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AUTHENTICITY AND THE PSYCHOLOGY OF CHOICE IN THE ANALYST

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There is a growing appreciation of an ethic of authenticity in analytic technique, a trend related to a recognition of the engagement of the spontaneous, unconscious dimension of the analyst's mind in the clinical situation. This liberatory trend in our theory of technique can and should be elaborated to take account of situations in which the analyst deliberately and strategically attempts to influence the patient for both analytic and therapeutic purposes. There is a complex, dialectical relationship between intentionally planning to provide mutative relational experiences for a patient and the irreducible emotional responsivity that marks every analytic encounter. It is suggested that the dangers of the patient's compliance with and idealization of the analyst usually associated with the analyst's deliberate enacting of attitudes presumed to be mutative are not necessarily inevitable.

In the 1920's, Ferenczi (Ferenczi and Rank, 1924) described a clinical approach in which he intentionally assumed the *stance* of an indulgent mother toward his patients. Later, Alexander (1950, 1956) advocated that analysts create particular *climates* in order to provide a corrective emotional experience for their patients. Kohut (1984) urged analysts to empathically *position* themselves in the patient's shoes in order to provide a mutative self-object experience. And Weiss (1993; Weiss and Sampson, 1986) has explicitly recommended that analysts strategically adopt certain *attitudes* intended to pass the patient's tests and to facilitate the patient's unconscious plan to overcome pathogenic beliefs.

These theorists—all of them critics of prevailing orthodoxy—differ from one another in crucial ways. However, they all share the assumption that analysts can and should intentionally provide particular experiences to the patient that are intended to counteract the consequences of developmental traumas. All of these positions have been subject to similar criticisms: they are said to invite analysts to be more or less inauthentic, manipulative, and presumptuous in providing corrective experiences for patients (for samples of these criticisms, see Rubovits-Seitz, 1988; Wallerstein, 1990). Any theory which suggests that the analyst deliberately fashion a stance, attitude, or position in order to provide a particular mutative psychological experience for the patient leaves the analyst open to the charge of disingenuousness or role-playing. When used in this negative way, "role-playing" refers to the analyst's attempt to influence the patient by acting in a manner which does not come naturally to that analyst in that particular clinical moment.

I will describe how current trends of thought about the nature of the analyst's emotional involvement focus increased attention on the question of authenticity in technique. This new awareness has profoundly deepened our understanding of the intersubjectivity—the complex relationship between two *whole subjectivities*—in the clinical interaction. In addition, these theories about how we experience ourselves in our work have generated pointed criticisms of any technique that presumes that we can deliberately shape our self-expression as part of "technique" and regulate our effect on patients. However, I suggest that our deliberate enactment of particular role relationships and intentional provision of certain affective experiences for the patient can be entirely compatible with the current emphasis on the analyst's authenticity and irreducible subjectivity (Renik, 1993b). I believe that when a fuller account of the analyst's mind at work is considered, the apparent tension between deliberate planning and authenticity in analytic technique can begin to be resolved.

THE PROBLEM OF AUTHENTICITY

Many have argued (e.g., Kohut, 1977; Mitchell, 1993) that today's psychoanalytic patients tend to seek treatment because they feel estranged from their true selves: they feel they are fleeing from or inhibiting a sense of internal authority, or they are longing for a more centered experience of being a "self." One could argue that the problem of authenticity of the self has replaced repression as our central clinical concern. Some of the most important developments within psychoanalysis over the past fifty years have turned on this new concern with the self. Winnicott, Kohut, and the psychoanalytic baby watchers led by Daniel Stern, for instance, have placed patients' search for confirmation of and attunement to their "true" or authentic selves at the center of their motivational theories.

At the same time, the personal authenticity of the analyst has also become the subject of debate. For example, in the relationship with the patient, how fully does the analyst express his or her subjectivity, including idiosyncratic conflicts, character style, and unconscious perceptual and interpretive biases? Freud's position was that the analyst should strive for the objectivity of a surgeon, should listen neutrally to and interpret the patient's distortions of a reality of which the analyst has a privileged grasp, and should restrain his or her more private self from contaminating the clinical encounter. This view has become radically transformed in the current intellectual climate. The voices of the social constructivists (Aron, 1992; Hoffman, 1983, 1991), interpersonalists (Greenberg, 1991a, 1991b; Mitchell, 1993), and hermeneuticists (Schafer, 1983; Spence, 1987) have joined with fellow travelers within the post-structural model psychoanalytic mainstream (Jacobs, 1991; Poland, 1988; Renik, 1993a, 1993b) to form a growing challenge to and revision of the main assumptions underlying Freud's classical vision of the analyst as detached observer. In its place there has emerged an acceptance not only of the inevitability of the full and authentic engagement of the analyst's personality in the clinical encounter, but a

growing sense that it is in the reparative effects of such an engagement, along with its retrospective analysis, that the core of analytic work actually occurs.

In this view, the analyst's self-representation as a neutral observer of uncontaminated processes *inside* the patient is an illusion fraught with various potential dangers and limitations. According to contemporary critics, the classical view discredits the patient's perceptions of the relationship with the analyst, which often leads to the patient feeling blamed and/or subtly undermined. Further, any model that brackets the analyst's subjectivity too much can potentially invite the patient's compliance and idealization and risks depriving the analyst of a rich source of information about the patient's idiosyncratic ways of influencing and using his/her important objects.

In contrast, the modern paradigm emphasizes the "perspectival" and constructed nature of *all* human knowledge, including analytic knowledge, and sees the analytic process as necessarily involving a passionate unconscious and authentic engagement between analyst and patient. Hoffman (1983), for instance, levels a powerful challenge to the implied premise that the patient is a "naïve observer" of the analyst, unable to perceive anything which the analyst wants ignored. Renik (1993a, 1993b) has argued that even the more modern analytic notions that countertransference is inevitable *still* mistakenly assume the possibility of objective behavior in the analyst independent of his or her essential subjectivity. From Boesky's (1990) assertion that the patient's resistances are not simply "in" the patient but are shaped, at least manifestly, in reaction to the analyst's personality, to Gill's (1982) theory that there is always a kernel of truth in the patient's transference distortions, analytic theorists are increasingly skeptical about the possibility of any technical position that views itself as free from the omnipresent influence of the analyst's authentic, personal, and multidimensional subjectivity.

This sensibility has emerged as a reaction to and critique of the presumption within the classical tradition that the analyst

can be more or less neutral and can therefore "know" that the patient's experience is transference based and not accurate. The evolving modern paradigm holds that because the analyst's ability to "know" himself/herself, as well as the patient, is inherently limited, the analyst cannot presume to predict in advance what effect interventions will have. Therefore, the analyst cannot strategically provide relational experiences for the patient with any confidence that they will have a selectively mutative effect. This position would tend to hold, for instance, that deliberately aiming to correct infantile defects or traumas through enacting a specific role relationship would cause the analyst to be inauthentic and self-deceiving. It is inauthentic because someone's emotional responses cannot be planned and deliberate. And it is self-deceiving because it rests on the illusion that the patient will "read" the analyst's behavior and affects exactly as the latter intends.

There are many examples of this kind of debate in the analytic literature. Just as Alexander was attacked for being manipulative, Kohut has been criticized for unrealistically attempting to provide an idealized mothering, and Weiss for claiming that the therapist can "know" in advance the patient's singular unconscious plan. Clearly, these theoretical models have been critiqued on multiple grounds, but the most common objection is that they all invite a potentially manipulative and inauthentic form of role-playing at the expense of analytic inquiry (for a further example of this line of criticism, see Renik, 1993a, 1993b).

While the current emphasis on authenticity is a necessary corrective to an authoritarian bias in our theory of technique, I would suggest that it risks oversimplifying the complex interplay of deliberate and unconscious responsivity in the psychology of the analyst. In particular, the assumption that the deliberate attempt to provide a patient with corrective experiences is necessarily inauthentic and manipulative is mistaken. I believe, instead, that it is possible to integrate a view that puts a premium on the analyst's intentionally striving to give the patient what he

or she needs, in words and actions (including corrective relational and developmental experiences) with a view that cherishes surprise, an appreciation of ambiguity, spontaneous responsiveness, and an acceptance of the free play of the analyst's unconscious. The picture of analytic technique that results might be controversial on a number of fronts. I am arguing, after all, that, without compromising our emotional authenticity in any way, we can deliberately and selectively feature one aspect of our emotional repertoire over another in order to influence the patient to more safely analyze and even directly alter unconscious conflicts.

Objections can be raised that my technique is manipulative and unduly "psychotherapeutic." I am arguing, however, that if these criticisms amount to more than a priori assumptions, then they have to be demonstrated clinically. I hope to show, for instance, in a case vignette that the presence of a high degree of premeditated intention and planning by the analyst to influence the patient is inevitable and can be deeply authentic. The issues which should legitimately distinguish the theories that feature the providing of corrective experiences from those that feature insight include how we validate our clinical proposition, the potential difficulty of identifying patient compliance, and our methods for evaluating the quantity and durability of analytic change. In this context, authenticity recedes as an important defining dimension of analytic technique.

THE PSYCHOLOGY OF CHOICE IN THE ANALYST

A clinical example might be useful to illustrate the complexities of the issue of choice in the analyst. I will choose an example in which I deliberately and strategically used humor with beneficial results. (This vignette is presented in greater detail in Bader [1993]).

John was a thirty-year-old Asian-American contractor who

complained to me about his unsatisfactory marriage to a critical woman, with whom he felt trapped and toward whom he felt "allergic" but guilty about feeling this way. In the transference, John seemed to experience me as relatively helpful, as long as I did not try to interpret the underlying meaning of his behavior in terms that he could infer were even remotely "psychoanalytic." He tended to insist that I give him practical advice and would accuse me of "one-upmanship" whenever I attempted to interpret these wishes. When I was silent for too long, he would excoriate me for my defensive withdrawal behind my "technique." He was exquisitely sensitive to feeling blamed and accused.

Over many months I attempted to talk to John about various dimensions of his experience of our interaction. I talked to him about how his relationships eventually turned into struggles of dominance versus submission, and how he had a great many anxieties about mutuality and collaboration. We reconstructed family history that seemed to relate to this problem, including his rage at his highly critical mother's efforts to control him and his despair at never being able to satisfy her. He remembered how even on Sunday drives in the country, his mother would harshly quiz her children about vocabulary and arithmetic. His experience of his mother's perfectionism and relentless dissatisfaction with her family was complicated by his perception of her underlying depression and self-condemnation. John had seemed to respond to this conflicted relationship by internalizing her accusatory and punitive aspects.

Harsh with himself and perfectionistic with others, John repeated this problematic object relationship inside and outside the transference. I pointed out to him that by putting me in the role he had passively endured with his mother, he was showing me what it was like for him to be the object of his mother's chronic dissatisfaction, unable to bring pleasure to her eyes. He found these interventions sterile and unhelpful, even if they might have been accurate. I explored with him his fantasies of magical rescue and his wish that we collude in denying our

respective limitations. He felt accused. We talked about the ways in which his reflexive need to denigrate my attempts to help him might be a form of attachment and might also serve to defend against separation anxieties. While he felt that this line of investigation was true, he derived little help from it.

In the countertransference, I felt frustrated and periodically demoralized by these no-win struggles, even as I also appreciated John's intelligence, wit, and obvious wish to master his self-defeating patterns. I engaged in a determined self-analysis which revealed that my experience of John's "assaulting" me with his dissatisfaction contained elements of my relationship with my own mother, who had often burdened me as a child with her complaints of being cheated and dissatisfied as a mother and a wife. These infantile echoes could be felt in my resentment of John's intense critical scrutiny and complaints about my ineffectiveness. In addition, I sought out consultation that helped me use these self-analytic insights to understand more compassionately how John's need to frustrate and torment me expressed his identification with the aggressor, turning passive into active, and various projective-introjective solutions to anxiety.

At least in part as a consequence of these efforts, I began to feel less trapped by John and freer in my emotional responses to him. For instance, because I felt less oppressed by John's discontent, I felt more willing and able to enjoy his wit. I noticed that he responded well to humorous exchanges between us. By well, I mean that he seemed to relax and be able to reflect on himself more analytically and to begin to tolerate a slightly wider range of affects. In response to these observations, I began to develop various clinical hypotheses. I came to understand the salutary effects of my humor as related to the metacommunication it conveyed about my internal psychological state. Specifically, I believed that my humor reassured John that I was not injured or demoralized by his dissatisfaction and criticisms in the same way that he was at the hands of his mother, providing him with a sense of safety and a model of identification. Further, I

believed that my humor communicated that I liked him and could maintain an appreciative connection with him in spite of his provocativeness, that I did not mistake the part for the whole, and that if I could tolerate ambivalence and relational complexity, and adaptively sublimate hostility, perhaps he could as well. I developed these hypotheses early on in the context of our joking. They became stronger as he continued to respond affirmatively. And, most important, they provided an enabling framework within which I allowed myself to both initiate and respond with humor and playful wisecracking.

The following would be a typical example: John was characteristically instructing me, during one session, about how one of my comments was poorly worded and implied blame. He ended his dissertation by coolly asking me: "Are you able to follow this?" I responded, "Wait. . . . could you speak more slowly?" He replied that he was trying his best but that I was a dumb student. I sensed that he was "playing" with me a little bit more than usual. I responded: "But I thought this was just a Sunday drive!" This allusion to his account of the pressure-filled Sunday drives with his mother made him laugh, and he then began to talk about how one of his clients had been "picky" about some remodeling that he had done for her. He realized that this kind of criticism could spoil his whole day, but imagined that *I* might think of this as an over-reaction. I commented that perhaps we had just gotten a glimpse of where part of his conflict might have originated. John responded, somewhat sadly, "Sunday was supposed to be a day of rest—but I don't even get that." After a pause he demanded, "O.K., hot shot, so now what?" I replied that he didn't want me to get lulled into the delusion that we were actually working together! He then went on to ridicule my apparent hopefulness, although his tone seemed to remain ambiguously playful.

These interactions were brief but increasingly common. The humor is subtle but characteristic. I felt that there was evidence that my willingness to play with John was an important factor in his gradual willingness to trust me and to think about his own

feelings, behavior, and history. I took as confirmatory evidence my regular observation that he seemed better able to engage in psychological self-observation as a response to my *choice* to engage him playfully or with humor at a given moment.

Now, the purpose of this vignette is to illustrate the complexities underlying a "choice" made by the analyst. In what way, for instance, does it make sense to say that I "chose" to respond to John with humor? Since it wasn't as if I were telling him premeditated jokes, wouldn't it be more accurate to say that I was *responsive* to something in John, that my humor was spontaneously *elicited*? In fact, isn't it somewhat self-canceling or at least suspect on its face to talk about being deliberately playful, or to plan to be witty? And isn't playfulness or humor better understood as an aspect of my character that is somehow going to come through to each and every patient in some form or another? What then, does it mean to *decide* to "use" a capacity that is as natural to me as breathing and is therefore always influencing the way that I interact with my patients?

I would argue that a more complete view of the analyst's subjectivity has to include the extent to which the conscious and rational aims and theoretical models that the analyst holds both shape and regulate what she or he experiences *and* what she or he expresses to the patient. The current emphasis in theory on the analyst's necessary irrationality and subjectivity has provided a powerful corrective to the view that the analyst has a privileged access to rationality. However, it would also be accepted by all sides that a major aspect of the subjectivity of the analyst includes her or his conscious analytic and therapeutic aims, theories of the mind and of analytic technique, and the host of moment-to-moment decisions about what she or he wants to convey to the patient in the office. A more variegated representation of the analyst's mind at work, then, somehow has to describe the dialectical relationship between what the analyst *believes* he or she is doing—and *intends* to do—and what he or she is unconsciously enacting. Both levels of being are obviously constituents of the analyst's omnipresent subjectivity. It is within

this complex relationship that a discussion of deliberateness and strategic choice in the analyst must take place.

We ask our patients this question all of the time: how much do you live your life and how much are you lived *by* your unconscious life? Unlike Freud's vision of mental health that celebrates rational control of the instincts, the modern answer has more to do with an ability to sustain a paradoxical and creative tension between control and surrender, between self-assertion and recognition, between autonomy and dependence. This should be true in our theories about the optimal functioning of the analyst's subjectivity as well. We need to be able to experience ourselves as both *in* and *out of control*, both strategically planning and spontaneously reacting (Levy, 1987). It seems to me that what differentiates us from the patient in this regard is mainly that we have powerful therapeutic aims and a distinct vision of both how the mind works and how our interventions and actions can help the patient achieve our jointly construed therapeutic goals. Just as it is crucial for us to appreciate the inevitable and mutative value of our own passionate unconscious engagement with the patient, so, too, it is important for us to focus all of our conscious resources on the task of helping the patient make use of analysis in order to change. This is axiomatic within our field.

Most of our theories of change assume that the analyst's intellectual abilities, capacity to regulate affect, professional role, and conscious and continued attempt to formulate meanings reflexively are crucially mutative in the analytic process. Whether it is the analyst providing a holding environment, a container for the transformation of projective identifications, or an observing/auxiliary ego, the conscious and intentional aspects of the analyst's professional activity have always been a part of how analysts view their function. The problem, in my view, has been that our theories have not adequately conceptualized how these more rational processes interact with the silent, unconscious, intersubjective dimensions of the analytic relationship.

So, for instance, I believe that I deliberately planned to re-

spond to John in a playful way. To overstate my case somewhat: my use of humor was strategically intended to provide a certain experience for him that I had inferred from the past would be reassuring in particular ways so that analytic exploration and certain novel and potentially relational experiences could develop. It could be argued that humor was simply a way I found of communicating with John in a manner that he found "safe" and that this merely constituted the starting place for the more definitive interpretive work. For my purposes, this is a moot point. It is not necessary to agree with my personal belief that when one intentionally provides safety to a patient, one is disconfirming a pathogenic unconscious belief and, therefore, not only making inner conflicts more accessible to analysis but also *directly* contributing to resolving them. It is enough to recognize that a great deal of crucial activity in the analyst's mind takes place in the service of strategic aims.

On the other hand, it is equally true that this form of humor and play is characterologically natural and easily accessible to me, and, to the extent that this was also true for John, it evolved as the kind of naturally occurring private language that usually comes to exist within an analytic couple. However, the theoretical model I had in my mind of what was going on in this relationship, as well as my theory of change and of the analytic process, seemed to regulate the quantity *and* quality of the humor and playfulness. I do not give vent to all of my naturally occurring responses—including humor—to a patient. For instance, there are patients with whom I experience a more cautious restraint than I did with John. In these cases, I have a conscious awareness that this kind of interaction would be a repetition of pathogenic patterns that might reinforce the patient's self-defeating beliefs. In other cases, I become aware of vague but greater than normal superego signals when I am tempted to be playful, signals that I have learned to heed, examine, and use to restrain my joking "reflex."

With John, my understanding of what was going on within him and within the transference set me free to be able to delib-

erately provide him with an experience that seemed to help him and our work. I pictured John as defensively repeating with me a pathological object relationship with his highly critical and unhappy mother, and alternately identifying with one or the other side of it. Observing his progressive responses to my humor, I formed the hypothesis that he was able to feel safer when he had unmistakable evidence that I was *not* going to join him in these enactments, evidence that he could apparently not perceive in a more muted or "neutral" affective analytic stance. Therefore, I decided to *initiate* humorous interchanges at times, sometimes without clear-cut invitations, more so than I would with another patient. I engaged in them for longer periods of time. I felt under less pressure to attempt immediately to analyze these interactions after the fact than I do with other patients. In other words, I believe that my conscious model of the situation, together with my particular professional therapeutic aims, regulated my experience of this patient and also enabled me to shape my attitude and behavior with him.

The resulting playful repartee felt entirely "natural" to me. Within my planned, strategic approach, which included permission or even encouragement for me to play with John, I felt "at home" when I did so. I did not experience myself as wooden or artificial or phony. Further, given John's exquisite sensitivity to being put down, patronized, "one-upped," or treated as a "case," it would seem to me that if he had experienced me in these ways, he would have responded negatively. Although I will discuss the patient's experience of my stance in more detail later, at this point I would suggest that John's salutary responses of increased reflectiveness, affectivity, capacity for positive connection, etc., were encouraging, if not confirmatory, signs that my way of working with him felt authentic and "real" to him, just as it did to me.

In some sense, my choosing to "use" humor in a way that felt natural and spontaneous reflects a universal dimension of all social interactions. In many of our interpersonal encounters, we intuit how the other person experiences the world and feels

most comfortable relating, and we tailor our words, tone, style, and actions in ways that are intended to connect with the person and to make him/her feel comfortable and affirmed. We are gratified in complex, unconscious ways while we are doing this. Nevertheless, we are molding who we experience and present ourselves to be, all of the time under the regulatory control of various aims and purposes. And while it is true that psychoanalytic theory has shown us that these aims and purposes are usually unconscious, it is also true that preconscious and even conscious aims and purposes are often of paramount importance in normal social intercourse. So, for instance, while I am inclined to wisecrack often with my friends and sometimes with my patients, I am usually also guided by considerations of context, person, and timing. I do not usually wisecrack with a humorless person, with a policeman writing me a traffic ticket, in the moment before orgasm, or when my best friend loses his wife to cancer. My aims as well as my inclinations are influenced by various complex considerations.

My point here is that deliberateness or strategic attempts to influence or connect with the other by subtly employing shifts in style, tone, or attitude are ubiquitous in everyday social life, as well as in analysis. Sometimes the issue is simply one of connecting with another person. For instance, in analysis, we often assume the importance of "speaking the patient's language." Hidden under the theoretical rubric of "tact and timing," this often involves a complex decision-making process, both conscious and unconscious, deliberate and spontaneous. I tend, for instance, to speak in a manner that is plainer and rougher in syntax and vocabulary when my patient is uneducated and streetwise, not because I'm role-playing a streetwise average Joe (which I am not) but because this sort of communication is easy for me, and, more important, I intuitively sense that the patient will be able to listen safely to me and understand me better this way. Is this spontaneous and reactive to the unconscious communicative play between parties? Or is it deliberate and strategic, proceeding from a conscious intent to make oneself "heard" by the other

and to avoid the potential danger of the patient's feeling intimidated or resentful of an elitist educated authority? I think that most analysts would say that it is both.

The objection could be raised that these kinds of automatic attunements that we all make in relationships are not in the same inauthentic ballpark as role-playing in psychoanalysis. I would suggest that the dividing line tends to be entirely arbitrary and varies according to the theorist's wish to define something as "nonanalytic." The continuum is complex and blurry. It is not easy, for instance, to differentiate among: (1) intuitively and preconsciously "tracking" and "mirroring" a patient in voice, tone, and gesture (a phenomenon that many analysts have noticed is ubiquitous); (2) consciously attempting to speak and act with a manner, tone, and style informed by one's knowledge of the patient's background and current conflicts so as to be maximally "heard"; and (3) deliberately enacting a role intended to counteract or disconfirm the patient's earlier object relationships. Simply labeling something as inauthentic or manipulative runs the risk of reducing the complex inner states of the analyst and the multiple levels of the intersubjective field to simple black/white or good/bad categories.

With my patient John, for instance, my use of humor was at first a naturally occurring but also intentional attempt to empathically respond within a linguistic and affective register that the patient found familiar, safe, and affirming. Because of my self-analytic efforts, my increased sense of clarity about the dynamics of the maternal transference, and my awareness of my clinical goal of creating conditions of safety to encourage the patient's self-exploration, I altered my own internal psychological environment. What had previously provoked or mildly injured me no longer did, and I was able to maintain our connection through a genuinely playful and communicative style. The patient responded to me as authentic and natural. Two processes coincided to produce this authentic engagement. First, the humor that is a natural relational style for me became more accessible because I formulated the case in a clearer way. In this

way, increased cognitive clarity regulated my spontaneous affectivity. Second, the patient needed to have such an experience, and thus was inclined to make good use of it, whether or not he actually felt that at each and every moment my humor was truly heartfelt.

In this sense, we are always both deliberate and spontaneous. Duxler (1993) has suggested that the relevant metaphor might be musical improvisation. Jazz musicians, for instance, are able to improvise without appearing to think about it in advance or without having to interpose any conscious framework of musical theory. Because they understand the abstract relationships among chords, keys, and harmonies in great complexity, on some level, they can take the scaffolding for granted and respond and improvise "spontaneously." There is a dialectical relationship between theory and spontaneity, between conscious intentions and unconscious playfulness and creativity. The knowledge of theory makes spontaneity possible. Similarly, in the analytic interaction, the analyst's deliberate intentions and theoretical understanding provide the scaffolding, within which a great deal of spontaneous interpretive and affective improvising can occur.

THE PATIENT'S RESPONSE TO THE AUTHENTICITY OF THE ANALYST

My discussion of authenticity has thus far centered on the analyst's internal experience. Authenticity, however, is also important in the eye of the beholder. As modern analytic theory has demonstrated, patients are as sensitive to signs of artificiality in the analyst as the analyst is to indications of falseness in the patient. The objections to the analyst's being too deliberate or strategic in her or his emotional expression are based, in part, on the presumption that falseness or inauthenticity in the analyst will be detected and felt to be manipulative by the patient, and that this perception, along with defenses against it, will have

deleterious consequences. The chief danger in the patient's adapting to the analyst's inauthenticity is in complying with the analyst's idealized authority at the expense of the patient's defining and analyzing her or his conflicted needs and fears (Renik, 1993b). A further risk is that the patient might defend against or ward off her or his perceptions of the analyst's pathological need to help or manipulate for a desired effect, with some kind of collusion or pseudomutuality developing (Greenberg, 1991b; Hoffman, 1983). In either case, the patient might adapt to the analyst's disingenuous enactments in ways likely to repeat pathogenic patterns—patterns that are difficult to detect and analyze precisely because they are accompanied by symptomatic improvement and confirm the analyst's view of himself or herself as helpful.

Compliance is extremely difficult to detect because its very intent is to be confirmatory of and pleasing to the analyst. Given this problem, the analyst is often well advised to eschew taking positions which are at odds with what she or he feels or which are based on too authoritative a prediction about how a particular attitude will affect the patient. The growing articulation, then, of an ethic that recognizes the tentative nature of the analyst's interventions, and that strives to resist temptations within the analyst's theory and psyche to arrogate to him/herself too much authority to define what is "good" for the patient, is based on concerns about clinical consequences. It is an ethic intended to minimize patient compliance and false adaptation to the analyst—or, at least, to maximize the ability to analyze these processes. Falseness in the analyst invites falseness in the patient.

I believe, however, that an analyst can be highly deliberate and strategic, in words and in deeds, and neither feel nor be perceived as false. Role-playing, for instance, can be—but is not necessarily—false. Most of us would accept that we can hardly relate to other human beings outside of roles. Clearly, the issue of authenticity in the analyst is extremely complex and difficult to define. In addition, however, some measure of our evaluation

of the authenticity of an analyst's interventions must lie in assessing the nature of the patient's responses. To some extent, we need first to ask the question: how interpersonally *successful* has the analyst been when he or she chooses deliberately to express or provide to the patient a particular attitude, role, or emotional response that the analyst believes will help the patient? By successful, I mean the extent to which the patient perceives and experiences what the analyst wants the patient to perceive and experience. In other words, to what extent can the analyst fashion his or her subjectivity and feel confident that the patient will read the result in the way the analyst intends it?

In the case of John, I would argue that there were various indications that pointed toward the probability that he experienced my humor as I intended him to experience it—both as a reassuring disconfirmation of his omnipotent worry that he could hurt, paralyze, and enrage me and as an expression of my pleasure in connecting with the healthier side of him despite his provocations. The indicators included an uncharacteristic lightening of his mood, a perceived—and sometimes acknowledged—relaxation of his stereotypical and rigid distrust and defiance of me, the appearance of new affects such as sadness, an increased ability to tolerate feelings of remorse and affection toward me, the emergence of new memories, and an increased ability to think about himself psychologically. These changes were often subtle and rarely occurred all together, but they were also more evident following my recognition of the potential strategic value of allowing myself to play and joke with him. I think that John's exquisite sensitivity to being manipulated or treated by a "technique" behind which I hid my true self would have led him to escalate his attacks or countermeasures in response to a perception of me as fraudulent.

I am not arguing that the fact that a deliberate enactment or role seems to have the intended effect necessarily means that the patient is oblivious to the other complex, unconscious, aspects of the analyst's personality. It *might* mean, however, that these other perceptions are unimportant, or not of great clinical in-

terest at the moment. For instance, although I strategically decided to use humor with John, I would be the first to admit that my use of humor typically subserves various other motives and functions. For instance, it helps me to sublimate aggression, to protect and please the other, and to ward off anxieties about competitiveness and/or separation. These complex dynamics constitute the subjectivity that I undoubtedly communicate unconsciously in all of my interactions. My conscious aim in this case, however, was selectively and preferentially to feature my sense of humor more prominently in my interactions with John in the service of the particular therapeutic aim of increasing his sense of safety by disconfirming the pathogenic beliefs expressed in his transference. Based on these considerations and understandings, I expected my use of humor to have a salutary effect on John and the analysis. I felt that there was evidence that the patient did, in fact, respond to what I had intended that he respond to—the humor and its attendant communicative meanings. He did not seem to me to respond to what I did not particularly want him to experience in my joking—my aggression or competitiveness, for instance—even though those affects were present.

This example seems to suggest that while a patient is never a naïve observer, he or she is always a selective one and the analyst can, to an important extent, regulate what the patient is maximally liable to observe and can do so in the service of giving the patient something that he or she needs. Of course, psychoanalysis *always* understands the patient as a selective observer of and responder to the analyst's psychology. Classically, this has meant that, under the sway of the transference, the patient distorts the reality of the analyst's personality. More modern observers have offered the corrective that the patient often quite rightly perceives the unconscious mental life and character of the analyst, although the way that these perceptions are elaborated is highly idiosyncratic and subject to distortion.

If one adds to this view the equally modern but more controversial concept that the patient uses the analyst for needed de-

velopmental, self-object, or safety reasons, and that he or she is motivated by a wish to grow and to master as well as to repeat pathology, then it is easy to understand how the patient can find one attitude or behavior in the analyst extremely relevant and helpful and other aspects of the analyst's psyche irrelevant or uninteresting. It would not be the case that the patient did not perceive multiple, unintended aspects of the analyst's personality or that the analyst should not be always alert to the fact and potential meanings of these observations, but that these perceptions might often *not* matter too much to the patient in proceeding with the task at hand. In other words, the patient might perceive certain unintended things about the analyst without any significant clinical consequences, while other perceptions might have great consequences for the patient insofar as they bear directly on the conflicts that the patient is either repeating or trying to master and work through. Therefore, it would be possible for the analyst quite deliberately to emphasize one attitude or trait or de-emphasize another. If he or she were attuned enough to the patient's needs at that moment, the patient might not care if there were aspects of the analyst's personality being suppressed or withheld. Even if the patient did perceive that the analyst *was* enacting a role more than usual or in a more exaggerated way than before, the patient would not necessarily feel manipulated or experience the analyst as false, particularly if this role was reassuring or useful and helped the patient engage and work through key developmental traumas or pathogenic beliefs. For some patients, *any* sense that the analyst is doing something deliberately *for* them might be unconsciously problematic because of idiosyncratic associations with that perception. For many others, however, it would not be so much the question of the analyst's deliberateness, or role-enactments, but rather whether the roles, attitudes, and experiences provided were empathically responsive to what the patient needed in order to move forward.

John, for instance, indicated at several points that I had changed my style somewhat and was more emotionally playful,

humorous, and available to him. He clearly liked it, and he did not seem to experience it as manipulative or artificial. In fact, his overall feeling was that I understood him better, that I was more attuned to him, and that he could trust me more. I would argue that this was because the attitude that I deliberately made available to both of us—my playful and sarcastic humor—accurately spoke to certain issues that he was struggling with, issues around omnipotence, helplessness, and passivity. My humor provided tangible reassurance that these outcomes were not inevitable in an intimate relationship and that a more gratifying experience of mutuality was possible.

CONCLUSION

Psychoanalysis has undergone a transformation in its understanding of how the clinical situation involves the interaction of two complex psyches. Much as the classical picture of a patient containing discrete symptoms has broadened to envision a self striving in conflicted ways to feel authentic, so our picture of the analyst applying an objective technique isolated from her or his own subjectivity has been broadened to include a *whole* analyst involved in a genuine, multidimensional, and passionate relationship. The experience and the analysis of this complex relationship are now both presumed to be mutative. The new emphasis on and valuation of personal authenticity in the analyst has proceeded in step with the modern acceptance of the deep and continual role of the analyst's personal psychology in the clinical interaction. Analysts have been increasingly liberated from the impossible demands of the reified ideals of analytic objectivity and correct "technique."

It seems to me, though, that psychoanalysis has not yet adequately integrated into its new understanding of the omnipresent expression of the analyst's unconscious the critical role of her or his equally inevitable deliberate strategies to influence the patient to achieve analytic and therapeutic aims. Analysts are

increasingly open about the ways in which they "customize" their technique to suite the idiosyncratic requirements of the patient: how they deviate from their "roles" in whatever way helps the patient accomplish the goals that each analytic couple generates. These goals might range from intra-analytic goals, such as greater awareness of resistances or increased self-cohesion, to broader therapeutic goals of symptom relief and heightened subjective pleasure and efficacy. To accomplish these aims, analysts develop elaborate theories which change over the course of an analysis about the kind of help that the patient seems to need to move toward the goals. These theories dictate divergent interventions, from resistance interpretations to the assumption of particular attitudes intended to directly reassure the patient.

In any case, the interventions flow in part from the analyst's wish both to help and, broadly speaking, to influence the patient. It seems to me that it makes sense to call this dimension of analytic technique deliberate and strategic. It is deliberate because it is guided by the careful therapeutic aims of the analyst. The particular form that the intentionally helpful interventions take varies enormously among competing analytic paradigms. But the key differences among these models are not defined by their degree of authenticity. Some models, like my own, might claim to know more in advance about what the patient needs in order to move forward analytically and therapeutically. I might therefore be legitimately challenged on both empirical and epistemological grounds. How do I know? How do I validate my propositions? How do I guard against compliance? What are my criteria for change? These are crucial questions. Authenticity is not one of them. The association of inauthenticity with a technique that advocates the deliberate and planned attempt to influence the patient is not a useful or even necessarily accurate connection.

I would argue that role-playing in some form is an inevitable part of all human interactions, including the analytic one. It is no more compelling to view this as inauthentic than to see a

patient's desire to make his or her analyst feel good as necessarily disingenuous or false. In circumstances such as those described in my work with John, making a premeditated choice to be more openly playful is no more inauthentic than an analyst's expressly limiting a patient's self-destructive acting out despite his or her own feelings of hostility toward that patient. Role-playing in the analytic situation can be as salutary and necessary as such commonplace interactions as a father's deliberate expression of pride and pleasure in his daughter's appearance as she leaves on her first date, despite his conceivably feeling jealous or anxious.

The modern critique of the classical ideal of analytic objectivity is powerful and extremely useful clinically. It is my belief that as an ideal, analytic authenticity is compatible with theories of technique ranging from those based on the analysis of resistance to those emphasizing the deliberate and strategic provision of certain emotional nutrients to a patient. Whichever clinical approach an analyst favors, the challenge of authenticity is critical.

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