Chapter 6

Basic Therapy Processes

> [Psychotherapists] hold no brief for the greatness of their hearts—they are among the least of those who work beyond themselves—but to some extent they lessen the man-made misery of man. They stand by. Hatred they endure, and do not turn away. Love comes their way, and they are not seduced. They are the listeners, but they listen with unwavering intent, and their silence is not cold.
>
> —Allen Wheelis (1958, p. 246)

Analytic therapy requires one person to talk freely and the other to listen receptively, neither of which is easy to do. There are many different technical approaches in psychoanalytic work, depending on the client, the clinician, and the context, but all of them involve the joint effort of therapist and patient to appreciate the themes and meanings in the patient's self-expression. People who are pleased with their psychotherapy experience seldom report that it was a practitioner's dazzling verbal interventions that brought about significant changes. Rather, our satisfied customers mention the quality of our presence and the sense that we care. Most of our copious literature on technique represents efforts of different writers to specify ways we can facilitate a natural process of self-understanding and psychological maturation.

D. W. Winnicott (1958), a pediatrician who became a psychoanalyst, emphasized how critical it is to the development of a sense of identity and agency for an infant to experience the sense of "being alone in the presence of the mother." For the psychotherapy patient there is, ideally, an analogous sense of being alone in the presence of the therapist. The practice of taking oneself seriously and listening to oneself respectfully is often a new accomplishment for individuals adapting to the role of client, an experience for which they may need considerable

support. Helping individuals to embrace the goal of the examined life may take considerable tact, patience, and technical flexibility.

Psychotherapy is a conversation, a back-and-forth collaboration in which listening and talking alternate on both sides of the therapeutic partnership. As such, it is represented rather artificially in sections on listening and talking, respectively, as if those processes were separable, but for purposes of organization, I describe aspects of that conversation under these headings. Then I share some observations about various influences on therapeutic style and speak briefly about combining psychoanalytic work with other therapeutic approaches. Finally, I consider the respective roles of power and of love in the psychotherapy process.

LISTENING

Psychotherapy technique has more to do with how one listens than with how one talks. Most ordinary conversation depends on assumptions that a psychodynamic practitioner takes pains not to make, such as that the person talking feels friendly toward the listener. Social dialogue includes a lot of extraneous "noise" created by the fact that both parties to a conversation have needs for both self-expression and acknowledgment from the other. Friends may interrupt, talk over each other, and change the subject at whim. In contrast, listening in a professional capacity is a disciplined, meditative, and emotionally receptive activity in which the therapist's needs for self-expression and self-acknowledgment are subordinated to the psychological needs of the client. The condition of therapeutic receptiveness shares with hypnotic states the combination of deep relaxation and an enhanced capacity for concentration (Casement, 1985; Freud, 1912b; Ogden, 1997). It is also ultimately exhausting (see Chapter 11).

It is not uncommon to hear people characterizing psychoanalytic therapists as "being paid just to sit there." They should only know how hard it can be just to sit there! When it is done well, "just" sitting there encourages clients to get brave enough to confide something painful, to figure out their own solutions, to find their sense of agency in the presence of a person who welcomes their increasing confidence and competence. The therapist is deprived of the illusion that it is his or her clever formulations that created that change, a frustration that it takes a good deal of training to be able to give up. We do not let our clients struggle along without any responsiveness from us, but we also do not rush to tell them that we understand or that we have a solution. We are keenly aware of the fact that full understanding of another person's

psychology is impossible, and that a coping strategy that might work for ourselves could be disastrous for someone else.

Psychodynamic therapists vary how much they interact verbally, depending on the specific needs of each person—with some clients we may sound almost chatty, but we try to do so in a state of mindfulness of therapeutic goals. Bertram Karon (personal communication, January 25, 2003) described to me a young, relatively unsophisticated woman who went, on his recommendation, to a psychodynamic therapist after having been treated on and off since age eleven with psychoactive drugs and short-term cognitive-behavioral interventions. She came back to thank him after a therapy experience that had been deeply healing, saying, "I know now how to tell you've got a psychoanalytic person for a therapist. They're the ones that when you talk, they hear you."

Preliminary Considerations

In psychotherapy, listening is more important than talking. In fact, most of the ways that therapists talk during the clinical hour are intended to demonstrate that they are listening. We live in an age and civilization in which emphasis tends to be on doing rather than being, in which prevailing conceptions of science emphasize prediction and control rather than disciplined naturalistic observation, in which pop gurus counsel people about how to have various effects on others rather than about how to let others become comfortable being themselves. The idea that listening should be privileged over talking comes up against a strong Western cultural bias. Still, most of us can probably remember transformative instances when we felt the effect of someone's thoughtful attention, or when we were touched by someone's understanding, or when we were struck by an insight that entered our consciousness in a moment of repose.

Bion (1970, p. 57) counseled therapists to listen to each session "without memory or desire." By this impossible advice I understand him to mean that we need to clear our heads and try to take the patient's thoughts and feelings in without preconception. He emphasized the therapist's role as a "container" of images and feelings too toxic for the patient to tolerate. Winnicott's (1955) emphasis on the "holding" function of the psychotherapist and his (1971) and later Ogden's (1985, 1986) stress on "potential space" are similar: We have to create a space in which it is possible for the person to tell the truth of his or her experience. This can be much harder than it sounds. As Charles (in press) commented about her effort to be a container for a deeply unhappy, angry, and demanding client, "*My* work, during this arduous first year,

consisted of containing my own distress sufficiently that I could provide an environment in which Ruth could continue to tell her story" (p. 32).

The therapeutic effects of being carefully listened to are substantial. Many patients, especially those from families that had depressed, distracted, or overworked caregivers, are amazed to learn that the therapist actually remembers what they say. Later, they tell us how much that meant to them. I often comment, toward the beginning of a course of therapy, "I'm going to be pretty quiet for a while, just trying to get a better sense of you and the problems you came to work on. As I start to feel I understand something, I'll let you know what I'm thinking, and you can tell me whether that feels right or whether I'm off in some way." With patients who have considerable background in disciplined introspection, including those with previous analytic therapy, I may comment that for a while they will know a lot more about themselves than I know about them and that I will appreciate their tolerating a period during which I am catching up with what they have already figured out about themselves. It is rare that someone responds to statements such as these with irritation and impatience; rather, clients seem relieved that I will not be trying to impose on them my prepackaged understandings and pet recommendations.

Early in treatment, it is unwise to let silences extend or accumulate. Silence can sometimes be profoundly meaningful to patients—as in occasions in which they feel deeply and wordlessly understood, or sincerely respected by the therapist's willingness not to hurry them, or warmly appreciative of a reticence to impinge upon their moments of silent contemplation. But they are unlikely to have anything other than an unproductively anxious reaction to early silences. When clients have trouble talking, it is better to address the problem and work out a temporary solution. One option is to ask what the therapist might say or do to make it easier for them to talk. Another possibility is to engage in mutual problem solving, exploring what the effect would be of different responses, such as the therapist's attempting to draw them out versus the therapist's waiting quietly. Silence is tolerated much better if the patient understands it as respectful and has participated in the decision not to rush to fill the air space.

The primary aim of the psychoanalytic therapist is to encourage free expression. An effect of our doing so is that we give patients the experience of having a relationship in which honesty is possible. The appropriateness of any intervention or therapeutic stance should be judged by the criterion of whether it increases the patient's ability to confide, to explore more and more painful self-states, and to expand access to more intense and more discriminated emotional experience—

in other words, to elaborate the self. The classical analyst's reserve has this aim (Greenson, 1967), but so does the empathic mirroring of the self psychologist, the patient- and analyst-centered interpretations of the Kleinian (Steiner, 1993), the here-and-now/you-and-me confrontation of the transference-focused therapist with the borderline patient (Clarkin et al., 1999), and the countertransference disclosure of the relational therapist (Aron, 1996). All the psychoanalytic approaches to technique are designed to facilitate this ongoing, deepening, ultimately self-righting process of self-exploration and self-expression. They apply more and less well, respectively, to different patients, different stages in the clinical process, and the personalities of different therapists.

I mentioned in Chapter 4 the empirically derived work of Joseph Weiss and Harold Sampson and their colleagues (Weiss, 1999; Weiss et al., 1986), who have concluded that patients know at some level what they need from treatment and have an unconscious "plan" for therapy. Then they test the therapist to see if he or she can cooperate with that plan. This fits my clinical experience. With most clients, I become impressed with the power, notwithstanding all the anxieties about change that impress the analytic therapist as resistance, of their wish to take in new experience and grow. If we listen carefully, they will try to tell us (usually in the first session) what they need from us in order to do so. Although they may subsequently behave in ways that evoke responses from us that are opposite to the ones they said they needed, I think Sampson and Weiss are right that such experiences constitute tests, and that our therapeutic role is to try to stay supportive of the client's original plan.

For example, some clients will tell a therapist—either in words or in actions—that they cannot stand too much warmth, that they need to be challenged and confronted, that they are allergic to motherly concern. They experience caring as a soul-threatening seduction, or they worry that the longing it evokes for what they lacked in childhood will pull them into a malignant regression. Or they know that their self-esteem will be traumatically shattered by the evocation of their dependent wishes. Consequently, despite the therapeutic effect of warmth on most clients, such individuals will regard a therapist's effort to offer empathic resonance as tantalizing, entrapping, and consuming, a threat to their continued existence as separate individuals. This dynamic is frequently found in people with trauma histories, toward whom it may be hard *not* to express sympathy. They typically find ways to demonstrate their preference for our keeping a certain respectful distance, but then, unconsciously to test us, they may behave in ways that invite us to rescue them with our love. The therapist who listens

carefully and develops a tentative psychodynamic formulation of each person as a unique individual (see McWilliams, 1999; Peebles-Kleiger, 2002) will do much better with such stresses than the therapist who applies a favored theory to everyone.

Styles of Listening

As therapists, we essentially use each patient as a consultant, learning from him or her what style of listening and responding is most helpful (Casement, 1985, 2002; Charles, in press). There is usually a fair amount of bumbling along, especially at the beginning of any treatment. During this bumbling, the main thing for a therapist to keep in mind is the importance of helping the client to talk freely, to expose as much inner life as possible. Asking periodically, "Are you feeling comfortable talking with me? Is there any way I could make it any easier for you to be frank and open?" can help both client and therapist with their adaptation to each other. Even in short-term, structured psychodynamic treatments, there should be an effort in the first couple of sessions to be sure that the client has been put sufficiently at ease to tell his or her story with the least possible interference by inhibition of any sort.

The therapist thus tries to convey an attitude that will prevent or reduce feelings of shame and humiliation about whatever is revealed. Throughout treatment, but especially in the beginning, whenever shame emerges, addressing and reducing it are high-priority matters. I have known several individuals who have learned a lot about their dynamics in psychotherapy but who seem to remain deeply ashamed of them. Self-knowledge is one goal of psychoanalytic treatment, but a more profound goal is self-acceptance. The more one accepts aspects of the self that have been seen as shameful, the less one is controlled by them. Psychoanalysis as a field has tried to name one after another propensity that comes with the territory of being human, including all the seven deadly sins, with the assumption that acknowledging these tendencies allows us to find better ways to deal with them.

One way to communicate acceptance and to dissolve shame is by what I think of as the "Yeah . . . so?" response, either verbally or nonverbally. In other words, we take in whatever the patient has confessed with a tone or a look of unsurprised matter-of-fact-ness, implying that we are not quite sure why this is such a big deal. Sometimes we make a quick connection that allows us to make a casual comment to the effect that given what the person has said about his or her family of origin, the disclosure is hardly surprising. Or we mutter a comment such as "Well, naturally," or adopt a puzzled tone and ask, "So what's so terrible about that?" when a patient seems to be drowning in shame

while disclosing some crime of the heart. Sometimes it is helpful to ask, "Do you have a sense of why this seems to involve a lot of shame for you?" conveying that it is not self-evident why someone would be mortified by confiding something human beings inevitably feel.

It is also important throughout the therapy to try to keep one's own temptations toward narcissistic display under control. What I mean by this is that it is natural to want to demonstrate our competence, to show our patients that we have something to offer. This inclination can get in the way of maintaining enough reserve to let people make their own discoveries and come up with their own solutions to the problems in their lives. Therapists must be careful not to one-up their clients. A tone of "So you've finally figured out what I've known all along" can poison the process. The temptation to do this is especially strong with patients who are devaluing and challenging. Better to comment wryly, "Sounds like you can't imagine how a bonehead like me could be of help" than to try to demonstrate one's clinical brilliance.

The much-parodied verbal tic of the analytic therapist ("Hmm" or "Mm-hmm") is an effort to convey our "there-ness" without interrupting the client. Greenson (1954) noted that the sound "mm" is predominant in words used for "mother" in a great number of languages and may also express delight at something tasting good. Perhaps with this locution we are nonverbally signaling to clients that we are as open to their hunger and aggression as a nursing mother. I find myself making a number of facilitating grunts and nods intended to give messages such as "I'm listening," "Keep talking," "That's interesting," "That surprises me," "That must have been painful," "I'm not sure what you mean," and "I get it."

Lawrence Hedges (1983) delineates four different listening perspectives, for patients with a neurotic personality organization, narcissistic personality organization, borderline personality organization, and "organizing" personality, respectively. His last category refers to those clients whom others have called primitive, understructured, and psychotic-level, who probably correlate highly with the disorganized attachment style described in the empirical literature (see Coates & Moore, 1997; Fonagy et al., 1996; Main & Solomon, 1991). He recommends listening for Freudian themes (drive motivations, structural conflict, and defense) with neurotic-level clients, self-psychological themes (self-cohesion and fragmentation in relation to selfobjects) with narcissistically organized clients, object-relational themes (merger vs. abandonment, affect differentiation, separation, and individuation) with borderline clients, and Kleinian themes (greed, envy, hatred, the paranoid–schizoid position) with personalities trying to organize themselves. Hedges's recommendations, made in the context of an erudite

exploration of relevant philosophical and psychoanalytic literature, are generally consistent with those that I summarized in *Psychoanalytic Diagnosis* (McWilliams, 1994) with respect to different orientations toward patients with differing levels of personality organization. They are consistent also with the assumptions underlying Kernberg's "structural interview" (1984).

TALKING

How one talks in the role of therapist expresses a unique combination of one's theoretical orientation, understanding of the client's psychology, and individual personality and conversational style. The intellectual effort to formulate one's comments according to the rules of some expert can interfere drastically with the receptive sensibility that moves treatment along. Although there was a rather perfectionistic era in psychoanalytic history (roughly coinciding with the years when American analysts were trying to define psychoanalysis as a specifiable medical procedure), when analytic practitioners idealized the concept of the "accurate" as opposed to "inexact" interpretation (Glover, 1931), contemporary psychodynamic therapists tend to follow Spence (1982) and Schafer (1983)[1] in regarding the therapist's communications as efforts to promote the development of mutual understandings that account for the patient's experience.

In addition to having rejected its former perfectionism, the analytic community has, for the most part, outgrown its early, naive confidence in the capacity of a therapist to "uncover" the truth of a person's history in the way an archeologist can excavate ruins or a detective can solve a mystery; instead, we regard the project of psychotherapy as a joint effort to develop a narrative that makes sense of a person's subjective experience and personal problems. Most of us view truth claims (especially those made in a tone of undiluted certainty) as suspect, both because validation for clinical hypotheses and historical reconstructions are hard to come by and because both therapist and patient have unconscious reasons to ignore or distort phenomena that make them anxious. The upside of this change toward embracing not-knowing is that there is much less pressure on beginning therapists to craft their interventions along the lines of some rigid model of interpretive precision.

Facilitating the Therapeutic Process

As I argued in the previous two chapters, the earliest comments of the therapist should be oriented toward establishing safety, communicating

a wish to understand, explaining relevant aspects of the process of therapy, clarifying the frame, and identifying any issues that might get in the way of the person's willingness to collaborate or the therapist's capacity to help. Next, I recommend that therapists devote a session to taking a comprehensive history, during which they may develop and find a way to share a tentative dynamic formulation of the individual's problems.[2] After this, the therapist's activity should be oriented toward increasing the client's capacity to speak freely and with full emotional engagement. Interventions such as "Can you say more about that?," or "Sounds like there's a lot of feeling there," or "That must have been difficult," or "Have you been in similar situations?," or "What comes to your mind as you think about that?," or "Does that remind you of anything?," or "How are you feeling as you tell me this?" are common ways of doing this.

Each clinician must find words that feel personally genuine in the situation; otherwise, he or she will sound mechanical and insincere. In advising therapists about the tone that should inform psychodynamic treatment, Schafer (1974) has urged that we not bracket ourselves off patriarchally from the therapeutic conversation by speaking in stilted versions of professional speech. Instead, he reminds us that psychotherapy is an "I–Thou type of exploratory dialogue." He gives the following examples of natural, more egalitarian styles of speech as opposed to stiffer locutions:

> "I am wondering what that could be about" as against persistently remaining thoughtfully silent. "Congratulations!" as against "You must be very proud of yourself." "I don't feel at ease somehow and I have a hunch you are trying to get me to feel that way" as against "You are trying to make me feel ill at ease." "That's a helluva way to live" as against "Your life does not seem very satisfying or easy." And "I'm not surprised" as against "That might have been expected." (pp. 512–513)

Sometimes, when the phrase of a patient has seemed pregnant with unspoken feeling, a therapist will simply echo it in slower or softer tones than the patient used, hoping to elicit the affect behind it. Many psychoanalytic therapists, including me, bring up the subject of dreams early in treatment, inquiring about recurrent dreams, memorable childhood dreams, and recent dreams in order to expand the client's sense of the topics that are welcome in the therapy room. Asking about fantasies, or explaining that it will be valuable to think about the client's fantasy life together, is also helpful.

If the patient is talking freely without the therapist's facilitative comments and educative inquiries, there is no reason to speak until toward the end of a session, when the client may reasonably expect some verbal response. This response may come in the form of a question about the way the client has been interpreting the incidents that have been recounted (i.e., a request for clarification), or a statement of encouragement to continue talking about the material so that the two parties can get more understanding of it (a reinforcement of the therapeutic alliance), or an exploration of how the patient is feeling having made these disclosures to the therapist (a preliminary examination of transference reactions), or a comment on ways in which the person seems to be keeping the material at an emotional distance (analysis of defense), or a summary of a theme that the therapist has been hearing between the lines (a tentative interpretation), among many other possibilities. Again, the most important feature of any intervention early in treatment is the communication that the therapist has been listening.

Addressing Resistances to Self-Expression

Because we want our patients to speak from the heart, we gently try to reduce any verbal defensiveness that interferes with or mutes that process. With tact, we call attention to the ways they seem to keep the full intensity of their experience at arm's length. Common defenses against frank verbalization include such mannerisms as talking in the second person (e.g., in response to "How did you feel?", "Well, you know, you feel bad when that happens"), talking in the third person ("I guess it's natural for people to feel bad in that situation"), dramatizing or demonstrating things that could be simply expressed ("I was SOOOOO angry!" with an exaggerated eye-roll that slightly ridicules the feeling it portrays), trying to bring the therapist into the experience ("Can you believe the bastard did that to me?"), avoiding the naming of affects and substituting a vague term ("How did you feel?," "Kinda weird, I guess"), changing the subject when feelings get too close, talking in baby talk or some other affected way about more intimate topics, and many other unconscious strategies to keep pain and shame at a distance.

There is a vast clinical literature—not just in psychoanalysis but in the other humanistic therapies such as Gestalt, client-centered, and existential approaches—on helping people become more connected with their feelings and more comfortable expressing themselves directly. Therapists who work with couples often find it valuable to give both parties the direct instruction: "Speak to each other in 'I' statements and say what you feel" (and then often, they have to go on to explain that the locution "I feel that you're insensitive" is not exactly what they meant). When partners can move from describing what is bad in the

other to what is experienced in the self ("I feel hurt when you ignore me"), a giant step has been taken toward improvement in the relationship. Individual therapists usually take a less didactic stance than professionals trying to improve the communications skills of two partners, but the aim is similar: to encourage clients to speak nondefensively and in the first-person voice about their emotional experience.

Many analysts (e.g., Fine, 1971; Greenson, 1967) who write about ways to increase the therapeutic power in the clinical conversation have urged their colleagues to use straightforward, ordinary language, including for experiences as intimate as sex (e.g., "You went down on him" rather than "You engaged in fellatio"). Greenson (1950) has noted how advantageous it is for clients brought up in other cultures if the clinician is familiar with the language of their childhood. Schafer (1976) recommended that therapists use, and encourage clients to use, "action language"—that is, emphasizing verbs rather than nouns, especially abstract ones ("You're feeling pretty guilty" rather than "You're suffering pangs of conscience" or "Your superego is attacking you"). Levenson (1988) advised "the pursuit of the particular," that is, asking for the details of experiences when the client makes a general statement ("What exactly did you say when you 'asserted yourself'?"). Learning a client's personal metaphors and developing vivid metaphors together can further this process of greater expressiveness as well.[3]

Every therapist–patient dyad evolves its distinctive rhythms of speech and silence, self-elaboration and reflection, talking and listening. Some patients hardly let the therapist get a word in edgewise, while others sit there helplessly waiting for the professional to steer the conversation. One of the reasons psychoanalytic therapists are so fond of the literature on infant–caregiver relationships, even though we are quite cognizant of the fact that the adult in treatment is not reducible to a fixated infant, is that the process of synchronizing oneself with a patient's idiosyncratic style feels strikingly similar to descriptions of parents' efforts to adapt to the temperament and rhythms unique to their baby (Brazelton & Als, 1979; Escalona & Corman, 1974; D. N. Stern, 1995).

INFLUENCES ON THERAPEUTIC STYLE

Many disparate and converging factors influence the style and tone (prosody) adopted by the clinician in any given therapy session. Among them are the characteristics of the patient, the stage of the treatment, and the personality of the therapist. In addition, there is the matter of

the practitioner's theoretical orientation or choice of a particular type of dynamic therapy that suits the circumstances (e.g., a short-term model such as that of Mann, 1973, or Luborsky & Crits-Christoph, 1990, that prescribes a particular focus). I confine myself in the next section to a discussion of the first variables, as the explication of different psychoanalytic models is beyond my scope here.

Patient Characteristics

How we talk with people depends on the situation they are in when they come to us and on our understanding of their personality structure. Obviously, people in crisis require an immediately responsive, problem-solving kind of attention. Those who come for more gradual or general problems need to develop a relationship in which those problems can be elaborated and examined in depth. For individuals who seem to have considerable ego strength, who readily make a friendly connection with the therapist, and who have a lot of self-observing capacity, less is more. That is, the more we can get them talking, and intervene only when they seem to get stuck, the better. The most typical mistake that beginning therapists make with mature, high-functioning people is to say too much or speak too often. Unfortunately, such clients are much rarer in the practices of most beginning therapists—and probably also more seasoned ones—than much more disturbed and difficult individuals.

For patients who are more terrified, who struggle with psychotic-level anxieties, who feel unable to regulate their emotions, containment is the main function that the therapist's style of interaction must provide. Clarity about boundaries and tolerance of their intense and often negative reactions to the therapist's limits are critical. Closeness is often a much more terrifying condition than abandonment for them, but they are also exquisitely reactive to separations and consequently cause therapists to struggle with guilt over time off. Clear boundaries are also critical for clients in the borderline range who have profound difficulties with affect regulation, as is the exploration of the stark good-versus-bad polarities in which they see the world. People with borderline dynamics also respond well to therapists who do not try to hide their own affective reactions in the name of trying to be professional or neutral (Maroda, 1999; Holmqvist, 2000).

There is a continuum from predominantly supportive (in the technical sense—all therapy is of course supportive) to predominantly exploratory psychotherapy (Rockland, 1992). Where we work on that continuum with any client correlates reasonably well with Kernberg's (1984) levels of severity of psychopathology: For those in the neurotic

range, we can keep opening up questions and inviting exploration; for those in the borderline range, we expect a dyadic struggle that requires us to be active, limit setting, interpretive of primitive dynamics, and focused on the here-and-now relationship; with those in the psychotic range, we need to be educative, normalizing, and explicitly supportive of the patient's capacities. Prosody varies also depending on the patient's personality type: the tough tone that comforts a paranoid person (at any level of severity) is quite different from the sympathetic attitude that comforts a depressive person, irrespective of the severity of any depressive symptoms or the level of personality organization (McWilliams, 1994). No matter how well read we are, most of us adapt our tone to the patient on the basis of intuition and experience.

In a 1991 article I argued that devotion and integrity, which can be understood as the preeminent values expressed in good mothering and good fathering, respectively, must both be present in psychotherapy. I had become impressed with empirical research that was documenting infants' needs for both soothing and stimulation (e.g., Brazelton, 1982; Yogman, 1981) and the apparently universal tendency for babies and young children to associate soothing with mothers and stimulation with fathers, irrespective of the personalities or roles of their caregivers (Lamb, 1977; Clarke-Stewart, 1978; Belsky, 1979). It struck me that different psychoanalytic theorists have tended to emphasize either more soothing-maternal or more stimulating-paternal styles of therapy. For example, Freud was more paternal in style and tone, while his colleague Ferenczi advocated a more maternal sensibility. Over the course of psychoanalytic history, there have been many highly publicized controversies between a more paternal theorist or school of thought and a more maternal one, both of whom were competing for status as the favored paradigm (e.g., Fenichel vs. Reik, Melanie Klein vs. Anna Freud, Brenner vs. Stone, Kernberg vs. Kohut, the classicists vs. the relational analysts).

Like most therapists (e.g., Pine, 1998), I find such debates rather arid. As many clinicians have argued, different kinds of patients need different kinds of responsiveness. The balance of maternal and paternal tone differs for different clients, and usually practitioners figure out what is helpful by trial and error. For example, most of us find ourselves behaving in more Kohutian, maternal ways with people with more empty, depleted narcissistic dynamics (McWilliams, 1994), who tend to experience interpretation as attack. But we learn to interpret in the more paternal, confronting tone of Kernberg when trying to deal with the more arrogant, entitled version of narcissistic pathology, because such patients tend not to respect anyone who fails to stand up to

them. Most patients need both tones, and the capacity to shift gracefully from one mode to another is central to the art of psychotherapy.

Research on attachment suggests that therapists adapt their manner to the specific attachment style of each patient (see Cassidy & Shaver, 2002; Cortina & Marrone, 2003; Fonagy, 2000). Individuals with secure attachment patterns respond well to interpretation of internal conflict, whereas those who have an anxious attachment style may require more soothing. Therapists may have to tolerate an oscillation between fears of engulfment and fears of abandonment in clients with an ambivalent attachment style (cf. Masterson, 1976). I have mentioned previously several problems that arise when one works with people whose attachment paradigm is disorganized and disoriented.

Eventually, we will know a lot more about differences in the brain that make one person long for a straight-talking, tell-it-like-it-is style of intervention while another responds to the therapist as traumatically interfering whenever he or she introduces the most gentle of questions. The work of neuropsychoanalytic scholars such as Mark Solms, Joseph LeDoux, Allen Schore, Antonio Damasio, and Bessel van der Kolk is already giving us a whole new language for understanding the nuances of interpersonal experience, including that of psychotherapy. But having new paradigms, including respectably scientific ones, will not obviate the need for therapists to rely on their right brain and to go through an intuitively informed, sometimes painful trial-and-error process with each client.

Phase of Therapy

What any given person needs from a therapist may change over the course of the work. I learned this originally from the narcissistically devastated woman I took on as my first long-term client. At that point in my professional development, I was palpitating to do the classical psychoanalytic work that had been so helpful to me, and this woman wanted to come three times a week. I knew that she was too regressed to be a candidate for the couch, but I wanted to try to be as orthodox as possible otherwise. When she would ask me, with the intention of talking about some relevant issue, whether I had seen a certain movie or read a certain novel, I tried responding with "I wonder why that is coming to your mind now." After two or three unproductive exposures to the rage reaction that this response provoked, I decided it was more conducive to her self-exploration for me to say yes or no and wait for her to continue. Then at some point in our third year of therapy, she made such an inquiry, and I opened my mouth to reply. "DON'T ANSWER!" she exclaimed. "Don't you realize that when you answer,

most judicious use of "parameters." I gradually realized that what each of my supervisors was most concerned to pass on to me was an orientation that corrected for the disadvantages of his own temperament. It was also the attitude that each one seemed to feel would have been most healing to him as a patient.

Around the same time, I began noticing that some theorists recommended a particular therapeutic attitude that they not only believed would have been helpful to them as clients but that also normalized and generalized their own dynamics. Heinz Kohut might be a convenient exemplar of this tendency. Strozier's (2001) biography depicts a man who thrived on the experience of being idealized by others. Kohut's urging the analytic community to accept idealizations from admiring patients, rather than trying to resolve idealizing transferences by interpretation, was consistent with his personal *modus vivendi* and was the stance that he clearly believed, given the autobiographical nature of his most famous case (Kohut, 1979—see Note 1, Chapter 11, here) would have been more healing to him than the standard analytic interpretation of defense. Another irresistible example is Melanie Klein, who was frequently experienced by others as forceful and opinionated (Grosskurth, 1986). Klein urged analysts to name children's presumed dynamics with confidence and to interpret them authoritatively, a therapeutic version of her own interpersonal style.

I have concluded over the years that when clinicians talk most passionately about an attitude or process that is "at the center of" or that is "the essence of" the healing process, they often prescribe a stance that either normalizes their own dispositions or compensates for the limitations of their character type. In either case, they seem to be trying to heal themselves. Generalizing about what is helpful in therapy on the basis of one's own psychology is frequently useful, because we are all much more similar than we are different as human beings. There are times, however, that to be a good therapist for a particular patient we must find and draw on specific qualities in our personalities that, if evident in our therapist, would *not* have facilitated our own treatment. For example, if the therapist of an individual with marked antisocial tendencies is unable to connect with the more ruthless, power-oriented parts of his or her own personality and thereby set an authentically skeptical, no-nonsense, tough-guy tone, he or she cannot expect to develop any semblance of a working alliance.

As I observed in the previous chapter, many therapists have depressive dynamics and as a result emphasize availability, the holding environment, noncritical acceptance, and similar attitudes that are healing to those of us with this psychology. The work of Donald Winnicott, who certainly had a powerful depressive side, is often cited by therapists for whom depressive themes are personally resonant. I notice that my own metaphors for psychotherapy tend to have a maternal-availability-as-healing tinge, and not surprisingly, Winnicott's writings have always appealed to me. There is evidence, however, that as a therapist, Winnicott had trouble tolerating his own aggression and thus had difficulty setting limits. His inability to do so may have been rationalized by his belief that very troubled patients need to regress to a state of primary dependence (see Rodman, 2003). His painfully public failure with Masud Khan (see below) and his probable mistakes with Margaret Little have been widely regarded as evidence for this limitation (Flournoy, 1992; Hopkins, 1998; Rodman, 2003).

Again, one of the reasons for therapists to have personal therapy is that we all need to find parts of our personalities that can be accessed for work with people whose dynamics are different from our own central themes and variations. Such explorations in the nether regions of our psyches help us to stretch as therapists. And yet because there are limits to everyone's flexibility, some patients will not be a good fit with a particular therapist's range of authentic treatment styles. I would not recommend that any practitioner, novice or otherwise, try to adopt a tone that feels either false or too distant from his or her most temperamentally congruent inclinations.

INTEGRATING PSYCHOANALYTIC THERAPY WITH OTHER APPROACHES

Unlike theorists and researchers, who understandably prefer their categories to be uncontaminated, most therapists want to do whatever helps their patients most and fastest. They readily combine psychoanalytic treatment with nonpsychoanalytic efforts to reduce suffering, including cognitive-behavioral therapy, twelve-step programs, eye movement desensitization and reproccesing, hypnosis, relaxation training, support groups, Gestalt exercises, meditation, and other interventions. Evolving out of the pioneering work of writers such as Wachtel, Messer, and Arkowitz (e.g., Arkowitz & Messer, 1984; Wachtel, 1997), there is now an international organization concerned with the integration of different models of psychotherapy: the Society for the Exploration of Psychotherapy Integration. It has grown rapidly and has attracted considerable clinical enthusiasm.

Recent articles in psychoanalytic journals (e.g., Conners, 2001; Frank, 1992) have described circumstances in which analysts should consider supplementing their usual work with cognitive-behavioral interventions. Some of us do the collateral therapy work ourselves, and

you cut off my ability to fantasize about what the answer is?!" Thus, once I had finally learned to work like Heinz Kohut, this patient had moved on to wanting Charles Brenner for her therapist.

Therapists are always having to strike a balance between more ostensibly passive and more obviously active interventions (often construed as empathy and interpretation, holding/containing and confronting, provision of experience and enhancement of knowledge). These two kinds of activity are perhaps always both present, but one usually predominates with a particular patient or in a particular phase of treatment. Several theorists (e.g., Josephs, 1995; Seinfeld, 1993; Stark, 1999) have explored the coexistence and oscillation of these two therapeutic processes. Seinfeld (1993), who also (independently) explored maternal and paternal metaphors for therapeutic style, suggests that the more maternal voice is a better fit with psychologies of developmental arrest or deficiency, whereas the more interpretive, paternal tone is better suited to the treatment of problems caused by unconscious conflict. Like many writers, he notes the artificiality of contrasting these activities as if they were mutually exclusive or even qualitatively different (see, e.g., Moses, 1988; D. B. Stern, 1984, 1988): A good interpretation is taken in as deeply empathic, and the therapist's empathic attitude can be received as an interpretation—for example, as a nonverbal way of saying, "Despite your feelings of shame, it is possible to accept you as you are."

Seinfeld goes on to note that the psychologies of most of us contain both deficit and conflict. It follows that at different points in treatment, anyone in therapy tends to be working in one or the other place predominantly. Thus, many patients whose backgrounds contain serious deprivation need a fairly long period of experiencing the therapist as a noncritical, available, and supportive other before they are able to tolerate more focused attention on an area of internal conflict. They may need to take in the more maternal aspects of the relationship before they feel "held" enough internally to deal with an interpretive style that would have overwhelmed their previously more fragile sense of security and self-esteem. There are other patients—for example, virtually all markedly psychopathic individuals, some people with schizoid dynamics, and most people with paranoid psychologies, narcissism of the entitled sort, or significant hypomania—who are so suspicious of or frightened by maternal acceptance that they cannot take it in as supportive until they have established that the therapist is separate enough, strong enough, and tough-minded enough to "get" the way they see the world and survive their toxicity.

In the case of a person who needs a long period of a reassuring maternal presence before being able to take in anything more stimulating, a movement from deficit to conflict may be signaled by a change in the therapist's countertransference. The first time this happened to me, I thought I was losing my empathy. A man I had been working with patiently and supportively for months began ridiculing himself in familiar ways, a tendency I saw as related to his growing up with six siblings. In his family, the only way he could get attention from his beleaguered mother was by playing the helpless fool. But suddenly one session, instead of thinking "Poor guy, given his history these masochistic reactions are inevitable," I found myself wanting to smack him. I was irritated, impatient, and barely in control of the impulse to unload my hostility in an interpretation.

Instead, I ran to supervision, full of shame about my countertransference (an interesting parallel process [Ekstein & Wallerstein, 1958], by the way, to the client's self-hating attitude). My supervisor and I figured out that over the course of our work, this man had been quietly moving toward more capacity for self-assertion. Now when he debased himself, he was no longer behaving in the only way he knew to relate to others (in therapy, he had slowly learned a different way to relate); instead, he was defending against the fears that would have attended his behaving with self-respect. He was not stuck at this point in a state of deficit. Rather, he had a conflict about whether or not to change his behavior, and because he was frightened of change, he was choosing the regressive option. This behavior irritated me now, as it had not before, because I knew he could do better. As long as I had felt that change was not possible yet, I could be genuinely accepting of his symptomatology, but when I began to feel he was selling his capabilities short, I smoldered. Having understood this, I found a way to challenge his behavior that did not feel like unloading on him. Interestingly, my countertransference irritation was more genuinely empathic to his state of mind—that is, to both his capacity and his fear to change—than an effort to condole with him for his self-hatred would have been.

The Therapist's Personality

Years ago, in the context of working intensively with two excellent supervisors who had markedly contrasting therapeutic styles, I became fascinated with the interaction between a practitioner's personality and his or her therapeutic style and theory of healing. One of my mentors, a reserved and somewhat socially awkward man who described himself as schizoid, put considerable emphasis on being spontaneous, warm, real, alive, and flexible. The other, an affectionate, demonstrative, sociable person who joked about his hysterical and exhibitionistic tendencies, would go on at length about restraint, discipline, reserve, and the

some refer to other practitioners, either because they have better training in a given technique or because it would complicate the transference unduly for us to be in two rather different roles. To us, this is no big deal. Working therapists are rarely purists, a fact that may come as a surprise to people who assume that analytic clinicians are ideologues. Interestingly, Freud was the first therapist to advocate moving beyond the customary interpretive stance into an "active" problem-solving approach. In 1919, noting that standard analytic technique arose from work with hysteria and must be adapted flexibly to the treatment of other problems, he recommended an early version of exposure therapy:

> One can hardly master a phobia if one waits till the patient lets the analysis influence him to give it up. He will never in that case bring into the analysis the material indispensable for a convincing resolution. . . . One succeeds only when once can induce [people with agoraphobia] by the influence of the analysis . . . to go into the street and to struggle with their anxiety while they make the attempt. (p. 166)

POWER AND LOVE

Both the virtues and the dangers of psychoanalytic therapy lie in the fact that the therapist is in a position of substantial emotional power. Power is morally neutral: It can be applied to good or evil ends. It can turn a therapist's unthinking act of ordinary thoughtfulness into a revolutionary therapeutic moment, and it can convert a minor lapse into a full-scale calamity. Appreciating the extent of one's power is critical to the lifelong process of trying to maximize good and minimize harm with which conscientious therapists struggle every day. Psychoanalytic therapy also generates love between practitioner and client; in fact, I believe it is love that endows the therapist with the emotional power to foster change and love that gives the patient the courage to pursue it. It is not the only therapeutic factor, but love may be the one that allows the other curative processes to do their work.

Power in the Role of Therapist

Much of the power in any kind of therapy derives simply from the therapist's role. Anyone who has been promoted from an institutional position of equality to that of a higher-up has learned the emotionally startling lesson that one's former colleagues immediately begin to act with a special circumspection, deference, or hostility, no matter how relaxed

they were formerly. Role and status are potent realities. In secular Western society, being a therapist is probably psychologically comparable to being in the sacred status accorded in other cultures to gurus, religious leaders, teachers, healers, prophets, shamans, elders, oracles, and other tribal authorities (cf. Frank & Frank, 1991). Whatever the therapist's theoretical orientation, the situation in which one person has a need and the other has expertise to address it tilts the power relationship heavily in the therapist's direction. In the psychoanalytic literature, Phyllis Greenacre (1959) was perhaps the first to elaborate insightfully on the "tilted" nature of therapeutic collaboration. The therapist may take an egalitarian tone, but the playing field is not level (see I. Hoffman, 1998, for a more recent exploration of this topic).

An additional source of power specific to therapy inheres in the fact that the client is asked to reveal sensitive information, while the therapist discloses little of a personal nature. Again, this imbalance applies to all types of treatment. In psychoanalytic work, this aspect of the power imbalance is magnified by the fact that the therapist may ask about dreams, fantasies, sexual practices, and other intensely intimate domains of experience. Even the most shame-free, self-confident client feels the asymmetricality of the analytic collaboration; not surprisingly, most people are conscious of being more than a little frustrated by it. Patients may seek to rectify the power differential in numerous ways: by seizing on small indications of a therapist's personality and commenting on them, by reading articles that the therapist has written, by looking up information on the Internet, by asking personal questions, by behaving seductively, by bringing gifts or giving advice that sends the message that the client, too, has something to offer to the other person in the relationship. Novelists and other writers portraying a treatment on the couch have depicted how carefully patients listen for the pencil scratching away behind them, as they try to discern something about the therapist's interests from figuring out which topics seem to inspire the note taking ("scribble, scribble, scribble," one of my analysands teased).

Once someone is perceived as in a powerful position, it is virtually impossible for him or her to counteract the perception of power by being voluntarily out of role. I once sat on a board of education where members would sometimes feel aggrieved if they had tried to speak with a teacher "just as a parent, not as a school board member!" only to find the teacher unable to talk nondefensively to a person who, whatever the board member's current self-definition, was the teacher's employer. Bill Clinton (Renshon, 1998) reportedly could not comprehend why anybody cared about his sexual indiscretions or why Monica Lewinsky might have found it hard to refrain from telling her friends

that she was having oral sex with the President of the United States. He seems to have wanted to believe he could be perceived by the public and by his girlfriend the way he perhaps perceived himself: as a somewhat overweight and insecure guy who finds sexual fidelity difficult. He may be at some level just that, but his role made the perception by others of that self-representation out of the question.

Thus, the one kind of power we do not have in an authoritative role is the ability to suspend our power. We cannot just redefine a situation that by its nature evokes in others the universal primary experience of being dependent on people considerably more powerful than they are (i.e., that elicits transferences). As Freud learned when he tried to talk his earliest patients out of their insistence on projecting parental qualities on to him, transferences cannot be unilaterally suspended. Along the same lines, the first analysts, including Freud, overestimated the extent to which a transference could be "worked through" in a short period. Later psychoanalytic writing on transference (e.g., Bergmann, 1988) assumes that once people are in a powerful role, especially that of analyst, they are never likely to be seen as just another human being struggling along in life. Changes in the ethics codes of various psychotherapy professions in the direction of prohibiting sexual contact between client and treater for a considerable time after therapy has ended reflect the accumulated experience of individuals who have suffered because the psychological power differential does not go away even after a treatment is over.

Psychoanalytic Listening and Therapeutic Power

In psychoanalysis and psychoanalytic therapy there is an additional power problem that goes beyond role. It is a morally challenging issue that may say a lot about the widespread animosity toward the psychoanalytic tradition even as it accounts for the effectiveness of many analytic treatments. That is, in psychoanalytic work, therapists draw power to themselves. By attending repeatedly to the reactions that a client has toward him or her, a therapist selectively reinforces the patient's attention to and preoccupation with the therapeutic relationship. My understanding of the reason we cultivate the client's transference in traditional analytic work is that if we are to modify the very powerful, unconscious, pathogenic voices that haunt the people who come to us, we must accrue a degree of power comparable to that of their internalized early objects.

If change were easy, psychotherapists would be out of a job. People do not come to therapy if their own sense of agency or the experienced power of the authorities in their current life is great enough to bring

about solutions to their problems. Sometimes the nontherapeutic resources a person has are powerful enough: Good advice, emotional support, and even insightful interpretation of disavowed motives by friends and acquaintances can sometimes set off chain reactions of increasingly healthier behavior. The salutary effect on the forger Frank Abagnale by FBI agent Carl Hanratty portrayed in Spielberg's film *Catch Me If You Can* is a poignant case in point. In that movie, Abnagale became less desctructively psychopathic as a result of Hanratty's influence. People seek psychotherapy, however, when ordinary resources are not sufficient to foster the kind of adaptation they need to make. It is not uncommon for an individual coming to treatment to have exhausted friends, relatives, teachers, doctors, and spiritual counselors in an effort to solve some intractable psychological problem. And often, these failed sources of help have behaved with impeccable intelligence and concern, only to confront ultimate exasperation in the face of someone's incomprehensible resistance to change. Schlesinger (2003) astutely compares trying to make serious changes in someone's personality organization with trying to make significant reforms in an entrenched bureaucracy.

Even authorities in a very powerful position, including therapists, do not have adequate clout *via their role alone* to counteract the effects of many messages from childhood that rattle around in less accessible areas of the brain. A friend of mine who had been raised by sexually repressive parents in a strict Boston Irish Catholic subculture struggled to develop her stifled erotic potential; in particular, she felt a formidable internal prohibition on masturbation. Intellectually, as an adult, she found her inhibitions absurd. She wanted to be able to enjoy her body, but every time she even thought about touching her genitals, she became either unbearably anxious or physically anesthetic. A priest to whom she confessed her problem explained to her that most authorities in the contemporary Church do not consider masturbation a sin—in fact, they regard it as preferable to forms of sexual expression that exploit or misuse other human beings. He encouraged her to enjoy God's gift of her capacity for self-arousal. She went home exhilarated, expecting that this authoritative permission would liberate her. And yet when she tried to masturbate, she was still overcome by guilt, and her physical responsiveness shut down completely. Subsequently she saw a sex therapist, but when she found she could not bear to do the carefully graduated homework exercises she was assigned, she dropped out of treatment.

In contrast to this experience, she described to me how later, in analysis, her transference had slowly reached an emotional peak. With the invitation to explore her emotional life in the safety of her analyst's

office, she started to experience herself as more and more like a child in the presence of her prudish, intimidating mother. As the analyst's ordinary boundaries began to feel like arbitrary and irrational restrictions on her freedom, she slowly found the courage to express her anger and resentment without censorship. After weeks of attacking her therapist for what she was experiencing as his oppressive "rules," she was able to take in the fact that he was actually on the side of her capacity to enjoy her sexuality. At that point the masturbation taboo began to dissipate. Once the analyst had become, in her subjective world, as emotionally powerful as the repressive mother of her girlhood, his "permission" carried much more clout than that of either her sensitive priest or her competent sex therapist.

This story is both illuminating and cautionary. It has a happy ending because the analyst could tolerate the emotional storms that were unleashed by his cultivation of the transference and because despite the siege on his boundaries, he was unfailingly clear about keeping them. He was appreciative of the power he had and did not misuse it. Other, more ominous endings would have been written if the analyst had acted in a way that made his patient feel humiliated about either her inhibition or the intense feelings that surfaced as she tried to address it, or if he had prematurely tried to "reason" with her, or if he had defensively explained away her rage at being constricted by insisting that these feelings belonged to her mother rather than to him (this could have easily been rationalized as "interpreting the transference")—not to mention the disaster that would have ensued if he had been narcissistic enough to decide that what his patient needed from him was not emotional availability and professional discipline but sexual stimulation.

A quarter of a century ago, Hans Strupp and his colleagues published a book aptly titled *Psychotherapy for Better or Worse* (Strupp, Hadley, & Gomez-Schwartz, 1977), written partly in response to claims that psychotherapy is ineffectual. Some psychologists had concluded from outcome studies that therapy (presumably psychodynamic treatment, as that was the major kind available at the time) is no more effective than spending an equivalent amount of time on a clinic waiting list. Strupp and his colleagues noted that when one carefully examines the data, therapy appears to have been *either* beneficial *or* damaging for the patients studied. A reasonable inference is therefore not that therapy does not matter but that it matters for good or ill—not exactly a comforting finding for clinicians, but at least not a shocking one to those of us who make our living trying to help people, who see again and again the unmistakable positive and negative consequences of our work and that of our colleagues. The problem of "negative effects" still troubles

the field and is the flip side of the phenomenon of the therapist's power.

Resistances to Appreciating One's Power as a Therapist

When I first began doing psychodynamic therapy, despite all my training I found myself shocked by the fact that my patients took my interventions seriously, developed powerful transferences to me, and got better. I remember thinking, "It makes sense that I would react to *my* therapist that way—after all, he's a very powerful person. But I'm only me." We all carry around as a primary identity the sense of being a child, of being the one dependent on the power of others, perhaps even of being an innocent. For many people with significant power, it never ceases to be a bit surprising that others defer. Unless a defensive grandiosity has silenced the weak child within, most powerful people harbor some fears of being found out as an ordinary human being. Inadequate appreciation of the far-reaching implications of their power is not uncommon.

I doubt that most clinicians fully appreciate the nature and extent of their power. By temperament and calling, most therapists identify automatically with the weak and relatively powerless. Not only do we all have the residue of our childhood belief that it is the other people who are really in charge, we also have recurrent experiences that remind us how slow and incremental our work is. Especially in contrast to the compensatory childhood fantasies that may have attracted us to this way of earning our living, we must repeatedly acknowledge how little capacity we have to instigate the dramatic rescues we may have once imagined. It can consequently be a rude awakening every time some casual or even carefully empathic remark precipitates a devastated reaction in a client. It is not surprising that therapists have a reputation for carefully weighing their words, even outside the clinical situation. It is a hard habit to break.

On the other hand, there are aspects of the therapy situation that insidiously reinforce grandiosity and buttress the attractive assumption that one's words are *intrinsically* powerful, not just powerful because of one's role and activity in that role. A psychotherapist seeking support for unconscious fantasies of omnipotence does not have to be clinically effective or interpretively brilliant or even competent. On any given day, a therapist sees one person after another for whom he or she, by virtue of a particular ritual and role, has become a highly significant figure in that person's current life. Even when a client conveys hostility and devaluation, a sensitive clinician can feel how much preoccupation and emotional energy those feelings contain. Clients put us at the cen-

ter of their affective experience, supervisees look for someone to idealize, and only the most courageous students readily take issue with mentors who are in a position to influence their careers. After a while, it becomes easy for those of us with clinical authority and narcissistic vulnerability to believe we are pretty special.

Anyone who wants to see the worst-case illustration of this dynamic should read Linda Hopkins's (1998) chilling reflections on the personal and professional fortunes of Masud Khan, the brilliant but characterologically flawed *enfant terrible* of midcentury British psychoanalytic circles. My friend Arnold Lazarus, who delights in providing me with examples of the most appalling aspects of psychoanalytic history, recently forwarded an article on Khan to me, evidently having concluded that psychoanalysis has been irredeemably corrupted by omnipotent misbehavior of this sort by everyone from Freud on down. I have seen enough integrity in analysts and enough malfeasance in denizens of other therapeutic communities to suspect that the problem is not so much with analysis as with human nature and the seductions of power. But it is incontestable that psychoanalytic therapy provides fertile territory for misusing one's role.

Empowering the Patient

In the course of psychotherapies that are going well, clients gradually feel more realistically powerful and less dependent on their therapist's power, more emotionally equal and less inferior in their role. Many of the standard features of psychoanalytic practice represent the effort to help patients find, embrace, and expand their power. For example, by withholding advice and overt personal influence, therapists implicitly express their confidence that patients can discover or craft their own answers once they understand themselves better. By waiting for the client to choose the topics discussed in any session, we try to convey a sense of trust that some inner dynamism in the patient "knows" how to get to the problem area. By surviving the intensity of their negative feelings, we demonstrate that their power is not necessarily destructive. Even when we work with people whose psychology requires us to be more active and advisory, we take pains to respect their potential autonomy as far as this is possible and safe.

By the phrase "realistically powerful" in the previous paragraph, I allude to the fact that there are clients who begin treatment with a sense of omnipotence (sometimes of psychotic proportions) and thus feel anything but weak. Some of these clients are miserable because they feel their power is evil and dangerous; others complain that despite their obvious power, there seems to be something wrong with

their capacity to enjoy life. For such individuals, the sense of power is defensive: Their grandiosity protects against feelings of terror, rage, envy, humiliation, or unbearable grief. It is also ultimately illusory. It contrasts stunningly with the realistic power expressed in a growing sense of authentic competence, perception of options and choice, willingness to take risks, and confidence in one's ability to handle problems—in other words, those capacities that arise in therapy out of repeated experiences of unpunished self-expression and mutually examined efforts to alter self-defeating patterns.

Under ideal circumstances, by the end of a successful course of therapy the patient feels grateful for the therapist's professional competence but not awe-struck at the therapist's wisdom, goodness, or power. Some degree of idealization may work in favor of the therapy process, but as termination approaches, idealizing feelings should have shrunk to normal appreciation, by both parties, for a job well done. The patient feels empowered to leave and also to choose to come back if problems arise in the future. By this time, there is typically a warm, egalitarian feeling between client and clinician. (Therapists joke among themselves that the job is a masochist's paradise: Just as we come to feel that a patient is easy to be with, pleasant to listen to, someone we would enjoy having as a friend, we have to let him or her go and greet the next miserable malcontent.)

The foregoing description may not apply to patients with severe psychopathology—some of whom have to hire and fire several therapists before they can settle in with one they dare to try to trust. It also does not fit the circumstances of practitioners who work in settings where the length of therapy is not under the patient's control. Under conditions of forced termination, the best a therapist can do is to try to maximize his or her power during the main portion of the treatment and then take care toward the end to try to "return" it to the patient. A common way of doing this when the work has gone well is to congratulate the client for the progress and to make explicit statements about how whatever was accomplished reflects not just the therapist's skill but the patient's talent and hard work. Residual idealization is probably more common after short-term than long-term work.

Love

The psychotherapy situation naturally elicits love from clients. In fact, it does so in such a reliable way that Martin Bergmann (1987, p. 213) has observed, "For centuries men and women have searched for mandrake roots and other substances from which a love potion could be brewed. And then . . . a Jewish Viennese physician uncovered love's se-

cret." The secret is to listen carefully, to be genuinely interested in the other person, to react in an accepting and nonshaming way to his or her disclosures, and to make no demands that the other party meet one's emotional needs—defining aspects of the psychoanalytic arrangement.

It has long been known that many patients fall in love with or come to love their therapists. It has been less highly publicized that therapists love many of their patients, though there is a certain amount of fantasy about this that can be inferred from some movie versions of psychotherapy. Matter-of-fact acknowledgments in the psychoanalytic literature that we love our clients are rare, and even rarer are suggestions that it is our love that is the main therapeutic agent (see, however, Ferenczi, 1932; Gitelson, 1962; Hirsch, 1994; I. Hoffman, 1998; Lear, 1990; Little, 1951; Loewald, 1960; Nacht, 1962; Pine, 1985; Searles, 1959; Steingart, 1993). In fact, there has been a certain amount of disdain in some psychoanalytic quarters for the idea that love cures. Kohut's theories were more than once critiqued on the grounds that his ideas were reducible to trying to heal patients via the analyst's love and hence were *ipso facto* suspect.

But there are signs that the L-word is coming out of the closet. In the year I was getting this book ready for publication, there appeared two ground-breaking articles on the role of love in therapy, both from analysts who assume intersubjectivity and mutuality in the psychotherapy process. Joseph Natterson (2003) suggests that we view psychotherapy as a "mutually loving process" in which the therapist's "subordinated subjectivity" fosters an actualization of love along with an actualization of self in patients, through a natural progression of desire, belief, and hope. Daniel Shaw (2003), after noting the skittishness with which psychoanalytic writers have addressed the question of their love for their patients, concludes that "analytic love," which he differentiates from romantic, sexual, and countertransferential love, can be a critical element in healing. Shaw raises an interesting question:

> Psychoanalysis provides a ritualized setting for a process that encourages the development of the analysand's intimate awareness of himself. In the process, analyst and analysand inevitably and necessarily become intimately involved with each other, intellectually and emotionally. At the heart of this endeavor . . . is a search for love, for the sense of being lovable, for the remobilization of thwarted capacities to give love and to receive love. This may seem a more fitting description of the analysand than the analyst, but consider our choice of profession. Is it not likely that we chose our work, at least in part, because it affords us the means of realizing the aim of being especially important to—especially loved and valued by—our analysands? (pp. 252–253)

I would add that being a therapist offers us the opportunity to experience ourselves *as loving*, a state of mind that is inherently rewarding and good for the self-esteem. And as Racker (1968) noted, the loving attitude inherent in conducting therapy also assuages guilt by symbolically making reparation to early love objects whom we unconsciously believe we have damaged.

It is increasingly clear from empirical studies of psychotherapy that it is the relationship that heals. But "the relationship" is a bit of an abstraction. What happens between two people when one enters the relationship suffering and leaves it feeling less symptomatic, more alive, more agentic, more genuine? Neuropsychological studies are revealing that objectively, when we remain in intimate emotional contact with another person, changes take place in our respective brains (see Chapter 11). But subjectively, it certainly seems that love has been generated in the dyad and has been taken in by the client with therapeutic effects. I think Bergmann (1987) is right (and this was Freud's meaning as well, in his comment to Jung that psychoanalysis is a cure through love) that what initially inspires the patient's love for the therapist is the sense that the therapist is both similar to (by being in a caregiving role) and different from the childhood caregivers. After the alliance is established, it is often the ways the therapist differs from the parents that touch clients most powerfully.

But at some point (early with more borderline and psychotic clients and later with neurotic-level people), the therapist is experienced as just like the pathogenic early love objects. With each new patient I become awed once more by the emergence of transference and transferential reenactments. The recurrence in the therapeutic relationship of the main emotional currents in the client's history is a wondrous phenomenon. What makes it especially fascinating is that both parties to therapy start out earnestly resolving that what happened to the client earlier *will not happen* this time around. The patient is looking to undo the prior damage and thus tries to choose a therapist who offers a contrasting experience to the one internalized in childhood; the therapist longs not to fail the patient as the early caregivers did. And yet with stunning inevitability, both parties find themselves caught up in repetition: Patients who are convinced that all authorities are critical elicit the critical part of the therapist, those who presume that all men are narcissistic somehow evoke the narcissism of a male clinician, and so forth. If our hopes that we can love someone into health via understanding and good intentions are doomed, if instead we replicate the pain of the past, where does the love come in?

I think the therapist's love is experienced mainly in processing the repetitions. The client may feel hurt in ways excruciatingly like his or her childhood suffering, and yet the therapist, unlike the early love ob-

jects, tolerates the client's pain, knows that the interaction feels horribly familiar, and by empathy and interpretation contributes to the client's capacity to distinguish what has happened now from what happened in the past. The patient's activity in recreating the situation is examined nonjudgmentally, leading ultimately to an increase in the sense of agency. The affects attending the repetition are accepted and processed as they were not the first time around. And frequently, the therapist's remorse about having participated in replicating a painful early experience is evident to the client, who feels the loving repair that is inherent in apology. It can be deeply touching to patients to realize that the therapist's narcissistic wishes to be perfect or to be seen as innocent take second place to his or her honesty and wish to restore the therapeutic connection.

Winnicott (1947) was doubtless right that hatred is as inevitable and important as love, and that many patients need to evoke the therapist's sincere hate before they can tolerate his or her love. And Ferenczi (1932, cited in Shaw, 2003) seems intuitively accurate in bemoaning the fact that one cannot just decide to love a patient; the feeling must be genuine to be therapeutic. Those clinical populations that are most damaged in their capacity to love, namely, antisocial and narcissistically organized individuals, are also the most notoriously difficult to help. Could that be because their incapacity to love makes it hard for therapists to feel genuinely loving toward them?

I have worked with people it took me literally years to love. I had to endure a lot of hostile, defensive posturing that was very off-putting before I felt I had made contact with the hurt and lovable person under all the layers of self-protection. It troubles me when I cannot find something to love in a person who comes to me for help, and I suspect that this feeling is not uncommon among therapists. With the patient I mentioned in Chapter 3, whose passive hostility sparked the unsatisfying interchange with my would-be Rogerian supervisor, I was not able to feel any genuine compassion toward her until I serendipitously caught a stomach flu. My gastrointestinal symptoms were strikingly similar to those of the psychosomatically implicated ailments about which she interminably complained, and they were miserable. When I "got" viscerally the kind of pain and nausea she coped with every day, discomforts I had to bear for only a day or two, my heart finally went out to her. In a similar vein, my friend Nicole Moore, a psychiatrist in the U.S. Air Force, confided (personal communication, August 20, 2003):

> I don't like *myself* when I can't find something to love in a patient. I *look* for it. Often I can find something in the person's history that stirs my genuine compassion; I can love the child who went through that and hold an image of that child in my heart. I think when patients see the love reflected back at them, they start to believe they are lovable after all, and they start to get better.

I want to make it clear that psychoanalytic love includes respect and is anything but infantilizing. It is not incompatible with all the negative feelings toward patients that get stirred up in therapy, nor is it incompatible with setting limits, interpreting defenses, confronting self-destructiveness, and inflicting inevitable pain—both by accurate observations that are hard on a patient's self-esteem and by inaccurate ones that disappoint because the therapist has again demonstrated fallibility. Like any kind of love worth the name, it is not based on distortion; that is, therapists do not idealize clients in order to feel loving toward them. We try to love them as they are and have faith that they can grow in the ways they need to grow.

I doubt that anyone can feel truly loved unless he or she has been truly recognized as a combination of positive and negative qualities, good and evil. Here I return to the theme of honesty: In supporting the effort to pursue and name what feels true, no matter how unattractive, the therapist creates the conditions under which clients can feel loved for who they really are. In the context of this love, they can begin to expand, to experiment, to hope, to change. As Shaw (2003) concluded:

> Analytic love is indeed complicated and dangerous, and like all loving, carries the potential for devastating disappointment. This knowledge, rather than leading us to ignore, omit, or cancel our love, seems instead a call to persist in loving, as authentically, deeply, respectfully, and responsibly as we can. (p. 275)

NOTES

1. Although Spence and Schafer take their observation in radically different directions, they have both pointed out that clinical narrations cannot be assumed to be historical "facts." Schafer has recently commented, "Donald Spence . . . a confirmed empiricist . . . criticizes psychoanalysis for not amassing hard historical facts through scientific research that would satisfy hard-nosed experimentalists. I view Spence as my polar opposite. For me, clinical narrations are versions of a life that are as close to true versions as one can hope to get through analysis" (1999, pp. 348–349).
2. I have made the argument for formal and comprehensive history-taking in Chapter 1 of *Psychoanalytic Diagnosis* (McWilliams, 1994). I have discussed

the process of developing and sharing a dynamic formulation in Chapter 2 of *Psychoanalytic Case Formulation* (McWilliams, 1999).

3. For an interesting use of this principle within a classical psychoanalytic treatment, see Volkan (1984). In more recent psychoanalytic writing on helping therapists to help patients to speak with feeling, Martha Stark's (1994) explication of her distinctive interpretive style, Stephen Appelbaum's (2000) book on "evocativeness," and Karen Maroda's intended book on technique from a relational perspective document different ways of furthering authentic expression.