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ELEMENTS OF THE THERAPEUTIC SITUATION

The Psychology Of A Beginning Encounter

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Elements Of The Therapeutic Situation:

The Psychology Of A Beginning Encounter

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Elements Of The Therapeutic Situation: The Psychology Of A Beginning Encounter

The beginning encounter is a good place to look for the basic elements of psychotherapy. That is not because it encompasses all important features. The over-all shape of the relationship is important. The way treatment ends is important. Some psychoanalysts feel that treatment does not even begin until the initial phase is over and a solid relationship with the therapist is established. Nor is the beginning a simpler subject than a total therapy, for in many respects the early phase is more chaotic than anything that follows.

The beginning of treatment is interesting because in it major problems of the therapeutic *task* stand out most boldly. Meeting a psychiatrist adds a multitude of layers to the already myriad aspects of life; it supports an endless variety of theories. With so many possible ways of describing a therapeutic relationship, one looks to grasp it by its most insistent and least random protuberance, namely, the problem, task, burden, or work imposed.

This chapter is about the challenge that people accept in undertaking psychotherapy. The challenge exists on several planes of abstraction, the more concrete difficulties mirroring the more general ones. Some repetition is unavoidable as we examine the tasks of coping with a new experience, a new person, a new psychotherapist, and a new type of relationship. For the

sake of simplicity, the discussion will be confined to individual therapy.

Encountering Something New

The meeting of a patient and therapist is first of all a new event in their lives. That by itself presents the task of incorporating something new in an old self. Although it has been suggested (Gendlin, 1964) that people who seek therapy have trouble assimilating new situations, assimilation is by and large a routine, continuous task of life, handled easily and without attention. Nevertheless we do not entirely understand how it is done. Philosophers have pondered this question for centuries. It is noteworthy that two recent philosophers, George Herbert Mead and Alfred North Whitehead, thought that the growth of the mind was the clearest picture of the way a thing can be itself and yet develop. Mead (1932) held that something changes when it is in two different perspectives at once, as for instance when I incorporate another's image of myself with my own image, and affect him in different ways than I affect myself. Whitehead (1941) believed that nature's fundamental task is to combine stability with change. He wrote that inanimate things do this by "ignoring" most changes, sacrificing richness to endurance, whereas living things, and especially the mind, can respond to changes by incorporating them into pre-existing purposes. This makes our existence rich but vulnerable. Nothing could set the stage for our subject better than Whitehead's paradox (1941):

The world is thus faced by the paradox that, at least in its higher actualities, it craves for novelty and yet is haunted by terror at the loss of the past, with its familiarities and its loved ones . . . Part of the joy of tile new years is the hope of the old round of seasons, with their stable facts—of friendship, and love, and old association. Yet conjointly with this terror, the present as mere unrelieved preservation of the past assumes the character of a horror of the past, rejection of it, revolt . . . [p. 516]

Among psychotherapists, the existentialists have been most aware of this very general problem of therapy. May (1958), for instance, appreciates the cost of destroying what one is to become something new—a problem confronting every organism in every encounter with a new event, and therefore confronting patient and therapist in therapy. It is the sort of task that Piaget considers to be the engine of development and the source of cognition. In Piaget's (1951) system the need to reverse an impingement, to get back one's balance when surprised by something new, to preserve a constancy whatever comes—in effect, the need to be less affected without being insensitive— is what makes an organism an organism. A similar task has been referred to by others as homeostasis, repetition compulsion, identity needs, the orienting reflex, and so forth (Friedman, 1965; Friedman, 1968; Lewis, 1972; Pribram, 1971).

Meeting a New Person

More particularly, in psychotherapy, the new event is a meeting of two people, and that presents a more particular problem. "The self-system," Sullivan wrote, "views the stranger as an enemy (1954). Existentialists like May have pointed out that the milieu a person creates for himself is part of his identity (1958), and in the face of the stranger people will seek "to preserve their *center* (1961). At the same time, a person's mere identity is scant company, and his potential loneliness drives him toward others though it means destroying what he is in order to become something new (Lewis, 1972; May, 1958; May, 1961). The strangers in a meeting thus threaten each other as assailants and as tempters.

To ease this risk, society provides formalities that blur the sharp edges between private worlds. There are conventional politeness's and expectations, obligatory recognitions of the other's position. There are standard greetings, gestures of welcome and hospitality, allotments of host and guest status, attentions and avoidances in facial expression. All of these cushion the crunch of strangers on each other.

Yet a cushion also separates. Social niceties allow people to remain strangers to each other (Berne, 1961). Cushions that are not dictated by social convention are often called "defenses" by psychotherapists, who notice that they distract from the business of therapy—which is, after all, concerned with intimacy. Nevertheless these protocols provide a structure of familiarity as an

orienting grid, thus easing therapy’s first task, which is to keep stranger anxiety within bounds (Gitelson, 1962; Sullivan, 1954). Even a highly idiosyncratic meeting style serves for that patient the same function (among others) as a simple hello.

Meeting a Psychotherapist

The Public Role of Patient and Therapist

Psychotherapy is not the type of random conversation that two strangers might strike up on an airplane. Defined social roles both facilitate and complicate the meeting. Roles quickly become conventionalized in our unstable society, where communications are highly developed. Among sophisticated people in metropolitan regions of the United States, established patterns of psychoanalytic procedure affect patients’ expectations. And the newer patterns that are developing (encounter groups, T-groups, guru-guidance, and so forth), though they may be hard to describe, are not for that reason unfamiliar or strange even to beginners.

Despite the proliferation of styles, there are features common to most psychotherapeutic roles. The therapist is entitled to make certain demands and his partner certain complementary demands (Redlich, 1966). Usually the therapist is vested with authority, so the entitlements are apt to be obedience

on the one hand and care-taking on the other. As an authority, the therapist can represent society as a whole and can demand some token of conformity in return. Frank (1961) has shown that this exchange is common to many different techniques of changing people's attitudes.

To the extent that the therapist represents society he may seem to be a super-adult and his patient, accordingly, a child. There is general agreement that, for better or worse, this is one of the most significant built-in structures that shape the meeting. It is the occasion of deep shame and high expectations, and of various behaviors designed to disguise them. The patient's subculture may qualify how much the therapist's social-expert role parallels the role of the patient's parent, since we know that patients from different social classes have different attitudes and expectations toward therapists that radically affect the fate of treatment (Hollingshead, 1958).

The Patient Is Observed

In industrial society, psychotherapy partners usually meet as physician and patient regardless of the therapist's title or intent. A patient will naturally feel the meeting to be an examination. And since he submits for examination not his body but himself as a person, he will feel intensely observed—the more so if he seeks help for what he ordinarily keeps hidden. Defining the meeting as an examination limits its ambiguity, but it does little to soften the

stranger’s threat to the patient’s supportive world. One of the patient’s most pressing questions at the beginning of therapy is, "What does the therapist think of me?" The patient silently guesses. He is hyper-alert to hints, and thereby open to subtle suggestion (Frank, 1961). According to Greenson (1967), the awe-inspiring uncertainty prompts the patient to endow the examiner with attributes of important people in his past. Identifying with the examiner may help in understanding him (Lewis, 1972).

Heider (1958) suggested that being observed puts one person in another person’s power, because the subject’s region of action is integrated with the observer’s. (For instance, the therapist can pass judgment.) At the same time, one who is observed exerts power and control over the observer. Thus, being observed can make one feel important, especially with a prestigious observer, and the increased self-esteem may allow the subject to risk greater closeness. Paradoxically, being observed also makes a person more aware of himself as separate. It can lead to self-consciousness, humiliation, concealment, and disguise (Lewis, 1971), and make the therapist seem hateful.

Observing someone not only compliments him but also enhances the dignity of the feelings he displays, thereby encouraging him to give those feelings longer tether and a more respectful hearing. Subtly imagining the observer’s response, the patient creates an internal dialogue that extends

self-inquiry. (We can carry a thought further when explaining it than when thinking alone about it.) If, in addition, the patient senses that the observer reacts accurately and responds concretely to rather vague feelings, the patient is likely to discover additional significance in what he expresses (Gendlin, 1964; Gendlin, 1968). If the patient even wrongly believes that the observer can tie the patient's feelings into "the order of things," he will be more hopeful, introspective, and respectful of those feelings. This force not only affects the patient's attitudes to his feelings generally, but also his attitude to the specific areas in which the therapist shows interest. The impact of *focusing* has been discussed by Coleman (1949) and Gendlin (1968).

Thus, exposing and being observed allows the patient to feel his identity more strongly as he extends his influence to another, but at the same time leaves him open to disruption by an alien perspective. The status of the examining therapist gives the patient social support, dangling the lure of individual companionship and society's approval. However, it also subverts the patient's comfortable ability to take himself for granted and makes him feel isolated. The relationship of patient and therapist makes a meeting more defined than a meeting of socially anonymous strangers, but that very definition creates still other uncertainties that are even more uncomfortable and exciting.

The Public and Private Roles of the Therapist

So far we have considered the involuntary aspects of therapy: the roles that cling to participants as members of their society. These roles are not chosen nor indiscriminately reinforced as therapy progresses. The same cannot be said for roles imposed by the therapist's subculture: the world of therapy and therapists. As a result of his habitual activity, a therapist usually acquires a very different picture of himself from the one that prospective patients piece together out of popular culture and imagination.

The patient's view of the therapist is closest to the therapist's own view in folk healing and aboriginal therapies (Frank, 1961). But even in such thoroughly socially integrated activities there may be the beginning of a split between the doctor's appearance to the patient and how he sees himself, since there is evidence that the "witch doctor" uses tricks unknown to his patient. Certainly the difference between the therapist's role as seen by the patient and by the therapist widens progressively as we approach modern, "dynamic," "expressive," therapies.

Meeting a Prospective Therapy Partner

Although meeting a psychotherapist is an ambiguous social situation, bringing together parties who are far from unanimous about protocol, we have seen that there is some *de facto,* temporary agreement on roles, which

fits the meeting into a recognizable pattern and makes it understandable to the patient. In any important meeting we try to find something familiar to help us master its newness, but it is especially urgent in therapy because therapy is more than a chance encounter and more than an encounter with a therapist. It is a meeting that is supposed to lead to a relationship that has duration and direction, and the partners must find ways of getting along with each other. The conventions of meeting are a platform from which some sort of ongoing relationship may be launched. The social structure gradually, though at best only partially, gives way to an individualized one (Berne, 1961).

Showing and Perceiving Needs

Individualized structures are based on wishes. In order to have an ongoing relationship, patient and therapist must fit their desires together. To do that each must show his needs and look for the needs of the other. Both "probe the other’s reaction to alarm" (Ruesch, 1952). Conventional roles can only help a little in manifesting and scouting needs. Consequently in the beginning of therapy there is urgent activity to pin down these variables. (In this the beginning of therapy is unique (Fenichel, 1941), and offers unique opportunities that are sometimes wasted.) The patient looks at the therapist and asks himself, "Can he give me what I want? What does he want from me, and how does that jibe with what I want?" The therapist looks at the patient

and asks himself, "What are my chances of success with him? How well does he take to my personality and procedure? How much leeway does he give me?" In other words, both patient and therapist weigh their opportunities, and these deliberations give a clearer shape to stranger anxiety and determine initial moves.

Exhibiting needs and scouting wishes are very complex tasks, because they affect each other. We identify people's attitudes by those signals that have meant the most to us in the attitudes of people who have been important to us. These ubiquitous transferences of previous forms onto a present companion have been called by psychoanalysts "floating transferences" (Glover, 1955) or "pseudo-transferences"" (to distinguish them from the specific response to the psychoanalytic atmosphere, known as the transference neurosis, [Freud, 1955]). They are a universal kind of recognition. In a sense, they enable man to create his surrounding world, and in the same sense psychotherapy partners "create" each other (Friedman, 1968, Levenson, 1972, May, 1958).

So Peter paints Paul with Peter's palette. But Peter's palette is not just a collection of colors accumulated at random over the years. He has gathered pigments according to his pressing needs and interests. Needs help to organize the phenomenal world (Friedman, 1969; Levenson, 1972; May, 1958; Wallen, 1970), and especially the human scene. (For instance, needs

affect the transference image of the therapist.[Greenson, 1967]) So when the patient wonders, "What does the therapist want from me?" he will answer in terms of what he wants for himself.

The therapist does the same thing. He has his own transferences (about which more later). He also has a preexisting theory that makes his new patient's wishes familiar. By means of the memory of people in his past, the patient's transference traces what the therapist can offer to his hopes. Similarly, by means of doctrine and clinical experience, the therapist's theory translates the patient's behavior into therapeutic objectives. (For instance, the theory of psychological "mechanisms" is a biased way of describing the patient according to the therapist's focus. [Ruesch, 1968])

Mutual Accommodation and Its Limits

Each party in therapy progressively estimates what his partner wants from him and tries to show his needs in a way relevant to the other. Each finds ways of complementing the other, of putting himself in the other's world. Even therapists who plan no intense personal relationship realize that they have to "attract and keep the patient" (Eysenck, 1970). A therapist must meet at least some of the patient's expectations (Sullivan, 1954). He must perform a real service, plainly intelligible to the patient, in addition to whatever role he allows the patient to imagine for him (Stone, 1961). In the

beginning he must reply to the patient in the patient’s mode (Ruesch, 1952). But with the best will to accommodate, neither party sees the other the way the other sees himself. The patient addresses his wishes to a tempting therapist who he suspects will scorn, resent, ignore, or—most upsetting of all — respond to them. Since the patient is not aware of all that he wants, he is also not aware of those fears, but he is automatically cautious and indirect.

Although more aware of discordant images, the therapist also tends to see a very different person from the one the patient feels himself to be, and gently refuses to address himself exclusively to the persona that is offered. (Coleman warns against total bypassing. [1968])

And after all, neither party in therapy has the best will to accommodate. The patient will not give up what is most important to him in order to "play the therapy game" the way the therapist might wish (Friedman, 1969). And neither will the therapist blend into the patient’s world without reservation, because however necessary some accommodation might he, it is not retractable. What helps partners get along smoothly also limits their further possibilities (Szasz, 1965).

Thus a patient who feels like a guest and supplicant may he required to find his own seat and direct conversation. Or a therapist who feels like a stimulating listener may expect a patient to he reflecting while the patient is

really waiting to he rewarded by a "treatment" for information already given. The one thinks, "He is rude and withholding." The other thinks, "He is passive and oversensitive.[1] The reason for the discomfort lies in the nature of the partnership.

Forming a Psychotherapeutic Partnership

Psychotherapy is more than an ongoing relationship between people who recognize each other as patient and therapist. It is supposed to supply something unavailable in other relationships. Therapists picture the "something extra" in various ways. Some say that it is information (Ellis, 1968; Ruesch, 1968); others, a unique emotional experience; still others, a kind of child re-raising (Gitelson, 1962; Stone, 1961). The patient may not be deliberately looking for any kind of relationship. He may simply want to get rid of a disturbance. He may expect a relationship no more exotic than the one he has with his family physician. That relationship is far from simple, but it *is* defined by previous experience. If a patient expects to have such a familiar relationship with his therapist, he will not be able to figure out how it can help his different kind of problem.

The Patient Develops a Theory

Probably all patients wonder, "How can talking help?" This universal

bewilderment is often heard by therapists as a demand for a magical cure derived from infantile myths (Nunberg, 1948). Someone who spends his life practicing therapy may find it hard to fully appreciate how little a prospective patient may know about therapy (Coleman, 1949). (Therapists themselves understand it far from perfectly.) Beyond reflecting the vagueness of the talking treatment, the wish for a "magical" cure may simply express the helplessness of a person who is offered a promising relationship so novel that it does not fit any image of what he needs. To delineate a partnership in this anomalous relationship is a magnification of the task two strangers have in getting along together. The patient must work harder to make the benevolent apparition materialize in terms of his wishes and understanding than he needs to in ordinary situations (Lewis, 1972).

In other words, the patient has to develop an implicit plan or theory about his therapist's possibilities and the approach that will get results.[2] The patient has many wishes, not all mutually consistent, and corresponding conflicting fears. His tacit theory has to subordinate some of his wishes to others, and to heed some of his fears more than others. His theory will include accustomed compromises. To the therapist, the patient's theory may represent a deception, a pose, an indirection, a lack of straightforwardness, a game. He will sympathize with it as a manifestation of anxiety or inner conflict. But if the patient's wishes are brought into conflict in dealing with a vaguely defined therapist, the patient has no alternative but to work on some

such incompletely fulfilling and partially expressive theory or plan.

The Therapist Develops a Personal Theory

The therapist already has a theory that governs his professional behavior. But, like the patient, he also needs a plan to integrate his subtle, nontechnical goals and tastes with the new person in his life. Therapists generally discipline these needs. There has even grown a belief that a proper therapist is self-less in the conduct of his work. The picture is an ideal model, useful for encouraging self-understanding and self-control, but it is not the picture of a living therapist. No treatment or training abolishes the unconscious; sexual responses are not completely governable; a person will always have nonspecific habitual characterological attitudes (Thompson, 1964). All of these parts of the therapist's humanity may foster implicit plans or tacit theories about how to proceed with the patient. A therapist may establish a transference to his patient. (Gitelson (1952) warns that an initial over-all attitude toward a patient is a sign of the therapist's transference even when it pretends to be an intuitive recognition of the patient's needs.) And then there are approaches to the patient coaxed out of the therapist by the patient's approaches to him—the counter-transferences of psychoanalysis. They cannot be avoided and are often not even detected (Levenson, 1972; Lewis, 1972; Shands, 1972; Tower, 1963).

This means that some inexplicit theories by which the therapist operates, just like the patient’s theories, are ways of harmonizing his personality with that of his partner. (Wexler [1970] says that not all of the ideas the patient develops about the relationship are unreal and not all of the therapist’s ideas are real.)

The therapist may even choose his technical theory to match the kind of relationship he wants to have with patients. The gross difference between types of therapists found by Whitehorn (1960) may be matched by subtle differences within each group. Some therapists have static and some dynamic self-images (Ruesch, 1968). Some especially respect the discovery of theoretically germane information, others respect more the evocation of dramatic affect. Some pride themselves in helpfulness, some in research. Some fancy themselves midwives, others surgeons. Some hold themselves out as models, others as muses. This is what Rank (1945) referred to as the therapist’s "vocational psychology." The way the therapist fits his personal needs into the patient’s pattern reflects a nonprofessional and undeliberate theory that highlights certain significant features in the patient and singles out certain approaches to him. It is, again, the counterpart of the plan or theory that the patient is at work on.

The Therapist Has a Prefabricated Theory

Nevertheless, the most distinctive feature of the psychotherapeutic relationship is that one party has some standard, prefabricated, goal directed theory in addition to whatever personal plans he may develop during the meeting.

Theories of different therapists are not all equally explicit. Some therapists operate with elaborate, abstract theories, others with a cloud of implicit theory supporting a kind of therapeutic reflex.[3]

Thus while patient and therapist each develops a tacit theory about how the new companion relates to his outlook and ranked goals, the therapist is also busy relating the experience to his (usually more explicit) professional theory. Whereas people in a relationship ordinarily integrate themselves according to their own wishes and wishful perceptions, *the therapist, by adopting a professional theory, adds an artificial set of "wishes" and "wish"-determined structures that stands in the way of both parties finding fast arid familiar harmony.* (Lewis [1972] says that the therapist has "Plans to change the patient's Plans.")

Therapeutic Conflict

The above statement means that the psychotherapeutic relationship is characterized by a special estrangement between patient and therapist, which makes their adjustment more difficult than the adjustment of two people who

merely seek to get along with each other. It results in a struggle or conflict that may be quite invisible or may be loudly evident, but in some fashion is preserved by the therapist with an artificial stubbornness in honor of a rival allegiance to his professional theory.

The limitless and contradictory hopes that most therapies encourage cannot be satisfied, and even the limited ones that can be are slow of fulfillment. Add to this that a patient who has difficulty in living is presented with a task that in some ways is even more difficult, and the result should be chronic dissatisfaction. Actually, dissatisfaction is not as apparent in therapy as one would expect. Perhaps it is slowly worn down, or waits for the time of termination and flourishes after the end of therapy. But in light of the patient's theory, the therapist's theories, and the struggle between them, the therapist is often an unwilling deceiver and a willing frustrater. One job description of a psychotherapist is that he must bear the obloquy for defaulting on his (apparent) promises without justifying himself or retaliating. In that respect his theory repays him for the trouble it has caused. (Unhappily it must be acknowledged that the theory is also sometimes used to counterattack. [Balint, 1968])

Literature on the Psychotherapeutic Struggle

Haley (1963) has specialized in therapeutic struggle. Adler (1972)

described the therapist’s struggle against the patient’s wrong direction. Nunberg (1948) portrayed the psychoanalyst as forcing the patient to give up infantile demands by an implicit threat of abandonment, a theme that is implicit in Freud’s dictum that cures are cures of love. According to Strupp (1972), the therapist forces the patient against his will to trust and depend on him. We shall discuss below the principle of absolute nongratification (e.g. cf., Fenichel [1941]); this would surely reflect a struggle or conflict between patient and therapist. Bird (1972) says that analysis is not merely an intellectual or emotional exercise, but a conflict (albeit a conflict projected onto —i.e., attributed to—the relationship from within the patient’s own mind). Levenson (1972) is eloquent on the struggle of the therapist to keep clear of the roles that the patient desperately tries to make him take. Ruesch (1973) says that the therapist does not accept the role the patient offers him, despite considerable pressure. And Berne (1961) wrote that when the therapist, properly, does not take up the role that is thrust on him by the patient, it breaks the smoothness of the relationship and leads to trouble.

The psychoanalytic theory of resistance concerns the struggle in therapy (Freud, 1948). Rank (1945) was particularly interested in the therapeutic struggle. He described a "battle of ideologies between therapist and patient," which he saw as a fundamental conflict of wills. "That something is exacted of the patient by the therapist other than what he expects, is one of the oldest fundamental theses of psychoanalysis." Nevertheless, said Rank,

"As the therapist can only heal in his own way, the patient also can only become well in *his* own way" (1945). Even Greenson (1967), who counts on a great deal of harmony between therapy partners, acknowledges that the patient is primarily interested in what he can get out of the personal relationship (in Greenson's words, the transference), while the therapist's primary investment is in relatively detached observation (in Greenson's words, the working alliance).

Tarachow (1963) contrasted the stringent conditions of formal psychoanalysis with ordinary social responses, where, for instance, a plea for help is answered by giving help, or the wish to fight is answered by fighting. The psychoanalyst, according to Tarachow, is required to create a "therapeutic barrier." Szasz (1965) also cautions against the ordinary social attempt to create an early harmony. He acknowledges a great deal of struggling and even bullying in most therapy, but feels that it is avoidable if the therapist shows the patient what he is willing to provide and leaves the patient free to do what he wants with it or reject it. Experience is necessary to determine if this avoids or intensifies the struggle. Lewis (1972) believes that the therapist's job is to place obstacles in the patient's customary path and thus help him to learn. Klauber (1972) feels that one function of psychoanalytic interpretation is to keep the analyst from resonating with the patient's sexual urges. He refers to an "inherent struggle in psychoanalysis—almost a tease." The emphasis placed by Rogers (1957; 1961; 1961) and

Truax (1963)— and also by Szasz (1965), in a different spirit—on the steadfastness with which the therapist maintains his genuineness is an acknowledgment that the therapist’s theory makes a mutual accommodation harder, at least early in therapy. Gestalt therapists (Levitsky, 1970) sometimes forbid patients their habitual style of communication, and Fagan (1970) is keenly aware of the need to fight the patient for control. In behavior therapy, patients are forced (however willingly) into situations they seek to avoid. Ruesch (1973) refers to an inevitable "stalemate."

We will now consider this strange, frustrated cooperation in terms of the polarity and mutuality of therapist and patient.

The Therapist’s Role

Therapists tend to think of themselves as educators. They see themselves as revealing either the nature of reality or the true state of affairs within the patient, or the most "real" way to experience feelings, or the most fruitful way to live. A therapist may see himself as dispelling the patient’s myths about living (Ellis, 1968), his harmful habit patterns (Dollard, 1950), his illusions about himself and about others (Sullivan, 1954). He intends to demonstrate the inefficiency of the patient’s patterns (Horney, 1950; Thompson, 1964) and the futility of some of his hopes (Freud, 1937).

Usually the therapist believes that he sees things correctly where the patient errs, and that he can show the patient’s view to be insupportable or without value. This belief is not held by all therapists, but it underlies most theories of psychotherapy and almost all practices. In such a perspective the patient appears negativistic (Adler, 1916; Rank, 1945), resistant (Glover, 1955), rigid (Gendlin, 1964; Reich, 1947; Wallen, 1970), self-indulgent (Freud, 1948), stubborn (Freud, 1948), partially lifeless (Gendlin, 1964), misled (Ellis, 1968), or badly trained (Dollard, 1950; Ruesch, 1968). And as an educator, the therapist may correspondingly present to his patient the figure of a taskmaster and critic.

Psychoanalysts have elaborated the therapist’s pole in the concept of the therapeutic alliance (Stebba, 1934). The therapeutic alliance is where the therapist wants the patient to be; it therefore represents the therapist’s professional wish. It is usually described as a disinterested or drive-independent way of organizing perceptions (Freud, 1969). (Berne expresses a wish for an adult-adult relationship in therapy. [1961]) Some form of the therapeutic alliance is a touchstone for many dynamically-oriented psychotherapists. Correspondingly, a therapist employing Ruesch’s outlook (1952) will want his patient to be more interested in pure communication than in warfare or diplomacy. Haley’s (1963) therapist wants his patient to cease trying to control the therapy situation. Influenced by Horney (1950), a therapist will want his patient to give up futile posturing and accept himself

for what he is. Therapists of all persuasions basically want their patients to be braver than they are.

The Patient’s Role

Being a patient is not a profession, so patients organize the shadowy new psychotherapeutic relationship in even more diverse ways than do therapists. But experience shows some common features. The patient wants to maintain his self-esteem, and manages the situation with that in mind (Sullivan, 1954). In his heart a patient wants to be loved as he loves himself. He evaluates the situation in terms of the likelihood of such admiring love, and tries to identify the therapist as someone whom he can love for the love, appreciation, admiration, and partisanship he shows for the patient (Nunberg, 1948). He may try to recapture in the therapeutic relationship a two-person harmony, or a merging with another person that he wanted in the distant past and never acquired (Balint, 1953; Kohut, 1971). Yet he may sense dangers in that situation (such as feeling himself to be less whole, individual, or capable) that justify animosity to the therapist (Reich, 1947; Saul, 1958).

The most universal and definitive past pattern for structuring the therapeutic relationship is that of child and parent. Many therapists regard the infant-mother relationship as the central orienting structure of therapy (Gitelson, 1952; Spitz, 1956; Stone, 1961). According to Nunberg (1948), the

patient does not simply want to shed symptoms, he wants to realize all the grandiose fantasies of his infancy, to be all-powerful and to be permitted all indulgences. Fenichel (1941) wrote that the patient wants the unrealistic gratifications that his symptoms symbolize.

This is not to say that patients ask to be treated like infants. Adults are usually intensely ashamed of such wishes. We have noted that the patient’s pole includes the wish to seem admirable and, especially in the United States, that means to be independent. Therefore the patient’s implicit plan usually involves a covert quest for parental care and overt rejection or resentment of it, which in turn may be disguised by a dutiful submission. Some authors feel that "hostile dependence" is a frequent prelude to therapy and an absolutely dependable part of the therapeutic scene (Saul, 1958). The situation illustrates the dangers of either opposing or cooperating with the patient’s theory.

Other patterns can be discerned as well. The patient sees an opportunity to be understood. Understanding may be a token of love (Lewis, 1972) or a demonstration of symbiotic closeness. But it may also be a separate need (Ruesch, 1973), a foil for the kind of internal dialogue that keeps experience alive (Gendlin, 1964). The patient may recognize in therapy a chance to learn and develop. That may be reminiscent of earliest care-taking (Stone, 1961). Or it may be a formative aim in itself (Maslow, 1968).

Not all investigators, therefore, feel that the patient's orientation is a reenactment of earlier dramas. But many have thought that almost all of the patient's urgent orientations are significant because of their historical meaning. Psychoanalysts in particular feel that one very strong pull by the patient is in a "regressive" direction,[4] i.e., is aimed at making a past relationship come to life again with the therapist (Glover, 1955). The disharmony between patient and therapist is therefore described by psychoanalysts as a struggle between the patient's regressive strivings toward childish satisfaction and the therapist's forward urgings toward adult responsibility. Everyone agrees, however, that most patients also want forward movement, while the therapist often encourages regression to provide information for growth.

The Overlap

Harmonizing Forces

Pure disharmony between patient and therapist would be no relationship at all (Tower, 1956). But after all, the struggle between them is only an exaggeration of the general difficulty of fitting a new partner and a new relationship into familiar terms, and of fitting oneself into another framework. As previously noted, fitting is a reciprocal process. To an extent, the patient gives the therapist what he wants (Fromm-Reichmann, 1950;

Stevenson, 1959) while the therapist tries not to disappoint the patient (Coleman, 1949; Klauber, 1972).

Although therapeutic fitting together is more difficult because the therapist’s theory intrudes, therapy provides compensating factors that foster harmony. On the patient’s side the need for help induces "suggestibility" (Frank, 1961). Some authors believe that the specific kind of frustration that brings patients to treatment also produces a receptive attachment to the therapist (Gitelson, 1952), although others say that patients who need therapy most are least suggestible (Strupp, 1972). The patient also initially grants the therapist respect and accepts his authority (Coleman, 1949; Frank, 1961).

Certain qualities of the therapist also facilitate agreement. Most therapists (not all) observe a rule of gradual and gentle introduction of their own perspective. Moreover, therapists develop ways of braking the pull toward the patient’s pole. In psychoanalytic terms this means modulating the "regressive" tendency of the patient (Coleman, 1949; Klauber, 1972).

Another therapist-inspired aspect of most therapeutic relationships that moderates opposition is tentativeness, which is made possible by the therapist’s limited participation in the activities of the patient’s life (Lewis, 1972). There is less playing for keeps than in other relationships.

Commitment is only partial (Berne, 1961), games are welcomed (Braatøy, 1954), play is encouraged directly (Levitsky, 1970) or by the therapist joining the patient's progression of thought without really subscribing to his views (Tarachow, 1967). The therapist does not stick to any one role (Ruesch, 1952). He discourages too much seriousness too soon (French, 1958). Orthodox psychoanalysts select patients who can put on and take off childlike attitudes (reversible regression). The therapist arranges an atmosphere of experimentation (Dollard, 1950; Frank, 1961) He engages his patient in a middling rather than passionate or detached fashion (Scheflen, 1965).

Certain of the therapist's social skills also help to reduce disharmony. He should handle stranger anxiety with ease (Gitelson, 1952) and be a good conversationalist (Schofield, 1967), i.e., have a talent for effectively including another in his perspective and vice versa, which docs not necessarily employ seduction or persuasion. The therapist should be imaginatively evocative (Applebaum, 1953; Fagan, 1970).

One of the most significant harmonizing elements in therapy is the therapist's theory—the very theory which we have seen to be an obstacle to easy harmony. The therapist's theory is designed to encompass many human frameworks and relate them to therapeutic goals. Ideally it is elastic enough to translate any attitude of the patient into a familiar and hopeful perspective of the therapist. Labeling patient behavior in terms of the therapist's theory

draws the patient into the therapist’s orientation.

Gratification

The overlap between the patient’s and the therapist’s goals is often called "gratification." The therapist’s fidelity to his own perspective leads him to be cautious about gratification. Like most authorities, Sullivan (1954) warns that the therapist must want nothing from the patient by way of personal response, except respect for his competence; he must not "come on" to his patient. Here the restraint clearly augments the patient’s freedom as well as his security, though it may at the same time hurt his pride in himself and his therapist. In a venerable psychoanalytic tradition, gratification is to be totally avoided precisely because it compromises the therapist’s stand (Fenichel, 1941). And yet some sort of harmony is required for a relationship, and some sort of gratification will be had (Coleman, 1968; Tower, 1956).

The therapist is gratified by progress (Fenichel, 1941) and the patient can be gratified by pleasing the therapist. Sullivan (1954) said that the therapist’s expertness reassures the patient; that achievement must gratify the therapist as well. Furthermore, the therapist is mildly excited by the coloring his theory gives to the picture of his patient, and the patient is similarly excited by the drama of his theoretically described situation (Klauber, 1972).

Competitive desires may be visibly or invisibly gratified in the struggle between the patient’s pole and the therapist’s (Haley, 1963). Overt sexual behavior, of course, is ethically prohibited. Inability to overcome the prohibition often makes the patient profoundly resentful—hurt in his sexual pride and snubbed in his wish to be special to the therapist or at least accepted by him as an equal. (The Freudians relate this to oedipal ambitions.) In a way, the sexual prohibition echoes the inability to achieve natural harmony with the therapist. The patient has a rival in the therapist’s theory. Tarachow (1963) thought that masochistic gratification was required for enduring therapy. And yet the patient can seduce the therapist in countless subtle ways: for instance, by playing on his therapeutic ambitions. Indeed it is possible that the patient must *succeed* in seducing the therapist on a subtle emotional plane if he is to make major improvement (Tower, 1956).

We have seen that therapy offers an echo of early dependency. Many therapists regard this particular indulgence as a healing device, just as many worry that dependency gratification interferes with growth (Bird, 1972). But even if the therapist wants to moderate it he does not have the unilateral power to do so. The common experience that patients report as, "My therapist doesn’t tell me anything," may increase dependency more than a stream of authoritative advice. Since a relationship is whatever it is felt to be (Bateson, 1972; Levenson, 1972), and since relationships can in some ways be enforced (Chessick, 1969; Haley, 1963; Lewis, 1972), the patient’s plans will succeed in

some degree.

Obviously too much sexual success deprives the patient of some dependency gratification and blocks other wishes. Too much dependency robs him of self-respect and buries other tendencies. Insofar as any behavior can be camouflage for other behavior, gratification may mean that the therapist agrees with the patient about the wisdom of hiding other stifled wishes. Therefore both patient and therapist have mixed feelings about gratification. Nevertheless, however wary, in the end they gratify each other in many ways.

Literature on Gratification

Even among those who consider gratification the enemy of therapy, some patients have been allowed to compromise the therapist's role in a limited way through what the Freudians call "parameters" of technique, which allow transactions between therapist and patient other than interpretation. Tower (1956), in fact, asserts that no one is cured by interpretation per se. Like French (1958), she feels that some progression of gratifications is the moving force in treatment. Even Tarachow (1963) allows that there must be some agreement between therapist and patient. Eysenck (1970), as noted, holds that the therapist must attract and keep the patient before he can expect anything from him, whatever the theory of cure. Stone

(1961) says that the patient must actually find something of what he seeks in the physician, in other words, some real gratification in the therapeutic relationship. The recent trend in psychoanalysis led by Loewald (1960), Stone (1961), and Gitelson (1952) represents a quest for a gratification of the patient that is compatible with analytic aims. These psychoanalysts believe that the overlap on which patient and therapist can agree is gratification of the wish for good parenting, i.e., the wish for a parent who helps to integrate and discipline the child's needs with an eye to his potentialities as an adult (1960), a parent who is able to promise a satisfactory wholeness out of what is expressed by the child, who guarantees continued concern and caring (Gitelson, 1952; Stone, 1961), who serves as a loving model, who can accept the wish for attachment and for independence at appropriate intervals, and who can perform the functions of the mother of separation and the mother of nurturance.

Stone (1961) believes that these roles are acceptably combined in the vocation of the physician. Saul (1958) also feels that the therapist is in a position to gratify the child in the patient without slighting the adult. Greenson (1967) says that the combination of "mother" and researcher gratifies the patient without the danger of compromising either role. Giovacchini (1972) holds that the analyst can in good conscience be a comforting and gratifying haven for wishes of symbiotic union, while still helping to untie the symbiosis. Balint (1968) and Kohut (1971) emphasize the

passive but willing gratification of certain "regressive" needs (such as idealizing or merging with a parent-figure), which the patient must experience before he can move on from his own pole toward the therapist's. Maslow (1968) also suggests that some gratifications (of what he calls deficiency needs) may have to be combined with the teaching of independence (which he calls gratification of growth needs). Berne discusses this as well (1961).

All of these ideas are ways of describing the overlap between patient pole and therapist pole. They are a bridge between what is familiar to the patient and what is new. Although the therapist remains slightly aloof, out of loyalty to his theoretical postulates, in the overlap area he provides the patient something old which is something new, something that connects with the past while it leads forward—as, for example, the mother of nurturance who is also the mother of separation. The therapist makes some of the patient's dream come true.

At the same time we should keep in mind the reservations of Tarachow (1963), Szasz (1965), and Bird (1972), who remind us of the hazards of this double role. They speak about the dangers of infantilizing the patient. The wishes at the core of the patient's pole are mutually contradictory (as are everyone's wishes, including the therapist who wants maximum suggestibility and independence on the part of his patient). That means that

any gratification is also a frustration. The patient wants something familiar that he can integrate with his experience, but also some movement, improvement, relief, and increased freedom. The struggle in therapy prevents the frustration of some wishes (for growth or change). By the same token, the gratification of overlap may foster that very frustration.

The tradition of Loewald, Gitelson, and Stone tried to find the middle ground that stands for the old and the new at the same time and therefore does not shortchange one wish for another. They found it in the paradigm of the child's relationship with his parents, which should not, ideally, be *infantilizing.* However, there is some doubt whether such a middle ground is still available for an adult patient. Tarachow and Szasz think not. Rank says that you cannot raise a grown person again; he can only be accepted. Many patients distinctly feel that therapy at its best is still infantilizing.

The search for a relationship that represents at once the therapist's new pull and the patient's old orientation is not confined to psychoanalysts. Gratification of any sort seems to have to do with love. Practitioners would like to say that love is the bridge. But love is different things to different people and is usually recognized diversely by patient and therapist. (Such a discrepancy is often what brings patients to therapy.) Moreover, there is no reason to think that therapists have a greater capacity for love than anyone else, and every reason to think that theirs is limited and makes its own,

personal, and not necessarily therapeutic demands. So therapists are tempted to define love as whatever it is they especially have to give. Formulas such as "love equals understanding" naturally abound. But that simply transfers the problem from love to understanding, which is just as ambiguous.

Some of the most systematic efforts to pick out of the therapeutic transaction an element that is universally desirable, unconflicted, and compatible with both patient’s and therapist’s poles, have been made by theoreticians of evocativeness, such as Rogers and Gendlin who hold that the therapist is not so much a guide as he is a medium or foil who elicits the patient’s potential. Avoiding the difficulty of integrating the mother of nurturance and of separation, or of choosing between mothering and an egalitarian relationship, these investigators have, in effect, asked what universal, interpersonal gift the mothering relationship itself exemplifies. Gendlin (1964) feels that the very process of living requires a dialectic of feedback. Everyone needs someone’s reaction to make concrete the vague possibilities of his body feeling. Such a helper is not a condescending comforter but an interlocutor who crystallizes the patient’s meaning by bringing it into a process of new, adaptive experience. For Rogers and Gendlin, the mother of union and the mother of separation are two aspects of every person (therapist or non-therapist), aspects that are essential to any sentient being. One aspect is an otherness that allows a person to see more in his potentialities and thus move his experience in a fluid and living fashion.

The other aspect is an empathic togetherness which makes a real response possible. There is some empirical evidence, collected independently of this school, that such factors are crucial (Kernberg, 1972).

But the problem is not so neatly solved. Rogers points out that the therapist must not only be empathetic but also be *seen* as empathetic (1967). The patient may insist that empathy be shown in *his* way, and that leads back to the conflict between patient and therapist poles. And Gendlin has admitted that some patients do not use the therapist's feedback profitably, which suggests individual variation even in this basic human need. (Perhaps Witkin's work (1962) bears on these individual differences.)

There is, therefore, still much room for further understanding of how patient and therapist get together while keeping apart in a helpful way. A synoptic example is the situation of the therapist as an accepting and tolerant person while being something like a critic.

Polarity and Overlap: Criticism in Psychotherapy

A patient who comes to therapy suffers the realistic danger of an authoritative put-down. But because he is alert to any possible self-affirmation, he may also spy an opportunity within that danger. A judge who can condemn can also exonerate; a critic can praise; and therefore the patient can easily fit the therapist's educative program into his own plan (for self-

adulation, for instance). Or he may see an opportunity to become a powerful judge by identifying with the therapist. Furthermore, a judge can accept a confession (Schofield, 1967). Tacit forgiveness in the form of non-criticism is enormously important in the early stages of therapy (Dollard, 1950; Greenson, 1967; Rogers, 1961).

Exposure to shame is, however, quite different (Lewis, 1972). The need to hold on to self-respect is paramount. Patients welcome the chance to express guilt but stubbornly conceal what would produce shame (Nunberg, 1948). Even to enjoy exoneration can feel shameful, as being worthy only of a child. Indeed, shame can and frequently does arise simply from exposing oneself to a therapist without reciprocation."’"’ Therapists are aware that fear of criticism and contempt reinforces the patient’s rigidity and his resistance to the therapist’s pull. Most therapists therefore make great efforts to be accepting and non-judgmental (Rogers, 1961; Schofield, 1967). But once again, the therapist does not decide how he will be seen or indeed what he will actually be to the patient. It may be impossible for the therapist to be non-judgmental, since the therapist moves in a genuinely conflicting direction from the new patient. Patients sense where their guilty or shameful impulses correspond to the therapist’s technical taboos; and that, rather than the therapist’s willingness to listen to confessions, is where his acceptingness is tested. What strivings the therapist will or will not allow is told by how he reacts to the patient’s conduct in therapy, not by how he reacts to life

situations and issues that do not involve him. So the therapist’s divergent professional wishes suffice to limit his acceptingness or appreciativeness of, and even possibly respect for, the patient.

A still more vital issue is at stake. The patient’s general goals are represented by specific behaviors that the therapist may criticize when they occur in the consulting room. That disapproval is tantamount to condemning the general aims that stand behind them. Unresponsiveness to his therapist’s wisdom may be sexually satisfying to a patient; disapproving that "resistance" may be equivalent to a Victorian sexual taboo (Levenson, 1972). This is a problem as long as interpretations are admitted to have overtones of criticism (Tarachow, 1963).

Judgment, then, is something that the patient wants and fears. It is difficult for the therapist to avoid judgment, partly because of his educative commitment and partly because the patient, for educative and other reasons, entices him to judge. Yet the therapist knows that judgment is often restrictive and discouraging. The situation shows how tricky the task is that patient and therapist face in maintaining a rich relationship with a permanent built-in estrangement.

Outcome

Psychotherapy exaggerates and prolongs the inherent difficulty of a

new relationship, namely, the difficulty two people experience in trying to find an opening for their wishes in the other’s wish-system. By exaggerating the difficulty, therapy keeps possibilities open. In all of the conflicts between patient and therapist, an area of hopefulness is enforced. The patient may fight with the therapist for endorsement of his strivings (as currently clothed in his neurosis), but because he does not win the fight he can hope that other, opposite ambitions are also approvable. And because his struggle for approval is not neatly won, he can retain the hope that he is autonomous and does not need an authority’s approval. The therapist may find a stubborn enemy in the patient’s "unrealistic" attitude toward him, while discovering hope and opportunity in the patient’s resulting respect, which lets the therapist "reach" him. Though they are not likely to visualize their conflict or their opportunity in the same way, both patient and therapist find a hopefulness, an open-endedness, that would not be there without the conflict.

As long as there is conflict, no hopes are ruled out. As long as there is conflict, no roles are ruled out. As long as there is conflict, no perspectives are ruled out. As long as there is conflict between therapist and patient, no premature, intrapsychic, institutionalized resolution need congeal.

Two people in therapy stretch their usual way of seeing and wanting (on the part of the patient) and seeing and wanting and theorizing (on the part of the therapist) in order to encompass the recalcitrant partner. The

stretch leads to hope.

The Literature on Hope

French (1958) has shown in detail how hope leads, inch by inch, to the resolution of problems. Frank (1961) has pointed out how crucial hope is to a change in attitudes. Stotland (1969) has gathered evidence for the strengthening effect of hope, both hope offered from outside oneself and hope from noticing one's success. (This is important, since several authors have pointed out that the sheer magnitude and length of the therapy project cumulatively instill certain feelings in its participants.) Sullivan (1954) said that the patient must always be able to see a convincingly likely benefit in order to progress through any interview. Ruesch (1973) says that there is always a covert promise in therapy.

We have seen how psychoanalysts try to find some genuine personal but legitimate gift that is immediately hopeful to the patient, even while the therapist plans to demolish other hopes. The balancing of closeness and separateness, gratification and deprivation, is the therapist's way of encouraging hopes without confirming them. Levenson (1972), Lewis (1972), Chessick (1969), Haley (1963), Gestalt therapists, and many others recommend a fluidity in the therapist's attitude that prevents him from being trapped in the stereotype that the patient's pole draws him to. Most writers

stress how important it is to break the patient out of his old structures. The shiftings of the therapist's outlook between old and new, between one role and another, preserve the therapy as a convertible situation that is new but also reachable by variations of past themes. Old hopes are encouraged but not allowed to smother other hopes.

Hope leads to courage and discovery and change. Risks are dared and anxiety found to be unrealistic. The encouragement comes not from the therapist's theory but from the flexibility the theory imposes on the relationship, where it constructs a free field for experimentation (Dollard, 1950) or an arena of transference (Freud, 1948).

The dialectic of a personal encounter is enormously complicated and descriptively inexhaustible (Gendlin, 1964; Levenson, 1972). We need to develop many different conceptualizations of the therapeutic relationship. A concrete event such as a meeting in therapy can only be understood by using many coordinates and locating their intersections.

One such intersection seems to be that the therapist offers structures that tempt the patient because they are familiar to his active wishes but are different enough to arouse dormant ones. Such a new structure might be the comfortable acknowledgment of a frightened impulse; a different moral standard; a new definition of a feeling; a therapist who does and does not act

like a parent; a theoretical formulation; a new connection between two thoughts; an imaginary re-positioning of the patient in a remembered encounter; a new attitude; a new way of listening to oneself; an ordered behavior; or a programed confrontation with what has been avoided.

In practice, different therapists aim for different degrees of flexibility. Sometimes the therapist seems to lay down structures for the patient to adopt. But what is common to therapy generally is not a proffered set of structures so much as a *temptation* lurking in therapy's curious welcoming obstacle path—a temptation to risk a difference.

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Notes

1 For useful inventories of patients' initial concerns see Coleman (1949; 1968), Goldstein (1969), Ruesch (1973), Redlich and Freedman (1966), Szasz (1965), and MacKinnon and Michels (1971).

2 Sullivan (1954) said that both patient and therapist have a theory about the other’s behavior. Reik (1948) holds that in everything we do we unconsciously picture the other’s reaction. Mead (1932) says that objects get their meaning from the tacit plans we have for them. Ruesch (1952) says that therapy aims to develop the patient’s ability to perceive his actions, codify them, and respond to the therapist’s reactions, so that he will be better able to derive meaning from his and the other’s behavior. This is a way of saying that therapy is a polishing of patient’s theorizing abilities.

3 Rogers (1952) holds that the personality of the therapist heals despite the obstruction of his theory. But what he means is that only as much theory is needed as is employed by any healthy person in his dealings with everyone. Since the Rogerian qualities of (self) congruence, empathy, and uncriticalness are only a few of the attitudes that people show to others, a special concentration on them for beneficial purposes is part of a theory. Rogers’ view of the source of his patient’s discomfort, although simpler and less individualized than many popular theories of pathogenesis, is nevertheless another part of his theory.

4 Psychoanalysts disagree among themselves over how much the patient’s quest and the analyst’s are at odds. Freud (1937), Tarachow (1963), Nunberg (1948), and Fenichel (1941) feel that many of the patient’s efforts run counter to the analyst’s. Some of their writings suggest that the patient’s moves toward his analyst are not really directed toward a person, but rather toward himself as imagined in the loving eye of an analyst. In this sense the strivings are said to be not "object-directed" but, rather, "narcissistic," and a retreat from the real world. Other analysts such as Gitelson (1962), Stone (1967), Loewald (1960), and Balint (1968) feel that a healthy quest is larval in the patient’s primitive wishes, just as the adult is implicit in the child. These writers do not give the impression that strivings toward the analyst are the opposite of what the analyst considers healthy.