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The Therapeutic Relationship as a Paradoxical Experience

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The therapeutic relationship exists within multiple levels of reality—including that of ordinary life and that of the therapeutic frame. This interplay between these two levels of reality gives rise to paradoxical experiences for both participants. Certain "principles" or "rules" of technique can be understood as a means of enabling the therapist to cope with what is usually referred to as "boundary" issues. It is essential that the analyst or therapist demonstrate capacity to shift playfully from one level of reality to another. The "rule" of abstinence and the asymmetry of desire that exists between the two participants are discussed. Gratification within the therapeutic frame is paradoxical in that gratification at one level of reality leads to privation at another level of reality. These paradoxical experiences for both patient and analyst are examined in relation to projective identification and to the analyst's countertransference.

Anyone who has experienced therapeutic relationship, either as a patient or as a therapist, knows quite well that it is unlike anything else in ordinary life. It cannot easily be placed within any recognizable category; although there is no question that there exists a genuine bond between the two participants, this bond is different from that of a friendship or a love relationship as experienced in ordinary life. Yet patients may feel genuine love for their therapists, and sometimes this love is reciprocated. Unlike other love relations, however, the partners will inevitably separate when the aim of the treatment has been realized; this separation is a fact that neither participant can forget.

We know that the psychotherapeutic relationship shares something

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with the bond that forms between physicians and their patients. Freud (**1912**) described this component, when present in a psychoanalysis, as the "unobjectionable positive transference" (p. 105). Clearly, the psychotherapeutic relation is more intense than most physician-patient relationships, and physicians do not customarily utilize their affective interactions with their patients as part of the therapeutic process.

Freud (**1915**) observed that there is something fundamentally paradoxical in the phenomenon of transference inasmuch as it is simultaneously both real and illusory, but he did not acknowledge the importance of this experience of paradox. I believe that Freud avoided drawing attention to paradox as he was intent upon establishing the scientific credentials of psychoanalysis. Bohr, who later introduced the principle of complementarity into physics, was influenced by James's (**1890**) observation of the paradox of the mind observing itself (**Holton, 1973**): the continuity that characterizes the stream of consciousness is interrupted by observation, and there is a disjunction between the experiencing mind and the observing mind. Bohr (**1958**) later suggested that paradox may be central to human psychology, as it is to atomic physics. But such ideas were not part of the scientific concepts that formed Freud's intellectual world in the late 19th and early 20th centuries. As a quality of consciousness, paradox refers to the recognition and acceptance of the coexistence of two disparate and contradictory forms of experience. More specifically, I hope to show that the therapeutic relationship is intrinsically a paradoxical experience for both participants in that our affective responses to our patients and patients' affective responses to us are real, yet they occur within a relationship that is demarcated from that of ordinary life and accordingly may be viewed as unreal or illusory. The acceptance of paradox means the acceptance of contradictory phenomena without striving for a synthesis, in this instance, the acceptance of the coexistence of these two different levels of reality, that of ordinary life and that of the therapeutic frame.[1]

Freud (**1915**) alludes to this problem in his paper on transference love. Freud asks the question: is the patient's love for the analyst genuine, or is it an illusion? His first response is that it is no different from love outside the transference, as all forms of loving are based upon infantile antecedents, and woe be it to the analyst who scorns patients' love or tells

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[1] I have described the paradoxical nature of the therapeutic relationship in greater detail elsewhere (**Modell, 1990**).

them that their love is not real. Freud (**1915**) goes on to state that analysts should not only not reciprocate the patient's love but must treat it as something *unreal*, as it is a love that has no analogy in real life:

> It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; *it is one for which there is no model in real life*. He must take care not to steer away from the transference-love, or to repulse it … but he must just as resolutely withhold any response to it. He must keep firm hold of the transference-love, but treat it as something *unreal*, as a situation which has to be gone through in the treatment and traced back to its unconscious origins [p. 166; italics added].

For both therapist and patient, the other person is experienced both as an individual in ordinary life and as someone transformed by the therapeutic process, a process that creates a different level of reality that we label as transference and countertransference. Therapist and patient are also everyday people, but within the frame of the therapeutic process an illusion is created that can be described as another level of reality. This interplay between these two levels of reality, between ordinary life and the transference, gives rise to paradoxical experiences for both participants. I believe that paradoxical experiences of this sort follow inevitably when there is a mixing up of different levels of reality. Although such paradoxical experiences are unsettling, this interplay of different levels of reality is widely acknowledged to be a necessary and fundamental part of the therapeutic process. Using different language, I am referring to Winnicott's (**1971**) view that psychotherapy is a form of playing.

From this point of view, certain principles of therapeutic technique, such as the so-called rule of abstinence and therapeutic neutrality, can be understood to be technical recommendations that are designed to help the therapist cope with the implicit paradoxes of the therapeutic relationship. Such principles or rules of technique are reminders to the therapist of the peculiar nature of this relationship. As a kind of technical shorthand, the term *boundary* has developed a certain current usage and serves a similar function, referring to the border between everyday life and the frame that contains the treatment. Both therapist and patient

are advised not to cross over this invisible boundary that exists between them. But in another sense this advice is contradictory as the therapeutic process requires a playful interchange between these two levels of reality. This contradiction is implicit in Freud's advice that transference love was not to be gratified or suppressed. As the therapist is expected to be, at least within the context of the treatment, the more mature and experienced partner, the therapist is also expected to set an example by demonstrating capacity to handle this paradoxical relationship. In this way the therapist can serve as a vicarious form of consciousness for patients, until such time that they can master the process on their own.[2]

It is essential, then, that the therapist be able to handle this paradox, for otherwise the treatment could not proceed. I shall present some commonplace observations with the hope that there is something to be gained by viewing what is familiar from a somewhat different perspective.

The therapeutic relationship is nearly coterminus with what has been called the psychotherapeutic setting, the invention of which is perhaps Freud's greatest contribution to technique. The therapeutic setup includes the ritualized arrangements concerning the matter of the length of the treatment session, but, more important, Freud established certain principles, or "rules of the game," concerning the therapist's affective responses that are also, in a sense, ritualized, as they have become established as essential elements of technique. I have already alluded to the problem of gratification in the quotation from Freud, in which the analyst is advised neither to gratify nor to suppress the patient's desires. Freud was not referring only to physical gratification, for he believed that the patient's unfulfilled desires of a nonspecified nature would serve as a motivating force in the service of the treatment. In this so-called rule of abstinence Freud was establishing a therapeutic principle that demarcated the treatment from relationships in ordinary life. Desires are not always gratified in ordinary life, but at least the possibility is open-ended. In this paper Freud also alluded to the therapist's desires concerning the patient, which, like the patient's desires, are also not open-ended. There is a certain asymmetry between the therapist's desires and the patient's desires, as I shall shortly discuss. This implicit compact regarding the

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[2] Vygotsky asked the question: how does the less competent individual learn from the more competent? Vygotsky's answer (as described by **Brunner, 1985**) was: "The tutor or the aiding peer serves the learner as a vicarious form of consciousness until such time as the learner is able to master his own action through his own consciousness" (p. 24).

kinds of gratifications that are permissible and those that are not permissible within the therapeutic setup is a clear reminder of the distinction between this special relationship and those other relationships of everyday life. It is in this sense that Bion (**1970**) enjoined the analyst to approach each hour without memory or desire. The therapist, of course, cannot be without desire, but the expression of the therapist's desire regarding the patient, one hopes, is consistent with the therapeutic intent of this special relationship. Therapists desire to be useful and to further the work upon which they and their patients are both engaged, but we also know that if the therapist is too desirous of therapeutic success, this desire will paradoxically ensure failure. We know that therapists are no different from individuals in ordinary life in that they experience in relation to their patients the entire gamut of human emotions that are present in any other human affiliation. Therapists may seek narcissistic gratification from their patients and wish to be admired and loved, and patients may be experienced as objects of sexual desire or may be perceived as competitive rivals, and in the latter case the therapist may have an impulse to belittle the patient. We all know that if the therapist intrudes such ordinary desires into the treatment, the treatment itself will become derailed.

On the other hand, the patient, unlike the therapist, is not enjoined from expressions of desire in relation to the therapist, for indeed such expressions are the motor force of the transference. This affective asymmetry of desire—or, perhaps more accurately, asymmetry regarding the *communication* of desire—is, as I have said, one of the ways in which the therapeutic relationship is demarcated from other close relationships of everyday life.

The intimacy of the therapeutic relationship is further distinguished from that of ordinary life in that the former is intended only to be a proxy for the latter, a preparation or training for other relationships. We hope that the therapeutic relationship will serve only as a proxy and not as an end in itself. Freud said (**1915**): “He [the analyst] must not stage the scene of a dog-race in which the prize was to be a garland of sausages but which some humorist spoilt by throwing a single sausage on the track. The result was, of course, that the dogs threw themselves upon it and forgot all about the race and about the garland that was luring them to victory in the far distance” (p. 169).

For some patients the therapeutic relationship is a protected sanctuary where it is safe to experience the love and hate that cannot otherwise be

expressed. This direct expression of love and hate does, as we know, pose certain problems for the therapist, inasmuch as our body in its response to the patient's affects does not make a distinction between individuals in ordinary life and those within the therapeutic frame. We are all hardwired to respond in a complementary, albeit idiosyncratic fashion: the patient's hatred, the patient's love, and, in some cases, the patient's sexual arousal will induce in us some affective responses, the precise nature of which will, of course, vary. For example, the patient's rage may, in some therapists, evoke rage while in others it may evoke anxiety. As part of the "rules of the game," we try not to communicate this complementary response, or at least we do so in a measured fashion that serves the interests of the treatment.

On one level of reality, therefore, the two participants are ordinary people, while at another level they are part of a peculiar asymmetric setup, the nature of which has no parallel in everyday life. In the process of becoming a seasoned therapist we learn how to obtain some mastery over this paradoxical situation. This mastery becomes part of our professional persona. It is a process whereby, unlike in ordinary life, we discipline ourselves to inhibit our affective responses but not our affective perceptions. We learn to interiorize our affective responses so that they can be placed in the service of the treatment. It is a kind of sublimation in the interests of our profession. If the process miscarries, our professional work ego is thrown out of balance.

Not infrequently therapists are thrown off balance, or, as one patient expressed it, thrown off their perch, by the phenomenon known as projective identification. This phenomenon, originally observed by Klein, has been defined in various ways.[3] I would define projective identification as a process whereby specific elements of the patient's inner, affective constellation are communicated to the therapist without the patient's conscious intent. Therapists, in turn, may not recognize that what they are experiencing has its primary origin in the patient's mind and not in their own mind. Therefore projective identifications, if not recognized as such by the therapist, may exert a disruptive influence upon the treatment. Sometimes the patient communicates by means of actions that induce in the therapist the very same affective response that

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[3] The importance of the phenomenon of projective identification has become increasingly recognized by non-Kleinian analysts. For a comprehensive discussion see Sandler (**1987**).

the patient experienced as a child. In other instances the means through which the patient's affective experience is in a sense “placed” within the therapist is not clear. This uncertainty has led some early observers mistakenly to consider projective identification to be an occult or nearly mystical process. Many believe it to be a remaining vestige in the adult of a form of primitive preverbal or paraverbal communication that exists between the mother and her young child. I wish to emphasize that we are not simply considering the communication of affects without semantic content, for projective identifications are always embedded within a specific content, so I suspect that when transference affects are intense there usually is some element of projective identification.

In the following example from supervision, the method of communication of a projective identification was not at all mysterious. In this instance the patient was struggling to keep out of awareness a sense of personal defectiveness. To defend herself against this self-awareness, the patient subjected her male therapist to repeated personal criticism. The patient was especially critical of her therapist's technique and focused upon some errors of technique for which the therapist was in fact responsible. The patient believed that her therapist, who was very competent, was inept and ineffectual. This criticism unfortunately resonated with my student's own self-doubts, so that he responded to it as if it were simply a true accusation. It took some time before he could realize that, although he had in fact made some comparatively minor errors of technique, the question of his therapeutic competence was not the principal issue; he was participating in a process that had its origin primarily within the patient. In effect, he did not perceive that the patient was projecting her own sense of defectiveness and, in a sense, placing that experience within him. While the therapist could be faulted regarding matters of technique, he was also temporarily unable to recognize that his affective responses to his patient paradoxically referred to two different levels of reality, and he responded to her only as if she were someone in everyday life.

We know that the transference fairly frequently makes use of the objective reality of the therapist's personality and behavior; the therapist's objective character and personality become the peg upon which the transference is hung. We are all prepared for and accept the expectation that, over time, our patients will form some objective, realistic perception of us. The egalitarian ideals of our society, combined with a critical consumerism, have effectively removed therapists from a position of

authoritative infallibility from which they treat the patient's criticism as a transference "distortion."[4] We all welcome this change, which has resulted in an improved technique, but the current fashion of focusing only on the here and now and "objective" reality will miss the interplay of the past upon the present.

As I indicated, some aspects of the theory of psychoanalytic technique may be viewed as a means of helping therapists cope with their affective responses to their patients. One such theory that has a considerable influence upon technique is that of the therapeutic split in the analyst's consciousness between the observing ego and the experiencing ego. This concept is implicit in Freud's papers on technique and was further expanded by Sterba in his paper (**1934**). The concept is essentially a recommendation that the therapist be detached in the face of the patient's passions. The therapist's detachment represents not a withdrawal but rather a dissociation or split in the analyst's mind between the experience of the patient's passion and the intellectual contemplation of that experience. In this regard, Sterba's concept is not unlike James's (**1890**) observation of the paradox of the mind observing itself. This split between the analyst's experiencing ego and observing ego can be thought of as a form of consciousness that we hope that our patients will acquire from us. If this form of consciousness, in which affects are observed as they are being experienced, is internalized by the patient, we then say that the patient has formed a therapeutic alliance.

The broadening of the concept of countertransference has also significantly improved our technique and has enabled the therapist to cope with the paradox of experiencing the patient both as an ordinary person and as someone within the therapeutic frame. As I mentioned, in accordance with our changing culture, our theory of treatment has become more egalitarian. The therapist is no longer modeled on the authoritarian father of the Victorian period, a model that persisted well into the middle of the 20th century. As a consequence of this more egalitarian atmosphere, patients are now given support in recognizing that their responses may be in reaction to the therapist's objective reality in the here and now (**Gill, 1979**). In similar fashion, therapists have also been given permission to acknowledge the objective reality that lies behind their reactions to their patients. This development in the theory of technique comes under the heading of the broadening of the concept

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[4] Gill (**1979**) has been an eloquent spokesman for this point of view.

of countertransference.[5] As is well known, the term *countertransference* originally referred to analysts' unresolved neurotic response to their patients' transference. In this early period, the countertransference was regarded as an impediment to the treatment and implicitly condemned. This narrow definition has been replaced with a new definition in which countertransference is equated with therapists' total responsiveness to their patients, whether a response is neurotic or not.

Such a definition now appears to us as perfectly obvious, but we did not arrive at this point easily, for it required the contribution of those analysts who were courageous enough to reveal the details of their countertransference responses. I am thinking of Winnicott (**1947**), who revealed his hatred, and Searles (**1959**), who described his guilt and embarrassment in recognizing that he, not infrequently, had oedipal fantasies toward his female patients, including thoughts of marriage.

Winnicott (**1947**), in his pioneering paper "Hate in the Countertransference," tells of his response to objectively very difficult psychotic patients. What he says, in effect, is that his hatred is an objective response to his patient's impossible behavior. Winnicott recognizes that analysts or therapists, whatever their intentions, respond to the patient as an ordinary person; he reminds us that we will, whether we like it or not, respond to patients as if they are individuals in everyday life. Winnicott describes how these responses can be placed in the service of the patient's treatment, which requires the paradoxical interplay of ordinary life and the therapeutic frame. He relates his analysis of his own anxiety dream in response to a psychotic patient. His dream informed him that his irritability toward this patient was a reaction to his anxiety in sensing that the patient behaved as if she had no body.

When the countertransference can be used as a carrier of vital information regarding the patient's, not necessarily the therapist's, psychopathology, this news is very welcome to the analyst. It is a relief when we can trace our negative feelings toward our patients to their unconscious manipulation of us; on the other hand, we are uneasy when our negative reactions, such as our dislike of a patient, cannot be woven into

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[5] Money-Kyrle (**1956**) described the "normal" countertransference as follows: "The analyst, as it were, absorbs the patient's state of mind through the medium of the associations he hears and the posture he observes, recognizes it as expressing some pattern in his own unconscious world of phantasy, and reprojects the patient in the act of formulating his interpretations" (p. 364).

the fabric of the treatment process, for this situation is a threat to our professional persona and a threat to our work ego.

Today countertransference is understood to be a form of communication, as in the process of projective identification, in which the therapist's affective responses to the patient form a cognitive process that can be used to illuminate the patient's psychic reality. Analysts who have contributed to this insight include Heimann (**1950**), Racker (**1968**), and Bion (**1970**), who understood projective identification to be not primarily a defense, as Klein had believed, but a communicative process.

No one doubts that therapists have a "real" relationship with their patients. I place the word *real* in quotation marks because we need to question what we really mean by a "real" relationship. I have been attempting to illustrate that this so-called real relationship is fundamentally paradoxical in that it encompasses multiple levels and different kinds of reality. It is, as I have been emphasizing, a relationship that is unlike any other in ordinary life. In everyday life, the intensity of involvement on the part of one partner may or may not strengthen the relationship. In the therapeutic relationship the intensity of the therapist's involvement with the patient frequently has a paradoxical effect. This topic is usually considered under the heading of neutrality. We cannot be uninvolved with our patients, yet too intense an involvement will spoil the treatment. In this regard I would like to quote from King (**1962**):

> In a way the analytic relationship is in the nature of a paradox as are so many phenomena related to unconscious processes. Looked at from one point of view, we matter very much to our patients. They rely on us and trust us to maintain and care for the analytic setting. Looked at from another point of view, the patient does not, and during certain phases of his analysis is unable to care who we are or what we feel. In these circumstances the communication to the patient of any feelings of either love or hate may make the analyst of less use to the patient [p. 277].

King is saying that we must at the same time be both involved and unattached, but this Zen-like pronouncement is, as we know, a very difficult position to master. This paradox of attachment and nonattachment refers not only to the therapist's attachment to the patient

but also to the therapist's attachment to the treatment itself, especially with regard to the therapist's agenda for the patient. It is impossible for a therapist not to have some expectation or agenda for the patient's treatment. The therapist cannot literally be, in Bion's aphorism, without memory or desire, yet imposing this agenda upon the patient will spoil the treatment.

Some patients intuitively understand at the outset that they have entered into a very peculiar relationship that is simultaneously both real and unreal. More commonly, however, this paradoxical nature of the therapeutic relationship is something that the patient will only gradually discover through testing of the therapist and observing how the therapist shifts from one level of reality to another.

As I discussed earlier, the analyst's consciusness has been customarily described as a split between the observing ego and the experiencing ego. I would take this description a step further to add that the analyst's consciousness includes the capacity to shift between different levels of reality. As I have noted, there are some patients who have this capacity at the start, but more commonly the capacity to handle paradox must be acquired. As therapists, we are all acquainted with those patients who, despite our best efforts, cannot borrow this kind of awareness from the analyst and hence do not learn to accept the paradox of the therapeutic relationship. It would seem that the acceptance of paradox may in some way be connected to mental health, inasmuch as our sickest patients, those described as borderline or narcissistic characters, evidence the greatest difficulty. For example, there are some patients in this group who are unable to experience a transference: the therapist is viewed concretely and perceived simply as they would perceive the therapist outside of the treatment. We may encounter the opposite case: patients who experience us only within the transference and lose sight of us as ordinary people. Both types of patients may lose sight of the therapeutic setting itself, and their love and hatred of the therapist are experienced as no different from the affective encounters of ordinary life. If therapists remain either the target of a prolonged and remorseless transference rage or the recipient of a persistent erotic interest, they, when all other measures fail, may be forced to remind the patient that this relationship is, after all, a treatment. These patients cannot handle the paradox of experiencing us both as ordinary people and as people who are transformed by fantasy.

The role of paradox in psychotherapy and psychoanalysis was first

emphasized by Winnicott (**1971, p. xii**) who made the plea that paradox be accepted, tolerated, and respected. I should also mention, parenthetically, that Bateson (**1972**) predicted that certain patients might be unable to handle paradox, a prediction that has been confirmed.

When therapists experience intense countertransference affects, they are faced with the paradox of experiencing "real" affects in a setting that is not ordinary life. As I described earlier, one's perceptual apparatus does not initially distinguish between the affective experiences of ordinary life and those experiences that belong to the different kind of reality that is contained within the therapeutic frame. One feels angry, guilty, sexually aroused, and so forth in precisely the same way as one does in everyday life. We automatically respond in a complementary, yet idiosyncratic, fashion, and some mental labor is required to transpose this experience back into the therapeutic frame. The patient, who is the primary source of this affective interchange, has, of course, the identical problem. Those patients who are not able to share vicariously in our capacity to handle paradox may need practice in shifting from ordinary life to the therapeutic frame and back again. To obtain this practice, they may repeatedly attempt to knock us off our therapeutic perches: they enlist us as partners in a special kind of affect training (**Russell, 1985**). In this exercise some patients will force us to demonstrate over and over again our capacity to handle paradox, a capacity that they then can observe in our attempts to scramble back onto our therapeutic perch.

This processing of real affects within an "unreal" context is, to a considerable extent, a symmetrical procedure for both patient and therapist. If we now turn to a different aspect of the therapeutic relation, the gratification this relationship provides, this symmetry no longer applies. In the earlier quotation from Freud (**1915**), he notes that it is just as disastrous for the analysis if the patient's craving for love is gratified as it is if it is suppressed. The course the analyst must pursue is neither of these. In this same paper Freud refers to the "principle" of abstinence:

> I have already let it be understood that analytic technique requires of the physician that he should deny to the patient who is craving for love the satisfaction she demands. The treatment must be carried out in *abstinence*. By this I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's needs and longings should be allowed to

> persist in her, in order that they may serve as forces impelling her to do work and to make changes, and we must be aware of appeasing those forces by means of surrogates [pp. 164-165; italics added].

What Freud did not elaborate, and what we must consider, is that the therapist, acting appropriately as a therapist, can be a source of very meaningful gratification. This is usually described under the heading of dependency, which can also be viewed as a component of the holding environment. The "principle" of abstinence, as Freud indicated, alludes not only to sexual gratification but also to gratification of a nonspecific nature. Although Freud was not explicit, we may assume that he was referring to the gratification that ensues from the dependent relation with the therapist, which may interfere with the patient's motivation for a cure. Where in everyday life can you find persons who, for an agreed-upon period of time, will place their own needs and desires to one side and be there only to listen to you and who are more than usually punctual and reliable and can, for the most part, be counted on not to retaliate and to be free of temper tantrums? It is no wonder, then, that patients develop an idealizing transference. This is not based only on wishful fantasy; it is, in part, based upon what an ordinarily good-enough therapist does. Some patients, understandably, may have problems in differentiating licit from illicit gratification.

This gratification, which is absolutely necessary for the therapeutic process to proceed, can also act like Freud's joker who spoiled the dog race by throwing a sausage on the track. We serve only as a proxy for ordinary life and not as its substitute. Finding the therapeutic relation a substitute for life can become a problem for those individuals who have little tangible satisfaction in their everyday lives. This may be another example of the biblical proverb that to those who have, it will be given.

Transference gratification has always been implicitly acknowledged to be paradoxical. Analysts have long recognized that the extent to which the analytic relationship approaches the characteristics of a relationship in ordinary life will preclude or inhibit the development of the transference. Strachey (**1934**) noted this fact when he said: "The patient's sense of reality has the narrowest limits. It is a paradoxical fact that the best way of ensuring that his ego shall be able to distinguish between phantasy and reality is to withhold reality from him as much as possible" (p. 285). For this reason we restrict our social contacts with our patients, just as we restrict the sharing of the kind of personal information that would be

commonplace in a friendship. Yet if this process goes too far and an analyst or therapist ceases to behave like an ordinary human being, this occurrence will impede the development of a therapeutic alliance (**Zetzel, 1970**). I am also reminded here of a statement of Anna Freud's (cited by Greenson and Wexler [**1969**]): "I feel still that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other" (p. 27).

I perceive in this discussion a principle that can be stated as follows: Gratification at any one level of reality leads to paradoxical frustration at another. If a female patient demands love from a male therapist and if this love is gratified as if the participants are two ordinary people, the treatment, as we well know, will be destroyed. If, on the other hand, the therapist interprets that her wish to be loved is only a displacement of her wish to be loved by her father, she might feel that such an observation is patronizing and rejecting, as if the therapist is saying that this wish is only a transference reaction. Further, if she experiences within the therapeutic relationship a father love that she had lost or never had and experiences love in relation to the therapist as if he were a father, the gratification might lead to an acute sense of loss. Gratification of a father transference in current time may induce a mourning for what had been lost.

As a result of the fact that gratification within the treatment setup is apt to be paradoxical, we need to find a certain balance between different levels of reality. Some analysts (**Fox, 1984**), instead of recommending "abstinence," suggest the need to "titrate" a tension between gratification and withdrawal. This approach is something that most experienced therapists use instinctively; they know quite well how to maintain a balance between relating to patients as individuals in ordinary life and relating to them as individuals within the therapeutic frame. Others (**Sharpe, 1950**) have advised that during the transition between ordinary life and the therapeutic setting that occurs at the beginning and at the end of each hour, patients be treated as if they are guests in one's house. If this level of everyday life is overemphasized, we know that this emphasis may preclude the development of transference illusions. On the other hand, if, out of some misguided principle, the therapist fails to recognize the patient as a mature, equal adult, difficulties of another nature will arise. When I began my psychoanalytic training in the 1950s, I heard of stories, possibly apocryphal, of analysts who remained silent

even when the analysand said, “Good morning.” Some analysts became a caricature of themselves for fear of doing anything that might interfere with the development of the transference. This fear led to a style of practicing psychoanalysis that, charitably, could be called austere abstinence. In response to errors of technique of this sort, Zetzel (**1970**) underlined the importance of the therapeutic alliance.

I believe that this excursion into such abstract matters as levels of reality is justified to the extent that it enables us to understand with a certain clarity what we do instinctively and intuitively. I can summarize very simply: The therapist's consciousness must include the acceptance of the paradox of the coexistence of the asymmetric relation within the frame and the egalitarian relationship outside the frame.

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