How Do We Understand Another Person?

ONE-PERSON AND TWO-PERSON PERSPECTIVES

One important source of confusion surrounding the distinction between one-person and two-person approaches is that the distinction has been brought to bear in at least three different ways—to refer to issues of epistemology, of personality theory, and of practice. These are certainly not unrelated contexts; each in part influences and is influenced by the others, and certain key ideas and assumptions tend to show up in all three realms. Nonetheless, they are by no means totally equivalent, nor do they always map onto each other in easy one-to-one fashion.

In this chapter, I will primarily focus on the epistemological realm, on how two-person or intersubjective theorists present an alternative vision of what it is possible to know about another person and of what getting to know him entails. In Chapters 3 and 4, I will turn more to the differences between one- and two-person conceptions of personality. In all three chapters, I will consider the implications of these differing views for day-to-day clinical practice.

In the epistemological realm, two-person theorists emphasize the strong and inevitable influence of the therapist's behavior, personal characteristics, and even mere presence on what we may observe about the patient. From the two-person perspective, it is pursuing an illusion for the therapist to attempt to get a “true” or “uncontaminated” picture of the patient's inner world by diminishing her own input. “Keeping out of the way” or being “nonintrusive” in order not to distort the transference or influence what emerges or unfolds from the depths of the patient's unconscious (Wachtel, 1982a) will simply provide access to what the patient experiences or reveals in relation to the therapist's “keeping out of the way,” since keeping out of the way is itself a way of being with another person—and one that is no less real, specific, or even evocative than any other.

From the vantage point of a two-person epistemology, the impact of the observer is so pervasive, continuous, and inevitable—so intrinsic a part of the field of observation—that to attempt to eliminate that impact is not only to engage in self-deception but actually to generate a less accurate or reliable picture. In part, the decrease in accuracy is due to the self-deception itself. If the therapist is not alert to her influence on what is being observed, if she denies or minimizes it, then it is difficult to take it into account, to understand that she is not really observing “the patient,” but the patient in relation to a particular kind of interpersonal relationship with a particular individual who has particular qualities and is responding to the patient's own qualities in particular ways. The therapist who does not appreciate this tries to solve the wrong equations, so to speak; she works with equations that do not include the factor of her own influence, and hence yield misleading solutions.

A two-person epistemology does not completely eliminate the problem, of course. Knowing that one is influencing the observations does not abrogate that influence. It does, however, enable the therapist to at least ask or consider how she enters into the equation, to employ multiple perspectives to gain a better understanding of what, on the one hand, is pervasive in the patient's makeup and manifested in a very wide range of relationships and contexts and what, on the other, is more specific to the circumstances of observation that the therapy...
The effort to understand the patient is futile or that the understanding arrived at is spurious. Our understanding of other people is always infused with and mediated by our own subjectivity, but we could not have survived as a social species if it were completely arbitrary. Even if imperfect, our understanding is often quite capable, to borrow from Winnicott (1953), of being “good enough.” The aim of a two-person epistemology is not epistemological nihilism but a more sophisticated understanding of the ways in which we can potentially mislead ourselves in order to increase the odds that our understanding will be “good enough.”

### TWO-PERSON EPistemology AND ITS IMPLICATIONS FOR CLINICAL PRACTICE

Although the discussion thus far has been focused on the epistemological aspects of the one-person–two-person distinction, rather than on one- and two-person views regarding personality dynamics or clinical practice, it is important to be clear that the epistemological critique that is the focus of this chapter has significant implications for how—and how well—the therapeutic task is pursued. When the therapist believes that what she is observing is what spontaneously “emerges” or “unfolds” from the patient’s unconscious (see Wachtel, 1982a), she is motivated to minimize what she views as the “distortion” introduced by her own presence and her own participation. Under such rubrics as “neutrality,” “anonymity,” or avoiding “gratifying infantile needs” (so that those needs will build up and emerge more strongly and clearly), therapists guided by a one-person epistemology have tended to restrict their own behavior in the session, attempting, in effect, to bracket out their own influence so that what is observed comes exclusively, or at least preponderantly, from the patient.

In a variety of ways, this restriction on how the therapist may interact with the patient places unnecessary—and clinically counterproductive—

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2 A logical requirement of this position, it should be noted, is that the therapist must pay a good deal of attention to the patient’s daily experiences with others outside the consulting room. Although this seems rather obvious, in fact much relational writing suggests that in practice many relationally oriented therapists and analysts rely rather heavily—sometimes almost exclusively—on the transference as the focus of the work. When this is the case, the ability to sort out what is a response to the therapist in particular and what is a more generalized characterological tendency for the patient is significantly impaired. I shall discuss this issue further from the perspective of therapeutic technique in later chapters.

3 As I discuss later in this chapter, there is a way in which it is useful and accurate to think of what transpires in the session as “emerging” or “unfolding,” in the sense that something spontaneous and unpredictable occurs as the two people interact with each other. What is misleading is the view that the “true” transference or the “real” internal structure is just “there,” ready to be seen in singular, undistorted accuracy if only the analyst gets out of the way and lets it “emerge.”
limits on the therapist’s options for helping the patient overcome his conflicts. These restrictions include not only specific interventions that considerable evidence demonstrates can be helpful (Wachtel, 1997), but limitations on the degree to which the therapist can participate in the relationship in ways that facilitate change. Increasingly accumulating evidence, both from clinical observation and systematic research, indicates that—over and above whatever insights are achieved in the work—the therapeutic relationship is one of the most powerful sources of therapeutic change (Norcross, 2002; Lambert, 2004; Wampold, 2001). The restrictions on that relationship deriving from the assumptions of a one-person epistemology not only hinder the establishment of a fully therapeutic engagement with the patient, they even impede the therapist from appreciating how pivotal the relationship is in the work, not simply as a background precondition for the “real work” of promoting insight but as a central curative agent in its own right. One of the clearest and most widely cited articulations of the rationale for attempting to restrict the therapist’s behavior was offered by Merton Gill (1954). He wrote that “the clearest transference manifestations are those which recur when the analyst’s behavior is constant, since under these circumstances changing manifestations in the transference cannot be attributed to an external situation, to some changed factor in the interpersonal relationship, but the analysis must accept responsibility himself” (Gill, 1954, p. 781). In this statement, Gill is specifically addressing the patient’s transference manifestations, but his point clearly is intended to address the larger issue of understanding virtually all of the material that emerges in the course of the analysis. It is a statement of how the real insides of the patient, so to speak, are best revealed by minimizing the distorting effects of the therapist’s behavior. By remaining constant, in this view, the analyst’s influence is essentially removed as a variable in the equation of understanding.

Interestingly, Gill himself later became one of the sharpest critics of this one-person point of view. In a series of influential books and papers, Gill (e.g., 1979, 1982, 1983, 1984, 1994; Gill & Hoffman, 1982) emphasized that the patient’s transference reactions are always a response to something real in the analyst and in what she is doing—

and, simultaneously, that this in no way limits our ability to utilize the patient’s transference to illuminate his psychological life or probe the depths of his character. Transference, Gill argued in these later publications, is best understood not as a “distortion,” much less something made up out of whole cloth, but as the patient’s particular way of making sense of and emotionally reacting to what is happening. What the patient must learn is not that he is “wrong,” but that he is selective, and that that selection may be motivated and rooted in past experiences in ways he has not understood. Transference, in Gill’s later view, is a matter of perspective, and the question to be pursued, in essence, is “Why this perspective, why this way of seeing things?” (as well as such related, and clinically important, questions as “How else could you see it?”, “What other perspective might you bring to bear?”, or “What keeps you from considering that possibility?”).

Gill (1984) notes that, for reasons closely related to those he outlined in his 1954 paper, many analysts are reluctant to interact very much with their patients, fearing that they will distort the transference by doing so. But, he now argues, “the notion of an ‘ uncontaminated’ transference is a myth,” and it is a myth that fosters an unfortunate restraint on the analyst’s part. This restraint may lead to emotional deprivation for the patient, but it does not provide a superior pipeline to the patient’s emotional truth. Rather, it points to the analyst’s failure to be fully aware that because analysis takes place in an interpersonal context there is no such thing as non-interaction. Silence is of course a behaviour too. Nor can one maintain that silence is preferable for the purpose of analysis because it is neutral in reality. It may be intended to be neutral but silence too can be plausibly experienced as anything ranging from cruel inhumanity to tender concern. It is not possible to say that any of these attitudes is necessarily a distortion. (Gill, 1984, p. 168)

Elsewhere, in a comment that again challenges the conservative position represented by his 1954 paper and still maintained by a significant portion of the psychoanalytic mainstream, Gill notes that if the analyst remains under the illusion that the current cues he provides to the patient can be reduced to the vanishing point, he may be led into a silent withdrawal, which is not too distant from the caricature of an analyst as someone who does indeed refuse to have any personal relationship with the patient. What happens then is that

4 For a more detailed account of the transition in Gill’s views, from a colleague who worked very closely with Gill for many years, see Hoffman (1996). See also Silverman and Wolitzky (2000).
silence has become a technique rather than merely an indication that
the analyst is listening. The patient's responses under such condi-
tions can be mistaken for uncontaminated transference when they are in fact
transference adaptations to the actuality of silence. (1979, p. 277, italics
in original)\textsuperscript{5}

Gill's emphasis centers on two key themes—that this mistaken,
epistemologically naive position can lead to unnecessary, and clinically
counterproductive harshness and withdrawal, and, further in contrast to
his earlier position, that it can actually render the analyst's inter-
pretations less persuasive. Attempting to prove to the patient that his expe-
rience of the analyst has little or nothing to do with what she is really like
or how she is really behaving is actually a formula for creating resistance.
There is more likelihood of common ground, of the patient feeling seen
and heard and taken seriously, and hence of the patient being in a position
really to consider the alternative view that the analyst is putting forth, if
the message takes the form of “I understand that what I did/what I said/
what I failed to say felt to you that I... Is there any other way it could
also be seen?”

ADDRESSING INDIVIDUALITY AND THE UNCONSCIOUS:
ONE- AND TWO-PERSON VIEWS

More sophisticated “one-person” theorists, it should be noted,
acknowledge many of these considerations, but view quite differently
their implications for how best to go about understanding the patient
or building theory. They recognize that the influence of the analyst on
what is observed is inevitable, but they attempt to at least reduce that
influence as much as possible, and they believe they can do so effect-
ively enough to gain a reasonably accurate and reasonably undistorted
picture of what the patient's personality and dynamics are “really” like
apart from that influence. In one discussion of this issue, in a psycho-
analytic group to which I belong, a proponent of the traditional rules
of neutrality and anonymity remarked that although the “contaminat-
ing” influence of the analyst can never be completely eliminated from
our observations, this no more implies that we should not attempt to

\textsuperscript{5} For an interesting discussion of similar issues that usefully com-
plements Gill's discussion
and offers a wealth of clinical examples, see Ehrenberg (1992).

 minimize that influence than the fact that the operating room too can never be a completely sterile field implies that we should do surgery in a

cesspool.

At the heart of the one-person view, both epistemologically and
technically, is the conviction that there is something “inside” the
patient that exists independently of the observer and her influence and
that can be seen by the observer (or at least inferred by the observer, or
interpreted by the observer) even if the understanding achieved is less
than absolutely perfect. This conviction includes as well that the inclina-
tions and characteristics that come to light in the course of the ther-
aperative work have been long-standing in the patient's psyche, that they
existed before the therapist's observation and (unless change is suc-
cessfully initiated by the therapeutic process) will continue to exist
long after the therapist's observations. We may not be able to exclude
our influence perfectly or completely, but the effort to do so as much as
we can will be rewarded by a more accurate and complete understand-
ing.

In contrast, those operating from the vantage point of a two-

person epistemology argue that in principle we cannot observe the re-
ality of another person's psychological structures or experiences in an
“objective” fashion that is divorced from the relational context within
which we gain access to them.\textsuperscript{6} Moreover, this is not just a matter of
observer bias or incorrect interpretation of the observations. It is more
intrinsic than that. What actually is changes as a function of the partic-
ular observer and his or her behavior and characteristics (see, e.g.,
Aron, 1996; Hoffman, 1998; Mitchell, 1988a; Stern, 1996). As Ogden has
pitifully put it, playfully tweaking Winnicott's (1975) famous phrase
about mothers and babies, “there is no such thing as an analyst apart
from the relationship with the analyst, and no such thing as an analyst
apart from the relationship with the analysando” (Ogden, 1994, p. 4).

It is important to be clear what such a position does and does not

\textsuperscript{6} This position is often likened to Heisenberg's uncertainty principle or to the ideas in rel-

ativity theory about the way such fundamental dimensions as time or distance, once thought
to simply "exist" independently of the conditions of observation, are dependent on the posi-
tion and relative motion of the observer. No doubt, the ways in which both quantum theory
and relativity theory shook to its core our very notion of reality had a profound effect on
thinkers in all realms, including the psychological. But the resemblances to these two highly
mathematical conceptualizations—addressed to phenomena occurring at close to the speed
of light or in the realm of the almost unimaginably small—are at best very loosely analo-
gical. Ideas about "uncertainty" or "relativity" in the psychological realm must stand on their own
feet, without the borrowed prestige of these quite different kinds of theories.
Imply. Critics of two-person theorizing sometimes argue that the two-person position entails denial of the very existence of enduring psychological structures or of the possibility of understanding another person as more than a mere product of his interaction with us in the present moment. Although it is possible to find writings by two-person theorists that seem to lend themselves to such an interpretation, mostly this is an exaggeration or caricature of the two-person point of view. In my own work, notwithstanding my clearly falling on the two-person side of the divide, I comfortably assume that there is a “there” there—that however constrained our perceptions may be by our personal biases or by our relation to what is being observed (whether in the realm of perceiving the physical world or the psychological), there is something there to perceive. We may not be able to perceive the other “objectively,” but neither are our perceptions simply arbitrary. They are meaningful, useful, and usually refer to something “real,” even if they are also infused with our own subjectivity and particular point of view—that is, even if they are also partial, in both senses of the word (i.e., incomplete and biased).

Similarly, although it is illuminating to understand the degree to which our perceptions or memories are always constructions—advances in recent decades in the understanding both of perception and of memory make it clear that we do not directly “see” anything (i.e., that perception is always a creative act of putting together a picture from bits and pieces of information) nor do we ever simply remember by calling up “memory traces” that function like pictures to be pulled out of a file (Schacter, 1996, 2001; Schimek, 1975b)—this does not mean that there is no real thing or event that we are seeing or remembering or that there is not a meaningful distinction between more and less accurate memories (though of course determining which is which is not always a simple matter). We may construct our memories and perceptions, but we do not usually construct them out of whole cloth.

Where does this leave our understanding of the unconscious? Implicit, it seems to me, in the relational or intersubjective critique of the one-person model is a critique of “The Unconscious” as something residing inside the person, playing out its own agenda almost as a separate entity apart from the person inside of whom it is assumed to reside. “The Unconscious” is a one-person conception par excellence, something inside waiting to be discovered. In contrast, concern with unconscious processes, with the way in which so much of what constitutes psychological life proceeds without awareness, is perfectly com-

patible with the two-person critique. We do not “discover” or uncover what has been there all along. Rather, we engage in processes of construction (and co-construction) which bring forth and help articulate experiences in a dynamic, constantly evolving fashion. What emerges from the therapeutic process is not something that was previously buried and is now brought to light (see Chapter 6 for further discussion of this theme), but something that is at least in part new, something that emerges in a different sense—in the sense of an “emergent” phenomenon that cannot be reduced solely to its origins or its components.

But in conceiving of what emerges in the course of the therapeutic process as new, it is important to be clear, one is not engaging in the fictional caricature of relational thinking that portrays relationalists as denying that the patient had a personality or specific characteristics or inclinations before he walked into the consulting room. What is constructed in the session, we might say, is built with already existing raw materials. What changes is that experiences that were previously unformulated, to use Stern’s (1997) generative and perspicacious term, achieve a greater degree not just of focal awareness but also of structure and articulation.

I shall have a good deal more to say about Stern’s important concept, and its implications for therapeutic practice, in Chapter 8 in particular, but it is highly relevant to the present discussion as well. In the process of articulating previously unformulated experiences, these experiences and the psychological inclinations associated with them inevitably change. An articulated version of an experience is, by its very nature, different from an unarticulated or unformulated version. And, moreover, once that articulation is achieved, it almost inevitably leads to still further changes. These changes may be small and unstable; that is why psychotherapy that aims at deep and comprehensive change can take so long. But they are the daily bread of the therapeutic endeavor, the way the process continually proceeds. Change is not the result of a prior process of discovery, something that must wait until the digging is completed and the treasure unearthed from the layers in which it was buried. Change is the process, and what is discovered is not simply something that was there all along but something that emerges from the process of exploration and interaction itself. Something would have been there, in the sense (again) that the person does have a personality before he enters the consulting room. But what was there before is different from what is “discovered.” We can never discover what was lying buried before we entered the scene because our entering the scene
inevitably changes the person’s experience of the world. The change (alas) may not always be positive, and (also alas) it may not always be large. But it is the foundation on which further change is constructed, and an understanding of the process in this fashion opens up a host of new possibilities for engaging the patient in a helpful fashion.

THE DEFAULT POSITION AND "EPISTEMOLOGICAL ANXIETIES"

Concerns about epistemology, I have begun to suggest, are far less removed from the conduct of daily clinical practice than one might initially imagine. Indeed, in good measure, epistemological concerns were responsible for how the practice of psychotherapy evolved in its crucial early years and for the emergence of what I referred to in Chapter 1 as the "default position," the almost automatic stance that therapists assume almost without noticing and regarding which the burden of proof has fallen disproportionately upon those who would challenge or depart from it.

In principle, there were—and are—an enormous range of ways in which a therapeutic relationship might be structured. But once a particular way of working begins to be accepted as standard procedure, it is not long before the wish to belong and to feel "professional," and the disinclination to reinvent the wheel all conspire, as it were, to restrict our vision and our imaginations. Certain features of the psychotherapist’s stance that were to some degree historical accidents (and were certainly not the only way that one could productively or appropriately construct a therapeutic relationship) have, over the years, become "standard" in such a way that they may appear to be simply "how things are." As a consequence, these assumptions and habits of practice have persisted, little noticed or reflected upon, in the work of many contemporary therapists. The epistemological assumptions that have characterized the "one-person" point of view were the foundation on which the modern profession of psychotherapy was constructed, and although that point of view has come under increasing scrutiny and challenge over the years, many of the habits and assumptions about clinical practice that evolved in relation to this foundation have persisted. Indeed, if one looks closely, they are often evident in the work of therapists who explicitly identify with a two-person position and even of therapists whose identifications lie outside the psychoanalytic realm altogether. This is the case because much of what we learn about actual clinical practice we learn not from reading or course work but from identification with our supervisors or the direct experience of our own personal therapy. And since our profession is still relatively young, only a few generations separate the period of psychoanalytic hegemony from the current state of multiple and competing orientations and viewpoints. This means that even if one’s personal therapist or one’s most recent supervisors were not themselves Freudians, their supervisors, or their supervisors’ supervisors, were. And since aspects of the basic stance toward the patient—the emotional tone, the readiness to answer particular kinds of questions, the degree to which one spontaneously expresses aspects of one’s own views and reactions or even shares one’s sense of humor—are learned largely through identification and less explicit or conscious procedural learning (Lyons-Ruth, 1999; Stern et al., 1998), these dimensions of the work change much more slowly than explicit theoretical positions and conscious strategies. As a consequence, the "deep structure" of many therapists’ work may reflect ideas that have persisted largely unchanged and unexamined from an earlier era.

These considerations suggest that it behooves us to look more closely at the assumptions that guided therapeutic work in its early years because significant traces of those assumptions (and the practices associated with them) may be evident among therapists who do not consciously identify with the original point of view or who even explicitly challenge it.

Much of what the relational movement in psychoanalysis has been about has been, in essence, a challenge to what I am calling the default position. As we shall see in the next few chapters, however, the challenge has not always been as sharp or as thorough as it might have been. Greater understanding of how and why the default position arose in the first place—including the way in which it was shaped by concerns about potential challenges to the evidential base of psychoanalytic formulations—may facilitate a more probing reexamination that can enable us to better sort out what is and is not still valid and useful.

To a degree that is rarely discussed or appreciated, the origins of the default position lay in a set of epistemological concerns on Freud’s part that it would not be an exaggeration to call his epistemological anxieties, concerns that the entire corpus of his work would be dismissed as merely the product of suggestion. Freud has been fairly consistently
described by his biographers as a man whose primary identity and primary investment was as a discoverer rather than a healer. He shifted from a career in research to one in clinical practice only reluctantly and under the financial pressures associated with getting married and establishing a family (Jones, 1953), and he stated quite clearly that he lacked therapeutic zeal. If the judgment of the scientific community, whose respect he greatly sought, were to have been that his method “worked,” but that it worked by suggestion and not because his “discoveries” were valid, that would have been, for him, a bitter pill to swallow.

Although Freud soon turned away from the directly suggestive treatments he had utilized very early in his career, he struggled with the recognition that nonetheless suggestion was never really fully left behind. It remained a continuing feature of the psychoanalytic relationship, threatening to corrode the very foundations of his claims to scientific discovery. Freud repeatedly alternated between, on the one hand, acknowledging how pervasive—and even therapeutically essential—the role of suggestion actually was in the psychoanalytic process and, on the other, attempting to banish, deny, or transcend its influence. As I have discussed in a more detailed examination of Freud’s writings on suggestion and their clinical implications (Wachtel, 1993, Ch. 9), often these conflicting acknowledgments and claims could be found in the same paper, sometimes even on the same page.

In his Introductory Lectures on Psycho-Analysis, for example, Freud (1916) states:

When the patient is to fight his way through the normal conflict with the resistances which we have uncovered for him in the analysis, he is in need of a powerful stimulus which will influence the decision in the sense which we desire, leading to recovery... At this point what turns the scale in his struggle is not his intellectual insight—which is neither strong enough nor free enough for such an achievement—but simply and solely his relationship to the doctor. In so far as his transference bears a “plus” sign, it clothes the doctor with authority and is transformed into belief in his communications and explanations. In the absence of such a transference, or if it is a negative one, the patient would never even give a hearing to the doctor and his arguments. (p. 445, italics added)

Indeed, he goes on to say that “it must dawn on us that in our technique we have abandoned hypnosis only to rediscover suggestion in the shape of transference” (p. 446).

This quotation from Freud is remarkable for its frank confrontation with a difficult and thorny question. But it also highlights why Freud felt it necessary to continually offer counterarguments maintaining that in one way or another this suggestive influence was limited or transcended in psychoanalysis in a way that it is nowhere else in human relationships. If the suggestive influence of the transference creates a belief on the patient’s part in the therapist’s views, if the analyst is “clothed with authority,” then what does this say about the epistemological foundations of the findings of psychoanalysis? Are they validated by the patient’s assent, or even by his cure, or do both just reflect the patient’s compliance, his readiness to believe—even to believe deeply—what the analyst has told him or what the analyst has suggested in more subtle and implicit ways? This was Freud’s great nightmare, and it is what has led me to use the term “epistemological anxiety” to describe the frame of mind that so fatefuly shaped psychoanalytic history.

In one of the most direct and explicit statements of these concerns, Freud stated that “whether we call the motive force of our analytic transference or suggestion, there is a risk that the influencing of our patient may make the objective certainty of our findings doubtful and that what is advantageous to our therapy is damaging to our researches” (p. 452). Plunging further into the heart of darkness, he acknowledges that if this account of what transpires in analysis were valid, “psychoanalysis would be nothing more than a particularly well-disguised and particularly effective form of suggestive treatment; and we should have to attach little weight to all that it tells us about what influences our lives, the dynamics of the mind or the unconscious” (p. 452).

Freud had two major strategies for dealing with this threat to his reputation as a scientist and discoverer. One was stated in an encyclopedia article on psychoanalysis that he wrote in 1922. Its aim was to differentiate the role of suggestion in psychoanalysis from how suggestion is used in other therapeutic approaches:

Psycho-analytic procedure differs from all methods making use of suggestion, persuasion, etc., in that it does not seek to suppress by means of authority any mental phenomenon that may occur in the patient. It endeavors to trace the causation of the phenomenon
and to remove it by bringing about a permanent modification in
the conditions that led to it. In psycho-analysis the suggestive
influence which is inevitably exercised by the physician is diverted
on to the task assigned to the patient of overcoming his
resistances, that is, of carrying forward the curative process.
(Freud, 1923, pp. 250–251)

This strategy for addressing the impact of suggestion essentially
attempts to tame the troublesome beast by harnessing it to the core
psychoanalytic aims of exploration and discovery. It acknowledges
the role of suggestion but does so in a way that interprets it as an aid to the
exploratory process itself. In this view, suggestion is employed not to
put new ideas into the patient's head but to discover those that were
already there. Had this been Freud's only way of attempting to put to
rest the threat that suggestion carried for the credibility of his discover-
ies, psychoanalytic technique might have evolved very differently. In
Chapter 9, for example, I explore the momentous implications for
therapeutic practice of a theoretical revision Freud published only a
few years later (Freud, 1926), in which he radically revised his under-
standing of the role of anxiety in the evolution and dynamics of
psychopathology. One key implication of this theoretical revision, we
will see, is that it makes more central than had previously been the case
the therapist's efforts to help the patient become less afraid of his feel-
ings and wishes. From this vantage point, the employment of suggestion
to help the patient with "the task assigned to [him] of overcoming
his resistances" can best be understood as one of creating an atmo-
sphere of safety for the patient and encouraging him to face, little by
little, the very experiences from which he has previously retreated in
helpless terror. As the analysis in Chapter 9 aims to make clear, this way
of putting the demon of suggestion to rest points to a much more sup-
portive approach to therapy and highlights why such an approach can
be more, not less, effective in promoting meaningful exploration as
well.

But the argument that suggestion is used in analysis, but used dif-
ferently, was not Freud's only line of defense. Indeed, it was not really
even his primary line of defense. Perhaps because the threat posed by
suggestion was so great, Freud employed another strategy as well,
designed not just to reinterpret the role of suggestion but, ultimately,
to eliminate it. Suggestion, Freud claimed, could be used for the pur-
poses of the work for a while, but eventually it had to be "dissolved."8
Thus in his Introductory Lectures, just a few pages after the passages
quoted earlier acknowledging that the transference "clothes the doctor
with authority and is transformed into belief in his communications
and explanations" and that "we have abandoned hypnosis only to redis-
cover suggestion in the shape of transference," Freud goes on to say,
"In every other kind of suggestive treatment, the transference is care-
fully preserved and left untouched; in analysis it is itself subjected to
treatment and is dissected in all the shapes in which it appears. At the
end of an analytic treatment the transference must itself be cleared
away" (1916, p. 453).

We may note to begin with that the phrase "in every other kind
of suggestive treatment" clearly implies that psychoanalysis too is a
suggestive treatment.9 But even if we were to take it as meaning that
it is a suggestive treatment in which, uniquely, that element of sug-
gestion is later dissolved, we must confront a further challenge: what
means "to clear away," or even "to analyze," the transference, is
far less clear than Freud's deft rhetorical trope seems to imply. One
may, of course, point out to the patient the element of authority or
suggestion that has been carrying the therapy thus far. And in that
sense, one is "interpreting" the transference dimension, and, perhaps,
attempting to dissolve it. The problem with this line of argument,
however, is that in the attempt to "interpret away" the transference
influence, the very same structure of authority and of potential sug-
gestion exists. Why does the patient now accept this interpretation?
Can we reassure ourselves that this time we have stepped outside the
structure that Freud acknowledges both in the quotations above and
in numerous other places throughout his writings?10 The attempt to
wriggle out of this dilemma requires us, essentially, to posit an
epistemological skyhook. It also, as I will discuss next, led to the

8 "Dissolved" is the word used in the English translation that appears in the edition published
by Basic Books as the Collected Papers. In the Standard Edition translation the term used is
"cleared away."
9 We may perhaps wish to amuse ourselves here by noting, apropos this revealing phrase,
Freud's own comment, in another context, "no mortal can keep a secret. If his lips are silent,
he chatters with his fingertips; betrayal ooze out of him at every pore" (Freud, 1905, pp. 77–
78).
10 See Wachtel (1993, Ch. 9) for a more detailed account of these acknowledgments of the
suggestive influence in psychoanalysis and of Freud's struggle with their implications.
enshrinement of a one-person approach to the therapeutic relationship from which psychoanalysis (and in certain ways much of the entire field of psychotherapy) is still struggling to emerge.

THE FEAR OF SUGGESTION AND THE MINIMIZING OF THE RELATIONSHIP

Freud's comment (quoted above) that "what is advantageous to our therapy is damaging to our researches" holds in the opposite direction as well. The research aim of psychoanalysis, its focus on discovery of unconscious contents and the construction of the therapy around the need to protect the findings of the research from the charge of suggestion, placed constraints on the therapeutic efforts of psychoanalysis, constraints that are still being struggled with today. In particular, the concerns about suggestion and the commitment to the idea that exploration and discovery were the heart of the therapeutic process led to a downplaying of the relationship as a crucial and powerful therapeutic influence in its own right. Rather, the relationship was seen more as a medium through which the decisive therapeutic processes of discovery of unconscious contents and promotion of insight could be most effectively and persuasively pursued. Transference analysis was, first and foremost, a form of analysis, a way of understanding and discovering. The role of the therapeutic relationship as a powerfully transformative emotional experience quite apart from whatever insights it generates was, in the foundational years of psychoanalytic work, decidedly played down.

In later years, psychoanalytic writers such as Alexander (1956; Alexander & French, 1946) in the United States and Winnicott (1971, 1975) and Fairbairn (1958) in England began to place the relationship and its potential for therapeutic impact in its own right much closer to the heart of the process, picking up a thread that had been earlier introduced by Ferenczi (e.g., Ferenczi, 1926; Ferenczi & Rank, 1925), who encountered fierce criticism and even character assassination for his efforts (Aron & Harris, 1993). As we will see especially in Chapter 10, in recent years this appreciation of the central role of the relationship per se has increasingly become the cutting edge of psychoanalytic discourse about the therapeutic process, and this emphasis dovetails with a rapidly expanding body of findings from systematic research (see, e.g., Norcross, 2002; Lambert, 2004; Wampold, 2001). Indeed, the attitude that insight and new relational experiences are competing paradigms for the therapeutic process has increasingly been replaced by the view that they are in fact complementary—that the therapist’s communication of her understanding of the patient’s as yet unexpressed and unarticulated yearnings is to a very significant degree what the new relational experience consists of, and that, conversely, what enables the insight to have a deep emotional impact on the patient is that it is achieved in the context of an intimate and meaningful relationship (see, e.g., Stolorow, Brandchaft, & Atwood, 1987). We will also see, however, that the shadow of the default position nonetheless continues to be powerfully evident in many aspects of therapeutic practice to this day.

Ironically, as I noted in Chapter 1, the restrictions were less evident in Freud’s own clinical work than they were in those who relied on his writings as a guide to practice. But Freud was nonetheless clearly the source of what is today called the one-person model. This model may not have been so evident in his actual practice, but it was strongly evident in what Freud wrote about the therapeutic process. There he famously used metaphors likening the analyst to a blank screen, a reflecting mirror, or an impassive surgeon—images that both placed constraints upon the therapeutic relationship and the interaction between patient and therapist and bolstered the depiction of the psychoanalytic process as one characterized by objectivity and science.

These rules and restraints in the literature on psychoanalytic technique (largely constituting what I have called the default position) had multiple sources. In part, Freud was concerned about what he viewed as misguided humanitarianism, the consequences for the therapeutic process of the analyst trying too hard to be helpful, the ways in which impulses and inclinations which in everyday life are fine and even salutary could be harmful to the progress of an analysis (Freud, 1912a). But there is much to suggest that it was his epistemological anxieties that were most responsible for the shape that he gave to the therapeutic approach we call psychoanalysis (and, indirectly, to much nonpsychoanalytic work that followed). It was most of all the effort to safeguard the discoveries, to protect them from the claim that they were merely the product of suggestion, that gave rise to such ideas as that the therapist should remain as anonymous as possible, that she should respond

11 In a much more conservative fashion (see Hoffman, 1983), this dimension was introduced relatively early as well by Strachey (1934).
FROM EPISTEMOLOGY TO SUBSTANTIVE THEORY

Thus we may see that epistemological concerns, far from being an abstruse intellectual preoccupation, were at the very heart of how the psychoanalytic approach to therapeutic practice was constructed and, as discussed above, in certain respects shaped the course of a still wider range of therapeutic approaches in unappreciated ways. To a significant degree, the relational point of view—with its emphasis on mutual influence and co-construction—evolved from the effort to overcome the constricting epistemological assumptions with which psychoanalysis was far too long linked, assumptions that were not really intrinsic to much that constituted the contribution of psychoanalysis to human knowledge or to its capacity to help people lead more vital, self-aware, and satisfying lives. Relational writers have incisively and probingly critiqued the epistemological foundations of psychoanalytic theory, and in the process have pointed us toward new and important theoretical conceptions. But because relational thinkers have often not been as clear about the ways in which epistemological concerns shaped psychoanalytic practice, they have been hampered in fully developing the implications of their critique. Many extremely important innovations have emerged from the relational movement, of course—this is, after all, a book that proudly declares itself to be a part of that movement. But I hope to show that there is still greater potential for therapeutic change and innovation implicit in the ideas that have emerged from the relational critique and that part of the realization of that potential requires us to appreciate the impact of epistemological concerns in shaping the very structure of the psychoanalytic relationship and of psychoanalytic practice.

At the same time, however, it may also be said that epistemological concerns have been too central in the canon of relational writings and in the demarcation of the relational point of view. The “two-person” perspective that characterizes the epistemological stance of most relational thinkers has not always been carried forward into their framing of the substantive theories that guide their work—theories regarding the dynamics of personality development and the sources of psychological dysfunction. As I discuss in the next chapter, the relational versions of these theories have often been characterized by what might be called two-person content embedded in a one-person structure. It is to this topic, and to a number of other important confusions and misunderstandings regarding the two-person point of view and its implications for practice, that I now turn.