DEEPENING THE TREATMENT

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CHAPTER 1

Setting the Stage—
Providing the Structure
(An Ongoing Process)
Psychoanalytically oriented psychotherapy is a journey inward. Travelers are always anxious to some degree. When the vehicle of transport seems safe and sturdy, and the pilot or captain impresses the passenger with her expertise and confidence, the traveler can relax to some extent. The therapist has the same obligation: providing a safe and secure environment for travel.

Many people who come to a therapist have felt betrayed early in life and therefore do not trust easily, if at all. Since the unique relationship between patient and therapist that evolves over time provides new opportunities for trusting, setting the stage is very important. The therapist’s attitude of respect, patience, and benevolent curiosity combined with her confidence in the analytic process is what impresses the patient and permits her to stay in treatment. The persistent durability and constancy of the therapist and her functions presents the patient with a new reality, one that holds the potential for reviewing and experiencing the calamities of life in a new way. Differentiation becomes safe. Separations become bearable. Competition becomes acceptable. Feelings of effectiveness become more rewarding than feelings of omnipotence and grandiosity. Experiences of success and failure can exist side by side and do not cancel each other out. Closeness and intimacy become possible.

How do we set the stage for the deeper work that needs to be done? How do we create a safe environment? How do we pass the tests?

1. By having an inner conviction that each person has a unique story to tell, and respecting his or her way of relating it;
2. By listening carefully and following what the patient says attentively so that we can make connections and interpretations when appropriate;
3. By being confident that the long-term process of working through is necessary and possible for the patient to resume development and diminish conflict;

4. By being nonjudgmental, nonintrusive and open-minded;

5. By listening for strength as well as for pathology, and not letting premature diagnoses or diagnostic labels cloud the picture;

6. By being respectful of the patient’s pace and autonomy;

7. By being firm and flexible when either are appropriate, and learning how to know when to be which;

8. By listening with respect, and by being comfortable not knowing the answers—or even the questions sometimes;

9. By encouraging and protecting the patient’s curiosity and capacity for self-reflection;

10. By not burdening the patient with personal information and opinions;

11. By remembering that no two cases are alike, and that each patient creates her own theory (not fitting the patient into the theory);

12. By setting the conditions of treatment such as fee, payment, vacation policy, and missed session policy in the consultation phase so as to clear the way for work without distraction;

13. By remembering that growth and not cure is the goal;

14. By being consistent, reliable, calm, and benevolently curious;

15. By providing an atmosphere of trust, safety, and confidentiality.

Benevolent curiosity is a phrase I learned when reading Ella Sharpe’s (1950) collected papers. Two chapters in this collection, “The Analyst,” and “The Analysand,” are basic reading for anyone who practices psychoanalytically oriented psychotherapy and psychoanalysis. Since psychoanalysis is a psychoanalytically oriented psychotherapy I will use the terms psychoanalytic treatment and psychoanalytic work most of the time. I reserve the term analyst for those clinicians who have undertaken their own personal analysis and analytic training. I use the term therapist to refer to all clinicians. I assign Sharpe’s pa-

pers to every technique class I teach because they explain the essence of our work.

Sharpe says:

The fundamental interest of a would-be technician must be in people’s lives and thoughts. The dross of the infantile super-ego in that fundamental interest must by analysis be purged. The urgency to reform, to correct, to make different, motivates the task of a reformer or educator. The urgency to cure motivates the physician. A deep-seated interest in people’s lives and thoughts must in a psycho-analyst have been transformed into an insatiable curiosity which, while having its recognizable unconscious roots, is free in consciousness to range over every field of human experience and activity, free to recognize every unconscious impulse, with only one urgency, namely, a desire to know more and still more about the psychical mechanism involved. . . . When we come to a habit of thought, a type of experience, to which we reply: “I cannot understand how a person can think like that or behave like this,” then we cease to be technicians. Curiosity has ceased to be benevolent. [pp. 11, 12, italics added]

Benevolent curiosity comes easier to some than to others and is easier to practice with certain patients than others, but if we keep it as the most important stance to strive for we can interest the patient in deepening the treatment. One reason is that patients see therapists over time as nonjudgmental and worthy of their trust. Another reason is that through identifying with the analytic attitude patients become less critical and more curious. In fact, if there is one thing that engages patients in looking inside it is the ability to be benevolently curious about themselves. The therapist’s spirit of inquiry is what makes analytic work possible.

Often, in the beginning of a treatment (and later on, too) the patient expresses curiosity about the therapist. This brings us to numbers 9 and 10: “not burdening the patient with personal information or opinions” and “encouraging the patient’s curiosity and capacity for self-reflection.”

Every therapist has heard different versions of the following words: “How can I have thoughts or feelings about you? I know nothing about
you. If only I knew if you had children or were married or were ever divorced or used drugs or liked to cook or went to movies—then maybe I could trust that you’d understand me."

Beginning therapists often have difficulty not answering personal questions because they see this as depriving the patient and possibly damaging the alliance. In all my years of teaching, supervising, and treating I have found that once this therapeutic attitude of not answering questions is explained the patient feels safer and the treatment deepens. There are always exceptions to every guideline because each patient is unique and because different clinical situations require different responses. The stance of benevolent curiosity, however, usually saves the therapist from making uninformed decisions.

When a patient asks me a personal question I explain, with utmost tact, that questions are very important to the work of understanding but that by answering personal questions or giving personal opinions I would cut short an important learning opportunity. The opportunity is the patient’s fantasy about the answer. I say something like, “Your questions are very important to me, and in a different setting it would be polite to answer. Here, we want to learn about your thoughts and feelings. Your questions about me are valuable ways to explore them. It would be easy for me to answer but in doing so I would be depriving you of a chance to wonder about and to picture me any way you want to.” Such an explanation is basically reassuring to a patient. It says to her that there are boundaries; that this is not a social situation where politeness is required; and that her therapist is interested in helping her reflect. Said early in treatment it helps educate the patient about how the work is done.

How many of us have never answered a personal question? Therapists who do psychoanalytic work understand the idea of abstinence but because we learn best by experience most of us have answered a personal question or been tempted to offer advice. What we learn is that rather than help the patient trust, these answers often do the opposite. If the therapist answers one question, why would the patient not expect all questions, or at least most, to be answered? Answering questions takes away the patient’s right to wonder and to explore her own fantasies. I have heard patients ask the questions and then reassure me that they really don’t want me to answer. Despite the current debate on self-disclosure, with some analysts advocating the sharing of personal information and others preferring the traditional approach, it seems that if the therapist understands and respects the patient’s right to imagine she will protect that right as best she can. There are some patients who cannot seem to tolerate a therapist’s nondisclosing stance and it is at these times and with these patients that common sense and experience must guide us.

Telling a patient where you’re going on vacation in most cases oversteps the bounds of the professional atmosphere so crucial to the work. It may seem like a minor point but if the analyst starts sharing personal information, how, when, and where does she draw the line? Telling a patient a little can be tantalizing, as if one says, “Take a peek, but only a peek.” My preference is to give the patient the space to explore in fantasy where I go and to preserve my privacy. Of course, there are exceptions. A woman began therapy right before my winter vacation. In the last session before the vacation, when at the door, she said, “Oh, where are you going?” I asked if we could talk about it in a week when I returned. She never came back. I realized the minute this woman left that what I said had appeared rude. I had not yet had a chance to explain the value in exploring questions with this person. I have never made that mistake again. With most patients I respect their right to picture me wherever and with whomever they want. Thinking about the therapist as having a “real” life is difficult for some patients, especially toward the beginning of treatment. A patient who pictured me vacationing on an island with only books for pleasure gradually over the many years of work added a dog to the picture and eventually a family. Waterskiing replaced reading as issues of object loss, separation, envy, jealousy, and oedipal rivalry entered the treatment and were worked on. Taking away this patient’s opportunity for fantasy by giving her facts would have deprived her of the chance to work at her own pace.

There are times when it is appropriate to tell a patient where you go on vacation. Someone who suffered from severe separation anxiety that seriously disrupted her functioning was able to maintain her stability by bringing an atlas to sessions prior to the vacation break.
Tracing the therapist’s travel route was the patient’s solution and the therapist respected this autonomous idea.

With a fragile patient who might be wounded rather than helped by not getting an answer the therapist might say something like, “I will answer your question but can you work with it first? This way we will learn more than if I answer you quickly. Then, if you still feel that my answering will be helpful, I will.”

A different kind of challenge appears in the context of a bicycle accident I had many years ago while on vacation. When I resumed work my eye was black and I was still limping. I felt that my patients deserved an explanation so I told them the truth. One patient said, “Likely story! Your husband probably did it.” This was said with a laugh but we were able to use her “joke” to tap into her anger at my absence and at my husband, whom she imagined as her rival for my attention. Some therapists might have chosen to wait for the patient’s reactions. My self-disclosure in this case had roots in my unconscious. Any time the therapist makes a decision to disclose personal information it is most helpful if she analyzes her decision. The point is that there is no absolutely correct way for the therapist to be in the myriad situations that come up when working analytically, except to understand as best she can what motivates her and to preserve the frame whenever possible.

Mr. Baldwin asked in his first interview if the therapist was Catholic. He could not imagine how a non-Catholic could understand his background. The therapist said that although she understood his concern she was sure he could convey what it was like. Even if she was Catholic, that did not mean their experiences were identical. Her tone conveyed respect for his ability to articulate his experience and he was satisfied enough to continue treatment. The therapist could have explained in more detail the reason for her policy if the patient had persisted in knowing. She might have said something like, “It would be so easy for me just to answer your question but if I did it would deprive you of a chance to understand yourself on a deeper level by putting me in the spotlight instead of you. Our job here is to understand you. Sharing my experience would really not help us reach our goal of understanding.” Such

an explanation, when given respectfully, gives the patient more than the answer to the question asked. It gave Mr. Baldwin the message that the therapist believes in her method, is able to set a boundary, and is genuinely interested in exploring his fantasy and in valuing his curiosity. If the therapist had answered the question, Mr. Baldwin would have been deprived of picturing or imagining the therapist anyway he needed or wanted to. Even a small bit of information can interfere with the patient’s freedom to fantasize about the therapist.

A supervisee had to cancel her appointments in order to attend a funeral. She thought it would be polite to give the patients her reason so they would not think she was frivolous or unreliable. After discussing her rationale in supervision she realized that by giving this information she would curtail the patients’ reactions to the cancellation. It is difficult to express anger and annoyance when a funeral is involved. Since a patient must feel free to express anger at the therapist she must be very careful about interfering with that ability. With very fragile patients the therapist must use clinical judgment. Our aim is not to harm a patient, it is to maintain enough anonymity to permit the development of transference fantasies. Personal information about the therapist becomes a burden because it usually requires a realistic response.

An action-prone, hostile patient responded to his therapist’s last-minute cancellation with concern—the first nonsarcastic reaction in the treatment—by saying, “I hope everything is okay.” Asked about his thoughts he said, “You’re always here and always on time—something very important must have happened.” This moment of reflection might have been precluded had a reason been given.

Being “always here and always on time” means reliability (number 14). Many patients have never experienced reliability, consistency, and respect. These three attitudes are required if the treatment is to deepen.

Even a commonplace question like “How are you?” becomes grist for the mill in psychoanalytic work. Mr. Spacey habitually greeted
his therapist, Dr. P., with the same question. One day, Dr. P. pointed it out.

Therapist: I notice that when I open the door you always ask how I am.
Patient: Oh, it's just a habit—something I usually say.
Therapist: I understand, but what are your thoughts?
Patient: Well, I have wondered if you're tired. I must be your last patient of the day—I can't imagine how you concentrate.
Therapist: What comes to mind?
Patient: My wife is exhausted by the time I get home—the kids wear her out all day and we don't talk much in the evening. My mother was that way too. With all those kids none of us really got any individual time. [Mr. Spacey continues to reflect about his loneliness and eventually becomes aware of his anger and sadness at feeling neglected.]

It would have been easy for Dr. P. to let the "How are you" go because it is a socially accepted form of greeting. By approaching the question with benign curiosity he accomplished several things. He engaged the patient in looking beneath the surface, showing him that there were many feelings behind a simple, normal question.

Clinicians who are psychoanalytically oriented differ on the matter of how they address their patients (Fancher and Hall 1989). A question frequently asked by patients during a course of treatment, and often in the consultation phase is, "Will you call me by my first name?"

One of my first patients began seeing me in a clinic that specialized in drug-related problems. He was a charming, seductive homosexual who had been arrested for possession and for having a sexual encounter in a public men's room. The Judge gave him a choice between jail and therapy. He chose the latter. After three appointments he asked if he could call me "Jane" so that he could relax and talk more easily about his drug use and lifestyle. He could also experience therapy as a friendly process instead of something he was required to do by the Judge.

I agreed to his request because the agency therapists were almost all on a first-name basis with the patients, and I was concerned that by not granting his request I would injure him narcissistically.

What I want to point out with this seemingly understandable and well rationalized example is that granting this request without understanding its unconscious roots set a tone of avoidance that was hard to overcome in the many years of treatment that followed. Joe was a seriously disturbed man who was used to expressing his feelings through actions and dulling them through drug use. The treatment did deepen into analysis after several years of twice-a-week work, but there was always an undercurrent of teasing and refusing to take things seriously. I mention this case as an example of failing an early test that made later tests harder to pass. Looking back, I see that my countertransference was both induced and personal. It had to do with the seriousness of this patient's pathology, which he avoided seeing at all costs, and with my wish to be liked. This enactment was an unconscious collusion on both our parts to overlook the gravity of Joe's situation and the past that led to it.

Today, I would have dealt with that early test differently. I would say something like, "Your request is important and certainly understandable, but before we make any decisions can you try to explore your request some more?" I would go on to explain, if necessary, that if he allowed himself to see and say what came to mind we would be able to understand things in ways that would help us get to know him. I would say this with tact and sincerity but with a firm belief in my method. This way the patient would have a chance to learn about me, too. He would learn about my benevolent curiosity, my confidence in my method of working, and that he could not seduce me as he seduced everyone else in his life. He would also begin to see that reflecting about something is far more interesting and satisfying than acting first.

Using formal means of address usually makes it easier for the patient to express embarrassing material. First names imply a friendship to most people, and although the therapist is often experienced as a friend she is far more. The therapist is first and foremost a pro-
fessional. Second, and equally important, she is a transference figure. The formality of surnames serves as a frame for the transference fantasies and feelings that will be expressed with time. I know from my experience supervising that many therapists prefer using first names. This is usually because their own therapy was conducted using first names. Other reasons for using first names have to do with custom and culture. However the therapist decides to introduce herself, it is important to understand a patient's request to change the form of address once treatment has begun.

After a year of analysis a patient told me that it had angered him when I referred to myself as Mrs. on his message tape when I returned his phone call. "Why can't I call you 'Jane'?” he asked. I asked him to talk about his anger and what it might mean to call me "Jane." After his associating to a distant mother I said that calling myself "Mrs. Hall" suggested to him that I was distant. I asked him to talk about that. Once the transference issue was addressed the name issue lost importance.

With a different patient I explained that she would be having all kinds of feelings about me, would want to call me different names as the treatment deepened, and that these feelings would be safe because of the professional atmosphere of treatment. This was my way of preparing her for transference. Like a guide telling a traveler some of the things that might occur on a journey, I find it helpful to pave the way with new patients by explaining that many different feelings will come up.

Pressure to give advice is a dilemma for many therapists and I have heard many examples of the therapist succumbing. Giving advice often gets in the way of listening with benevolent curiosity. The therapist's ability to engage the patient in exploring her conflict around making a decision is ultimately what fosters the patient's autonomy. Explaining this to a patient requires tact and timing, and it is an excellent opportunity to increase the patient's own benevolent curiosity. Once the therapist makes the mistake of giving advice it is difficult (but not impossible) to stop. There are many mistakes we make, especially in the beginning. In supervision we learn new techniques and ways to hear things. There is nothing wrong in saying something like, "Although I have given you advice before, I think that by both of us looking at the question you will find a comfortable answer." Changing technique is not only permissible, it is necessary because we are always learning new and better ways to hear and respond.

The reasons to refrain from advising a patient are:

- Advice from a therapist is antithetical to the analytic work of understanding.
- Advice from the therapist assumes a value judgment.
- Advice infringes on a patient's autonomy.
- The therapist who gives advice is doing so often because of unanalyzed countertransference; there are so many ways to enlist a patient's decision-making skills without such advice.
- Once advice is given the patient may feel obligated to follow it.
- If the patient can't follow the therapist's advice, a whole new dynamic is introduced that can add to guilty or shameful feelings.
- If the patient does follow the therapist's advice and things go badly, it is more difficult to explore the meaning of what happened.
- There are usually plenty of people in a patient's life who offer advice. The therapist is usually the only one who cherishes the patient's ability to reach her own decision, for better and for worse.
- If a patient is about to make a destructive or damaging decision the therapist can always point that out and analyze why the patient is contemplating hurting herself.

It is important to understand with the patient why advice is requested. Understanding the request is far more useful in the long run than any advice the therapist might give. The demand or request for advice can be a test to see if the therapist can be consistent in her neutral, benevolently curious stance. Recently the concept of neutrality has been challenged by Stolorow (1990) and others (Panel
1997). I maintain that the analyst who takes a stand or makes a judgment one way or the other about most issues is stepping out of bounds. In most instances, taking sides interferes with the analyst's stance of benign curiosity and the patient's quest for autonomy. Examples in which a therapist might be tempted to make a value judgment include: whether a patient finishes or drops out of school, whether a patient considers giving up a seemingly important chance for professional advancement due to neurotic conflict, even whether the patient threatens to quit treatment. Taking a stand on such issues takes the therapist away from analyzing. For the analyst, the natural hope that a patient does the "best" or "right" thing must take a back seat to understanding why a patient chooses to do something. This is a test that happens in almost every case (especially in the beginning) and, if failed, can interfere with the patient's ability to trust. If a parental figure gives in to a child's demands frequently or randomly, the child will continue to test for boundaries. Love is behind the parent's ability to be consistent and firm. Rejection is expressed by a parent's inconsistent behavior. A therapist's ability to be firm and to set safe boundaries adds up to concern, something many of our so-called "difficult" or "borderline" patients have never felt sure of. For example, when a patient asks for advice about changing jobs or leaving home I say something like, "What's best for you is something only you can figure out. If you talk about it and see what comes to mind I think things will become clearer." If the patient persists in wanting me to take a stand I focus on the persistence by saying something like, "Let's try to figure out what's behind your wish for me to decide." If that fails to deepen the work I explain, "My giving advice would be presumptuous because I can't know what would be best. Can you explore the pros and cons of the different decisions available? That way we can learn more." When a patient is contemplating an action that clearly would put her in jeopardy I would say, "This choice will obviously result in pain (or loss, etc.). Why do you think you would take such a step?" If the patient has a pretty good idea what the best decision is and still needs the therapist's approval, I focus on that by saying something like, "My approval seems so important to you. Can you talk about that?"

Mr. North sought treatment because he was depressed. The analyst he was referred to chose to help the patient assert himself by giving advice and encouragement. The analyst recommended books to read and plays to see. Mr. North was reminded of a Mel Brooks/Carl Reiner comedy record in which the analyst says to a patient whose problem is "tearing paper," "Don't tear paper." Mr. North realized that advice such as this was not what he was paying for and left treatment. Had the analyst considered Mr. North in why he had difficulty in asserting himself, he might have stayed in treatment.

Striving for a neutral stance does not mean that the therapist is a blank screen or mirror. Indifference is not what we feel or wish to convey. When a therapist hears that a patient is setting herself up for mistreatment or abuse she says something like, "It sounds like you're asking for trouble to me. Can you talk about that?" If the patient is behaving in a way that threatens a relationship or a job this must be pointed out with concern by the therapist, but advising or directing is not an analytic technique.

Feeling neutral when hearing about mistreatment is impossible and it is not unusual for the therapist to feel angry with her patient's abuser and with the patient for letting herself be abused or for abusing others. Expressing outrage and pain, however, is the patient's right, and assisting her to exercise that right is the therapist's goal. If the therapist actively takes sides she risks soothing the patient before the intense feelings that have often been avoided for years surface in the transference.

An exception to the guideline of not taking a stand involves a patient's suicidal behavior or threats. In such cases the therapist's first concern is the patient's health and safety. Involving the patient's family or friends and recommending hospitalization when appropriate are measures the therapist takes.

The stance of benign or benevolent curiosity is really the foundation of psychoanalytic work. If the therapist is consistent about this attitude the treatment will deepen naturally. Consistency and constancy apply to all the therapist's policies and to her demeanor. Being ready for the patient is important, even when the patient is late. While I do not feel that reviewing the previous session notes is usually nec-
essary, I do try to clear my mind of distractions and to be aware of my feelings about seeing the patient.

A supervisee once had to move her office twice within one year. Her patients had varying reactions from annoyance to anger to fear. The disruption affected some more than others. A patient who had moved often during childhood was particularly upset. It took her time to adjust and she gained new understanding about just how upsetting her childhood moves were. New material emerged and was useful in understanding her need for consistency and her need for control.

One day she was late and found her therapist working at her desk when she arrived instead of sitting in her chair as she usually was. She became angry and talked about her fear of interrupting her therapist doing something she shouldn't see. This led to primal scene material heretofore repressed or avoided.

Although this material was useful I believe that it is important to be sitting in your chair, ready for the patient when she is late. I do not talk on the phone while waiting in case the patient is trying to call. It is important to convey to the patient that you are ready during her time.

I learned early in my training that there are two things you can guarantee a patient: the first is consistency and being on time is part of that; the second is your undivided attention. This means not taking phone calls during a session. It also means not drinking coffee during sessions. I have heard of therapists who work early in the morning and have coffee while the patient is on the couch. This seems disrespectful, impolite, and distracting to me. This also holds true when the patient brings coffee. I find eating and drinking during a session distracting and probably symbolic of something I don't understand. When a patient brings food or drink I say with all the tact I can muster something like, “Can we explore what bringing coffee to your session might mean?” If the patient takes this request as a rejection or seems angry I ask her to express these feelings. I then say calmly and tactfully something like, “I have found that eating and drinking during the session can be distracting and can interfere with our work.” If the patient seems hurt or angry I ask her to tell me what she is feeling. With a fragile patient I might add that my request is not meant to deprive but to make our work easier.

Many therapists say that the patients they call borderline cannot tolerate the abstinence required in analysis. (The word difficult has replaced the term borderline with many therapists. This is a step away from labeling but difficult describes the therapist's problem. I prefer the word troubled or the phrases deeply troubled, self-destructive, lacking in the capacity to self-regulate or self-soothe, fragile, or disturbed because they are more descriptive and less judgmental.) These therapists advocate parameters such as giving advice, answering personal questions, not charging for missed sessions, and so on. I have found that patients respond best to explanations for different analytic policies and poorly to parameters that they find infantilizing and patronizing. If the therapist can convey her respect and confidence in analytic work the patient will feel respected and more convinced about the analytic process. Most of all, the patient will see that the therapist is not frightened of expressions of anger and disappointment.

These guidelines are meant to ensure consistency and to show respect. Naturally, because we are human, we will be late at times, and if there is an emergency in our lives we may have to answer the phone. If a patient is having an anxiety attack or is in emotional upheaval I don’t bring up the coffee issue at that time. Common sense is our most valuable asset.

There are times when a patient may be seriously considering taking an action that is self-injurious, such as marrying someone who seems dangerously inappropriate or quitting a job that would compromise her self-sufficiency. One patient was planning to tell off her boss in a hostile and impulsive manner, thereby jeopardizing her job. If poor judgment is being exercised the therapist can ask the patient to talk about the pros and cons of her intended action. Aside from suicidal or dangerous actions, however, it is risky to take a definite stand. The risk lies in shifting from the neutral, benevolently curious attitude we strive for.
Ms. Weston was furious at her boss and had written a letter of resignation that she was about to mail. The boss indeed sounded like a difficult person but I wondered to Ms. Weston if there was anything else that had exacerbated her anger recently. She told of a conversation with her older sister who indeed reminded her in ways of the boss. I wondered if she felt that it was worth losing a good job to punish the boss who in many ways stood for someone else. Her rage did not subside immediately but thinking about things from a different angle bought her some time. When she cooled down she modified her strategy and asked for a transfer at work. This anger at the boss had reached a crescendo a week after I announced my summer vacation date. I asked Ms. Weston if she had some feelings and thoughts about my announcement. She began to see that she resented my calling the shots and saw that this reminded her of the boss and her sister, who always seemed to have special privileges. Ms. Weston had only been in treatment for six months and this was our first opportunity to hear about her feelings towards me. These feelings are known as transference manifestations (see Chapter 3). In the following session Ms. Weston brought up the boss’s unfairness again and I asked if she thought my vacation felt unfair on some level. “Well,” she said, “it did seem unfair that just as things were getting interesting you would decide to take a vacation.” We learned that Ms. Weston’s wish to get rid of or leave her boss was connected to my getting rid of her. If she could leave first, the pain of being left could be avoided. Using Ms. Weston’s material to focus on her feelings about me set the stage for further work in the transference.

Mrs. Jenkins tested me from day one. She was always flirting with danger and had been for most of her life. She described a childhood of emotional abuse. A rejecting mother tethered her to a tree when she was 2 and 3 because she wandered away from home. We wondered if even at that age she was trying to get away or to seek something better. At age 8 she was left in charge of a younger cousin who ran out into the street where she saw him hit by a car. These facts combined with others led to guilt and rage that were usually self-directed. Mrs. Jenkins said she owned a gun for protection on an isolated farm in the country and threatened to take it on vacation. I did as much interpreting of her feelings about our separation as I possibly could and finally told her that, although I had no power to keep her from taking or even owning a gun, I certainly thought it was a very dangerous thing to do. The difference between advising Mrs. Jenkins not to take a gun and sharing my thoughts about it is a subtle one. You might say I offered my perception strongly but left the decision up to her. When Mrs. Jenkins returned from vacation and we resumed our work she told me that she had gotten rid of the gun and had really meant to frighten me. It was important that I did not try to force her to give up the gun and also that I showed my concern.

Before a vacation break Mr. Farnon told his therapist that he took LSD or amphetamines on occasion. He was an unstable and frightening patient in many ways but showing fear would have frightened him away. The therapist could only express concern. Before the vacation the therapist mentioned that if things were getting out of control Mr. Farnon could go to his hospital emergency room for help. The therapist suggested that he visit his local hospital so he knew exactly where to go. He was also given the name of a covering therapist to call if he wished. Again, expressing concern while allowing the patient to be responsible for himself proved very meaningful to this very disturbed young man.

A patient once told me that had I become involved in his life outside of the office he would not have continued treatment. He needed to rely on my ability to help him question his life and behavior, not to direct him. He had people to call in emergencies and his family was always advising and telling him what to do.

Every therapist gets drawn into action at times. A supervisee told me about a patient whose husband was exhibiting severe manic-depressive symptoms. My supervisee acquiesced to her patient’s request to speak with her husband’s psychiatrist, who seemed not to realize the severity of the husband’s depression. The supervisee felt pulled into the marital problems and out of her inquiring stance. This supportive activity is required at times. Later on, when the outside or reality issues settled down, the supervisee and her patient were able to focus on the patient’s internal life and her reactions to the
therapist’s involvement. Speaking to a third party on a patient’s behalf is not recommended unless a situation reaches crisis proportions. When the therapist does intervene, it is important to obtain written permission. In most cases the patient should be present or should see the communication.

The structure, frame, and therapeutic environment are supportive in themselves. A patient once said, “When I come here I know you won’t react each time I present a dilemma. You give me time to gain my perspective—to look at things from different angles. It’s such a relief to have time to think things through. My friends and family are always putting their two cents in—giving me advice or cautioning me. When I started therapy I remember asking you for your opinion and for advice. It took me a while to realize that you respected my ability to think about things and come up with my own answers. And even if I goofed I would learn something.”

There are two major sources of confidence (number 2). Our own analyses provide a model and convince us that the unconscious is both powerful and decipherable. Our work with our own patients substantiates these findings. When this confidence flags I have found that supervision or consultation is enormously helpful. Another source of confidence building is, of course, our studies. Even after formal training, study groups keep us in touch with psychoanalytic concepts and case material. After many years of analytic work with a man who seemed unable to alter his sadomasochistic life style and character structure both patient and analyst felt they had reached a stalemate. The analyst’s countertransference began compromising her ability to be benevolently curious. Instead she felt that her own sadism, mixed with disappointment and frustration, was causing her to interpret in an impatient tone of voice. Such enactments are not unusual and can actually deepen the work if analyzed, but they are not always easily and satisfactorily analyzable. After consulting a supervisor for a period of time and returning to the literature on this subject she was able to regain her confidence. The articles brought her new understanding and made her feel less alone with her patient, who was pushing her away and trying to kill her effectiveness. Reading and consulting allow us to see that we are not alone.

Listening with respect and being comfortable not knowing the answers or even the questions (number 8) involves the technique of silence. If the therapist thinks about silence as active listening it is often easier to practice. The therapist’s silent stance is not withholding; it is quite the opposite. How many patients have felt listened to in a nonjudgmental, attentive way before therapy?

Sometimes a patient begins therapy saying, “I don’t want a silent therapist. I need you to talk and not just sit there.” The therapist’s response to this kind of statement can be used to educate the patient about the method of work. I usually say something like, “Listening to you is the best way I have of getting to know you. I promise you that when I think of something to say I will say it, but in the beginning it is especially important for me to hear you. When I am quiet I am concentrating on what you’re saying.” The patient may then continue to need assurance that you are paying attention, but your facial expression and an occasional question in face-to-face treatment usually allays that anxiety. Once the patient begins using the couch she is used to her therapist’s listening stance. Some patients become anxious when they cannot see the therapist’s face but a few words of reassurance usually suffice. If there is history of loss or neglect a deeper interpretation can often be made connecting the patient’s present reaction to the past. This in itself encourages the patient’s curiosity and ability to reflect. It also is a way to introduce the concept of transference.

When treating a patient who grew up with parents who rarely spoke the therapist will not want to repeat the experience by extreme silences, but even in such cases there are ways to be more actively quiet. “Hmm,” “I see,” “Can you tell me more about that?” “Is that a familiar feeling?” assure the patient that you are actively listening and present. The psychologist Carl Rogers had a way of repeating or echoing what the patient was saying, and this is another technique to consider when the patient is afraid or anxious about the therapist’s silent stance.

The therapist’s ability to be silent is extremely important in analytic work. Only when the therapist stays out of the way can the patient feel free to follow her thoughts without interruption. When
a patient is given the opportunity to see where her thoughts go the idea of free association becomes sensible, reasonable, and informative. All the therapist has to say when the patient complains that there is nothing to say is something like, “See what comes to mind.” If more explanation seems necessary the therapist can say something like, “It will help us understand things if you can see where your thoughts lead. If I talk a lot my words and thoughts will get in your way.” This approach seems more sensible to me than talking about a “fundamental rule.” Appealing to a patient’s sense of logic enlists the patient’s ego. Giving a rule invites a power struggle or a compliant attitude.

Saying what comes to mind can feel threatening to a patient and she may need encouragement. When this is the case the therapist can say something like, “Something always comes to mind. If you find yourself editing or withholding a thought you can try to figure out why. If you’re afraid of saying something that seems embarrassing or if you’re afraid of my reaction we can try understand why.” When a patient says, “My mind has gone blank,” the therapist can say, “This often means that there are thoughts about me going on.”

I find nothing wrong in explaining to a patient in the beginning of treatment that analytic work is done by seeing where thoughts lead (free association). I also say something like, “You’ll be having thoughts and feelings about me as we go along and it will be helpful if you talk about them along with whatever else comes to mind.” This approach differs somewhat from the stereotyped approach in which the analyst points to the couch after the first session and waits.

Since the majority of our patients do not come to us asking for analysis or even to do psychoanalytic work, it is up to the therapist to present her method of work in a way that makes sense. Patients are consumers and have a right to know something about the journey that they contemplate taking. This approach falls under the heading of respecting the patient and having confidence that saying what comes to mind and expressing feelings is valuable and leads to understanding.

Some therapists go to the other extreme, perhaps in reaction to a rigid approach. I have heard of therapists who invite patients to their homes or who have lengthy phone conversations as friends would.

Their rationale is that they are providing an experience they feel the patient missed in childhood or adolescence. I once heard of a therapist giving his patient a picture of himself before a vacation to “promote object constancy.” Another therapist gave her patient recipes because the patient was a newlywed and felt she could not cook for her husband. These actions are not psychoanalytic techniques and must be considered supportive therapy at best. Such techniques and others like them overstep professional bounds and threaten the safe environment necessary to analytic understanding. They are usually the beginning of the end of treatment. The therapist’s consistency, benign curiosity, and respect for a patient’s autonomy are more supportive than the more active techniques just mentioned. With very anxious and fragile patients phone contact between sessions is sometimes necessary, but I have found that brief conversations are usually enough. The wish to talk between sessions can be a clue that more frequent sessions are appropriate. I have supervised a number of cases where the patient picks up on the therapist’s anxiety and feels the need for contact between sessions. Once the therapist deals with her own anxiety either in her own treatment or in supervision the patient calms down.

The psychoanalytically oriented therapist will work towards promoting autonomy even in the most fragile patient. I have known patients who hold onto a bill or call the therapist’s tape to hear her voice during vacations. The patient uses creative and autonomous ways of enhancing object constancy. This corresponds to the infant’s choice of the transitional object. The mother cannot influence that choice.

Knowing when to be firm and when to be flexible (number 7) is a complex issue. Our firmness is extremely important to the patient who is testing our strength and conviction. Many therapists use their wish to be courteous, to be liked, and to form an alliance as reasons to alter their technique or to disregard the frame. A common example is letting the session go over. This is usually a mistake because it threatens the stability and safety of the hour. I have treated many patients who present a dream or other important-sounding material or affect in the last few minutes of a session. They often do this because it is
anxiety-provoking and they feel safer knowing that the hour is almost up. If we go overtime the patient loses the safety net she consciously or unconsciously set up. In these situations it is important to stick to the boundary of the session. At such times there are different things we might say to the patient such as:

"I think if you start here next time we will learn something, but we must stop for today."

"This dream can tell us a lot, and your leaving it to the end also tells us something."

"It sounds as if you need more time. Once a week makes it difficult to get everything in. We could talk about adding another session next time" (see Chapter 3).

Comments like these respect the patient’s pace while acknowledging her timing. As with all guidelines there are exceptions. When a patient is expressing intense affect towards the end of an hour the therapist wants to help her regain her equilibrium. I will say something like, “Our time will be up soon. I know you are very upset but for today can you calm yourself? Your feelings are so important to us but we must stop in a few minutes.” These comments or others like them are said in a calm, respectful, concerned way. They are meant to assist the patient in composing herself and let her see that feelings do not have to be overwhelming to either party. If we allow extreme emotionality to go unchecked at the end of a session we may frighten the patient, and her trust in our knowing what’s best is compromised.

Here the test involves the therapist’s ability to be in charge and to protect the patient. It also has to do with the therapist’s ability to provide structure and not to be seduced into changing it. There are patients who find it very difficult to leave and who linger. When this happens I recommend walking to the door and if necessary opening it to let the patient see that the time is indeed up.

Another test involving reliability and consistency is the request for changes in appointment times. Again, the ability to know when to be firm and when to be flexible comes into play. I have found that every request for a change must be explored first. If the request is well founded, and if I can reschedule, I will. However, it is important to listen for a reaction about the change in time. Patients come to rely on a permanent schedule and any shift can evoke memories of impermanence and inconsistency. Many patients have histories of unavailable caretakers and insecure early environments. This is why the therapist’s consistency is so important. Experience teaches us that a secure frame is required for in-depth work. Accommodating a patient may seem polite but is often a way to say “Don’t be angry.”

One patient said she was getting too work late and asked if she could be seen at 7:55 AM instead of 8:00. The therapist, not wanting her patient to get in trouble, agreed to the request without exploring it. The patient accepted the new time but instead of appreciating her therapist’s flexibility she felt uncomfortable in getting her way so easily. This reaction allowed the issue of trust to be explored. It emerged that the patient feared being able to seduce the analyst into giving her what she wanted.

It is important and easier for both therapist and patient to stick to a schedule. A policy of shifting appointments for either party makes a steady pace of work difficult. Needless to say, rigidity is not the goal—stability is.

Patients try in many ways to seduce us. It is not that they come in one day with a plan to get us to shift our stance or change a rule. It is usually a more unconscious process and it is really a very reasonable way for the patient to determine just how professional and strong we are. The patient is seeking professional help, not friendship, when she chooses a therapist.

A colleague’s patient asked for a progress report after two months of analysis. It was clear to the analyst that the patient was anxious about going deeper. The patient was a lawyer who was the head of his law firm, and progress reports were part of his life. The analyst felt intimidated at first but after some reflection told the patient that progress
reports were not part of analytic treatment and wondered if there were feelings behind the question. This answer let the patient see that the analyst knew what was best and opened the door for the expression of feelings. The patient had been testing the analyst’s strength and was relieved not to have frightened the analyst into answering. This patient had cut down his hours once before and he was re-testing his analyst’s conviction and confidence in his method.

A difficult situation for some therapists is a patient’s invitation to attend a concert, marriage, art show, or some other very important event. Some therapists accept such invitations, but I have found that exploring the request or invitation like any other question is the first order of business. Usually after the request is explored and it is understood what the effect on treatment would be, saying no is not necessary because the patient realizes that the therapeutic relationship would be compromised. With some patients, however, a courteous explanation about the therapist’s reason for declining the invitation is necessary and welcomed by the patient in the long run.

A candidate told about a patient who in the first session asked her to see his art exhibition at a local gallery because he felt that this would help the therapist understand him. While at the gallery (the patient was not present) the therapist read the guest book. In it she noticed a lovely comment from the patient’s mother. The patient had complained about his cold, disapproving mother and seeing the comment made the therapist question her patient’s perception of the mother.

This is a good example of why we try to stay in the office. We owe our patients neutral listening. If a patient tells us something that makes us wonder about their perception this is appropriate because we are listeners with investigative ears, but hearing or seeing information from anyone but the patient compromises our ability to hear with objectivity. Complete objectivity is impossible to achieve for many reasons but it is something we strive for. (This is why it is best not to share information with a therapist who treats a friend or family mem-

ber of your patient.) If the therapist remembers that she is being hired by the patient she will find it easier to listen only to the patient.

During the termination phase of a long psychoanalysis, a patient invited his analyst to his wedding. It was a milestone in his life that he wanted her to share. The analyst was very moved and pleased at his success but declined the invitation. As much as she would have liked to attend she knew that her presence would be inappropriate on several levels. First of all, the patient had known her in a professional atmosphere for fifteen years. The special relationship they had developed with all of its ups and downs, love and hate, frustration and reward was unique and had to remain private. Overstepping the boundaries of this relationship would have made it vulnerable. They had not yet terminated and, even if they had, seeing each other outside of the office would have compromised the analytic atmosphere.

This may seem like a rigid or strict approach to some therapists but most patients are relieved by this therapeutic stance. Patients understand that extra-analytic meetings can threaten their work. Also, once a therapist ceases to protect the frame with one patient, she will be worrying about when, why, and if to do so with another patient. Having to make such decisions is stressful and takes us away from our analytic work. We begin to make value judgments and decisions that distract us from our purpose. Preserving the analytic atmosphere is our most important function and, although I realize that analysts do make exceptions, I have found that passing the test of consistency is one of the most important.

Training analysts differ about the need to avoid extra-analytic contact when analyzing a candidate. When the patient belongs to or is in training at the same institute it can be difficult to avoid such meetings. Some analysts believe that during the analysis of a candidate the analyst should have the choice of attending an analytic function and the analyst in such cases should defer. There are other ways to handle this kind of situation. For example, patient and analyst can discuss the situation and agree on what to do, having analyzed it first.
The main idea is to analyze the issue. The fantasies that are stirred up by seeing the analyst with other people in other settings are myriad and naturally become grist for the mill.

Charging for missed sessions is another problem for many of the people I have taught and supervised. The rationale can be traced to Freud, who conceived of treatment as leasing his hours. Practically speaking, the therapist is a professional person earning a living. If a patient cannot keep one or some of her appointments the therapist should not be penalized. Electricity, rent, and other bills continue whether our patients are there or not. If all or half of our patients cancelled in a given week the financial loss would be great. Having a policy that includes all patients is one way of avoiding favoritism or unequal treatment. The fact that we protect ourselves by charging for missed sessions may upset a patient initially, but this policy has never lost me a patient. To the contrary, patients feel safer when they see that therapists can take care of themselves. As for rescheduling appointments, that is an individual decision. Some therapists have the time flexibility and can change their schedules. I recommend that if rescheduling is possible, it be done in the week of the missed session. A request to reschedule can have many meanings, conscious and unconscious. The therapist who acquiesces quickly and frequently may be saying, “Don’t be angry, see how accommodating I am.” I learned an important lesson early on. I found that when I rescheduled an appointment without fully understanding the patient’s request I would sometimes forget the new time. I learned that I found shifting appointments distracting to the rhythm of my work. I also found that often a patient would be upset with a new time and would forget to come or would resent my flexibility.

There are different ways of explaining this policy of paying for missed sessions. For a patient who has a job with sick day and vacation benefits, it is fairly easy just to state the policy. For people who travel regularly for work something more flexible can be arranged. Some therapists hold the missed time but charge half the fee; others make up the time. This is most difficult when the patient is in analysis because of the frequency of sessions. Whatever the policy, being firm is part of being consistent. It also conveys to the patient that we can tolerate anger. This is a major test that must be passed continually if the treatment is to deepen.

I have heard of patients who ask why they are not paid when the therapist is away. This is not a logical question and must be explored. All of these discussions are best done in the beginning of treatment. Towards the end of the first session or consultation phase when times are being arranged I say something like, “We will meet on Tuesday and Thursday at 6 PM. These times are yours. They belong to you and if for any reason you can’t be here you will be responsible for them.” I have had a patient cite a friend’s therapist who does not charge if there is 24-hour notice. I said something like, “I imagine different people have different ways of working but I have found this works best for me.”

This policy also entails being paid on time. Being a psychotherapist is difficult and serious work. Training and supervision, conferences, and reading are necessary and time-consuming. Being paid as well as you can be is important. The psychotherapist is not a philanthropist or a banker who extends credit. If a patient tries to build up a debt with us it is inappropriate. Borrowing money from a relative, friend, or bank or putting off treatment until one can pay protects the safety of the analytic atmosphere (see Blanck and Blanck 1974). Maintaining our professional identity is extremely important for us and for our patients.

I can usually think of an exception to any guideline but it is difficult with this one. It is only when we respect and take care of ourselves that we can do the same for our patients. No matter how kind and generous we are, we do a disservice by extending credit. If a patient loses a job or her source of income, we can decide to lower the fee or even to waive the fee (if absolutely necessary) temporarily. I recently heard that some analysts, because of managed care, arrange to have the patient pay them for uninsured sessions after the analysis is completed. I don’t have enough information about how this policy works or how it affects the work so it would be wrong to comment at this time. Needless to say it is a policy that must have different meanings for different patients and would have to be analyzed in all cases.
Mrs. Cohen worked twice a week in psychotherapy for four years. During this time she was able to extricate herself from a destructive marriage, and began seeing what led her into it in the first place. Her ability for self-reflection, for reporting dreams and associating to them, and for exploring her feelings about me was evident. Due to her changed financial situation after the divorce she could no longer afford twice-a-week sessions even at a very reduced fee. I felt that analysis would greatly benefit Mrs. Cohen and I explained why. After a six-month period of work she chose to accept a referral to an analyst who would see her for a very low fee, making it possible for her to have the treatment of choice. Her original problem had been dramatic, and a long period of work on separation issues alleviated her anxiety to the point where she could function independently. She also had time to test the constancy and consistency of the therapist and to see that looking inside made sense and was helpful. Psychoanalysis had not been the initial treatment of choice for Mrs. Cohen but it became so, and when it did she was helped to pursue it.

Had Mrs. Cohen been able to continue her twice-a-week sessions at the original fee I still would have recommended analysis because that had become the treatment of choice. If I had been in the early phase of my practice with the time and need for an analytic case I would have discussed reducing Mrs. Cohen's fee and deepened the work into analysis myself. The psychotherapy we had done did not include measures that would have contaminated the transference. In this case my reality and her need made it a clear-cut issue. Unfortunately there are therapists who prefer to hold on to a patient at once or twice a week rather than refer to an affordable analyst. They rationalize that they are more experienced than a beginning analyst is and that the patient will be in better hands with them. I question this assumption. Beginning analysts are in excellent supervision and furthermore the frequency of analysis makes it easier for the patient to tolerate the anxiety inherent in deepening the work.

In Mrs. Cohen's case diagnosis was not an issue in my mind. I saw no need to give her a label at any time during treatment (see Chapter 2). When she came to treatment her separation issues and her masochism stood out. Her anger at her husband was turned against herself. During the four years we worked together she gradually felt safe enough to direct her anger towards me and she learned that I could not be destroyed by it. Her dependency needs manifested themselves in a perverse symptom. It became clear that analysis would be required to effectively deal with her issues. One well-known psychoanalytic institute rejected her for analysis based on a borderline diagnosis. An equally reputable one accepted her. I share this information to remind us of number 5. A person's resiliency, psychological-mindedness, and motivation are far more meaningful than a diagnostic category. Mrs. Cohen is evidence that respecting the patient's pace and permitting the treatment to deepen by passing the tests on both sides of the couch lead to growth. The stage had been set for Mrs. Cohen's growth and she responded quite naturally.

When and how does the therapist raise her fee? This is a question often asked and discussed. There is a school of thought that once a patient decides to undertake analysis the therapist is bound by the original fee. I find this impractical and unrealistic. There are several issues to consider:

1. Inflation: some therapists raise their fees every year.
2. Countertransference: after a number of years of hard work the therapist can begin to resent not having a raise just like any other employee.
3. Higher income: the patient's ability to earn more money as a result of therapy warrants an increase in fee if the patient began at a reduced fee.

I find it easiest to raise the fee in January. I announce the fee raise in November when I give my bill to the patient. This advance notice gives the patient time to respond. Some therapists say to the patient before the August break that the fee will be raised in September. I find that with all of the feelings about vacation this is not the best time to bring up the fee. When a patient becomes able to pay more than the original fee, especially if the fee was a reduced one, it often appears in the material, either directly or indirectly.
To sum up, two people who decide to work together in psychoanalytic psychotherapy must both be as comfortable as possible. It is the therapist’s responsibility to create a safe environment for the patient and a workable environment for herself. The therapist must consider her needs according to where she is in her personal and professional life just as she considers her patient’s needs.

Therapists who practice psychoanalytic psychotherapy become more adept at deepening the treatment as their own analyses deepen. Only by recognizing and analyzing our own conflicts can we deeply appreciate and empathize with the conflicts of our patients. We must be able to look inside ourselves in an intensive and extensive way before we can guide another on the journey of self-exploration. Our own analyses prepare us for the rigors of our work and give us proper and deep respect for the unconscious. Our own analyses prepare us for the intense, often uncomfortable transferences and projections we must endure, understand, and interpret. Our own analyses enable us to recognize and deal with the induced and personal countertransference we are bound to experience. We are the recipients of all sorts of projections and feelings and our own analyses give us the courage and stamina to endure them.

All of these abilities are conveyed from unconscious to unconscious—the way most important information travels. Our insecurities, fears, and weaknesses, though ever present to some degree, can be sufficiently mastered, allowing us to set the stage for deeper work.