The demise of the person in the psychoanalytic situation

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The capacity to acknowledge the existence of a personal relationship with one's patients, and the wherewithal to engage it freely in a manner that complements the specific needs of each treatment situation, lends a dimension of genuineness and authenticity to the relationship that has profound implications for the way analysis is experienced, and even how technical principles are applied. The trend to 'depersonalise' the psychoanalytic relationship is surprisingly recent. In this paper, MICHAEL GUY THOMPSON explores some key questions: What accounts for this glaring dichotomy in our conception of the personal relationship and why is there such reluctance to recognise and, in turn, systematically explore the vital role this relationship plays in the analytic process? Why does the word 'personal' arouse so much concern that it has been more or less banished from our characterisation of this process? Finally, what role does the psychoanalytic conception of the unconscious play in these considerations, and how did our conception of the transference as a strictly unconscious phenomenon become incompatible with the notion of a personal dimension to the analytic relationship?

The demise of the person in the psychoanalytic process may seem like a strange choice of subject matter as the words *'person'* and *'personal'* are not technical terms in standard psychoanalytic nomenclature. Typically, both terms are invoked, if at all, in a strictly offhand way when referring to non-transferential and non-technical behaviour or experience in the context of the psychoanalytic treatment relationship. For the majority of analysts, so-called personal aspects of the treatment situation have little, if any, role to play in the psychoanalytic process as it is typically conceived. For many, it is the absence of a personal engagement with patients that distinguishes psychoanalysis from its user-friendlier cousin, psychodynamic psychotherapy. It has become increasingly commonplace that contemporary psychoanalysts of virtually all persuasions reduce the psychoanalytic process to the analysis of transference, resistance, and more recently, enactments. This has resulted in the general assumption that virtually all of a patient's reactions to the person of the analyst should be treated as transference manifestations. Similarly, most if not all, significant interventions by the analyst in response to transference phenomena are informed by whichever technical principles a given analyst elects to follow. This is a view held typically, for example, by Kleinian, classical Freudian (i.e., American ego psychology), and most contemporary relational analysts, all of whom tend to deconstruct the very notion of a person-to-person engagement out of the psychoanalytic process. Such analysts often concede that interactions of a personal nature occur invariably during every analytic encounter, but such occurrences usually are deemed irrelevant, and even impediments, to the analytic process, and are avoided scrupulously or, when unavoidable, systematically analysed.

As a topical example of just how far this attitude has evolved, I cite a recent article in *Psychoanalytic Psychology*, which was discussed subsequently in the *New York Times*, that questioned the efficacy of analysts treating patients in their home office. The author of the article, Karen Maroda (2007), offered that such arrangements may serve as 'keyholes' into the analyst's personal life and consequently *'over stimulate and overwhelm'* the patient. She argues that any contact with the analyst's personal life will result inevitably in an unsettling, even harmful experience (if indeed knowledge of a personal nature about one's analyst is inherently traumatic, which I doubt).

Even a cursory survey of the psychoanalytic literature over the course of its long history shows how the trend to 'depersonalise' the psychoanalytic relationship is surprisingly recent. An extraordinary number of seminal contributors to matters of technique—including Freud, Ferenczi, Reik, Fairbairn,

Winnicott, Lomas, Erikson, Loewald, Stone, Fromm, Leavy, Lipton, among many others—believe, on the contrary, that the personal relationship between patient and analyst should be acknowledged in order to accommodate the unpredictable nature of the total psychoanalytic encounter. These analysts argue that a wide assortment of object relations, in addition to transference phenomena, occur over the course of every psychoanalytic treatment, and that the astute handling of such non-transference and non-technical interactions are an indispensable component of the proverbial analytic process. On the other hand, Ferenczi, an important advocate of informal technique, may serve inadvertently as a confusing model for a more personally-engaged way to conduct psychoanalytic treatments. For example, Ferenczi was noted for his gregarious and affectionate personality in the way he behaved with patients. Ferenczi also engaged in a series of technical experiments that were designed to make the psychoanalytic process more democratic and less authoritarian. Ferenczi is often cited by contemporary relational analysts (Davies & Frawley, 1991; Ogden, 1994; Mitchell & Black, 1995) as the first advocate of a two-person psychology, yet his inherently outgoing personality traits are confused typically with his more deliberate technical innovations, so that both are conceived erroneously as aspects of technique, in the strict sense of the term. As a consequence, the specifically spontaneous, unpredictable attributes of a given psychoanalyst's personality have been incorporated into deliberate, circumscribed technical recommendations that effectively compromise the uniquely personal component of the analyst's participation in the process.

Another example of this development can be found among relational analysts who take umbrage with the more classical characterisation of transference phenomena as distortions of the patient's real or realistic perception of the analyst's behaviour. Relational analysts argue —in my opinion, correctly—that such perceptions may (or may not) be accurate and even insightful observations of the analyst's behaviour, about which the analyst may be unaware. Yet, in so doing, these same relational analysts tend to treat such ostensibly accurate perceptions as aspects of the patient's transference. Consequently, such perceptions are not conceived as components of the ongoing personal relationship, but rather as an 'expanded' notion of how classical analysts typically conceive the transference situation. For instance, whereas Hoffman (1983) advocates more spontaneity and truthfulness in the analytic relationship, his principal concern is a technical matter, that analysts should encourage their patients to reflect upon and verbalise how they are experiencing their relationship with their analyst. Hoffman points out that analysts have traditionally not been taught to perform such interventions. Moreover, he believes that many of the analysts (e.g., Stone, Loewald, Strachey, Greenson, Langs, Kohut) who have emphasised the importance of the 'real' or personal relationship existing alongside the transferential do not encourage their patients to verbalise their experiences about their relationship. He also chides these analysts for adhering to the traditional depiction of transference phenomena as 'distortions' of what is really occurring in the analyst-analysand dynamic, thereby setting themselves up as authorities on what is real and what is not. Analysts who encourage more personal or human engagement with their patients fall prey to what Hoffman sees as a stubborn adherence to the analyst as authority figure to the patient as supplicant; these analysts may be compassionate, but they call the shots as to what is actually going

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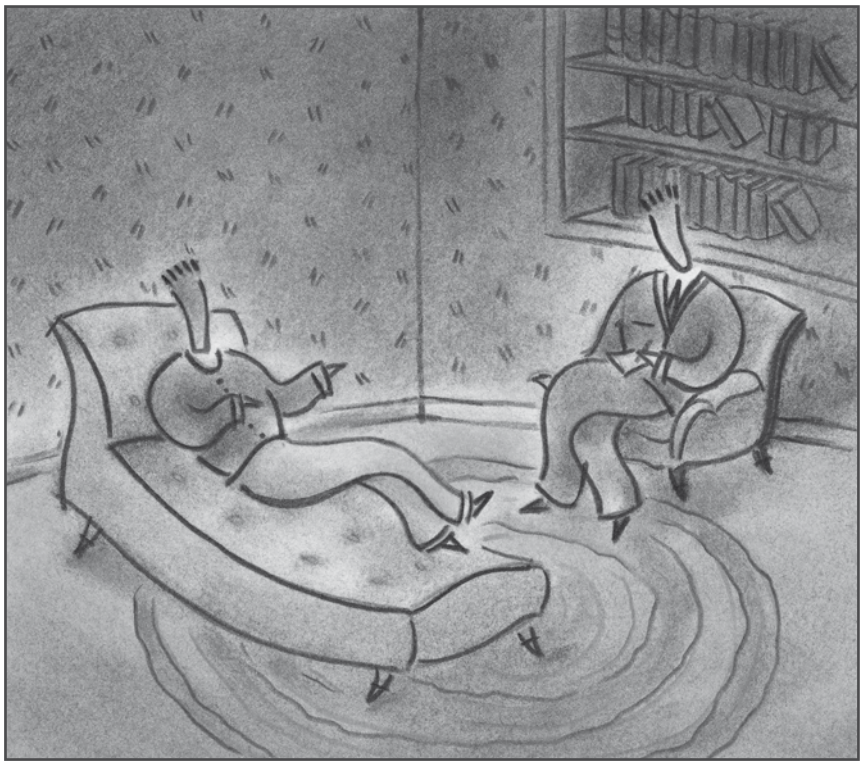

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on. This characterisation of so-called classical or orthodox analysts has been criticised roundly by Haynal (1997) for oversimplifying the complexity of the historical evolution of psychoanalytic theory and technique over the past century, especially in Europe.

I admit to being puzzled by Hoffman's criticisms. It would seem to me that a relational perspective that is rooted firmly in the Interpersonal tradition (initiated by Sullivan and subsequently developed by Fromm, Fromm-Reichmann, C. Thompson, O. Will, and numerous others) would privilege spontaneity *and* personal engagement by both analyst and analysand, a manner of engagement that cannot be reduced to technical interventions, however enlightened or perceptive such interventions may be. Hoffman complains that there is no way to distinguish between personal and transferential aspects of the analytic dyad and says even Freud, with his conception of the unobjectionable transference[1], observed that transference is ubiquitous in virtually all human relationships. Hoffman chastises Stone, for example, for claiming that the transferential and real relationships are distinct but intertwined when he says that *'the transference will, under [certain] circumstances, include realistic perceptions of the analyst'* (p. 49). Hoffman argues that Stone cannot have it both ways—to say that one can distinguish between the two and yet insist they can commingle.

It seems to me that Hoffman is genuinely confused about the distinction between the personal and technical aspects of the analytic experience and, so, reduces it to unrelenting tech-ridden interventions that pervade the treatment situation. This problem probably originates with how Freud envisioned matters of technique, and the subtle differences between real and transferential love, outlined in Freud's seminal and most exhaustive paper on the nature of love, *'Observations on Transference-Love'* (1915). Because Freud saw transference phenomena as contemporary editions of the patient's Oedipal, unrequited love, he recognised that so-called transference experiences occur in all human encounters, including outside the analytic situation. We only call this phenomenon transference (instead of love) in the context of analysis because no one can fall in love with their analyst as innocently as they might otherwise in the normal course of events. This is because the comportment of the analyst with whom the patient forms a positive transference is essentially a *contrivance*. The analyst does not show concern, curiosity, and compassion for the patient because of the compelling character traits the analysand happens to possess. He does so because that is what he is being paid to do; it is his job. That doesn't, however, mean that the feelings of concern and compassion he displays toward his patient are not genuine. They are. They are two human beings who spend a lot of time together and the analyst feels these things because that is what makes him human. He may also harbor his own personal reasons for wanting to help people. Perhaps he took care of his mother when he was a child and developed a tolerance and ease with such uncommonly intimate and intense relationships that he has opted to turn this talent into a vocation. The patient is thrown effectively into an intensive relationship not unlike she might with a married colleague. Familiarity breeds intimacy and the situation that brings people together may elicit emotional reactions that they would otherwise never experience with that person.

The personal and the transferential do blend, but they can be distinguished, with effort.

Another way of putting it is that transference is ubiquitous because our capacity for love is universal and always operative. If we were not capable of such feelings we would not be effective practitioners. Indeed, it is a prerequisite for, and the foundation of, every intimate relationship. The personal and the transferential do blend, but they can be distinguished, with effort. A patient may come to trust me because I remind him of his grandfather whom he loved and admired, but also because I treat him in such a way that invites such trust. The technique of non-judgmental neutrality is not just a technique: it speaks to my capacity to suspend judgment and keep an open mind, a personal attribute. When this furthers my patient's analytic attitude and his ability to free associate and reflect on my interpretations I don't have to bring it to my patient's attention that *'this is only transference, you know',* even if that is true. On the other hand, it is a judgment call as to when and how often I feel the need to offer transference interpretations, be they of the genetic or here-and-now variety. But the technique of rendering such interventions occurs in the context of a personal relationship that is guided by our respective character traits, including our respective capacities for intimacy, candor and affiliation. Hoffman seems so intent on bringing our attention to a favored technique that he ends up throwing out the baby of personal engagement with the bathwater of classical technique.

Hoffman advocates a less dogmatic and more sceptical manner of sharing interpretations with his patients, and I applaud him for that. Behaving with more compassion and sensitivity with one's patients is a no-brainer. But in my view, the inherently personal aspects of the analyst-patient relationship should not necessarily be subject to analysis, nor should they always fall under the rubric of technique. That which is personal is, by its nature, generally taken for granted and permitted to pass as that dimension of the analytic relationship that is both genuine and authentic. *It is from this foundation of the ongoing personal relationship that transference phenomena derive.* The significance of this distinction will become more apparent below.

What accounts for this glaring dichotomy in our conception of the personal relationship and why is there such reluctance to recognise and, in turn, systematically explore the vital role this relationship plays in the analytic process? Why does the word 'personal' arouse so much concern that

it has been more or less banished from our characterisation of this process, and relegated to psychoanalytic 'psychotherapy'? Finally, what role does the psychoanalytic conception of the unconscious play in these considerations, and how did our conception of the transference as a strictly unconscious phenomenon become incompatible with the notion of a personal dimension to the analytic relationship?

It is a common assumption that the unconscious is the pivot around which psychoanalytic theory and practice orbit and that distinguishes psychoanalysis from other kinds of psychotherapy, such as CBT, family therapy, or humanistic and psychodynamic therapies. It follows that one of the cardinal questions raised by the psychoanalytic conception of the unconscious is the role of the subject or person who is engaged in this therapeutic endeavor. Freud's earlier topographical model addressed this question in a somewhat ambiguous manner when he coined the term, *Gegenwille* ('counter-will' in English) in order to locate the role of unconscious motivation and how intentions can be operative yet unknown to the subject (Leavy, 1988). The term 'will' has been marginalised historically by psychoanalysts for a variety of reasons. Being a verb as well as a noun, the term always implies a subject. When I do something that I claim I didn't mean or intend to, it does no good to plead that blind, impersonal forces 'did' the act. Those so-called unconscious forces are me.

'Counter-will' served as an early marker for how Freud conceived the unconscious as a subject who *performs* acts about which the actor is to varying degrees unaware. Though this term endured for some twenty years, after 1912 it more or less disappeared as the generalisation collapsed into concepts like 'resistance', 'repression', 'unconscious conflict' and 'drive'. Freud's subsequent structural model cemented this process even further, with his explicit depersonalisation of unconscious agency in the language of 'id', 'superego' and 'defense mechanisms'. But the gain in specificity was accompanied by the loss of a *personal*, and thus responsible, will. As Freud pursued his project of establishing the empirical causes of symptoms, his earlier notion of the unconscious as a secret agent or anonymous ego—i.e., counter-will—receded into the background.

The tendency to depersonalise the unconscious has been more or less adopted by virtually all subsequent schools of psychoanalysis and adapted to their myriad conceptions of the unconscious. Its explicitly *impersonal* status has persisted while accompanied by technical interventions that emphasise impersonal dimensions to the transference, motivation, and resistance to such a degree that the person engaged in the process has effectively ceased to exist. Increasingly abstract and ever more arid conceptions of the unconscious have led to more and more impersonal and disassociated conceptions of the transference, and the accompanying treatment relationship. Yet the very concept of transference has not been completely embraced. It has even been criticised by some analysts as offering an all-too convenient defense for practitioners who are uncomfortable with the unavoidable personal engagement with patients that the intimate psychoanalytic situation fosters. For example, Chertok and de Saussure (1979) argue that Freud's conception of transference often serves, *'a defensive measure—a kind of prophylaxis that depersonalises the relationship and interposes a 'third person' between the patient and the doctor, like the duenna-nurse who peers over the gynecologist's shoulder during examination'*. Thomas Szasz (1963), back in the days when he was still a psychoanalyst, also alluded to the role of transference as a mode of defense when he observed that *'the concept of transference serves two separate analytic purposes: it is a crucial part of the patient's therapeutic experience, and a successful defensive measure to protect the analyst from too intense affective and real-life involvement with the patient'* (p. 437). Szasz avers, *'the idea of transference implies denial and repudiation of the patient's* ***experience qua experience****; in its place is substituted the more manageable construct of a* ***transference experience***' (p. 437). These authors suggest that the analysis of transference is employed frequently to help analysts who are uncomfortable with the personal intimacy aroused between themselves and their patients by attributing such feelings to transference, instead of acknowledging the emotions they genuinely feel for each other, or simply letting them be sans interpretation.

I suspect that a significant part of the problem derives from our conception of unconscious process and its role in our repression of the personal dimension to the treatment relationship. The term 'person', or *'persona'*, was first invoked in Roman

law to refer to citizens who possessed the right to vote in a democratic political process. To vote implied an agent who possessed sufficient autonomy to assume responsibility for the decision-making process in which he participated. Because a slave lacked such autonomy he was not deemed a 'person' and, accordingly, was denied the right to vote, as only persons (i.e., non-slaves) were granted these rights. Similarly, Freud, who saw the ego as slave or servant to unconscious processes, decided over time that the unconscious is not personal but impersonal, meaning analytic patients could not be held responsible for acts, thoughts, or intentions they are unconscious of harboring or committing *at the time* they commit them. Unconscious ideation becomes impersonal precisely when, and because, it lacks agency. In principle, such thoughts can nevertheless become personal again (or for the first time) once they become conscious and the person in question accepts responsibility for them. Yet the trend in contemporary psychoanalysis is to maintain the impersonal conception of the transference throughout the treatment experience, no matter what insights patients may have about the feelings they harbor for their analyst.

The psychoanalytic conception of transference phenomena characterises the patient's experience of, and attributions about, the person of the analyst as an inherently unconscious process. Efforts by relational analysts to render this dynamic more democratic have subjected the analyst to the same kind of scrutiny as the patient, but the notion of an explicitly personal engagement of the kind I am describing and that falls outside the purview of *technical interventions* is typically overlooked or rejected. Consequently, the psychoanalytic literature has tended to focus on transference-countertransference phenomena, their specifically unconscious function, and the ways that analysts are affected by their patients' projections. This has led to a consensus that analysts should focus their attention on analysing such projections while avoiding interactions of a personal nature which, by implication, are defined as *non-interpretative* communications because they do not speak to unconscious processes. To return to the slave metaphor, for relational analysts both analysand and analysts are enslaved *equally* by their respective unconsciouses, in an endless to-and-fro of intersubjectivity and infinite regress.

Consequently, all vestiges of the personal relationship shared with patients have been transformed into aspects of the patient's transference with the analyst and the analyst's countertransference with the patient, both of which are interpreted and analysed systematically. From a classical perspective, transference is conceived as a rarefied, trance-like state of childlike hypnotic regression that places the patient in a one-down position from which she cannot extricate herself, because she is always 'in' the transference, which she cannot, by definition, escape. This has the chilling consequence of perceiving the analysand as never really being the author of his or her experience, or a proper adult in an 'I-Thou' relationship, but the 'effect' of unconscious forces to which only the analyst is privy. The more recent relational and contemporary effort to extend this process to a similar analysis of the analyst's conscious and unconscious process only duplicates—but neither addresses or resolves—the problem.

These relatively recent developments fly in the face of a long history of analysts, going all the way back to Freud and Ferenczi, who embrace the concept of a personal or realistic component to the analytic relationship. Greenson, as Hoffman observed, focuses on what he calls the 'real' relationship as distinct from the transference, which pertains to perceptions by the patient that are deemed realistic rather than fantastic or inappropriate. In Greenson's depiction of the real relationship, however, he tends to focus on the patient's experience of the analyst, neglecting the analyst's relationship with the patient. Because the relationship between analyst and analysand is not symmetrical, the correlation between their respective positions is not identical. Whereas the patient's experience of the analyst is couched in terms of varying degrees of transference phenomena, the analyst's experience of, and behaviour toward, the analysand is couched typically in terms of technique, a circumscribed set of behaviours epitomised by interpretative strategies. The concept of countertransference similarly falls under the purview of technique, whether it is conceived as unconscious impediments to the analyst's optimal functioning in the analytic dyad, or as aspects of the analyst's conscious experience that conform to technical scrutiny. Increasingly, countertransference phenomena are defined simply as the totality of the analyst's experience, including what used to be deemed 'personal' reactions, but subsumed under technical oversight, eliminating a genuinely personal component to the relationship.

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In other words, most of what the analyst says nowadays is monitored by technical considerations, whereas anything of a personal nature—which is to say, anything that is uttered spontaneously and without calculated regard for its intended effect on the patient's transference—is virtually eliminated. Greenson and other analysts who are concerned with distinguishing between transferential and real components of the patient's experience of the process do not address its correlate: *the technical and non-technical components of the analyst's behaviour.* It is this aspect of the

analyst-patient dyad that is the specific concern of this paper.

Even those relational analysts who object to the classical characterisation of the patient's transference as nothing more than distortions of reality tend to conceive most of the analyst's behaviour as aspects of technique. For example, Renik (1999) advocates acts of self-disclosure by the analyst and characterises such revelations as conforming to a technical strategy whose purpose is to exercise a desirable effect on the patient's transference, reminiscent of Alexander's advocacy of manipulating the transference in order to facilitate a corrective emotional experience. In such a scheme, the analyst's acts of self-disclosure are not, strictly speaking, personal but rather are calculated to have a specific effect. In order for such interventions to be personal they would have to emanate part and parcel from who the analyst is, not what the analyst does. Renik does not advocate self-disclosure simply because that is who he is, and he sees no harm in simply being himself. Instead, he contrasts self-disclosure with the idiosyncratic foibles of a given analyst's personality traits and characterises his self-disclosures as technical interventions. Renik argues that such self-disclosures should be adopted by all analysts, *as a new standard of technique.*

Yet, like Hoffman, Renik seems genuinely confused about the difference between the technical and personal domains of the analytic relationship. For instance, Renik says:

'My own style as a person, and therefore as an analyst, is toward the active, exhibitionistic rather than the reserved end of the spectrum. All things being equal, I usually prefer to mix it up with a patient and field the consequences rather than risk missing out on an opportunity for productive interchange. By suggesting that the analyst play his or her cards face up, however, I am not rationalizing my personal style or elevating it into a technical principal. ***Willingness to self-disclose, as a policy, can and should apply across the individual styles of various analysts***' [emphasis added] (p. 531).

Despite Renik's claim that he is not elevating his personal style to a technique, as soon as he advocates this way of working for *all* analysts he is not suggesting that they be like him, but that they adopt a manner of working—by definition, technique—that he believes will bear greater analytic success. If Renik put his observations down to an attribute of his personality, that that is simply who he is and he adapts his technique to fit his personality, then he would be explaining how conducting analysis suited him, period. But as soon as he advocates his interventions for all he is advocating a technical intervention. As a technique that he advocates for others to follow, it is no longer a character trait but the application of his mind and comportment in the analytic situation.

The specifically personal dimension to the analytic relationship

What would behaviour of a personal nature look like in contrast to a prescribed set of techniques? And how would such behaviour be beneficial to the patient's treatment? Am I merely splitting hairs by attempting to distinguish between analytic behaviour of a personal rather than technical nature? I don't believe so. The recognition and elaboration of the personal relationship obviously should *enhance* the therapeutic process, not compromise it. Acting from the analyst's person simply for the sake of it would not make much sense if it had a deleterious effect on the treatment relationship. On the other hand, if its aim is to benefit the analytic process, then why wouldn't such personal engagement—on a par with Renik's definition of self-disclosure—entail a *technical* intervention, by definition?

The problem with conceptualising the personal engagement that all analysts experience with their patients as a component of technique is that in order to come across as a genuine person analysts need to be true to their given personality traits and behavioural characteristics, whatever they happen to be. In order to be genuine, the analyst's way of conducting him or herself should be natural, spontaneous, and without guile. The most common complaint patients typically make about analysts who conform to classical technique is the *lack of genuineness* concerning the way they conduct themselves.[2] Yet, one of the principal goals of analytic treatment is to increase the patient's capacity for genuineness in their manner of relating to others, as well as themselves. On the other hand, those analysts who object to a classical or austere way of behaving with patients and advocate doing the opposite, e.g., affecting a more conversational and emotional engagement with their patients, invariably argue that *all* analysts would be advised to behave that way, even if such a way of behaving feels out of character or unnatural to a given analyst. It is my impression that most analysts are not naturally talkative, nor do they wear their hearts on their sleeves. For them, being 'themselves' might well entail remaining silent throughout most of their analytic sessions, not because their technique tells them to, but because that is what they are comfortable doing, with more or less everyone. To become talkative and responsive would not only feel unnatural to them, it would also be experienced by their patients as contrived and artificial, perhaps weird. Winnicott is a perfect example of an analyst who learned over many years the value of saying little, yet was regarded by all who saw him in treatment as uncommonly considerate and genuine. Analysts typically connect with their patients in ways they are not entirely aware of because, in so doing, they are just being themselves, whatever that entails. By extension, an analyst cannot be him or herself and conceive doing so as a *standard of technique*. Being oneself is, by definition, personal. As such, it is an act of creativity that is *uniquely one's own*.

So what is the criteria for being oneself that most analysts find so objectionable that it has been factored out of the psychoanalytic treatment perspective? Unlike the techniques that analysts adopt, *there cannot be universal standards* for how a given analyst uses his or her personality in the treatment of each patient. Freud wasn't even comfortable with mandating strict standards for his technical principles, let alone the personal ones! As a rule of thumb, what is deemed personal is common-sensical, if not immediately

predictable or obvious. It is both outside technique and subject to individual variation. It cannot be codified because, just as analysts differ from person to person, each analyst's conception of the personal relationship will vary accordingly. Moreover, analysts are liable to form different conceptions of what the personal relationship entails at different stages of their careers and with different patients, when they succumb to this or that mood, the time of day, how long they have been working with a given patient, and so on.

For the personal relationship to be spontaneous, unpredictable, and authentic it has to be free of contrivance and subterfuge, a manner of being that, for lack of a better word, comes from the heart. This is why the most common incidence of the personal relationship is often manifested in the form of *spontaneous conversations* that evolve between analyst and patient. Such conversations may include self-disclosures by the analyst, but not necessarily. The basic idea is that not everything the analyst says is limited to offering interpretations, eliciting data, or other technical considerations. Classical analysts tend to reject conversation out of hand because they believe 'conversing' has no discernable role in the analytic process, whereas relational analysts tend to reduce such otherwise spontaneous conversations to a technique that can come across as contrived and manipulative. Conversations are obviously gratifying for patient and analyst alike and are necessarily restrained by the use of abstinence, but to abandon them entirely becomes artificial for those analysts who, like Freud and Ferenczi, are naturally conversational. For example, there are times when patients may want to muse about ideas, whether philosophical, literary, or spiritual, when reflecting on the human condition and their place in the scheme of things, and ask their analysts to reciprocate. Analysts may in turn participate in such conversations without the need to reduce such musings to manifestations of transference and analyse them accordingly. Some analysts may even initiate such conversations when the spirit moves them to, for reasons that are not apparent to them at the time. It is my sense that such spontaneous, inherently extra-analytic exchanges have a profound impact on the analytic relationship and, hence the outcome of treatment, but in ways that we may be incapable of determining on a case-by-case basis, let alone moment-to-moment.

Permitting one's personality to become part of the constellation of elements that analysts utilise serves as an invaluable source for authentic relating with patients. *It is my thesis that these incidents of feeling genuinely connected to one's analyst are critical, if unconventional, even controversial, components of every successful treatment experience.* Because each analyst's personality is unique, each analyst's manner of personal engagement with patients will vary. Feeling free to converse spontaneously is only one personality trait among many that cannot be reduced to technical edicts. For example, a given analyst's capacity for affection, disaffection, concern, kindness, courage, consideration, compassion, curiosity, and wisdom are all personal characteristics that will differ fundamentally from one analyst to another. Moreover, such characteristics cannot be taught in psychoanalytic institutes, nor can they be learned in supervision. You might say they are so personal that each analyst has to struggle in her own analysis to discover which ones epitomise the peculiarities of her own personality, and determine those that are strengths and weaknesses by developing her clinical style accordingly. They are not only traits of personality, but part-and-parcel aspects of the analyst's *way of living* and operative in all aspects of it, including the relationships that are fashioned with one's patients.

The role of character in the personal relationship

Of all the psychoanalytic perspectives that have emphasised the role of the personal relationship, the interpersonal and existential perspectives are the most explicit in addressing this aspect of the analyst-analysand relationship. This is not to suggest that other perspectives have neglected this issue. On the contrary, there is a rich psychoanalytic literature that both addresses and advocates the role of the personal relationship in the analytic process, as I noted above.[3] The existential tradition has even questioned the efficacy of making clear-cut distinctions between the personal and transference relationships.[4] Historically, existentialists have tended to avoid terms like 'technique' and instead focus on the phenomena that the patient is aware of and not aware of—what is accessible to awareness and what is not.[5] The fact that analysts occupy a necessarily professional role in their work does not imply that the relationship fashioned with their patients is not personal. Yes, there are professional relationships that do not occasion a personal dimension. For example, x-ray technicians in a hospital setting may have little if any opportunity to engage in personal conversation with their subjects because they can carry out their role with minimal if any personal contact. Psychoanalytic relationships, however, cannot avoid such contact because the personal medium of engaging in conversation is the essence of their professional activities. The boundaries between the personal and professional are evolving constantly in ways of which we are not entirely aware.

It should be apparent by now that the character, or person, of a given analyst is of critical importance to how that analyst's patients will experience and benefit from that relationship. Whereas technical principles are indispensable to every analysis, the question I am addressing is the often neglected, but equally important, issue of the analyst's unique personality and attendant character traits. For some analysts—and I would include myself among them—the role of the analyst's character is of far greater importance than the technique a given analyst opts to employ. While it would be a challenge to substantiate this claim empirically, I believe it, nevertheless.

That being said, the psychoanalytic conception of character has been pathologised historically as embedded structures of the personality that compromise the individual's ability to obtain maximum gratification from

or adaptation to life. Freud employed the word 'character' in two distinct ways. In his earlier writings, but also sporadically in later papers, he referred to character in the sense of a virtuous, upstanding individual, but the vast majority of his publications refer to it in the second sense, as a form of psychopathology that is embedded deeply in the patient's personality. The first to catch his attention was the obsessional type, soon followed by a host of others and expanded on subsequently by a succession of new generations of analysts. Because they are so deeply embedded the individual is profoundly adapted to a given constellation of character types, e.g., hysterical, obsessive, schizoid, narcissistic, paranoid and so on. The notion that character may refer to features of one's personality structure that are inherently *virtuous* is not a typical preoccupation of contemporary psychoanalytic literature or nomenclature. We speak in an off-hand way of a person possessing good character or strong character to signify an individual of exemplary moral fiber who epitomises excellent values, such as the ones I listed above, e.g., kindness, generosity, courage, integrity, honesty, resolve and the like. But these examples of character are usually invoked only when employing non-technical terminology about the patient, somehow outside the analyst-patient dynamic.

Though Freud referred to his first use of character only fleetingly (see, for example, Freud, 1905), he never abandoned his belief that virtuous character traits are an indelible ingredient of every successful analytic treatment. He perceived the British, for example, as a culture he admired for possessing 'excellent character'. Moreover, he believed that candidates for analytic treatment should possess a degree of good character, but the precise character traits they should exhibit are left for us to ponder. Since Freud analysts have tended to remain silent about such expectations. As the treatment of severe psychopathologies (e.g., schizoid, narcissistic and borderline character structure) has increasingly dominated the psychoanalytic literature the question of analysability has receded into the background. Freud questioned whether schizoid and narcissistic patients could be analysed because he believed they were too self-absorbed; yet this assessment was based on their pathology, not their character, specifically. Freud's focus, as we know, was on neurotics, yet many of them he deemed 'good for nothing' and unsuitable for the kind of perseverance, honesty, and will that he expected analytic patients to embody. These character traits were, in his way of thinking, independent of the pathology (whether neurotic or psychotic) a given patient suffers.

Similarly, Freud (1913) expected analysts to possess an even higher degree of virtue than the patients they treat, most prominent among them honesty.[6] Freud didn't say a lot about honesty because it is not a matter of technique but concerns the analyst's personality. He or she either has honesty or not, but it cannot be turned on or off like a switch, or learned via a course of study. Moreover, analysts who do not possess a high degree of character will find the trials and demands of analytic work not to their liking. They may well succeed in becoming analysts, but it was Freud's opinion they will not be very good at it because they will serve as poor role models for their patients. Until recently, analytic institutes assessed for character in screening prospective applicants for training, but increasingly this question is omitted from consideration because character is so difficult to measure and depends more or les entirely on the subjective opinion of the analysts conducting the interviews. Ironically, in order to make the admissions process less subjective and more democratic, the relevance of and preoccupation about the relation between the analyst's character and technique has receded into the background.

Even if personal virtue cannot be taught, the concept can be and should be included in the curriculum of psychoanalytic institutes. Though we cannot 'learn' to be virtuous, we can raise our awareness to those aspects of our personalities that disclose our attitudes about our work and frustrations and the role our character plays in many of our notions about theory and technique, the kinds of patients we like to work with and those we do not. Given the vast amount of literature on character pathology, it would also be instructive to distinguish between the two types of character I have been discussing, including their relationship to personality (now employed more or less interchangeably with character), and what I have been depicting as the personal relationship.

So what is the criteria for being oneself that most analysts find so objectionable that it has been factored out of the psychoanalytic treatment perspective?

In conclusion, the capacity to acknowledge the existence of a personal relationship with one's patients, and the wherewithal to freely engage it in a manner that complements the specific needs of each treatment situation, lends a dimension of genuineness and authenticity to the relationship that has profound implications for the way the analysis is experienced, and even how technical principles are applied. Fortunately, most analysts know this intuitively—if not deliberately—and conduct themselves accordingly.

Footnotes

1. Though this term is rarely invoked nowadays, it has been replaced here and there with terms such as the personal or real relationship, or the working or therapeutic alliance.

2. For an illuminating example of such complaints, see Daphne Merkin (2010) in a recent article in *The New York Times Magazine,* August 8, 2010, pp. 28-47.

3. For example, see Ticho (1982); Ticho and Richards (1982); Gill (1988); Gitelson, (1962; 1952); A. Reich (1958); Bouvet, (1958); Nacht (1958).

4. See Laing (1967); Tillich (2000); and Buber (1970) for informed discussions concerning the personal nature of every therapeutic encounter.

5. See Askey and Farquhar (2006) for an illuminating review of existentialist and phenomenological critiques of the unconscious.

6. See Thompson (2004) for more on Freud's views about honesty.

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