with dimly felt, often developmentally earlier self-organizations . . . . to evoke original feeling states and earlier versions of the self" (p. 120). Mitchell says that this "evocative use of language dissolves its consensual dimensions [i.e., the clarity that the interpersonalists strive for] to allow hidden resonances to be heard."

Developmental Influences on Relational Psychoanalysis

Even the many self-defined relationalists whose core theory is interpersonal and who don't go along with the idea of the adult patient as a child seem to me to be interested in some of the ideas from the developmental approach, and influenced by them in several ways. These ways include the likelihood of being more attentive and sympathetic to the nuances of the patient's self-states, including patients' readiness and openness to the analyst, and more specifically to have a bias toward accepting the patient's experience of vulnerability at face value, as compared with many interpersonalists, the likelihood of allowing themselves to be "used" (Winnicott, 1969) as some kind of healing object by their patients (Aron, personal communication, 1997), and being more open to allow the therapeutic relationship to take its course for longer periods of time, without understanding or needing to clarify where it is headed.

Several relational analysts have discussed the need, not simply to throw the cold water of "reality" at the patient, but to take the patient's state of mind into account. Greenberg's (1991) relational approach to the concept of neutrality, for instance, proposes that "the neutral analyst occupies a position that maintains an optimal tension between the patient's tendency to see him as a dangerous object and the capacity to experience him as a safe one" (p. 217; original in italics). Along these lines, in a later article, Greenberg (1996) expressed "sympathy with the idea of analytic restraint" (p. 212), despite his belief that the analyst can never be removed from participating in the flow of action in any treatment. Similarly, Aron (1991, 1996) has proposed that although the analytic relationship is mutually regulated and aims toward mutual recognition, it is nevertheless asymmetrical. The analyst has responsibilities toward the patient that the patient does not have toward the analyst, and so assumes a different role than the patient. Hoffman (e.g., 1991), despite his commitment to the ideas that the analytic relationship is mutually constructed and that the analyst is inherently transparent to the patient, nevertheless believes that "some aspect of the idealization of the analyst by the patient may be . . . necessary" (p. 97) and helpful to the analytic process. Interpersonalists who struggle with the compelling aspects of the con-
cept of regression, for instance Bromberg (1994, 1996) with his explication of the idea of multiplicity of selves in which both child and adult selves are experientially authentic, soon come to be regarded as relational psychoanalysts.

Developmental Critique of Interpersonal Psychoanalysis

My own observations suggest that the interpersonal approach can be empowering and freeing for many patients and can lead to a deepening of their experience of what they are feeling. But I also think the interpersonal approach can sometimes foster a moralistic tone. Due to the certainty that the analyst conveys, or that the patient inevitably attributes to her (this happens with all analysts, but more, I think, with those, like many interpersonalists, whose authoritative behavior tends to confirm this transference), the patient may end up feeling that something about him is "wrong," and he may tend to suppress aspects of his experience and ways of being which don't fit in with this direct approach. The patient may also come to believe that his interpersonal difficulties and resistances are somehow "willful," yet be unable to act differently. The patient may also feel coerced to "change" in order to comply with the analyst's (explicit or implicit) values. If the patient does, the "cure" is by identification rather than self-knowledge; or else, unable to comply but still identifying with the therapist's values, the patient may further feel bad or a failure.

Bromberg (1991) believes that an interpersonal approach can "adulterate" (footnote, p. 417) certain patients, and that it is "vital" for these patients to be "allowed to reconnect with the [experience of being a] baby as a reality that is lived with the therapist," or else "the therapy is simply one more exercise in pseudo-adulthood in the patient's life." Balint (1968, chap. 17, extending Ferenczi's 1933 ideas about identification with the aggressor in the analytic relationship) and Winnicott (e.g., 1960b, pp. 50-51), both speaking from the developmental point of view, take the Kleinian approach to task for its directness, in critiques that might just as well apply to the interpersonal approach. They both agree that the analyst's interpretations may be taken as an attack by the unready patient, rather than as usable information, and therefore will be dealt with as a trauma to be coped with, often in pathological ways, such as idealization of, and identification and compliance with, the aggressor-analyst.

Interpersonal Critique of the Developmental Approach

Interpersonalists counter that the "developmental" approach is patronizing and inauthentic; that the patient is an adult, not a child, and the analyst who treats the patient as a child conflates the patient's fantasy about her level of maturity with her real developmental state; that analysts who worry that the patient is too anxious or defensive to take in an interpretive comment are likely to be projecting their own anxiety onto the patient and mistaking it for the patient's anxiety and unreadiness; and that the existence of significant, two-way unconscious communication in the analytic relationship means that the analyst who treats the patient as not ready to hear what the analyst is thinking may be requiring the patient to collude with the analyst's fantasy of the analytic relationship and to deny the patient's own sense of the analyst's real motives. According to this critique, a more "developmental" approach may reify a patient's fantasy of herself as a child, and may therefore have the effect of disempowering and infantilizing the patient and requiring the patient to dissociate some of her perceptions rather than own them (see Wolstein's 1988a, 1988b discussions of some of these issues, and Mitchell's 1993 discussion of Fromm's point of view, p. 145).

Relational Psychoanalysis as Integrative

Relational psychoanalysts are neither pure interpersonalists nor pure developmentalists; rather, whatever their core theory, they attempt to work with the truths of both of these conflicting positions. One of the central problems with which relational psychoanalysis struggles is the tension between such ideas, on the one hand, as analytic neutrality, or the "developmental" idea of the analyst as playing a self-effacing, parental, protective role—ideas that may presuppose the patient to be ignorant of what is going on in the analyst's mind—and, on the other hand, the idea of significant unconscious perception by the patient into the analyst's mind. In a somewhat different slant, the tension is between the idea of the patient as being like a child, unable to face certain aspects of reality, as opposed to being an adult, with the capacity to face unpleasant reality as it presents itself (see Giont, 1992). Put still another way, how do we focus on the patient's inner experience without slighting external, social realities? Put less positivistically, it is crucial that the analytic relationship encompass and value both the patient's perceptual real-
ity and the often conflicting reality of the analyst’s experience (see Ghent, 1989). All these sentences address what Benjamin (1997) has called “the tension between (inherent) mutuality and unavoidable asymmetry” (p. 797) between patient and therapist. They are all different ways of stating the relational paradox.

The tension between these conflicting perspectives has been a source of creative theorizing in several areas among relational analysts. For instance, the opposition between ideas of the adult patient as “really” a child or as really adult has given rise to the current relational interest in multiplicity of selves (Bromberg, 1993, 1994, 1996; Mitchell, 1993). The idea here is that we all have a variety of self-states, each inherently discontinuous from the others, and each with a particular experience of self, of the other with whom we are in relation, and characterized by certain affects, moods, patterns of thinking, and patterns of interacting. From this perspective, the patient can be authentically both child and adult (see Harris’s 1996 reconsideration of the concept of authenticity), and the analyst’s task becomes to engage and facilitate elaboration of all the patient’s self-states within the therapeutic relationship—rather than needing to choose which adult or child state is authentic, with the consequent attitude toward competing self-states as defensive. In terms of the patient’s readiness to hear a comment or interpretation, the idea of multiplicity of selves raises the question, not only of which self the therapist is addressing, but of how each of the patient’s selves—the various adult and child selves—is hearing the interpretation. Perhaps an adult self is taking in the information, while at the same time a child self simply feels hurt, abandoned, or angry.

The extent to which relational psychoanalysis is an integrative approach can be seen in Mitchell’s (1993) description of the analyst’s participation based on the idea of multiple selves. Mitchell explains how such an analyst responds “to the complex textures of the patient’s experience” (p. 118) through a multidimensional appreciation and engagement of the patient’s various, and apparently contradictory, selves. The analyst tries to be attuned to the patient’s “core” self (as self psychologists do, in the self-psychological approach, the “core” self is a child self), and to facilitate the patient’s need to “hear the echoes of other voices, to feel other presences of earlier selves. . . . to be ready to surrender his hold on the misleading, apparent continuity of his experience” (p. 118; an object-relations approach), and to help the patient “come to appreciate that he was much more effective than he knew” (p. 118, that is, the patient is seen as an adult, an interpersonal approach); and to make it possible for the patient “to discover the permeability of the boundaries between his experience of self and others and to appreciate what is often the exchangeability of the contents assigned to each” (p. 119; a different approach to the self, based on the work of the Kleinian school).

The idea of multiplicity of selves also makes possible some of the new relational perspectives on trauma, in which the centrality of dissociation as a response to trauma becomes more elaborated in terms of the reorganization of self-states as a result of trauma (Davies & Frawley, 1994) and the functions of various self-states in coping with trauma (Grand, 1997).

Thinking of the relational paradox in terms of the universal struggle within each interpersonal relationship to encompass the conflicting experience of two different people has led to Benjamin’s (1988, 1992) work on intersubjectivity. She makes the point that we must recognize the other even as we assert ourselves; otherwise, the other’s recognition, which gives meaning to our own experience of ourselves as subjects, is useless. Following Hegel, she proposes that the alternatives to intersubjective relating involve dismissal of the other person or of oneself: master or slave; sadism or masochism. Frankel (1993) extended this idea to the analytic relationship, proposing that some variation of unconscious, sadomasochistic collusion between patient and analyst is a constant (and therapeutically essential) countercurrent as patient and analyst struggle toward an ideal of increasing intimacy based on mutual recognition and acceptance. Gerson’s (1996) reinterpretation of analytic neutrality in relational terms, as an ideal of mutual acceptance which is constantly undermined by “intersubjective resistances,” portrays the analytic relationship in similar terms.

The concept of intersubjectivity is related to the relational interest in negotiation as a therapeutic process (Pizer, 1992; Mitchell, 1993; Frankel, 1998). Therapy may be partly understood as a reconfiguring of enduring patterns of self-other relationships through negotiations between two people—patient and therapist—who have different needs and perceptions. The idea of multiplicity of selves adds a dimension to the concept of negotiation: Negotiations in therapy take place not only between two people, but simultaneously between different versions of self within the patient (and sometimes within the therapist) and between various selves of the patient and selves of the therapist.
The ideas of multiplicity of selves and intersubjectivity have become integrated with each other through the recognition that self-states are interpersonal events (Bromberg, 1996; Frankel, 1998). Any self-state engages other people in related self-states through ubiquitous processes of identification (Racker, 1968) and projective identification (Ogden, 1994) and due to the fact that every act of self-regulation in an interpersonal context also involves regulating the other's state and behavior (Beebe & Lachmann, 1988). The relational interest in play as inherent in the therapeutic process reflects all these facts. Play involves not only accepting and enjoying the coexistence of one's own self-states with each other, but also an enjoyment of, and an active approach to, the interaction of one's own self-states with those of the other person (Frankel, 1998).

This emphasis on the interaction between the self-states of patient and therapist may lead to a sense of the therapeutic interaction that is quite different from the interpersonal idea of clear boundaries and direct talk with the patient. Rather than maintaining his or her distinct boundaries, some relational therapists may feel more comfortable, at times, loosening boundaries between themselves and their patients, letting themselves be swept up in a shared experience and a mutual enactment—even one in which it is not clear who is feeling or doing what or, even for extended time, what it means. In fact, Bromberg (1996) says that “the analyst is always ‘deaf to the patient . . . , at least with regard to certain dissociated aspects of the patient’s self’ (p. 527), and that it is through the analyst’s participation in enactments with the patient that the analyst may wake up these dissociated aspects of the patient.

When the therapist is willingly carried along into an enactment, he allows himself to become a therapeutic object. But this is not the same as being a parental object. That is only one possibility. The therapist can become a “playmate” of various kinds: a “lover,” “enemy,” loving parent, failed parent, collaborator, coconspirator, and so on. The therapist’s participation in mutual enactments may entail conflict and strong negative emotions toward the patient. Grand (1997) notes that fuller experience of certain disavowed self-states in some patients may require the therapist to respond to the patient with her own strong emotions, including her hatred. In contrast to relationalists, who I think are more likely to be comfortable being “playmates” and going with the flow of mutually, unconsciously directed self-state shifts, involving both patient and therapist (see Frankel, 1998), some interpersonalists, I think, seem to try to hold to what feels like their singular most authentic self, their “psychic center.”

INTERPERSONAL AND RELATIONAL ANALYSIS

(Wolstein, 1988a). Relationalists, in turn, reexamine the concept of authenticity, suggesting that it is not reserved only for select self-states, but may characterize many different self-states, depending on the context of the moment (Mitchell, 1993), and they critique the idea of a dichotomous “split between the socially emergent [i.e., that which is reactive to the environment and the personally authentic” (Harris, 1996, p. 551; also, see Mitchell, 1993).

Along the lines of going with the flow of enactments, whereas both interpersonalists and relationalists may rely to a great extent on their own responses to their patients as a guide to knowing what is going on with the patients, some interpersonalists (in the tradition of Sullivan’s 1954 technique of detailed inquiry) may more quickly inquire when they don’t know what something means, whereas relationalists may tend toward letting things develop without knowing. Letting things evolve in their own time can be the relationalist’s method, even as it may lead to being direct, choosing the patient’s adult self-state as the one that needs talking to. For instance, in working with one patient, I realized the extent of his disavowed hostility, and knew I must be blunt about it, when I sensed how angry and closed I felt toward the patient after he canceled a specially scheduled appointment at the last minute.

Relational and Interpersonal Attitudes toward Self-Other Differentiation

Aron (1996) alerts us to how our language makes it easy to talk about individuals as acting, thinking, or feeling, but difficult to talk about a relationship acting, thinking, or feeling. He suggests, along lines similar to Hoffman’s (1991) discussion of how it is impossible to say who is the originator of a thought or feeling, that it is often inaccurate to think in terms of boundaries between patient and therapist that are too distinct, and that it is more accurate to think of certain thoughts and feelings arising between patient and therapist.

Making a different point, but also one that emphasizes a relational perspective on not asserting the analyst’s own boundaries, Mitchell (1993) talks about “the usefulness (sometimes) to the patient of the analyst’s allowing himself to be ‘used’ by the patient as a vehicle for self-exploration. Intimacy . . . involves a continual, mutual surrender. One
JAY B. FRANKEL, Ph.D.

offers oneself up to be shaped, arranged, explored, in the service of the other's self-expression. This happens all the time in analysis" (p. 147).

This lack of self-other differentiation, which I think is more comfortable for relationalists to accept, seems to me to be at odds with the interpersonal (and most other schools') sense of the analytic interaction. For instance, the interpersonal analyst in Levenson's (1972, 1983) theory is often striving to define and assert his own perceptions and boundaries and to resist being transformed or co-opted by the patient. For Levenson, getting carried away in one's relationship with the patient may be an inherent part of the therapeutic process—"the interpersonalist commits himself to the stream" (Levenson, 1983, p. 99)—but it is the therapist's resisting this that is ultimately the therapeutic act.

Perhaps the more "sober" kind of therapist that interpersonalists often seem to be is an updated version of the analytic neutrality that they were pioneers in debunking, in the sense that the separateness and distinctness of boundaries that the interpersonal analyst strives for is to some extent an illusion, and one that is quite susceptible to being used defensively: the analyst may seek to differentiate himself from the patient as a way of disidentifying from a frightening aspect of the patient's personality or avoiding intimacy or loss of self.

Two Views of Cure

I think that each of these schools has an idea of cure very different from the other. Interpersonalists see challenging the patient's perceptions as the key to cure. Relationalists seem to have a dual approach toward understanding cure. Like the interpersonalists, they also recognize the therapeutic value of introducing perceptions that are at odds with those of the patient. Bromberg (1996) states that "an enacted collision of realities between patient and therapist" (p. 530) is required to change the patient's perceptual reality. Harris (1996) points to "misunderstandings ... I speak to someone not always present in the treatment," and says that "These differences, ruptures in understanding, are new potentials for internal movement in the patient" (p. 545). But relational analysts also try to foster elaboration and articulation of the patient's perceptions as an act with its own inherent therapeutic value.

The emphasis on challenging the patient's perceptions can be seen in the tradition of Ferenczi's "active technique" (e.g., Ferenczi, 1919): The therapist interferes with the patient's comfortable compromises and thereby brings them into sharper relief. Interpersonalists 'interfere' by making direct, confrontative comments and through their detailed inquiry, which calls into question the narratives the patient has organized in a particular way. These techniques bring into the therapeutic field data that is discrepant with the patient's way of experiencing the world. Within the therapeutic relationship, the discrepant data may consist of analysts' observations about the patient, of their own experience with the patient, or it may simply be their efforts to "be themselves" while resisting being influenced by the patient (Levenson, 1972). Their simple "otherness" may be discrepancy enough. Freedman (1985) has discussed how the analyst's simple discordant presence is the catalyst in the patient's articulating himself in a symbolic way. In Piaget's terms, the discrepant data introduced by the therapist requires the patient to accommodate to data he cannot assimilate into his current way of perceiving the world. Ferenczi's active technique, and its interpersonal descendents, highlight the therapeutic importance within the therapy of a reality outside the patient's experience.

The developmental approach follows Ferenczi's later interest in his "relaxation technique" (e.g., Ferenczi, 1929) of maternal kindness, which he used with "regressed" patients. But he came to see that his "relaxation technique" sometimes foundered on these patients' keen perception of their analyst's unconscious negative countertransference toward them (Dupont, 1988; Ferenczi, 1933). In his final works, Ferenczi wrestled with the tension between what he continued to see as the importance of speaking to the patient in a protective way, as to a child (also, see Ferenczi, 1931) and the importance of absolute, even brutal, honesty with patients. In this way, he is also the prototype of relational psychoanalysts in their struggle with the tension between these conflicting points of view. In another sense, Ferenczi's struggle foreshadowed relationalists' current effort to develop an intersubjective therapy, in which both the patient's experience and the therapist's reality can coexist (e.g., Benjamin, 1988; Frankel, 1993).

Conclusion

Neither interpersonal nor relational psychoanalysis are monoliths. There are various strains of each, and there is considerable overlap between the two groups. Political and personal factors do sometimes deter-
Balint, M. (1968). The Beebe, Aron, silent adult, and the idea of the patient as vulnerable child. In contrast, appear to relationalists to contain truth: the idea of the patient as a re­
ternalists tend to resolve this tension in favor of seeing the patient as a
REFERENCES

INTERPERSONAL AND RELATIONAL ANALYSIS
FURTHER THOUGHTS ABOUT INTERPERSONAL AND RELATIONAL PERSPECTIVES* 
REPLY TO JAY FRANKEL

It is pleasing to me that one as erudite as Jay Frankel was sufficiently stimulated by my review to write a spontaneous response. Clearly there is more to be said about the interpersonal and the relational. This reply gives me an opportunity to address some issues that I overlooked in my review of Lewis Aron's (1996) important book, as well as some significant additional issues raised by Frankel. I want to be clear from the outset that the views I express are not necessarily representative of others who identify with either perspective. I feel identified with both the interpersonal and relational designation (though I normally refer to myself as interpersonal), yet I know that many others who do as well might disagree with much that I say here.

First, I wish to reiterate the point that "relational" began as an umbrella term and interpersonal psychoanalysis was a very central tradition (perhaps the most central) that was included under that umbrella. The relational orientation has since expanded in meaning to include, as well, a blending of perspectives under that original umbrella. I do not see a singular relational "school" Spezzano (1998) addresses this question in some depth and comes to the same conclusion. Like Spezzano, my sense of the term "relational" is that it reflects both a variety of independent traditions and a mixture of traditions that have some key things in common, much as originally described by Greenberg and Mitchell (1983).

The subtitle of the journal *Psychoanalytic Dialogues* is "A Journal of Relational Perspectives," (author's italic), and to me, this pluralistic spirit is continuous with my understanding of Greenberg and Mitchell's intentions. Therefore, I cannot agree with Frankel when he juxtaposes relational and interpersonal as separate perspectives, as if relational was...