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The Analyst's Unformulated Experience of the Patient

Interpersonal influence can be effective without being known. We take this for granted. Constant and mutual influence is the rule. We do not have to know what we are doing to affect others, and we do not have to be able to think about influence to accept it. Quite the contrary. The most profound interpersonal influence goes as deep as it does because it is not known by either party. We are most likely to participate unwittingly in precisely those interpersonal patterns we would describe as problematic—that is, if we could see the patterns well enough to describe them. This is no less true inside the consulting room than outside it, and no less true for the analyst than for the patient. We can only choose not to participate after we know what we have already been involved in. And by then the essential work has been done. This means that the spontaneous, unconsidered reactions of analyst and patient to one another may be the sole evidence, the footprints, so to speak, of the very influences which cannot be articulated by either participant, but which most need to be known. Sometimes, as with footprints, constructing the beast from the evidence would require so much speculation that the task is best left until more data accumulate. At these times, though the analyst may suspect that his direct experience reflects an entanglement in unseen interactive realities, he cannot see how to use his reaction. The links between his experience and the patterns he wishes he

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This paper is dedicated to the memory of Edward S. Tauber, M.D.
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could describe remain obscure, and he must wait. Other times, the analyst's reaction informs him immediately about the state of relatedness the patient intends to create. In any case, it is vital for the analyst to know explicitly and continuously his direct experience of, and with, the patient (e.g., Ehrenberg, 1982, 1984; Epstein and Feiner, 1979; Feiner, 1979, 1988; Fromm-Reichmann, 1950; Levenson, 1972, 1983; Tauber, 1954; Wolstein, 1975, 1981). Any difficulty we have in knowing countertransference is therefore of primary clinical significance. Operationally, for the working psychoanalyst, knowing his experience of the patient means being able to formulate it in words, if only to himself. The present paper is an exploration of the difficulty we all sometimes have in finding these words, in just knowing what our ongoing experience of the patient is, much less the additional problem of knowing what it means. The inquiry will focus on aspects of the question which are least influenced by the characterological difficulties the analyst brings to the interaction, because they have been written about so often, and in fact are relatively rare in the everyday countertransference of seasoned analysts. I will not discuss the typical problems in which the analyst, for private reasons, refuses to know how he feels about a patient (Ehrenberg, 1985; Tauber, 1978).

The investigation will concern two broad areas: the nature of the analyst's unarticulated experience of the patient, and the implications of this problem for an understanding of how the analyst's later, articulated understanding of the patient comes into being.

The Nature of the Analyst's Experience

The very nature of the analyst's experience of the patient contributes to his difficulty in knowing it. Reactions to others occur in a form with which words are not easily compatible. It is a different kind of experience than words—like music, say—and so putting it into words is problematic, and the result of the attempt is generally an incomplete representation. We cannot speak music or painting. We cannot even describe them without a loss of content so thorough that the description is meaningless without direct acquaintance with the work itself. The analyst's experience of the patient is, like these forms, nondiscursive in nature. Its truth is not sequential or logical, but presentational, like artistic truth (Langer, 1942). What we glean from our reactions is not the propositional truth of language, but what William James (1890) calls "knowledge of acquaintance."

Prelogical Experience

The earliest conceptualization of the analyst's experience as pre-­presentational is Tauber and Green's Prelogical Experience (1959). Countertransference was one of a variety of types of experience these writers described as prelogical, by which they meant experience occurring in symbolic but nondiscursive, or nonlinguistic, form. Participating in the awakening of a humanist intellectual Zeitgeist in the late 1950's, Tauber and Green, like their colleague and mentor Erich Fromm (1941, 1947, 1950, 1955) before them, rejected scientism and sterile language and logic. They were also heavily influenced by Suzanne Langer (1942) and other philosophers who had turned away from positivism and had begun to insist that nonrational and nondiscursive meaning was no less valid for not being linguistic in form. Tauber and Green broadened the psychoanalytic understanding of symbolism to include not only dreams, fantasies, and parapraxies, but also such marginal processes going on at the edge of awareness as illogical thoughts, hunches, intuitions, extrasensory perceptions, subliminal perceptions—and irrational countertransference.

The authors' understanding of the self is reminiscent of Fromm's (e.g., 1941, 1947) presentation of the same issue. The self is a selective limiting aspect of experience which registers only a fraction of the totality of consciousness. When the self is, as Fromm (1941, 1947) describes, "a form with which words are not easily compatible."
This "vast waterfall" is prelogical experience. We know more than we can say:

A great deal of what we do among one another consists in apprehending nonpropositional emotional responses and ... in fact goes on in the prelogical mode (p. 3). Prelogical experience is thus not merely the outcome of an internal psychic process, as nonrational symbolic phenomena are understood in intrapsychic theories. Nonrational symbolic representations are instead embodiments of poorly comprehended aspects of reality, necessarily distorted because they represent something only dimly understood. As one might expect, Tauber and Green cite as the most specific inspiration for their theory Fromm’s (1951) conception of dreams and other symbolic phenomena. The chief aim of Tauber and Green’s work was to reconceptualize the nature of the analytic situation. The analyst’s prelogical thoughts "... could be a bridge to the subthreshold communications existing between the patient and himself” (p. 5). What Tauber and Green refer to as "acting-out" by the analyst, such as the genuine and unexpected expression of sadness by the welling up of tears, may be "... an unconscious scanning response to the neurotic atmosphere communicated in subthreshold form to the analyst’s receptive unconscious.” The authors continue:

If the acting-out contacts the patient’s past experience in neurotic interaction with others, then a laboratory situation has been created that closely resembles the actual conditions of the patient’s living. An interpersonal set of appropriate coherence and perspective has been fashioned. The reconstruction-in-immediacy of a genuine laboratory problem in living increases the probability that something pertinent is being solved (pp. 141-145).

Tauber and Green suggest that if the analyst does not or cannot react directly to the patient’s neurotic involvements with him, "...
Language in the Work of Fromm and Sullivan

Any position about the role of language in experience is rooted either in the capacity of language to create new meaning or its tendency to prevent it. Tauber and Green, while acknowledging that new experience must eventually be represented in language to be analytically useful, lay their primary emphasis on the vitality and truth of presentational forms. Fromm (1947, 1947, 1960, 1962) took a similar position when he claimed that language was one of three aspects of the "social filter" by which culture blocks the full experience of what it is to be human. (The other two were logic and the culture-wide exclusion from awareness of certain content.) In accordance with Fromm, Schachtel (1947, 1959) wrote that we are robbed of directness and vividness in individual experience by the banal schemata we develop as we are socialized. These schemata, often or even usually linguistic in form, are a means by which the status quo is maintained, because the very categories that eventually imprison one's experience also come to be the only categories within which experience can be known. True and "raw" experience, says Schachtel, would destabilize society, provoking individuals to become aware of how much of what they could have been they have sacrificed. In this respect societies are as conservative as personalities: radical change is not easily accommodated. Schachtel, however, an eloquent and subtle writer, was not unsympathetic about language. For example, despite his attitude toward conformity and conventionality, he made a point of saying that even the most hackneyed phrases retain evocative power if the speaker is in genuine contact with the experience he is trying to express (Schachtel, 1959, p. 190). It is an emphasis Schachtel places on the regularizing influence of language, not an exclusive focus. It is in this relative sense, for Schachtel, for Tauber and Green, and for Fromm, that language, while not the villain of the piece, is most often a necessary evil. It may on occasion stretch around something new, but it is more likely to capture and shape experience in conventional, trivial forms.

During the same period, Harry Stack Sullivan was developing a view of the relationship of language and culture which, while in-
it a hallmark of his work not to limit his clinical interest to the pragmatic aspects of his patients' lives (Ehrenberg and Sugg, 1981; Landis and Tauber, 1971; Tauber, 1959). Sullivan saw himself as a solver of problems in living (Sullivan, 1940, 1954). It would have been consistent with Sullivan's position for him to feel that reaching toward the limits of human potential, or even trying to chart the boundaries, was irrelevant to psychiatry (Thompson, 1950).

Thus, for Fromm, Schachtel, and Tauber and Green, truth, or value, resides more often in direct apprehension or immediacy (Tauber, 1959), less often in verbal comprehension. Fromm (1960) writes,

> The opposite of the alienated, distorted, parasitic, false, cerebrated experience, is the immediate, direct, total grasp of the world which we can see in the infant and child before the power of education changes this form of experience (p. 128).

And lest there be any question how strongly Fromm held that what we can say contains less truth than what we sense, but cannot say: "Freud recognized that most of what is real within ourselves is not conscious, and that most of what is conscious is not real. ... Even if we are sincere with regard to what we are aware of, we are probably still lying because our consciousness is "false," it does not represent the underlying real experience within ourselves (Fromm, 1962, p. 89)."

Prelogical experience is a way of conceptualizing from the perspective of Fromm the nature of unconscious experience, or at least the nature of our route of access to it.² We are most likely to be surprised, to learn something new, if we pay attention to experience which has little organization. Once experience is organized and worded, its truth value has probably been irreversibly diluted or irretrievably lost, a casualty of the social filter. The value and

² E. Singer (1970, p. 299) wrote that countertransference in prelogical experience is "very much in line with" Sullivan's understanding of the therapeutic process, because "... the therapist could not remain a detached bystander but had to be a participant observer."² This point can be made about the clinical work of both Fromm and Sullivan, though the term "participant observation" is of course Sullivan's. However, the concept of prelogical experience is more specifically consistent with Fromm on irrational symbolic representation than with Sullivan (1940), because Sullivan considered irrational symbolic products parasitic and therefore useful only if they could be translated into conventional verbal representation (i.e., consensually validated).
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Was this patient's experience of missing something already present somehow "in" the patient before her reading of the newspaper article? Was that feeling of missing something "there" prior to her first words for it? In what form?

These are all experiences which were unformulated (Stern, 1983, 1987) prior to being reflected upon. It is the attention paid to them, and the words consequently chosen to represent them, that give them an explicit shape. The unformulated is experienced as what Gendlin (1964) calls "felt meanings" and what William James (1890) refers to as "feelings of tendency." These are vague senses of what meaning is to come. Before being articulated the experiences are relatively undifferentiated, and thus in the sense that they cannot be known—cannot be reflected upon—they do not exist. Words do not clothe experience. They construct it. The analyst's interpretation of the dream, for example, was not already "there" inside the patient. Rather, the analyst's words, by helping the patient to accomplish a bit of self reflection, encouraged a transformation of certain murky and unnoticed cognitive and affective material of the patient's into a clear and convincing piece of meaning.

Elsewhere I have characterized unformulated experience as follows:

... Unformulated experience is experience which has never been articulated clearly enough to allow application of the traditional defensive operations. One can forget or distort only those experiences which are formed with a certain degree of clarity in the first place. The unformulated has not yet reached the level of differentiation at which terms like memory and distortion are meaningful.

Most psychoanalysts seem to operate on the basis of the implicit hypothesis that people may resist the clarification of certain aspects of their experience, preferring vague, impressionistic formulations for which there genuinely are no words. We work as if the meaning ... remains to be formed, as if there is not necessarily an underlying and pre-existing clarity in experience (Stern, 1983, p. 79).

There is no single meaning which inevitably surfaces as unformulated experience is articulated. Because the unformulated exists at a level of articulation too vague to represent or even to imply conventional meaning, the meaning or meanings to be created from it are not entirely predetermined. There are constraints, of course. It is not a wholly relativistic view (Stern, 1985). Beyond certain limits, to claim a relationship between an articulated meaning and the vague or unformulated mental activity which preceded it would be experienced as false, or even ridiculous. If you tell the patient that the explanation for his silence is anger when it just is not, the patient can generally tell you that you're wrong even if he cannot yet substitute wording that feels to him like a more precise description of his state. It is like watching a figure emerge from a dense fog. There is a shape there, but it is fuzzy. It could be a person. It could even be a dancing bear. But it couldn't possibly be an elephant.

If thoughts and memories were based on more or less enduring traces, as Freud accepted throughout the years during which he developed psychoanalysis (e.g., Freud, 1900, 1915, 1937), then not being aware of a particular thought or memory would require that access to consciousness be blocked or that the unacceptable element be changed in such a way that it is unrecognizable. This is the familiar psychoanalytic model of the defenses. However, it is accepted in most academic quarters today that thoughts and memories are based primarily on schemata, not on enduring traces. For example, Gardner's (1985) fine and gripping history of the "cognitive revolution" which has taken place over the last thirty years in academic psychology contains not a single reference to traces or trace theory, though the rise of schema theory is one of the book's themes. (See also Bartlett, 1932; Paul, 1967; Rumelhart, 1975; Schachetel, 1947). Schemata are sets of instructions about how experience is to be constructed. While the cognitive product of the operation of a schema must bear a relationship to whatever traces it contains, this relationship is not necessarily direct. Adaptive variation is the rule. The process of constructing experience is responsive to the demands of the moment, conscious and unconscious.6

6 Loftus (1979) provides a wealth of convincing, and sometimes disturbing, demonstrations of the malleability of eyewitness testimony. Consult also Bartlett's (1932) classic experiments showing how quickly original experience deteriorates into increasingly conventional memories—to the point of gross distortion. Rumelhart (1975) has built on the work of Bartlett, among others, in his modern demonstrations that people regularize memories according to whether or not the story with which they are presented corresponds to what they expect a story to be (what he calls a "story grammar.")
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Not being aware of a thought or memory, then, means not constructing it. If it is not made, the experience literally does not exist. There is a blueprint, but no house. And while the materials of which the house will be constructed may or may not change over time, their arrangement is likely to. The blueprint is subject to continuous review. One result of this line of thought is that preconscious contents can no longer be conceived as concrete or literal, but must instead be understood as potential mental activity: thoughts not yet thought, connections not yet made, memories one does not yet have the resources or the willingness to construct.

In Freud's conception (1900, 1915, 1937) unconscious content is well enough formed to be capable of symbolic representation. Bringing it from the unconscious into the preconscious is therefore a matter of attaching verbal labels to it. By comparison to the preconscious to conscious, the path from preconscious to conscious is both less arduous and less conceptually significant, requiring only that attention be focused on the preconscious content.

Unformulated material, however, must change in form to enter consciousness as in the focusing of a view through a telescope. Something that could be labelled a "view" exists prior to adjusting the focus, but it is fuzzy enough that it could conceivably be articulated as any of several lucid images. It is in this sense that perceptions, thoughts, memories, meanings, etc. literally do not exist prior to being constructed in words. Words focus psychic material to lenses focus images.

While unformulated material and preconscious content are both excluded from awareness by the deployment of attention, the similarity is superficial. For Freud, the distribution of attention is a relatively simple matter: Attention is deployed whenever something preconscious needs to occupy focal awareness. The preconscious is like that part of the street not bathed in the light of the streetlamp: All that is needed for it to become visible is to change the direction of the lamp's beam. The movement from preconscious to conscious is a cognitive event, not a dynamic one. Resistance, for example, is irrelevant to it, since anything preconscious has by definition already passed through the censor. Attention for Freud is not involved in defense.

Sullivan (1940, 1953) proposes, on the other hand, that attention, while serving everyday cognitive functions, can also serve one's intention to avoid anxiety, resulting in an unconscious control of attention. The deployment of attention becomes a defensive process.

Thus, for Sullivan, one of the primary defenses is essentially "not thinking about it." This is accomplished by means of selective inattention, a process on which Sullivan (1953) lays heavy emphasis. What it means is that the control of focal attention, which helps separate the wheat from the chaff in everyday experiencing... can also be used to keep something out of awareness. If one's focal attention is never focused on this "something," one is never aware of it; and if one is never aware of it, it remains para-alternative—unformulated. It is never elaborated into an experience in the syntactic mode. In turn, this means one can never reflect on it (Stern, 1983, p. 76).

For either analyst or patient, experience of the other may remain unformulated for reasons of comfort or security. One's attitude about the other may remain familiar, banal, uninqustoned, even unnoticed. Unfamiliar experience, which of course cannot be predicted and may therefore be dangerous, is avoided under these circumstances. Disturbing glimmers of meaning are terminated before they reach the level of articulation at which they would be explicitly meaningful. The corresponding conscious experience may be vagueness, confusion, boredom, or complacency, and absence of curiosity about the other. Or the experience may be a conviction of one's negativity, inflexibility of observation and interpretation, a cleaving to one view which may appear to be active involvement but which masks the refusal to formulate alternatives.

Defense for Sullivan, then, is less a matter of self-deception than it is for Freud, for whom latent content always exists, fully formed. For Sullivan it is for Freud, for whom latent content always exists, fully formed. Defense for Sullivan, then, is less a matter of self-deception than it is for Freud, for whom latent content always exists, fully formed, behind the omissions and distortions of the manifest. For Sullivan the primary defense is refusing to construct a meaning which one has the tools and the data to articulate. Defense is more often betrayed by a gap in the patient's material—a puzzling or missing

Note that Schachtel's concept of the schema, which he adopted from Bartleby, has become a mainstay of the contemporary study of cognition. There is an irony in this, for while the two writers were aware of the value of constructivist views of experience long before these theories became fashionable, Bartleby used the idea of the scheme to explain everyday forgetting and Schachtel used it to explain childhood amnesia. These are descriptions of the loss of experience, not its construction—though they are constructivist ways of understanding the loss.

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aspect of his perceptions, thoughts, behavior, etc.—than, as in the work of both Freud and Fromm, by an irrational symbol. There may be no latent content for the simple reason that explicit meaning has been prevented from coming into being. Self-deception is replaced by the refusal to know or to learn.

Understanding the nature of the analyst’s experience as unformulated has implications for clinical practice, to which I now turn.

The Formulation of the Analyst’s Experience

That part of the analyst’s experience which will eventually be most analytically useful feels as if it comes naturally. It is not experienced as intentional; it just happens. It is unbidden and more often than not unnoticed. Levenson (1988) puts it that what the analyst does not know about the patient is the countertransference. The most significant of our experiences of the patient are defined by this quality of being out of our grasp. Much of countertransference is embedded in that vast realm of experience which is seldom directly apprehended, but which everyone is dimly aware of, the unattended everyday, everything that is just the way of the world. It is in this part of the analyst’s responsiveness to the patient that genuine surprises germinate.

Prior to being put into words, then, the analyst’s experience of the patient is unformulated. And since the unformulated can usually be put into words in more than one way, countertransference experience which will later become useful is not inevitable. It remains to be constructed. Each time something new appears in the analyst’s experience of the patient or the interaction, it is a sign that the process of transmutation from presentational and unformulated to articulation in language has been accomplished once again. Parataxis has become syntaxis.

The psychoanalyst’s primary problem is not how to select a correct interpretation. The primary problem is how to sense that there is something there to interpret. The problem of interpretation arises only when material is visible, speakable, available for understanding—an everyday state of affairs, of course, but not the most central or most difficult. Interpretation can be merely wrong, but experience itself can be absent, and absence is the greater difficulty. One has no reason to look for something the existence of which is not suspected.

Clinical examples of the unformulated nature of the analyst’s experience of the patient are problematic. The lack of differentiation and the indeterminacy of the unformulated are immediately violated by the verbal description one has no choice but to use. While it is impossible to imagine the material without formulating it, it is possible to describe the form of the analyst’s experience and then try to imagine back to that which was not being articulated at the time.

A middle aged academic had formerly had satisfactory treatment elsewhere in the country with a highly regarded senior analyst. The analysis had ended prematurely because of the offer of a post that the patient felt he could not turn down. Academic posts were rare in his field; tenured positions, such as the one he was offered, were nearly nonexistent. The departure had been extremely painful for the patient.

The patient had consulted several analysts in New York, and felt he was comfortable enough with me to schedule sessions, but my experience, which given my age was obviously less extensive than his former analyst’s, gave him pause. He decided to go ahead nevertheless.

The former analyst had maintained more formality and emotional distance than the patient felt I did. Questions about my professionalism arose. The other analyst’s office had been austere, while mine had several watercolors and a colorful poster on the wall—improper decoration, he felt, for an analyst. The other analyst spoke little, but was pithy; I talked too much. The other analyst was accommodating regarding when the patient could schedule hours; I, he felt, was not. And so on. I charged too much. I was not worth my fee.

All these complaints were delivered in a calm, reasonable, almost regretful manner, as if the patient were terribly sorry to have to display the bad manners to point out these gaffes of mine. He was also careful to point out his warm feelings about me, and his positive observations; and in the first few weeks he asked himself several times whether his criticisms of me might make most sense as displacements from the past. This had less the quality of self-examination, though, than of protecting himself in advance against what he expected would be my interpretations. He concluded sadly that he had to stand by his observations.

In fact, it seemed to me that most of the attributes he com-
explained about were real enough. My office is not bare. And given that the former analyst had been classical, it was plausible to believe that I talked more. Yet I was interested and puzzled about the patient's focus on these things, since he was not critical enough to leave, though he said often that his doubts about my skill made him question whether he should commit himself to the treatment. He did not merely stay, though. I sensed a budding attachment, and his involvement seemed clear: He was never late, usually early, and he worked hard, not at all as if he had the doubts he claimed.

One day six or eight weeks after the initial consultation the patient complained about a painting on my wall that he felt was derivative in style and inferior in execution. He said he realized that it would be "snotty" of him to conclude that I was shallow on the basis of my taste in art, but he nevertheless found himself, he said, having to contend with this perception of me. I would not be able to understand him in the necessary depth. His admission of having to worry about my lack of substance did not lead him to conclude that he was being "snotty," of course. It was instead another maneuver meant to defuse any defense I might have, analytic or otherwise—since he would have interpreted anything I said other than acceptance of his idea as defensive. And, as I will indicate, it probably would have been.

I did not at this point understand any of this, so for the time being I said nothing. He went on to discuss something else, related, no doubt, but beyond my recall. I felt uncomfortable, a kind of pressure to respond that I usually hope to resist because of its very insistence. If I had responded, I think I would probably have felt this way, and I could put into words (to myself) that my patient was not merely critical, but contemptible. I had withered under his glare; probably as many others had, maybe as he himself had under the glare of someone else—a parent...What kind of feeling state in me was this intimidation meant to result in? What did he then feel? Given the simultaneous presence of his attachment and his intimidation of me, did my being threatened play some important part in the kind of connectedness he sought with me? How? Why? Was this perhaps the best he could do to create an atmosphere of intimacy? Or maybe he wanted to distance me in order to prevent my behaving in a way that would provoke an intense attachment. Had I in fact threatened him (and maybe interested him as well) by not maintaining the degree of distance and silence he had come to associate with psychoanalysis? These questions were eventually productive in the detailed description of the field and the patient's character.

Until I began to question myself about my fantasies about the patient, an important aspect of my experience of the patient had been unformulated. I had been so buried in my direct presenta-
Wignall, nondiscursive) experience of his intimidation and contempt that I could neither articulate it nor even know that something significant was invisible to me. My intimidation did not exist in an explicit verbal form; though, pre-described and ready to appear in awareness the moment I would accept it. The words to construct it had to be found.

Could the experience have come into being in a different form if I had used different words to describe it to myself? This question is impossible to answer conclusively, because experience can only be formulated once.1 After one has used satisfying words, the union of experience and word usually seems to have been inevitable, as a matter of fact, that the whole process of constructing the kind of experience capable of being reflected upon is very seldom noticed at all. Psychoanalysis is one of the few contexts which offers such an observational opportunity. In addition, if I had formulated the experience in different words, I would probably also have described differently what led up to it, which means that to be convincing, an alternate formulation might have been different if I had said to myself that I felt ignorant and embarrassed, or disliked, both of which would have been true at that moment. Even assuming I had been able to observe these reactions before I acted on them, the inquiry that followed would have been different than the one that took place. The words we choose guide us more than we know. And the current situation, described by Sullivan as "the physician, the patient, and the parataxic concomitants" (1940, p. 190), guides the formulation of a different experience. Schafer (1983) puts it this way:

Thus, when one says, "That's it exactly!" one is implicitly recognizing and announcing that one has found and accepted a new mode of experiencing one's self and one's world, which is to say, asserting a transformation of one's subjectivity. Something is now said to be true, and in a sense it is true, but it is true for the first time. Nothing just like it has ever happened before. And nothing like it can ever happen again, for the second time cannot be the same as the first. One can't step in the same river twice (p. 128).
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"The field grips the participant, unformulated experience of the patient grips the participants, motivations depending upon the participants and the nature of the interaction; and the experience is unformulated, occurring in a form not conducive to language. The two reasons are interlocked, however. They are not alternate explanations. They explain the same phenomena at different levels of observation. The creation of states of relatedness, as Tauber and Green (1959) pointed out, is exactly the kind of experience that goes on in the presentational mode. Breaking the Grip

As long as patient and analyst are reacting to one another without questioning what they are doing, they are caught in the grip of the field. They may even believe they are questioning themselves and, unbeknownst to them until some later time, still be mired. As long as the grip is maintained, the participant's experience of the field remains unformulated. They simply do not see it. They generally do not even suspect there is something to see. Those of us whose theory leads us to expect to be mired, incidentally, are not inoculated by our expectations. The phenomenon is enough a matter of life that theory cannot protect us from it. Nor in fact would we want to be protected. To be gripped, or "transformed," as Levenson (1972) puts it, is not a problem to be avoided, but a reality to be accepted. If the analyst could not be gripped by the field, the patient, as I have already quoted Tauber and Green (1959), "... would have no respectable card of admission to the relationship" (p. 146). The analyst, in turn, would be denied firsthand experience of the patient's problems.

But of course the grip is only useful because sometimes it is broken. This happens only when patient or analyst becomes capable of observing the interaction and questioning it, i.e., formulates it. The one who questions is usually the analyst, of course, but it is by no means always the analyst, especially if the analyst is receptive to the patient's observations of him. The patient's experience and the analyst's are reciprocal in this respect: If either participant can find a way to a true and felt reaction to the other, the work may proceed. In the patient's case this reaction must be spoken to be useful; in the case of the analyst the reaction is usually not spoken but serves as the inspiration for renewed inquiry. However, if neither patient nor analyst can question the face value of what happens between
them, there is a halt in the treatment until such questioning occurs, and the experience of the interaction remains unformulated for both parties until that time.

What determines whether and when the analyst will formulate his experience of himself and the patient? It requires work for the analyst to stop, reflect on the interaction, and see it well enough to put words to it. It requires that the analyst be able to imagine alternatives to the interaction as it is occurring. He cannot know what he is feeling toward the patient until he can imagine feeling otherwise. For instance, he may not know that he is worried about a patient's suicide potential (i.e., he may not be able to say to himself that he is worried), until he can see that he feels anxious if the patient is even a minute or two late for an appointment. Until this happens, the analyst is buried in his own reaction. He does not see that he is worried until he can question himself about the source of his anxiety at the patient's tardiness, and he cannot question his reaction until he can imagine not having it. The analyst must be able to see that it would be possible to feel otherwise. He must be able to say to himself, "The patient's lateness does not demand this response from me." As long as only one way of seeing is available, this way of seeing must be experienced as "just the way things are," unnoticed and unremembered.

The process by which the analyst arrives at the possibility of alternatives in his experience of the patient is part of what Casement (1985) means by "internal supervision" and what he later describes as "interpretations that arise from monitoring what the analyst is feeling in the presence of the patient" (Casement, 1986, p. 558). Even closer in meaning are Feinier's (1979) conception of the necessity for the analyst to "clear imaginative space" for himself by understanding countertransference and Symington's (1983) description of the "act of freedom" performed by the analyst in

Ernest Schachtel, though he did not write about clinical practice, addressed the same state of unthinking familiarity from which clinicians such as Casement, Feiner, and Symington describe their efforts to emerge. Schachtel (1959) termed this state embeddedness, and felt it originated in "the quasi-intermediate embeddedness during which mother constitutes the infant's world" (p. 53). Later in life this way of being can be a retreat or protection from the existential anxiety which must be borne if one is to achieve "openness" to people and things. Emerging from embeddedness, finding and facing the unfamiliar, is the great task of life, accomplished over and over again in productive and satisfying lives, in ever more subtle and mature ways. One must emerge from embeddedness, or, more properly, always be in the process of struggling with it, in order to "directly encounter" others and the world around one.

The analyst in the grip of the field is embedded in it. He formulates his experience and emerges from this particular episode of embeddedness when he maintains the allocentric attitude. At any particular moment the analyst can have one of two attitudes toward the patient, autocentric or allocentric. These are concepts developed by Schachtel in his work on perception, though he broadened them to describe more general attitudes with which one faces the world (1959). In the autocentric attitude the other person is what Schachtel calls an object-of-use. One has some predetermined purpose for him. One looks for something in him rather than opening oneself to him. This is the attitude with which we necessarily approach the physician or the dry cleaner or anyone else from whom we want a particular thing or service—though in some of Schachtel's more extreme examples entire lives are constrained within the bounds of the familiar. Novelty is seldom experienced. Objects and people are merely registered as members of a category before attention flits on.

We look around and say to ourselves, silently and implicitly: "This is the store at the corner of X street, this is the red house, this is the tree in front of it, these are people going to work, this is the bus stop, this is the chair and the floor lamp, the desk, the window, the bed, etc." While we see all these objects, in this perspective we do not see them fully, in their own right. What is the use we put them to when we just recognize them in this
The allocentric attitude, by contrast, is curiousity, an openness or receptivity that requires the tolerance of ambiguity and uncertainty, and sometimes pain.

To perceive another person allocentrically is to be as curious as possible, open to all the alternate formulations one finds unfinished in oneself, including one's reactions to the other. The uncertainty of the unformulated is preserved, even nurtured. Alternatives are allowed to percolate and glimmer, emerging as indeterminate shapes, some of which then attain enough form for words to give them coherence. The other person is seen from all sides. There occurs what Polanyi (1958) echoed in the psychoanalytic way that we work without being drawn into contemplation of everything along the way, i.e., fully, not just with part of himself. The act of interest is total and it concerns the totality of its object (1959, pp. 220–221). To give them coherence. The other person is seen from all sides. There occurs what Polanyi (1958) echoed in the psychoanalytic way that we work without being drawn into contemplation of everything along the way, i.e., fully, not just with part of himself. The act of interest is total and it concerns the totality of its object (1959, pp. 220–221).

The allocentric attitude, and the consequent attitude to the unformulated, is an ideal, possible to assume only part of the time, and not even desirable to assume constantly. One would never do anything else, for example, if every glance at a clock provoked absorption in the movement of the hands. One would never arrive at a destination unless it were possible to follow a familiar route. But the allocentric attitude, and the consequent attitude to the unformulated, is an ideal, possible to assume only part of the time, and not even desirable to assume constantly. One would never do anything else, for example, if every glance at a clock provoked absorption in the movement of the hands. One would never arrive at a destination unless it were possible to follow a familiar route.

It is perhaps more feasible to maintain the allocentric attitude in the everyday world (1959, pp. 169–170). It is on this point that my presentation differs with Witenberg (1979), the only other writer, as far as I know, to relate countertransference and the allocentric attitude. Witenberg writes, "For heuristic purposes I will call anything other than the allocentric attitude countertransference" (p. 47). And later: "I am suggesting that any change in this type of allocentric attitude may be labelled countertransference" (p. 48).
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was taking the day off from work and wanted to have no responsibilities at all. He said this matter-of-factly, finding nothing in it worthy of note. He assumed, he said, that he would be charged for the hour. My immediate response was frustration and annoyance. I inquired routinely about what the patient liked about having no responsibilities, and about his perception of the session as an obligation to be fulfilled or avoided, but privately I felt that there was no nonadversarial way to address the real question—why the patient insisted on feeling oppressed by me. As I perceived it, any time I had broached this question in the past, the patient had withdrawn from active participation, becoming overtly compliant but secretly sullen. The patient seemed to feel oppressed by and remote from active participation, becoming overtly compliant but simply saw no way to carry the inquiry further.

My reaction at this point was autocentric. I was in the common and contradictory position of feeling that the patient would not let me do my job. For the moment the treatment was stymied.

The analyst's experience of the patient remains in the autocentric mode only as long as it is not directly represented in the analyst's awareness. If the analyst allows himself to formulate the experience, thus making it possible to hold it at a distance, reflect upon it and not merely react to it, he can maintain the allocentric attitude. Schachtel (1959) says that our capacity to experience in the allocentric mode is, if we are receptive to it, essential equipment in registering the other's full impact. He writes, "It is the attempt to escape from such feelings, rather than the existence of them, which prevents man from turning fully, with his whole being, toward the object" (p. 227).11

In my example, the problems in the interaction would probably have spiralled if I had not been successful in understanding this feeling I had that the patient was obstructing progress. Events were more favorable, however. It occurred to me to question myself about why I had not just accepted the patient's lead regarding

the next session. I could simply have waited to see what would happen. Inquiring about it as I did may have made sense, but had I been attached to a particular outcome? It seemed so. I wanted the patient to come to that session. Actually, I realized, it was not only the idea of missing the session that had annoyed me—it was the matter-of-fact tone of the patient's voice. It now seemed to use that this tone had been insistently matter-of-fact. If I were to question this decision, being presented so reasonably by the patient, I would be cast as the oppressor. I had therefore avoided directly questioning it, but I apparently resented this control over me. However, I noted that by this point in the interaction I had in effect become the oppressor, since I had responded to the patient's challenge by at least feeling like imposing my will. By now, the patient was probably reacting to my suppressed annoyance as yet another instance of my intention to control him. A silent power struggle seemed to be taking place.

I now asked the patient if it was possible that he was feeling pushed around. I offered some of the details I have just reviewed as reasons why the idea had occurred to me. The patient was somewhat wary, probably of my intentions in bringing this up, but said that in fact he was feeling pushed around and that it had happened several times before. It seemed to him that at these times I became less responsive to him, less interested, but he had never considered the possibility that my reaction might have something to do with his own. I could then ask the patient if he could identify anything I had done, maybe in the previous session, that had made him feel that I was lording it over him. If I had done something like this, it might account for his feeling that it was necessary to wrest back from me control over the situation. The patient was able to remember such an incident, something subtle enough (hardly "lording," as a matter of fact, but that was the word I had used with him) that he had felt that his angry reaction, which had been only momentary, was unreasonable. He had swallowed his reaction, which of course had only increased his resentment about having to submit.

The inquiry did not stop here. Further questions to be raised included the characterization of my experience in the previous session: In what way might I have attempted to control the patient? And to what extent might the patient's seemingly collaborative approach to this investigation actually represent merely a
more subtle version of the oppressor-oppressed scenario, with the patient playing the compliant or obedient child, afraid of the parent-analyst? Or perhaps, eager not to disappoint me, he was trying to please me and hating himself for it. All of these possibilities were plausible given what I knew about the patient, and eventually I could feel that I knew whether they were true. By then, though, new questions had arisen. The recapture of the allocentric attitude and the formulation of the analyst's experience offer no permanent solutions, but they do allow both participants greater freedom to articulate the next problems.

In looking I would like to offer a final example which I hope will illustrate the sequence of events I have selected for description: the grip of the field, formulated in the experience of neither patient nor analyst; the analyst's emergence from embeddedness and regaining of the allocentric attitude; and the formulation of the analyst's experience of the patient, leading to a break in the grip of the field.

An executive in her late twenties had entered treatment a year earlier in order to be able to establish and maintain a relationship with a man. We were bogged down in one important respect. The patient had no more than the average difficulty in finding appropriate and available men, but usually, to her surprise and dismay, the man left the budding relationship after a matter of a few weeks. These departures were sudden and mysterious, and left her feeling discouraged and sometimes hopeless. I suspected that the patient, who gave a first impression of self reliance and resourcefulness, and who in fact did have these characteristics, very easily in order to illustrate the sequence of events arising from embeddedness and regaining of the allocentric attitude; and the formulation of the analyst's experience of the patient, leading to a break in the grip of the field.

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alternative to it. Her subtle apology, awakening in me an awareness of her difficulty in dealing with me about her defense, had made it possible for me to feel compassion, and this compassion was the alternative that made my previous frustration visible to me. Of course, prior to this I would not have known there was a gap in my compassion for this woman, nor would I have been able to see clearly that I felt critical. As is often the case, the grip of the field became visible only as it was broken.

The interaction I have characterized here between this woman and me—the patient repeatedly turning to me needily (to help her fix something) and me retreating critically, leaving her feeling discouraged—is precisely the interaction we had been trying to investigate elsewhere in her life. With my recognition of my reaction to the patient and my part in the interaction it was possible to rediscover an allocentric attitude toward her and to investigate the problem in the transference-countertransference field. It was natural to me at this point to change the nature of my participation, and in fact from then on it would probably have felt uncomfortable to have maintained my participation as it had been. This new participation, in turn, encouraged the reciprocal formulation of new experience by the patient. Inadvertently the patient had behaved in such a fashion that I was able to formulate an aspect of the field which until then had been invisible to both of us.

REFERENCES


UNFORMULATED EXPERIENCE OF THE PATIENT