

Therapeutic Interaction in the Bipersonal Field: Part I  
Contributions of Robert Langs to Clinical Psychoanalysis, 1973 - 1979<sup>1</sup>  
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The present paper is a review of the contributions of Robert Langs to psychotherapy, as found in books which he published during the period from 1973 to 1979. It describes an adaptational-interactional approach to psychotherapy in which attention is directed to the therapeutic and anti-therapeutic role of introjection and identification with the therapist. More specifically, Langs has been concerned with preventing iatrogenic emotional and behavioural disturbances, by teaching therapists to monitor the effectiveness of their interventions through attending to the client's commentary on them.

In writing this review, I have taken the liberty of quoting extensively from Dr. Langs' own work without, however, providing the voluminous number of quotation marks which perhaps should have been provided in order for this paper to be entirely proper. Thus, the reader should be advised that I make no claim to originality, and that my main purpose in writing this paper is to introduce to the broader psychological community this most brilliant analyst whose writings have not yet received the attention that I think they deserve.

In classical psychoanalysis and psychoanalytically oriented psychotherapy, the central motivating factor in the treatment situation and in the patient's communications is his intrapsychic anxieties, conflicts, fantasies, and memories. The therapist, although a participant, is essentially a passive, neutral, and flexible figure toward whom these fantasies are projected and displaced; and work is undertaken primarily around conflicts and issues outside of the therapeutic relationship. In treatment, the therapist creates the conditions for the unfolding of the patient's transference, and the emphasis is on the transference component of the relationship rather than on the interaction per se (Langs, 1978 b).

There is room in this conception for an occasional gross error on the part of the therapist, and for countertransference-based therapist input into the interaction. There is also the possibility of direct pressure exerted by the patient on the therapist to respond in some inappropriate manner, viewed in terms of unconscious efforts by the patient to repeat his past rather than to remember it. However, the major determinant of the patient's behaviour in the therapeutic interaction is conceived of as being his unconscious fantasies about the therapist or other obvious displacement figures; and the therapist's job is to receive and interpret these relationship-distorting fantasies and their underlying meaning so as to free the patient from the repetition of his past (Langs, 1976 b).

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<sup>1</sup> When I submitted this paper for publication, it was turned down because it didn't contain anything original, i.e., the reader could learn anything it has to teach just from reading these books by Langs. Now, doesn't that boggle the mind!

It was within this classical psychoanalytic context that Langs made his first major contribution to the understanding of treatment. Beginning with the observation that the day's unfinished business is often the crucial organizer through which unconscious meanings take shape and can be recognized in the interpretation of dreams, Langs (1972) found that other types of communications from patients, such as descriptions of recent events and behaviours in and out of the treatment hour, could also be more readily understood in terms of the real-life precipitants or adaptive contexts of the major sequences of material produced by the patient in treatment. Furthermore, Langs observed that it was frequently the therapist's behaviours, his confrontations and interpretations (and errors such as modification of the ground rules of therapy), which served as the primary adaptive context for the patient's communications during therapy. Indeed, certain types of material, such as acting out, were usually found to represent the living out of real as well as transference reactions and fantasies related to the therapist and his behaviour in the treatment situation (1976 a). Nevertheless, in his earlier writings, Langs still located many of the patient's primary adaptive tasks outside the therapeutic relationship and believed that the main job of the therapist was interpretation of the transference.

Langs (1973) next added to his model of treatment the concept of the therapeutic context. Whereas the primary adaptive task was seen as a first-level organizer of the patient's material, the therapeutic context, i.e., those indicators of difficulties and resistances within the patient which tend to call for interventions from the therapist, was seen as a second-level organizer of the patient's material. Thus, the communications from the patient were first to be understood in terms of their adaptive context, and frequently in terms of the reality of the interaction between the patient and therapist, and only then in terms of the patient's internal psychopathology. This two-level approach to transference was intended to emphasize that many intrapsychically significant reactions within the patient occur in response to the therapist's behaviours and interventions. And it was noted that these therapist behaviours could be either positive or negative, constructive or destructive, necessarily or unnecessarily hurtful, and within the framework of valid interventions or based on technical errors on the part of the therapist.

It was within the context of this two-level approach to transference that Langs (1974) then began to explore the much neglected introjective side of the patient's relationship with the therapist, and to emphasize and investigate the unconscious communications contained in the therapist's interactions with his patient. Reconceptualizing the patient's relationship with the therapist in adaptational-interactive terms, Langs noted that many of the regressions and symptoms within the patient are therapist evoked, i.e., primarily introjective in nature and based on the therapist's errors in intervening, either interpretatively or in terms of his management of the framework within which the treatment occurs.

Consideration of the latter led to an increasing emphasis on maintaining a secure therapeutic "hold" on the patient through rigorous adherence to the basic ground rules of therapy, i.e., an explicit verbal agreement between the therapist and patient regarding fees, appointment times, and length of sessions; an understanding that the patient will say everything that comes to mind in his therapy sessions, without exception, and that the therapist will give the patient his undivided attention, attempt to understand the patient through what he says, and offer that understanding to the patient primarily through his interpretations of material supplied by the patient; and an understanding that the therapist will offer no other gratification to the patient. That is, there will be no physical or social contact, verbal interaction will be confined to the therapist's office during regularly scheduled appointments, the therapist will remain relatively anonymous, and confidentiality will be *de rigueur*.

By making use of this increased understanding of the adaptive context as an organizer of the client's communications, it became increasingly clear that much of what the patient said about outside relationships and experiences had a significant although unconscious and disguised bearing on the therapeutic interaction (Langs, 1976 a). In previous psychoanalytic writings, it had been suggested that once it is determined that the material from the patient unconsciously alludes to the therapist, it is essential for the therapist to make the added assessment of the extent to which the material also contains veridical perceptions as opposed to fantasy-based distortions, using the therapist's self-knowledge as well as clues provided in the associations from the patient. This latter resource, however, had been relatively neglected up to that point, and it is to Langs' credit that he not only recognized its significance but elaborated on its significance in treatment. The recognition that the patient unconsciously perceives the therapist's errors and, further, unconsciously attempts to call them to the therapist's attention, and even to correct him wherever possible, proved to be the beginning of an extensive investigation of the patient's positive and negative responses to erroneous interventions, and of what ultimately proved to be the patient's unconscious curative efforts on behalf of both the therapist and himself under these circumstances (Langs, 1979 a).

This understanding of the function of the client's communications as a commentary on the therapist's communications, albeit in symbolic and derivative terms led to an image of the patient as an individual with enormous unconscious, valid, and creative sensitivities rather than as someone who is virtually always sick, distorting, misunderstanding, and responding inappropriately, even though his perceptions of and reactions to the therapist's behaviours may take place entirely at the unconscious level, e.g., through references to having himself behaved badly or done something wrong or having known someone else who did. And this conceptualization of the therapeutic interaction as involving the therapist's responses to interaction as involving the therapist's responses to the

patient and the patient's responses to the therapist's responses has more recently been elaborated in terms of a spiralling interaction within the therapeutic field (Langs, 1978 a).

Working from the idea that the patient's communications are frequently a commentary on the therapist's interventions, Langs (1978 b) went on to describe various communicative styles among patients, in which the reporting of analyzable derivatives (by which was meant that, in a given session or over several sessions, the patient would unconsciously communicate with the therapist about the adaptive context, through meaningful indirect communications related to that context) was but one of several options available to the patient in how he would choose to communicate with the therapist, albeit the most useful from the standpoint of psychoanalysis or psychoanalytically oriented psychotherapy since this style of communication allowed the therapist to readily interpret to the patient the unconscious meaning of his communications. There were, in addition, at least two communicative styles among patients which were felt to be less useful for therapy. Some patients would report material seemingly rich in symbolic derivatives of their unconscious fantasies but without any apparent adaptive context to provide it with definitive meaning; and some would report a series of seemingly crucial adaptive contexts but without the accompanying meaning-laden derivative associations. Initial observations suggested that these latter styles were based on factors within both the patient and the therapist, and therefore within the therapeutic interaction.

As Langs' ideas about therapy continued to develop, so did his concern about iatrogenic illness, the symptomatology within the patient that results from psychopathology shared by both the patient and therapist. Symptom resolution was seen as resulting from (1)cognitive insights derived from the therapist's interpretations, (2)the therapist's serving as a model of integrity and "straight"communication through his adherence to sound principles of technique and maintenance of the ground rules and boundaries of the therapeutic interaction, and (3) the inevitable positive identifications with the therapist which are derived from the two former types of experience. And where previous writers had viewed the ground rules as a kind of unobtrusive backdrop for the therapeutic experience and as a means of safeguarding the transference, Langs (1976 a) emphasized more and more the importance of maintaining a firm therapeutic hold in order to allow the patient to communicate with the therapist regarding his own psychopathology rather than the therapist's.

As Langs moved further and further away from viewing psychotherapy as dealing solely with the patient's intrapsychic contents, and towards a greater emphasis on the mutual interactional aspect of the therapeutic encounter, he found himself somewhat at a loss for a vocabulary with which to communicate his growing understanding of the therapeutic process. The necessary terminology was found

in the Kleinian literature. Explication of the unconscious communicative interaction between patient and therapist was particularly helped by adoption of the term projective identification (Baranger and Baranger, 1966).

Now, transference has been defined as the patient's conscious and unconscious relations with the therapist based on all prior and current object relations (i.e., relationships with others), both internal and external, beginning with the primary relationship with the breast-mother that has subsequently been internalized. In this context, projective identification is defined as an early primitive mental mechanism through which the infant splits off from consciousness painful negative internal self-representations, and omnipotently places them into the "object," usually the mother. It is a mental mechanism which matures with later development; although its earliest expressions occur before self-object differentiation is complete, its later forms occur within the context of clear object relatedness and constitute interactional efforts to place parts of one's inner self into others, so as to manage intrapsychic disturbances in interactions with others. Thus, while projection is essentially an intrapsychic defense mechanism in which parts of the inner self are attributed to others without direct interactional pressures towards them, projective identification constitutes an actual interactional effort to evoke in others some aspects of one's own inner self. Introjective identification is the complementary process through which an individual incorporates into his own self-representation and inner world the projective identifications of another. In this context, Bion(1977) speaks of the relationship between the container and the contained. This metaphor alludes to the contents which are projectively identified as being the contained, while describing the object who incorporates these contents as the container. In therapeutic interaction, one important function of the therapist is to contain the patient's pathological projective identifications, accepting them consciously into himself and "metabolizing" them into understandings which can be interpreted to the patient.

Langs (1978 c) then distinguished between three major communicative styles in patients and therapists. The first communicative style, which he termed Type A style, is characteristic of patients who communicate an adaptive context and analyzable derivatives of it, and who use symbolic communications to do so. The second communicative style, Type B, is characterized by projective identification and the acting out of internal conflicts, so that the patient's verbal associations usually do not yield meaningful interpretative insights into the dynamics of his behaviour. In the Type C communicative style, the adaptive context is either repressed or obliterated in the presence of seemingly rich associations, or the patient communicates entirely about either realities or trivia, or if there are significant adaptive contexts then they are not accompanied by meaningfully related indirect associations. The resistances of these patients are neither readily analyzable nor expressed in derivative form. Instead, their

associations are flat and empty, or rich but without organizing meaning. They serve as an impenetrable barrier whose function is to destroy meaning rather than to convey it. The Type C communicative style is a field designed for lies and falsification, and for destruction of any real person to person interaction between patient and therapist.

In the Type A communicative field, the patient uses language to communicate with the therapist symbolically about his unconscious conflicts, fantasies, memories, introjects, and perceptions. The therapist in turn interprets the patient's verbal offerings, associations, and behaviours. In general, there is a sequential alteration between periods of resistance and revelation, with interpretive resolution of the inevitable resistances and insight into their unconscious sources and meanings, as well as insight into the patient's core fantasies and memories and the like.

In the Type B field, which is established largely through the patient's use of projective identification and the discharge of tensions through acting out, the therapist's main task is to experience and contain the patient's interactional pressures and to translate them into cognitive understanding. The main interpretation offered to the patient will be the therapist's understanding of the implications of the patient's attempts to invoke in him various roles and images. Often the therapist is under considerable pressure to intervene with these patients, and he may even have to do so in times of crisis, but he must work to develop the capacity to silently tolerate any interactional pressures until they can be cognitively understood and interpreted to the patient.

In the Type C field, the patient uses communication primarily as a barrier, for the destruction of meaning, and the destruction of relatedness. The therapist must recognize that the patient's oftentimes elaborate communications actually serve to keep the therapist from getting to know and understand him (as will be recognized when the therapist tries to organize the patient's communications around some specific adaptive context); and he must refrain from responding to the manifest contents of the material, which would only serve to maintain distance and to perpetuate and support the patient's resistance to meaningful communication. Instead, he should strive to identify those metaphorical representations of the patient's communicative style which do appear, for example, in allusions to safes, walls, dead-ends, voids, deception, and so on. Whenever possible, these metaphors should be linked to an adaptive context and their defensive-barrier function either stated or implied. Only then is derivative material, usually quite chaotic and regressive, likely to become momentarily available for interpretation.

Type A communication can only exist with any consistency within the context of a secure framework, i.e., proper management of the ground rules of therapy by the therapist. Alterations in the framework are, as a rule, a function of and tend to

further evoke the Type B and Type C communicative modes. Thus maintenance of the framework of therapy is essential to the development and maintenance of a Type A communicative style which, in turn, is essential to the development of a complete understanding by the therapist of the unconscious meanings of the communications of the patient (as they relate to the patient's psychopathology, to the patient's significant genetic past, and to the actual inputs from the therapist) so that these unconscious meanings can be communicated to the patient and the resultant insights used by him in the management of his life.

Implicit in this formulation is the belief that the client cannot discuss his unconscious ideas and fantasies with the therapist directly, but can only do so indirectly, and that it is through the interpretation of this derivative communication (i.e., understanding of this derivative or symbolic communication, offered by the therapist) that these unconscious ideas and fantasies can be understood. Thus, any response to the manifest content of the client's communications, including interpretation of it in terms of past or present interactions with others, while quite possibly justified in some contexts, does not constitute treatment of the neurotic problem for which the client has sought psychoanalytically oriented psychotherapy, i.e., the bringing into consciousness of the unconscious beliefs and motivations which have led him into ineffectual living and symptomatic distress.

In this model of psychotherapy, which I believe far surpasses anything else written on the subject, it is the patient who determines the direction and extent of his communications within any given session, establishing his priorities as he shares with the therapist the various thoughts which come into his mind. The therapist, in turn, is to approach each session without desire, memory, or understanding (Langs, 1978 a) so that the interpretations which he offers to the patient may be prompted entirely by the material which the patient presents and thus be as free from bias and distortion as possible.

Since the most significant unconscious communications are most likely to derive from the therapeutic interaction itself, interventions are usually most effective when it is clear to the therapist how the patient's communications relate to the ongoing therapeutic relationship, in terms of the patient's allusions to the therapist's previous interventions and management of the groundrules of psychotherapy, a specific adaptive context, and the patient's intrapsychic anxieties, conflicts, fantasies, and memories as these relate to his interactions with significant figures in his past. Each of the therapist's interventions, in turn, will become a portion of the adaptive context for any succeeding communications from the patient, and the therapist must listen to these succeeding communications in order to determine the validity of his intervention for that patient at that time.

Langs (1978 b) discusses six basic interventions. These include silence (the

preferred intervention in the absence of understanding the patient's material); establishing and maintaining the framework within which psychotherapy occurs, and rectifying and analyzing any errors in application of the ground rules of psychotherapy; playing back to the patient selected elements from among his communications in an effort to foster expression of the necessary missing communicative elements which might serve to identify an adaptive context for the patient's communications; the metabolizing and interpretation of projective identifications or attempts by the patient to evoke in the therapist behaviour which is more appropriate to some other, non-therapeutic role; and the identification of metaphors used by patients who employ the Type C communicative mode. Of these six, interpretation is the preferred mode of response.

In the course of empathically listening to the patient's material and formulating an understanding of its meaning, the therapist generates silent hypotheses and makes silent predictions which he then silently validates from the patient's continued associations before choosing to intervene. These interpretations should consider not only, or even primarily, the manifest content of the patient's communication or even those inferences which can be drawn directly from the patient's material. Although the patient's communications always have a certain manifest content from which inferences may be drawn, interventions offered to the patient on that basis tend to be isolated and intellectualized without any central dynamic meaning, and tend to be responded to by the patient in a manner which does not constitute validation of the interpretation. Such formulations can be distinguished from inferences made from the manifest content of the patient's communications organized around a specific adaptive context; and valid interpretations which begin with a specific adaptive context and organize the patient's manifest associations as derivative communications related to that adaptive context tend to be validated through the patient's subsequent communications.

To reiterate, Langs is quite emphatic in stating that the therapist should always listen to the patient for symbolic or derivative references to an adaptive context, which is not infrequently the therapeutic interaction itself. He should attend to references to the framework before all other material, to medium of expression and communicative style before content, to reality before fantasy, and to analyst before patient. He should interpret resistance before content, and interactional resistance before intrapsychic resistance. He should try to avoid asking questions and providing clarifications of his ideas since these types of interventions have usually been found to occur at points in the treatment session where the patient is working over, through displaced and disguised derivatives, some aspects of his relationship with the therapist, and usually some countertransference-based input (and typically, the therapist intervenes with a question or clarification directed towards some outside relationship or an aspect



of the manifest content, and the intervention serves the purpose of offering the patient a Type B or Type C barrier to more meaningful communication).He should accept the supervision or direction offered by the patient's (oblique) references to his errors and correct them wherever possible, so that the therapy can progress (Langs, 1979 b).

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