Theories of therapeutic action are shaped by underlying conceptions of the aims or goals of treatment, and aims, in turn, reflect both explicit and implicit beliefs about what is possible in human relatedness and how it is most desirable to live. Such beliefs are values. They are statements about what is important in life. While it is not often recognized, then, theories of therapeutic action are not only laden with values, but actually assert them.

It goes without saying that no psychoanalyst sets out to decide questions of values for patients. The analysand's autonomy has always been paramount. But theories of change are rooted in values, whether we like it or not. The way a particular analyst thinks and works nudges the patient toward living in one way and not another. There is nothing wrong with that. It is simply a fact, inevitable and, therefore, unreasonable to condemn. And so, while psychoanalysts will and should struggle not to decide questions for patients, they frequently cannot avoid favoring one side of the patient's conflicts over others. The scale will be tipped one way or the other, ceaselessly and inconspicuously. The analyst's task changes from the attempt to maintain that perfect balance Anna Freud (1936) first characterized as equidistance from the psychic agencies to the perception and acceptance of the inevitable imbalances in the analyst's attitudes and the

Dr. Stern is Supervising Analyst and Faculty, William Alanson White Institute, and Faculty, New York University Postdoctoral Program in Psychotherapy and Psychoanalysis.

I would like to thank Emmanuel Kaftal, Ph.D. and Stephen Mitchell, Ph.D. for editorial advice and help in clarifying certain points.
search for ways not just to extirpate them, but to incorporate them in clinical practice. The analyst's values, like countertransference and the analyst's own history, become not merely passive objects of investigation but inexhaustible sources of meaning.

Theories and facts are no less significant for being social constructions, though. They are not even any less true. This point is often lost in arguments over social constructionism, which is frequently characterized as nihilistic in such debates. It is not, or at least it does not have to be. Acknowledging that our values are probably limited to our place and time, in ways we cannot imagine, does not and should not make us think about them with any less passion or fight for them any less doggedly. Passionate commitment to a point of view is perfectly consistent with knowledge as a social construction. It's just that we must accept that the battle decides nothing for the ages; we are fighting for our views of what is true or best here and now, given all the circumstances in which we live and given our inevitable ignorance of some of the cultural factors structuring our views.

It is one thing, though, to point out the desirability of formulating the values inherent in our theories; it is quite another actually to accomplish the task. Implicit values are, by definition, invisible, and they stay invisible until one can imagine the possibility of an alternative to them. It is a Catch-22: You have to see an alternative to the implicit value before you can see the value itself, and yet you can't imagine an alternative without formulating what the alternative is alternative to. In the absence of explicit alternatives, the belief still exists, but as an unconsidered assumption. Such unconsidered assumptions can serve as reasons for any kind of experience, ranging from concrete perceptions to complex abstract phenomena. For example, people from Western cultures who oppose abortion are aware of the possibility of taking a different position, which makes their view a choice; we refer to such choices as commitments or opinions. The opinion is perhaps made thoughtfully, perhaps not, but it is an opinion nevertheless, because it could have been made otherwise. But consider the plight of the Polynesians who are said to have been literally unable to formulate a coherent perception of Captain Cook's ship as it sailed into their harbor, because they had no cultural preconception for the image. We can imagine that all people are ceaselessly in both positions, though of course we only know about the former.

Unconsidered
assumptions lie at the heart of the consensual realities of any culture, and consensual realities define the culture's psychic dwelling place. There is no winning freedom from culture, then, only in culture, and freedom from culture's structures and dictates can never be more than relative. We will always be blind to parts of life we don't even know enough about to wish to see.

The acceptance of unconscious processes and the psychic blinkers they force on human living makes it natural for psychoanalysts to keep in mind that culture's formative role is never fully visible. Social products, such as psychoanalytic theories, bear the same relation to culture that conscious beliefs bear to the individual mind. And so, like an analysand assessing his own beliefs, the adherents of a theory are in the best position to learn if they remain open to the likelihood that the ideas they embrace are partially structured by cultural factors so familiar and so much a part of the fabric of living that they cannot be articulated. In the words of the hermeneut Hans-Georg Gadamer, “prejudices, in the literal sense of the word, constitute the initial directedness of our whole ability to experience” (translated and quoted by Linge, 1976, p. xv). And again: “It is not so much our judgments as it is our prejudgments that constitute our being” (p. xvii).

Keeping in mind these limitations, I now turn to three broad models of therapeutic action and the therapeutic relationship, each the result of a definable set of values. Each set of values has been especially influential during a particular era. As successive models of change have arisen, the previous ones have not disappeared, only lost some of their influence, so that today there are adherents of all three.

Each model of change tends to build on those that have come before. The first model, interpretation, was the pad from which psychoanalysis was launched. Then, from the 1930s to the 1970s, developmentally based conceptions of the analytic relationship and therapeutic action flourished. These first two models are closely related to one another, because the second is not a clear departure from the first, but a commentary on it. Finally comes the social model of therapeutic action, or the model of continuous mutual influence, which also had its first incarnations in the 1930s and 1940s, but which has recently gathered steam, particularly over the last decade or so. The social model is a clear break from the first two, not attempting to
present itself as a commentary or a set of correlaries, but as a new set of ideas.

Recognizing our theories as social constructions is yet another incursion of mortality on pride. But accepting that even our best ideas are ephemeral is least painful and most natural for those analysts who already believe, no matter how capable and clinically astute they may be, that they are also—and that they have no choice but to be—routinely unaware of some of the most significant sources of their moment-to-moment participation with their patients. People who believe they don't necessarily know everything about what they are doing in a personal sense are in a good position to accept the likelihood that they don't know, either, everything that their theories are doing or what their theories may be leading them to do. For that reason, it is probably adherents of the social model of therapeutic action, based as it is in the idea of continuous, reciprocal, and not necessarily knowable influence between analyst and analysand, who will find it easiest to consider social constructionism.

I. The Interpretive Model of Therapeutic Action: Information from an Unimpeachable Source

In the first several decades of psychoanalysis, the link between values and theories of relatedness was obscured by the fact that psychoanalysts had only one way of understanding the latter. Freud's conception of relatedness was such a basic assumption and so in tune with the times that, like the islanders who could not see Captain Cook's ship, early psychoanalysts did not imagine the possibility of an alternative. In this scheme, the analyst and the patient each constitute a separate, self-contained psychic sphere, fueled, shaped, and motivated from the inside. Since all the most important psychological processes take place in this self-contained universe, it is conceivable that one can interact with another person without being basically affected. One experiences interaction with others in shapes supplied by one's own internal life. Except in the case of trauma, experience is said to be socially determined only very rarely.

As for the analyst: He has mastered a technique that is supposed to make it possible to exert even less direct influence on the shape of the patient's experience than other people do; he subtracts himself from
the social equation. As long as he behaves according to the prescripts of classical technique, the transference remains uncontaminated, leaving the analyst in a position from which he believes he can understand and interpret the clinical interaction as the relatively undiluted expression of the clash of the patient's internal psychic agencies. Transference in this model is distortion, and reality is singular. Cure is contingent on the patient's acceptance of the truth about himself. The analyst must be skilled not only in knowing and telling this truth, but in identifying for the patient the complex ways in which he resists it. In order to avoid undue personal influence, the analyst must keep close track of the conflictual elements of the patient's experience and avoid siding with one aspect of a conflict at the expense of another.

This model has endured into the present day, of course, though it has changed. In the first days of psychoanalysis, reality was simply the unvarnished truth, understood as a correspondence between what one believes and the “actual” circumstances of the (independently existing) world. The analyst had to decide what part of the patient's relatedness was distortion and what part of it was “real,” and then he had to correct the patient's errors of perception and understanding. Take the case of poor classic Dora (Freud, 1905), who was deeply distressed by what has been clearly visible to later commentators as her father's hypocrisy and willingness to see her exploited to serve his own purposes (e.g., Erikson, 1964), but who Freud dealt with as if her symptoms derived only from the vicissitudes of instinct. Freud constructed a version of reality without suspecting that he had exercised even an iota of choice.

And why should he have suspected such a thing? Like everyone else in that era, analysts seldom imagined that perceiving, absorbing, or sensing reality could be understood as a process of selection. Because reality was self-evident, any evidence of selection in one's picture of reality was also evidence of psychopathology. Therefore, it was only patients, not analysts, who played a role in establishing their own views of what was real. For analysts, reality was a given; it was simply and solely what they believed it to be. From today's perspective, cure in that time was often probably contingent on agreeing with one's analyst—more a matter of colonization, actually, than cure.

Eventually, philosophy changed, and so did psychoanalysis. Today, even those holding the most conservative intrapsychic views would
agree that the analyst is in no position to define for the patient what is real. Nor would conservative analysts even wish to exert such influence. Quite the contrary. Transference is no longer distortion, but an expression of psychic reality, and it is therefore neither right nor wrong, accurate nor inaccurate. The only question is whether the patient is able to acknowledge his own internal world, and therefore the analyst's only task is to learn the contours of that world. In this way, the conservative analyst may seem to have sidestepped what most contemporary thinkers have come to see as the arrogance of assuming epistemological authority.

Yet, unintentionally, analysts working according to the interpretive model do continue to judge whether the patient's psychoanalytically relevant knowledge and understanding correspond to a criterion. The operative version of truth is still correspondence theory. It's just that in this latter-day version the criterion is no longer external reality, but the patient's own inner world: psychic reality. Who decides when the patient has acknowledged psychic reality? Must it not be the analyst who plays this role? And is the analyst therefore not right back in the position of arbiter? Even if not enforcing a particular view of what is real in the external world, is the analyst not still in the position of having to decide for the patient what constitutes a full appreciation of the inner world?

The likely rejoinder would be that, by attending to transference, symptoms, character structure, and signs of anxiety, the analyst avoids claiming to be the only one who knows the nature of the patient's psychic reality. Observing these visible (and therefore presumably objective) indicators of unconscious conflict allows the analyst to plan interventions and judge progress without having to map the invisible inner realm. And let us also acknowledge that all analysts try to maintain a collaborative atmosphere. It goes without saying that analysts of any stripe want to share their observations, not impose them.

But even if we recognize the regularity of a collaborative atmosphere, and even if we acknowledge that psychoanalytic expertise is partially composed of the capacity to observe the relevant signs and symptoms, the problem remains. Even though the analyst no longer has to tell the patient what is real, he is left with another equally vexing problem of the same kind. Are transference, resistance, anxiety, and character structure really self-evident to the competent
observer? Who decides when the patient is exhibiting them? Who decides what view of the analyst and the patient himself is reflected in the transference? Who decides when any of these signs changes for the better or worse? Since, in the conservative view, these conclusions cannot be mutually constructed, the contemporary grounding of the interpretive model in psychic reality merely tosses the analyst out of the frying pan and into the fire.

Focusing on psychic reality, then, does not really relieve the analyst of ultimate epistemological responsibility; it merely shifts the problem sideways. As long as humans are understood to be self-contained units imposing the shape of life on the external world, and as long as it is conceivable for one party of a relationship to observe the other without being routinely affected or influenced by that other, therapeutic action must remain a matter of omniscient analysts impressing knowledge on benighted patients. Even a collaborative patient cannot participate on an equal basis.

The halcyon days of interpretive psychoanalysis coincided with the end of the era during which Europeans and Americans saw many of the rest of the world's cultures as primitive and in dire need of Western religion, morals, wealth, and industrialization. Precisely because they seemed to be so needy, these faraway people were seen as weak, incapable, and innocent. In the early part of the century, the idea that Europeans and Americans might eventually be able to establish a mutually beneficial two-way relationship with “primitive” peoples would have been outlandish. Today, we look back and reinterpret our desire to help as unwittingly patronizing. We see, too, even less savory aspects of Western motives, such as smugness, hatred of novelty, and rationalized greed.

But it was not only unacknowledged motives that were responsible for what now appears to us as our arrogance; it was also the unquestioned epistemology of the Western worldview, including the assumption that persons are self-contained units, and the belief that in any situation there exists a single truth. The West, of course, was in possession of that truth; it was only right to offer it to those unfortunates who lived elsewhere. As a result of this orientation, it was often difficult for Westerners to understand their reception in other cultures. That native inhabitants might feel not only equal to their visitors, but often vastly superior to them, would never have entered Westerners'
minds. And so when the perceptions of “primitive” peoples differed from their own, Westerners concluded that the primitives were in need of education and guidance. They needed to change and were therefore supplied with the appropriate “superior” knowledge. What followed, as we know, was sometimes more crusade than simple generosity.

I think it is not stretching things too far to compare the “education” of the third world with the provision of insight to analysands in the conservative intrapsychic model. In both, a benevolent authority attempts to impress the truth on those who seem not to know it, with the aim of bettering their lives. Of course, the differences are legion, so many, in fact, that it would be silly even to begin to enumerate them. I want to focus only, and very narrowly, on the conception of help underlying these two social arrangements. Are these two conceptions of help expressions of the same cultural themes?

I hope it is clear that, while I do not favor the interpretive model, I do not make this comparison with the intent of calling into question the motives of its founders and practitioners. At the turn of the century, people of the West could not imagine helping those they believed were in need, whether the needy were hysterics at home or “primitive” inhabitants of far-off lands, without treating them in a way we would today call authoritarian and condescending. Today, pure interpretation as the sole path to understanding, and as a set of role relationships in the consulting room, feels different to many analysts than it did to analysts a generation or two ago. To these contemporary analysts, the interpretive model is uncomfortable. It feels stilted and unnatural. It is like walking out in the street wearing the clothing of a different era.

II. The Developmental Model of Therapeutic Action: Picking Up Where Parents Left Off

The twentieth century is often described as the era of the self, the time during which personal experience has come to the forefront of social consciousness. In the eyes of some social commentators, the rise of the self, because it has drawn attention to the legitimacy of individual misery and thereby made entrenched group relations unjustifiable as reasons for social policy, is responsible for the various liberation movements in the West—civil rights, feminism, gay and lesbian
rights, and so on. The Vietnam War, fought to maintain the status quo in international relations, was opposed in America by people who believed that the individuals concerned, American draftees and Vietnamese peasants alike, should be free to choose their own destinies.

The list of events and movements that could be described this way is very long. I will leave it to social historians to make the case. For the present purpose, the important thing is to compare and contrast this growing respect for individual experience with the attitude of the Victorian era, during which the interpretive model and psychoanalysis itself arose. In those early days, while individual physicians were no doubt deeply concerned about how their patients felt, the explicit understanding of psychopathology—that is, the version that was written down and that therefore reflected what people of that time considered relevant—had very little to do with individual suffering and a great deal to do with mechanical malfunction, comprehensible in terms of objectively verifiable laws of nature. The interpretive model was invented to address this way of understanding psychopathology: the physician introduces the truth, and the pieces rear-range themselves into the correct order. Until the very recent past, therapeutic zeal, or an enthusiasm for cure, was considered bad form, a more naive and less worthy aim than simply locating the truth. Cure should take care of itself.

The transition from the interpretive to the developmental model is nowhere more eloquently or compellingly represented than in R. D. Laing's (1960 pp. 28-31) moving reinterpretation of an interview Kraepelin conducted with a schizophrenic patient. Basing his comments on a transcript Kraepelin himself published in 1905 (which Laing quotes in enough detail to make his point impossible to deny), Laing sees a continuous stream of unmistakably meaningful statements from the psychotic young man, many of them direct comments on his ongoing interaction with Kraepelin and the other doctors conducting the examination, where Kraepelin himself saw only a demonstration of the meaningless dysfunction of the mechanics of mind. Laing's orientation was existential, so it had little to do with strictly developmental views, but Laing is nevertheless very much an advocate of the developmental model of therapeutic action, because he focused, as Sullivan and Fromm-Reichmann had before him, on the self of the schizophrenic patient, and he believed that cure was rooted...
in the kind of understanding that can be accomplished only through authentic relatedness. The essence of the developmental model of change lies in the belief in the curative value of relationship. Kraepelin, of course, was a purely descriptive psychiatrist and not a psychoanalyst, which was part of the reason he was deaf to the patient's communications—but not all of the reason. He was also a man of his time. If social constructionism applies to one kind of professional, it applies to another, and Kraepelin did participate in the same Zeitgeist that informed the early years of psychoanalysis. Laing saw meaning in the patient's utterances because, unlike Kraepelin and the other physicians of that earlier day, he had the perspective that the schizophrenic man on display in grand rounds was not merely a walking illness, but a seat of individual experience, a person who, however psychotic he might be, still faced the same need the rest of do to make our experience comprehensible and to be understood. Laing writes: “One may see his behaviour as ‘signs’ of a ‘disease’; one may see his behaviour as expressive of his existence.” And then: “He wants to be heard” (p. 31).

So through the perspective of the individual self, suffering and its alleviation became more important in both psychoanalysis and the surrounding culture. But that was not the only set of influences that would change psychoanalysis in these years. A growing interest in psychological development was natural in the psychoanalytic literature of the years after World War II. The culture was deeply immersed in building families and homes and rebuilding Europe. After the senselessness and brutality of the war years, people longed to immerse themselves in family matters, which were portrayed in the popular entertainment of the 1950s as serene and untroubled. A reaction formation rooted in a belief in perfect nurturance and rational authority was the order of the day in America.

Ego psychology was in full stride. There was a new fascination with the maturation of cognitive and emotional faculties in both psychoanalysis and the wider culture (there had never before been a figure like Dr. Spock, because there had never been the demand for one), and there was a dawning recognition that the actual people and events in the growing child's life had a significant effect on these matters. The concept of development broadened and deepened far beyond the model of the psychosexual stages posited by Freud and Abraham.
Eventually, ideas of developmental deficit and corresponding corrective aspects of clinical psychoanalysis began to appear in the work of writers from a number of traditions. Psychopathology began to be conceptualized not only as the result of conflict, but also as the outcome of deprivations and derailments, essentially social in nature if not in effect, suffered in the course of development. More than that, the self began to be regarded, especially through the efforts of the English independent school of object relations, and then by the self psychologists, as the core of the personality, with its own developmental line. Many psychoanalysts were drawn to the perspective that, if the self was not disrupted by untoward influences during the early years, it would naturally unfold into the wellspring of the personality, the origin not only of the sense of identity and continuity, but of healthy interpersonal relatedness, ambition, self-esteem, agency—and even desire.

The model of the analytic situation also changed and in the same directions. The strictly hierarchical and somewhat severe arrangement of the interpretive model, less acceptable in a world that wanted nothing to do with Germanic discipline, slowly yielded, supplemented by conceptions and clinical practices more and more frequently modeled on the nurturant aspects of the parent-child bond. That is, both developmental themes and the current suffering of the patient were more directly acknowledged in clinical theory. The analyst's authority remained in force, but there began to appear an explicit concern with tact and sensitivity and with providing the analysand with an atmosphere of emotional safety. There was much more concern that the analysand feel understood, not just capably treated. While it was no doubt always true for many analysts, it began to be acknowledged in the literature more and more frequently that the quality of the relationship between patient and analyst was an important determinant of treatment outcome. The dialectic between insight and new experience, the theme of the literature on therapeutic action ever since, had been established.

I have so far emphasized the differences between the developmental model and the interpretive one that preceded it, but it is just as true to say that the two share certain vital interests. Both are firmly rooted in the romantic and modern rebellions against classicism, the worldview according to which beauty and truth value are less a matter of
substance than of adherence to accepted canons of form and expression. A piece of art, for instance, is judged in classical terms by how fully and beautifully it embodies these standards. An individual life was much the same. How well a person lived had everything to do with how well he appeared to live, that is, how well he embodied canons of proper behavior, not (as the romantics and modernists thought about it) how fully he experienced. At least part of the reason Freud's doctrine of infantile sexuality was so shocking, for instance, was the stifling propriety of the age. Individual expression, then, is just as frowned upon in the classical view as it is central to the psychoanalytic vision. For psychoanalysts, the secret and agonized romantic self has always been the heart of the matter. Psychoanalysis has always been sympathetic to the modernist vision, too, because modernists, while they are not averse to assigning a high degree of significance to form and do not place the same emphasis on the self as hidden or secret, are just as committed as romanticism to the truth of the self, that is, individual perspective. Cubism is one good example; psychoanalytic treatment is another.

And so the developmental model of therapeutic action was really a commentary upon the interpretive model, a dialogue with it, not a displacement of it. There is no better illustration of this point than Macalpine's (1950) classic paper on the development of transference, in which the author suggests that transference is not a spontaneous eruption of the neurotic personality, but the patient's forced adaptation to a rigidly infantile setting—infantile not by conscious design, perhaps, but that much more perspicacious for having to await its theoretical justification until the role of development could be spelled out. A common attitude in the literature of the developmental model of therapeutic action is that previous ideas were entirely right, but perhaps—understandably—not for all the reasons visible to psychoanalysts modern enough to grasp the significance of development. Thus, in the same article in which he contributes a set of developmental and relational ideas about therapeutic action that might very well be described as new, Gitelson (1962) also writes, “I think that in the existing form of the analytic situation, without benefit of the corrections and admonitions which it has received in recent years, there reside all the ‘curative factors’ which neo-analysis in its various forms presumes to have discovered” (p. 196).
The general underlying psychoanalytic theories of the two eras, then, drive and ego psychology, along with their respective theories of therapeutic action, are defined as much by their relation as by their difference: The truth is not the father, but the mother; psychopathology is not only oedipal, but preoedipal; development is not just a matter of how drive is handled, but is just as significantly the history of defense and the other ego functions. In terms of therapeutic action, we can say that while the patient's feeling of being understood becomes more important in the developmental model, the content of that understanding remains predictable to the analyst, just as it was in the interpretive model. Theory, that is, still allows the analyst to know the truth. The developmental model of therapeutic action represents an example of theory building according to the “strategy of accommodation” (Greenberg and Mitchell, 1983): As novel findings and new points of view arise, the old point of view, if it is to last, changes to accommodate them, but without relinquishing its central tenets. In the process, at least until the point at which contradictory new findings make the old theory impractical or unwieldy, accommodation allows old theories to stretch into richer and more complex forms.1

In the new atmosphere of the developmental model, more experiential aspects of cure took their place beside the interpretive process. In England, and then in America, the concept of therapeutic regression began to be accepted not only as a means of dispelling poor resolutions of oedipal conflicts, but as an actual developmental event, a reliving in the analytic situation of certain primitive and unstructured states. Contrary to the most orthodox theory, according to which mutative effects in the analytic situation, apart from interpretation, were uniformly dismissed as transference cures, in these new ideas the analyst was thought to have the opportunity, if the transference was properly managed, to offer the patient growth-promoting experiences in the here-and-now. The natural unfolding of self development was to

---

1 This point gives me the opportunity to add that a differentiation should be made between the interpretive certainty of the ego psychologists of the first generation and the object relations writers of the present day, both of whom qualify as practitioners of the developmental model. Some contemporary object relations writers have rejected the old idea (the analyst knows the truth and merely awaits the patient's capacity to tolerate it) no less thoroughly than practitioners of the social model—though not often for the social analyst's reasons (which I will get to in the following section). In a recent book review, for instance, Adam Phillips (1993), remarks that, “Like too many psychoanalytic books, [this one] is for people who like believing that we are all really the same, that there's only one story and we already know what it is” (p. 9).
be set back on track. In some quarters, profound regression, even to the point of psychosis, was celebrated as a state of innocence and internal chaos, a new beginning that some patients simply had to go through prior to the restructuring of recovery. Generally speaking, the analytic situation became “softer” and more intentionally indulgent and nurturing. The strictest injunctions against transference gratifications began to be laid aside or simply ignored. The analyst began to be understood, at least during certain crucial moments in the treatment, as a genuine and particular person in the patient's life. Some analysts began to think of transference not only as an expression of the most conflicted aspects of the inner life, but also, in favorable cases, as a more benign and constructive version of the original relationship with the parents. If the excesses of an era reflect its themes in high relief, then it was no accident that Alexander published his theory of the corrective emotional experience during these years.

Psychoanalysis, then, was more and more frequently portrayed as a process of maturation, a matter of resuming arrested development through an attachment to a benign parental figure who offers a kind of experience that may actually be new but is at the very least the necessary condition for change. Let me offer just a few of the best known and most influential examples of these views. Spitz, fairly described as the father of the movement, was responsible for the immensely important observations of hospitalism (1945) and anaclitic depression (1946), as well as the later influential conception that the analyst's supportive, parental “diatrophic function” (1956) makes the patient's analytic commitment possible. Gitelson (1962), claiming that “the patient who presents himself for consultation, and whom we see in the first phase of analysis, is like the child whom we must ‘lift to a secondary level of development’ “(p. 196), goes on to suggest that the analyst must offer “fostering influences of the kind which emanate from the effective mother during the child's early development” (p. 199). Nacht (1962) writes that the many patients who have been traumatized by actual (as opposed to psychic) reality can be helped only “… if the analyst's attitude of gratification, experienced as the longed-for love of the parents, constitutes what I have called the indispensable ‘reparative gift’” (pp. 209-210). Balint (1969) bases his understanding of psychopathology in the “basic fault” and prescribes the analytic experience of “benign regression.” Winnicott's (e.g., 1958,
commitment to the centrality of maturation and direct environmental participation in development and in psychoanalysis is particularly well known, and following and elaborating upon his example, we can count (among others) Khan (e.g., 1960, 1963, 1964) and Milner (e.g., 1969). For Loewald (1960), too, the parent-child relationship serves as a model for psychoanalysis, because like the parent, the analyst needs to see the patient as he is while mediating a vision of what he could be. And Kohut (e.g., 1971, 1977), of course, though he was not the first theorist of developmental deficit, was the greatest influence in sparking the debate over both the developmental and clinical issues. Kohut originally described the selfobject as a person who was sufficiently responsive in just the ways the parents were not.

It is tempting to speculate that all these recommendations of love and nurturance derive from a single underlying, organizing cultural theme having to do with the natural development of the individual self and the care and succor to which the self is entitled. Whether or not one agrees with this hypothesis, it is at least clear and visible, that is, knowable, which it may not have been during the decades in question. If it were to have been stated in those years, it would be unlikely to have been described as a social construction, but rather as an inescapable aspect of the human condition that was only then being fully articulated.

Today, though, especially for the generation that was young during the 1950s and 1960s, irony, sly humor, and relativism are the tenor of the time. And if these attitudes seem shallow or mysterious to the generation that came before (and are questioned even by those who find—sometimes with surprise—that they hold them), the so-called baby boomers themselves, when they observe the generation coming up behind them, are wistful for the culture's previously unquestioned idealization of love and nurture. Among youth, even open displays of affection are unfashionable—unless the affection can be justified as sensuality. Watching MTV for half an hour will dispel any doubt about this point.

In this very different world, linking divergent cultural expressions—in particular, what in years past would have been called high and low culture—no longer implies either disrespect of fine art or the attribution of profundity to popular culture. Thinking this way is natural to the generations born during and after World War II, as natural,
ironic, funny, and valid, for example, as a recent volume, a serious venture by a well-known art book publisher, presenting reproductions of paintings of Mickey Mouse that have been done over the last several decades by widely respected artists. We cite context more, eternal verity less. We begin to take the perspective that, until proven wrong, we should expect to find evidence of unexamined assumptions in truths that seemed immutable only yesterday. We struggle to see how we remain buried in what is so familiar that we take it for granted. Cherished beliefs are suddenly open to question, and we turn back on our own experience with increasing regularity. We find ourselves engaging in ceaseless commentary and reflection. We have entered the postmodern age; in psychoanalysis, we approach the social model of therapeutic action.

**III: The Social Model of Therapeutic Action: The Analysis of Continuous Mutual Influence**

The social model of therapeutic action bears a different relationship to the interpretive and developmental models than either of these earlier models bears to one another; for just as postmodernism is not a commentary on either romanticism or modernism, but a step outside of both, the social model is not primarily a commentary on previous ideas about change. While the theoreticians of the social model and the clinicians who use it share with their theoretical forebears the concepts of unconscious processes, transference and countertransference, and resistance, they do not define their ideas as extensions of what has come before, but as something new. Their work is defined against the background of older ideas, not in dialogue with them.2

Though it was probably suspected by almost no one at the time, the beginnings of the social model sprang forth all at once in the independent reconceptualizations of countertransference that arose in the early 1950s in England (e.g., Winnicott, 1947; Heimann, 1950; Little, 1951, 1957), South America (Racker, 1953, 1957), and the United

---

2 Emmanuel Kaftal, Ph.D. suggested the idea that the developmental model is a commentary on the interpretive one, while the social model is essentially different in this respect. Dr. Kaftal also suggested that the first two models share in the romantic and modern rebellion against classicism. In referring to the social model of therapeutic action, I mean to establish a continuity with what Hoffman (1983) calls the “social paradigm” of transference-countertransference.
States (e.g., Berman, 1949; Fromm-Reichmann, 1950, 1955; Cohen, 1952; Crowley, 1952; Thompson, 1952; Tauber, 1952, 1954; Colm, 1955; Tower, 1956; Wolstein, 1959). Without their express intention, and in many cases actually contrary to their beliefs, these writers were among the first psychoanalysts to question whether the individual self ought to be considered the sole source and engine of experience.3

It had long been held by some analysts, primarily those of the American interpersonal school (e.g., Erich Fromm, Frieda Fromm-Reichmann, Clara Thompson, and Harry Stack Sullivan), most of whom, following Sullivan, conceptualized human relations in terms of field theory, that the analyst had no choice but to be a real person in the treatment situation, and in the patient's experience, and that absolute neutrality and an “uncontaminated” transference therefore made no sense. The actual person of the analyst, that is, directly influenced the patient's experience.

It was entirely consistent with field theory for the patient to exercise the same kind of influence on the analyst. In fact, in retrospect, we can see that field actually demanded social reciprocity. But both classical psychoanalysis and the cultural definition of expertise (expertise being equated with uncompromised objectivity) were inconsistent with the analyst's vulnerability to the patient's influence, and so, for some years, even among the field theorists of psychoanalysis, the social understanding of psychoanalysis remained incomplete.

During the 1960s, interest in countertransference broadened, and in the 1970s it became a flood (see Epstein and Feiner, 1979). By the early 1980s, the idea that countertransference is inevitably informative was commonplace. While there were still opponents to the idea (and of course there still are), every analyst by then was familiar with it, at the very least. Pulling together the work of writers from many psychoanalytic perspectives, Hoffman memorialized the seachange in 1983, dubbing those who accepted social reciprocity as “radical critics of the blank screen model,” and counting among them Ehrenberg, Feiner, Gill, Heimann, Issacharoff, Levenson, Racker, Sandler, Tower, Searles, and Wachtel. Today, the list is much longer.

In the social model of therapeutic action, because of the existence of continuous mutual influence, much of which is unconsciously

3 Recently, it has become clear how much credit Ferenczi (1932), deserves for originating these questions and for offering novel and radical answers to them (Aron and Harris, 1993).
transmitted by one party and unconsciously received by the other, both analysts and patients are understood to be continuously embedded in certain social aspects of their own experience. That is, some portion of what is most significant in one's experience of the other and in the meaning of one's own social conduct is always invisible to oneself. It may be visible to the other person, though, so that analysts working with the social model of therapeutic action elicit the patient's transference perceptions not only to interpret them, but also to understand what they themselves are up to—not only in experience, but in their behavior as well. The concept of acting out has come to resist easy definition, because all conduct now qualifies (see especially Levenson, 1979). Interpretation itself becomes suspect because the analyst can no longer believe that saying something to the patient is simply a matter of conveying content. Like every other act, interpretation is part of a complex and only partially knowable interchange, and therefore the analyst may not be privy to exactly what he intends to accomplish by making a comment that he believes is nothing more or less than helpful and incisive (e.g., Levenson, 1972). For the same reason, the analyst cannot rely on taking any particular attitude toward the patient. The empathic attitude, or the empathic mode of perception, is no less likely to become embroiled in the interaction than any other kind of participation. Empathy can mask the analyst's aggression or anxiety, or, through its unconsciously intended impact, it can muzzle the patient—not to mention the possibility that someone else might not even agree, in a particular instance, that the analyst's attitude is actually empathic. The same problems hold, of course, for the analyst's certainty that what he is offering is tact, support, an atmosphere of safety, a diatrophic presence, a corrective emotional experience, authentic relatedness, and so on. While many of these attitudes remain just as desirable as they always were, it is increasingly difficult to believe that the analyst can maintain them through the simple exercise of choice.

Then what is left for analysts to do? They do what is possible: They do their best to disembed themselves, which they accomplish by trying to specify the patterns of relatedness transpiring in the consulting room. They learn the unconscious assumptions that structure the tiny culture of analyst and patient. Eschewing the search for universal unconscious structures, they try to grasp what the anthropologist
Clifford Geertz (1983) calls, in a different context, “local knowledge.” The therapeutic ingredient is the insight gained in this way, along with the new experience that is the inevitable result of unpacking the interaction. In fact, if insight is seeing how one is embedded, it can only be accomplished in the context of a new experience, because the old one, by definition, does not allow it.

It is sometimes possible to describe these small installments of therapeutic change after they have happened, but it is very difficult, perhaps impossible, to do the same thing prospectively—that is, to say how such events can be made to occur. Theory of therapeutic action was simpler in the earlier models, because if the patient could not understand, it was presumed that the analyst could, or if the patient needed the analyst to provide a certain kind of environment, the analyst did. But now that the range of the analyst's choice, too, is limited and the analyst is embedded right along with the patient, the old solutions just do not work. How can we see what we cannot see? How can we say how to see what we cannot see? This problem is the central challenge for the social model of therapeutic action; though, because the problem is a paradox, it probably has no single solution. The only way to attack it is to formulate esthetically and emotionally satisfying ways of talking about it. The closest I have been able to come is to refer to the process as “courting surprise.” The analyst can prepare the ground, trying to open himself as fully as possible to an awareness of the presumptions that structure his experience with the patient, but the mutative event itself, that is, the explicit awareness of these preconceptions and the new kinds of interaction that such awareness makes possible, cannot be made to happen. These events can only be unexpected. They are surprises, and surprises are unbidden (Stern, 1990). The process of change is inherently mysterious.

So while analysts are still the experts in the room, it is no longer because they know exactly how to relate or exactly what to look for in the patient's experience—or in their own. Rather, they know how to look. They know to expect to be entangled and to expect to have trouble seeing the tangle and digging out of it. They are often unsuccessful, or rather, they may be unsuccessful for long periods. But when they are successful, disembedding themselves helps their patients do the same (e.g., Racker, 1953; Levenson, 1972, 1983, 1991; Sandler, 1976; Feiner, 1977; Symington, 1983; Hoffman; 1983, 1991, 1992a, b).
Experience that had never been formulated enters the realm of language and can finally be reflected upon by both participants. This “act of freedom” (Symington, 1983) increases the analyst's range of choice vis-à-vis the patient, of course, but more importantly, it increases the patient's range of choice as well, because it takes both participants to maintain the unwitting repetition of old patterns and experiences of relatedness. Once the analyst finds his way to kicking over the traces, the same old unwitting kind of relatedness becomes impractical and unnatural, even unpleasant, for the patient as well. Such a process takes place in response to every novel and convincing interpretation of the transference or the countertransference—which are, coming 360 degrees, those same disembedding moments that cannot be made to occur.

As I have said, the social model of therapeutic action is defined against the background of the two earlier models, rather than in dialogue with them. On the other hand, the prior models are the social model's predecessors, even its progenitors, and we know that as different as one generation may be from the next, it is equally true that the apple never falls far from the tree. We should therefore ask how the social model has incorporated essential aspects of the earlier ones.

The contribution of the interpretive model is easy to point to: the analyst's interpretive activity is just as important as it ever was; it's just that the truth value of the interpretation and the analyst's unconscious intention in making it are always in question. The influence of the developmental model is more difficult to specify, but not because of any fundamental disagreement. Rather, advocates of the social model have yet to offer a thorough description of how the patient's feeling of safety can be conceptualized and facilitated in terms that do not require the analyst to adopt and maintain a particular stance toward the patient.

There have been some attempts in this direction. Recognizing the absence of a consideration of the patient's feeling of safety in Harry Stack Sullivan's work, Bromberg (1979, 1980a, b) integrates Sullivan's interpersonal thinking with the kind of therapeutic regression described in the literature of the English independent group of object relations writers. In more recent work, although he dispenses with explicit consideration of Sullivan, Bromberg (1991, 1993, 1994)
continues to marry interpersonal thinking with the developmental model's central concern for the patient's feeling of safety. Hoffman (1983), claiming that all patients know "at some level" that they create in the analyst an experience reciprocal to the transference, suggests that an interpretation of the transference is the only genuine reassurance the analyst can offer that he is not "drowning in the countertransference" (Racker's phrase). The patient senses, that is, that if the analyst can interpret the patient's experience of him, he is not on the verge of acting directly on his own experience of the patient, so that a transference interpretation is a (momentary) reassurance of the safety of the situation. The essence of Hoffman's point of view is the recognition that the analyst cannot be expected to maintain any particular attitude toward the patient, but Hoffman does not go on to address, as Bromberg does, the creation of an enduring atmosphere of safety in the treatment. The issue of the patient's emotional safety thus remains to be adequately addressed in the terms of the social model. Given the burgeoning interest in conceptualizing therapeutic action from the social perspective (e.g., Hoffman, 1993; Mitchell, 1994), though, this lack no doubt will be remedied in the near future.

For most advocates of the social perspective, memory is no longer fixed: a memory cannot be depended upon to be the same whenever it is accessed. Differences in a memory from one occasion to another do not necessarily represent the traditional distorting effects of defense. Memory is, instead, understood as a creation of the present, constructed to satisfy present purposes, and present purposes are, in turn, understood more broadly than traditional concepts of defense would suggest (Hirshberg, 1989; Stern, 1992). But given this substitution of a constructivist theory of memory for the older trace theory, the patient's history retains the traditional degree of significance in the social model of psychoanalytic change. Contemporary interpersonal patterns, articulated for the first time in the treatment, are understood as outcomes of the patient's significant relationships, especially those early in life.4 Unconscious processes, too, retain the traditional degree of significance, because one's history leaves one motivated to dampen interest and curiosity about certain aspects of what transpires between

---

4 The plasticity of memory is limited, of course. Constructivist theory is perfectly consistent with the recognition that stretching a memory past a certain point results in delusion. I should also add that there are practitioners of the social model (e.g., Levenson, 1990), who do not accept constructivist principles.
oneself and other people. Much of what is usually understood to be repressed, however, is conceptualized as unformulated, that is, as never having been known (Wolstein, 1982; Stern, 1983).

While interpretation, history and memory, the feeling of safety, and unconscious processes must be redefined to be used in the social model, they retain their degree of significance. But when we come to the concept of the self, the social model suggests a shift of greater magnitude. Until recently, we have assumed that the interiority of the self is inevitable and immutable and that the dual conception of individual uniqueness and agency are aspects of the natural world, simply part of the universal human equipment and, therefore, an immortal idea. It seems not to be. We are moving toward a conception of the self as manifold (Mitchell, 1991), as a collection of characteristic ways of dealing with certain kinds of interpersonal situations—the self, that is, as a set of socially defined roles experienced under the single umbrella of personal being. Writers with very different perspectives and sensibilities are converging on this view (compare, for example, Harré, 1984 and Curtis, 1991). In Kenneth Gergen's (1991) words: “… we may be entering a new era of self-conception. In this era the self is redefined as no longer an essence in itself, but relational. In the postmodern world, selves may become the manifestations of relationship, thus placing relationships in the central position occupied by the individual self for the last several hundred years of Western history” (pp. 146-147).

Cushman (1992) lists a number of

---

5 This idea was one of the mainstays of Harry Stack Sullivan's operational psychiatry. Sullivan's most trenchant exposition of the notion appeared in 1950. He was quite clear in that posthumously published paper that he believed the self was a social construction. In fact, he believed human life was entirely a matter of culture. Referring to the process of socialization and clearly taking issue with the standard psychoanalytic view, he wrote, “don't permit yourself to think that the animal can be discovered after it has been modified by the incorporation of culture: it is no longer there. It is not a business of a social personality being pinned on or spread over a human animal. It is an initially animal human developing into what the term human properly applies to—a person” (p. 210).

This idea is perhaps not surprising from a man who was inspired by George Herbert Mead. But Sullivan's misgivings about the individual self have been the least acceptable aspect of his views to analysts of the interpersonal school, who have otherwise accepted and developed many of Sullivan's notions. I might go so far as to say that this is the only one of Sullivan's positions that has been abandoned with near unanimity by the analysts who otherwise tend to find his work most useful. Ironically, though, this is the aspect of his views that may make Sullivan's work a useful point of connection between psychoanalysis and social constructionism. Cushman (1992, 1995) makes a similar point.
contemporary writers who claim that what they all characterize as “the bounded, masterful, hypertrophied self” is not a universal phenomenon, even today, and did not exist at all during most of human history. He also summarizes the work of a number of others who show that the idea of the self arose during the “flowering of individualism” that took place in the Renaissance, and even then was not a matter of humanity wrenching itself into a higher form of being, but was instead an adaptive response to changing social and economic conditions. And thus the self can be understood to be neither interior nor unitary—not even irreducible. It seems that this perspective is today becoming accessible to large numbers of people for the first time since the self was invented.

As a concrete and contemporary illustration, take the art of Cindy Sherman, who uses makeup and clothing to reconstruct her image, imitating people of many different eras, occupations, and stations in life, and then photographing herself in this regalia. Her portraits are always convincing, often funny, and sometimes purposefully bizarre. And quite simply, in any other era within recent memory, they would have been deemed psychotic. Yet, today, they reach people of unquestioned sanity. While they may be controversial in the academy, they are among the most popular and widely known images of contemporary art. We recognize something ironic and true in the constructibility of these absurd mock portraits and something sad in their degree of representational success. Such easy imitation should not be possible. Or at least it would not be possible if the self were the fixed entity we have always believed it is.

While the social model may lead to painful dislocations, it also lends new significance to a value analysts hold increasingly dear: democracy in the consulting room becomes not only supportable, but inescapable. The patient's view can no longer automatically be understood as distortion, but must be respected as a perspective on the truth. Disagreement is expectable. Differences cannot be settled by appeal to an objective standard supplied by theory, but must be arbitrated. Free association is often temporarily derailed by discussion—or even argument (Hoffman, 1992a).

This point of view may tempt a few analysts to relax into the position that they are nothing but mutual participants, raising the possibility of the clinical situation degenerating into something resembling
chit-chat over the back fence. But if psychoanalysts are careful to retain that part of their authority that remains rational (that is, the analytic attitude and the relatively uncompromised curiosity that is the hallmark of already having been analyzed), then the profundity of the analytic experience need not be compromised, and democracy in the consulting room can be nothing but a boon.

I have not addressed the social model as a construction of the culture, other than to point out its consistency with the broad cultural changes that go under the name of postmodernism. This omission is due to our closeness to the era. The social model must be socially constructed, too, of course, but we are too close in time to speculate on the relevant issues. It will not be long, though, before that topic, too, comes within the range of reflection, for pundits have been announcing the death of postmodernism for some time already.

**Coda**

The Romantic vision is strong. The self as interior truth, an independent core of agency and continuity in contact with the external world but persevering on its own course, is a powerful and noble metaphor for living, and most theories of therapeutic action are based upon it. One of the most positive images psychoanalysts have of themselves is as the liberators or midwives of this transcendental self. The culture has offered analysts every reason to take on this image and to take pride and satisfaction in it.

In the romantic view, culture is imposed on people from without, shattering their natural unity, stifling their passion and creativity, destroying their innocence, and leaving them agonized. For the romantic, people are charged with the task of creating themselves. The social constructionist, on the other hand, a semiotician at heart, argues that this position overestimates the power of the individual and underestimates the degree to which people are actually constituted by the roles they adopt, and the degree to which these roles and their accompanying languages have been created by the generations that have come before. Culture is not imposed from without; it is the fabric of our “within.” Culture is not only responsible for our notions of the content and structure of the self; it is culture that determines whether the idea of self is formulated at all.

- 288 -
In challenging us to see that every concept is a social product, social constructionism reveals that we have more choice about how we think than we generally believe we do. Since each set of ideas has implications for living and may influence the course of human lives, our awareness of the degree of choice operative in our intellectual life gives us a heightened sense of responsibility for how we think and what we believe. The complaint is sometimes made by opponents that social constructionism encourages relativism and moral chaos; a better argument is that it leads to a greater sense of social responsibility.

The psychology of the romantic self can arouse in us a sense of rightness and conviction. It lends dignity to human affairs and numinous significance to psychoanalytic work. It is reassuring. It is very hard to remove ourselves far enough from it to gain a foothold for critical reflection. But it is in our interest to do so. Romanticism is an orientation to living we can adopt if we choose, but the choice has social, political, and clinical implications. Contained in the romantic notion of the unique individual self are strong influences on our views of how we should treat other people and how we ourselves ought to live. What ought to be important? What aspects of living are most worthy of respect? Of government support? There are implications for relations with authority, for social programs, and so forth. This paper is not the place to address these questions, but they have begun to be examined elsewhere (e.g., Cushman, 1991, 1992, 1995; Gergen, 1991).

Psychoanalytic writers examining social constructionist views report that they see new choices in aspects of clinical practice they had taken for granted, thereby expanding the range of interactive possibilities that can take place in analysis while maintaining the core values of the process, that is, unfettered curiosity and understanding. Where do these new interpretive possibilities and alternative conceptions of analytic conduct come from? For some, they come from a new freedom to mix and integrate metaphors, so that certain analysts (chiefly the relational group) no longer feel confined to the bounds of one theory or another (e.g., Mitchell, 1988). But most commonly, new freedom has been claimed simply by allowing into the consulting room more of the interactions of everyday life, while maintaining an analytic attitude and a commitment to thoughtful discipline. Clinical illustrations of this idea are particularly abundant in the contemporary

- 289 -

Many of our best thinkers have concluded that psychoanalytic theory can no longer be considered a map of eternal and universal human experience and that the psychoanalytic process cannot transcend the culture that spawned it. In the romantic worldview, so very hard to leave behind, these are sad conclusions. But they are unavoidable. Psychoanalysts are defined by their culture no less than are the maladies of their patients and—coming full circle—the values that underlie their theories of therapeutic action.

References
Berman, L. (1949), Countertransferences and attitudes of the analyst in the therapeutic process. Psychiatry, 12: 159-166.[Related→]
Crowley, R. (1952), Human reactions of analysts to patients. Samiksa, 6: 212-219.[Related→]

- 290 -


Sandler, J. (1976), Countertransference and role-responsiveness. Int. R.

Tauber, E. S. (1954), Exploring the therapeutic use of countertransference data. *Psychiatry*, 17: 332-336. [Related→]
Article Citation [Who Cited This?]
PEP-Web Copyright

Copyright. The PEP-Web Archive is protected by United States copyright laws and international treaty provisions.

1. All copyright (electronic and other) of the text, images, and photographs of the publications appearing on PEP-Web is retained by the original publishers of the Journals, Books, and Videos. Saving the exceptions noted below, no portion of any of the text, images, photographs, or videos may be reproduced or stored in any form without prior permission of the Copyright owners.

2. Authorized Uses. Authorized Users may make all use of the Licensed Materials as is consistent with the Fair Use Provisions of United States and international law. Nothing in this Agreement is intended to limit in any way whatsoever any Authorized User’s rights under the Fair Use provisions of United States or international law to use the Licensed Materials.

3. During the term of any subscription the Licensed Materials may be used for purposes of research, education or other non-commercial use as follows:

   a. Digitally Copy. Authorized Users may download and digitally copy a reasonable portion of the Licensed Materials for their own use only.

   b. Print Copy. Authorized Users may print (one copy per user) reasonable potions of the Licensed Materials for their own use only.

Copyright Warranty. Licensor warrants that it has the right to license the rights granted under this Agreement to use Licensed Materials, that it has obtained any and all necessary permissions from third parties to license the Licensed Materials, and that use of the Licensed Materials by Authorized Users in accordance with the terms of this Agreement shall not infringe the copyright of any third party. The Licensor shall indemnify and hold Licensee and Authorized Users harmless for any losses, claims, damages, awards, penalties, or injuries incurred, including reasonable attorney’s fees, which arise from any claim by any third party of an alleged infringement of copyright or any other property right arising out of the use of the Licensed Materials by the Licensee or any Authorized User in accordance with the terms of this Agreement. This indemnity shall survive the termination of this agreement. NO LIMITATION OF LIABILITY SET FORTH ELSEWHERE IN THIS AGREEMENT IS APPLICABLE TO THIS INDEMNIFICATION.

Commercial reproduction. No purchaser or user shall use any portion of the contents of PEP-Web in any form of commercial exploitation, including, but not limited to, commercial print or broadcast media, and no purchaser or user shall reproduce it as its own any material contained herein.