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### Varying Modes of Analytic Participation\*

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The current debate over whether insight or a new experience with the psychoanalyst is the primary mutative agent in psychoanalysis is artificially resolved by dividing the patient population along diagnostic lines. A widely held perspective (e.g., **Stolorow and Lachman, 1980**) is that insight via interpretation in the classical blank-screen model is appropriate for neurotic patients and that a new relationship is necessary to heal those patients who have not developed up to that level. Different sorts of new relationships are posited by various non-blank-screen or “participant” schools; some that include and others that exclude insight as also important. Most of these deviations from the blank-screen model have been developed by analysts who targeted either more seriously disturbed patients or children as their focal group (e.g., Fairbairn, **1952, 1958**; **M. Klein, 1957**; Winnicott, **1958, 1965, 1974**; **Sullivan, 1953**; Kohut, **1971, 1977, 1984**). As Greenberg and Mitchell (**1983**) have suggested, this is either a strategically planned or inadvertent political move to develop a new overall theory of therapy without directly challenging the dominant Freudian model. Upon examination it is evident that these innovators work with all of their patients in their new mode and show little interest in the traditional, classical model with any of their patients. This may be so while simultaneously, in their writing, maintaining that the innovations only pertain to a delimited population of patients (e.g., Winnicott and Kohut).

There are a variety of analytic models that I shall call “participant” models. They are all based on the view that the analyst participates

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from somewhere within the analytic process or analytic field and that the analytic relationship is more fundamentally connected with analytic change than is insight, per se. This contrasts with the traditional position of the neutral, objective screen operating and interpreting from outside of the patient's field. These “participant” models may otherwise differ sharply from each other, and at times, more than they differ from the blank-screen model (Gill, 1983). Following Hoffman's (1983) paper, which discusses radical and conservative critics of the blank-screen model, I shall attempt to compare and contrast some of the more influential “participant” models, with a primary focus on Hoffman's “radical” group.

Perhaps one extreme opposite of the blank-screen paradigm is illustrated by Michels (1985) in his review of the competing current trends in psychoanalysis. The most radical position he outlines is that discussion of the patient's life is merely the designated psychoanalytic task. The patients' description of their life, history, dreams, transference, etc., is what the two parties have decided to do together, but they might just as well agree to build a canoe (Michels' example). The awareness or insight achieved is irrelevant, or at least incidental to the new relationship that gets established and that is the sole mutative agent. The real reason for getting together is to develop an ultimately therapeutic relationship, and since discussion about the patient's difficulties and insight into them are the tradition, this is the vehicle used. He does not associate any particular theorists or known school with this point of view.

Another radical departure from blank-screen, nonparticipatory ideology is outlined by Hoffman. Hoffman's “radical” refers to a “new social paradigm” in contemporary psychoanalytic thought. This paradigm is composed of theorists from a variety of different perspectives. He cites as examples Gill, Levenson, Racker, Sandler and Searles. These theorists resemble Michels' illustration in that they attach great significance to the mutative features of the analytic relationship. Where they starkly differ is that they do not consider the advantageous effects of the relationship as sufficient in producing enduring gains. They consider clarification or insight into the relationship or into the dyadic process as essential for this procedure to be called psychoanalysis and for the benefits to be long-term. In addition, most of the above theorists would say that it is also crucial for the patient to recognize parallels between the transference relationship and both current and past significant configurations. Without one or both of these features, Gill would refer to the changes as “transference cures.” Here then is one integration of the insight position and the new relationship emphasis.

With this group the new relationship has priority, and insight focuses less on genetic insight or reconstruction. The main cognitive aim is a clarification of the ongoing psychoanalytic engagement, and the past is referred to more for that purpose than reconstruction and recovery of the repressed.

A red thread that runs through these writers is that analysis occurs not only from within the patient's system but from so deeply within that the analyst is sometimes unaware of his entanglement. Not only is the analyst other than an objective, neutral, blank-screen, he can be lost inside the patient's world. Relativism, rather than absolutism, reigns. The analyst as an emeshed "observing-participant" is in no position to speak of absolute truth or to convey purely intrapsychic insights. His observations are subjective because he is not sufficiently detached or outside the relationship to be objective. Hoffman does not view this as an unfortunate limitation on our science but as a human inevitability. The analyst, in consonance with tradition, tries to be the observer but cannot help also being a participant. He believes that what these "social paradigm" thinkers are saying not only applies to their particular way of working but is an inevitable feature of most analytic engagement. He proclaims that most analysts become engaged in the patient's system and lose objectivity. Many analysts do not know this and believe that they are being objective and analyzing from without. The focus is more on the objective therapist treating the ill or distorting patient and correcting the distortions by promoting insight or by providing reparative experience as would a good doctor.

Hoffman underscores the point of view that patients are always telling us a great deal about the way we are engaging with them and that they are, to a reasonable degree, probably accurate. It is the analyst's guide to becoming aware of unconscious experience and unwitting participation. Analysts who believe that they are working from outside the system are likely to view these observations as distortion or projection, and those who are like Hoffman's group are more prone to examine the plausible interaction addressed by the patient. Hoffman's social paradigm group believes that the interaction, which is a repetition of the past, is to some extent actually taking place. Other analysts believe that the interaction is not taking place at all, but that the patient either wishes it were, is projecting from inside, or distorting from the past. The analyst is always in control and always knows the remedy.

The names that Hoffman mentions (Gill, Levenson, Racker, Sandler, and Searles) come from different theoretical backgrounds. Some, like Levenson and Racker, are fairly representative of their theoretical

homes. For Levenson this is the contemporary interpersonal school and for Racker this is the Kleinian group with its roots back in Little's (1951) work on countertransference. Gill, Searls, and Sandler bridge different theoretical orientations, feeling free to blend and to take what they think is the best from a variety of reference points. I will not refer to other contributors when describing this group, although there are many. Ehrenberg's (1982) article is a good reference source for these theorists who see themselves as engaged as "participants" yet at the same time maintain an observing function. In fact, I think that Fromm's (1964) term, "observing-participant" is a far better one to describe this group than the one Hoffman chose; "social paradigm."

To my thinking, the key distinction between the "observing-participant and some other "participant" analyst is that the former is both deeply engaged and at the same time analyzes that engagement. The "observing-participant" gets caught-up in the relationship both affectively and behaviorally but when aware of this, attempts to make the dyadic configuration explicit. As noted a moment ago, this group does not wish to simply influence the patient by their participation. They do not want to help the patient without the patient knowing how the relationship is helpful. Being a new and better interpersonal experience is not enough. Gill (1982, 1984) is most clear about this when he warns against transference cures. He feels that the effects of the analyst on the patient that are known to the analyst and not to the patient is blatantly unanalytic. If a patient is helped by a new relationship and does not know what is going on in this process, for Gill, this constitutes "supportive psychotherapy." It speaks to the analyst as a powerful mystifier, leading the blind patient to some place good. Levenson (1983) speaks of the patient's need for clarity, for what he calls semiotic control. To be clear is to be more integrated; clarity is psychic health. Gill does not feel that the unarticulated new relationship really takes hold permanently because it relies too much on the power of the analyst and his influence. The patient is too passive.

One of the other hallmark similarities of the observing-participant group is that they view as inevitable the analyst unwittingly repeating with the patient the patient's significant early relationships. Sandler (1976) refers to "role responsiveness," Levenson (1972) to "transformation," and Searles (1965) to "pathological and therapeutic symbiosis." There are some differences in these concepts, but they all refer to the patient's unconscious efforts to consistently recreate their old environment, with all its bad but comfortable features. This is somewhat similar to the notion of repetition compulsion and to Fairbairn's ideas about "internal objects." In this instance, however, the

analyst does his share in the repetition of the patient's early significant dramas. The analyst is not trying to do this, but the power of the patient's influence (**Feiner, 1977**) nudges him into this role. The patient does not only imagine this as is believed in the blank-screen model. Here it actually happens as part of a natural process. In a sense the analyst feels toward the patient and relates to the patient in ways not entirely different from other people in the patient's past and current life. That is, we all shape our current experience with others to repeat the past, and a masochist will have sadistic lovers and friends as well as a sadistic analyst. The observing part of the analyst often does not help him avoid this but does help him see it once it is in process. The therapeutic task is to examine and clarify what the engagement has developed into, and in so doing begin the effort to work out of it. Of the five theorists mentioned, only Racker (**1968**) does not write specifically about this process. He does, however, spell out so clearly the interactive and mutually influencing nature of the analytic engagement that I believe his spirit is in harmony with this group. It is interesting that in two articles that have become classics in the field, Tower (**1956**) and Bird (**1972**) discuss transference neurosis in a way similar to the above. More recently McLaughlin (**1981**) has also addressed the inevitability of the analyst losing himself in the analytic engagement during the more intense periods of the work. All three Freudian authors view analytic objectivity as thoroughly lost at such times and see the analyst as going through a countertransference neurosis reciprocal to the patient's transference neurosis. The analyst is as thoroughly in the process as the patient, becomes aware of this at some point, and then addresses the interaction.

It is important to address the question of the analyst's feelings on the one hand and his actions on the other. Some “participant” analysts believe that feelings and actions are entirely separable and that analysts have the full range of feelings toward their patients but that these do not show and are not acted-out in any way. That is, for example, the analyst can act benevolently while feeling rage and the patient will not know it. The classical position is that some feelings may be present, but if they show, it reflects a countertransference problem. The “observing-participant” goes beyond the acknowledgement that the analyst often feels toward the patient similarly to the patient's past and current figures. Analysts from this group view responsive repetition as inevitable. These feelings cannot be effectively disguised and will be, in Tauber and Green's (**1959**) terms, unconsciously communicated. They will also influence what the analyst does. As Racker says, the patient is always influencing the analyst, and the analyst is always

influencing the patient. The key to this way of working is to constantly encourage the patient to specify how the analyst is being and to view these observations as plausible at the very least. Without this the analyst's actions may continue out of awareness, and the analysis could easily become an endless repetition of the past. When in Hoffman's words the patient interprets the analyst's experience, the analyst is in a position to be conscious of his side of the repetition. This would be less significant if the "observing-participants" were only focusing upon the analyst's feelings. Feelings alone can be experienced and not acted upon, and the patient might sense these feelings but then again may not. Feelings that are seen by the patient (unconsciously communicated) in the analytic interaction become more than feelings; they become actions. This group believes that analysts' feelings do become actions, that is, they are visible to the patient. If one thinks that the patient is not likely to see the analyst's interactions, such observations will not unlikely be encouraged. The "observing-participants" not only believe that the analyst is always feeling something and caught up in the process in some way, but that the patient is aware of this. The significant variable is not whether or not the patient perceives but if the analyst encourages or discourages these perceptions.

Another shared characteristic of the "observing-participant" analyst is the significance of conflict in human experience. This differs from the classical view of conflict where the focus is on the conflict between structures of the mind (id-ego-super-ego). One of the bases of Freudian theory is the ever presence of conflict between id impulses and the ego and super-ego. Conflict from the perspective to which I am referring addresses the issue of attachment to the sameness and comfort of the past on the one hand and the openness to growth and to individuation on the other. The inevitable repetition that the analyst lives out with the patient is a function of the patient's wish to repeat the past in all current relationships. This attachment is strong in all of us and most strong in those with more troubled pasts. The greater the trouble, the more the need to hold on to whatever one has and the greater the fear of seeing anything new. Thus, even patients with strong early backgrounds are inclined to repeat the troublesome aspects of their past and are reluctant to leave these configurations behind. The analytic aim is to promote a more differentiated and autonomous self (see Fromm, 1964, 1980; Searles, 1965, 1979; Barnett, 1978, 1980; and Fairbairn, 1958 for a more detailed discussion). The "observing-participant" analyst sees how likely it is to become emeshed in this conflict. The patient does not simply wish to change, he both wishes to be open to the world and also to remain embedded in the past. When caught-up in the patient's relational patterns, the analyst

is reinforcing the side of the conflict leading toward embeddedness. When aware of this and trying to work out of it, the analyst is providing a new experience for the patient. Nobody is available for a new and better relationship without considerable struggle or conflict. The patient is not simply looking for a rescuer to come along and carry them to a better place. Would this be so, our work would be simple.

To summarize this section, there are three key issues that distinguish the “observing-participants” from some other “participant” analysts:

- (1) The inevitable, unwitting enmeshment of the analyst in the patient's pattern of repetition
- (2) The view of the patient as being in basic conflict between repeating the past and remaining incompletely differentiated from it, and differentiation of the self and being open to new possibilities
- (3) The primary importance of providing clarity to the patient by making the shifts in the analytic interaction and process verbally explicit as they occur

I will attempt to illustrate this distinction by addressing some of the significant analytic “participation” developments and contrasting them with the “observing-participation” group. These distinctions will not always be clean, and there will often be considerable overlap. The “participant” theorists to be compared are Fairbairn, M. Klein, Winnicott, Kohut, and Sullivan.

Fairbairn's (1952, 1958) strongest impact on analytic technique relates to his notion of “internal objects” and as an early contributor to the view of the analyst as a new object. He is very close to the “observing-participant” group. Fairbairn entered this arena and strayed from classical notions via the usual route: work with other than so-called neurotic patients. Over time he believed that his original schizoid patients were not so separate from others, and that everyone had a schizoid core that reflected the heart of their psychopathology. This schizoid core was seen as a means of protection from the bad aspects of the significant early relationships. On the other hand he saw these bad relationships as internalized. They reflected a cherished connection to loved figures of the past and a way of holding onto whatever love did exist. Fairbairn saw that the key to successful analysis was providing a better relationship but that the patient was so attached to the internalized objects that it was difficult to get through in order to provide this better relationship. That is, although the only release from schizoid protection was a new experience that rendered the protection less necessary, the old bad relationships dominated the psyche.

Fairbairn clearly saw the conflict between sameness and differentiation of the self and realized that the analyst was not simply a welcomed rescuer. He knew that the patient was not passively waiting

for him to provide a benign experience. From what can be determined, he was inclined to make explicit the patient's attachment to the bad objects and their efforts to convert him into, or see him as one of, the bad objects. Analytic change occurred by the analyst's efforts to resist being a bad object and the patient's eventual recognition of this new object. He thus differs from the "observing-participant" in that he does not inevitably become enmeshed in the patient's repetitions. That is, he does not actually see himself as first becoming a bad object but as successfully resisting doing so. An "observing-participant" analyst would say that this cannot be entirely successfully resisted. With regard to making the interaction explicit, Fairbairn did this up to the point where it was relevant for him. He made the patient's conflict explicit as he did the patient's resistance to letting him in as a new object. He could not make the enmeshment explicit because he did not see this as inevitably existing. Fairbairn did not believe that interpretation was sufficient but that participation as a new object was necessary. He got inside of the patient's system partially, as a new and good object, but did not enter as a repetitive bad object. It is this primarily that distinguishes him from the "observing-participant" group.

Melanie Klein (1957) and her followers (e.g. Segal, 1964) were a strong force in opening analytic access both to children and to more seriously disturbed patients. In working with the most primitive features within everyone, in a sense everybody was regressed and "seriously disturbed." Although all Kleinians do not work alike (there are South American Kleinians and British Kleinians), Bion's (1977) analytic model of the "container" reflects a reasonably well shared Kleinian characterization of the basic analytic model. In this model the analyst knows the patient's experience because in their interaction the patient projects his insides into that of the analyst. This is called projective identification. It is both a way for the patient to aid the analyst in knowing him and a way for the patient to cure himself of his internal problems. The analyst is to hold the patient's insides for safekeeping until the patient is ready to reintegrate them in a less overwhelming and more mature way.

In one respect the analyst is a very fully enmeshed participant, since he holds the patient inside of himself and feels the full impact of the patient by doing so. Indeed, the analyst can feel confused between where he ends and the patient begins. It is a bit like a blood transfusion. To follow this analogy, however, the patient's blood goes into a container inside of the analyst and not into the analyst's bloodstream. This container is relatively free of the analyst's own personal insides and cleaned out to receive the patient. To the extent that this is so,



the analyst is not really enmeshed with the patient but is always able to distinguish what belongs to him and what belongs to the patient. If the container is really clean and empty, the analyst is actually similar to a blank screen, only the screen is inside the analyst's body and not like an external movie screen (**Levenson, 1983**).

The Kleinians, as a group, do make the here and now experience most explicit. The focus, however, is more on the patient than on the dyad. That is, it is on the dyad, but the analyst is not seen as a real contributor to the dyad. The analyst points out what the patient is doing or how the patient is using the analyst, but the analyst is not generally seen as unwittingly falling into a reciprocal role or becoming transformed. The analyst does not really become the bad object but is containing the patient's badness and is only seen that way in the patient's fantasy. This, of course, resembles the classical model. The analyst, therefore, does not live out the bad object in the patient's conflict between change and nonchange. Therefore this "observing-participant" interaction cannot be made explicit. It really isn't seen as part and parcel of the relationship. Conflict is not a central theoretical aspect of Klein's theory of therapy.

Winnicott (**1958, 1965, 1974**) pays repeated obeisance to the distinction between analytic work with psychotic or borderline patients and neurotic ones. He clearly states that it is the analytic setting that cures in the first instance and traditional interpretation in the second. In all of his writing, however, he shows no interest whatever in the latter. In reports of his treatment from prominent patients (**Khan, 1975; Guntrip, 1975**), there is no indication of anything that resembles classical analysis and no distinction from what he describes as his work with psychotic or borderline patients. Winnicott is fully a "participant" analyst who entered the field through pediatric medicine. He is a loving and benevolent doctor with all of his patients. Interpretation means little or nothing. The analytic aim is to be a "good enough mother," a reparative parent, and a replacement for the deficient parent. He views psychoanalysis as a reproduction of good mothering technique. The benign analyst is there to be used and abused by the patient and to survive. His patients are seen as in "the care of."

Indeed, Winnicott preferred to lecture to teachers, ministers, and child care workers than to analysts or psychotherapists. The former group resembled more closely what he saw as psychoanalytic work. In the pediatric tradition Winnicott did whatever necessary to "take care of" his patients. Regression was encouraged, and the analyst provided a "holding environment" during long phases of regression to dependence. Management of the patient was always emphasized

while the patient abandoned his “false self” features to the trusted analyst and found his heretofore “forbidden self.”

This summary does little justice to the literature of Winnicott and his followers, but there is no clearer example of a “participant” analyst who is not an “observing-participant.” Winnicott views the analyst as a totally loving figure. Even when the analyst hates, he is hating objectively and doing it for carefully planned therapeutic reasons. Winnicott believes that his good mother can resist being a bad mother. He maintains a good parent position and doesn't become enmeshed as a bad parent. He does not see the patient as attached to his bad objects as does Fairbairn but as quite willing to relinquish them in the face of a consistent, loving environment, as does Guntrip. The patient wants only to give up his bad parents and will do so for as long as it takes him to find out that the analyst is good enough.

Mitchell (1984) characterizes this model as reflecting the notion of a passive patient. The patient is an infant in an adult's body and cannot grow until the early unmet needs are gratified. These needs must be met in the way they were originally unmet: parent to child. This is done without the interaction being made explicit. The analyst does his reparative work, and this has an effect. The patient regresses, is held in dependency by a new and better object, abandons his false self, and finds his true self. The analyst does not try to clarify this dyadic experience while it is happening or even necessarily after it has occurred. This mutative experience is lived out without being spelled out. Gill would call this transference cure.

To summarize this example of “participation” as distinguished from “observing-participation,” Winnicott becomes a new object without ever being enmeshed in the patient's system. He is able to maintain his position of good mother without falling into the bad parent entanglement. He does not make the therapeutic interaction explicit and monitor it as it proceeds. The process happens without the patient gaining clarity. Finally, he does not see conflict within the patient between attachment to the old and wish for something new. He therefore does not view the patient as actively making his environment into a repetition of the old but as a victim of the past, longing to be released from his prison (Miller, 1981).

Kohut (1971, 1977, 1984) has gradually evolved into a “participant” analyst for all patients. His last writings and the work of a number of his colleagues are clear in their belief that the essence of cure is not cognitive but based on the analyst's mutative way of being with the patient. This is not any longer viewed as solely true for narcissistic patients, although, to the end, Kohut did not see schizophrenic

or borderline patients as analyzable in any fashion. For Kohut the analyst participates in three fundamental ways: as a listener, explainer, and as a failure. All are necessary for change to occur, and the latter is inevitable in any analytic relationship. Kohut sees selfpsychology, analytic procedure as essentially the same as classical procedure, except that the analyst periodically fails to understand or otherwise loses empathic connection with the patient. This actually happens and is not the patient's fantasy or his projection. The analyst is exquisitely sensitive to the patient's reaction to this (usually rage, depression, or withdrawal) and encourages the patient to relate to the fullest his feelings about the actual interaction. This likely leads to recollections of early similar injuries and disappointments that have led to narcissistic rage and withdrawal and incomplete development of the self. By helping the patient become aware of the immediate and past interpersonal stimuli for such withdrawal, the patient gradually relinquishes his narcissistic protection and lives more fully in the world. Kohut helps the patient see and articulate the sequence: analyst's withdrawal, patient's depression or rage, patient's narcissistic withdrawal. The analyst who allows the patient to respond to his empathic failures becomes, for the patient, what Kohut calls a self-object. The patient is narcissistic because he withdrew from unavailable significant people in his environment. He can now complete development by not withdrawing from the analyst who is more available both because of his greater empathy and his willingness to allow the patient's open reactions to the analyst's failures. The patient completes faulty original identifications with this new person and develops more of a tolerance for empathic failures. The analyst makes the latter explicit but does not clarify the "transmuting internalizations" and "idealizations" to the patient. That is, the entirety of the interaction is not spelled out, although the exchanges around breaks in empathy are clearly articulated.

Kohut's view of the range of the analyst's participation is narrow. He views the analyst as operating like a standard blank-screen except for one element, a repetition of empathic failure and a willingness to not deny this to the patient. This deviation from the blank-screen is a theoretically very important one because it does place the analyst *inside* the interaction. For this interaction alone, Kohut is an "observing-participant." His unwitting withdrawal from the patient is the heart of the analysis. It makes the wheels turn. It seems unlikely, however, that this is the only way the analyst becomes enmeshed in the patient's life system. Empathic failure is not the exclusive reason for troubled development, and if Kohut were a wider ranged "observing-participant,"

he would report numerous ways in which the analyst repeats past interactional patterns. Another way in which Kohut is distinguished from the “observing-participant” group is in his view that the patient does not influence the analyst into failures in an effort to repeat the past. That is, as with Winnicott, there is no conflict between a wish to change and loyalties to past objects. In Kohut's schema the patient simply wants to change, and if the analyst provides a sufficiently empathic environment, the patient will eventually receive it. Kohut, again like Winnicott, would never see the patient as initiator of his own problematic interactions. He would consider such a viewpoint as moralistic and judgemental. The patient is not seen as involved in evoking the analyst's empathic withdrawal.

Kohut's notions of identification and idealization are thorny ones. Certainly it is normal for patients to identify or wish to identify with the analyst. Some identification is probably inevitable. This is one way an analyst can participate and possibly help patients, especially ones who have had deficient parenting. It has long been thought, however, that this was a decidedly unanalytic mode of change, and it has been associated more with supportive psychotherapy. Singer (1965a) particularly emphasized the importance of the patient establishing his own unique identity, something that is compromised when one adult identifies with another. As Gill points out there is something contradictory between identifying and analyzing. The analytic tenet, making the transference relationship explicit, is usually ignored when identification is promoted; Kohut, like Loewald (1960), who also saw identification as a key mutative factor, does not question these identifications when he sees them occurring. That is, the analyst does not convey to the patient that he is now in the process of identifying or that he wishes to do so. The analyst lets it happen because it is thought to be needed by the patient. The “observing-participant,” on the other hand, is always striving to address the analytic relationship and clarify it. From this point of view identifications or idealizations are less likely to be promoted because the very act of making the process clear works against it ultimately happening. The view here is that although the identifications are wished for they are not needed. The interaction is closer to one adult enriching another adult than it is to a parent providing supplies to a child. The latter mode of therapeutic action can only exist when aspects of the interaction remain silent. It is judged to be good for the patient to just let it happen.

The concept of empathy merits a brief note in this context. Kohut's reintroduction of the term has served a very useful purpose. Analysts are now more aware of the importance of seeing things from the

patient's perspective and respecting the patient's perceptions as accurate or plausible and not simply as projections. Some of those influenced by Kohut, Schwaber (1983) for example, carry the virtue of empathy to the extreme of making it an objective property of the analyst. That is, if the analyst's aim is to always understand the patient's perspective, how does one know when this understanding does not also reflect the analyst's own perspective? That is, given the undoubtable value that it is always worth trying to understand the patient's perspective, how is it possible to know if the understanding really is from that perspective? Whatever understanding an analyst arrives at must be influenced by the person of the analyst and by the interaction the analyst has been drawn into with the particular patient. Thus, try as we may, empathy does not only reflect pure empathy but a mixture of this with the psyche of the empathizer. This notion of pure empathy no less reflects a belief in the analyst's objectivity than does the blank-screen model or the clean container model.

Sullivan (1953), the last to be discussed, is the founder of the interpersonal school from where the concept of the "observing-participant" arises. Sullivan, of course, tried to promote a major change in the analytic model in the United States and did so by developing his participant-observation model from his early analytic work with schizophrenic patients. His "participant-observer" stemmed from the then new idea in basic science, that the observer is inevitably part of what he observes, and the trend toward field theory in the social sciences. The blank-screen or detached observer is, therefore, not even possible in basic science and research much less in such a personal and subjective arena as psychoanalysis.

Sullivan viewed the analyst as a new participant in the patient's life. He was a great believer in the salubrious value of subsequent relationships when the early parental ones were poor. Bad early interpersonal experience leads to the development of anxiety in connection with subsequent interpersonal experience. Anxiety leads to withdrawal, resulting in an impoverishment of experience, restriction of awareness, and low self-esteem. As a participant who clearly conveyed that he was on the patient's side, Sullivan hoped to enhance self-esteem, reduce interpersonal anxiety, promote awareness, and enrich the patient's experience. He was careful to avoid arousing anxiety and tended to be very indirect in order to do this. He would play-act, feign reactions, avoid affective interchange, and do anything necessary to modulate anxiety. Sullivan's patient was seen by him as fragile and was easily lost to withdrawal if not handled gingerly. Along the same lines, Sullivan kept away from direct, explicit focus on transference

material in the here and now of the analytic relationship. He used the patient-analyst field as data but did not address it directly. His primary manifest data were detailed descriptions of current interpersonal relationships and past relationships. He was not especially concerned about genetic insight as he was about clarity. That is, he cared more about the “what,” which is descriptive, than he did about the “why,” which is explanatory. He believed that if people were aware of what they were like with others, they could not be too seriously disturbed.

Sullivan saw himself as an expert in interpersonal relations. His role as an expert provided security and reduced anxiety. He was a pragmatist and was less involved in resolutions than in helping people live better with others. He sounded informal, homespun, folksy, and spontaneous but was none of the above. Everything he said was well planned and part of a strategy to achieve specific effects. Like Winnicott and Kohut he did not see the patient as easily able to draw the analyst into repetitions of past interactions. He thought that his patients were frightened of interpersonal intimacy but wanted it and would welcome it, if and when anxiety were sufficiently reduced. His designation of himself as an expert implied that he felt he could avoid countertransference entanglements. If the patient viewed him as a malevolent figure, for instance, he would see this as a transference distortion. His “observing-participant” colleagues, on the other hand, would likely address it as a plausible perception.

Sullivan's legacy has taken two directions in the interpersonal school. Those who have stayed closest to him (e.g., **Witenberg, 1973; Zucker, 1967**) focus minimally on the here and now transference issues and on making the analytic relationship a main focus of discussion. The primary focus of the analytic inquiry is the patient's past and current extratransference relationships and what the analyst can clarify to the patient about himself via these interactions. The patient gradually opens up and lets this expert, who is on his side and who is warm and caring, into a trusting and open relationship. This leads to a shift in expectancies vis-a-vis other people in general and to a greater awareness of one's interpersonal impact. The here and now process remains unaddressed.

Those who have become “observing-participants” (e.g., **Singer, 1965b; Levenson, 1972; Wolstein, 1975**) were more than likely influenced by Fromm at least as much as by Sullivan, although Sullivan opened the door for this position. They are acutely aware that the patient is not simply looking for a better relationship but is deeply attached to the old ones. They expect that it is unavoidable that the

analyst will become caught up in the patient's life patterns. The patient is seen as an initiator who actively goes through life inducing significant others to repeat old patterns. The patient wants to change but always seems to be doing something to promote the status quo and repetition with others and with the analyst. The analyst is more likely than Sullivan to make this here and now engagement explicit.

The “observing-participant” views the patient as more aggressive and initiating than did Sullivan, even in light of the patient's own felt deficiencies. Patients act on their environment and shape it to conform to the past. This happens with the analyst, who gets stuck in it and bores out from within. The analyst is not an expert but a fellow traveler who enriches the adult patient by pointing out process and staying with the immediacy of the relationship wherever it goes. For those closer to Sullivan this is too anxiety-producing a place to be.

Thus, we have a blank-screen model where insight is primarily mutative, and we have a “participant” model, originating through work with more severely disturbed patients and children, where the relationship is primarily mutative. Within the category of the “participant” paradigm there is a radical group, dubbed by Hoffman as the “social paradigm” and referred to here as the “observing-participants.” Then there are the other “participant” theorists. All “participant” theorists view the analyst as a potentially beneficial new object who is not a detached, scientific observer. The similarity may stop there since there are many different ways of participating. Characteristic of many “participant” groups is the reluctance to analyze the effects of the analyst's participation. This has led to charges that transference cures are being viewed as psychoanalytic cures. Also emblematic of many “participant” groups is the vision of the patient as a relatively passive victim of early experience, searching for a good object to replace the old bad one. The analyst is seen as that replacement who, by being different from the bad objects helps the patient open up. The “observing-participant,” on the other hand, sees the patient as constantly trying (and succeeding) to enmesh the analyst into his past relational configurations based on a wish to repeat old attachments. The key to change involves helping the patient see the conflict between pulls toward the old and the potential of the new while unwittingly falling into these old patterns and making these patterns explicit as they reach awareness. From a position inside the troubled interaction, the patient-analyst relationship as a process is repeatedly brought into verbal focus.

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