CHAPTER 6

“THE WEARING OF ATTRIBUTIONS”
A GUIDELINE FOR THERAPISTS TO DISCOVER WHO THEY HAVE COME TO BE FOR THEIR PATIENTS

This principle of technique crystallized for me when I found myself repeatedly telling therapists whom I supervised, “You are searching for the patient’s latent message to discover the transference, the who that the patient unconsciously and consciously regards you to be. All the while you ignore or fail to utilize the opportunity available to you through the patient’s overt or implied attributions about you. You should ‘wear these attributions.’” From infancy on, humans follow a particular pattern in giving meaning to relationships. Infants detect salient features of emotion stirring interactional sequences and develop categories for similar repeated events such as feedings or “conversational” playing. As attachment research attests, by one year of age infants distinguish between a familiar caregiver and a stranger and have a clear category of expectations of how their caregiver is likely to respond to their entreaties and distress. Once they enter the realm of symbolic processing, toddlers draw inferences from their intersubjective experiences. Parents have long held a view of who their baby is to them: a very special little girl just like her mother, or a burdensome, demanding whiner. Now child and parents use their experiences with one another to create identities that typify their lives together. Each person uses the mirroring they receive from the other to stabilize their identity and to regulate their interactions. This process of finding oneself in the mind of the other becomes a central feature of exploratory therapies. I have called the guideline that facilitates therapists locating and accepting who they have come to be in the minds of their patients the “wearing of attributions.”

The wearing of attributions, as I illustrate, involves therapists’ recognizing an attribution made about them and then attempting to regard their selves as portrayed in the attribution. Once therapists listen to their patients and themselves from the perspective of the attribution, a unique, highly revealing dialogue often ensues.

The example of Nancy’s preoccupied speech in chapter 5 included a number of attributions about me that proved central to the issues we were exploring. “I take all the responsibility and you get all the fun.” “I don’t like the feeling of being manipulated, which is how I feel in here.” “My brother would examine things—pull the wings off a fly and watch it squirm and get pleasure. That’s what you are doing! You’re part of it. You can do nothing about it but make your living off it.” “Before this when I got really angry with you I could tie myself down [crying] by reminding myself you seem to be a decent man. It doesn’t help now. You look benign.”

My first task in wearing these attributions was to wonder how my presumed sadistic malevolence could be combined with a deceptive (seem to be) appearance of benignity. What picture of myself was being held up to me that would fit a benign appearance with a malevolent intent? I suggested, “If my very presence and my benign appearance invite your interest and curiosity, does that become a part of the problem?”

Nancy and I then focused on her sense of the unfairness of having all responsibility placed on her and women for men’s actions. Nancy then added a further attribution: “Another strange thing in this is all related to your going away. For the last 24 hours, I’ve been aware I won’t see you for two weeks. I had real ambivalent—not ambivalent; I want you to go! Not to have to come here and talk. Out of sight, out of mind. As long as you’re here, I have to deal with whatever my unsuccessfully repressed fantasies are.” Returning to
the opening attribution, I said, “Absent I’m not an invitation for your fantasies and feelings.”

PATIENT: Right [pause]. I’m not at all certain you’re not just an awful human being. Who are you? Am I doing the right thing by coming? Can I trust you? Yet I find myself not wanting to be separated from you. Whatever you are, it’s better than being alone. I hate myself for that. I hate you for not being one or the other—good or bad. I seem not to be able to deal with the notion that you are human, not perfect.

THERAPIST: In the imperfections you experience me as having, is the one about my going away the most problematic at this time?

PATIENT: I don’t know. I wouldn’t have said that was necessarily an imperfection—I don’t want to admit that’s it. I did think of it, that’s true, but I don’t want to admit that separations are as distressing as they are. I get so angry at you and at me. What is wrong is I feel so dependent. Yet I’m frightened when you go away, I want to hang on so tight. I want to say you aren’t worth the allegiance. I’m so mad. It catches you up again and again. I’m no better off. You let me be—or don’t stop me from being dependent. I think with a sick feeling in my stomach of what happened in January or February when you were gone. [Nancy had gotten into serious trouble by gossiping about a student she knew had cheated on a test.] I pointed out the girl to my friend, told her she’s the girl who cheated.

THERAPIST: You’re feeling I’m responsible for letting you down.

PATIENT: I’m going to say my problem with your being benign is I try to trust you—things will be okay—and they aren’t, and then it’s my problem.

THERAPIST: We also looked at your feeling that I cheated. I tempt you to trust me and then I go away.

PATIENT: [Crying] I’m the one who has to stay and take care of things while you’re gone. Make mistakes. I hate you for going away and doing that. The same way I hated my mother. I have a vision of getting up and throwing everything in this room at you. A barrage of stuff. That’s what I’m doing right now.

Throughout this session, I tried to envision myself as Nancy portrayed me through her attributions. In general, Nancy made it easy for me because of the clarity of her attributions. And much of Nancy’s view of me did not seem foreign: I did invite her trust, and I did leave her in states of distress when I went away. I did not see myself as a sadistic puller-off of wings, although I could recognize myself as someone who might at times insist on “exploring” even if it contributed to the patient’s momentarily feeling she was being treated like an “object.” Often I or any therapist opening himself to how he is conceived of in the patient’s mind will learn about aspects of himself he either hadn’t recognized or, if he did, didn’t believe he was revealing.

Who, then, is the therapist? Nancy sees similarities to her brother and father, who invited and then betrayed her interest and trust and then blamed her for it. She also sees me as similar to her mother, who invited and then betrayed her trust and dependence by going away on visits to her family, leaving Nancy unprotected “to take care of things” (keep house) for the men and “make mistakes,” that is, get into sexual activities with her brother. The attributions are about who I am to Nancy in the present. Her view of me in the here and now is, however, entwined with significant figures in her past. This brings us to a discussion of transference.

TRANSFERENCE

Psychoanalysis received one of its greatest revelations when Freud discovered that his patients were reacting to him in a manner disparate to his actual identity and then found that they were projecting onto him unconscious repressed aspects or attributes of their important childhood figures. Freud believed the energy that characterized the early relationship was transferred to the analytic relationship with him. This discovery of transference, an influence arising from the past affecting a present relationship, was momentous for psychoanalysis. Freud’s further conception was that the attributes
of the parents projected onto an analyst were based not on the actual parents or events but on distortions created by the primitiveness of sexual and aggressive drives. The explanatory value of drive distortion has proven less convincing and is, I believe, supplanted by our current account of development. In a current account, lived experience arises out of multidimensional systems of motivation organized by mutual and self-regulation, is propelled by positive and negative affective expression of self with others, and is constrained by limitations in cognitive capacities in the presymbolic and early symbolic periods.

From the earliest moments, infants organize, categorize, and generalize their lived experience. The patterns of self with other that characterize these lived experiences lead the child to form expectations. Good experiences of self with other lead a child to expect that she will have other similar good experiences. Children invariably have enough disappointments, however, to know that bad experiences can be expected, too. Children who have had significantly bad experiences of self with other develop a dread, an often fatalistic and pessimistic expectation, that comparable bad experiences will befall them. Alternatively, most children, no matter how abused or neglected, have enough good experiences or fantasies of them to have an overt or latent expectation that this time it will be different. Without some hope that life can be better, treatment cannot be successful. These two-sided expectations that take the form, respectively, of good again but sometimes bad, or bad as usual but this time maybe different, tilt the perspective of everyone (patient and therapist).

This view of biphasic expectations directly contradicts the positivist objectivist conception that dominated thinking at the time Freud discovered transference. Freud reasoned that an analyst's neutrality and abstinence would allow him to present himself as a blank screen to his patient. The patient would then have imprinted on the screen the identity, behaviors, and attitudes of a past significant figure as veridical as a photographic image. I believe no exploratory therapist could or should want to be a blank screen, certainly Freud never was. Rather, a therapist is and must be an active, affectively present individual. Therapists are continuously communicating aspects of themselves through their speech, silence, accent, posture, chair squeaks, clothing, breathing, remembering, forgetting, reliability, absences, illnesses, office décor, jewelry, "ums," grunts, stomach noises, walking pace, and, most important, the ups and downs of their affective expression. In fact, rather than a blank screen, hundreds of cues emanate from therapists all the time, explicit and implicit, known to them or unknown, and constantly changing in response to altered contexts presented by the patient and by the exigencies of their own lives. A patient is consciously or unconsciously searching for and registering cues that confirm or contradict a positive or negative expectation. For Nancy, the slightest nuance of condescension in my voice, a tone unrecognized by me until I "wore" the attribution, could send her into a frenzy of righteous indignation. In a further erosion of an illusion of objectivity, we find that quite minor cues patients identify can lead to greater-than-anticipated reactions, whereas larger occurrences on either side, such as an act of kindness or an analyst's mixing up an appointment time, may have little effect.

From some perspective of the patient, the therapist's presence and influence is omnipresent. At all times, the therapist-in-the-patient's-mind is categorized on a spectrum of a secure to insecure base. This placement on the spectrum exerts a background influence regulating the cues sought in the foreground. In addition, a patient's current life experiences and the therapist's overt and covert communications tilt the patient's focus toward or away from the therapist and specific attributions about him.

CLINICAL EXAMPLES

Jacqueline was in an ending phase of a successful exploratory treatment. She and her husband were in a period of considerable stress—she with sick children, and he with his career. They generally got along very well, an outcome she attributed to her treatment, which had enabled her no longer automatically to anticipate insensitivity, abandonment, and denial from others. Our relationship was also generally friendly and collaborative. From the beginning of the therapy, I had consistently taken up any disruptions and breach between
us and tried to engage her in describing and acknowledging the sources for her that arose in the treatment. The session I present to illustrate my “wearing” of an emerging transference attribution followed a weekend in which she and her husband had been unusually testy with each other.

PATIENT: Boy, I need to come today. Ben (her husband) and I are at a low ebb—maybe the lowest. He is coming home late and keeps getting work calls when I need him to help me with the children. Then he says I should manage better and I was unfair to want him to give up his Sunday tennis. I say he should work less. He says we need the money and started asking me about my personal credit card. We kind of made up and were lying in bed when he said maybe you ought to get your sister to come and help you, and I can go away for a short trip. I thought, where is that coming from? No! He wants to leave me. Not we go away, but him. He’s never said that before. I was shocked. I started to think—he wants to get away from me. I’ve done something wrong, and he’s punishing me. That’s my mother, that’s not Ben. So I tried to control myself and I really do believe it’s OK for him to go away himself with his friends. I’m glad he has friends. But I couldn’t contain it. I felt so hurt. [An unusually long pause followed.] Where are you? You usually have something to say, to help me.

I was startled by the attribution—where are you? Have you left me too? Something is happening that is unusual. I have come to expect you to take up problems, to help me see aspects of myself I’m not seeing. For me her attribution was accurate in one respect: I had left her in that I was not seeing the experience as presenting the threat she viewed it to be.

THERAPIST: You’re right. I have not been with you in the way I usually am. My view has been too different.

PATIENT: Well tell me. I need to hear it whether I’m going to like it or not.

THERAPIST: OK. As you described what Ben said, I heard a husband who felt overworked and troubled spinning out a daydream of escape.

PATIENT: Oh, you didn’t hear him just wanting to get away from me. I felt that so strongly even though I told myself that’s not Ben. But we had such an awful weekend of not getting along. [Pause] What were you hearing? A day dream? Just to have a time out? [Both curious and skeptical]

THERAPIST: You might be skeptical about me. I did abandon you in a sense—or abandon sharing your view and concern.

PATIENT: OK. Help me see what’s happening. I’m having trouble.

THERAPIST: I think the difficulty you are describing arises out of the feeling of stress you and Ben are both feeling so that rather than one helping the other as you have come to expect, you are each trying to protect the areas of sanctuary and autonomy you have left. So over the weekend you started to attack his doing his athletics, and he was getting on you about spending. After these territory battles started, you couldn’t hear Ben having an escape fantasy but only the relentless battling with your mother that had been so personalized and wounding.

The remainder of the session was devoted to exploring the way Jackie had dichotomized disagreements into turf wars with no empathy for the position of either by the other but rapid entry into paranoid-like thinking. She reported the next session how she had used humor and understanding to help Ben out of his irritable state as they playfully talked about when each might go for an escape adventure. She dreamt about being in a wonderful store with an older couple who, although her parent’s age, were jolly and easy to talk to and who sold her wonderful things and even gave her an unexpected gift. She easily recognized and acknowledged that the attribution presented through the dream imagery referred to the prior session.

In the vignette from Jackie’s therapy, the therapist wore the attribution in the form of recognizing and acknowledging that he had “left her” actually and metaphorically. The example of Nick, treated by Frank Lachmann and reported in The Spirit of Inquiry, describes
an analyst wearing an attribution through an imagined confirmation expressed in humor. Nick was a dependent, isolated gay man who was easily wounded, prone to shame and humiliation, and subject to severe outbursts of self-defeating rage. The analyst was extremely sensitive to Nick’s frequent failures in affect regulation and his difficulty with bodily and sexual tensions. “He had a rau-
cous sense of humor, which occasionally broke through his clouds of despair. At those times I would respond in kind, and, for a while, we were able to sustain a playful tone” (2002, p. 61). In one session, Nick was struggling with his shame about his sexuality. “He wondered what I do in my office when I’m alone. He spoke of his ‘jerking off’ and imagined me in my bathroom ‘jerking off with The Psychoanalytic Quarterly.’” I said, ‘Oh, you mean because it has all those pictures?’” (p. 66).

A complex communication was condensed in the analyst’s humorously wearing of the attribution. The analyst’s empathic understand-
ing was that Nick was trying to construct a sense of commonality with his revered analyst. If they were both masturbators, Nick would not have to feel such terrible shame. Seen in this light, the analyst wore the attribution by offering an imagined self “jerking off” in response to the stimulation of erotic pictures. Further, they had cocreated a twinship of ironic comedy based on the absurdity of the dry, intellectual abstraction of a technical journal as the equivalent of pornographic literature—the popular caricature of psychoanalysts and their journals as preoccupied with sex.

As with any other response to a patient, a therapist wearing an attribution has many possible ways to communicate. He might have interpreted his explicit understanding of Nick’s meaning. Lachmann states, “Interpreting ‘you want to make me similar to you’ might have been a betrayal of the spirit of our ongoing communication. I would have suddenly left my somewhat ambiguous position in a ‘play space’ with Nick and differentiated and distinguished myself as the analyst” (p. 66).

Mary Jane (referred to in chapter 3) regularly voiced her attributions. In fact, her reference to problems and doubts emanating from me were so frequent they often furnished the most dynamic moments in the session. Not unexpected from her childhood emotional and sexual abuse, she was inordinately sensitive to negative cues. To help her recognize her selective filter, I offered her the analogy of a person driving across the city. The person gets to a red light and fumes, “Damn it, why do I have a red light? Why do I have to stop? I’m in a hurry.” The light changes. She drives through three green lights still fuming until she comes to another red light. This triggers another rant. “Why do I get nothing but red lights? How can I get anywhere when I have to put up with this unfairness?”

After a brief pause, she said, “That’s not an analogy! That’s exactly how it is when I drive.” With this sensitivity to negative cues, Mary Jane picked up any sign of my wavering interest, or annoyance, or skepticism. For example, she might tell a story about an event with so great an overload of detail that my attention would flag. “You’re bored with me” would follow. I would answer that my attention had been high when she started telling me about what her friend had said when he picked her up. My attention was sustained through some of the detail about their argument about which movie to go to. But then the details about the relative distance to the two theaters left me dropping out.

At times she would get carried away by her anger and make accusations about coworkers sabotaging her. She would recall that she had been told by a previous therapist whom she had trusted that her raging got under people’s skin. Nonetheless she would expostulate about what this and that coworker had done. I noted she had remembered her therapist’s reference to her raging before she told me about the coworkers’ maliciousness.

She talked on about the coworker and then abruptly said, “You’re angry with me!”

I acknowledged that when she offers a potentially useful association and drops it even after I remind her, I do feel disappointed and sometimes annoyed, but what did she pick up about me?

PATIENT: It’s not what you said. I expected that. It was your tone.
THERAPIST: My tone? [Trying to hear my voice]

PATIENT: Yes, not your usual soft tone but hard, cold, matter-of-
fact, no sympathy.
THERAPIST: [Hearing that in my voice as I replay my comment to myself] OK, I can hear that.

PATIENT: You wouldn’t use that tone if you weren’t really angry.

THERAPIST: I don’t know. I wouldn’t go that far. I draw a distinction between when I’m annoyed and really angry.

PATIENT: I guess you can. I can’t, and I wish I could.

ACCESSION, TRANSPARENCY, AND ACCEPTABILITY

To disclose or not to disclose? Answers analysts have given to this question have varied greatly over time. No disclosure was recommended when anonymity was regarded as a necessary safeguard so that transference attributions would arise solely from the patient’s experience uncontaminated by knowledge of the analyst. Some disclosure was recommended when analysts were encouraged to demonstrate a “physicianly attitude” (Stone, 1961). For Stone it seemed natural for analysts to answer impersonal questions such as where they were going on vacation. Much more open disclosure is recommended now when the therapists’ authenticity, or being “real,” is regarded as a necessary ingredient of the type of relationship that is a foundation for exploration. But now the question shifts to what to disclose? My answer is whatever helps to elucidate what is being experienced in the dyadic relationship. A therapist is both an active participant in an intersubjective exploration and an observer and interpreter of the process. A developmental perspective helps to explain my answer.

The security of all relationships is based first on acceptance of the other. Parents prepare to accept their baby long before birth. Mothers gain a sense of their baby’s acceptance of them as the baby accepts their mother’s feeding and other ministrations. Then with the delight of a glow each parent reads acceptance in the baby’s smile. This process of experiencing acceptance or, unfortunately, lack of acceptance continues throughout life and lays the foundation for expectations that play out in therapy.

How do babies or mothers, patients or therapists, know they are really being accepted? Each member of the dyad must be sufficiently transparent to the other. Caregivers start this process by making themselves far more transparent to babies than they are aware. They tell their baby, “I know and accept you when you want to play or be left alone, need to suck or sleep, hate to be diapered, or like teddy as your favorite toy.” They tell in actions, but also they tell in words, the importance of which we have only come to realize. They chatter, they label, they praise, they criticize. “Oh you don’t want any more.” “That’s a lovely smile.” “Don’t pull Mommy’s glasses off again.” They reveal what’s on their mind and what they believe is on their baby’s mind. So babies enter the world of their own verbal usage having all kinds of information in deeds and words about themselves and their caregivers. Strong research evidence supports the view that when mothers recognize accurately their infant’s mental life and comment on it using mental state language, their children will perform well at age four on tasks that identify the mental states of others. Alternatively, mothers who comment inappropriately on their child’s affective mental life and who inaccurately treat a baby’s emotion as referencing them have children who rate low on recognition of the mind states of others and also have a high incidence of adolescent dissociative symptoms. Stated simply, mothers who make themselves known to their infants as able to enter the affective mental state of their babies have children who can enter the mind-states of others and themselves. They provide a transparency, an open book of their own and their baby’s emotional life together; they enable their children to open the book on themselves and others.

These studies on the significance of maternal revelation about mental states provide the basis for therapeutic transparency. Just as parents can promote their children’s capacity for accurate sensing into the mental state of others and themselves, therapists, through their disclosure of what they are recognizing, feeling, and thinking, encourage patients to be more effectively reflective. Therapists accomplish this first through their willingness to reveal what they learn from their empathic entry into their patient’s affective mental state; second, through their openness to reveal their own mental state as demonstrated by wearing attributions; and third, through their openness to recognize and identify the affective state of the ambience they and their patient together have cocreated.
Transparency, revelation, and disclosure by patient or therapist are not without risk. Each may find what he or she has learned about the other to be unacceptable. Early in my training, in accordance with my supervisor’s instruction, I refused to accept a small gift from a patient at Christmas, revealing to her and to me a rigid authoritarian potential in me. The patient reacted with pain and rage, and for a very long time all positive feeling was lost. Although we were able to connect the injury to her mother’s repeated rejections of the patient’s efforts to please her, her sense of being injured by me lingered. Happily the therapy ended well, but years later, at a chance meeting, the patient thanked me for the help but reminded me of my “unforgivable” error. Sometimes the unacceptable discovery can be resolved by a broadening of perspective. Sometimes an impasse or stalemate occurs, or worse, a disruption of the treatment. If the continuity can be retained, revelations by one or both can lead to changes that significantly move the therapy forward and add to the mature self-knowledge of both participants. My experience is that when a therapeutic relationship has developed a background of safety, the uproar from an “unacceptable” disclosure in the foreground can be contained and resolved with more generosity and tolerance from either partner than might have been expected. Early in her therapy, Mary Jane responded with wounded outrage to any small or large failure on my part to be fully responsive to her, such as being a minute late by her clock. As she gradually, over a long time, built up a background feeling of my reliability and empathic understanding of her struggles, she could bring into our exchanges a mutual consideration of her experience of errors on my part, such as a confusion in scheduling or a lapse in my attentiveness.

In chapter 1, I suggested guidelines for making arrangements to begin an exploratory therapy. The next chapters are devoted to guidelines about how therapists listen. Chapter 2 describes the overarching principle of empathic listening, that is, therapists deriving from patients’ communications information about patterns of experience, intentions, and meanings as seen largely from the patients’ own perspective. Chapters 3, 4, and 5 provide more focused guidance to therapists’ listening, indicating priorities for attending and understanding the message. In chapter 3, I emphasize the importance of discerning the emotional component of communications to perceive the nature of a patient’s experiences and intentions. In chapter 4, I present the guideline that the message as delivered by the patient verbally and nonverbally is the primary focus of empathic perception. “The message contains the message” guides therapists toward the fullest possible extraction of meaning from a patient’s overt explicit communication with all its implicit complexity, rather than regarding the message as a screen obscuring a hidden secret. Chapter 5 guides therapists toward obtaining all the information needed for patients’ narratives to come alive as a revealing rendering of their experiences, especially those experiences that have been and are deeply touching to them.

In the remaining five chapters, I shift from guidelines for therapists to listen actively to guides for therapists’ active participation, their stepping out onto the “stage” of the “theater of the mind.” Chapter 6 presents guidelines for therapists to respond to overt and covert attributions that patients make about them. As therapy moves forward, subtle changes occur in the nature of self with other (patient with therapist, therapist with patient). For exploratory therapies to proceed, therapists need to discover who they have become for their patients, and “wearing the patient’s attribution” is critical to their aspect of the inquiry.

The guidelines in this chapter have focused on the identity of therapists as viewed by their patients and as potentially enlarging therapists’ view of themselves. In chapter 7, I shift the focus from patients or therapists to experiences they have created between them. An analogy can be drawn between these experiences and dramas or enactments that are sometimes easily recognized, but more often are puzzling. A guideline to their understanding and exploration is the joint creation of “model scenes.”