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Theoretical Models and the Analyst's Neutrality[1]

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FEW ISSUES IN PSYCHOANALYSIS are quite so muddled, or tend to generate quite so much confusion in the mind of the clinician, as the relationship between theory and technique. There are many reasons for this, all related in one way or another to the poor match between the kind of work that theory-making is, and the kind of work that clinical practice is. One aspect of this is the inescapable but jarring mismatch between an activity which is inherently public and one which is fundamentally private. Theorizing, necessarily, is done publicly. Theoretical contributions by their nature must be written down or spoken aloud. When they are debated, all participants have access to what is said, if not necessarily to what is meant. Technique, on the other hand, is obviously private. There exists no record of all the transactions constituting an analysis, nor could such a record exist, even in principle.

Because of this, the translation of theoretical principles into technical precepts eludes outside observation. Theory applied is, inevitably, theory interpreted. Personal predilection gives the application an idiosyncratic, and decisive, cast. By the time it is run through the analyst's particular vision of human life, not to mention his personality, the impact of theory is difficult to trace.

It is a commonplace that no beneficial analysis can be accomplished "by the book, " that is, by simple application of theoretical premises to the life history of an individual analysand. However, to deprive technique of the influence of theory altogether is equally harmful. It is certainly true, as Joseph Sandler **(1983)** has noted, that every analyst—at least preconsciously—holds a theory

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in mind. Theory-making as a formal discipline requires the analyst to articulate his own assumptions and to assess them with respect to alternatives which inform the work of others. This discipline prevents retreats to the kinds of naive and sterile claims that have given psychoanalysis a bad press within the broader intellectual community—claims that we have subordinated theory to intuition, empathy, or pragmatism.

Despite the poor fit between theory and technique, it is nevertheless possible to draw important technical conclusions from broad theoretical premises. Mitchell and I have addressed this extensively with respect to one technical issue—the analyst's interpretive armamentarium. We have documented the ways in which the theoretical model which an analyst implicity or explicitily holds will determine the content of his interpretations **(Greenberg and Mitchell, 1983)**. In this paper, I will address the implications that models have for the analyst's stance within the psychoanalytic situation. I will be particularly concerned with the much maligned but, as I hope to demonstrate, still useful concept of analytic neutrality. I will discuss the origin of the neutrality concept in Freud's early theory, the problems which remain attached to it because of its roots in that theory, and the improvements which can emerge from re-defining it on the basis of modified theoretical premises.

In our book, Mitchell and I distinguished two major competing models which have dominated the history of psychoanalytic theory: we labeled them the drive/structure model and the relation/structure model. The drive/structure model originated in the early work of Freud, and was developed and maintained in his later work and in that of his major followers within the "orthodox" psychoanalytic tradition. The relational/structure model was prefigured in the early dissents of Adler and Jung, and emerged fully, albeit independently, in the theories of Fairbairn and Sullivan. It has been developed in various ways by many of those typically designated as object relations or interpersonal theorists. The models themselves are broad groupings of theories—they are envelopes which contain compatible although by no means identical points of view.

Approached from the perspective of their implications for the analyst's clinical stance, two characteristics distinguishing the models require special mention. First, the drive/structure model is an individual psychology, while the relational/structure model is a field theory. This decisively affects the way that each model understands

the position of the analyst as an observer. Secondly, the models attribute psychic structure, the source of regularity and pattern in emotional life generally and in psychopathology particularly, to different processes. The drive model understands structure as the transformation of original drive energies, while the relational model sees structure as the developmental sequelae of early interpersonal exchanges. I will address each of these fundamental premises in turn, beginning with the premises of the drive model.

Freud's model of the analyst's role is based on the position of the observing scientist as that was understood in the 19th century. The Spanish philosopher Ortega y Gasset critically characterized this scientific attitude well:

> At last man is to know the truth about everything. It suffices that he should should not lose heart at the complexity of the problems, and that he should allow no passion to cloud his mind. If with serene self-mastery he uses the apparatus of his intellect, if in particular he uses it in orderly fashion, he will find that his faculty of thought is ratio, reason, and that in reason he posseses the almost magic power of reducing everything to clarity, of turning what is most opaque to crystal, penetrating it by analysis until it is become self-evident (1940, pp. 170–171).

Compare Freud's statement in a letter to Theodore Reik that "scientific research must be without presumptions. *In every other kind of thinking* the choice of a point of view cannot be avoided" **(1928p. 196, my italics)**.

Freud's comment embodies a formulation which contemporary philosophers would consider to represent an outmoded, not to say particularly presumptuous, notion about the nature of scientific investigation. Derived from the Cartesian philosophy of science, which Ortega mocks, this formulation holds essentially that the observer stands outside of his observational field. His externality brings with it a kind of univolvement, using that word in its structural and emotional senses. It is this very uninvolvement that allows the impartial application of reason, and which facilitates the emergence of truth.

Freud did not develop a comprehensive, systematic set of principles regarding the analyst's clinical stance. His comparison of technique to the rules of chess, emphasizing the near infinite variability of procedures during the prolonged middle phase of analysis, suggests that full systematization is undesirable or even impossible

(Freud, 1913). I suspect that Freud—in contrast to many of his followers—had an inclination to give the individual clinician wide berth and to let technique evolve out of the peculiar mix of personalities that creates and defines each analytic encounter. At the same time, his individual technical guidelines do hang together; they have much in common because they share a root in his attitude toward science. The posture of "evenly-hovering attention, " the "blank screen" or "reflecting mirror" analogies, and the suggestion of an attitude of "surgical detachment" **(Freud, 1912)** ; **(1913)** all derive from the idea of the externality, objectivity, and impartiality of the analyst-observer.

If a philosophy of science dictates the desirability and even the possibility of externality and full impartiality, we still need a psychology to define the forces among which the analyst must be impartial. This is where the psychodynamic and structural hypotheses of the drive/structure model are decisive. To state these briefly, the model holds that psychic structure, with the partial exception of autonomous ego aspects of the undifferentiated matrix, evolves out of the transformation of the energy of constitutionally determined sexual and aggressive drives. On the basis of different levels of exposure to environmental influence, and consequently with different degrees of distance from the original drive aims, the three structures, id, ego and superego, emerge. Each structure embodies a more or less consistent pattern of needs—it is this relative consistency of the structures themselves and of the balance among them that allows us to conceptualize a regularity which we call personality and/or psychopathology. It is also these structure, and their mutual influences, which constitute the observational field for the drive model analyst.

The philosophical and psychological premises of the drive model converge in the technical principle of neutrality. Freud himself used the term neutrality rarely. It first appears in the context of advice to analysts about how to handle patient's declarations of love. Responding in kind, whether encouragingly or discouragingly, will defeat the analysis, Freud warns, and he goes on to say that "… we ought not to give up the neutrality toward the patient, which we have acquired through keeping the counter-transference in check" **(1915p. 164)**. Freud went no further in spelling out what he intended neutrality to mean. In fact, despite its being a keystone of the traditional conceptualization of the analytic posture,

a formal definition of neutrality did not appear until Anna Freud suggested one in 1936. In *The Ego and the Mechanisms of Defense* Anna Freud wrote:

> It is the task of the analyst to bring into consciousness that which is unconscious, no matter to which psychic institution it belongs. He directs his attention equally and objectively to the unconscious elements in all three institutions. To put it in another way, when he sets about the work of enlightenment, he takes his stand at a point equidistant from the id, the ego, and the superego **(1936**p. 28).

Notice in this the assumptions I have been discussing. There is the objectivity borne of externality, the rationality leading to enlightenment, the impartiality of the reasonable observer. Also, of course, there are the dynamic forces contained within the tripartite organization of the structural model. Joseph Lichtenberg has summarized this: "… the dictatorship of truth and reason irrevocably commits itself to being open-minded—each element in the individual—impulses, ego, and superego will therefore receive the position it deserves" **(1983**p. 207).

The neutrality concept is not particularly popular in many analytic circles recently. To understand why, let us turn to the *Oxford English Dictionary*. There neutrality is defined in various ways. For the analyst, the first definition is useful as well as dangerous: "Not assisting or actively taking the side of either party in the case of a war or disagreement between … states; remaining inactive in relation to the belligerent powers." This is close to what Anna Freud had in mind, but notice the stress on inactivity. Some analysts mistakenly believe that impartiality is best achieved through inactivity. But even if inactivity is possible politically, as the dictionary suggests, it is never possible interpersonally. Hoffman **(1983)** and Wachtel **(1982)** have both argued persuasively that no behavior of the analyst can be considered simply inactive. Rather, all the analyst's behaviors must be understood as activity of one sort or another.

Because of this difficulty, even among those currently relying on neutrality as the keystone of a correct clinical posture, there remains considerable confusion about how it is best expressed within the psychoanalytic situation. Considered broadly, there is general agreement that neutrality has to do with not imposing values on the patient and with keeping countertransference in check. Chused has nicely characterized a neutral attitude as "a

nonjudgmental willingness to listen and learn" **(1982**p. 3). Poland has put it this way: "Neutrality is the technical manifestation of respect for the essential otherness of the patient" **(1984**p. 289). The plot thickens, however, when it comes to realizing these attitudes in terms of technical procedures—for example, in determining their relationship to issues such as level of responsiveness, expressions of encouragement, or enforcement of conditions of abstinence **(see Panel, 1984)**. Most authors who use the term translate it into behaviors such as non-responsiveness or anonymity. There is a tendency when discussing neutrality to equate non-alignment and colorlessness.

These clinical applications of the neutrality concept are reflected in subsidiary definitions in the dictionary. Indifference and colorlessness appear there among the meanings of the term **(see Poland, 1984)**. On this account, as a summary statement of an analytic stance, "neutrality" seems pallid, failing to capture the intensity of the emotional experience that clinical encounters are or should be. Many clinicians feel that as a term neutrality is too cold and aloof, that it doesn't convey the kind of affirmation that patients not only need but typically get in a well conducted treatment.

Why should psychoanalysis be stuck with a concept which inextricably ties impartial acceptance of all parts of the patient's personality to the analyst's inactivity and non-expressiveness? The reason, I believe, is traceable to neutrality's roots in the epistemological premises of the drive/structure model. There is a direct line from the Cartesian stress on the observer's potential externality and objectivity to the drive model's equation of non-alignment with non-participation. Inactivity in the interest of discovery is at least an apparently logical next step.

Clearly, neutrality is a burdened term. Some analysts believe that it should be abandoned altogether. However, despite its limitations, I see some important advantages in retaining neutrality as both a concept and a term. Especially in the context of its formal definition as a kind of "equidistance, " neutrality conveys the idea that the analyst should occupy a certain position and that the position should be a balanced one, that it should be between something and something else. This is a particularly important prescription for the analyst, who is continuously buffeted by a variety of forces, pushed and pulled into responding in one way or another. The temptation to ally oneself with one or another force in the

patient's personality, to favor one of his tendencies at the expense of others, is always present. In the face of this, neutrality is a necessary, if incomplete, way of expressing an optimal analytic stance. The connotations of indifference are unfortunate, but this is not sufficient reason to discard it. Further, the term is in use and I have not been able to come up with an apt replacement.

If we are going to retain the term, however, we must be careful what we mean by it. Neutrality itself is far from a neutral word: any definition of it inevitably changes with alterations in the underlying theory. When Freud first introduced the term, he was talking about the need for the analyst to resist countertransferential pressures. He was not talking about equidistance from psychological structures, as Anna Freud was later in her definition, nor could he have constructed the concept in those terms. At the time of the technical papers, Freud was working with the topographic model; the mind was divided into the systems UCS., PCS., and CS. The analyst in this model was explicitly allied with the UCS.: the very goal of analysis was to make the unconscious conscious. Any notion of equidistance awaited a crucial theoretical change: the tripartite structural model with its inherent idea that there are unconscious elements in all psychic structures.

In fact, Anna Freud's formulation is not simply a derivative of fair-mindedness. The classic definition appears in the context of her argument for the legitimacy of studying and analyzing the ego: it is not only technical prescription, but also theoretical polemic. As Lichtenberg **(1983)** notes, this argument was directed against the large number of analysts who refused to abandon the older system, in which ego functioning was considered the sort of superficial study that could be of interest only to academic psychologists.

Just how tied neutrality is to an underlying theoretical system becomes clear in light of another consideration. When Anna Freud defined neutrality, she was operating out of a model that viewed the Oedipus complex as the core issue both in development and in treatment. Working with the Oedipus complex as classical analysts did, and do, makes a number of assumptions about the patient, of which two are especially relevant here. First, it is assumed that the patient has achieved a set of structured goals (that is, instinctual aims) which have consistency and coherence over time and across a variety of different situations. Secondly, it is assumed

that the patient is an independent agent capable of active pursuit of these goals, although this may be interfered with on the basis of internal conflict. The "neutrality" of the analyst is an equidistance from all the forces operating within this sort of person.

However, as many analysts have come to appreciate the importance of developmental residues from the preoedipal years, the very vision of the patient as an autonomous, active agent has become a departure from neutrality. More accurately, I should say that the assumption of autonomy and activity is a departure from neutrality for those who accept the theoretical emendations of recent developmental theory. It is a departure because it involves an implicit rejection of the earliest developmental needs, seeing these as secondary to defensive retreats from the oedipal situation. On the other hand, for those who maintain an unmodified classical perspective, the serious consideration which is often given to preoedipal development may consititute non-neutrality, for example by being too accepting of the patient's passivity or of his regressive defenses.

These considerations make it clear that a theoretical model based on radically different psychological and epistemological assumptions requires a redefinition of neutrality from that currently in use. The relational/structure model rests on such alternative assumptions. However, there has been no attempt to formulate the required redefinition. I now propose to do so, after reviewing the fundamental theoretical premises on which such a definition would be based.

As I mentioned earlier, the theories comprising the relational model are field theories. Based not on Cartesian rationalism but on a philosophy of science informed by Heisenberg's uncertainty principle and Einstein's relativity theory, the relational model postulates an analyst who is, in Sullivan's **(1954)** phrase, a "participant observer" or, in Fairbairn's, an "interventionist" **(1958)**. These concepts are not themselves technical prescriptions (i.e., suggestions that one ought to participate or to intervene), they are statements of fact from a particular philosophical perspective **(Greenberg, 1981)**.

From the psychodynamic point of view, every relational model theory postulates some idea of an internal object world, or a representational world. This is a stable, structured set of images consisting of transformations of relationships with other people **(Sandler and Rosenblait, 1962)**. Sullivan's

"personifications" and "illusory others" and Fairbairn's "internal objects" are the constituents of the representational world in their particular versions of the relational model. The representational world of the relational/structure model theorists is not simply a collection of images, however—it has both motivational and structural properties. Put very briefly, the represented experiences constitute both a guide to what is desirable, expectable, or anxiety-ridden in human relationships, and also a template for judging contemporary experience with others.

Combining these two relational model premises, we arrive at the following formulation: the analyst inevitably participates somewhere within a historical continuum of the patient's relationships with others. That is, he "fits" somewhere into the patient's representational world, either assimilated into an old relational pattern or experienced as new, and different from what the patient has experienced before. To reiterate: that he participates is not a choice; technique is a matter of specifying how he should participate. With respect to the neutrality concept, a relational model revision of Anna Freud's concept of equidistance would "place" the analyst somewhere within the historical continuum of the patients' relationships. I will take this up shortly, but first must take a brief detour through another aspect of the psychoanalytic situation.

A theme which is being increasingly stressed in recent discussions of the psychoanalytic process is the need to create what Schafer **(1983)** has aptly termed an "atmosphere of safety." (See also the "atmosphere of tolerance" of Sandler and Sandler **[1983]** and the "conditions of safety" of Weiss **[1982]**.) Only under conditions of perceived security can the patient risk elaborating the thoughts, fantasies, and feelings which need to be brought to light and examined if analysis is to proceed beneficially **(see Myerson, 1981a)**, **(1981b)**. In the absence of this sense of safety, as Schafer puts it, "the analysand could not take on what he or she ventures to confront during the analysis, and instead would continue simply to feel injured, betrayed, threatened, seduced, or otherwise interfered with or traumatized" **(1983**p. 32). In agreement with Schafer, I see an intimate connection between the analyst's neutrality and the patient's experience of safety.

The stress on the need for safety depends on an important theoretical

assumption that, although prefigured in Freud's late writings and in some of Hartmann's work, was developed most fully in the work of relational model theorists. This is the assumption that repression always has an interpersonal component; it takes place in a context that determines when a feeling or impulse is dangerous **(see Myerson, 1977)**. Both Schafer's and Myerson's work stress the importance of creating an atmosphere in which the conditions under which repression once became necessary are not recreated. In terms of the relational model premises which I have spelled out, the atmosphere of safety would depend on the analyst's ability to create conditions in which the patient perceives him as a new object. Strachey **(1934)** conceptualized this as the need to breach the vicious circle of projection/introjection through which archaic bad object relationships keep being re-created. I think Schafer implicitly recognizes this in his statement that without the atmosphere of safety the patient would continue to feel injured, betrayed and so on.

Ironically, however, the analytic situation cannot be too safe. I mean, of course, that there has to be room for transference, with all the dangers that the eruption of threatening feelings within the context of an archaic relationship entails. Many patients—and, I hasten to add, some analysts too—eagerly and defensively embrace the emergence of the analyst as a "new" object. They embrace him eagerly because there is genuine relief from a life of relationships gone awry; they embrace him defensively because the "good" therapeutic relationship temporarily de-fuses conflict. But the analyst who is too much a new object has fallen into a trap: it is in working through the disruptions of safety (and, thus, in its re-establishment) that the most important progress occurs.

I am suggesting here that there is a need to strike a kind of balance between danger and safety, which can be roughly translated as striking a balance between being seen by the patient as an old or a new object. This recalls the relational model concept of a historical continuum within the representational world. It is also reminiscent of Anna Freud's idea of neutrality as equidistance, although when addressing operations within the representational world I prefer a term like "optimal tension" to equidistance because of its dynamic connotations.

This brings me to the new definition of analytic neutrality. In my contribution to a panel discussion on this issue, I have suggested

that neutrality is best understood not as a behavior or series of behaviors, but as the goal of all the analyst's behaviors **(Greenberg, 1986)**. I said that neutrality is a work like "democracy, " which refers to a kind of government rather than to the particular laws that implement it. With this in mind, we are in a position to define neutrality from the perspective of the relational model: Neutrality embodies the goal of establishing an optimal tension between the patient's tendency to see the analyst as an old object and his capacity to experience him as a new one.

This revised definition is not simply terminological; it has important technical implications that will occupy the remainder of this paper. For one thing, as defined within the terms of the drive model, neutrality has a static ring to it; it implies that the "neutral" analyst occupies a fixed position. That is, from one analysis to another, the neutral posture would always look more or less the same. This accords well with the model of the analyst as 19th century scientist which informed Anna Freud's thinking.

Under my proposed reformulation, the activity of the neutral analyst is always dependent upon the quality of the patient's relationships with others. The analytic behaviors which implement the goal of optimal tension between old and new necessarily vary with the openness to new experience of a particular patient's internal object world. Generally speaking, the silence and anonymity which constitute unmodified classical technique enable the patient to include the analyst in his internal object world, while a more active or self-revealing posture establishes the analyst as a new object. Thus, with a patient who is firmly encased in a closed world of internal objects, the analyst will have to assert his newness more affirmatively to achieve an optimal level of tension, while with the more open patient just such assertiveness would constitute an impediment to the development of transference and to insight about it. Neutrality is thus not to be measured by the analyst's behaviors at any moment, but by the particular patient's ability to become aware of and to tolerate his transference.

The value of establishing a neutral atmosphere is closely related to Schafer's recent, stated, formulation of ego-syntonicity. Schafer wrote:

> … the concept of ego-syntonicity has always referred to those principles of constructing experience which seem to be beyond effective question by

> the person who develops and applies them … Metaphorically, they are the eye that sees everything according to its own structure and cannot see itself seeing …
>
> One might say that these principles are beyond question in so far as the person treats the relevant questions about them not as questions but as evidence …
>
> In undertaking the analysis of a character problem, one counts on there being some diversity of experiential principles … The point of access may be some well-guarded for of thinking hopefully, some shrugged-off way of esteeming oneself realistically, or some shyly hidden but stable kind of loving **(1983**pp. 144–146).

Schafer's point applies equally to the representational world of many patients. The patient can become aware that he is assimilating the analyst into his world of archaic internal objects only when he has already become aware that there is an alternative possibility. Unless he has some sense of the analyst as a new object, he will not be able to experience him as an old one. The inability to achieve this balance is responsible for many analytic failures. If the analyst cannot be experienced as a new object, analysis never gets under way; if he cannot be experienced as an old one, it never ends.

In distinguishing between neutrality as a goal and the specific actions that support and implement it in my earlier paper, it was my intention to cast analytic behaviors such as emotional openness, self-revelation, and even expressing judgments in a new light. The theoretical framework developed here further clarifies these relationships. That is, I think that these behaviors, which are typically thought of as *prima facie* non-neutral, may actually contribute to neutrality when judiciously applied with the right patient. Conversely, the traditional, purely interpretive posture which Glover **(1955)**, for example, feels defines neutrality may actually detract from it. Let me develop this possibility.

In his important writings on relational aspects of the psycho-analytic situation, Myerson has pointed out that in bringing material into analysis, patients express "… a need or determination to know something *about* as well as *from* the analyst. The analysand wants to ascertain how the analyst would react if he were to express his desire or anger more directly as well as what the analyst thinks is the nature of his experience" **(1981ap. 98)**. This fits well with my idea about the need to see the analyst as a new object.

Let me take as an example a set of circumstances which arises

frequently. Many analysands need to know something about the analyst because they are frightened of the impact that their transference fantasies (including the perceptions of which these fantasies are generally eleborations) have on their analysts. Transference represents an assault on the analyst's sense of self, a point on which analysts as theoretically different as Levenson **(1972)**, Racker **(1968)**, Sandler **(1976)**, and Searles **(1965)**, **(1979)** have been especially eloquent. For a patient to experience his own transference fully, including its assaultive aspects (and here I include so-called positive as well as negative transferences) he must be able to assume that the analyst will experience the impact of that transference differently than the original objects did. The patient must be able to probe the analyst's weak spots, to get beneath his professional calm and reserve, either with some confidence that the probing will not be murderously destructive or with a firm belief that the analyst—having promulgated the free-association rule—is significantly responsible for his own reactions to what comes up. Compare Myerson's emphasis on the child's need for parents who can allow him "to discover for himself that if he acts upon or expresses his desire or his anger sometimes at least, nobody will hurt him or be hurt by him or reject him and that even when someone is upset by his actions, that person bears some responsibility for this reaction" **(1981bp. 178)**.

Let me suggest a few commonplace examples that arise in analyses. Levenson has mentioned that patients often have thoughts about being younger than their analysts, and more attractive, and leading more active and varied sex lives. Many patients are richer than their analysts, or plan to be. Many are more creative or ambitious; they look forward to being more successful. Many are simply younger, and have reactions organized around their having more years to live. All of these realistic perceptions intermingle with fantastic, archaic loving and hateful intentions to give the individual transference its unique character. But the patient must worry if the analyst can stand it, both in terms of the intensity of archaic feeling involved and also in terms of the awesome reality.

These concerns are often at the core of what Gill **(1982)** has called "resistance to the awareness of transference." The patient feels responsible for destroying the analyst's (presumably) fragile sense of self. Both impulse and perception must be denied in favor of maintaining the analyst and the analytic relationship. In these

circumstances, some analysands will hear any interpretive intervention as a condemnation, specifically, a condemnation borne of the analyst's fragility and sense of having been damaged. Interpretation, whether defense, impulse, or affect is stressed, is experienced as blame, as holding the patient culpable for his transference wishes and perceptions. Needless to say, it will be as hard for the patient to become conscious of his anxiety or guilt about the destructive impact he is having on the analyst as it was for him to gauge his effect on his parents. The insidious effect of the analyst's anonymity will thus be to confirm the patients worst fears about intense, erotic, hateful, or even simply loving feelings. The technical problem is how to avoid creating and sustaining a vicious circle. In this context, the goal embodied in the concept of neutrality becomes especially important. The central question of technique is determining the behaviors that support the neutral posture.

Chused has suggested recently that for child patients who had intrusive or over-controlling parents, the non-responsive posture of the classical analyst facilitates the development of a new, growth-promoting object relationship. Her formulation can be read as an updating of Hartmann's "principle of mulitple appeal of interpretations." Hartmann suggested that "… the incidental effects of interpretation … frequently transcend our immediate concern with the specific drive-defense setup under consideration, and … are not always predictable" **(1951**p. 152). Chused updates Hartmann by indicating that there is multiple appeal not only to interpretations themselves, but to all the analyst's behaviors.

The allegiance of both these authors to the premises of the drive/structure model make it difficult for them to follow through the logic of their important insights. Hartmann, although he speaks approvingly of "… variations of our technical principles according to each patient's psychological structure, clinical symptomatology, age level, and so on" **(1951**p. 144), is unable to develop a systematic basis for such variations, or to systematically trace their effects. Similarly, although Chused acknowledges that the analyst's behavior can be the source of genuine structural change, she cannot allow that for some patients the non-responsiveness which characterizes her classical vision of neutrality may thwart the possibility of any treatment.

Reformulating neutrality within the terms of the relational

model allows a consistent approach to these problems. For example, there are many patients for whom analytic reserve is simply too close to the aloof, self-protective posture with which their parents guarded themselves against their children's erotic, competitive, challenging or hostile impulses. With these patients, reserve and anonymity can actually detract from neutrality, by confirming the patient's sense of having harmed the analyst. For all intents and purposes the patient's rage turns the analyst into the damaged, archaic object. Self-revelation can be the road back to neutrality under these circumstances. This is an especially likely situation in the case of the patient who is most locked into the constraints of his internal object world.

Along the same lines, there are some patients who were exposed to parental indifference bordering on neglect. For these people, the traditionally neutral non-judgmental attitude can be genuinely dangerous. Under these circumstances, passing judgment on the patient's behavior (e.g., that it is provocative or self-destructive) or on important people in the patient's life (e.g., a disturbed or cruel lover or relative) can be essential to the establishment of neutrality. Schafer is referring to something similar when he says that "It is not a departure from neutrality to call a spade a spade" **(1983**p. 4).

Let me conclude with an example of the sort of behavior that can support neutrality as I have redefined it within the terms of the relational model. I would stress in this connection that I don't think what I will be describing is terribly unusual from the point of view of current clinical practice. I do think, however, that these are interventions which are not typically included in case reports, because there is no theoretical framework for encompassing their effects, and that my new definition will enable them to be more comfortably included in our technical bag of tricks.

The patient is a middle aged, married man who came to analysis because of an obsession about a woman with whom he had recently had a brief flirtation that had come to nothing. Although he presented himself as simply wanting to be rid of thoughts about the woman, with very little encouragement he quickly came to care less about the obsession itself, and to become more interested in his sense of chronic dissatisfaction with his life at home and at work.

Within a relatively short time, some fairly dramatic improvements occurred in this man's life. The obsession disappeared, but

more importantly, he began to feel generally more open to people in a way that he described as making life far richer than it had been. The scope of his involvement with people and activities grew dramatically. He reported liking himself better and being less anxiously self-absorbed. He acquired new interests.

Despite all these changes, the patient felt that there was a distance between him and me that placed limits on his potential for full self-exploration and growth within the analysis. He felt that he had "no relationship" with me, that I was distant, aloof, and inscrutable. For instance, I didn't answer his questions, preferring instead to demand (as he saw it) his fantasies. Also, he objected to my ways of running my practice. He could not see why I charged for missed sessions. He could understand being charged if he missed for frivolous reasons, but when he did miss it was always unavoidable. And why didn't I even tell him why I did what I did, beyond brief references to my need for some financial stability? Was I just a small-minded cheapskate who hid behind the convenient mask of analytic anonymity?

As the work proceeded, more details of the transference emerged. My failure to answer questions and the demand for fantasies was, as he experienced it, fundamentally a sadistic and voyeuristic exercise for me: I loved to see him squirm and to come up with fantasies that were "wrong". Also, I used both my sadism and my analytic status to protect myself from his own assaults—fundamentally, I was afraid of him and, more pointedly, afraid of my own weakness.

The elaboration of these fantasies was essentially affectless. The patient could not allow himself to feel very much about what was emerging because he was convinced that what he saw was true. We were able to connect the fantasies historically to his perception of his father, a weak, frightened man who had been jilted by his mother and who had carried a torch for her all his life. The father had taken a great deal of his helpless anger out on his son—from criticizing his penis size and taking him for hormone shots as a small child, to denigrating his very real school and work accomplishments later on. Still, he claimed, there was no real involvement. We both learned a good deal as we constructed his transferential feelings in terms of defense against and reaction to his relationship with his father, but nothing much changed. The "bottom line" for the patient was that I was like his father or, as he put it other times, "analysis" is too much like his father.

Over a period of time, I came to believe that perhaps these complaints were justified; perhaps unmodified anonymity was too much like the begrudging, self-protective attitude which the patient had experienced as coming from his father. This led to a change in tone in the sessions. For example, during an exchange organized around some sessions cancelled because of bad weather, the patient again asked me why I persisted in the small-minded practice of charging him when I knew perfectly well that he had a good reason for not coming. This time, I told him that, although I had no doubt that it would have been impossible or extremely difficult for him to make the appointments, I charged him because I didn't want to be in the position of judging whether he had good reasons or not. Further, I said that I thought it would be disrespectful for me to pass on the validity of his reasons for missing a session on any particular occasion, and that I felt most comfortable simply relying on guidelines established in advance.

The patient, surprised and pleased, responded "Oh, why didn't you tell me that before?" I said that it was because I hadn't thought it would be helpful, but that perhaps I had been wrong. This opened up a period of sustained anger—the first expressions of anger beyond the potshots or hit and run attacks that had characterized the earlier work.

During this time, which lasted for several weeks, the patient thought seriously of ending the analysis. Why had I been so like his father for so long, why should be have to put up with and suffer for my mistakes. He also was clearly afraid of what he was feeling. He speculated that maybe it was all for the good, that it was better to feel something for me than nothing. He sought reassurance that this was a sign of analytic progress, but I did not give it to him. In fact, I said, it was possible that the anger was a first step in the end of the analysis, that it was something to be taken very seriously.

As the anger subsided, the patient was able to react more directly to my having told him why I charged for the session and, more important, that I respected him. His reaction was, of course, not unambivalent. He had a dream in which he, an avid tennis player, was playing with John McEnroe. He had the sense that he could beat McEnroe, or at least give him a good game, but he noticed that although several of his own shots were out, McEnroe was calling them good, giving the patient a break. He was able to hear and elaborate my interpretation—that he felt I was toying with

him, letting him think he was in my league, building him up for a harsh disappointment. This was the first time that he was able to connect in a full emotional way with a transference implication of one of his dreams.

In the context of these exchanges, the patient rather quickly became able to experience and accept both angry and admiring or even loving feelings toward me. The analysis took a decisive turn, and the material clearly had a more powerful emotional impact on him. Moreover, he subsequently reported that during the period of greatest anger he had, for the first time in the analysis, felt "really myself."

I see my departure from anonymity—a departure which with my new definition I can say promoted neutrality—as relatively minor. It also came well into the analysis. With other patients, the more active technique must come earlier (sometimes from the first session) or be more dramatic. Notice that my intervention did not truncate the most intense or regressive transferential feelings. In fact, the patient could not have tolerated sustained rage until after I had ventured to become less anonymous. Nor did the change in my position make things more comfortable in any conventional sense. The change enabled the patient to feel that what I did was not self-protective, hostile and small-minded in the way he had experienced his father. This enhanced his sense of analytic safety, but that in turn allowed the emergence of a range of feelings that were at least temporarily more dangerous to both of us and to the continuation of the analysis itself than the earlier indifference had been.

Defining neutrality as optimal tension between the patient's experience of us as old or new objects gives a clear reference point in the patient's experience for evaluating our interventions, and for monitoring our technique throughout the course of an analysis. By relying on this standard, we have a good chance of maintaining the neutral posture, which I continue to believe best serves the goals of psychoanalytic treatment.

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