DEEPENING THE TREATMENT

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6. Need to externalize;
7. Level of patience;
8. Ability to be flexible;
9. Defenses favored. (If a patient’s history sounds traumatic in any way I listen for how the patient reacted in the past and how she views her reaction today);
10. Ability to include the therapist. (Anxious patients and patients with histories of intrusive parents often flood the therapist, making it impossible for her to get a word in.)

Sometimes the therapist is thrown off balance in a first meeting. The patient who exhibits unusual or inappropriate behavior, the extremely silent patient, the patient who brings her lunch and proceeds to eat it during the session are a few situations that occur to me.

One of my first clinic patients told me in the initial interview that he had a garbage machine in his head and, opening his mouth, asked me if I could hear it. I was a student and not at all prepared for this situation so I listened, said no, and asked him to tell me about himself. Where did he grow up, who did he live with, and so on. He answered my questions and a beginning rapport was established. Focusing him seemed to allay some of his anxiety. We later came to understand that the garbage machine stood for unacceptable thoughts. His initial behavior was his way of saying, “I’m a frightened person with dirty thoughts. Will you be afraid of and disgusted by me?” My benign curiosity and common sense carried me through an unusual situation.

The main goal of the first meeting or meetings is to have more meetings. These are far more likely to occur when respect and benevolent curiosity overshadow the need for labels.
Once the therapist has set the stage for psychoanalytic work and has passed the initial tests, once the two parties have sized each other up and a beginning rapport has been established, deepening the treatment becomes the therapist’s focus. By deepening the treatment I mean engaging the patient in looking beneath the surface, thereby expanding her understanding of what makes her tick. I will illustrate the process by introducing Mr. Lopez.

Mr. Lopez came to a clinic for therapy at age 21 as a condition of probation. He had been arrested for selling drugs on campus at the college he was attending. He initially viewed therapy as a way of avoiding jail. His probation term was five years. The therapist was not expected to report to the probation officer but if asked was expected to verify attendance. (This never happened.)

In adolescence Mr. Lopez began smoking marijuana and went on to experiment with both soft and hard drugs at college. While using drugs was a definite part of the culture at the time, selling drugs became more satisfying for him. It provided him with the self-esteem and identity he sought. Being important and powerful was the high he became addicted to.

Mr. Lopez’s parents came to this country from Cuba, and the long, hard hours they worked in their restaurant left little time or energy for raising their six children. Mr. Lopez, the youngest by ten years, was alternately spoiled and neglected as a child. Because his parents were rarely home to supervise and set limits, Mr. Lopez felt abandoned, lonely, and deprived, but when his mother was home he felt coddled, entitled, and smothered. He described himself in childhood as a tyrant with no discipline. Mr. Lopez was highly intelligent and did well academically. His teachers either hated or loved him. His strong need for attention was either gratified or rebuffed by them.
He remembered his behavior in school as either endearing or disruptive. He was calling for attention while at the same time pushing it away.

Mr. Lopez began once-a-week therapy, saying that he would fulfill his probation requirement but didn’t see the point of therapy. His therapist said she understood that he saw therapy as a must but thought he might find it an interesting process. Later in treatment Mr. Lopez reflected on the first sessions and said he found the therapist’s hopefulness relieving. He also remembered the therapist’s calm way of talking and was impressed by her interest in what he had to say. No one had ever listened to him without arguing or judging him before. After several sessions Mr. Lopez said he would use therapy to “get it all together, to have different interests and to get to know Gilberto Lopez.” In the first month of treatment Mr. Lopez shifted his attitude towards therapy and articulated his wish for a “second chance.”

What happened to effect the change in Mr. Lopez’s attitude? His therapist conveyed her interest, respect, patience, and hopefulness by her nonjudgmental and attentive demeanor, and by her benevolent curiosity (see Chapter 1). It was not just what she said to Mr. Lopez, it was how she genuinely felt. Her thoughts ran like this: Here is a young man who had a difficult and lonely childhood (empathy). He’s in trouble (benevolent curiosity). He is here in my office (hopefulness); He has a story to tell (interest); He survived (respect). I like him.

Empathy, interest, hopefulness, and the ability to like the patient set a tone of acceptance that is felt and responded to by the patient. It is the therapist’s attitude more than her words that conveys the message. In fact, if the attitude of respect and hopefulness is missing, words will mean nothing. This is what I mean by unconscious communication and gut feeling. The therapist’s attitude determines her ability to use psychoanalytic technique effectively. Hearing and interpreting resistance, transference, acting out, enactment, dreams, associations, and silence (making sense out of the patient’s communication and lack of communication) rest on the therapist’s knowledge of unconscious processes, an ability to be hopeful, and a basic ability to like the patient.

Mr. Lopez began his fourth session by reporting the memory of a fight at age 12 with a neighborhood kid who said Mr. Lopez’s parents didn’t love him because they were never home. Mr. Lopez remembered fighting because he felt hurt. In looking back he felt it was true. In college he felt comfortable by being cool and unemotional. Here, he was giving the therapist a glimpse of the work ahead. He was telling the therapist that he could be very demanding and could cover his neediness by seeming not to care. He was also testing to see if she would be judgmental by agreeing that his behavior was bad. After a while, Mr. Lopez became silent. The therapist took this opportunity to tell him that he would learn about himself by saying whatever came to mind, even if he had thoughts that seemed not to relate to the subject he had been talking about. Mr. Lopez responded by saying, “The world is round.” The therapist waited quietly and eventually Mr. Lopez began commenting on things in the office. He expressed some discomfort by challenging the relevancy of what he had said. The therapist said, “If you follow your thoughts they will lead you somewhere, and you will learn about yourself.” Mr. Lopez shrugged and said that the mind was really complex. He smiled as the session ended.

Introducing the patient to the idea of free association is really quite simple and natural. If it is done in a gentle and thoughtful way and if it makes sense to the patient he feels accepted and encouraged. Mr. Lopez felt a lifting of the pressure to perform. He also heard that his therapist was interested in whatever he had to say, whether it made sense or not. This does not mean that the patient will associate freely at all times. In future sessions Mr. Lopez spoke of feeling blocked or of his mind going blank. This often means that thoughts about the therapist are going on. The therapist can say, at such times, something like, “Usually when your mind goes blank or you feel blocked about saying something it means you are having thoughts about me.” I have found that such an explanation gives the patient permission to talk more freely about the therapist. Many patients will say, “I didn’t think my thoughts about you were part of therapy.” Other patients say, “As a matter of fact, I was wondering . . .” I have never heard a patient complain about this information/permission, which serves to
Deepen the treatment. Patients frequently have conscious thoughts about the therapist, especially in the beginning of treatment. Later in treatment the analyst listens to the patient’s material with an ear for the indirect expression of transference. For instance, if the therapist has announced a separation or vacation and the patient begins talking about how angry or upset he is with his boss the therapist can ask if the patient is having angry feelings towards her. I might say something like, "I wonder if your anger at the boss also applies to me.” If the patient denies recognition of anger or upset at the therapist, she can explain that in announcing a break in treatment she is like a boss who makes the rules or calls the shots without consulting the employee.

In the following session Mr. Lopez spoke about his father’s illness and death and connected his fear of “not getting it all” before it was too late. He worried about dying young. He remembered crying when he first learned about death when he was 4. At the end of the session he asked if he could come to therapy twice instead of once a week. After exploring his request the therapist said she would let him know when there was an opening in her schedule.

In following sessions the theme was instant gratification. The patient said that part of him wanted instant happiness and a perfect life and that part of him knew there was no such thing and that the latter part questioned the former part. The therapist connected his wishes to the previous session and the therapist’s not granting his request for more sessions per week immediately.

The capacity to have mixed feelings was an indication of conflict and Mr. Lopez’s ability to question his thoughts indicated an observing ego. The therapist used this information to form diagnostic impressions. Other impressions were based on Mr. Lopez’s difficult childhood, inconsistent parenting, his difficulty tolerating frustration, his faulty judgment (which led to selling drugs), and his mistrust of teachers. The therapist was impressed by Mr. Lopez’s intelligence, sense of humor, resilience, and psychological-mindedness. One could say that therapist and patient were assessing and testing each other.

As treatment progressed and Mr. Lopez felt engaged and “into it” he began to regress. He wanted the therapist to meet his mother, to give him more time, and to call him by his first name. He was angry at not getting his way but at the same time he made it clear that he valued his treatment and the therapist’s ability to provide boundaries. These boundaries were tested vigorously over time because Mr. Lopez had rarely been given limits. He acted out his anger at the therapist for setting limits and for not arranging to see him twice a week immediately by fighting with his roommate. The therapist told him that his actions reflected his anger at her. After this interpretation Mr. Lopez asked if he could swear in therapy.

Regression is to be expected in psychoanalytic work. Along with transference it is the key to understanding the past and how it affects the present. The past is repeated in the present with the therapist as transference object and as a new object. Loewald (1960) in his paper “On The Therapeutic Action of Psychoanalysis” explains the process:

Analysis is thus understood as an intervention designed to set ego development in motion, be it from a point of relative arrest, or to promote what we conceive of as a healthier direction. . . . This is achieved by the promotion and utilization of (controlled) regression. . . . The transference neurosis, in the sense of re-activation of the childhood neurosis, is set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new “object-relationship” between the patient and the analyst. The patient tends to make this potentially new object-relationship into an old one. . . . The patient can dare to take the plunge into the regressive crisis of the transference neurosis which brings him face to face again with his childhood anxieties and conflicts, if he can hold on to the potentiality of a new object-relationship, represented by the analyst. [p. 224]

The term transference neurosis is usually reserved for psychoanalysis proper but in many cases of psychoanalytic psychotherapy taking place twice or even once a week the patient does become involved with the therapist on an intense level that is based not on present reality but on past scenarios. I have heard analysts call this a psychotic transference and I disagree. Usually these patients have less rigid defenses and regress more quickly than those with a more neurotic (well-
defended) structure. These patients are seen as having a borderline structure that indicates trouble differentiating self and object. Differentiating self and object is not an all or nothing-at-all process, however. In times of stress and anxiety such differentiation can ebb defensively. These difficulties do not add up to a psychotic transference—a term, like other labels, that cuts off exploration. An analogy that occurs to me is that of a car with good shock absorbers as opposed to one with less effective shock absorbers. With the latter the ride is bumpier. Both cars work and can travel the necessary distance but one journey will be smoother than the other. When traveling on a smooth road the difference is not necessarily felt at all. One common result of treatment is more effective shock absorbers.

In the first few sessions a patient will often present his highest level of functioning. This is helpful, for it shows the therapist what has been achieved in terms of ego development and ability to relate to another person. (Sometimes a patient will present florid symptomology or disorganization in a first interview due to high anxiety. As the anxiety abates a higher level of functioning and organization often becomes apparent.) The nature of the analytic atmosphere and the regular meetings between patient and therapist are conducive to (controlled) regression and to the manifestations of transference.

A child's ability to pretend and play act is an important way of communication that reemerges in treatment. As treatment progresses, the patient begins to see that the therapist has no fast answers or solutions, and that the work involves looking inside and to the past in order to make sense of the present. By monitoring the ways the patient thinks and feels about the therapist and by paying attention to the patient's relations with the outside world, which reflect past attitudes being acted out in the present (the transference and the tendency to repeat), the therapeutic dyad begins to see patterns. Making sense of the patterns is one goal of psychoanalytic work.

Mr. Lopez began to express hatred of his mother and, for the first time, empathy for his father. He felt that his mother acted like a child and he had to be the adult. With feeling he reported how his mother had leaned on him both emotionally and physically during his father's illness and after his death when Mr. Lopez was 17. His older siblings had left home and had families of their own. He spent a session remembering his father, whom he saw as a depressed man. Father's illness began when the patient was 12. There were operations and periods of convalescence during which Mr. Lopez felt guilty and frightened.

The therapist began to have an idea of how the transference would develop. Mr. Lopez would bring his anger, frustration, yearnings, and mistrust into the treatment with the therapist as recipient of these and other feelings. With a history of neglect and overindulgence the treatment is usually a stormy one because the rage is intense.

During the first four months of once-a-week therapy Mr. Lopez's history unfolded naturally and with much appropriate affect. Learning about a patient's childhood history is meaningful to both therapist and patient, especially when it unfolds naturally. Taking a detailed history during the consultation phase is exactly that: a taking. Both therapist and patient learn far more when it emerges in the patient's own time and at his own pace. A person's history is never completely or accurately given because memories are recovered in their own time and because as the treatment progresses things are seen differently—in three dimensions and living color. A history given in the first few sessions can be helpful to the therapist (Chapter 2) but it is usually one-dimensional because it is given at the therapist's request and before any trust has developed. Analytic work is best done without direction. A patient cannot be expected to tell embarrassing and shameful things to someone unless he can be relatively sure that he will not be judged. This takes time for many people and it means testing and retesting the safety of the waters.

One day, after a particularly difficult session filled with memories of his father's death, for which he felt responsible in some way, Mr. Lopez came close to throwing a book. He left the session abruptly and came back in a few minutes to apologize. He saw that the therapist was not about to retaliate and instead invited him to finish his session. Mr. Lopez later told the therapist that this incident was a milestone for him for two reasons: not throwing the book meant that he had more control than he realized, and he saw that the therapist...
remained calm. A test from both sides had been passed and Mr. Lopez felt safe enough to deepen the treatment by sharing more material. The therapist learned that Mr. Lopez was volatile but not violent, and the patient learned that the therapist could remain calm and nonjudgmental.

In the fifth month of therapy Mr. Lopez began coming twice a week. More frequent contact helped him bring more anger and frustration into treatment. Instead of fighting with friends and relatives he began attacking his therapist verbally. "Why can't you know what I'm thinking?" "Why can't I have primal scream therapy?" "You don't know anything." "Why can't you help me?" This tantrum ran its course and Mr. Lopez associated to how dependent his mother was after his father's death. He had to be the adult, pick out her shoes, hold her up at his father's funeral. And now she was seeing another man who was taking her time. Mr. Lopez was jealous and furious at losing his place of importance. He admitted having felt like "ruler of the roost" as a child, threatening to have a tantrum unless his parents obeyed him. He also began to see how powerless he really had been and how his behavior protected him from this realization.

This material was difficult and painful for Mr. Lopez and for the therapist as they began to see even more clearly how ineffective his parents had been. In the following session Mr. Lopez began by saying, "I've been thinking about last time and my need for omnipotence—how I need to control situations. As a child I gave orders and even hit my mother. My parents couldn't control me." He continued to talk about a seductive, provocative mother who still talked with him about her sex life. He admitted to having sexual fantasies about her; sometimes they were violent. He wondered if the therapist could handle him. Maybe he'd want to kill her. More painful memories emerged and, after a period of rage and provocative behavior with the therapist, Mr. Lopez became sad and wanted to give up. Maybe he would kill himself. He blamed the therapist for his sadness. He was angry with himself for wanting a magic wand, hypnosis, an easy way out, and at the therapist for not giving him answers and easing his pain. Recalling what a tyrannical child he had been embarrassed and saddened him. The therapist explained how he had been hungry for consistent attention and boundaries and that his behavior had been an attempt to get his parents to give him these things.

In the ninth month of treatment Mr. Lopez reported having good thoughts about his once-hated probation officer. He was surprised at how much he appreciated this man who stood by him and helped him stay out of trouble. The therapist heard this as a transference message but filed it away. It was important for her to see a positive sign after sitting with and tolerating Mr. Lopez's tantrum-like behavior. Other positive signs took the form of some pleasant childhood memories. There had been a period in childhood when he was given gold stars for good hygiene. Another time his father gave him a dog. As these positive feelings about the past increased Mr. Lopez began blocking his thoughts about the therapist. He found it easier to keep her at a distance, avoiding his longings for closeness. In the past these hopes had been painfully dashed. Each time he trusted his parents he felt betrayed by their inability to love him consistently and appropriately. Eventually, he was able to express sadness and jealousy about the therapist's vacation. Realizing that she had an outside life was difficult for Mr. Lopez and he began sexualizing the transference rather than feeling his yearning for closeness. The therapist interpreted this defensive reaction and, although Mr. Lopez heard her, it became a repetitive theme over the many years of treatment.

In summary, I have tried to illustrate, using Mr. Lopez's first nine or ten months of treatment (which eventually shifted to analysis), how both patient and therapist tested each other and how the treatment deepened as trust was established. Techniques used in this initial phase of treatment included:

1. Listening with an ear to how the past affected the present;
2. Connecting actions outside of treatment to feelings about treatment and the therapist;
3. Forming diagnostic impressions with an eye to psychological-mindedness and ego strength;
4. Introducing the idea of free association;
5. Interpreting the patient's tendency to act rather than to feel and to articulate;
6. Introducing the concept of transference;
7. Setting limits and providing boundaries;
8. Permitting and interpreting regression in treatment;
9. Assessing the patient's resilience and the ability to tolerate therapeutic regression;
10. Listening for positive identifications as well as negative ones;
11. Evaluating the patient's ability to use interpretations of transference and resistance.

These technical measures were used with the list in Chapter 1 as backdrop. I do not mention listening for ego defect or deficit. Assessing the ego in these terms in order to determine the treatment plan can be imprecise and misleading especially in the first stage of treatment. Patients who have been severely damaged (see Miss Carter in Chapter 5) can do psychoanalytic work to varying degrees and should be given the opportunity to try. Therapists who look for developmental lags in determining what treatment is suitable run the risk of underestimating the patient's capabilities.

When uncomfortable issues threaten to reach consciousness or when the patient is faced with fresh anxiety she often doubts her capacity and the therapist's ability to handle the material or affect about to emerge. These doubts can be conscious, preconscious, or unconscious. The therapist detects the doubts and interprets them. Actions such as coming late, missing sessions, forgetting to pay, and threatening to quit treatment are some of the ways the patient tests the therapist. If the therapist maintains the frame and does not acquiesce to inappropriate requests or demands, choosing to explore the action instead, the patient is reassured that the therapist is comfortable and strong. This is not quite the same as analyzing resistance because resistance is ubiquitous and always present. Testing is viewed as a way to establish and reestablish trust.

To emphasize the purpose of deeper work I will review the concepts of transference and the tendency to repeat the past in the present. In doing psychoanalytic work the therapist allows herself to be a recipient of the patient's feelings, positive and negative and anything in between. Because patients (and people in general) perceive the present through lenses formed by past experience, the therapist is seen in ways that reflect past relationships and experiences, whether actual or fantasized. Echoes of the past affect how a person hears in the present. The tendency to repeat goes on in everyday life. The choices we make are always based to some degree and in some way on unconscious fantasies and perceptions of the past. Whereas people are chosen by the patient (and by people in general) and influenced to play set roles in an unconsiously scripted drama, the analyst's job is to comment on and to interpret the drama. Rather than react in kind to the patient's provocation, the therapist tries to weigh what transpires in a neutral, nonjudgmental, benevolently curious manner. I say "tries" because this is the most difficult part of our job and the crux of our work. To the degree that the therapist manages to interpret and not to get caught up in enacting with the patient, the work is useful. Enactment means that the patient and the therapist relive something together. This happens in all therapy, and is an important component in analytic work when spotted and understood.

Mrs. Blue, an actress, was about to leave on tour. This entailed a five-week break in treatment. The therapist, after hearing anxiety in the material, suggested that Mrs. Blue might want to keep in touch regularly during her trip. At first Mrs. Blue responded positively. She had been brought up by self-involved parents who paid little attention to their children. The therapist's suggestion gratified a deeply felt need. However, before the trip Mrs. Blue decided that regular contact would be a step backward and would interfere with her hectic schedule. She said that she knew the therapist's phone number and would make use of it if necessary.

In reviewing the intervention, the therapist realized that she had imposed her wish to be helpful rather than letting the patient exercise her autonomy. The therapist overstepped her boundary by suggesting rather than interpreting. She had presumed to predict the patient's need based on her understanding and the patient's expression of anxiety, rather than remaining the neutral interpreter. She could have said something like, "I hear your anxiety about the sepa-
ration. Have you any thoughts about how to handle it?" Why the therapist presumed to predict instead of remaining the neutral interpreter is an interesting question with many possible answers. She may have been responding to her own separation anxiety; she may have been nervous due to inexperience; she may have been responding to the patient's script as others had in the past; and she may have wished to avoid the patient's anger about the separation. Hindsight is helpful to the therapist because she can learn how to handle future dilemmas more effectively.

The therapist's job is to engage the patient in wondering about the patient's perception, behavior, and feelings, and, when appropriate, the therapist explains to the patient why she feels what she feels. But before such connections are attempted the therapist will let the patient's feelings become clear enough to identify by letting them intensify in the transference. How much the therapist waits depends on many factors such as:

1. The amount of time the patient has been in treatment;
2. The strength of the alliance;
3. The therapist's countertransference (e.g., is she bored, anxious, worried that the patient will leave?);
4. Is the patient coming frequently enough to contain the anxiety elicited by intense feelings?
5. Diagnostic impressions (is the patient capable of hearing about the other person?);
6. The therapist's assessment of the patient's psychological mindedness and ability to reflect;
7. Is the patient threatening to disrupt the treatment?

The purpose of deepening the treatment is to permit new editions of old situations (sometimes called the transference neurosis) to emerge in the therapeutic setting so that patient and therapist can begin to understand such repetitions. The understanding is not merely intellectual, although the intellect is expanded; it is also emotional. The permission to express deep feelings heretofore repressed, split off, and avoided is not only cathartic. The expression of buried feelings reintroduces the patient to an important part of herself and frees the energy that had been spent denying those emotions expression.

The expression of feelings is also important in showing the patient that her feelings cannot destroy the hated object. Because buried feelings are often born in the patient's childhood omnipotent phase, the feelings are given enormous power in the unconscious. One of the difficulties in giving up the grandiose feelings is that the patient loses a sense of imagined power that has become gratifying. Also, the intense anger felt towards a parental figure, who has become introjected, is experienced as a threat to the self. The process takes varying periods of time but it certainly takes a long time. When a person spends twenty years and more finding ways to defend against the anxiety produced by recognizing infantile wishes and fears, it is arrogant and unrealistic of the therapist to be in any kind of hurry. The clinical reports of analysis being complete in three, four, or even five years set a standard that is false, in my experience. My experience comes from my own analysis, the analyses of colleagues who are open enough to share their experiences, from supervising people who seem to have had didactic rather than therapeutic analyses, and from my own work as an analyst.

Before reviewing the techniques on deepening the work let us look at what the patient is consciously and unconsciously thinking about. Consciously, there are issues of time and money but most frequently these issues mask the less conscious and unconscious fears every patient experiences at different times during treatment.

"Can I do this?"
"How can she (the therapist) really be interested?"
"How will I know that she can understand me?"
"I know she'll think I'm awful if I tell all."
"I've never told these fantasies to anyone. Why would I tell her?"
"I've avoided closeness all my life. Why risk it now?"
"All she cares about is my money."
"If I face and express my rage I'll destroy us both."
"Is she strong enough to tolerate my rage?"
"I'll be so cooperative and interesting she'll fall in love with me."
"She'll seduce me or I'll seduce her. Then what?"
"I can manage my life now. Why risk the unknown?"
"Does she really know what she's doing?"
"I'll contaminate her."
"I'll drive her away with my needs and demands."
"I'll gain control the way I always do. I'll get her to change my appointment, not charge for sessions I miss, call me by my first name, pay late, not pay, threaten to quit if she doesn't play my way. Then I'll know she's afraid of me, or that all she wants is my money, or that she doesn't know what she's doing and that I am right not to trust her."
"I'll be so good, bring so many dreams, pay exactly on time, improve so much, she'll think I'm wonderful. I'll be her favorite patient and that will be enough for me. I'll finally be the star in someone's eyes. Then we can be friends forever. She'll really love me if I'm good."
"Once or twice a week will be enough. More would put her to sleep or bore her."
"Everyone I know goes once a week. Why should I need more? I must really be sick."
"I get great pleasure from my symptoms. My depression has become a friend. My masochistic behavior keeps me attached to the past. My guilt makes my suffering necessary."
"I'm afraid to go deeper. The water is safe here by the shore and I don't think I'll be safe out there. My feelings will drown me."

These quotes represent some possibilities of the conscious, preconscious, and unconscious thoughts a patient may have about change and trust.

Listening for the unconscious transference communications is the key to deepening the treatment. Once the patient begins to feel understood she is far more likely to trust the therapist. Hearing, understanding, and using the transference is the psychotherapist's most important tool in helping the treatment deepen. It is the patient's most important means of communication. Here is a vignette of a 28-year-old man who sought therapy because he was feeling stuck in his life. He lived at home with his parents and held a job with potential for advancement. He had been in treatment once before and the therapist does not know why it ended. (It is helpful to find out about a patient's previous therapy experience in the consultation phase of treatment.) The focus will be on hearing the transference. Training the ear to hear this form of communication is necessary to hearing the unconscious.

Transference is ubiquitous. We all use our past experiences to formulate our present opinions and perceptions. A patient has transference fantasies and fantasies of cure before she makes the first phone call. As the treatment progresses these transference fantasies increase and when they stand in the way of going deeper they must be interpreted. This patient has been coming for one year.

Patient: Nothing's changed. I feel like I just try to get through each week. And you know, I fantasize so much every day and sometimes I wonder whether it gets in the way. But sometimes I think this is the closest I'm going to get. [laughs]

Therapist: The closest you'll get to what?

Patient: To succeeding. I guess I see that the fantasies aren't serving as an impetus to get me closer to anything.

Therapist: They're not serving as an impetus. Why might that be?

Patient: I'm afraid. And I don't feel that I have what it takes to really be on a certain level. You have to be someone who can be relied on to do a job and see it through to the end rather than run to someone for handholding. My boss just doesn't see me as someone who he can say "Here's the job—just get it done and send it out."

Therapist: What if he did see you that way?

Patient: Well, any euphoria I would feel would quickly be dampened by my fear about whether I could do the job.

Therapist: So there is ambivalence about whether or not you want to be seen this way.

Patient: Ambivalence? That just doesn't make sense to me. Why would I be ambivalent about this?
Therapist: Well, let's just say that there is a conflict about how you feel. Part of you wants to be thought of as someone who can be relied on and part of you doesn't.

Patient: You know, I think about people I see as players both socially and at work and I think about wanting to be part of that. You know, like a key player. People who are always looking for challenges. I hate to say it but I don't feel that's what I want. I wish that I wanted to be challenged but I'm too afraid of what could happen.

Therapist: And what could that be?

Patient: I might get in over my head. The worst scenario is that I would cause my firm to be sued by a major client—involving thousands of dollars in damages. [Later in the session the therapist makes a supportive remark about his functioning and the patient takes issue.]

Therapist: What just happened? I wonder if you were dampening my positive reaction.

Patient: Well, I feel that you're the doctor and I'm the patient and I have to make sure that you really understand in order for you to help me. If I say the problem is in my head and it's really in my foot, then you won't diagnose it properly.

Therapist: Hmm. Is there more to it?

Patient: You might think I'm fine and dismiss me.

This brief vignette, if looked at from a transference point of view, can tell us how the patient is feeling about therapy. He is telling his therapist that nothing has changed; that he has fantasies (about her) but worries that she doesn't want to hear them; that he's afraid that he "doesn't have what it takes" to succeed in treatment or with his therapist. He is afraid that he could do harm and cause much trouble if he asserted or expressed himself. He isn't sure he can be relied on to see this treatment through and he wonders if the therapist can be relied on. He worries that his therapist (boss) doesn't see him as someone who can see it through. (A previous treatment had ended.) He worries that the therapist will "dismiss" him. By saying this directly he is working with the transference feeling that his pain or fears will be overlooked.

How can the therapist be sure that the patient is talking about her and not just the boss? There is no proof. The patient is not necessarily aware that his comments are about his treatment and his therapist. It is the therapist's job to weigh the evidence that would indicate interpreting the transference meaning. The psychoanalytically oriented therapist learns that everything the patient brings into a session has transference meaning. Two people who meet regularly with no outside distraction will naturally develop thoughts and feelings about the other. In analytic work these thoughts and feelings become the major data. When and how the therapist uses the data of transference is based on skill that develops with experience. Earlier in the chapter I enumerated several factors that help determine when the material is ripe for interpretation. First we must learn to listen for transference manifestations. In the above vignette we may assume that because the therapist is usually perceived as the "boss" in the treatment, references to bosses in the patient's life often stand for the therapist. If this assumption is wrong the patient will reject it or correct it, but even if the patient rejects a linkage between therapist and boss it may still exist. Time will tell. The question is what might one do with this material to deepen the treatment by using the latent transference content. One thing to note is the first communication from the patient in each session, because the first comment is often a title to the hour. In this vignette "Nothing's changed" is the title. The patient then tells the therapist that he fantasizes every day and that he's afraid he hasn't got what it takes. How would we bring this material into the transference?

I would say something like, "While listening to what you've said I find myself wondering if your thoughts and feelings about work and your boss could also have to do with our work here and with me." If this was the first transference interpretation the patient might ask what I meant. I could then choose something in his material. For instance, I might say something like, "You began today saying that nothing was happening. Perhaps you feel that way about therapy,"
or "You said you fantasize every day. Can you tell me about your fantasies?" or "You expressed concern that I might think you’re fine and dismiss you. Tell me about that."

These interventions are in the service of deepening the work. They let the patient know that the therapist is listening carefully and that she is willing to share her thoughts and to wonder. This process recording illustrates numbers 2, 8, and 9 in Chapter 1. The therapist has maintained her stance of benevolent curiosity in the face of her patient’s passivity. He seems content to live with his parents and with his job level. However, he says that the therapy is his last hope and he shares a fantasy of destroying his firm and himself. The therapist feels distanced and ineffective at this point in treatment but she is aware that the patient is withholding important information. She knows very little about how the patient feels about her or about his early childhood and his relationship with parents and siblings. She lets the treatment unfold gradually by listening with respect and by being comfortable not knowing the answers or even the questions. As the patient gains trust he will begin to give hints of the deeper issues that bother him. We might speculate based on his fantasy of destroying the firm that he believes he has hidden power. We might imagine that he fears failure or that success is dangerous. (His uncle’s failure in business was talked about in a previous session.) Nothing in the material or history (so far) indicates that this man could not do well with more intensive work. On the contrary, the patient seems frustrated with the twice-a-week sessions. His failure to continue treatment with a previous therapist, when explored, would help make this determination. His fantasy of destroying the firm can be heard in terms of the therapy.

The most important tool that the therapist has is the transference. Transference manifestations can be seen outside of treatment when, for example, a patient consistently sees authority figures as evil and unfair. If the therapist can hear this in terms of the therapy it is most helpful, but starting with the figures the patient presents comes first. For example, connecting the boss to an older, bossy sister who is in the material of the hour is a first step.

Hearing the patient’s material in terms of her thoughts and feelings about the therapist is not difficult. Learning when to use what you hear requires experience and appropriate timing. By appropriate timing I mean keeping track of previous material and listening for when the patient is expressing affect.

Keeping track of the patient’s references and obvious lack of references to the therapy and the therapist serves several purposes. For instance, if the patient suddenly notices something in the office that has been there all along, I hear this as a reference to the therapist. I do not necessarily interpret this but I think of what it might mean. Often this indicates that the patient feels safe enough to relate to me as a separate person. It usually means that the patient is feeling curious.

"Is that a new vase or picture?" "Is the plant new?" "I never noticed those books before." Such comments often indicate that the patient is interested in who the therapist is. This is a sign that the work is deepening.

Conversely, if the patient never mentions anything about the therapist or the therapy, avoids eye contact, and is often or suddenly silent the therapist can wonder what thoughts are occurring about her and what prevents the patient from speaking about them. In the beginning phase of therapy the therapist can explain that there will be thoughts and feelings about the therapist and that expressing these thoughts and feelings will be helpful to the work.

Encouraging and protecting the patient’s curiosity and capacity for self-reflection can be accomplished without seeming intrusive by phrases such as:

What comes to mind about that?
I wonder if you have some more thoughts about that?
Do you suppose this has a connection to your dream?
Is that a familiar feeling?
Do you think that could have to do with missing your last session?
Can you elaborate?
These are gentle questions meant to help the patient reflect on the material. When the therapist is quite sure about hearing a connection there is no need to make the connection tentatively. Interpretations can be declarative statements and not just speculative invitations to entertain an idea.

Another important and sometimes overlooked technique in promoting self-reflection is silence. The sooner the therapist becomes comfortable being quiet the faster the treatment will deepen. Every intervention we make intrudes on the patient’s thoughts. Interventions are important when made in a timely manner but often the therapist’s need to be helpful or the pressure she feels to earn her fee makes her intervene prematurely. If we set the stage early in therapy by learning to be quiet the patient will feel free to see where her thoughts go. Being listened to quietly and nonjudgmentally is a new experience for most people, and although many therapists fear that their silence will frighten or displease the patient they quickly learn its value. This is also true when ending a session. “We’ll stop for today” is all that’s required in most instances. There is usually no need to wrap up a session for a patient.

If a patient lingers or continues to talk when the session is over there are different ways to respond.

The therapist can repeat that it’s time to stop and can invite the patient to continue the topic next time.
The therapist can get up and walk to the door.
The therapist can firmly say that there will be time to return to the subject.
If the patient does not realize that the time is really up, the therapist can begin the next session by explaining why sessions are time-limited.
The therapist can introduce the idea of more frequent sessions by saying something like, “You have much to say and once (or twice) a week doesn’t seem like enough time. I think more frequent sessions would be valuable.”

If the patient is ready to return to a topic in the next hour she will. If it is glaringly evident that she is avoiding what happened in the previous session the therapist can usually find something in the material that points out the avoidance, which is more useful than finding out what is avoided. Roy Schafer (1983) makes this point in his book *The Analytic Attitude*, where he describes how to analyze resistance before content. His example involves a patient who stifled her tears. Rather than wonder about what she wants to cry about he advocates addressing why she needs to stifle the crying.

Usually it is best to wait for the patient to return to a topic. If a topic is dropped the therapist can be sure that there is a reason. Letting things unfold involves letting the patient determine what she wants to say and what she wants to avoid, consciously or unconsciously. If the patient says, “I can’t remember what happened last time,” this can be a clue to wanting more time. It can also mean “Do you remember my last session?” The therapist can encourage the patient to explore the possible meanings of her question or statement.

Some patients prefer or can’t help staying very close to the surface. They are used to thinking in very concrete terms and seem to be unable even to wonder if there is more than what meets the eye.

Mr. Green was such a person. He came to treatment on the advice of his friend who was in analysis with a colleague. He was in turmoil about the demands his mistress was putting on him. He was a married man and the idea of ending his 30-year marriage was unthinkable, yet he was forced to consider it because his lover was putting pressure on him to decide between her and his wife. Mr. Green found it impossible to focus on anything but his real and present problem, and the therapist could only wait for things to unfold. It emerged that Mr. Green’s only daughter was to be married in a month and as he talked about the upcoming wedding his emotions surfaced. There was also sadness about his aging parents, who were getting frail and unable to care for themselves. Talking about these events and feelings calmed Mr. Green and he reported that his high blood pressure decreased. He learned that his initial and presenting problem was covering other painful feelings that no one had heard—including himself. He was amazed at his depth of feeling. One day I asked Mr. Green if he remembered his dreams. He said no, but after a few weeks he began to remember dream frag-
ments. It could be said that he was trying to please me, but that was interpretable and the dreams gave him a new part of himself to work with. Mr. Green became increasingly comfortable with my listening stance. It freed him to see where his thoughts led, and the treatment deepened as a result.

What happens when the treatment doesn’t deepen? What are the consequences of passing up opportunities to examine and understand with the patient the roadblocks that are inevitable in psychotherapy? In this book I discuss the patient’s right to test the waters and to travel at her own pace. The therapist has the duty, however, to listen for opportunities to deepen the work. Walking the fine line between not pushing a patient and remembering that connecting past and present depends upon in-depth work requires skill, timing, and most of all the conviction that second chances become possible by looking inside. Patients test the therapist at different times during treatment while developing the trust necessary to making the commitment to ongoing, intensive work. The following vignette can be looked at with this in mind.

Mrs. Hawkins, toward the end of her fourth year in treatment, announced that she was seriously contemplating taking a month off from therapy in order to save money. She told her therapist, Dr. S., that although she was giving only two days notice, she really hoped Dr. S. would understand and not be angry, the way her former therapist had been when she did the same thing. She jokingly said that Dr. S. would probably kick up her heels during the break. Mrs. Hawkins seemed determined to act on her plan. She asked Dr. S. if she could feel free to call during the break if she needed an appointment. Dr. S. felt helpless in the face of this “fait accompli” and her efforts to explore the action proved fruitless. She even offered to defer the fee until Mrs. Hawkins felt less financially strapped. Mrs. Hawkins remained adamant.

When a patient contemplates taking action, even when short notice is given, the therapist can say something like: “While I understand your situation logically I think it would be important to explore other, less conscious motivations before you act. Can you see what comes to mind?” or “You mention that you’re contemplating taking time off. That sounds like you haven’t decided definitely. Can you talk about the pros and cons of the action?” These comments and others like them tell the patient that you are concerned, unafraid, and dedicated to preserving the rhythm of the work. Mrs. Hawkins had shared the fantasy that the therapist would “kick up her heels” during the break. Was she worried that the work was becoming too heavy or boring? This fantasy would be important to explore. The therapist might say something like: “It sounds as though you think I would be delighted to have a break. Tell me about that.”

When Mrs. Hawkins returned after the month off she was in high spirits.

Patient: I have so much to say—some good things and other harder things. I started three paintings during the month. It feels terrific. Annie walks to school by herself now so I don’t have that commitment which is death to me. (More details about the month off; pause) Now I have to talk about the not so happy thoughts or the hard thoughts. I want to talk but how can I tell you? Just because I say it—it doesn’t mean I have to act on it. Nothing has to happen, it’s all right to talk about it—those are your words I hear in my head. I absolutely loved the freedom this month. Not coming here freed up two days. I had no decisions about when to work or when to paint. I don’t have to feel all that horrible telling you. I know I don’t make you furious at me—at least when I’m here in the room.

Therapist: Not in the room? What about that?

Patient: (ignores question) I felt I was out of school—like summer vacation when you let me take an extra month off and don’t charge me so I have two months away. The closer I got to coming back the more conflicted I felt. I had a great month. Not that I don’t need therapy. Was the month easy because I didn’t have to come here and think about things? Maybe keeping a lid on things is why I did so well. Is there a fear of some unknown thing that I know deep down I have to talk about? Having the extra
money was great. The thought of coming in here and it being my last day is so frightening and so sad. My fantasy is that once I walk out, that's it. Then in six months—do I dare say it? I guess I could start up if you were available. Don't worry, I'm not planning any escape tomorrow. Also, I know I can take you with me!

What is Mrs. Hawkins saying beneath the manifest content? The italicized phrases or remarks are important to explore and to understand.

1. *Commitment is like death.* Patient tells how frightened she is.
2. *Nothing has to happen.* Patient reassures therapist.
3. *I don't have to act—I can talk.* You taught me that. Patient says she has gained something from therapy.
4. *Do I make you furious at me?* Patient is worried that therapist will lose patience and wonders if she can provoke the therapist to be angry. When therapist tries to explore patient's thoughts about being furious at least not in the room patient ignores her. (When a patient ignores a therapist's intervention this can be pointed out with an interested, benignly curious tone by a comment like: "I noticed that you seem to want to avoid my question. What comes to mind?" If the therapist lets a comment about anger go, she runs the risk of letting the patient think that anger is to be avoided.)
5. *You let me go for two months in the summer.* Patient has thoughts and feelings about the long separation and the fact that therapist does not charge her, thereby sanctioning it.
6. References to being out of school and escaping tell therapist that she is seen as an authority figure.
7. *I'm afraid of some unknown thing deep down.* Patient asks therapist if she is afraid too.
8. *The thought of my last day is frightening and sad.* Patient is saying "don't let me go."

Dr. S. was being given another chance at deciphering the action, this time before it occurred. It is important to explain that when Mrs. Hawkins began treatment, Dr. S. was beginning her private practice and her training. Like many beginning therapists she had not felt confident enough to state a policy about charging for extra vacations. In a supervisory consultation following the first session after the break Dr. S. examined her countertransference. She felt as if her hands had been tied. Fearful of losing her patient she felt she could have done nothing to prevent the month break in treatment. At first she thought of the break as a rapprochement enactment with the patient attempting to go out into the world and come back to safety like a young child does with her mother. She also had feelings about being "laid off" for a month. After reviewing the sessions in supervision she began to consider the action as a test and a provocation. The patient seemed to be saying several things. "Are you afraid of my anger?" "Can I overpower you and control you as I have felt controlled?" "Do you really want to hear about the unknown things I keep deep inside?" "I'll show you how sudden abandonment feels." "You'll be happy to have a rest from me. You let me go for an extra month in the summer and maybe you're so relieved to be rid of me that you don't charge as you do for other missed sessions."

Dr. S. decided that more activity on her part was necessary when faced with Mrs. Hawkins's thoughts about ending treatment. This does not mean that she could prohibit her patient from action but that she would maintain her attitude of benevolent curiosity to find out what lay beneath the proposed action. Remembering that the patient hires the therapist and always has the final word helps the therapist avoid treading. If the therapist does her work chances are that the patient will feel encouraged to do her work.

Dr. S. could say something like: "I understand the reality of your wish but can you put that aside for a while and see what comes to mind?" "I wonder if something here in the treatment is making you want to retreat." "You mentioned the extra month you take off in the summer and that I allow that. Talk about how it feels to have such a long break." "If you can put your feelings into words we can begin to understand why you feel you need a break." "It seems that this idea to end therapy has a component of anger that may be easier to put into action than express in words." "Perhaps you worry that I need a rest. What does that mean?" "Talk about your fantasy of me kicking my heels up."
The supervisor also encouraged Dr. S. to state her present policy about missed sessions by saying something like: "I know that in the past I have not charged you for missed vacation sessions but my policy has changed. Because your appointments belong to you, when you’re not here I cannot fill them. Most important I think that breaks, aside from a month vacation in summer and a few weeks during the winter (if that is her policy), jeopardize our work seriously because we lose continuity." Said in a calm, firm, concerned manner, this intervention is meant to deepen the treatment. The therapist is saying: "I care about our time together. I can tolerate your feelings and I am not bored with or frightened of our work. I can take care of myself. It is safe to express your feelings in here. You may be concerned about the unknown but I’m confident that we can face your fears together. Burying them is not the answer."

Dr. S. also began to see the sadomasochistic aspect of her patient’s taking a month off. She filed this away because she felt she needed more evidence but she did introduce the idea that Mrs. Hawkins was angry. Whenever there is a separation between patient and therapist (Chapter 6) there is anger that must be explored in words.

I have tried to illustrate through this vignette that after four years of important work the patient started to balk. Her action alerted the therapist that she was frightened of going deeper. The therapist then took the opportunity to work with her patient on understanding and interpreting so that the treatment could deepen.

An interesting dilemma occurs when a patient comes in crisis and states that she can only be in treatment for a limited time. Crisis intervention is a specialty in the field of psychotherapy but here crisis will be looked at in psychoanalytic terms. When a crisis is brought on by the patient we must look at it as a communication.

A colleague consulted about a young man who came to her after an accident he had at college that required surgery. The patient was traumatized by the accident. As a result of the accident the patient was unable to complete his semester. He was due to leave for Europe in six months in order to spend his junior year abroad. My colleague felt pressured to accomplish something with this young man but she was perplexed as to how much she could deepen the work. Because she identified herself as an analyst I felt that this was how she must approach the material.

In the first session with the patient (who will be referred to as Mr. A.) the therapist learned a great deal. What was most important, she felt, was his awareness that he had been depressed ever since he could remember, that he drank alcohol every day, and that he was not "so drunk" the night of the accident. He also told the therapist that he had been having "negative thoughts" for several months. When asked to tell about the thoughts he said that he couldn’t stand the pressure anymore, that he had packed a bag many months ago, went to the highway to hitch-hike and run away, but was frightened by thoughts of jumping in front of a car. In addition the therapist saw that Mr. A. had all the vegetative symptoms of a major depression. She told him that medication was indicated and that she wanted to see him as many times a week as possible. She also shared with him that his accident was an unconscious attempt to get out of an intolerable situation. Mr. A. asked, "Can the unconscious do that?" My colleague told him that the unconscious was very powerful and that they could learn more in their sessions.

During the next two sessions Mr. A. described other suicidal gestures such as practicing unsafe sex and using various dangerous drugs. In the fourth session he asked the therapist if he should go to Europe. The therapist said that they would decide together as they learned more.

This vignette illustrates several things:

1. The therapist’s initial response of pressure was a countertransference response to the patient’s feeling pressured.
2. The therapist used her analytic background, with its respect for the unconscious, in order to understand this young man.
3. The therapist respected the patient’s autonomy by not giving advice but instead by inviting him to join her in deciding what was best.
4. Had the therapist advised the patient to cancel his plans she would have stepped out of her neutral position. Although
she felt that the trip was ill-advised, she avoided a possible power struggle by offering to collaborate with the patient in the decision.

5. The therapist referred the patient for medication to alleviate the depression. This decision was based on Mr. A.'s symptoms.

Another way of handling the question would have been saying to the patient something like, "From what you've told me it sounds like you have ambivalent or mixed feelings about the trip and serious concerns about the way you feel in general. I think these concerns can be best understood in psychotherapy." Hearing the therapist's impression under serious circumstances such as this can be relieving to a troubled patient. In this case the patient's parents were interested only in his performance and unable to adjust their expectations for their son, even when informed of the son's self-destructive behavior and depression. This was the pressure felt by both therapist and patient. When faced with suicidal behavior and major depression the therapist owes it to the patient to express concern and to offer a course of action. In this case the therapist did recommend medication and indicated to the patient that they would decide about future plans together.

I can't end this chapter without mentioning the patient who talks nonstop, never seeming to pause for air. Session after session goes by and the therapist literally can't get a word in edgewise. Such nonstop talking must be seen as a message. Some call it a resistance, which it certainly is; labeling it a resistance takes us only so far, though. The therapist, along with feeling assaulted, attacked, or shut out, uses her benevolent curiosity. This is the best safeguard against letting countertransference rule the day.

Miss Gilbert chattered incessantly and annoyingly during her sessions. Mr. D., her therapist, presented this dilemma in class. He was beyond feeling curious and was indeed furious at his patient. Members of the class commiserated and then tried to help him regain the feeling that he was indeed the therapist and not the victim. (Being in a class, seminar, or supervision group when treating patients is invaluable in maintaining a therapeutic perspective.) The class pointed out that the incessant talking was both defensive and aggressive. The class reminded him that at some point he would find a place to intervene if he could regain his neutral, interested stance. The point was made that Mr. D.'s distress and anger were registering with the patient in subtle and some not so subtle ways. (He forgot one appointment and was late for several others.) Once he regained his curious attitude the class felt that Mr. D. would find a way and a place to say something.

Here are some of the things he might say:

"If my therapist kept me waiting for an appointment I'm sure I'd have some feelings. Will you tell me yours?"

"I wonder if you're worried that I might say something upsetting because it seems hard for me to find a place to say anything."

"Have you noticed that I never say anything?"

"Sometimes I wonder if beneath all the things you say are feelings you'd rather not deal with."

"I worry that you want to keep me out. Is it because you fear I'll say something hurtful?"

If there is something in the patient's material that would shed light on her need to shut the therapist out this might give the therapist a clue. Miss G. did speak of an intrusive, meddlesome mother, and the therapist might say something like, "Perhaps you worry that I will be intrusive and bossy, too." All of the above suggestions are naturally meant to deepen the work by engaging the patient in benevolent curiosity.

In a well-conducted psychotherapy, after a period of testing, there will often be signals that the patient is ready to deepen the treatment in terms of frequency. What are the cues? A patient might say:

"The session went by so quickly."

"There never seems to be enough time."

"I hope I remember this dream until we meet again."

"I thought about calling you after our last session."
"Why do people use the couch?"
"I can't remember what we talked about last time."

Actions can convey the wish for deeper work:

Coming early for appointments;
Looking at the couch frequently;
Telephoning between sessions;
Putting one's jacket or other belongings on the couch;
Leaning back in the chair and looking away from the therapist;
Requesting extra sessions;
Coming on the wrong day.

How the therapist responds to these signals or cues can determine the future course of the work. With tact and appropriate timing the treatment should deepen quite naturally.