Presence and Enactment as a Vehicle of Psychotherapeutic Change

Milton Viederman, M.D.

This article addresses an aspect of psychoanalytic and psychotherapeutic process that leads to change. Focusing on an aspect of the patient-therapist interaction that the author calls “presence” of the therapist, it demonstrates how the experience of this may lead the patient to unconscious enactment of early wishful fantasies concerning the good parent. The gratification of these wishes implicit in the interaction influences the therapist-patient relationship and plays a significant role in change.

In this article focuses on a particular aspect of the patient-therapist interaction that I call “presence” and demonstrates how the patient's experience of the “presence” of the therapist may lead to unconscious enactment of early wishful fantasies for the good parent. The gratification of these wishes in the interaction influences the therapist-patient relationship and plays a significant role in change. “Presence” does not preclude or contradict usual interpretive work, nor does it foreclose analysis of negative transferences and resistances.

I illustrate this process first as it occurred in a brief consultation, then in a vignette from a psychoanalysis, and finally in a once-weekly therapy. I then discuss the nature of presence and enactment and the manner by which this leads to change.

(Note: I will use the terms dynamic therapy and psychoanalysis and therapist and analyst interchangeably, although there are differences between them that I will not address. I would also emphasize that I view therapeutic interaction as originating from the very inception of contact between patient and therapist.)

A number of points of clarification will avoid mis-
understanding. I am describing what I consider to be an important aspect of the therapeutic situation that may cut across all dynamic therapies, and for that matter others as well. I wish to make it clear that this is not the only aspect of therapy that leads to change.

“Presence” will be differentiated from the therapeutic alliance, from Winnicott’s holding environment, and also from Stone’s3 and Greenacre’s4 views of the primal or primary transference. Both its accessibility to consciousness and the nonconflictual nature of the phenomena associated with presence have led to the view that it is a superficial rather than a substantial ingredient of change.

The concept of presence and engagement as a vehicle of therapeutic change touches on another problem that has troubled theorists of psychotherapy since its inception. This is the problem of nonspecificity. Why do therapies of very diverse sorts seem to be effective? Why is it that certain personality characteristics of therapists of different persuasions seem related to therapeutic gain? Does it reside in the experience of an ideal parental transference?

A HOSPITAL CONSULTATION

The patient was a 77-year-old married father of three, a lawyer, who had been hospitalized with severe pulmonary disease secondary to bronchitis, now requiring the constant use of prednisone. He had had recurrent vertebral fractures as a result and requested consultation for depression.

The patient was an engaging, intelligent man who spoke spontaneously and coherently. He was psychologically minded and had been previously analyzed. He spoke readily of his life experience and how it had made him the man he was. His engagement, his continuing interest in life, his humor, all belied significant depression. He was aware of the seriousness of his illness and his truncated life expectancy. Yet he was “unwilling to put the final point on his life.” He was a poet and “had not finished his last poem.”

The patient had been one of two children born to a family of five generations of lawyers. He had been enraged at his father, also a lawyer, who had insisted that he go into law and give up a promising aspiration as an English professor. His father had been a difficult, controlling, and unaffectionate man.

He had lived a vigorous life, formed many close relationships, and had a somewhat conflicted marriage which he described with clarity and frankness, emphasizing his wife’s positive and negative qualities. Although there had been conflict between them at one time, things had smoothed out significantly. Of special importance to him were his three daughters, whom he admired and who apparently had great affection for him.

Six months before, he had begun to feel constant pain due to vertebral fractures. What he called depression reminded in the context of trips to his country home, but he began to experience claustrophobia related to a fear of suffocation, which contributed to what he thought was depression. There was no active suicidal ideation. I responded to him during this first encounter by communicating to him that I understood what he had been telling me. In particular I emphasized that he was not depressed but grieving for his anticipated death and the loss of all of the things that were dear to him. The patient was touched by this and requested a return visit.

At the time of the second visit the patient spontaneously indicated that he had had a delirious period in which he was fearful of suffocating. He realized that this had evoked a memory of a strange experience that he had in analysis when one day he accused his therapist of having stolen his belt. This led to the recovery of a memory of having been molested when he was six or seven by a man who pulled his belt off his pants and threatened to use it if the patient cried out. In spite of this, his cries alerted someone and there was no direct sexual contact.

He had been thinking about our previous conversation and spoke of his pleasure in having been such a good father to his daughters. He became tearful as he said that “they would lose all of that.” I responded by indicating that this was not true. What he had given them would remain with them and not be lost. He had been the father to them that he had never had, and this was a treasured source of satisfaction for him and was something that would remain with them and not be lost. The patient became tearful and expressed appreciation for what I had said. He began to speak of his tender affection for his therapist, whom he had seen as a mentor, and recognized that he had been looking for ideal fathers throughout his life. He smiled and said that although I was considerably younger than he, he experienced me in the same way, and now for the first time he felt he could cry in front of me. He expressed relief and appreciation. In the context of our discussion, he revealed his interest in psychoanalysis and asked me about my experience and practice. I commented on aspects of it, and in response to his indication that he had a special interest in art revealed that I had written about artists. At his request I sent him a copy of a paper that I had written. In a telephone conversation before discharge, he indicated that our last meeting had been most helpful, that he had been able to express his feeling to his family in a way that he had been unable to do before—“It was like lancing an abscess”—and he felt calm.

Two months later, I noted his obituary in The New York Times and wrote a note of condolence to his wife commenting on how important his family had been to him. I received the following letter from his wife.

Dear Dr. Viederman,

Your letter was an enormous gift to us. For us to hear about B. from someone who knew him only dur-
ing his illness, and for you to give us the “landscape” of the B. you saw, touches me deeply.

He told me about his visits with you, and how wise and sensitive you were.

After you sent him your Magritte paper (which I look forward to reading), he felt urgent about my taking L.’s [his daughter’s] book to you, in return. “Quickly!,” he said. “The weekend is coming! I want him to have it right away.”

So look what you’ve done: you helped B. during his terrible and difficult time, and now you’ve helped us.

With my thanks,

I have addressed various aspects of therapeutic engagement during consultations in other contexts, but for the purposes of this article I will allude to certain themes that will be addressed in greater detail below. This patient explicitly revealed a transference experience in which he associated me with his therapist, other mentors, and an ideal father figure. This did not appear to be a defensive idealization. It is important to emphasize that my engagement with him was neither neutral, non-gratifying, nor anonymous. I was committed to supporting his self-esteem and to offering express valuation of what he deemed central to his person. Moreover, I felt an emotional involvement with him and was touched by his predicament, a circumstance I am sure he did not ignore. In my brief revelation of my professional life I was not anonymous. This illustrates what I mean by “presence” in the consultation setting. My “presence,” though spontaneous and not a manipulation, evoked a positive transference and cast me in the role of the ideal parent. This is in keeping with a major thrust in psychoanalytic thinking today, one that suggests that the therapist contributes to the transference.5-7 In this situation the patient’s psychological-mindedness, intelligence, openness, spontaneity, and sensitivity made the transference paradigm explicit, but it is potentially available in many other consultation situations. The bonhomie of the engagement was an important but nonspecific aspect of the establishment of presence. It was important that the central dynamic preoccupations of the patient were addressed. These pertained expressly to his own valuation of himself as a father, his relationship with his daughters, and the support of his hope that he would leave a powerful imprint upon them. A route to the establishment of “presence” is an appropriate, communicated understanding of the patient’s primary concerns as they are rooted in his antecedent life story.8,9 It is this, rather than simply being nice, that defines emotional support.

AN ANALYTIC FRAGMENT

The patient whom I will describe is a 39-year-old single, highly successful professional woman, born in Europe and working for a European firm. She was referred for a severe suicidal depression of some months’ duration. This had been precipitated by her having learned that the director of the large firm at which she worked, who had been a patron and a powerful idealized and protective figure for her since she finished school, had indicated that he no longer needed her services. He was homosexual, and she felt that young men were vying for her position. In addition, the patient had had a number of long-term unsatisfactory relationships with men. Her most recent one was with a man over 20 years her senior. She had been unwilling to commit herself, although she admired and cared for the man, until he lost interest, at which time she felt rejected and pained.

The patient is an attractive, articulate, sensitive, seductive, histrionic woman who spoke readily in spite of her tears, but appeared quite depressed when first seen. Although she was intelligent and psychologically minded, there was a pseudo-naïveté in her questions to me about the reason for her behavior and difficulties. In light of her inability to establish an effective relationship with a man and her sense of life crises and nonfulfillment, we decided to begin psychoanalytic treatment.

The patient was the only child born to a beautiful young mother and a much older father who were divorced when she was 2. Her mother was narcissistic and non-nurturant, and the patient described overt and cruel rejection after the mother’s remarriage to another older man, and especially after the birth of the patient’s half brother when she was 13. This resulted in a damaged sense of self as unlovable and hence undesirable, which, coupled with powerful dependency needs that she felt would overwhelm any man, led to fear of a commitment in love. The patient recognized early in treatment that her mother had been envious and competitive with her as she developed into a beautiful young woman. The mother had had many affairs. The stepfather was kind, gentle, and ineffectual. When the patient was in her mid-20s, the mother, who had been rejecting and uninterested, especially during her adolescence, committed suicide at a time of crisis, having amassed many gambling debts.

The treatment was punctuated by repeated trips to Europe. In the light of these interruptions, the patient felt it was easier to sit up rather than to use the couch as she had done at the beginning of the analysis. Her depression lifted, and she broke away from the company for which she was working. She lived a rich social life, but there had been no significant change in her love relationships with men, although she had many very close and devoted friends.

The following are two sessions that took place about 3 years into the analysis.
The patient began by commenting that she realized while waiting for the elevator that she had many business calls to make. Coming to see me seemed like a distraction. She wondered what she would talk about that day. I commented that we had not had consistent appointments and that there were long lacunae in our contact. I suggested, however, that it was not the burden of external demands that affected her attitude. I said that I wondered whether there was something inside that she was reluctant to deal with. She confirmed this by indicating that she had had contact with a rather frivolous man in Paris (not a close or a sexual relationship) and that she was finding the time to call him every day for 45 to 50 minutes to reassure him, since he was alcoholic and suicidal. She acknowledged that clearly her feelings did not have to do with the issue of time or pressure.

She then turned to her handbag and said, “I have these letters and I keep feeling that I want to read them to you. Somehow if I do this I feel I can close the door on my mother.” (These were letters her mother had written to her when she was in boarding school. These letters were often critical of her.) I asked her why it was so important that she read them to me rather than tell me about them. She said, “I have a sense that you will have an objective view of my mother. I realize that I may have made her into much more of a monster than she is. If I speak to my own friends, they will just support my own view. I have the sense that you are critical of her.) I asked her why it was so important that she read those letters, those letters that were so hurtful to you, and what you want to do now is to be able to love her. In retrospect, I realize that in fact what was striking was the absence of a sense of narcissistic entitlement to feel rage at what she described as an extremely rejecting and depriving mother.) I responded, “Maybe guilt is affecting you, but I wonder if somehow you don’t want to be permitted or encouraged to love your mother.” The patient responded with intensity: “No, no, that is not true at all. As you know, I have always loved my mother. In fact, I have been in this masochistic love relationship with her, and it is this that I really want to break free from.” I responded, “This seems so clear at this point. You need to free yourself from your love for your mother to be able to freely love someone else.” The patient burst into tears. “You know, that is what brought me to treatment. My attachment to my boss. He was the incarnation of my mother. I needed so much to be in a love relationship with him, and when he broke off I became so depressed.”

The patient continued to talk about the importance of giving up her love for her mother, and that for her the conflict with the mother was overwhelming and central. I responded by saying, “Show me the person who doesn’t have conflict with their mother.” She laughed and told me a joke about three mothers, the first who said that her son had given her a diamond ring, the second who said that her son had given her a house on Palm Beach, and the third who said that her greatest gift was the fact that her son was going to a psychiatrist five times a week and spent 45 minutes a day talking about her. This interchange was characterized by informality and warmth.

The patient went on, “You know, it is so important that you are responding to me the way you are today, by asking questions and being so connected. The couch was so difficult (she was now sitting up). This is so much better.” I indicated that I realized that certainly at this point this was the case, and I asked her what was important about what was going on between us. She responded by saying that in her working with me, I, by virtue of my wisdom, would help her to understand what was happening. (I was struck by her comment about my wisdom, particularly in light of the fact that my earlier interpretation apparently had not been meaningful to her at the time. Yet she still maintained this view of me as the sage.) I commented that it was so important for her to see me as the wise man helping her and as a person who was set up above her and not as two equals working together intensely on the same problem (which was what I had experienced). She burst into tears and responded by saying that when she was an adolescent she had always wanted someone to direct her, to take charge, to be available for her. The complete independence that she had been given reflected the absence of someone who cared about her and would help her to direct her life. I commented, “You have been forever searching for the wise father to direct you, and you have been experiencing me this way.” Again the patient burst into tears and said that she had so much wanted someone like this.

I then said, “It suddenly occurs to me why it was so important for you to read the letters to me. You were all alone when you read those letters, those letters that were so hurtful to you, and what you want to do now is to be able to read them in the presence of a wise and supportive father, something you had been unable to do at the time.” The patient sobbed and indicated that this was true. She said, “I need this to close the door on my relationship with my mother.”

The patient went back to her wish to have the wise, good father and said with a smile, “This is sick, isn’t it?” I replied (knowing she would understand), “You wouldn’t be here if you weren’t sick,” and we both laughed.

The patient responded by saying that this was probably the most important session that we had had. She laughed at the thought that she had come in thinking that all she wanted to do was to make business phone calls.

The patient entered the next session and offered me two books, one by a French philosopher who had been very depressed and yet had a rich sense of humor, and the other a dialogue between Eli Wiesel and François Mitterand. She
went on to talk about the meaning of the last session and how much she had been affected by it. She wondered whether she was also trying to find her mother’s love and to deal with things that way.

I picked up the issue of the gift and wondered about it. Characteristically she asked what I thought and laughed. I indicated that I wanted to look at it with her but wondered whether it didn’t have to do with a gift to the good father. She responded immediately by saying no, that in fact she felt that it was much more like giving a gift to a friend, something that she had wanted to share, something that was important in this regard. I commented that having discussed the father theme seemed to free her to experience me as an equal.

She responded by saying that she was certain that she would want to go back to experiencing me as a father again but that wasn’t the way she felt that day. She touched the letters she still had in her handbag and said, “This really has to do with father.”

She reflected on the fact that at other times in the treatment she had experienced me as father. She had begun to feel this less intensely than when she began analysis. She said that she needed to use me in certain ways, to experience me in certain ways. “Isn’t this like growing up?” she said. “I never had anyone like this, and somehow as I allow myself to experience you this way, I am free to seek out other relationships. I believe this is a healthy relationship for me, and the fact that you allow me to be all sorts of things, the little girl, the equal, the person who is looking for a wise person; I never really had that.” The patient here underlined the facilitation of multiple transference manifestations.

In the analytic sessions I have described, the patient’s awareness of her experience of me as the good father was stimulated by an interpretation not immediately meaningful to her but presented in an emotionally engaged and caring way. This had occurred after a long experience of work together during which we developed a common language (which was at times literally French). The patient’s experience at that moment was different from mine, since I had felt it was a collaboration of equals. Her experience related to her own wish for a paternal figure. When she corrected me, my subsequent interpretation of her wish that I be the good father, present at the reading of the letters, was confirmed by her emotional release and the flood of associations that followed. Moreover, the new experience having been interpreted and now become conscious led to a shift in the transference paradigm and the patient’s acknowledgment of her use of me in various roles. The shared experience of working together, coupled with interpretation, made the experience meaningful and mutative.

A central theme in her life has been her self-denigration and the belief that she was not entitled to receive the attention and gifts of others—this in spite of her rich social life and the clear responsiveness of her friends. The experience of the ideal father-child relationship was an experience of expressed valuation of the patient, and it is in this context that the patient began for the first time to value herself and to feel deserving of gifts. Her previous inadequate sense of narcissistic entitlement gave way to a new freedom with her friends.

A PSYCHOTHERAPY ANECDOTE

To cover the range of therapeutic endeavors, I will illustrate this idea in an experience with a patient who had been in a therapy once a week for 6 months. This is to demonstrate the ubiquity of the concept that I am describing and to demonstrate that much can be accomplished in treatments that involve only weekly sessions.

The patient was a single man in his late thirties, successful in the banking industry, who presented in a state of high anxiety, with insecurity about his future, uncertainty about his relationships, and a pervasive anger and cynicism about the behavior of others, particularly those of power and wealth. Although financially able to support at least a twice-a-week therapy, he was unable to accept this, given his anxiety about his financial situation and a reluctance to experience emotional engagement.

In the session I am describing, he spoke of his painfully underprivileged background and how his move from the midwest to college in southern California had opened up to him a wonderfully privileged life that released him from the misery of the working-class Chicago suburbs. As he spoke of his pleasure at the wealth and richness, I commented on his ambivalence, since he was both desirous of wealth and critical of it. He had maintained his identification with both the underprivileged and the privileged. He was taken aback by the interpretation and began to examine the ambiguities of his position. As he spoke, he became tearful and was unsure whether he was sad or angry. I wondered whether he had been touched by the emotional intensity of the interchange. He responded tearfully as he spoke of his increasing ability to express feelings and thoughts that he had never before expressed. He spoke of my interest and my efforts to understand him, which he contrasted with his experience with his father, whom he felt was uninterested and deceitful. His experience of being unconnected had left him feeling lonely. He was reminded in this discussion of his increasing awareness of the affection he felt for two of his friends.

The patient began the next session by acknowledging that twice-a-week treatment would offer more continuity. He went on to discuss the themes of the previous week, the issue of the privileged and the underprivileged, this time intel-
tectually and without much feeling. I had the sense that he was struggling to recreate the experience of the last session that had so affected him, and I commented on this to him. He again became tearful as he acknowledged that the experience of the previous session had been very meaningful to him.

This anecdote illustrates the patient's search for the good feeling, for contact with the good parent to relieve the loneliness that has so dominated him and was so reminiscent of his lonely childhood experience.

DISCUSSION

The idea that the analysis of transference and of transference resistance is the central mode of therapeutic change in analysis is properly essential to the idea of change. By reliving the experience of the past in the transference, the patient can be helped to understand the distortions as well as the wishful elements that affect behavior (the totality of experience), thereby facilitating the creation of a new, freer, and more adaptive experience of the world. What changes people in analysis resides not only in the novelty of an interpretation, but in the new experience of the analytic situation, an experience that contrasts with previous experience and with continued maladaptive patterns of behavior. It is a corrective emotional experience—although not in Alexander's 10 sense of a manipulated experience in which the therapist takes a false and deliberate role to contradict a reexperienced transference. Words alone do not effect change. This principle is reflected in Rado's saying that the only thing that insight ever cured was ignorance. Words are powerful when they are expressed in an emotional context that leads to new experience.

I emphasize the element of transference manifested in the wish for a good, gratifying, supportive, valuing parent. This has been described by the Ornsteins as the "curative fantasy" with which many patients approach therapy. 11 They speak of the unconscious fantasy of patients approaching treatment, that they will find the perfect parents they never had in childhood and will thereby be cured. 12 I call this the "wishful ideal parental transference," it is an attempt to find a state of peace and a state of understanding to decrease the sense of isolation that neurotic symptoms and their distortions engender.

Clearly the experience of gratification of such a wish is a solution neither to intrapsychic conflict nor to life's problems. However, the full and rich affective reenactment of the discovery of the wished-for ideal parent, that is, the parent desired but never had, is potentially operative to a greater or lesser extent in a wide range of psychotherapeutic contacts—including brief consultations—and contributes to change in many therapeutic encounters. I distinguish here between a predominantly ideal transference and a predominantly idealized one; the latter is rooted in the conflict and is often a defense against aggression. 12 My emphasis is not on repetition of a past experience, but on repair of a developmental disturbance, a new experience that contrasts markedly with the past and thus has a powerful effect. Hence it includes not only conflicted repetitions to be corrected through interpretation, but also wishful new experiences, enacted in the transference and crystallized by the pressure of the therapist.

Neither substrate nor catalyst is a suitable word for what I mean by presence, since both have the quality of inertness and are not dynamic. Presence emerges rather than being directly brought about.

One aspect of presence clearly has to do with interpretation or communicated understanding. Meaningful interpretations—interpretations that lead to insights—have the quality of emotional conviction and create changes in one's perception of oneself in the world. Of special importance are transference interpretations that modify distortions emerging from the past. Inevitably, this interpretive communication by the therapist reflecting understanding of the conflicts and predicament of the patient over time gives the therapist a special status in the patient's eyes. The therapist's involvement contributes to this effect. Emotional engagement is an important aspect of presence: the experience of a shared enterprise in which the patient feels valued by the therapist's respect for the patient's struggle adds to the experience of presence. In short, traditional analytic work contributes to the establishment of presence but does not encapsulate the idea that I am presenting.

Empathetic awareness of the patient's emotional state is a substrate for intervention and for communication. Schafer 13 speaks of generative empathy, taking the term from generativity, a concept in Erikson's stages of adult life. 14 In my view, however, empathy leads to an understanding of the patient's predicament and thus prepares the terrain for a potential interaction with the patient that leads to establishing presence. Truax 15 and Truax and Carkhuff 16 establish an empirical basis for the therapeutic power of accurate empathetic under-
standing of the patient, unconditional positive warmth for the patient, and therapist genuineness. These elements lead to what I call presence. Empathy prepares the terrain for an active engagement of the patient.

But how does presence come about? Clearly it involves a positive attitude toward the patient, a sense that one likes the patient. In the real world, however, this is not always the case. If a patient is too hateful or evokes very negative feelings, problems are posed for the development of a working alliance. Yet emotional engagement is often possible at moments, thus having special meaning in its unexpected appearance. There are other circumstances in which presence can develop. I found myself working with a patient who was not especially articulate and was rather cut off from his feelings. I was frequently bored and felt absent. I began to actively construct scenarios from the experiences he was describing, to suggest motivations, conflicts and feelings, to fill in gaps, to provide a type of “connective tissue.” The patient began to ape my method, at times laughing as he recognized what he was doing, that he was speaking in my voice. Gradually it became his own, and he became enthusiastic in his endeavor as he began to recognize and acknowledge his inner life. As he did so, I became more alive, responsive, and present. (This experience echoes Goldberg’s elegant paper on modes of interaction with patients,17 in which he uses the analogy of music in modes of interpretation. The experience I have just described would correspond to his playing variations on a theme.)

It is important to emphasize that by “presence” I do not mean a uniform or standard response to the patient. On the contrary, it is my view that every relationship, whether in life or in analysis, has unique characteristics that develop in the context of repeated interactions. Particular qualities in the patient evoke in the therapist a special type of responsiveness unique to that patient. We develop personal languages in our dialogues with patients: modes of speaking, of delivery, special ways of communicating whether by humor, idiosyncratic vocabularies, uses of metaphor, or tones of interaction that are unique to the particular dyad. This responsiveness is enriched progressively by the shared experience in the treatment, in the common language that develops between the two participants. (I use the idea of a personal language as distinguished from a tongue, the latter having to do with the general and formal rules of psychoanalytic interpretation.) The therapist’s responsiveness in this regard is often automatic, intuitive, and without conscious awareness, particularly initially. It becomes a natural background for the dialogue. The therapeutic stance is also tailored and formulated on the basis of the therapist’s knowledge of the patient’s personality and what the patient can integrate and respond to at a moment in the analysis.

It is important to emphasize that these are experiential phenomena. They can be described and are in part shaped by conscious intent, although there is an important element of spontaneity. They must remain authentic and uncontrived. What has been described above has to do with the concept of intersubjectivity, and it touches on Pizer’s18 concept of negotiating a relationship. The development of presence with an individual patient is affected by the repertoire of possibilities in the therapist, which inevitably has limitations. I do not imply that my “presence” has a universal quality that is useful in work with all patients. I am well aware that my capacity to interact properly with certain patients is limited by my inability to respond to certain implicit demands generated by them. Moreover, presence is not defined necessarily by behavior that would always be described as active. Certain patients require a quiet silence on the part of the therapist or interpretations offered in a particularly tentative way rather than as defined statements to which they can react. The combinations are endless, and it is here that the patient-therapist match becomes important.

Therapists have different aptitudes in their abilities to respond, to allow presence to develop. The process is further complicated by the conditions of training, which discourage personal expression as behavior that deviates from the rules (often experienced as constraints) of neutrality, anonymity, and nongratification. This may lead to rigidity. Many unsuccessful analyses or impasses in analysis, even in the context of what appears to be reasonable understanding and interpretation, become so because of the “absence” of what is necessary under the circumstances. The development of an aptitude for presence depends upon personality and requires experience, confidence, and a capacity for appropriate spontaneity. It may even become dangerous, for in the wrong hands it can create a chaotic situation or wild analysis.

Although “presence” is an elusive concept, it can be described. It is not to be considered a matter of personal style, although the form it takes is personal. It is not a technique, but involves behavior of the therapist that is generated spontaneously in the relationship be-
between two people. As such, it reflects aspects of the “real relationship” as described by Greenson and Wexler,19 Viederman,12 and others. It is related clearly to the findings of Truax and Carkhuff20 and Truax,15 who have demonstrated the positive effect of warmth and genuineness as nonspecific factors in psychotherapy. Clearly, therapists vary in their emotional reactivity. Beyond this, I am speaking here of a progressive involvement on a personal level that goes beyond an intellectual curiosity about the process of psychotherapy. The involvement is unambiguously on the side of cure—though it is to be recognized that this wish for cure has potential pitfalls, not only in the form of negative therapeutic reactions, but also in the danger of imposition of the expectations of the therapist upon the patient. However, to recognize with Loewald20 that the analyst is on the side of change—though it is to be recognized that this wish for cure has potential pitfalls, not only in the form of negative therapeutic reactions, but also in the danger of imposition of the expectations of the therapist upon the patient. However, to recognize with Loewald20 that the analyst is on the side of change is not to impose the values of the analyst, but rather to create an environment in which the patient can develop according to his or her own potentiality.

“Presence” may be a stimulus for the analysis of unconscious conflict; it may be experienced as a threatening intimacy, which evokes anxiety and thus becomes a stimulus to further analysis. This was the case in a situation where a chance encounter with a patient in an elevator led to an interchange that evoked anxiety, which was subsequently analyzed.21

The only reference to the word presence in the psychoanalytic literature is by Sasha Nacht.22,23 The patient is led to believe that the analytic environment is benign. Vészy-Wagner24 notes:

Under “presence” Nacht understands a “constant accessibility” [being at the patient’s disposal], an “unconditional (kindly) reception,” an “unlimited patience,” and, what is most important, an “ability to give”. . . The patient should find “a good object” in the therapist and the effective management of the transference depends less on the technical abilities of the therapist than on his deeply felt and genuine attitude toward the patient. (p. 79)

This is a description of presence that echoes my own, although, as I will discuss below, I am referring to something much more variable and nuanced than a benevolent, nurturant attitude. Moreover, central to Nacht’s idea of presence is that this is a requirement for proper analysis and the substrate on which the analysis rests. I agree but add that it may become a major agent for change in its own right.

More recently, the psychoanalytic literature has reflected a growing interest in themes pertaining to the model I have described.25 Renik26 emphasizes the constant and inevitable enactment that characterizes the special dyadic relationship in analysis. He emphasizes spontaneity (of course, with awareness) and offers the analogy of a skier acted on by powerful forces but allowed a sort of freedom from excessive control—as would also be the case, he notes, in a good sexual relationship. Renik further speaks of the idealization of the therapist as a useful phenomenon; however, he does not distinguish between ideal and idealized transference. Jacobs27 also comments on the therapist’s spontaneity and use of “intuitive understanding of the patient’s state of mind and character to make unconscious adjustments in technique” (p. 12). Hoffman7 presents the constructionist’s view and speaks of “the personal, spontaneous aspects . . . of the relationship . . . with the cultivation of intimacy” (p. 114). None of these observations are organized in the form of the model that I propose.

It is important to emphasize that by “presence” I mean much more than what has been described by Winnicott as the “holding environment.”28 “Presence” is not simply the direct experience of a warm and nurturant attitude; it may develop in a confrontatory or what may superficially appear to be an aggressive stance. Winnicott’s holding environment differs from what I am describing in two important ways. First, the holding environment is an atmosphere generated by the experience of the therapist as a nurturant figure, much as described by Nacht. Second, it is essentially a revocation of a preverbal and primal experience.29 In this respect it is not interpreted and remains in the background.30 What I mean by “presence” has different configurations, generated by the interaction and based on the patient’s needs as they evoke intuitive and spontaneous responses in the therapist. At times what may be seen as an aggressive confrontational stance may solidify the relationship and actually be experienced as a mentorship. At other times a contrasting approach is necessary; the therapist must modulate his or her expression of feeling in order to respect the patient’s fear of emotionality and expectation of intrusion. These fears may be examined gradually as the analysis proceeds. Gradually a special quality of dialogue is established between patient and therapist, a dialogue that varies from one dyad to another. Most important is that this dialogue is in the experiential realm (in the domain

J Psychother Pract Res, 8:4, Fall 1999 281
of conscious and unconscious fantasy\textsuperscript{31}) and hence available for interpretation.

Multiple modes of interaction characterize human relationships. Levenson\textsuperscript{32} singles out two dichotomous modes of experiencing and acting in the world. He argues that both therapists and patients tend to cluster toward one of these modes and that their interaction in this context affects the nature of the therapeutic relationship and what happens in psychoanalysis. He defines the \textit{poetic mode} as one that involves an attention to the unconscious flow of ideas and says that a therapist working in this mode is more likely to encourage the flow, occasionally to raise questions about it but to be more passive regarding interpretation and active intervention. On the other hand, the \textit{pragmatic mode} focuses on skill in the world and touches on actualizing patients’ feelings in a very active way in the analytic situation. The latter mode in many situations evokes \textit{“presence,”} but the former stance is required at other times. This is the art of analysis, what makes \textit{“presence”} so hard to describe. There is no single road to Jerusalem.

At this point another question must be posed. Will my analytic patient wish to perpetuate a dependent ideal transference in the form of an incomplete and in-terminable analysis? Why should a person wish to give up something that is comfortable and gratifying for something involving danger and the unknown? One might also wonder whether this experience would mute her ability to manifest angry transferences. These are questions that have permeated the psychoanalytic literature for years. The libidinal and economic hypotheses suggested that the discharge implicit in gratification would decrease motivation for the examination of behavior and for change, although a proper balance of frustration and gratification is more in keeping with current thinking. With my patient, the experience of the ideal transference did not prevent her from manifesting angry transference reactions and working them through.

There is a long tradition of awareness of the influence of the therapist in relationship to the powerful thrust for development throughout life, a movement toward change and increased complexity.\textsuperscript{1,20,33–35} Chused\textsuperscript{25} emphasizes the role of idealization of the therapist in the young adult as a force leading to developmental progression. Loewald\textsuperscript{20} has argued that the analytic process is analogous to a developmental process, in which the therapist has a perception of the person that the analysand is becoming and helps to crystallize this perception for the patient as the analysis proceeds. This developmental process was expressly stated by my analytic patient, who described the multiple roles she had assigned and would in the future assign me. The sense of security often generated in our relationship permitted a new and richer exploration of the world endowed with new possibilities and replete with its own gratifications—not unlike aspects of the process of separation and individuation.

In each of the anecdotes described, the ideal transference took a paternal form that was concordant with the needs of the patient, reflective of his or her life experience as expressed at that moment in time. Did my gender effect this? Would an ideal maternal transference operate under other circumstances, or is it true that the maternal influence is directed toward affiliation and nurturance and the paternal one toward separation and independence?

A comment on the nature of change is indicated. By \textit{change} I mean a modification of self and object representations that permits the patient to experience the world in a different way. My analytic patient, who had previously lacked an appropriate sense of entitlement to take and receive from others, was able in the context of the experience of analysis to find herself worthy and to comfortably take from others. This was a reflection of an increased valuation of herself that had been generated in the psychoanalytic process. It is difficult to establish absolute connections between specific aspects of process and outcome because analysis is so complex and involves understanding on many levels. Although the change that she experienced was influenced by what I have described, the process of interpretation of intrapsychic conflict played an important role as well.

In conclusion, presence and enactment as described here is neither the whole nor the end-all and be-all of change in the psychoanalytic process. In the past this has been seen as a substrate for successful analysis rather than as a force toward change in its own right. It poses the difficult problem of the personality of the therapist. Moreover, it has been viewed with suspicion because it seems to contradict the tragic view of reality,\textsuperscript{36} the view of the essential human experience of conflict and pain so pervasively insisted upon by Freud.\textsuperscript{37} Yet presence and enactment may lead to an important aspect of change that complements usual analytic technique. As such, it may explain the efficacy of many diverse psychotherapeutic endeavors based on different
models of therapy. In this light, an aspect of the non-specific effects of psychotherapy may be viewed as a specific one. Moreover, this model lends itself to an understanding of aspects of all therapeutic encounters, from brief therapy to psychoanalysis.

Earlier versions of this paper were presented at the Samuel W. Perry, III, M.D., Memorial Lecture, Cornell University Medical College, New York, NY, April 3, 1996, and at the Massachusetts Institute of Psychoanalysis, Cambridge, MA, March 22, 1997.

REFERENCES

6. Renik O: The anonymous analyst and self-disclosure. Psychoanal Q 1995; 64:466±495
13. Schafer R: Generative empathy in the treatment situation. Psychoanal Q 1959; 28:343±373
23. Marasse II: Review of La presence du psychanalyste by Nacht S. Psychoanal Q 1965; 34:113±114
32. Levenson E: The relevance of frequency of sessions to psychoanalytic process. Panel presented at the annual meeting, American Psychoanalytic Association, December 1995, New York, NY