nevitability outcome of untamed sexual and aggressive drives of infant, oddler, and young child. The uncovering of defensive layers therefore was necessary to reveal the distortions and correct them through adult's knowledge of “reality.”

My perspective reverses the traditional view that our goal is to use the present to discover the past. I hold that we use what we can surmise about the past to understand perplexing influences on here-and-now lived experience. My view is based on a theory of motivational systems that reflect self and mutual influences throughout life rather than a dual drive-distortion concept. From all here-and-there experiences, expectations form that influence the way individuals experience the next here and now. We can never fully understand he present of our patients or ourselves without an appreciation of he past. Our goal in exploratory therapies, however, is to open the present to understanding and change. Knowledge of the past is indispensable to that goal, but is not the goal in itself. Our focus on the present opens to us the possibility of empathic entry into a patient’s emotions, thoughts, fantasies, and intentions—the fundamental guide to the approach I recommend.


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CHAPTER 1

A FACILITATING ENVIRONMENT

WE (LICHTENBERG, LACHMANN, AND FOSHAGE, 1996) have described the optimal environment as “arrangements that establish a frame of friendliness, consistency, reliability, and an ambiance of safety.” Clinical experience has taught therapists much about the creation of an environment that facilitates an exploratory psychotherapy.

The boundaries and procedural aspects of therapy are spoken of as the “frame.” Concretely, a frame is an enclosure and, in that sense, references an office and the physical surround, a commercial building, or rooms in a home. It is an environment a therapist selects for himself and his patients. The frame symbolizes other kinds of delineating and supportive arrangements, however, and in these less physical ways carries the imprint of patient as well as therapist. These include the timing of appointments, their duration, and the fee and payment arrangements. The critically important ambiance of safety develops from the collaborative creation of these arrangements. A mutual experience of safety evolves from creating a fit between the needs, desires, intentions, and goals of the treatment dyad. Like any delicate and subtle experience between two people, a sense of safety requires constant attention to the inevitable changes
in fit between the needs, desires, and goals of patient and therapist as the therapy proceeds.

What is dyadic interaction? When does dyadic interaction begin? It begins in a patient's mind in his or her contemplation of entering treatment and forms around the name of the therapist and whatever information about him or her the patient has. Similarly for the therapist. Then the telephone contact, the answering machine message, the back and forth about setting the time of the first appointment, and sometimes a question about the fee. But the most telling beginning occurs on meeting in the waiting room.

The first face-to-face, eye-to-eye encounter is a poignant moment for both participants. Both bring with them their own experiences, motivations, and goals—some similar, some different. Some expectations, of which patient and therapist may or may not be aware, converge, making friendliness easier to create. Some expectations conflict, leading to a less comfortable beginning, ranging from an appropriately cautious feeling out of one another to open discomfort and mutual aversion.

THE MUTUAL CREATION OF THE FRAME

Before the therapist enters, the patient in the waiting room has already been primed toward an affective response. Rushing to get there, she might be breathless. Lost on the way, he might feel flustered. Entering a separate waiting room, she might feel pleased with the privacy. Entering a common waiting room, he might feel reluctant to be seen by others or relieved of shame to see others coming for treatment. Some patients are consciously sensitive to their surroundings: the modern or traditional furniture, soothing or stimulating wall colors, personally chosen art objects or impersonal functional choices, padded chairs to sink into or firm seats. Some patients do not respond overtly to the therapist's choices, but all take them in and sense either this is a good place, an OK place, or a doubtful place for them.

Greetings fulfill an important role in the repertoire of human exchanges. Beginning in the earliest moments and repeated many times daily with closely attached people, acquaintances, and strangers, greetings demonstrate a procedural memory, an implicit way of relating. A therapist, walking into the waiting room and greeting her patient with a friendly hello, I am Doctor, Ms., or Sally Brown, receives a tentative, but friendly response from a well-dressed business person. They shake hands, and they are easily poised for the task of getting acquainted. Their implicit nonverbal communication suggests a fair likelihood that they can form a secure attachment while they open channels into the problems that bring him to seek her professional help.

A therapist seeking to offer a friendly greeting but seeing the prospective patient looking like a “deer caught in the headlights” recognizes that he must shift his greeting to an acceptance of the frightened state of the person who is viewing the experience as an actual or potential trauma in itself. The therapist might move more slowly toward a fearful person and wait for a cue before making physical contact. A firm handshake from the patient might suggest that, although he was extremely anxious, he was substantially present emotionally. This reassurance would modify the therapist's need to respond immediately to the patient's anxiety.

Coming to meet Miss Janis, a biologist whose treatment had been interrupted by her transfer to Washington, I was startled to see her avoid all eye contact with me. For me, our contact began with an eerie feeling as she conducted herself in a businesslike fashion while conveying to me a sense that I was not there and that she had no recognition of the oddness of our interaction. Confronted with her avoidant-detached approach, I fell into the role of proceeding with the consultative interview, equally making no reference to its oddity. I was somewhat reassured as I noted that although she never made eye contact, she moved her head back and forth, taking in little glances at me, gradually expressing less affective flatness and detachment.

Mr. Drew, immediately on the heels of my greeting, launched into a description of the difficulty he had finding the office and his uncertainty about whether to come. As he walked from the waiting room to the office, he started to tell me about his wife. His responses to my opening questions were scattered, full of irrelevant detail, indicating easy distractibility and little opportunity for
a good initial collaboration. He stopped himself momentarily, only to begin another story about his wife.

In their response to the moment of greeting, each of these patients revealed much about themselves, both explicitly in what they said and implicitly in how they communicated and interacted. Each of them provided a challenge for the therapist whose intention was to initiate a therapeutic experience. Therapists use different conceptual formulations to organize the experience and meaning of even such brief encounters as I have described. One way therapists attempt to meet this challenge is by formulating the patient’s psychology or psychopathology. Traditionally, therapists have used diagnostic categories to identify patterns of illness. Thus, the terrified-looking patient might be thought of as having a panic disorder or a hysterical character. Miss Janis could be provisionally diagnosed as having a schizoid personality disorder, and Mr. Drew as being obsessional (obsessional–compulsive disorder). Diagnostic assessments provide therapists with a background of knowledge about psychological illnesses, prognoses, and possible treatment choices, particularly psychopharmacological. Such assessments are often necessary for insurance coverage. Diagnostic typologies, however, have the disadvantage of structuring the interaction as a tilted relationship between a labeling observer (therapist) examining an ill person (patient) with symptoms and personality disorders. Clinical experience has taught therapists that a tilted relationship is not consistent with the creation of safety, an essential component of the therapeutic relationship. A much better alternative to an emphasis on pathological formations is an adaptation of perspective originally formulated by ego psychology and now reconceptualized by attachment research.

Attachment studies reveal that all infant–caretaker pairs develop a wide variety of interactional strategies for maintaining connectedness. From lived moments of early attachment experience, these strategies emerge to cope with perceived danger and loss. By one year of age, a securely attached child responds to a caretaker’s return after a stressful absence via a strategy of distress, appeal, and positive response to comforting. Other infants express distress but are resistant to comfort, their insecurity demonstrated by their hesi-
tance either to accept or move away from the caregiver. Other infants reveal no overt distress, although they have physiological signs indicative of stress. They appear indifferent to their mother’s absence and avoid contact on her return. Their strategy seems to say that they can best maintain an emotional tie to the important other by keeping their distance from her and make no demands or other protests. Sadly, a significant number of one-year-olds (10%) have had such disrupted patterns or serious moments of caregiving lapses that they have been unable to form a consistent strategy to maintain a secure connection. They may shift from approach to withdrawal and from being overwhelmed by emotion to momentary states of detachment, disorientation, or dissociation.

Clearly on first meeting, or even after several consultative interviews, therapists must be extremely tentative in making either a diagnosis or identifying the patient’s particular strategy for forming an attachment. Nonetheless, they are immediately confronted with the issue of creating a safe base for treatment. Unlike an observer attempting to be objective while making a diagnosis, a therapist beginning a therapeutic contact is necessarily a participant in the formation of an attachment. When working with a patient capable of establishing a secure attachment from which to explore the problems and vicissitudes of his life, most therapists will have little difficulty forming a therapeutic relationship. When confronted with a terrified patient, however, therapists will sense the existence of unresolved trauma and the requirement that they attempt to balance their desire for more information with the risk of triggering disorienta-
tion and further disorganization. Avoidant patients keep therapists at a distance while conveying the need to build bridges that permit contact despite the arid world that they cocreate. Preoccupied, chattering patients leave a trail of confusion and distress while filling the conversational space and shutting out the therapist whose orienting interventions are badly needed.

First meetings between a patient and a therapist are infused with a profound paradox. Two people meet who have made no commitment to each other and, as yet, have defined nothing of their individual and mutual plans. Yet from the beginning, they are, to a degree, already involved in what they are searching each other out
to arrange. The patient is determined to find help in some explicit and implied manner, and the therapist is committed to providing it. Along with the paradox of patient and therapist already entering into the treatment that they have met to talk about beginning lies an additional complication of separate and competing self-interests that can easily interfere with therapeutic goals. Therapist and patient have to resolve divergent pulls involving money and convenience of time availability. Beyond the pragmatics of self-interest, however, lies a powerful, hard-to-define factor of how far each can stretch to meet the personal characteristics, the individuality of “being” that each conveys to the other. The impact of each on the other can be a dramatic love, or hate, or love–hate “on first sight” by either or both. More common are less dramatic factors of similarity or disparity of gender, age, appearance, culture, religion, interests, and especially style of communicating—that is, listening and talking.

Arrangements are worked out explicitly; that is, they are thought and spoken about in words. They are based on an assessment of the prospective patient’s needs, the therapist’s availability, and the meshing of time and payment requirements. Each person who is seeking treatment has a story to tell, one she means to tell, one she means to keep hidden until it is safe to tell, and one she is revealing inadvertently through gestures and modes of speech. Despite our altruistic intentions and humanitarian values, the therapy consultation has elements of the marketplace. The prospective patient is “selling” himself as a suitable person for treatment while convincing himself that he needs therapy and will benefit if he commits to it. The prospective therapist is “selling” herself to the patient to accept her as a trained competent practitioner of a professional discipline and to herself to believe that she can work therapeutically with this man and the challenges he presents. Further, the patient may be “auditioning” the prospective therapist, having several other appointments set up, while the therapist may be seeking a patient to fill a particular clinical or time spot or for a referral he wants to make to a colleague.

On the basis of this confusing array of multiple motives, I make every effort to clarify to the patient that we are engaged in a consultation the goal of which is to arrive at a recommendation. During the consultation, I will learn as much as I can about him in two or three meetings, and he will have an opportunity to sense what talking to and with me is like. I will give him an opportunity to ask me questions, and I will offer him my preliminary understanding of the problem and my recommendation. I assure him he will have time to consider and sleep on any decision we arrive at and encourage him to do so.

In arranging the frequency of sessions I tend to follow patterns used by many therapists. These patterns have changed in recent years. Traditionally, four or five times per week psychoanalysis was regarded as the optimal treatment of psychoneuroses and one or two times per week psychotherapy as better suited for more “troubled” conditions—borderline, mood, or addictive disorders. Because of changes in approach that I believe are more widespread as reflected in many contemporary psychoanalytic theories, analysts nowadays are less distant and silent. They are less concerned that their more active involvement will be construed as a gratification that will lessen a patient’s motivation for treatment. As a consequence of their greater involvement (as I describe in later chapters), analyst/therapists have discovered that the treatment of more troubled patients is actually facilitated by the greater opportunity that more frequency permits. The benefits are twofold. First, the greater frequency offers more opportunities to recognize and discuss patterns (the same explicit benefit traditionally ascribed to the analysis of neurotic patients). Second, the consistency and reliability of the commitment offers a critical implicit benefit, a beneficial change that develops in the background, often outside of conscious awareness. The greater mutual opportunity and openness to explore facilitates growth in the implicit knowledge of how to work together effectively and in safety. Safety here does not mean freedom from disappointment, hurt, shame, and other kinds of disruption. This would be impossible for any therapist–patient pair regardless of the type of problem. Safety, in this context, means that, as much as possible, disruptions to the therapeutic relationship will be recognized, acknowledged, and explored. Alertness to disruptions, for therapist and patient, provides the optimal means to restore their mutual purpose, the ongoing pursuit of sustained inquiry and exploration.
When it comes to deciding on frequency of sessions, patterns of common usage may serve as guides, but each dyad is unique and involves the desires and constraints of the individuals involved. Some prospective patients regard greater frequency as a terrifying prospect. They may experience such a recommendation as indicating the therapist considers them to have severe psychopathology, thus evoking shame and dread. It may, for others, raise the specter of being too rapidly exposed or rendered dependent or vulnerable to exploitation. From my side as therapist/analyst, I recommend the frequency that I believe will give us the best start, given my appraisal of therapeutic needs and practical constraints. With the spirit of inquiry as my guide, the general approach I follow and the principles of technique I employ are essentially the same whether for one or five weekly sessions. Of course, the opportunity for continuity, for tracking communications, and for following up on themes and consolidating gains is greater with more frequent contact. I do not make this decision on the basis of traditional psychiatric diagnoses or the distinction between psychotherapy (one or two times per week) or psychoanalysis (three, four, or five per week). Rather, I try to arrive at a session frequency that will provide the optimal opportunity to help avoidant patients to feel safer revealing themselves, preoccupied patients to become more aware and organized, and patients with labile affect to experience more stability and calm.

By the end of the consultation, therapists have an impression of the session frequency to recommend and the acceptance or reluctant response their proposal is likely to trigger. I use a flexible approach. Although I recommend the treatment approach I believe to be optimal, I listen as open-mindedly as I can to the patient's response. If the patient accepts, does it indicate that, in our brief time together, we have already negotiated successfully? Or does the acceptance seem too quick, too much a submission to authority? If the patient objects, can we find common ground, or does the patient's request or demand indicate an insurmountable obstacle, calling for referral elsewhere? The search for a way to make an arrangement that will allow us to start in itself constitutes a beginning of treatment via the negotiation that takes place. Whatever plan we begin with, the ongoing negotiation of the ground rules for the frame arrangements continues through the treatment as a work in progress. By telling the patient my recommendation, even though I suspect the patient may not be prepared to accept that degree of commitment, I am opening the possibility of change as the treatment progresses. Of course, change can take place in either direction.

Fee arrangements can range from being simple and straightforward or complex and difficult. In any community, a “standard” fee for therapy sessions becomes established with variations. Graduates of psychoanalytic institutes often charge more than therapists without analytic training. Psychiatrists (MDs) often set fees higher than psychologists (PhDs), whose fees are apt to be higher than social workers (LCSWs). More experienced and better-known analysts and therapists may set higher charges, but often not. Almost all analysts and therapists have some variation or sliding scale, from “usual” to highest and lowest acceptable, and the scales of therapists and analysts in training may slide the lowest. Many communities have clinics that offer competent, unsupervised and supervised, therapy at low costs.

Third-party payers—for example private insurance, health-maintenance organizations (HMOs), managed care, and Medicare—provide benefits that make treatment possible, or at least less costly for many patients. Unhappily, some insurers introduce unnecessarily, burdensome complications for both patient and therapist. My practice is to tell prospective patients that our financial arrangements are directly between us. I will help with necessary forms and the providing of information, and they will deal with their insurer. In my experience, many insurers service their insures in good faith, but some clearly do not, endlessly “losing” forms, claiming errors that don't exist, delaying payments, and demanding overly frequent treatment updates, unsuitable for long-term care.

Long-term care—psychoanalysis or psychotherapy—is expensive. For many people, the cost is accepted as a facet in the flow of monetary exchanges—education, vehicles, vacations, and hospitalizations—that characterize life. These prospective patients, alone or with their family, budget the expected cost in anticipation, without heightened distress. Other people may feel an immediate fear of exploitation and respond with oppositional self-interest. Details about
sexual problems and intimate family secrets may be more easily revealed than facts about financial status, thereby making exploration of the financial aspect of the relationship impossible at the outset. Beyond the need to withhold information from others, a prohibition about revealing information about money may include not admitting to themselves or letting family members know, a practice that is followed in many well-to-do families with their grown children.

The discussion of fees brings the self-interests of patient and therapist into potential opposition. Polarities of greed and generosity, withholding and accommodating, rigidity and flexibility, inevitably play out in money (and other) negotiations. Issues that may require lengthy exploration during the treatment must be settled sufficiently to get the treatment underway. The patient has to divert money and time from other purposes, arrange transportation, deal with employers, or arrange babysitters. The patient can easily feel he gives the most, fills the therapist's open hours and pays for her lifestyle. The therapist is not a selfless participant in these exchanges. She does need her hours filled and the income to support choices for life satisfactions beyond those of her clinical work. Thus, patient and therapist are on equal footing as far as desires that derive from self-interest, but must be different in the way they manage their motivations. The therapist's professional discipline must operate as an intervening factor. What do I mean by professional discipline? The therapist's professional responsibilities include caring, stability, reliability, training, knowledge, sensitivity, dedication, and once again, caring—a commitment to put himself in the service of helping a patient. Paradoxically, however, if therapists were constituted only with these benevolent traits, they could not accomplish their therapeutic purposes. Therapists must have the capacity to sense into their own inclinations for greed, withholding, and rigidity to appreciate the place of these qualities in their patients' lives. Therapists must sense their own proclivities for problematic choices to explore those contexts during the treatment when negative attributes enter the exchange from either or both members of the dyad (chapter 6). A therapist's professional discipline refers to using knowledge of the self to monitor the byplay of contradictory desires while achieving the goals of the patient for a therapeutic outcome.

The patient's desire to be helped and the therapist's desire to help are both starting points for treatment and core motivations that sustain the treatment through its many strains.

A frequent source of strain arises from charges for missed sessions. As with the number and timing of appointments and the cost per session, many patients accept the therapist's proposal without rancor. For some patients, however, the prospect of being charged for missed sessions seems unbelievably unfair, if their work, vacation, illness, choice, or forgetting leads to their absence from a scheduled appointment. We do not generally expect to pay for services that have not been rendered or commodities we have not received. Alternatively, we do expect to pay rent or mortgage, or annual charges for a reserved tennis court even when we are away from our apartment, or house, or don't use the court. So with two distinct patterns for acceptable charge arrangements, therapists can select one, or the other, or a modification. My particular practice is to charge for missed appointments with two provisos: If I can fill the hour with a consultation, I will not charge; if I can arrange a substitute hour within the same week, I do so. If weather conditions make travel hazardous, I recommend we have the session by phone. Because many of my patients travel frequently, we try to work out maintaining the scheduled number of sessions by phone, often by being flexible about the timing of sessions. My goal is to maintain the continuity so necessary for effective exploration. To facilitate patients' planning, I furnish them with a list of times I am away four to six months in advance. Although I believe I can justify my policy as providing mutual benefit, I am fully aware that I am serving my self-interest in maintaining a steady income. Moreover, I found early in my career that getting into the position of judging the justification for a patient's absence interfered with the type of open listening that is integral to the "service" I am providing. My policy works for me as a person and with the type of practice I have, treating patients and supervising established colleagues and therapists-in-training over extended periods of time. Other policies employed by therapists include allowing a set number of cancellations or no charge for particular reasons or if notice of cancellation is made at a fixed time in advance.
“How long will the treatment take?” is a question that inevitably arises during the consultation, often explicitly, inevitably implicitly. And it can’t be answered. To know how long a treatment, project, trip, or war will take conveys a sense of security, especially when costs and sacrifices are involved. Any final statement of time for an exploratory psychotherapy or psychoanalysis would convey a false safety. Even averages and statistics do not help. In my experience, the length of time I have worked with patients in psychotherapy has varied from months to many years and successfully completed analysis from four to twelve years. Less is lost in acknowledging that no real assessment is possible than an illusory gain from the intellectual dishonesty of offering to predict the unpredictable and setting up an unrealistic expectation. The essential problem is that the exploration proceeds optimally when an open-ended spirit of inquiry prevails. Open-ended does not mean being without goal or direction or an awareness of pragmatic considerations; rather open-ended means therapist and patient cocreate an ambiance that works against easy assumptions and premature shutting down of inquiry. Meaningful reassurance arises from a recognition that, throughout the treatment, remaining open-minded can guide the process of exploration, while both patient and therapist can attend the process and recognize indications that the treatment is moving toward an ending stage.

Can a patient benefit maximally from intensive psychotherapy and analysis and also receive the benefit of an additional form of help? How are the arrangements affected if the patient is receiving medication, group therapy, a 12-step program, or yoga, or is learning meditation? Fifty years ago, intensive psychotherapy, and especially psychoanalysis, was thought to be incompatible with other methods. Analysts then feared that, if symptoms were relieved, patients would lose the motivation to endure the emotional and financial costs of lengthy treatment. Further, analysts believed that if other helpers were involved in the patient’s recovery, the transference experience would be split. The needed intensity would be reduced. Essential information would be scattered. Rivalries and jealousies would be set up and “acted out.”

Experience for many analysts, and certainly for me, has not borne out these fears. Although symptoms may be the precipitants that bring some patients to seek and accept intensive psychotherapy, most patients recognize explicitly or implicitly that their problems lie more basically in their sense of self, their long-term patterns of personality. The essential source of therapeutic leverage arises from interlocking processes of an intersubjective relationship and an exploration of experience, meanings, and motives. What do I mean by interlocking processes? The answer lies in the particular duality of a therapeutic relationship and an investigative exploration. No matter how beneficial a therapist–patient relationship becomes, alone it will not lead to the desired changes, unless the motives, values, and goals that comprise a person’s sense of self are explored, but motives and meanings cannot be explored unsupported by an essentially sustaining relationship. Moreover, a unique feature of intensive psychotherapies is that the shifting strains at the junction of a patient’s and a therapist’s communications create a relational experience, one that calls for definition and a comprehensible set of emotion-laden meanings. The relationship and the exploration interlock in that the shifting strains of the relationship provide crucial data from which the most significant aspects of understanding are derived.

Given this view of therapeutic leverage, medication and other means of relieving distress, adding understanding, and altering behavioral patterns, can provide background support, and often valuable information. My approach to medication is somewhat idiosyncratic. I believe to be an expert in the ever-increasing complexity of psychotropic medications is a specialty and an art in itself. Therefore, I believe my patients are better served by having me refer them to colleagues who have that expertise. Additionally, my patients and I will not need to deviate from our exploratory effort to discuss adjustments in dosage and shifts in drug choices. Furthermore, the patient has contact with a colleague who can serve as a resource when I am unavailable.

This then leads to the presumed danger of splitting, diluting, or rivalry. I take the view that if my patient can be helped with his addiction by a 12-step program, her anxiety by meditation, his shyness and isolation by being in a therapy group, or her body tension and weight concerns by yoga or pilates, the added help will facilitate the sense of safety and hope needed to sustain a long-term psychotherapy. Therapeutic understanding benefits greatly from exploring the
methods that patients employ to experience relief and vitality. As to rivalry and jealousy, where patients are consciously or unconsciously pulling their therapists into such roles by activating the potential of the therapists to be rivalrous or jealous, this becomes a fertile area for intersubjective recognition, self-inquiry by the therapists, and interpretive exploration with the patients.

Research in development describes how a child develops a sense of safety, and a person at any age creates and maintains security. Knowing that we have someone to whom we can turn at a time of danger and loss, someone who will comfort and restore, is basic. Likewise, the security of our attachments requires the experience of knowing that we are known, both to ourselves and to others, as the persons we deeply sense ourselves to be. Stated differently, we come into the world carried in the symbolic reality of our parents’ minds and retain a sense of existence from experiences throughout life in the caring minds of others, as they exist reciprocally in ours. We gain confirmation of our positive value as our feelings, thoughts, and actions are mirrored, that is, recognized and affirmed. We feel safe in the kinship of like-minded others and in situations of mutual respect and admiration. Finally, the ability to communicate to others via words and gestures secures our conviction of the power to influence our destiny.

I began this chapter referring to establishing a therapeutic frame that facilitates an ambiance of safety. Therapists lay the foundation through friendliness, reliability, consistency, and a mutually arrived at, workable agreement on time and fee arrangements. In subsequent chapters, I describe techniques that enhance the sense of safety for both. In a successful consultation, the patient will already be turning to the therapist as a secure base at moments of distress. Some sense of feeling understood will have begun, and, along with it, the respect and admiration that sustains hope. In the same way, parents prepare a space in their minds for their baby-to-be, both patient and therapist begin a process of carrying an expanding mental version of the other, and of the two together, in all their varied and complex emotional interactions. In the next chapter, I describe how therapists gain critically needed understanding of their patients’ needs, desires, intentions, emotions, and meanings through empathic listening.

CHAPTER 2

SENSING INTO THE MIND-STATES OF ANOTHER

EXPLORATORY PSYCHOTHERAPIES ARE BASED ON TWO HAPPENINGS IN THE DYADIC RELATIONSHIP OF THERAPIST AND PATIENT. FIRST, THE THERAPIST ATTEMPTS TO GAIN AN ACCURATE UNDERSTANDING OF THE CONSCIOUS AND UNCONSCIOUS STATES OF MIND OF THE PATIENT. SECOND, THE PATIENT INADVERTENTLY MISUNDERSTANDS THE THERAPIST AND THE THERAPEUTIC SITUATION BASED ON EXPECTATIONS DRAWN FROM HIS SIGNIFICANT PAST EXPERIENCE. BOTH OF THESE STATEMENTS, ALTHOUGH CORRECT IN THEIR ESSENTIALS, REQUIRE EXPLANATION AND EMMENDATION. I CONSIDER THAT THE THERAPIST’S PRINCIPAL UNDERSTANDING ARISES FROM AN EMPATHIC MODE OF PERCEPTION OR EMPATHIC LISTENING. THE PATIENT’S MISUNDERSTANDING IS CONSIDERED AS “TRANSFERENCE.” (I HAVE MUCH MORE TO SAY ABOUT TRANSFERENCE IN CHAPTER 6.) FOR NOW, I DESCRIBE WHAT I CONSIDER TO BE A THERAPIST’S FUNDAMENTAL TASK: THE SYSTEMATIC APPLICATION OF THE EMPATHIC MODE OF PERCEPTION.

In the past, patients could be said to pay an expert in psychological processes to have their problems become known and resolved. Even if an omniscient expert could perform this feat, the patients would have been shortchanged. Patients, indeed all humans who enter into an intimate relationship, wish to be known not as a col-