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Therapeutic Passion in the Countertransference

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The place of the analyst's "influence" in psychoanalytic theory and practice is explored. There is a current in the literature in which it is welcomed as an aspect of "corrective experience," although usually legitimized by being forced into the narrow channel of interpretation and understanding. A taboo on influence persists despite theoretical shifts that would seem to clear the way for greater acceptance of its importance. Among other factors, the aversion to influence is traced to its association with hypnotic "suggestion," which implies little room for the patient's autonomy. Opening the door to embracing the possibility of influence goes hand in hand with, on one hand, the analyst respecting the patient as a competent free agent and, on the other hand, the analyst combining willingness to take a stand with willingness to reflect critically on his or her participation. In that context, and with those caveats, the analyst takes on the responsibility to combat destructive introjects and to become an inspiring, affirmative presence in the patient's life. The analyst's passion for the patient's well-being and for changes that entail the realization of dormant potentials now has its place. Different kinds of expression of therapeutic passion in the countertransference are described and illustrated.

CONCEPTUAL GROUNDING

The Influence Taboo

There is a tension in psychoanalytic work between respect for every facet of the patient's experience, including those that are implicated in what appear to be symptoms, and interest in change in the patient's sense of self and ways of being in the world. Yet the analyst's desire to promote change has long been considered problematic.¹ A central feature of the psychoanalytic tradition has been concern that under the influence of the transference, the patient will too readily submit to the analyst's authority so that whatever changes emerge in the process will reflect sheer compliance with the analyst's values and desires. Historically, this concern has found expression in the ideal of facilitation of change that is generated from deep within the patient's psyche with minimal

¹Opposition to that desire has its roots in Freud. He wrote, for example, "The feeling that is most dangerous to a psycho-analyst is the therapeutic ambition to achieve by this novel and much disputed method something that will produce a convincing effect upon other people" (Freud, 1912/1958, p. 115).

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or no shape or coloring stemming from the analyst's personality, the analyst's values, the analyst's vision of what the good life would be for the patient.

Discussion of this issue has always been encumbered by the notion of "suggestion," which in psychoanalysis means quite the opposite of what it means in everyday common usage. A "suggestion" in that everyday sense is just that: something for a person to consider, something one could take or leave. But "suggestion" in psychoanalysis is linked to *hypnotic* suggestion, which is largely controlling of the patient's experience and behavior. The transference, moreover, is understood to have inherited the power of suggestion as it functioned in hypnosis and the psychoanalytic process could be viewed as a kind of "slow motion" hypnotic procedure, which is how Macalpine (1950) characterized it. It's no wonder that many analysts became virtually phobic about being sources of influence in their interactions with their patients beyond promoting, as in Freud, their analysands efforts to find, and come to grips with, truths about themselves and their worlds. That search for truth was undertaken in an objectivist paradigm, the implications of which I say more about shortly.

With the conflation of "influence" and hypnotic suggestion, the options that are possible get organized dichotomously. The patient is either effectively coerced or left on his or her own. I believe this dichotomous organization has had extraordinary staying power even as new ideas have emerged that seem to provide the grounds for liberation from it. Concepts that have had the promise of empowering the patient relative to the analyst—the working alliance, the therapeutic alliance, the conflict-free sphere of the ego, reduction in the analyst's authority associated with intersubjectivity and with attention to the countertransference as virtually ubiquitous, the rise of the influence of constructivism, recognition of the patient as a discerning "interpreter of the analyst's experience" (Hoffman, 1983)—these and many other related developments did not necessarily do the job, at least not with any consistency, in the sense of freeing the analyst of the constraints on influence. I think that's the way it often goes with resistance to change. Even when you have the right conceptual armamentarium, it's not necessarily going to overcome obsolete ways of thinking and being, at least not right away. Freud found that "insight" did not usually do the trick in terms of bringing about change. After that, "working through" was required, and God only knew how long that would take.

Now put the influence taboo associated with the power of "suggestion" together with the incest taboo and it's a lock that the analyst would stay relatively detached.² No matter that the needs that were considered primary were no longer narrowed to the Freudian preoccupation with incestuous desire, a desire that would have been bad to have gratified in the past and would be bad to gratify now. Instead, increasingly, in self psychology and in relational theories, for example, developmental needs have been recognized that were insufficiently met in childhood and that may be partially, not only understood, but also met in some form in the analysis. Despite these revolutionary changes, in Stephen Mitchell's (1993) terms, in our sense of "what the patient needs," we are still haunted by the specter of the "slippery slope" associated with incestuous wishes. So "touching" the patient figuratively, never mind in the literal sense, could be dangerous and could remain dangerous even as we gained understanding of the crucial importance of the good holding environ-

²There are no doubt other factors as well, such as the interest in depriving the patient of an object relationship in order to induce regression (Macalpine, 1950) and the positivist interest in avoiding "contaminating" the object of study, the patient's mind, with anything coming from the analyst-investigator (see Hoffman, 1998). But I believe the two factors identified in the text would be enough, in themselves, to ensure relative detachment.

ment, the good self-selfobject tie, optimal responsiveness, the importance of new experience, the “needed” relationship, as Steven Stern (1994) has called it, as opposed to the “repeated” relationship. I’m reminded of something in my own history. I decided I was an atheist by around the age of 16, no small feat for a junior at the Yeshiva of Flatbush High School in Brooklyn, New York. But 5 years later I was still avoiding unkosher food like the plague, and 20 years later I was still praying on take-offs and landings. I mean, why take a chance?

This paper is about taking chances, about taking risks in the analytic process. Psychoanalysts as a rule are much more frightened of the consequences of sins of commission than they are of sins of omission, a difference that is not proportional I believe to any difference in the actual dangers each kind of sin poses. The relationship between playing it safe and taking a risk in the analytic situation can be paradoxical in that the allegedly safe course may entail a danger of settling into something dead or deadening, possibly for years, with nothing short of slow motion tragic consequences, whereas venturing something that seems riskier can hold the promise of creating new possibilities, new vitality, and new hope.

My thesis is that the analyst has the power to inspire change in the patient through active imaginative involvement and the exercise of influence that often goes beyond interpretation although it certainly may include it. Indeed, the analyst’s exploration and understanding can be, in themselves, personally expressive, highly evocative, and moving. There are several assumptions underlying this perspective. *First*, the patient is not putty in the analyst’s hands. He or she has a mind and will of his or her own right from the start along with a capacity, even if partially compromised, for conscious collaboration (Hoffman, 2006b, p. 56; Loewald, 1980b/1970, p. 279), which entails, despite the analyst’s special authority, a capacity to differ as well as a capacity to agree in ways that are meaningful and that are self-expressive, *not* self-abdicating. Indeed, the patient, as an agent exercising, rather than allegedly suspending, his or her own judgment in “free associating,” bears significant responsibility for the co-construction of the analytic relationship (Hoffman, 2006b). *Second*, the relationship, nevertheless, is asymmetrical. The analyst has special authority that derives from a combination of analytic ritual and the patient’s need (Hoffman, 1998). The fact that the analyst is almost always in the caretaking role and that he or she may have his or her best foot forward a lot of the time are factors that lend themselves to cultivation in the patient of the “unobjectionable positive transference,” which may include a certain degree of idealization. The resulting special power that the analyst has gives him or her a fighting chance against the destructive influences of the patient’s past, but there is also reason for the participants to be concerned about the danger of the patient’s compliance with what the empowered analyst seems to want. *Third*, such concern, however, is not reason for despair and concomitant retreat into illusions of noninvolvement. Instead, the effort to address that issue can be, in itself, collaborative. The analyst’s and patient’s open discussion of the matter can go a long way towards ensuring the patient’s participation as a critical, autonomous agent even in the context of responding positively to the analyst’s influence. *Fourth*, just as the danger of compliance warrants thoughtful concern so does the danger of that “slippery slope” towards incestuous attachment. To conceptualize the issue at the most general level, we don’t want the analytic relationship to become merely an end-in-itself. It has to be generative of the patient’s growth and of his or her development of his or her life outside. But the analyst’s thoughtful emotional involvement can be fertile ground for such generativity. Like parents with children, the challenge is to find optimal levels and qualities of involvement, not to minimize it. The result is a relationship that combines end-in-itself and means-to-an-end features. *Fifth*, it is taken for granted that the analyst’s attitudes are partially shaped by many fac-

tors—cultural, moral, characterological, and countertransferential—of which he or she may not be conscious. That realization, which is part and parcel of the intersubjective nature of the interaction, calls for a certain degree of modesty on the analyst's part with respect to his or her influence. In a certain sense the analyst always *knows* that he or she does *not fully know* what he or she is doing. That awareness promotes tentativeness and openness to new information or new ideas that could result in the analyst's changing or modifying his or her point of view. At the same time, such openness does not preclude the analyst sometimes developing conviction on a matter that he or she might want to fight for even when the patient seems to differ. *Sixth*, to leave the patient "space" for choosing his or her own course, in life and in the session itself, is not necessarily described accurately merely as respect for the patient as an autonomous agent. It may also be tantamount to a kind of abandonment of the patient so that he or she has to fend for himself or herself against the attacks of various kinds of internalized bad objects, hostile introjects, in effect, that can have profound effects on the patient's sense of self.

Battling Introjects

With regard to such introjects, a common way of working begins and ends with interpretation and understanding as the route to therapeutic action. That is not to say that contemporary approaches do not encourage other kinds of participation as well, but I'm talking specifically about the structure of interpretive work as such. We might help people see the relativity of their own self-defeating ways to certain experiences in childhood over which they had no control. Thus, for example, after a success of some kind about which a person feels very proud and gratified, he or she fails to manage some easy task, feels like a loser, and is depressed. We point out the sequence and the likelihood of something akin to a negative therapeutic reaction in that a very promising moment is prelude to such retreat to symptomatic patterns. We remind the patient, perhaps, of the fact that one of his or her parents, who we had established was very competitive and insecure, often seemed less than thrilled when the patient came home from school with a good report card and that that parent would find some excuse soon after to be extremely critical of the patient for something, perhaps for his or her eating habits, or weight, or messy room, or misplaced keys. Analyst and patient then consider together the possibility that the patient's internalization of this whole sequence now has the form either of the patient's unconscious intent to fail on that easy task or of his or her self-persecutory attitude towards an inadvertent failure, so that the experience of success has no stability and is quickly undermined. I like to say that the hostile introject, the internal legacy of the resentful, envious parent, is an "opportunistic saboteur." After the patient's success, it is lying in wait for the moment of weakness. When it appears, the introject tastes blood and pounces with a vengeance. Before you know it the upshot of the patient's success is the patient's conviction, ironically, that he or she is a complete loser.

All that established I think we are inclined to feel we've done our job. The implication is clear enough that the patient's veering away from a sense of accomplishment and pride amounts to an irrational succumbing to the influence of impaired parenting, parenting, now internalized, that begrudges the analyst and such satisfaction and that, on the contrary, evokes in him or her vague feelings of shame for being too full of himself or herself. Not only does the patient's rational ego provide the realization that that reaction is uncalled for, but the implication could hardly be more clear that the analyst thinks so too. The whole inquiry is undertaken in the spirit of critiquing the symptomatic adaptation and its historical underpinnings. And that spirit of the inquiry, particularly as it

reflects the difference between the attitude of the analyst and the internalized parental attitude, goes without saying, doesn't it?

Increasingly over the years I've felt that the answer to that question, more often than not, is "no." Even if an intellectual understanding is established, the war to overcome the internal destructive "voice" remains unsettled at best. Those introjects are extremely powerful. They established themselves in the patient's mental life very early and now the patient has them in his or her bones, at the core of his or her being. Rationality and implicit support can be very valuable, but they are often not enough to overcome the influence of destructive introjects. I believe what is needed often is an opposing powerful voice, actual words, words spoken with passion and conviction, that the patient can hear and remember and that can do battle with the destructive voices of the past. It is here that the asymmetry of the analytic relationship and the special authority that accrues to the analyst as a result can be put to good use. Maybe it's this kind of "talk," the speech of *the analyst* on behalf of the patient's growth, on behalf of the patient's worth and potential, that constitutes and legitimizes psychoanalysis as the "talking cure."

So what could the analyst say? Many things, of course. But how about, hypothetically, something like, "You know it makes me so mad that your parents did that to you. You come home with those A's. You worked hard for them; you are brimming with pride. You so want them to be excited and pleased, to hug you happily and exclaim, 'Oh wow, that's soooo wonderful. You are terrific, you are one awesome kid.' And when you made that mistake later on, what you needed was something like 'Oh forget it. It doesn't matter honey. Today we're celebrating that fabulous report card and all it means about what a great student, what a great kid, you are. We are so proud of you.' And now, well, I hope it's not too little too late, but now I want to tell you that I think you are one terrific person and I think that that thing you did last week [the way you spoke up at that meeting, your incredible performance in that play, the way you managed that situation with your kids at home, the way you worked with me on that dream, whatever] is just a tremendous thing and I am actually proud of you right now and want you to know it. Those voices that are telling you you are a loser are ignorant, selfish, stupid voices and you should tell them to shut up; just shut the fuck up! And you know what else? You and I, we are going to beat them. It may take some time but we are going to beat them and we are going to create grounds for you to thrive with a sense of pride in yourself and with a sense of joy in living that should have been your right and your experience from day one!"

All that I would submit does not go without saying. Substitute your own versions adapted to who *you* are and to the patient you are with. I'm talking about sitting forward though, not sitting back in that stereotypic, stylized posture of psychoanalytic hyper-unperturbed calm. And I'm talking about speaking from the heart, with feeling. I'm talking about letting it come over you as you speak even if it's not fully there when you begin. There's a good chance that in many cases it will come, because the psychoanalytic arrangement lends itself to that kind of empathic identification with another person's struggle *to be* a person in the face of devastating hardship, the hardship of particular *unnecessary* traumas superimposed on the inevitable, *necessary* traumas of the human condition. I think Bion's call for "passion" in the analyst (see Billow, 2000) is closely related because it entails opening up to, rather than defending against, *thinking* that is infused with painful emotion. The psychoanalytic arrangement is a setup conducive to that happening. And we are often wasting the special opportunities it affords. Yes, wasting them!

And why? Why, in fact, do we so favor implicit over explicit forms of affirmation, indeed, implicit over explicit expressions of love? Might not a major factor be the fear of assuming full re-

sponsibility to do our utmost to foster another person's development, masked as that fear may be by pervasive still deeply institutionalized residues of scientific neutrality? Are we afraid we might fail? There are no guarantees, and surely the odds are often against us. Those introjects are formidable, sometimes so powerful they invade the patient's character so that his or her more lovable side has difficulty emerging in such a way that our own empathic potentials can be activated at all. Jody Davies (2003) confronted a very demanding patient who was constantly complaining about not being given the love she needed with the fact that "for someone who so wanted and needed to be loved, [the patient] had kept the 'lovable' parts of herself well outside our analytic exchange" (p. 22), a confrontation that led to a major shift in the climate of the interaction. We do have to worry when we attack hostile introjects, not only about the patient's attachment to them but also about the patient's possible identification with them. We have a substantial body of relational literature now about how to work through and out of enactments that might entail a good deal of negative transference and countertransference, some of which may have a starting point in patients' identifications with destructive aspects of original caregivers.³ But imagine that, with a lot of hard work, we have arrived there at the more loving transference-countertransference situation. Let's face it, even with those patients at that point, or even with the patients who, to begin with, elicit love in the countertransference in a way that seems relatively straightforward and uncomplicated, we tend to be quite constrained in what we say and do in keeping with those feelings.

I want to be clear that in this paper I am largely exploring that "simpler" countertransference situation because I think that's an important place to begin. And it is true that even with those people we cannot be sure how our own power to influence will fare relative to other forces and the patient's will. The patient is a free agent, not an organ system that we are treating. And we don't know whether he or she will take or leave what we have to offer. We have not only the introjects to overcome and the patient's attachment to them and to the secondary gains derived from those attachments but also what I've called the "dark side" of the analytic frame, all the things that contribute to our own bad-object potentials. The latter include the harsh reality of our self interest: money for relationship, money for love; the asymmetry of the arrangement that the patient knows affords us special narcissistic protections and advantages. There's a lens through which the whole enterprise could readily be seen as exploitative. The patient has to *forgive* all that in order to take the best that we have to offer (Hoffman, 2000). We are at the patient's mercy in that respect and at some level we know it. One could say it takes a huge act of generosity on our patients' parts to allow themselves to improve their quality of life under our highly compromised care, to give us the satisfaction of providing the "new childhood" that Racker (1968, p. 33; and see p. 627, this issue) says we should offer.

Sandra Buechler (2002) in the context of conveying her sense of Eric Fromm's approach to psychoanalytic work, wrote:

The analyst's deepest convictions about life's meaning will shape every particle of his work, whether he wills it or not. To face this dilemma and to consciously bear that who we are will have this much im-

³For examples in my own work of complicated enactments in which either the patient or the analyst can be seen as identified, at least partially and temporarily, with the "bad object" so that complex efforts on the parts of the participants are required to work their way out of those predicaments, see the case of Diane (Hoffman, 1998, chap. 8 and 10); the case of Ken (Hoffman, 1998, chap. 9 and 10) the case of Manny (Hoffman, 1998, chap. 10; Hoffman, 2000), and the case of Sarah (Hoffman, 2006a). The combinations of the enactments themselves and the struggles to transcend them constitute potentially transformative therapeutic action.

pact can be frightening, confusing, and burdensome. We prefer to think of the patient as finding himself, with us as helpful instruments. But we are not mere vehicles on a patient's guided journey. What we believe life is about will make a difference in how the journey's destination is understood by both patient and analyst. And the more we are willing to acknowledge our personal impact, the less we mystify the patient and force him to furtively glean who we are. We do not have a choice about having an impact. We only have a choice about whether to recognize it or not and *through a brave act of facing our responsibility* [italics added], grasp the courage to inspire. (p. 277)

So what I am saying we are called upon to do is, in fact, to risk it, to put ourselves on the line in that respect and let ourselves be vulnerable to that degree. We cannot hide anymore. The cat is out of the bag. We cannot admit that our influence is inevitable and ubiquitous and not take full responsibility for choosing what that influence should be and how we should exercise it. Minimizing it is not a viable option, not even by continually trying to analyze it. Acts of omission when Rome is burning can have dire consequences especially when they go on relentlessly for years and years, even for decades. I've seen many casualties of those kinds of analyses and those stories are heartbreaking, absolutely heartbreaking. And no one will ever be sued for *that*. No one.

I worked for 20 years with Merton Gill, who was a pioneer in bringing home the ubiquity of the analyst's influence on the patient's experience, including the shape from moment to moment of the transference. In contrast to the view that the transference was a mode of experience divorced from the real relationship with the analyst in a position to decide which was which, Gill proposed the revolutionary idea that the transference always had woven into it the patient's responses to the ambiguous realities of the analyst's participation, of which the analyst might only be partially aware. But the residue of the traditional aversion to influence in Gill (1982) and Gill and Hoffman (1982a, 1982b) and Hoffman and Gill (1988a, 1988b) was reflected in the view that the thing to do about the ubiquity of influence was to try to detect it and reflect upon it critically, in other words, analyze it, in order to free the patient of its unconscious impact. I don't think Merton and I gave much thought to the difference between the role in the process of suggestion as influence in the everyday sense and the role of suggestion as preemptive, coercive influence in the psychoanalytic-hypnotic sense. And with that, we just didn't think about anything the analyst might do with his or her power that would be, in itself, benign, creative, and transformative. I think there's a genre of literature (e.g., the work of Howard Levine, 1994, 1999) that has continued in that spirit of recognition of the inevitability of influence along with subtle depreciation of its constructive potentials.

Really Talking: The Climate and Epistemology of Psychoanalytic Conversation

All of the previous commentary on the analyst's influence and the patient's response to it is opposed to dichotomous thinking. The choices are no longer limited to the patient's submitting to the analyst's influence or being left entirely to his or her own devices. Responsiveness is not the same as compliance, independence is not the same as defiance, exercising influence is not the same as coercion or even pressure. The idea of suggestion has its common sense meaning restored and some suggestions can be very helpful and sometimes inspirational. The analyst and the patient are present as real people who are really talking. In effect, the ideals of free association and evenly hovering attention are replaced by active, personally meaningful engagement mixed with ongoing critical reflection on the process and its multiple possible meanings. Such reflection encompasses

struggle with the implications and effects of the asymmetry of power in the analytic relationship. One way of describing this subtle yet major shift in the climate I am trying to encourage is to say that it moves from a form of interaction that is *stylized* to one that is more authentic, more emotionally immediate, and in a sense more natural. The interaction doesn't reek of therapeutic purposes at every moment. In fact, there are more times, more interludes, when the conversation sounds like one that might occur in ordinary social life. I'm taking my cue from Samuel Lipton (1977, p. 269), who takes his cue from Freud in using the word *conversation* to describe the verbal interaction of the participants. Lipton pointed out that Freud, notwithstanding his more formal technical recommendations, took for granted that the context of the analytic work entailed a conversation between two people engaged in a real personal relationship. Yet the concentrated, critical attention to meaning and the consistent dedication to the goal of enhancing the patient's quality of life are among the features that set this relationship and this "conversation" apart from the ordinary.

In connection with the issue of stylized versus authentic engagement, I often think of a paper by Schafer (1974; 1992, pp. 281–292) published originally in 1974 and reprinted in 1992 in his book *Retelling a Life*. It was called originally "Talking to patients in psychotherapy." Schafer is focused in that paper on time-limited psychodynamic psychotherapy, but at no point does he provide any reason to restrict what he says to that modality, or any reason *not* to consider it applicable to any psychoanalytic process. And, in fact, psychoanalysis is always time-limited, even short term, because life, after all, is short. What Schafer suggested in that essay is that we might consider actually talking to our patients because what is prevalent instead, he said, is something he calls "impersonal diction," a manner of speaking that is devoid of all natural, personal spontaneity. Impersonal diction in response to "free association" is what I am calling stylized interaction. Alternatively one could think of it as profoundly dissociated in a manner that is thoroughly institutionalized. Schafer himself never gave his endorsement of authentic speech on the part of the analyst the epistemological underpinning that it needed to take hold in clinical practice (Hoffman, 1998, pp. 176–177).

One way to describe the approach I am advocating is through its underlying epistemology, which helps to illuminate certain aspects of the process that might otherwise be missed. In that respect it entails a relational, critical constructivist attitude rather than a one-person, objectivist perspective. Starting with the assumption that experience is ambiguous, the analyst knows that it is always open to interpretation and that any particular interpretation cannot be the whole story. He or she also knows that interpretations, no less than other kinds of action, shape or create the course of the participants' experience. In other words, there is no single reality that is just sitting there waiting to be discovered. The one arena in traditional analysis where the analyst's influence is accepted as relatively desirable is in his or her pursuit of the objective truth about the transference and about the patient's dynamics more generally. That acceptance derives precisely from the fact that objectivism invites the view that it's possible for the analyst to ascertain the objective truth of the patient's experience, a possibility that is seen as enhanced to the extent that the patient free associates and the well-analyzed analyst holds to a neutral position accompanied by evenly hovering attention. The possibility of compliance is not eliminated, but at least, if the analyst has it right—and it's seductive to think that he or she might—the compliance will be with the truth rather than with the analyst's personal, value-laden, and, to some unknown degree, unconsciously determined preference for one meaning as opposed to another.

From a constructivist point of view, because experience, conscious and unconscious, is *ambiguous*, the deciding factor in choice of interpretation (sort of like choosing among good form responses on the Rorschach) can rarely be reduced to the objective properties of the experience accurately perceived. It's not like favoring two plus two equals four over two plus two equals five. Subjective factors are always involved in what one "makes" of one's own and the other's experience. Catherine Elgin (1989), in her contribution to a collection of essays on relativism, wrote, "Subjective considerations function as *tiebreakers* [italics added] after the merit of the contenders has been certified by other means" (pp. 97–98). Consequently there is no sharp split in this respect between exploration and other kinds of participation on the part of the analyst.

The upshot is that, on one hand, interpretive activity is subject to *more* concern than it might be traditionally regarding the dangers of influence and compliance. On the other hand, other kinds of participation are regarded with equal but *not more* suspicion than interpretation because they are not split off as the unfortunate repositories of the analyst's subjective involvement viewed as an avoidable contaminant. Personal, not fully transparent influence is inevitable in both exploratory-interpretive and nonexploratory-noninterpretive activity. So what is required is a balance of, on one hand, effort to make that influence as wise, responsive, and creative as possible and, on the other hand, continual critical reflection on one's choices and openness to other possibilities that those choices may inhibit or exclude. That balance is called for *equally* in connection with interpretation and other kinds of participation.

Stephen Mitchell (1997) stated, "I find that I am using myself most productively when I struggle to understand the ways in which a patient is presenting himself to me in a particular session and then to try to reflect on the kinds of responses I find myself making" (p. 193), and further, "We are always committing ourselves to one or another form of responsiveness and participation and foreclosing others. . . . I believe that we make these continual choices on the basis of an implicit sense of an ongoing analytic process that we are trying to enrich and deepen through our participation" (p. 195).

The critical constructivist epistemology is not some abstract philosophical point of view divorced from the nitty gritty of clinical experience. On the contrary, it's a perspective that fosters certain ways of being and relating and that discourages others. The constructivist analyst is not trying, for example, to subtract his or her personal self from the engagement with the patient. That's not considered possible or desirable. As a corollary to acknowledgment of his or her ongoing self-expression in the process, "self-disclosure" fades as some kind of discrete, startling event because the analyst's personal self-expression is going on all the time. That is not to say that a moment when the analyst stops to say, in effect, "there is something I want to tell you about myself in this moment or in general" would not stand out as a special kind of subcategory of self-revealing behavior, but it doesn't have the same sharp edge of deviation from the baseline mode of participation that it has when the analyst is always trying – futile as that effort may be – to hide his or her subjective involvement.

Along with fully embracing that involvement, constructivist analysts are obliged to be continually reflective about their participation, and such reflection, if it is honest, entails, in line with Ferenczi (1955a, 1955b) as an early model, acknowledgment of the limitations of one's understanding, regular expressions of uncertainty, and language that is tentative and that leaves room for other perspectives. The constructivist analyst often says, "I was thinking maybe, on the one hand such and such, but on the other hand I don't know maybe that doesn't give enough

weight to such and such. . . . What do you think?" Jessica Benjamin (1999) in her review of my book (Hoffman, 1998) said, "I get the feeling of listening in on an internal dialogue or argument that runs like a familiar murmur in my head, saying 'yes, but what if,' and 'and also this,' and 'if I do this I might be overbearing, but if I do that I might be abandoning,' and 'this makes me uncomfortable, but avoiding it might not be right'" (p. 884). I would add that often the analyst would do well to bring those kinds of musings regarding his or her own internal conflict into the conversation with the patient.

Mitchell (1993) spoke of the "revolution in what the patient needs" as distinct from the "revolution in what the analyst knows." My own view is that they should be integrated because I think what the patient needs, the generic new, good object is one that has this kind of open-minded constructivist attitude towards his or her own experience as well as the patient's. The result encourages an interaction, a dialogue, in which self-expression and responsiveness form a dialectic, one that is worth aspiring to in many contexts, including those that entail an asymmetrical distribution of power, like that of parent and child, teacher and student, and analyst and patient. In those contexts (and many others), the asymmetry has the potential to be drawn upon to empower the one in the ostensibly subordinate position, as autonomy, self-expression, and the wish to influence are alloyed with responsiveness to, and respect for, the other, and vice versa.

SOME RELEVANT LITERATURE

The psychoanalytic literature that is relevant to my central point today regarding the desirability of therapeutic passion in the countertransference, and, more broadly, of "corrective experience" in the process is far too wide ranging for me to review here. I cite and quote only a few classical contributions that could be viewed as among those laying the grounds for later developments. In that spirit I am going to touch upon positions articulated by Alexander, Racker, Loewald, and Fairbairn.

Any discussion of new, corrective experience in psychoanalysis begins with *Franz Alexander*. Although I believe what Alexander finally recommends, in terms of "technique" that has the power to promote new experience faster than is likely in traditional analysis, is ill-conceived, the intensity of his commitment to finding ways to promote change has continuity with what I am proposing today. Alexander's willingness to encourage the analyst to assume certain prescribed roles with no concern whatever for authenticity is remarkable and the epitome of objectivism, associated with essentializing the meaning of *behaviors* regardless of the actor's inner experience. I think it's very interesting, however, that Alexander (1950), in defense of such "acting," points out that analytic "neutrality" is no more genuine than what he is advocating: "It should be considered that the objective, detached attitude of the psychoanalyst itself is an adopted, studied attitude and is not a spontaneous reaction to the patient. It is not more difficult for the analyst to create a definite emotional climate, such as consistent permissiveness, or a strong hand, as the patient's dynamic situation requires" (p. 493).

Heinrich Racker is forceful and uncompromising in his insistence upon the importance of the analyst's assuming responsibility for overcoming the destructive influences of the patient's past, but unlike Alexander he trusts the spontaneously emerging "complementary" and "concordant" countertransference to generate the emotionally meaningful caregiving, indeed the love, that the

patient needs. What is required and what Racker (1968) is confident the analyst will have available to offer is, indeed, nothing short of a kind of reparenting:

The patient can only be expected to accept the re-experiencing of childhood if the analyst is prepared to accept fully his new paternity, to admit fully affection for his new children, and to struggle for a new and better childhood, “calling upon all the available mental forces” ([Freud], 1917, [p. 453]).⁴ His task consists ideally in a constant and lively interest and continuous empathy with the patient’s psychological happenings, in a metapsychological analysis of every mental expression and movement, his principal attention and energy being directed towards understanding the transference (towards the always present “new childhood”) and overcoming its pathological aspects by means of adequate interpretations. (p. 33)

We can see here how far Racker goes in terms of calling upon the analyst to take on the daunting responsibility of being the new parent for the patient’s “new childhood.” And yet, in the end, he retreats—as I see it—from the full potentials of that stance and embraces the standard default position that requires that new experience in psychoanalysis must emerge primarily through “adequate interpretations,” while failing to mention any *other ways* in which it might occur. Friedman (2005), in his survey of the place of the analyst’s love in various theoretical perspectives, took note of the inevitable default position:

The comfortable thesis that, yes, analysts do provide love, but (never fear) it is nothing else than their understanding—this is the “hidden attractor” on which almost all definitions converge, as they progressively refine and sublimate and modify and control the more recognizable forms of love that are being mentioned. After various specific *feelings* are discussed, author after author concludes that love is embodied in the analyst’s understanding, which in turn is embodied in interpretations. (p. 356)

Limiting expressions of love to understanding and interpretation can become quite strained, like trying to fit a square peg into a round hole. The passion that is evident in the analytic attitude that a theorist like Racker encourages undoubtedly finds expression, not only in the cogency and affective immediacy of the content of his formulations, but also in his manner, tone of voice, and other nonverbal signs of his emotional engagement. Yet beyond even those factors, surely innumerable thoughtful, judicious yet not explicitly interpretive actions are *excluded* from consideration when they fall under the psychoanalytic taboo that prohibits any influential action on the part of the analyst that is not interpretive.

For the most part, *Loewald* regards interpretation as the route to therapeutic action. According to Loewald, what brings the new object relationship into play is largely the analyst’s interpretation of the patient’s distorted perceptions (Loewald, 1980a/1960, p. 225). Cooper (1988), however, pointed out that in Loewald’s more radical departure from traditional analytic technique, he linked therapeutic action with good parenting and seems to encourage ways of relating that are well beyond interpretation. And, in fact, Loewald (1980b/1970), after conveying a wide range of types of caring activity entailed in good *parenting*, including many modes of engagement that are psychological and physical, verbal and nonverbal—returns to the analytic situation and asserts, “In anal-

⁴Freud’s (1963) statement reads precisely as follows: “The decisive part of the work is achieved by creating in the patient’s relation to the doctor—in the ‘transference’—new editions of the old conflicts; in these the patient would like to behave in the same way as he did in the past, while we, by summoning up every available mental force [in the patient], compel him to come to a fresh decision” (p. 453).

ysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place” (p. 230, as cited in Cooper, 1988, p. 25).

Fairbairn (1958) is one of the clearest exponents of the corrective power of the analytic relationship relative to the destructive influences of the past. He wrote (quoting here from a review article by Wallerstein, 1990, on “corrective experience”):

From a therapeutic standpoint interpretation is not enough; and it would appear to follow that the relationship existing between the patient and the analyst in the psycho-analytical situation serves purposes additional to that of providing a setting for the interpretation of transference phenomena. ... The actual relationship existing between the patient and the analyst as persons must be regarded as in itself constituting a therapeutic factor of prime importance. The existence of such a personal relationship in outer reality not only serves the function of providing a means of correcting the distorted relationships which prevail in inner reality and influence the reactions of the patient to outer objects, but provides the patient with an opportunity, denied to him in childhood, to undergo a process of emotional development in the setting of an actual relationship with a reliable and beneficent parental figure. (Fairbairn, 1958, p. 377, as cited in Wallerstein, 1990, p. 314)

Beyond Alexander, Racker, Loewald, Fairbairn, and other foundational contributions (within their own schools of thought) including those of Ferenczi, Kohut, Winnicott, and others, the psychoanalytic literature on the role of the analyst in providing the patient with the opportunity for change-facilitating new experience in the analytic process is extensive. Contemporary theorists whose contributions are on this frontier in terms of the analyst’s personal participation in promoting change in the process include neo-self psychologists and relational theorists too numerous to list. What emerges is a whole tradition of advocacy of the analyst’s surfacing as a real person as part of what is considered absolutely essential for therapeutic action.

What I am recommending today may take us a little further along that path. I know I have gone further myself in the last few years in terms of offering more of an explicitly affirmative kind of presence to patients. I’m sure I am not alone in this regard. That kind of involvement can be found in the work of many contemporary authors, although my impression is that it is still more of a dormant than a fully realized potential for many of us.

I think it’s important to recognize that a theorist’s emphasis on the importance of provision of some form of corrective experience in the analytic process does not necessarily locate him or her in terms of epistemology. In fact, all the pioneering theorists I’ve mentioned—Alexander, Ferenczi, Racker, Loewald, Fairbairn, Kohut, Winnicott—are decidedly positivist in the way that they approach the work. You can see or hear it in the way that they talk to their readers as well as their patients. They speak with objectivist confidence about what is going on in the analytic relationship, about what the patient needs, and about what they are doing about it, or think should be done. With the exception perhaps of Ferenczi, one doesn’t hear any of these authors struggling either with epistemic uncertainty—in which they would be uncertain, at least at times, about what they thought they knew—or with existential uncertainty, in which they would be uncertain, at times, about what the patient should choose to do with his or her life. Perhaps the intersubjective turn in psychoanalysis *should* coincide with the constructivist turn, but I don’t think it does, certainly not in the case of these classical contributors to our understanding of corrective experience. From my point of view, therefore, in keeping with what I’ve said about integrating the revolution in our understanding of what the patient needs with the revolution in our sense of what the analyst knows (Mitchell, 1993), these theorists fall short of offering the aspect of the good new object that

is characterized precisely by the kind of struggling, self-critical, and open-minded attitude that a constructivist epistemology encourages.⁵

THERAPEUTIC PASSION IN THE COUNTERTRANSFERENCE: MODES OF EXPRESSION IN PRACTICE

Now let's look further at what "therapeutic passion in the countertransference" might mean in practice. A dictionary definition of passion is simply "a strong liking or desire for or devotion to some activity, object, or concept" (Merriam-Webster, 1983, p. 860). I know the term has various meanings in various theoretical perspectives such that of Bion (see Billow, 2000) for whom it connotes a special zeal about "thinking" and understanding, but for my own purposes the broader dictionary definition is good enough. I'm interested in particular in the analyst's "strong desire for . . . [and] devotion to" facilitating change in the patient's life in a direction that betters it in some way, makes it richer and fuller and more open to possibilities that were hitherto unavailable.

I am assuming that the very fact that one has chosen to be an analyst must imply some motivation of this kind, activated in each case in specific ways. Perhaps sometimes, as I've said, in addition to residues of the influence taboo and the incest taboo, the patient's character and transference may serve to diminish that motivation or even shut it down completely, but for the most part one would expect it to be a prominent aspect of the analyst's attitude, more or less owned or disclaimed, within the unobjectionable positive countertransference. Racker (1968) offered this particular speculation about the unconscious meaning of this motivation, a meaning he suggests patients are likely to sense immediately. He wrote,

The analyst communicates certain associations of a personal nature even when he does not seem to do so. These communications begin, one might say, with the plate on the front door that says "Psychoanalyst" or "Doctor." What motive (in terms of the unconscious) would the analyst have for wanting to cure if it were not he who made the patient ill? In this way the patient is already, simply by being a patient, the creditor, the accuser, the "superego" of the analyst; and the analyst is his debtor. (p. 146)

Whether one buys this speculation in its entirety or not, a more conservative version would simply posit some investment on the analyst's part in having the power to make a significant difference in the quality of the patient's life. That likely reality may activate all kinds of dynamics in *the patient* since it gives him or her the power to affect a transference-charged primary caregiver's well-being through the offering or the withholding of his or her "progress" as a reparative "gift," a dynamic I've discussed and illustrated elsewhere in the context of the patient's awareness of the analyst's mortality (see Hoffman, 2000). Is it really important that we deny the patient that power? I think under the guise of selflessly leaving patients "free" to decide their course without any influ-

⁵For my own and others' writings showing that various theorists commonly regarded as "relational" or "intersubjectivist" are, at least sometimes, if not more generally, objectivist in their thinking; see, for example, the following: on Winnicott—Hoffman, 1998, pp. 7–8, 171; Mitchell, 1993, pp. 68–73; on Fairbairn, Klein, Winnicott, Sullivan, and Schwaber—Hirsch, 1987; on Levenson and Sullivan—Hoffman, 1990; on Clara Thompson—Hoffman, 1998, p. 139; on Benjamin—Hoffman, 1991, 1999, pp. 911–913; on Racker—Hoffman, 1991, p. 542; 1998, p. 158n.; on Kohut—Black, 1987; Eagle, 1984, pp. 64–65; Hoffman, 1998, pp. 7–8, 110–111, 141; on Stolorow—Hoffman, 1998, p. 141; on Loewald—Hoffman, 1998, pp. 7–8; on Bollas—Hoffman, 2006b, p. 50; on Fonagy—Hoffman, 2004. Let me add that there are probably instances of objectivist thinking in my own work. The struggle against our craving for transcendent knowledge is ongoing for all of us.

ence emerging from us or from our patients' consciousness of the interdependence of their well being and our own, we deny our own vulnerability, we cultivate the illusion that all the power in the analytic situation resides with us, we exaggerate our dominance in the analytic relationship, we deprive the patient of opportunities to work out problems associated not only with the need for love but also with those associated with the capacity for being *sources* of love and concern for others.

There is an interference with the analyst's owning of therapeutic ambition and passion in the countertransference that is very simple and straightforward but also potentially embarrassing to consider. What I have in mind, again, is the analyst's ambivalence about the kind of responsibility that the role challenges him or her to embrace. Many of us have many patients under our care and it's not easy for us to bear the burden of being, as Racker (1968) put it, "prepared to accept fully [our] new paternity, to admit fully affection for [our] new children, and to struggle for a new and better childhood" (p. 33). That's not a small responsibility if we were talking about just one or two people, not to mention scores, possibly, of such quasi-"dependents." In addition to retreats from the special pressures of the role, there's the simple gravitation towards passivity, towards the easier path. And let's face it, our theories of technique are just packed with concepts that can mask and rationalize sheer laziness. The emphasis on just listening, on not interfering, on avoidance of suggestion, on being the blank screen for the transference, on promoting regression through optimal frustration, on allowing the patient to have the lead, on recognition of the patient's resistance to account for slowness or lack of movement, all these concepts can very easily serve as covers for failure to make the requisite intellectual and emotional effort to understand and formulate what might be going on, not to mention failures of imagination bearing upon more adventurous action. Slochower (2003) has written compellingly about the propensity that we all have towards certain kinds of seemingly small, as she says, "delinquencies." I think a subtle and pervasive delinquency in our field can be summarized first, as avoidance, in Racker's terms, of "the hard work the analyst must do to understand and interpret" (Racker, 1968, p. 31), and second, as backing away from what Buechler (2002) identified as the "brave act of facing our responsibility" through our highly personal participation, "to grasp the courage to inspire" (p. 277).

I want to illustrate various expressions of therapeutic passion through some clinical vignettes. I think such "passion" is multifaceted and any particular example of it will have one or another of its possible expressions in the foreground. Among the important possibilities to look for I would include (a) Working hard on understanding via thought, exploration, and interpretation. I think it's good to have ideas that are thought-provoking for the patient and that are potentially useful in concrete ways. Sometimes it's helpful to try to conceptualize and fully explain what one means. The conventional psychoanalytic premium that is placed on evocative brevity is replaced, at least sometimes, by attempts at clarity with elaborations and qualifications that may take time to spell out. Also, along with openness and willingness to change one's mind, sometimes, some persistence and some efforts to persuade given counterpoints that the patient may advance could be helpful. It's all part of "really talking."⁶ (b) Explicit affirmation through statements that are recognizing and appreciative of the patient's good qualities, strengths, talents, ways of being. I'm talk-

⁶I cannot emphasize enough that this type of expression of passion in the countertransference is of no less importance than the kinds I've identified and illustrated that are more dramatic and more obviously contrasting with common practice.

ing about stopping to say, explicitly, all those things that one might think “go without saying.” One of the tendencies that I think we have to overcome to do this is our habit of seeing the patient’s creative contributions to the process itself primarily as the “dependent variable,” as responsive to something good about the analytic setting, or to something more specifically good about what *we* did. In addition, “Free association” is a great example of a concept that strips the patient of responsible agency and therefore of any blame or credit for his or her contributions (Hoffman, 2006b). Here the determinants of the patient’s contributions are unconscious forces complementing the analyst’s therapeutic “interventions.” Why is it that analysts have “ideas” while patients have mere “associations”? (3) As I’ve already discussed, doing battle explicitly with “bad objects,” internal and external, through expression of feelings and attitudes that emerge spontaneously in the context of patients’ generously giving of themselves, allowing us to know them. Such feeling and such attitudes provide, potentially, a different kind of “presence” in the patient’s life, maybe it’s not too much to say a *loving* presence, one that can combat longstanding destructive influences on the patient’s sense of self; and (4) Promoting and supporting specific projects collaboratively identified and endorsed. We have so much fear of superficiality and of behavioral influence and compliance we can’t say “maybe it would be a good idea if you did such and such,” and respond, perhaps, to the patient saying, “Well, maybe, but I think such and such would be more realistic for me right now” with “I see, OK let’s make that the goal. But you know I’d like to ask how that went. Will you feel that’s too oppressively micro-managing you like your dad?” So much is mistakenly and reflexively blocked before it could possibly get off the ground by the question: “But is that really psychoanalytic?”

CLINICAL ILLUSTRATIONS

Neil

Neil is a man in his 70s, retired, married. He suffers from various physical ailments, a general sense of loss of physical well-being, horror at the prospect of dying and loss of a sense of worthwhile activity in the world after a rich career of academic achievement and social activism, however marred intermittently by conflict with, and alienation from, colleagues. He complains of irritability and of intermittent loss of temper over small things. He says he loves his wife dearly but feels there’s a certain distance between them, a lack of warmth and of demonstrations of affection. On the whole he says he “hates people,” thinks most of them are stupid and selfish. He realizes that his belligerent attitudes are partly shaped by a childhood characterized by poor care and abandonments. His father left when he was a baby and never tried to connect with him. His mother left him to be cared for by grandparents who were always working, and no one ever showed him any affection or concern for his well-being. Nevertheless, to me it always seems like he “protests too much,” like there is a vulnerable, warm person just beneath his curmudgeonly facade. I’ve always had good rapport with him and he’s always been appreciative of me, speaking frequently of how much he respects me intellectually. He’s read several of my papers and has given them rave reviews. So really! How bad a guy could he be? However, he says that basically, beyond him and me, there’s no one he feels deserves much respect. He has a good sense of humor and we banter a lot, sometimes rather aggressively.

In a session several months into the analysis, I hear him in the waiting room a half hour before the session starts. He has missed a few sessions because he was out of town with his wife following his father-in-law's death. I've got a cancellation but a lot of things to do. It occurs to me that a nice gesture might be to bring him a coffee in the waiting room on my way to the secretarial service across the hall, which I do. I realize that in 33 years of practice, it's something I've never even considered doing before. He's very appreciative: "That's so considerate," he says, "What's gotten into you?" I tell him I realize it's an "emergency" because he's missed several sessions due to his father-in-law's death. In that period he was forgoing phone sessions, which I thought would have been good to have. I say, my tongue still firmly planted in my cheek, that I thought another 20 minutes would be too much for him. He laughs. I tell him it's no ordinary cup of coffee he's got there. I say it's mother's milk. I tell him I'm fully expecting it to make up for all the love she failed to give him, especially in that cozy waiting room which is designed to evoke the sense of mother's womb. He laughs, "Yeah sure." "But," he says as he sips the coffee, "it sure is good."

The coffee is a special concoction of mine. He once commented, early on, that of course I have a cup and he doesn't. The next time there was one ready for him. He sits up on the couch so I had a wastepaper basket turned over as a convenient table for the coffee. The whole thing blew him away. He was totally shocked and delighted. I said "but you, in effect, asked for it." He said "So? Since when does an analyst do anything just because a patient asks for it?" The coffee by the way is made of two heaping teaspoons of regular instant, two heaping teaspoons of sugarless but sweetened powdered coffee, and a ton of no-fat powdered cream, vanilla flavor. If you aspire to any kind of therapeutic action in your work, you need exactly those ingredients.

The context for this particular moment in the waiting room is that there were several calls from him, including one in which he said, "You were right. I made a mistake in staying away so long. My anger is back. I've been losing my temper," plus several calls announcing he was definitely coming today. I returned them with one the day before this session just to tell him I was glad he was back and I wanted him to know I was looking forward to seeing him. After serving him the coffee in the waiting room I go out to give the secretarial service across the hall something to photocopy. It's a one-woman operation and she's not there. On the way back I feign a temper tantrum his style: "She's not there of course. People are no good. Ya can't trust 'em as far as you can throw 'em." I'm muttering curses. "Shit, fuck," and so on. He laughs at the not-bad imitation.

There's a theme in the work with Neil in which I am trying to persuade him that he benefits, not only from how smart he feels I am, but also from my caring about him. That, in turn, softens his angry temperament, I claim, and promotes his gentler and more loving side. I argue that his stubborn emphasis on our intellectual rapport is partly defensive against his emotional neediness and vulnerability. He tends to protest, in a manner that seems more automatic than heartfelt, that he doesn't believe me, claiming that it couldn't be true that I really give a damn because no one really likes him or cares about him, much less loves him. In one session, however, he did reflect on his father's disappearance when he was a baby, followed by no effort to connect with Neil throughout his life. Neil conveyed that he felt very injured by that and very angry about it, and he admitted that that probably added to his cynicism about anyone really caring. He spoke of the irony of having done the same, in effect, to his own kids. In his first marriage, he was a terrible husband and parent just like his father was. He slept around, went wherever he wanted to go, just acted irresponsibly in all kinds of ways. He is now totally estranged from his sons and wants nothing to do with them. At the same time he understands their hostility towards him, and that makes it a little easier to take.

He tells me that his older son's wife called and asked about bringing his grandson to meet him, but he has no interest he says because he wants nothing to do with his son Bill or his family. I suggest that his daughter-in-law might be carrying a message that his son cannot own up to because he's too estranged. Neil emphatically asserts that that's not possible in Bill's case, Bill is just too cold. I say that that doesn't mean he's not capable of having wishes that he has to split off and project into his wife. Then it's the wife who carries the message that Bill has to consciously disclaim, even oppose. This is what I mean by advancing and persisting with an idea, one that has potential practical implications. Now here is a piece of the interaction that I have transcribed from a tape of the session. Neil approves of my taping because, he says, he likes helping me to present and illustrate my approach:

IZH: It's like like the part of you that has trouble accepting that you want to be, and even believe that you might be, cared for by me. Those things are defended against for various reasons, so your son's softer side is what I'm saying [Neil: If he has one, I've never seen it] would only be represented in what *she* does, not in what *he* does, because he can't let that show.

Neil: Let me tell you something I just thought of ... It's almost time, I want to say this. What bothers me is I don't ... I don't want that little kid growing up saying "How come I never met my grandfather?" "Well, he didn't want to meet you." I don't want to hurt any more people like that. If that's the case, I will let him come up here. I just thought of that. I'm through with hurting family members. You understand what I'm saying? [IZH: Yes] You have to remember I'm changing to some extent. [IZH: I know] and I don't know whether there's some hidden thing going on with "I don't want to hurt that child."

It strikes me that this is a wonderful poignant reflection on Neil's part, an empathic softening of his attitude growing out of his sense of his own history and its impact on him. It's probably obliquely responsive to my efforts to touch his softer more loving self, but it's also decidedly his own creative integration, entirely different from what I had in mind.

A couple of weeks after this session Neil left me a voice mail telling me he told his daughter-in-law on the phone that he decided he'd like to find a time to meet his grandson after all.

Brenda

Brenda is a woman in her late 20s. She's a high school counselor who works with students on an individual basis as well as in groups. She suffers from anxiety, insomnia, some mild depression, and concern about her relationships, particularly the prospect of a long-term relationship with a man. I'd been working with her for several months. To me she seemed very appealing, personable, funny, smart, deeply thoughtful, and very astute psychologically. She's one of those people whose self-doubt seemed so unwarranted; instead I felt she deserved to be full of self-respect and pride. But her history included incredible relentless criticism from her parents, her mother especially, and her older siblings, two sisters and a brother.

Here's some process with her from a session about 6 months into the therapy.

She had a bag with her from which she took out a plate of tinfoil-covered lemon bars. She says, "These are for you, homemade." I exclaim, "Oh wow, thank you!" And I immediately start opening it up, saying, "You didn't think I had any capacity for delay, did you?" She laughs. They are unbelievably good and I rave about them. I tell her I know she's not sure whether to believe me.

After all, she's paying me. But I tell her that, in fact, they are wonderful. And I have a second one within like 10 seconds. They are in fact delicious.⁷

She says she asked her friend, "You think he'll interpret this?" and the friend said "Hell yes!" I say, "Yes, I interpret it as an expression of affection."

She says it is that, and she says her lemon bars are the one thing she has always had conviction about. She's amazed that that one thing has held up. She hasn't doubted herself about *that*. She says it's very unusual for her.

She tells me she brought them to express gratitude. She feels she has changed so much, it's overwhelming. It has been "such a relief." Now she becomes tearful, and I feel very moved.

Everything is different now: her work with the kids; asserting herself in all kinds of contexts, like fighting for a parking space someone tried to take from her or confronting the principal at school when he was rude to her. It's the way she feels about herself. "It's just so incredibly different." She experiences me as an advocate for her, an ally. And she is surprised. She's been in therapy before and found it helpful, but never in such a powerful way and never so fast. She says it's the whole way I am with her. She just cannot get over it.

She elaborates on how it feels doing her own counseling groups and individual counseling. She's interested; she's involved. But she's also freer and she isn't so constantly thinking there must be a *right* thing to say and do and she's surely getting it *wrong*. I suggest that oppressive professional-technical "standards" had picked up where mother's persecutory attitudes had left off. I talk to her about it being a matter of feeling *she* is good to be with: she as a whole person and the whole is different than and greater than the sum of its parts. The idea that she can just "be herself" more and that that will actually "work" along with the idea that if anything goes wrong it isn't all her fault, all of that makes the whole experience different and makes it so much more desirable to stay in her field whereas she'd been thinking she had to give it up.

Her parents, she says, "always, always, always, always, always" (I said, "That's 5 and I'm counting") they always made her feel there was something wrong with her.

I talk about what I've felt and done. I said I've simply been expressing what I feel about her, how terrific she is. The appreciative feeling is just there, like the feeling about her lemon bars. I said I'm sure it's all very complex, the factors contributing to her changing, but at the same time maybe there is something very simple about it: a matter of feeling loved by someone whose judgment she respected.

Later in the session she was speaking of her sense of the other person needing her to be a certain way and her feeling she had to do certain things to please. She said it was not that way with me. She doesn't feel she is going to be judged or dismissed. Like even the time she felt something I'd done was not good, the time she was upset because I gave her a speech about enjoying being alive, breathing, appreciating nature, and so on, regardless of anything else that was going on. I was saying that in response to her feeling depressed sometimes to the point of questioning whether there really was any point to life. The next time she told me she got scared that I wouldn't want to "go with her" into her anxiety and depression. I was too quick with glib clichés to talk her out of it. It

⁷What if I actually didn't like them? Is a "white lie" ever called for? I think often careful, honest, straight talk is the better route, even if potentially problematic and narcissistically injurious. For an example in my own work of disapproval of something a patient intended consciously to be an act of kindness, see the extended work with Manny after he comes to my home, ostensibly to deliver a check for as yet unbilled sessions the day of my return from the hospital following cardiac surgery (Hoffman, 2000).

reminded her of her mother, who insisted that she “think positively” all the time. Her feelings were not ever taken seriously. The way I took that disappointment in me, that criticism, was very freeing for her. It’s part of what makes her feel she can just be herself and it will be OK. I had, in fact, felt she had an important point, that I should be more accepting of her pain and not so eager to make her feel better. I told her that I was sorry that I had done that and that I would work on it, but also that I wanted her to call me on it if it happened again.

There is an example of an enactment here. But the way out of it is not only through interpretation, whether mine or the patient’s. It’s also through my taking seriously that I did something for which I am responsible and that warrants apology, reflection, and an effort to change. It’s not something merely “elicited” by the transference, an idea that can always be used to blame the patient for “starting it,” and to absolve ourselves of responsibility.

A CONCLUDING “SUGGESTION”

I leave you with just this “suggestion,” in its common, everyday sense of course (although maybe I wish I had all of you under a hypnotic spell). No example that I present here or that I’ve presented elsewhere is intended to imply that anyone should do anything that is the literal equivalent of something I’ve done. The general point is precisely that we cannot standardize modes of expression of “passion in the countertransference.” The only thing that I am arguing might be generalizable is that the analytic situation lends itself to a high probability that our experience within our analytic role will include intense, responsive, passionate feelings, if we open ourselves to them, as we hear the details of patients’ suffering, their historical origins, and the often impressive, even heroic strivings of the patient, despite the obstacles, to survive, to live, and even to grow. The challenge for each of us is to find our own way, expressive of our own personalities including sometimes untapped potentials within us, to express that passionate response in a manner that is usable by each patient in his or her unique way. I am saying that the analytic process holds the promise, not only for a special degree and quality of understanding but also for a special degree and quality of love and reciprocal inspiration. It’s a promise that I feel we have the responsibility, “calling upon all [our own] available mental forces” (Freud, 1917/1963, p. 453) to try our damndest to fulfill.

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