

## PSYCHOANALYTIC PROCESS AND INTERACTIVE PHENOMENA

One is cured of suffering only by experiencing it to the full—MARCEL PROUST

Psychoanalytic process is defined as the interaction between the psychoanalyst and the patient, primarily through the interplay of transference and resistance. Transference and resistance are understood as a unitary phenomenon that can be expressed either as an intrapsychic potential or as an interpersonal relationship.

One of the aims of psychoanalytic technique is to encourage, through interpretation, the expression of transference and resistance potential as an interpersonal relationship with the analyst. This promotes a fluidity of interchange between the intrapsychic and the interpersonal, leading to heightened interactions between analyst and patient. These interactions become a powerful tool to fully experience unconscious intrapsychic conflict and can be translated back into insight concerning intrapsychic conflict.

**P**sychoanalysis, as a study of the mind and as a technique of therapy, is primarily interested in two basic mental processes, intrapsychic conflict and interpersonal conflict. Intrapsychic processes refer to conflicts between opposing forces within the mind. Mental wishes and emotional needs, primarily loving or aggressive, come into conflict with opposing emotions, fears, and prohibitions. Through the growth and development of the mind, these forces become organized into relatively enduring patterns or structures. Conflicts between elements in different structures lead to the emergence of anxiety and the mobilization of defenses.

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Assistant Clinical Professor of Psychiatry, Yale University; Member, Western New England Psychoanalytic Society. A previous version of this paper was presented at the Western New England Psychoanalytic Society. I would like to thank David Carlson, M.D., for his helpful reading. This paper is dedicated to the memory of Hans Loewald who was my first supervisor as a candidate.

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Conflicts between elements within structures, such as ambivalent wishes or competing identifications, lead to divergent and dissociative phenomena (Kris, 1984). From a therapeutic point of view, psychoanalysis is the study of compromise formations, solutions to conflicts at various developmental levels that persist into adult life as fantasies, symptoms, character traits, or adaptations.

Interpersonal processes refer to the interactional field that develops in the emotional relationship between two or more persons. Each participant brings to the interactional field his or her special set of unconscious needs and expectations which come into conflict with the other person's needs and expectations.

Their mutual interaction determines the shape of the relationship. Each participant's set of expectations and needs is formed by internalizations of developmentally important relationships that form and mold intrapsychic structures. Within an interactional field, there is a tendency for each participant to reexternalize intrapsychic structural elements. In the field of the psychoanalytic relationship, the interaction between analyst and patient is utilized to study the patient's intrapsychic externalizations (Loewald, 1970).

## TRANSFERENCE AND RESISTANCE

I believe that intrapsychic and interpersonal processes are linked together by transference and resistance, which gradually unfold within the psychoanalytic situation as interactive experiences between the two participants (Loewald, 1970; Boesky, 1990; Dewald, 1990; Weinshel, 1990; Renik, 1993). Transference is usually thought of as a special type of object relationship. Greenson's (1967) definition is typical: "Transference is the experience of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present" (p. 171). While these interpersonal aspects are clearly observable, transference, as well, is an intrapsychic phenomenon. In *The Interpretation of Dreams*, Freud (1900) discussed an intrapsychic concept of transference. In the dream work, an unconscious idea or wish transfers intensity to

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a day residue and thus is “covered by” (p. 562) the day residue. The day residue represents the unconscious idea in the dream through a transfer of energy. In a similar way, we understand that all conscious thoughts and daydreams are linked by a network of associations to unconscious wishes and fantasies. The conscious ideas serve as a covering, an outer shell, which derive their varying intensities and meanings from the transference of energy and meaning from the unconscious (Loewald, 1960; Lear, 1993). From a structural point of view, the mind is made up of many layers, which both cover over and are, in turn, covered by other layers (Lear, 1993). Defensive aspects of the ego and superego are linked to the wishes they repress through dynamic and symbolic linkages formed by internalized object relationships and subsequent structuralization. As transference unfolds from intrapsychic structures, self and the object representations that had been integrated into ego and superego structures tend to differentiate back into their original forms and become available to infuse current relationships with meaning. Transference as an interpersonal phenomenon attempts to create an idiosyncratic world of meaning, a private version of shared cultural values (Lear, 1993). Each person develops a stable environment of expected reference points and relationships, with actively defended boundaries. In the transference relationship with the analyst, the patient endows the analyst with meaning and expects the analyst to behave accordingly. Here the analyst becomes the covering. This is the bridge from the intrapsychic world of the patient, which is the proper domain of psychoanalysis, to the interpersonal world of the psychoanalytic situation, which is the everyday experience of psychoanalytic work. The present immediacy of the transference relationship is a microcosm, a world of present unconscious fantasy shaped by past internalized relationships. I would suggest that *transference* is a dialectical term, taking the form of either a fully experienced relationship between patient and analyst or as a structuralized conflict among intrapsychic forces. I use *dialectic*, as Hoffman (1994) does, to understand that each pole of two opposing concepts, contains, embedded within it, aspects of the opposing pole. One pole becomes the figure while the other pole becomes the ground. It is always possible at any one moment to reverse the figure-ground relationship, so that the second pole becomes more evident.

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Like transference, resistance is a dialectical concept that can be described in either intrapsychic or interpersonal terms. *Resistance* is a term that is ambiguously defined in the psychoanalytic literature. As Schafer notes (1976), resistance concepts seem to include aspects of the totality of analysis. Because of this, I will turn first to a discussion of the various meanings of resistance. Freud (1893) first used the term *resistance* in the case of Fraulein Elisabeth Von R as a clinical description when he observed, “resistance offered by the patient in the reproduction of her memories” (p. 154). His famous dictum, “whatever interrupts the progress of analytic work is a resistance” (Freud, 1900, p. 517), is a wonderful clinical description of what every analyst experiences in the analytic situation. Renik (1995) finds that resistance is most useful as a clinical observation. However, when trying to account for resistance within a theoretical system, Freud described resistance in two distinct and different modes. One mode is intrapsychic where resistance is a force that blocks memory or consciousness. For example, in “Screen Memories” (Freud, 1899), he states: “One of these forces takes the importance of the experience as a motive for seeking to remember it, while the other—a resistance—tries to prevent any such preference from being shown” (p. 307). This is analogous to the previously described intrapsychic concept of transference, where, instead of a transfer of energy, there is a blockage of energy and a severing of the association network.

The other mode is interpersonal, when Freud describes transference as inevitably accompanied by resistance: “Over and over again, when we come near to a pathogenic complex, the portion of that complex which is capable of transference is first pushed forward into consciousness and defended with the greatest obstinacy” (Freud, 1912, p. 104). The resistance comes into play when hostile or erotic elements are activated and, we would now add, their associated defenses. Here, the resistance is clearly directed toward the analyst as part of the transference process. Freud continued throughout his career to describe resistance in both these modes, as is evident in his discussion of the types of resistance in *Inhibitions, Symptoms and Anxiety* (1926). He drew a distinction between repression resistance, which I would understand as intrapsychic, and transference resistance, which I would understand as interpersonal. He also noted a third resistance, that of gain from illness, which would now be seen

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as a type of transference. He thought resistance could originate from either the id, ego, or superego. The idea of an id resistance, based on the death instinct and compulsion to repeat, would not be widely accepted today.

Anna Freud, in *The Ego and the Mechanisms of Defense* (1936), further clarified the relationship between the two modes of resistance. She first describes resistance as a “counterattack by the ego upon the id” (p. 14), similar to Freud’s concept of repression resistance. However, her description of the ego’s defensive operations makes it clear that repression resistance is identical to the defense mechanisms. She goes on to describe how the defense mechanisms are activated as transference: “the ego’s defensive operations against such representations [repressed instincts] automatically assume the character of active resistance to analysis . . . the defense set up by the ego against the instincts takes the form of direct opposition to the analyst himself” (pp. 30–31). This occurs because of the transfer of defense as opposed to the transfer of wish.

Since Anna and Sigmund Freud, the term *resistance* has continued to be used to describe both of these modes, often without any clear distinction between them. Emphasizing resistance as an intrapsychic force, Rangell (1983) defines resistance as a defense against insight, a “second layer of defense” (p. 157) to augment preexisting defenses. Similarly, Renik (1995) sees resistance as an interference with self-awareness. Both of these formulations would fit under Freud’s concept of repression resistance. Gray, in a series of papers (1973, 1982, 1987), has focused on the subject of ego resistance. He has developed a technique for directly analyzing unconscious defenses within the analytic process by paying close attention to microscopic shifts in the patient’s associative flow, which he labels as *ego resistance*. I would understand this close process monitoring as an attempt to observe intrapsychic resistance more directly, yet Gray (1987) also understands that resistance is commonly mobilized through a transfer of external authority. Superego voices are reexternalized as prohibiting figures within the interpersonal transference. This would be an example of transfer of defense. A view of resistance understood entirely in the interpersonal mode is that of Schafer (1976). He defines resistance as “engaging in actions contrary to analysis while also engaging in analysis itself” (p. 224). Boesky’s

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(1990) suggestion that “the manifest form of a resistance is even sometimes unconsciously negotiated by both patient and analyst” (p. 572) highlights the interactional aspect of resistance.

We can see that resistance concepts have traditionally encompassed both ego defenses and analytic process. When resistance is spoken of as an intrapsychic concept, resistance is synonymous with various defensive structures and compromise formations that are in conflict with other mental structures, what Freud called repression resistance. I would argue for sake of clarity, with Gill (1982), that these phenomena be categorized under the general term *defense*. Then, I would restrict the term *resistance* to a description of a type of interpersonal process. Like wish, defense can be activated as part of a transference relationship and is an integral part of all transferences. When the resistance elements predominate within the transference, we call it *transference resistance*. When transference is blocked or displaced, we call it resistance to the transference. Each of these modes would be differing aspects of transference of defense (Gill, 1982). I see *resistance*, like *transference*, as a dialectical term, which, at any one moment, either the intrapsychic defensive operations or the interpersonal resistance aspects stand out in a figure-ground relationship.

Furthermore, transference and resistance also have a dialectical relationship. From an intrapsychic point of view, it is clear that any mental structure or operation can serve as either a transference or resistance function. Whether we attribute a transference or defensive function to a particular mental operation at any one moment depends on its complex relationship with other mental operations, a function of which set of operations that we focus on at that moment. From an interpersonal point of view, transference and resistance could be thought of as opposing tendencies that one person develops toward another: openness toward/closed off from, expressive/withholding, clear/disguised, energetic/sluggish, etc. At any one moment in a relationship, certain of these tendencies will be more in the foreground. In the interpersonal realm, resistance is really a type of transference, where the mental contents that are transferred are predominately defensive.

Thus, transference/resistance can be understood either as elements of wish and defense within the mind or activated as meaning

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in all human relationships. All dynamic descriptions can be stated simultaneously in both intrapsychic and interpersonal terms, although we ordinarily focus on either one or the other at any given moment. I will illustrate these dialectical forms in a brief clinical example. A woman patient was faced with my upcoming absence. She was aware of feeling humiliated that my absence bothered her. She would have preferred that she felt nothing or, at most, a mild regret. At this moment, the intrapsychic mode is in the foreground. Humiliation is defended against by repression and isolation. It is likely that the humiliation, in turn, defends against deeper affects. Later in the hour, she stated that she felt humiliated that I knew she was hurt by my absence. This represents a shift into the interpersonal mode. I then suggested, based on my previous experience of clinical interactions with her, that she was afraid I would enjoy humiliating her. She then became aware of a number of fantasies about me, that I would demand submission, that I would secretly gloat over her pain, and that I must want to flee from her demands, while, at the same time, her erotic wishes became more intense. She, herself, wanted to run away, and found it humiliating that she would return to see me after I returned. Images of envy and revenge surfaced. Suddenly, a vivid and complex interpersonal relationship is present. Underneath the humiliation is her view of me as sadistic, her own needs, her aggression, and her wish to withdraw. Wish is transferred in the erotic needs and defense is transferred in her view of me as sadistic and disinterested toward her. During this hour and subsequent hours, we explored wish and defense as different aspects of the transference dialectic come to the foreground. The erotic needs, which at this point represent wish, can later be understood as defense against need for symbiosis and closeness.

Until recently, orthodox American psychoanalysis has been preoccupied with an intrapsychic focus. At the same time, a considerable literature on the interpersonal process has grown up in the Sullivanian tradition (reviewed by Hoffman, 1991). I hope to show in this paper that these two processes stand in a dynamic relationship to each other and both are necessary to a full description of analytic process.

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## **ACTUALIZATION**

Using psychoanalytic technique, transference and resistance are activated and studied intensively within the psychoanalytic situation. I would understand the press toward actualization (Boesky, 1982) as an inherent aspect of all transference and resistance. Freud (1920) had this concept in mind when he stated: “the ‘repressed’—offers no resistance whatever to the efforts of the treatment. Indeed, it itself has no other endeavour than to break through the pressure weighing down on it and force its way either to consciousness or to a discharge through some real action” (p. 19). From the patient’s point of view, there is always a push within the interactional field for transference and resistance, first to activate intrapsychic conflict into a fantasy about the interpersonal relationship with the analyst, and then to move toward fulfillment of that fantasy. Actualization is a movement from thought to action. The actions that result from this activation can either be inhibitory or activating.

When a predominance of defensive elements is activated into a resistance, there is usually an inhibition of the forward press of actualization. Intrapsychically, there is a greater emphasis on blockage of ideas and affects. Interpersonally, the patient focuses on the analyst as a person to be feared or avoided and withdraws from the relationship. At these points, if the transference or resistance cannot be activated to or retreats from the interpersonal mode, the analytic process tends to become intellectualized and sterile. If this becomes a chronic state, the analysis produces no meaningful change.

When a predominance of transference elements are activated, there is a press toward two types of actions. The patient seeks a relationship with the analyst that repeats and preserves the patient’s fantasy expectation of that relationship, what is called the repetition compulsion. At the same time, the patient seeks a new or unexpected relationship with the analyst to repair old hurts and gain new gratifications. Kleinian analysts describe the move toward a new relationship as an aspect of projective identification, where the projection of the patient interacts in complex ways with the psyche of the recipient analyst (Summers, 1994). More classical analysts describe the possibility of a new object relationship within the transference (Loewald, 1960).

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In the interactional field of the psychoanalytic relationship, we cannot just speak of the patient's transference relationship to the analyst. The analyst has a similar psychological organization, which is generally kept relatively muted and unintrusive and is not the object of study (Loewald, 1970; Leavy, 1980). The analyst is subject to the forces of his own transference and resistance, which invariably leak out into the psychoanalytic process. I would suggest that the analyst develops both transference and countertransference toward his or her patient. Transference is the externalization of the analyst's internal conflicts, while countertransference is the analyst's emotional reaction to the patient's projected transference (Loewald, 1986). In practice, it is usually not possible to separate these two modes and they are often understood together as countertransference. In a similar way, the analyst may express resistance or counter-resistance.

I see the interpersonal transference as a joint production of the two participants (Compton, 1990; Hoffman, 1991; Renik, 1993; Gill, 1994). There is a joint activation of transference-resistance and countertransference-resistance in both the patient and analyst: noisy, open, and controlling on the patient's part, quiet, restrained, and receptive on the analyst's part, reflecting the asymmetrical relationship of the two participants. The patient, too, develops countertransference reactions to his or her experience of the analyst's transference, as well as the analyst's personality and way of conducting the analysis.<sup>1</sup> Every patient interprets the analyst's behavior from his or her own unique perspective. Countertransference and counter-resistance are continuous for both participants. What we call transference is really a product of the person's transference and countertransference. We could describe transference as a highly selective attention to certain aspects of the other's transference. The resulting transference would be composed of elements drawn from one person and pulled toward the other person. The experienced transference becomes a constructed meaning for the patient-analyst pair, highly unique and fluid (Hoffman, 1983).

Both the patient's and the analyst's transference and countertransference contribute to the interactional field that always develops

<sup>1</sup>This touches on realistic aspects within the psychoanalytic situation in both the analyst and patient that influence the interactional field. The rich literature of this subject will not be discussed in this paper.

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between them. I think that the analyst's contribution is not only inevitable and useful, but is essential to the process. To the extent that the analyst is receptive to the patient's transference projections, there will be an inevitable activated countering response from the analyst (both the analyst's transference and countertransference), providing a feedback loop to the patient, activating the interactional field. The absence of such a countering response from the analyst would signal to the patient that the analyst was not available and would lead to the patient's withdrawal. Freud's concept of the unobjectionable positive transference, various alliance concepts, and the concept of the holding environment are all variations of the patient's need to be responded to (Gill, 1994). The mutuality of patient and analyst at more activated levels of transference will be discussed in a later section.

I will illustrate these principles with another brief clinical example. A male patient, in the beginning phase of an analysis, opened an hour by talking about his weekend. I started to notice that I felt bored and detached but was unable to pinpoint what I might be feeling. He then started to complain about his lack of creativity and feeling blocked. Without any reflection on my part, I said to him, "What do you think stops you from doing these things?" I knew as soon as I spoke that this was an inflammatory statement. He said quickly, "I hate people asking me that," but went on to reassure me that it didn't bother him when I asked. I asked him how he felt when I asked him and he said, "Nothing." I then wondered if he wasn't being polite when he said it didn't bother him. He said, "Trying to protect you?" I said, "Yes." He then asked me if he had ever told me about his broken finger. He had been visiting his father for the weekend after his parents had separated. Trying to please his father, he was carrying objects too heavy for his age, fell and hit his hand. His hand continued to hurt and began to swell. His father refused to seek medical attention, then got angry and told him he was a sissy when he cried and continued to complain. It later turned out that he had a serious compound fracture that required months of treatment. As he was telling the story, he became visibly angry at his father. Only at this point could he say spontaneously to me, "I hated you when you said that." At the beginning of the hour, what was evident was his resistance and my counterresistance. I knew from my

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own analysis and previous clinical experience that boredom for me is often a signal of defense against aggression. I only became aware of my aggression after my first statement to him that contained obvious critical and aggressive elements, an eruption of my transference and countertransference (a mixture of my own activated anger and being drawn into his projected image of his father). He responded with activated anger, which he then tried to repress. I was now back on track and interpreted his resistance to transference. This allowed his activated transference to be gradually and fully expressed, first in the memory and then directly at me. There is a movement in the hour, from a predominance of intrapsychic mechanisms, toward a brief but intense interchange after my first statement and an even more intense interchange at the end of the hour.

### **INTERACTIVE PHENOMENA**

I would suggest that the ideal position for the patient–analyst pair along a continuum of actualization is a joint activation of transference and resistance to a level of fantasy about the other, where the push toward action is, as yet, minimal.

Internally, the analyst, when he or she is receptive to the patient's transference, is pulled into the same actualized level as the patient. The analyst must have the personal freedom to passively allow himself or herself to resonate with the patient, much as the overtones among strings in a piano or violin. At the same time, the analyst actively attempts to be as open as possible to his or her own feelings and fantasies. What is different between patient and analyst is the expression of the actualized transference and resistance. The patient is encouraged to verbalize his or her fantasies about the interaction, which then serve to further the press toward actualization. The analyst, on the other hand, does not verbalize his or her fantasies, but thinks about them and uses them to understand the nature of the interaction.

Even though the analyst does not ordinarily share his or her fantasies with the patient, it is necessary that the patient can sense the analyst's participation to sustain the activation. It would seem to

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me that this is accomplished by two parallel channels of communication. At an unconscious level, in spite of the analyst's efforts to contain transference and resistance, it inevitably and spontaneously leaks out into the interpersonal field, communicated through choice of verbal imagery, verbal slips, silences, and countless nonverbal ways. Because of the patient's activated transference needs, he or she will tend to understand everything that the analyst says or does (or doesn't say or do) as an action or indication of intention. The patient is unconsciously tuned into the analyst's emotional state and, to the extent that the patient can counter the analyst's transferences, will sense the analyst's level of actualization.

Isakower's concept of the analyzing instrument (Balter, Lohane, and Spencer, 1980) describes this state of patient-analyst attunement where there is a regression in a subsystem of the analyst's mind in response to and resonating with the patient's regression. On the analyst's side, this would involve a shift from "intentionally directed reflection" to "freely wandering or phantastic thinking" (Freud, 1921, p. 272). There is also a shift in the formal qualities of thought from rational logic to dreamlike images. At a more conscious level, the analyst tries to shape his or her interpretations to accurately reflect his or her understanding of the patient's activation. The patient unconsciously understands the analyst's interpretations in the same process described above. If the patient feels understood, he or she will also feel reassured that the analyst is sharing these experiences.

The interaction between patient and analyst at this idealized position was described as a special type of empathic relationship by Beres and Arlow (1974). They describe the appearance of a fantasy in the analyst's mind as an association to material from the patient: "A measure of the analyst's empathic capacity lies in his ability to be stimulated by the patient's unconscious fantasy when the analyst is not yet aware of the existence or the nature of the patient's unconscious fantasy" (p. 45). The nature of the patient's unconscious fantasy is a piece of transference or resistance that determines how the patient understands the reality of the analyst. It is the externalization of this conviction about the nature of the relationship that the analyst can sense and which in turn stimulates a fantasy in his mind. Empathy, in this sense, is actually the openness and awareness on the

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analyst's part of his or her own fantasy about the patient. Ideally, this allows the patient's transference and resistance to become a real experience in the analyst's mind. The analyst can then reflect on the patient's experience as a signal affect and fantasy within himself. This is what Dewald (1978) describes as an intermediate type of interactional relationship, between self-contained primitive core conflicts that are intrapsychic and repetitive or demanding external relationships. The analyzing stance of the analyst is one that both participates in the experience yet stands back to examine the core conflicts. I see empathy as the actualized transference fantasy with which the analyst makes a transitory identification. The analyst ideally uses the empathic relationship as an observational point, both of the patient's projections and his or her own transitory identifications.

The further activation of the patient's transference leads to a pull toward action, rather than contemplation. Action within the psychoanalytic setting usually takes the form of various types of enactments. These occur when both participants join in a mutual action. As the patient's transference is more activated into a wish for real gratification, the analyst's countertransference is activated to a mutual level, but takes the form of a vivid fantasy rather than action. Chused (1992) uses the term *actualization* in this sense. She notes a tendency for patients to take realistic characteristics of the analyst to use as proof and confirmation of the patient's transference fantasy. This tendency represents a partial move into action on the patient's part, where the analyst as yet is relatively uninvolved. The patient moves away from an empathic stance and increases pressure on the analyst to similarly abandon his empathic stance. Sandler (1976) describes the next step toward action in what he calls role responsiveness. The patient attempts to cast himself in a certain role and the analyst in a complementary role. A fixed interaction is imposed on the patient-analyst relationship. The patient attempts to activate the transference or resistance in a disguised way. To the degree that the analyst reflexively accepts the role being pushed on him by the patient, the role responsiveness takes on life and moves toward action and enactment. A total enactment represents the endpoint of actualization and role responsiveness when both the patient and analyst are fully caught up in a mutual emotional response. This responsiveness may take the form of a behavioral acting out of

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unconscious wish fulfillments (Jacobs, 1986, 1991; McLaughlin, 1991; Chused, 1991) or may be confined to verbal interactions (White, 1992). Both the patient's and the analyst's transferences and countertransferences are activated and contribute to the enactment. Enactments usually lead to repeating of old patterns of interaction. From the analyst's point of view, the shift toward actualization and enactment would involve his or her own shift away from the empathic and reflective relationship and toward greater degrees of transference involvement. Hoffman (1991, 1992), as I understand him, would push the concept of enactment much further. He suggests that enactments are a continuous and ever-present part of the interpersonal process. Moreover, the analyst is always drawn into the process in ways that he or she can never be fully conscious of (Aron, 1991; Renik, 1993). The analyst cannot know, with any conviction, how her own participation in the process affects her own understanding about either self or other. The patient, too, is subject to the same forces. Thus, patient and analyst are always caught up in a mutual experience that is constructed out of these activated transferences and countertransferences, that neither party can fully grasp or control.

I would agree that the processes of actualization and enactment are always present in the interaction and can be traced as microshifts within any session. Whenever the analyst is empathically open to the patient's transference or resistance, further push toward actualization, either in response to the patient's or the analyst's transference or resistance, becomes harder to control. I believe that the analyst, simultaneously, should allow him- or herself to be activated to the same level as the patient, and generally refrain from the open expression of the activation, knowing that inevitably such activation will continuously leak out and enter into enactments with the patient.

I think that movement toward role responsiveness and enactments is inevitable when the analysis is operating at empathic levels. The analyst who is receptive to trial identifications with the patient will inevitably activate his or her own transference to the patient in varying degrees. The analyst cannot help from time to time entering into enactments (Bird, 1972; Poland, 1992; White, 1992). I have argued elsewhere (White, 1992) that enactments may allow into consciousness certain transference configurations not otherwise available. Roughton (1993) notes that action may be a necessary

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preliminary step to recall in some patients. Sandler (1976) points out that the analyst may only become aware of a role imposition after responding in action. Renik (1993) similarly argues that the analyst can only become aware of his or her own motivation after getting drawn into the enactment. Hoffman (1991, 1992) and Renik (1993) argue that, since the analyst knows that he or she is always caught up in unconscious enactments, the analyst is then freer to be spontaneous, to let more of his or her personality to enter into the process. The analyst's spontaneity has a number of implications; for example, the enactment will be further activated in ways that cannot be anticipated. Hoffman (1991) is aware of the dangers of activation; the patient could be traumatized by being drawn into and then limited by the process, or the analyst could be more exposed or vulnerable than is comfortable. The analyst's spontaneity is countered by the dialectical use of technique; the analyst brings to the foreground critical reflection on the immediate interaction and the mutual contribution of both participants. Enactments are useful only to the extent that both participants can return to a less actualized state of relationship and can mutually reflect on the experience and its meaning. I believe that the analytic process is most powerful when it operates at the fluid boundary between empathic relationships and more actualized relationships. When the analysis operates at this level, both fantasy and enactments serve as sources of data about the patient. The analyst clinically moves through an irregular cycle of passivity and activity. He or she passively participates in the activated state of the patient, sometimes silently and sometimes more openly drawn in for a period of time. Then the analyst actively intervenes, both to lower the mutual activated state and to mutually reflect with the patient about the experience both have just undergone. When the analyst cannot actively intervene, there is a danger of being pulled into fixed or chronic enactments. The patient has entered analysis because of chronic, fixed enactments in everyday life. If the analyst gets caught up in these fixed enactments, there is usually a joint activation of resistance and a therapeutic stalemate.

Returning to the previous clinical example of the male patient, I would say that he and I joined together in a mutual enactment. The enactment was constructed out of his activated anger, my activated anger, and his countering of my anger. The enactment was

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simultaneously a real and vivid experience unique to the two of us and a reenactment of an aspect of his experience of his father. There was a movement for both of us toward unreflected expression of affect and a movement on my part toward reflection about the affect.

### ACTUALIZATION AND INTERPRETATION

I would like to discuss two aspects of interpretation as it relates to the interpersonal processes of actualization and enactments. The first of these aspects is the common clinical question of the analyst knowing when he or she is caught up in an enactment. Clinically, enactments can only be recognized in retrospect, whether it's the moment after one said something one wished one hadn't or days later when the patient points something out. Then, the analyst is faced with the impossible task of separating his or her transference to the patient from the countertransference. When is the analyst's fantasy about the patient a countering response and an accurate representation of the patient's reality? When does the analyst's fantasy represent his or her own transference to the patient? While the analyst can never fully grasp his or her own subjectivity, it is still worthwhile to try. The analyst is constantly trying to sort out these questions in order to gain a clearer view of the patient's psychic reality. I would suggest that the analyst utilizes two types of feedback loops, the first of which is internal. The analyst develops a trial conclusion about the patient's psychic reality and then cognitively reviews this conclusion for accuracy. Data for this review are multiple. What is the nature of the current interaction? Does the analyst feel a sense of clarity or playfulness? Does he or she experience a freedom to think about the patient, to pay attention to inner free associations and intuitions? Can the analyst easily move from being with the patient to thinking about the patient? All of these qualities would suggest the more empathic level of activation where the analyst's countertransference is a more accurate reflection of the patient's reality. The analyst then thinks about the patient's and his own fantasies, in terms of his own subjectivity. This might include common sense, personal life experiences, and self-knowledge gained from the analyst's own analysis, previous clinical experiences with the patient,

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knowledge of the patient's development, and theoretical understanding. This allows the analyst to try to understand the meaning of the fantasy in terms of the patient's reality and not his or her own reality. In this way, empathy and intuition can be subjected to an internal validation process.<sup>2</sup>

The second of these feedback loops comes through the patient-analyst interaction, through the patient's responses to the analyst's interpretations. The analyst expresses his or her trial conclusions in an interpretation to the patient, usually in the form of an understanding of the current interpersonal relationship. The patient then provides feedback, both consciously and unconsciously, concerning the accuracy of the analyst's conclusion. The patient, especially if the analyst is open and inviting to such responses, can offer interpretations of the analyst's transference (Hoffman, 1983). The problem here, clinically, is that the patient's feedback is seldom straightforward and often requires further understanding and interpretation on the analyst's part. The patient may agree or disagree, may feel surprise, recognition, indifference, fear, or avoidance, any of which may or may not be defensive. Provoking a resistance may indicate accuracy of content but poor timing. The patient's observations about the analyst may seem to the analyst to be accurate, to be a displacement, or may provoke countertransference and counterresistance, recognized or not by the analyst. When the patient is stimulated to think of confirming themes or bring forth new material, we often feel our conclusions are accurate and timely. Similarly, the analyst, through clarification of his or her own participation, often with the help of the patient, will understand the interaction more clearly. Because of this complexity, the feedback loop takes the form of an ongoing dialogue between patient and analyst, mutually trying to arrive at an approximate truth. Renik's (1993) conception of meaning as arising from the interaction of both the analyst's and the patient's interpretations of reality is similar to what I have in mind.

A second aspect of the interpersonal use of interpretation is the analyst's ability to control the level of activation. As noted earlier, there is always a press toward actualization of intrapsychic conflicts into the interpersonal transference relationship with the analyst. The

<sup>2</sup>The rich literature on how the analyst attempts this task will not be reviewed here.

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analyst-furtheres the actualization process by his or her personal freedom to receive and hold the transference projections of the patient. However, resistance aspects are also mobilized, leading either to a displacement away from transference or a defensive distortion of the transference. I would suggest that the analyst needs to promote the interpersonal expression of transference, through interpretation, by naming and linking these resistances to blocking of transference. The role of interpretation here is to facilitate a hermeneutic translation from the intrapsychic form to the interpersonal form. By analyzing resistance, the interpretive actions of the analyst promote the activation of intrapsychic conflict into the transference relationship with the analyst. In this direction, interpretation serves to remove obstacles from the expression of transference. This is one meaning of the "analyst as sculptor" metaphor. He or she chips away the resistances from the material, allowing the transference image to shine through (Loewald, 1960). The intrapsychic transference potential will naturally move toward interpersonal expression once the obstacles are removed. I see the aim of these interpretive actions to intensify, as much as possible, the patient's and the analyst's interpersonal experience of these conflicts.

The analyst, through interpretation, promotes the intense transference and resistance relationships and attempts to keep the transference and resistance largely confined to the empathic levels that allow for the possibility of interpretation and insight. I would define neutrality in this context as the ability of the analyst to maintain the analytic relationship centered at the empathic actualized level but with enough flexibility to allow swings both toward more intense enactment and toward cognitive insight. The goal of the analysis is to promote the expression of anxiety and other affects as a signal within both parties of the dyad. The move toward actualization may lead to experiences of affect flooding and a subsequent emergence of resistance or counterresistance. The analyst is better equipped to maintain anxiety as a signal affect and thus better able to step back from his or her own resistive tendencies to be more available to the patient who feels flooded.

I see the translation from the interpersonal experience of transference and resistance back to the intrapsychic system as more problematic. It goes against the grain of the natural actualization pressure

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toward expression of transference and resistance. The interpersonal expression of transference and resistance requires only a removal of impediments to flow freely and cognitive insight is not necessary. To the contrary, the patient will struggle against the translation back to the intrapsychic. It means that the patient must give up the person of the analyst, what to the patient is experienced as a real relationship and its various gratifications. The interpretive effort of the analyst is qualitatively different. Rather than be receptive and release a natural process, the analyst must provide a counterpressure, both to reverse the natural flow of transference and to counter the mutual tendency of both the analyst and the patient to maintain the reality of the relationship. The patient is asked to exchange the gratification of the actual relationship for various cognitive processes, a bargain that may not seem like much to the patient at the time.

I would suggest that the goal of this backward translation process is to provide the insight that the interpersonal experience of transference and resistance is a repetition of internalized expectations and conflicts that color all external relationships. Cognitive insight, as well as certain transference experiences, will produce the necessary counterpressure. The abstinence of the analyst and the time-limited nature of analytic involvement instills a constant mourning process in the patient, as the free-flowing push toward actualization is checked by the analyst. The mourning process is, of course, greatly accelerated in the termination phase but is present throughout the analysis as new aspects of transference are expressed and felt in the analytic relationship and old aspects of transference are worked through. It is the underpinning of this constant mourning process that pushes the patient toward detachment and displaces the flow of transference back to the world of internal relationships. The analyst is abstinent in several ways. By not responding to the patient's spoken or unspoken wish for gratification and personal knowledge of the analyst, the patient experiences disappointment and anger which contribute to the mourning process. The very act of the analyst's interpretation, which involves standing apart from the actual involvement and commenting on the action, provides another check of the press toward actualization. The content of interpretations, with emphasis on the self-observation of mental functions, tends to focus back toward the intrapsychic domain.

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I think that the other important experiential aspect of this reverse translation is the patient's experience of the analyst as a new and novel object relationship. Loewald (1975) suggests that both patient and analyst alike can experience an authentic responsiveness different from transference expectations. Hoffman (1991) and Renik (1993) would argue, I believe, that, to the degree that the analyst can allow his or her own spontaneity and view of reality to enter into the process, there is the possibility of moving from repetition of old patterns to the construction of new and unexpected meanings. It is crucial that the analyst not impose his or her own view of reality on the patient, but offer it as a possibility to be considered and negotiated, even including the analyst's own uncertainty about the matter. The analyst should assist the patient to recognize and sort out these experiences from repetitions. It is only through these new experiences that the patient can truly experience repetition as repetition, though a contrast to the new object relationship. This provides a link to cognitive learning. The insight that the patient's experience with the analyst is a repetition allows the patient to experience the transference as an intrapsychic process. Likewise, certain memories of past relationships may be brought into consciousness under the impact of new present experience, allowing understanding of old relationships in a new light.

Finally, the analyst should directly reverse the actualization process through the content of the interpretation. The analyst points out to the patient how he or she has distorted the relationship with the analyst through the externalization of intrapsychic structures. The patient, in order to fully accept the interpretation, must have fully experienced the transference both as a real experience and as not real, a repetition of past experiences.

This recognition in the interpersonal transference of multiple transferences, both repetitions and novel experiences, can be translated back to a refinding of lost internalized object relationships or new meanings to known object relationships. Loewald (1975) wrote: "In the course of the psychoanalytic process, narrative is drawn into the context of transference dramatization, into the force field of re-enactment" (p. 366). These new objects and new meanings, originally generated from transference and resistance, can come to infuse extratransference interpretive activities with new affective meanings.

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Dreams, memories, and extratransference relationships can now be understood by patient and analyst in a new way.

In everyday clinical work, interpretation can be stated in either interpersonal or intrapsychic terms. Often the same conflict can either be described as something happening between patient and analyst or as conflicted internal states. The analyst can make the choice depending on his or her wish to emphasize transference actualization or the reverse translation back to the intrapsychic. The analyst can exert control over the degree of actualization by the form in which the interpretation is presented, interpreting resistance to the interpersonal transference to heat it up or interpreting intrapsychic aspects of transference to cool it down. It is through these subtle changes in language of interpretation that the analyst can exert a powerful control over the translating function of interpretation.

The analyst can interpretively use these choices of language to exert some control over the level of activation from moment to moment within the hour. In the opening phase of an analysis, interpretation is used primarily to facilitate actualization of transference and resistance toward a fuller interpersonal experience in the here-and-now of the consulting room. In the termination phase, interpretation would primarily emphasize insight concerning intrapsychic processes and develop the ability for self-reflection. During the long middle phase of the analysis, ideally there is a sort of rhythm where periods of transference and resistance experience alternate with periods of examination and reflection.

## **CONCLUSIONS**

1. Transference can be described as an interplay and dialectic between what is internalized and what is externalized. Internalized object relations correspond to a transference-driven interpersonal relationship.

2. Resistance is a type of transference in which defense is predominantly transferred. There is a similar interplay and dialectic between internalized defensive operations and interpersonal resistances.

3. Transference has, as one of its inherent properties, a push toward actualization, an activation of intrapsychic potential toward

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a real interpersonal relationship. Resistance has a tendency when activated to inhibit actualization.

4. Any interpersonal relationship is a matrix comprised of each participant's transference, their countering reactions to the other's transference (countertransference and empathy), and other real external factors present at the time. These interactions are continuous and it is not possible for the analyst to fully understand the extent of his or her own participation.

5. The analyst, in order to study the patient's transference, sets up such an interpersonal matrix. The analyst ideally participates in this process in an oscillating manner, alternating between an empathic position in which the patient's transference-resistance predominates, and enactments in which the psychoanalyst's transference-resistance is drawn into the process.

6. This process allows the patient to have intense interpersonal experiences in which previously unconscious transference-resistance aspects are mobilized, alternating with quieter periods in which the patient, with the help of the analyst, can reflect upon and understand what has been experienced.

7. The analyst can exert some control over these processes by his or her own passive receptivity, through active interpretation of resistance and by choice of language.

8. The patient develops insight by translating, with the psychoanalyst's help, these interpersonal transferences back to an understanding of intrapsychic conflict.

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