THE TECHNIQUE OF PSYCHOTHERAPY

ESTABLISHING A WORKING RELATIONSHIP

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Establishing a Working Relationship

One great disappointment to the beginning psychotherapist is that painstaking and elaborate exploration of a patient's problem and a most thorough endeavor to reinforce constructive behavior may fail to influence the emotional ailment in the least. Even though the therapist seemingly has an understanding of the patient's difficulties and of the contingencies that aggravate them, the patient continues to suffer symptomatically, and there is no abatement in the distorted way that the patient relates to people. The therapist, as a consequence, may become frustrated and perhaps dismiss the patient from treatment on the basis of "unsuitability," or "severe resistance," or "negative therapeutic reactions," or "latent schizoid tendency."

When the causes of such treatment failures are explored, it is often found that the patient has been unable to take advantage of the benefits of therapy because of anxiety or because of the refusal to make any effort on the basis of an infantile magical expectancy. This militates against evolving more effective ways of adjusting to new modes of behavior by therapy. Further investigation usually shows that what is basically lacking in the therapeutic situation, and what probably has been missing from the inception of therapy, is the proper kind of working relationship between the patient and the therapist. This relationship ideally is a unique interpersonal experience in which the patient feels a quality of warmth, trust, acceptance, and understanding such as he or she has never before encountered with any human being. Patients who have in the past established mature, unambivalent associations with people are usually capable of developing working relationships with most therapists. Those whose contacts have been characteristically disturbed will require therapists who are skilled, experienced, and truly able to deal with transference distortions and their own countertransference (Kernberg et al., 1972).

A neurosis imposes on the individual distortions in the individual's sense of values that undermine security, depreciate self-esteem, and make the average pursuits of living vapid and meaningless. Before any significant change can occur in the system of neurotic balances and counterbalances that has been erected, it is necessary to win the patient over to a willingness to experiment with a new way of life.

The cultivation of the proper working relationship between patient and therapist is indeed the

primary objective of the first treatment phase. Without a working relationship the patient will not resolve basic resistance to the meaningful resolution of problems.

In some cases a working relationship develops as a projection of the patient's need for an idealized authority. In other cases the therapist will have to work hard at securing rapport. To illustrate, we shall consider an example from the sales field. In selling a product the salesperson is confronted with the universal phenomenon of sales resistance. Experience has taught that any attempt to force the product on the customer before this resistance is overcome will be futile. The salesperson has learned that the best way of resolving sales resistance is to sell oneself to the prospect. Once the prospect has developed confidence in the acumen and integrity of the salesperson, the prospect is more prone to accept any statements that the latter makes about the advantages of the product.

Although the therapist is not a salesperson who is trying to sell the patient a product in the form of a new way of life, there is still the problem of resistance even though the patient may seem eager to get well. Such resistance is often fashioned by a desire to maintain the status quo and yet rid oneself of suffering. The patient must be persuaded to accept conditions that will lead to health in the face of his or her resistance. To do this, the therapist must first win the patient's trust and confidence by establishing a working relationship. The relationship hopefully will enable the patient to overcome initial reluctance to face his or her problems and work toward rehabilitation. Without this the therapist may not be able to achieve the therapeutic goal, whether it be symptom relief, problem solving, restoration of a shattered sense of self-mastery, elimination of destructive feelings and attitudes, acquisition of a healthier feeling about oneself and one's past experiences, or achievement of more adaptive interpersonal relationships.

In reconstructive therapy, until a working relationship is constituted, the patient will be particularly unable to handle anxieties associated with unconscious conflict, investigate genetic origins, resolve archaic defenses, challenge the spurious pleasure values of the neurosis, or develop more constructive modes of adjustment.

VARYING NEEDS OF THE PATIENT

Militating against the establishing of a working relationship is the fact that the patient always seeks

to use therapy in a variety of ways, some of which are inimical to good rapport. Thus, the patient may desire dependence on the therapist to receive guidance, reassurance, and other bounties. The patient may search for unqualified sympathy and acceptance. The patient may seek factual understanding and objectivity to help evaluate his or her thinking and behavior patterns. The patient may want to express feelings that are turbulent and to act out impulses, demands, and other strivings customarily held in check. Finally, the patient may yearn for a cooperative give-and-take relationship without domineering or being domineered. Not only must the therapist be equipped, by virtue of personality makeup, to accept the patient's varied strivings but must be able to react to them in a therapeutic manner. The therapist must provide the patient with an experience that will act as a prototype of a different kind of human relationship—one that inspires new and constructive attitudes toward people. To do this, the therapist must deal with the constituents of each of the patient's needs.

The Need to Be Dependent

Because the emotionally ill person usually feels helpless, he or she wants a kindly agency to relieve distress, to give support and guidance, and to restore health. These regressive needs, conspicuous in many patients, are most extreme in those who are severely sick. It is impossible for the therapist to escape fulfilling some measure of dependency need. While the therapist may not wish to perpetuate the infantilism of the patient by playing the part of a "giving" authority, except perhaps in supportive therapy, this may temporarily have to be accepted without resentment, fear, detachment, or aggression. Astuteness will be required in diagnosing how much active help the patient needs, matching the support given to the severity of the sickness, and imposing on the patient as much responsibility as can be tolerated. The therapist must know when to resist dependency demands and how to convince the patient that their fulfillment may interfere with the patient's capacities to develop assertiveness, strength, and independence.

The Need for Unqualified Understanding, Acceptance, and Condonation

Such yearnings are part of the social nature of a human being. They may be especially urgent in the emotionally sick individual who constantly anticipates rejection and condemnation. In response to the patient's need for understanding and acceptance, it is essential that the therapist be capable of

empathizing with the patient, of giving warmth and understanding no matter how destructive and disturbed the patient may be. At the same time, the therapist must avoid overprotecting and smothering the patient with cloying kindness, which will tend to rob the patient of self-sufficiency. Any personality characteristics in the therapist, like detachment or hostility, that interfere with this empathic ability to feel and to communicate warmth will constitute insurmountable handicaps to the establishing of a relationship.

The Need to Relieve oneself of Painful Feelings and Ideas

The desire to unburden oneself of guilt, fear, and anxiety will often be overwhelming for the patient. Ventilation of suppressed and repressed feelings, attitudes, and past experiences is usually accompanied by immediate but temporary relief. The therapist must be able to endure cathartic outbursts of painful emotion that are delivered by the patient, displaying a non-judgmental, objective attitude, neither condemning nor sanctioning the behavior of the patient. Since some of the material divulged may be of an immoral or antisocial nature, the therapist must be able to handle personal untoward feelings that are inspired by such destructive and perverse recitations, avoiding rebuke and other culturally accepted responses to the material.

The Need for Factual Understanding

The patient always has a need for an understanding of what is happening to him or her in order to neutralize fears of the unknown. This requires objectivity on the part of the therapist. The ability of the therapist to remain objective helps to inculcate in the patient a factual appreciation of the existing problem in relation to inner beliefs and external reality. Essential is a good understanding in the therapist of human dynamics, interviewing techniques, methods of bringing to the awareness of the individual the meaning of the individual's behavior, and helping the patient work through resistance to insight and to the translation of insight into action. This knowledge must be tempered in the therapist with intelligent self-awareness to avoid contaminating the patient with personal prejudices and to allow the patient to develop a personal sense of values.

The Need for a Transference Relationship

Many patients seek media in which they can project and act out tendencies and feelings that relate to actual or idealized parental personages. The projection of attitudes and feelings that originate in past relationships (transference) requires for its appropriate handling an understanding of this phenomenon by the therapist as well as the ability to perceive, use, and manage manifestations of countertransference. The therapist must be able to manage any intense dependency needs, sexual demands, hostilities, and manifold misinterpretations that will be expressed by the patient in the course of therapy.

One of the fallacies in practice is the idea that it is possible to resolve past parental deprivations that have acted as the basis for the patient's psychopathology by supplying remedial nurturing or unconditioned love within the therapeutic situation or by encouraging the patient to indulge and gratify infantile need deficits. Sandor Ferenczi's original and failed attempts to put this principle into practice has not discouraged some therapists from repeating his disappointing experiments (Ferenczi 1950a, b, & c). A host of reparative procedures have evolved, ranging from open expressions of praise and affection to holding the patient on one's lap, bottle feeding, stroking, and using other physically soothing maneuvers. The result of these efforts, though temporarily reassuring, have failed miserably to relieve patients' pathology. Early deprivations and parental malfeasance are so structuralized and stabilized by defenses within the intrapsychic organization that they defy alteration through environmental manipulation. Indeed, attempts to unsettle the neurotic equilibrium may threaten repressive mechanisms that have enabled the individual to function up to this time, albeit with neurotic safeguards, precipitating strong anxiety. The defenses that protect against anxiety and maintain the patient's illness yield slowly, and only as the rigid internalized object representations change their fearsome and punishing quality through constructive cognitive alterations and congenial sustained interpersonal relationships. Translated into clinical practice, this means that the therapeutic encounter, though empathic and understanding, avoids cloying, intimate parenting. It should be intellectually and emotionally appropriate to the patient's present age, not regressively patterned to some presumed past age level, however much the patient may want to live at this level. This does not preclude role playing and revival of past traumatic memories through psychodrama, narcosynthesis, or hypnotic regression and revivification, when such techniques are deemed essential to loosen repression. But the basic

patient-therapist relationship should be reality, rather than phantasy, oriented.

The therapist's capacity to display warmth and to remain tolerant and yet firm and objective in the face of transference must be coordinated with skill in minimizing the intensity of transference and of working it through toward the objective of self-understanding such that it does not interfere with treatment objectives.

The Need for a Cooperative Human Relationship

Irrespective of how distorted previous relationships with people have been, the individual earnestly desires a wholesome relationship bereft of neurotic encumbrances. The effective management of the myriad demands of the patient will help to fulfill this basic need for a cooperative human relationship.

MULTIPLE ROLES OF THE THERAPIST

What then is a psychotherapist? A doctor who heals. A friend who consoles. An authority who guides. A teacher who educates. A catalyst who accelerates growth. These and other pursuits constitute the tasks of the creative professional.

Therapists may show different responses to patients with varied personality constellations. For instance, one may be able to express warmth and to remain remarkably objective toward submissive and dependent persons, while being totally unable to express therapeutically constructive feelings when in contact with domineering or hostile patients. Understandably, the more thoroughly therapists have worked through their own personal problems, and the greater awareness they have of their own relationship difficulties, the more flexible each will be in responding to a variety of patients. Therapists who have little awareness of interpersonal difficulties will find therapeutic effectiveness circumscribed to those patients with whom they can feel most comfortable.

In order to express his or her diverse needs, the patient usually strives to force the therapist into multiple impersonations, namely, the following:

1. A helping authority

2. An idealized parental image

3. An actual parental representative

4. A representative of other important past personages

5. A cooperative partner

The Therapist as a Helping Authority

The traditional patient-doctor relationship is that of the therapist as a helping authority. As an expert, the therapist is credited with knowledge and skills that can help the patient out of the patient's dilemma. The therapist succeeds or fails in this role in accordance with the degree of manifest skillfulness and the patient's interpretation of the therapist's maneuvers.

The Therapist as an Idealized Parental Image

The patient seeks an idealized parental figure who will grant bounties without stint. The character of this giving image varies with the personal biases of the patient. It ranges from omniscience and omnipotence to mere kindliness and acceptance. Often there is combined in the fantasy image a fusion of ideal paternal and maternal qualities. Accordingly, the patient may desire paternal firmness, strength, wisdom, and power as well as maternal lovingness, support, and protection. The intensity of such attitudes as well as their specific content, will be determined by the kinds of early frustrations experienced by the patient. These attitudes will be enhanced if the therapist seems to be the sort of individual who fits the patient's designs. It will be minimized by the therapist's refusal or inability to play this role.

The Therapist as an Actual Parental Representative

On the basis of previous experience, the patient may project into the therapeutic situation expectations of being treated by the therapist as the patient had previously been treated by his or her parents. The patient will then adopt defenses against the therapist in accordance with these

expectations and fears. Under certain circumstances the patient will even act out with the therapist a rather extensive series of situations representative of those that the patient experienced as a child. Such transference attitudes will be reinforced by a passive attitude on the part of the therapist or by the therapist's actually playing the kind of role with the patient that parallels the role of the parent. Transference will also be expedited by the use of certain techniques, such as the couch position, concentration on dreams, the use of free association, frequent visits, and a focusing on the past history and on conditionings in childhood. It will be minimized by the therapist's increased activity with the patient, the playing of a role opposite to that anticipated by the patient, infrequent visits, the use of the face-to-face position, the avoidance of dreams, fantasies, and free association, and a focusing on the current life situation and present relationships.

The Therapist as a Representative of Other Important Past Personages

The therapist may be employed as an object onto whom transference attitudes may be projected related to other important individuals besides the parents. The therapist may, for instance, be identified with a sibling, an important relative, a teacher, or a friend who has played a signal part in the early life of the patient. The therapist's manner, behavior, and physical appearance may expedite the display of such attitudes.

The Therapist as a Cooperative Partner

The therapist may be regarded as an individual with whom the patient is able to establish a friendly, unambivalent relationship. The patient probably desperately seeks such a relationship, but, on the basis of previous conditionings, may feel that it cannot possibly come to fruition. An objective attitude on the part of the therapist sponsors this kind of relationship.

A blend of several of the above attitudes toward the therapist is usually present at the beginning of treatment. Conflict is inevitable by virtue of the mutual contradictory nature of such disparate attitudes. Which attitudes will prevail will depend on both their intensity and how they are handled by the therapist. It is important that the therapist be equipped by training and experience to recognize and to deal with the patient's multiple strivings so that a cooperative working relationship may eventually

develop.

RESISTANCES TO A WORKING RELATIONSHIP

The length of time required to establish a working relationship will depend upon the skill of the therapist and also on the intensity of resistance exhibited by the patient. Among common resistances are defects in motivation and misconceptions about psychotherapy. Ways of handling such obstacles have been suggested in Chapter 32 "The Initial Interview: Dealing with Inadequate Motivation" and Chapter 34 "Answering Questions Patients Ask About Therapy." Even more important as a source of resistance are character problems that are parcels of the patient's habitually disturbed attitudes toward people.

Perhaps the most obstinate of these characterological, resistances is a clinging, dependent attitude toward the therapist, who is overvalued as the embodiment of all that is good and strong and noble in the universe. This kind of striving is rooted in an intense feeling of helplessness, escape from which is sought in an alliance with a being who can in some magical way lead the person onto paths of health, glory, and accomplishment. Building this being into a power figure who can satisfy one's magical expectations, and allying oneself with the object of one's creation, provides a spurious sense of security and heightened self-esteem.

The patient must be weaned from the attitude toward the therapist as an omniscient personage who can produce a fanciful Nirvana in which all needs are gratified. It is important to convince the patient of his or her own abilities and strengths.

Although recognizing and accepting a patient's dependency need and refraining from insisting on a completely mature relationship, the therapist may give the patient a rational reason for refusing to take the bulk of responsibility and making godlike decisions for the patient. The therapist, in exhibiting an understanding of the patient's need, may explain that supplying the patient's demands will inhibit the patient's self-growth and that it is out of respect for the patient's growth potentials that the therapist is not more active. Such an explanation may help resolve some of the hostility at what the patient otherwise might consider negligence and rejection.

Another unfavorable form of relationship is fear of the therapist as a potentially destructive or

malevolent being who threatens to injure or to engulf the patient by interfering with the patient's autonomy. Here the patient retreats whenever the patient feels the therapist is getting too close. A "testing period" precedes a final acceptance of the therapist as one who bears only good will toward the patient. During this period the patient will be torn between a desire to establish a gratifying relationship and an overpowering fear of injury. The outward manifestation of this struggle may be hostility to the therapist. Some patients may even attempt to provoke and to incite the therapist into acts of aggression to prove to themselves that all human beings are alike and are not to be trusted. This "testing period" will be especially prolonged in patients with immature personality structures, and it may be many months before the therapist is accepted as a friend.

Because of hostility, fear, and guilt, the patient may automatically expect the therapist to be condemning, prohibiting, or punishing for past behavior as well as for present attitudes and impulses. The patient may, therefore, display fear, distrust, or rage toward the therapist as well as defenses against these emotions. When fragmentary revelations of the patient's inner life fail to bring forth the expected punishment or condemnation, the patient may feel contempt for the therapist for failing to respond as a strong authority should respond and may evidence a desire for a more competent—more punitive—therapist.

The patient will usually anticipate criticism from the therapist as merciless as the patient's self-criticism. Furthermore, while the patient has managed to conceal from people personal elements that he or she considers vicious or contemptible, it is difficult to do this with the therapist. The patient will, therefore, constantly anticipate attack or condemnation and will be nonplussed when attack is not forthcoming. The patient may await the evil day when the expected blow will fall or may even become resentful at the delay of the "inevitable." As the patient recognizes that he or she can speak freely and that the therapist considers such revelations as neither good nor bad, the patient may begin to reevaluate concepts of the therapist as an arbitrary authority. A feeling of warmth emerges that is mingled with confidence.

Other strivings in the patient that interfere with a good working relationship are intense sexual feelings toward the therapist, submissiveness, masochistic impulses, and detachment. The handling of a patient's detachment is of particular importance because of its prevalence as a defensive character

pattern. With perseverance and tolerance, detached individuals may eventually be helped to enter a working relationship.

For example, a woman with a personality disorder of detachment comes to treatment because of depression, tension, and feelings of lonesomeness and isolation. She is aware of the fact that close relationships fill her with a sense of foreboding and that soon after a relationship has started, she becomes anxious and wants to run away. In therapy, as she develops confidence in the therapist, the same kind of anxiety and terror emerges, and the patient is seized with an impulse to stop treatment. Her respect for the therapist, however, and her incentive to get well halt the escape. Manifesting warmth, acceptance, and understanding, the therapist interprets what is happening. From a dream in which she crosses a bridge and becomes the target of sharpshooting snipers, the patient learns of her fears of attack in a confining relationship. She recognizes that this fear has been with her for years—as far back as she can remember—and has created the impulse to escape from entangling alliances and even from the threat of coming close to a person. This knowledge enables her to discriminate her feelings in relationship to the new kind of authority that she has perceived in the therapist, to test her anachronistic fears of hurt against her knowledge that the therapist does not desire to injure her. She then veers in her struggle between her old conviction and her new. Temptation to break away from treatment is compelling, but the therapist forestalls escape by pertinent interpretations. Eventually, perhaps for the first time, the patient is capable of accepting a person, the therapist, as a friend rather than a foe. She takes a bold step toward a working relationship.

In helping a patient master fears of a working relationship, the therapist must allow the patient to set the pace. The therapist must respect the patient's hesitation and other defensive mechanisms issuing from the patient's terror of discovering the same destructive potentialities in the therapist that the patient has found in other human beings. The realization of a different type of authority permits the patient to abandon compromising facades that have up to this time served unsatisfactorily to keep anxiety in check.

BUILDING THE RELATIONSHIP

Skill as a therapist is measured to a considerable degree by the ability to establish relationships

with patients that will be therapeutically meaningful to them. While no one is capable of establishing rapport with all people, the therapist should, if equipped with the proper training and personality, be able to relate to the majority of persons who come for help.

Knowledge of interviewing techniques will foster confidence in the therapist and expedite a working relationship. Thus, by appropriate facial expressions, gestures, and sub vocal utterances, the therapist may convey an attentive and accepting manner. By asking pointed questions, restating, summarizing, and other techniques, one may demonstrate to the patient that one is interested and observant. By reflecting feelings and making cautious interpretations geared to the level of the patient's current capacities for understanding, the therapist may exhibit an astuteness and perceptiveness about knowing what is going on in peripheral areas of the patient's awareness.

Specific personality problems of the therapist may, however, inhibit the establishing of such a relationship. For instance, an inability to tolerate hostility may make it difficult for the therapist to develop rapport with a patient who displays hostile outbursts. Or personal sexual problems may cause the therapist to respond with anxiety when the patient tells of sexual fears or impulses with which the therapist is preoccupied or is avoiding. The therapist may then fail to show the necessary warmth, objectivity, and empathy.

From time to time the therapist may experience emotions toward the patient that, if unchecked, may hurt the relationship. Hostility, boredom, apathy, uneasiness, fear, or sexual interest may be provoked by the patient's behavior or inspired by countertransference. Should such emotions emerge, self-searching will be indicated. The following self-directed questions are important:

1. Is the patient doing anything that causes these emotions?

2. Does the patient resemble or remind the therapist of anyone the therapist knows or has known in the past?

3. What does the therapist really feel about a person like the patient?

4. Does the therapist anticipate that the patient will do anything disturbing or upsetting while in therapy?

Arriving at answers to these questions requires a great deal of self-exploration in an attempt to understand any projections that are operative. For example, a patient talks about his deep problems of intolerance with people. As the patient relates several episodes illustrating his intolerance, the therapist becomes aware of a personal feeling of boredom and of not wanting to pay attention to what the patient is saying. She asks herself why such attitudes exist toward the patient, and she suddenly realizes that she considers the patient an extremely hostile person. She recognizes then that she fears a demonstration by the patient of hostility toward her. Knowing of her own problem in handling hostility, the therapist realizes that her boredom is a defensive means of avoiding closer contact with the patient and thus of circumventing any expressed hostility. Challenging the reality of her fear, she finds that she is able to overcome the response of boredom, and she becomes attentive to the productions of the patient. Another therapist may, in feeling irritable with a patient, examine this emotion. In so doing he realizes that he has had similar feelings of irritability with a brother with whom he was competitive and whom the patient resembles slightly. This insight results in a dissipation of the emotion of irritability. A third therapist observes that she feels resentful during a session. Thereupon she notices that the patient is talking about material that is stirring up anxiety within her. Under these circumstances, she may be able to handle her anxiety directly and thus overcome her resentment.

Where the therapist is unable to control disturbed emotions and attitudes by processes of self-observation, in fairness to the patient a referral to another therapist should be made.

There are a number of things that the therapist can do to sponsor a working relationship. Among these are communicating to the patient an understanding of the patient's problem and expressing toward the patient tolerance, empathy, and objectivity.

Communicating an Understanding of the Problem

Every patient wants his or her therapist to be intelligent, sagacious, and perceptive. It is generally not difficult to convince the patient of the therapist's competence by such simple techniques as reflecting unverbalized feelings and attitudes, putting into words the unexpressed worries and concerns of the patient, and displaying sensitivity to the patient's moods and conflicts. Although the therapist is fallible, it is essential to try to avoid expressions of confusion, such as acting bewildered and forgetting important

items of information about the patient. Since merely mortal, the therapist is bound to make mistakes sometimes, but these are not fatal if they do not occur too frequently, and if there is a fairly good relationship with the patient.

An excellent way of demonstrating an understanding of the patient's turmoil is available to the psychoanalytically trained therapist through dream interpretation. Dreams during the first phase of therapy are never interpreted deeply. Since dreams are condensations of a variety of items, including early traumatic experiences, basic conflicts, habitual mechanisms of defense, and present characterological strivings, it is usually easy to select from the dream the kind of content that will satisfy the goals of a particular phase of therapy. In the first phase of treatment important goals relate to a recognition of attitudes and impulses that act as resistance to a working relationship. For instance, a patient presents a dream in which he is traveling on a subway, sitting next to a man who is busily engaged in reading a newspaper. The patient tries to attract the man's attention, but all of his efforts are rebuffed. He finally gets up and leaves the train feeling humiliated.

In examining the dream, we observe the patient attempting to make contact with a man who, detached and disinterested, virtually rebuffs the patient. The dream may reflect a general fear in the patient of being rebuffed by people. We may speculate further that the patient is expressing in the dream a feeling that he is being rebuffed by the therapist. Riding on the subway would then indicate the therapeutic situation. These formulations are, naturally, not communicated to the patient. The method by which they are brought to his attention is illustrated in the fragment of the actual interview that follows:

Th. What thoughts come to your mind as you think about the dream?

Pt. Why nothing. I don't particularly like riding on the subway, but that's nothing. It's the quickest way of getting any place.

Th. Mm hmm.

Pt. And when you're in a hurry it gets you there, *(pause)*

Th. Any other thoughts about a subway?

Pt. No.

Th. Now, how about your feelings in the dream: what were your feelings?

Pt. I was anxious to talk with him, make friends, you see, but he was one of these types of people who was busy with his own things.

Th. What type?

Pt. Well, I should say studious type, not interested in me.

Th. Now what about this man; did he resemble anybody you know or knew?

Pt. Yes, he was like an uncle of mine. He is not too much older than I am. When I was a kid, he used to bring me things. I called him my second father.

Th. Mm hmm.

Pt. And when I was in boarding school, one of my roommates reminded me of him. That was the one I had that homosexual experience with I told you about.

Th. Was there any sexual feeling in the dream?

Pt. No, just that I wanted to know this person better.

Th. And when he didn't respond, how did this make you feel?

Pt. Terrible. I wanted to get out of the train.

Th. Angry?

Pt. No, just irritated.

Th. Now it's possible that when a person isn't responsive enough and giving enough, this may make you want to get out of the situation.

Pt. Yes.

Th. And that might also apply to me. *[a tentative probing for transference*]

Pt. Why ... (pause) why ... I don't think I should feel that way.

Th. After all, there is no reason why you shouldn't. But have you felt this way about me?

Pt. As you said, I shouldn't expect you to do everything for me.

Th. But you may resent the fact that I don't take over more responsibility.

Pt. I know I shouldn't feel that way.

Th. But you *might* feel that way *(pause)*

Pt. (*laughs*) Well I do … sometimes.

Th. And even want to leave treatment.

Pt. (laughs) I did feel that I wanted to quit.

Th. Like you wanted to get out of the subway train in the dream.

Pt. (laughs) Yes, you mean you could be the man on the subway? Come to think of it, I do think it's you.

Th. Do you want to stop therapy?

Pt. Of course not.

Th. Do you feel that I don't want to relate to you, that I don't pay attention to you, or like you?

Pt. Well, as you say, I must think that, but it isn't true.

After several weeks the patient exhibited evidences of greater security in the relationship. This was accompanied by a dream in which the patient saw himself trying to use a pencil that had no lead. A man nearby offered him a new pencil, which he accepted. The patient associated having "no lead in the pencil" to his vitiated masculinity. The man nearby was the therapist who was offering him new masculinity.

Communicating Interest

Showing interest in the patient as a person rather than as a laboratory of pathological phenomena is an important way of helping the relationship. By paying close attention to what the patient is saying about his or her personal life, ambitions, likes, dislikes, and goals, the therapist may indicate nonverbally that the patient is considered a worthwhile individual. Remembering and repeating to the patient personal details that the patient revealed in previous sessions impresses the patient with the genuineness of the therapist's interest. Sometimes the greater part of a session may profitably be spent talking about the patient's work, hobbies, or other random subjects, not for the purpose of eliciting information but to show the therapist's interest. Making necessary financial and time allowances for the patient, and a demonstrated willingness to do what one can for the patient within the bounds of therapeutic propriety, are other manifestations of interest.

Damaging to the relationship are evidences of disinterest, such as forgetfulness about important details that the patient has previously mentioned, reading of one's mail during a session, telephoning in the patient's presence, and other shifts of attention.

The therapist's attitudes toward the patient will, of course, not be the same from day to day. On some occasions, when feeling happy, inspired, and active, one will be responsive, alert, and sensitive to what is going on in therapy. At other times, when feeling slightly depressed, dull, and inactive, one will find one's mind wandering and will be somewhat insensitive to nuances in the therapeutic situation. Sometimes one will be pleased with the patient. Occasionally one may be irritated, particularly when the patient is hostile, aggressive, or accusatory. These ups and downs need not interfere with the setting up of a working relationship, provided that the therapist likes the patient and manages to communicate adequate interest.

Communicating Tolerance and Acceptance

The average patient comes to therapy at the mercy of a medley of moods and attitudes. Helpless in the grip of symptoms that are difficult to control, unable to conceal the resulting turmoil, alternating between arrogance and self-devaluation, the patient may interpret coming to psychotherapy as an insignia of defeat. Yet there is hope that the therapist will somehow magically wipe out existing troubles. Many defenses are mobilized against progress such as minimizing the seriousness of the problems, denying the depth of one's illness, plaintive self-abasing, diffuse expressions of resentment, and masochistic submissiveness.

No matter how mature appearing, the patient will always project into therapy some childish demands, needs, and misinterpretations. In casual relationships the patient may have these under control and may be able to disguise them with various blinds. But the therapeutic relationship will activate suppressed and repressed emotional foci. The patient's usual stratagems will be revealed for what they are. It is for these reasons that consummate permissiveness and understanding must prevail in therapy, with absolute avoidance of indignation and moralistic judgment. If the therapist is able to treat the patient as an adult in spite of the patient's immature feelings, respecting the patient's needs to display childish emotions and strivings and accepting them temporarily as inevitable, the patient will

best be helped to a more mature expression of feeling.

In dealing with the ambivalent emotions of the patient, the therapist must express as lenient understanding and acceptance as possible, neither condemning nor condoning the patient for drives and desires but accepting the patient's right to experience them in their current form. Irrespective of how provocative the patient may act, it is essential that the therapist control personal feelings. Some patients will subject the therapist to a barrage of hostility, accusations, and demands. To respond with counterhostility may prove fatal to the establishing of a relationship. Criticizing the patient for the inability to verbalize or to think clearly about himself or herself must also be avoided. The therapist must evade considering the patient's problems as "faults."

Other activities that sponsor convictions in the patient of the therapist's tolerant, non-punitive, nonjudgmental attitudes are attentiveness to everything the patient says, a calm and accepting facial expression, absence of irritability and emotional outbursts, and lack of expressed or implied condemnation or reproach. The continuing or stopping of therapy should be regarded as a choice of the patient, and the patient should be encouraged in the point of view that coming for treatment is predicated solely on his or her getting something positive out of the experience. Should the patient actually decide to discontinue treatment, this must be handled by the therapist as a manifestation of resistance.

Respect for the patient's defenses and resistances is another way of expressing tolerance. There may be the temptation to charge the patient's resistance to displays of ignorance or stubbornness. But if the therapist realizes that the patient is guarding against a flood of anxiety, it may be possible to display greater forbearance. The therapist must be content at the start of therapy to move at as slow or as rapid a pace as the patient's reactions dictate. There are times, nevertheless, when outrageous and destructive behavior go beyond one's capacities for complacency. Here discriminative confrontation, non-condemning challenges, and interpretation will be necessary.

Communicating Objectivity

Objectivity is insured by a non-punitive manner in the face of any attitudes, demands, or ideas

expressed by the patient. A sense of humor, the ability to take criticism, and an unflagging respect for the patient are other traits that help establish the therapist's objectivity. In handling personal feelings, the therapist should keep in mind the fact that the attitudes of the patient are not necessarily permanent ones.

Acknowledging the patient's right to opinions, even though they may be faulty, helps to convince the patient that he or she is not dealing with a despot. Other ways of demonstrating one's objectivity are by abstaining from imposing on the patient one's personal opinions, philosophies, judgments, and values and by observing the patient's right to self-determination, once the patient has become cognizant of internal motives. At all costs the therapist should avoid situations that make the patient feel that the patient must yield to the bias of a superior authority. This does not mean that the therapist condones or encourages neurotic tendencies; the therapist merely tolerates them temporarily, as long as they do not interfere with the treatment process. Should they obstruct therapy, the therapist deals with them actively as manifestations of resistance.

Communicating Empathy

All people have the craving to be liked. Neurotic problems make them feel unloved and incapable of evoking sympathetic responses from others. Yet they long to be appreciated in spite of their convictions of having no worth. By communicating empathy, the therapist attempts to convey to the patient a feeling that the patient's turmoil is understood. But communicating empathy presupposes that one *feels* empathic. There are no general rules about how to turn on such feelings. When interviewing a patient for the first time one may ask: (1) What is there about this person that I dislike—facial expression, manner of speaking (complaining, attacking, obsequiousness, pleading), content of communications, bodily movements, eyes, gait, aggressiveness? (2) What is there about this person that attracts me—physical appearance, manner, seductiveness?

Analyzing those reactions, one speculates how these may impair one's judgment, objectivity, and neutrality. The therapist may ask: "How would I feel if I had gone through what the patient has experienced, and if I were in the patient's situation now?"

Among the measures that may be employed toward this end are verbalizing for the patient how upset the patient must feel; elaborating on some of the obvious conscious conflicts that plague the patient, explaining why these may be disturbing; recognizing the patient's feelings and seeing things from the patient's point of view; being frank and sincere with the patient and accepting him or her in spite of any "bad" qualities that present; and expressing warmth, not in words, but by gestures, facial expressions, and other types of nonverbal behavior. Nothing is more damaging to the relationship than displaying a stilted, detached, and cold attitude toward the patient. Sometimes such an attitude is practiced by certain therapists in an effort to maintain anonymity. Usually this kind of behavior is interpreted by the patient as evidence of the therapist's unfeelingness.

The therapist must be able to extend support and reassurance to the patient when these are needed. Such measures are, of course, graded to the degree of shattering of the patient's adaptive powers and are not to be confused with domination or overprotection. A strong deterrent to the giving of necessary support is a fear in the therapist of making the patient dependent on the therapist. At the inception of therapy all patients are dependent to a greater or lesser degree, irrespective of the activity of the therapist. The dependency is not avoided by a detached attitude, nor does it necessarily become hypertrophied by a display of interest or warmth.

Empathy must also be demonstrated when the patient manifests hostility. One way of handling undifferentiated hostile feelings is by accepting them as inevitable. A casual explanation such as the following may be very reassuring to the patient: "People who suffer a great deal may become resentful toward the world and toward themselves. You may be angry at the fact that you are suffering, or that you need help, or that you have to come to see me. You may be angry at me for various reasons. And this is to be expected." Further responses will be determined by the reactions of the patient to this explanation.

Once empathy is communicated, the patient may experience considerable relief or there may be an abatement of symptoms. This may be due to a certain measure of psychological appeasement or to a feeling in the patient that he or she no longer is alone and helpless. It may be due to a concomitant emotional unburdening or because of the reassurance gained through contact with the therapist. This improvement, sometimes called a "transference cure," is usually temporary, lasting as long as the relationship with the therapist yields important satisfactions. The improvement may continue

indefinitely if coincidentally there is an amelioration of the stress-producing circumstance or if the patient has been able to master the stress situation in some way. This may be the sole goal in supportive therapy. In reeducative and reconstructive therapies, however, any relief achieved by this means is considered inadequate unless it is accompanied by more substantial behavioral changes.

Not all patients respond eagerly to a caring attitude evinced by the therapist. There are some, admittedly few, who prefer to work with a distant and impersonal therapist. But here we usually find that this need for a detached therapist is probably a defense against involvement, dependency, and being controlled, the analysis and working through of which may be highly productive. Being caring and empathic, however, does not justify overly supportive and smothering behavior.

It must be remembered that years of bitterness in the patient's human relationships may have eroded the patient's confidence in people in general. The therapist should, therefore, not be disappointed if the patient does not immediately become a confidant. It is necessary to prove to the patient by demonstrating through actions that the therapist is worthy of acceptance and trust. This may take time, particularly with the sicker patients and those who have severe problems with authority. Whether the therapist is capable of demonstrating empathy toward all patients is another matter. There is no valve that one can turn on to permit the flow of this feeling. The best one may be able to do if there is little interest in the case is to examine one's feelings.

SUNDRY RULES' FOR BUILDING OF THE RELATIONSHIP

It is not necessary to employ special tricks to establish a good working relationship. This will be readily forthcoming if the therapist has the proper training and personality. There are a number of rules that may help build a relationship more rapidly, however. These are illustrated in the following group of "unsuitable" and "suitable" responses to sundry questions asked by patients.

1. *Avoid exclamations of surprise.*

Pt. I never go out on a date without wanting to scream.

Unsuitable responses

Th. Well, for heaven's sake!

Th. That's awful!

Th. Of all things to happen!

Suitable responses

Th. I wonder why?

Th. Scream?

Th. There must be a reason for this.

2. *Avoid expressions of overconcern.*

Pt. I often feel as if I'm going to die.

Unsuitable responses

Th. Well, we'll have to do something about that right away.

Th. Why, you poor thing!

Th. Goodness, that's a horrible thing to go through.

Suitable responses

Th. That must be upsetting to you.

Th. Do you have any idea why?

Th. What brings on this feeling most commonly?

3. *Avoid moralistic judgments.*

Pt. I get an uncontrollable impulse to steal.

Unsuitable responses

Th. This can get you into a lot of trouble.

Th. You're going to have to put a stop to that.

Th. That's bad.

Suitable responses

Th. Do you have any idea of what's behind this impulse?

Th. How far back does this impulse go?

Th. How does that make you feel?

4. *Avoid being punitive under all circumstances.*

Pt. I don't think you are helping me at all.

Unsuitable responses

Th. Maybe we ought to stop therapy.

Th. That's because you aren't cooperating.

Th. If you don't do better, I'll have to stop seeing you.

Suitable responses

Th. Let's talk about that; what do you think is happening?

Th. Perhaps you feel I can't help you.

Th. Is there anything I am doing or fail to do that upsets you?

5. *Avoid criticizing the patient.*

Pt. I just refuse to bathe and get my hair fixed.

Unsuitable responses

Th. Are you aware of how unkempt you look?

Th. You just don't give a darn about yourself, do you?

Th. That's like cutting off your nose to spite your face.

Suitable responses

Th. There must be a reason why.

Th. Do you have any ideas about that?

Th. How does that make you feel?

6. *Avoid making false promises.*

Pt. Do you think I'll ever be normal?

Unsuitable responses

Th. Oh, sure, there's no question about that.

Th. In a short while, you're going to see a difference.

Th. I have great hopes for you.

Suitable responses

Th. A good deal will depend on how well we work together.

Th. You seem to have some doubts about that.

Th. Let's talk about what you mean by normal.

7. *Avoid personal references or boasting.*

Pt. My six-year-old child is balking at going to school. It annoys me.

Unsuitable responses

Th. I know exactly how you feel; I went through that myself with my youngster.

Th. I'd feel exactly the way you do under the circumstances.

Th. I'm glad you bring that up because I'm kind of an expert on managing problems of this kind.

Suitable responses

Th. Annoys you?

Th. Do you have any idea why your child is balking?

Th. It must be upsetting to you.

8. *Avoid threatening the patient.*

Pt. I don't think I can keep our next two appointments because I want to go to a concert on these days.

Unsuitable responses

Th. You don't seem to take your therapy seriously.

Th. If you think more of concerts than coming here, you might as well not come at all.

Th. Maybe you'd better start treatments with another therapist.

Suitable responses

Th. I wonder why the concerts seem more important than coming here.

Th. Maybe it's more pleasurable going to the concerts than coming here.

Th. What do you feel about coming here for therapy?

9. *Avoid burdening the patient with your own difficulties.*

Pt. You look very tired today.

Unsuitable responses

Th. Yes, I've been having plenty of trouble with sickness in my family.

Th. This sinus of mine is killing me.

Th. I just haven't been able to sleep lately.

Suitable responses

Th. I wouldn't be surprised, since I had to stay up late last night. But that shouldn't interfere with our session.

Th. I've had a touch of sinus, but it's not serious and shouldn't interfere with our session.

Th. That comes from keeping late hours with meetings and things. But that shouldn't interfere with our session.

10. *Avoid displays of impatience.*

Pt. I feel helpless and think I ought to end it all.

Unsuitable responses

Th. You better "snap out of it" soon.

Th. Well, that's a nice attitude, I must say.

Th. Maybe we had better end treatment right now.

Suitable responses

Th. I wonder what is behind this feeling.

Th. Perhaps there's another solution for your problems.

Th. You sound as if you think you're at the end of your rope.

11. *Avoid political or religious discussions.*

Pt. Are you going to vote Republican or Democratic?

Unsuitable responses

Th. Republican, of course; the country needs good government.

Th. I'm a Democrat and would naturally vote Democratic.

Suitable responses

Th. Which party do you think I will vote for?

Th. Have you been wondering about me?

Th. I wonder what you'd feel if I told you I was either Republican or Democrat. Would either make a difference to you?

Th. I vote for whomever I think is the best person, irrespective of party, but why do you ask?

12. *Avoid arguing with the patient.*

Pt. I refuse to budge an inch as far as my husband is concerned.

Unsuitable responses

Th. It's unreasonable for you to act this way.

Th. Don't you think you are acting selfishly?

Th. How can you expect your husband to do anything for you if you don't do anything for him?

Suitable responses

Th. You feel that there is no purpose in doing anything for him?

Th. Perhaps you're afraid to give in to him?

Th. How do you actually feel about your husband right now?

13. *Avoid ridiculing the patient.*

Pt. There isn't much I can't do once I set my mind on it.

Unsuitable responses

Th. You think a lot of yourself, don't you?

Th. Maybe you exaggerate your abilities.

Th. It sounds like you're boasting.

Suitable responses

Th. That puts kind of a strain on you.

Th. Have you set your mind on overcoming this emotional problem?

Th. You feel pretty confident once your mind is made up.

14. *Avoid belittling the patient.*

Pt. I am considered very intelligent.

Unsuitable responses

Th. An opinion with which you undoubtedly concur.

Th. The troubles you've gotten into don't sound intelligent to me.

Th. Even a moron sometimes thinks he's intelligent.

Suitable responses

Th. How do *you* feel about that?

Th. That's all the more reason for working hard at your therapy.

Th. That sounds as if *you* aren't sure of your intelligence.

15. *Avoid blaming the patient for his or her failures.*

Pt. I again forgot to bring my doctor's report with me.

Unsuitable responses

Th. Don't you think that's irresponsible?

Th. There you go again.

Th. When I tell you the report is important, I mean it.

Suitable responses

Th. I wonder why?

Th. Do you know why?

Th. Perhaps you don't want to bring it.

16. *Avoid rejecting the patient.*

Pt. I want you to like me better than any of your other patients.

Unsuitable responses

Th. Why should I?

Th. I don't play favorites.

Th. I simply don't like a person like you.

Suitable responses

Th. I wonder why you'd like to be preferred by me.

Th. Perhaps you'd feel more secure if I told you I liked you best.

Th. What *do* you think I feel about you?

17. *Avoid displays of intolerance.*

Pt. My wife got into another auto accident last week.

Unsuitable responses

Th. Those women drivers.

Th. Women are sometimes tough to live with.

Th. The female of the species is the more deadly of the two.

Suitable responses

Th. How does that make you feel?

Th. What do you think goes on?

Th. How did you react when you got this news?

18. *Avoid dogmatic utterances.*

Pt. I feel cold and detached in the presence of women.

Unsuitable responses

Th. That's because you're afraid of women.

Th. You must want to detach yourself.

Th. You want to destroy women and have to protect yourself.

Suitable responses

Th. That's interesting; why do you think you feel this way?

Th. How far back does this go?

Th. What feelings do you have when you are with women?

19. *Avoid premature deep interpretations.*

Pt. I've told you what bothers me. Now what do you think is behind it all?

Unsuitable responses

Th. Well, you seem to be a dependent person and want to collapse on a parent figure.

Th. You've got an inferiority complex.

Th. You never resolved your Oedipus complex.

Suitable responses

Th. It will be necessary to find out more about the problem before I can offer a valid opinion of it.

Th. We'll continue to discuss your attitudes, ideas, and particularly your feelings, and before long we should discover what is behind your trouble.

Th. That's for us to work on together. If I gave you the answers, it wouldn't be of help to you.

20. *Avoid a dogmatic analysis of dreams.*

Pt. I had a dream the other day. I was sitting in the kitchen and food was being spilled on the floor by someone. When I tried to pick it up, someone kicked me in the face, and then I saw a man standing with a knife ready to stab me in the back.

Unsuitable responses

Th. This dream indicates fear of a homosexual attack.

Th. You must feel orally deprived.

Th. Your mother must have been a depriving woman.

Suitable responses

Th. What does this dream seem to indicate to you?

Th. What associations come to your mind?

Th. How did the dream make you feel?

21. *Avoid the probing of traumatic material when there is too great resistance.*

Pt. I just don't want to talk about sex.

Unsuitable responses

Th. You'll get nowhere by avoiding this.

Th. You must force yourself to talk about unpleasant things.

Th. What *about* your sex life?

Suitable responses

Th. It must be hard for you to talk about sex.

Th. All right, you can talk about anything else that you feel is important.

Th. Sex is always a painful subject to talk about.

22. *Avoid flattering and praising the patient.*

Pt. Do you like this dress?

Unsuitable responses

Th. You always show excellent taste in clothes.

Th. I think you make a very excellent appearance.

Th. Any man would find you attractive.

Suitable responses

Th. Yes, but why do you ask?

Th. Do *you* like it?

Th. Perhaps you wonder what I think of you?

23. *Avoid unnecessary reassurance.*

Pt. I think I'm the most terrible, ugly, weak, most contemptible person in the world.

Unsuitable responses

Th. That's silly. I think you're very good looking and a wonderful person in many ways.

Th. Take it from me, you are not.

Th. You are one of the nicest people I know.

Suitable responses

Th. Why do you think you feel that way?

Th. How does it make you feel to think that of yourself?

Th. Do others think the same way about you?

24. *Extend reassurance where really necessary.*

Pt. I feel I am going insane.

Unsuitable responses

Th. Maybe you are.

Th. Sometimes this happens even with treatment.

Th. If you do go insane, you still can be treated.

Suitable responses

Th. I find no evidence of insanity in you.

Th. The feeling of going insane is one of the most common symptoms in neurosis. Fortunately, it rarely happens.

Th. I wonder if you aren't really worried about what may happen to you in other ways too.

25. *Express openmindedness, even toward irrational attitudes.*

Pt. I think that all men are jerks.

Unsuitable responses

Th. That's a prejudiced attitude to hold.

Th. You ought to be more tolerant.

Th. With such attitudes, you'll get nowhere.

Suitable responses

Th. What makes you feel that way?

Th. Your experiences with men must have been disagreeable for you to have this feeling.

Th. Understandably you might feel this way right now, but there may be other ways of looking at the situation that may reveal themselves later on.

26. *Respect the right of the patient to express different values and preferences from yours.*

Pt. I don't like the pictures on your walls.

Unsuitable responses

Th. Well, that's just too bad.

Th. They are considered excellent pictures by those who know.

Th. Maybe your taste will improve as we go on in therapy.

Suitable responses

Th. Why?

Th. What type of pictures do you like?

Th. What do you think of me for having such pictures.

27. *Clarify the purpose of the interview as often as necessary.*

Pt. But what am I supposed to do to get well?

Unsuitable responses

Th. Well, you just let me take care of that.

Th. Once you get confidence in me, you'll start getting well.

Th. The more cooperative you are, the quicker you will get well.

Suitable responses

Th. We will talk over your problems and your ideas about them. Things will then gradually clarify themselves, and you will get a better idea of what to do about your problems.

Th. In discussing your reactions, your ideas, and your feelings, you will be better able to understand what is happening to you, and the understanding will permit you to take definite steps to correct your difficulty.

Th. It may puzzle you as to how talking things over helps, but that is the way to understand yourself and your problems. When all the facts are known to you, the solution to your troubles will become clearer.

28. *Make sympathetic remarks where indicated.*

Pt. My husband keeps drinking and then gets violently abusive in front of the children.

Unsuitable responses

Th. Why do you continue living with him?

Th. Maybe you do your share in driving him to drink.

Th. He's a no-good scoundrel.

Suitable responses

Th. This must be very upsetting to you.

Th. It must be very difficult to live with him under these circumstances.

Th. You must find it hard to go on with this kind of threat over you.

SIGNS OF A WORKING RELATIONSHIP

Evidence of a working relationship are, on the part of the therapist, liking the patient, making emotional contact with the patient, eliciting good response from the patient, feeling able to help the patient irrespective of the syndrome or the severity of the condition. On the part of the patient there are verbal and nonverbal evidences of liking, feeling relaxed with, and being confident in the therapist.

The length of time it requires to establish a relationship will vary. With some patients a working relationship can be established in the first session. With many patients a dozen sessions may be needed. Occasionally, with patients who are fearful, detached, hostile, or unmotivated or with therapists who have problems in relating to patients, one or more years may be required before a relationship develops. When severe transference and countertransference reactions interfere with the setting up of a working relationship, they will have to be dealt with before any progress can be made.

The following is from a session illustrating the beginning of a working relationship. It is an excerpt from the sixth session with a divorced woman of 32, who came to therapy because of anxiety, tension, and feelings of detachment from people. The first four sessions were spent discussing her problem generally. During the fifth session she introduced with some anxiety the idea that she believed her problem to be due to suspected sexual experiences in her childhood, when she might have been seduced by her father, her mother, and perhaps her sister. She has no recollection of such experiences, but this was, in her opinion, due to amnesia, since her dreams were often about sex with members of her family. Although I was tempted to underplay the possibility of such a situation, I listened attentively to her theories and remarked that a situation about which she felt so strongly must be taken seriously. The attitude I envinced was one of neither endorsement nor rejection of her theory, but one of acceptance of her right to entertain the ideas that she had, which we were obliged to explore. This attitude seemed to

precipitate the working relationship since it apparently meant that I was tolerant and accepting.

Pt. I don't know exactly where to begin because I don't feel as desperate as I did the last few times.

Th. Mm hmm.

Pt. I certainly have a feeling. I'm grateful for the last, the last session because you went out of the way, as far as I was concerned. I'm glad you had me speak it out, because if I hadn't done it, I probably wouldn't have mentioned it again, because it was fresh then and it did mean a lot to me.

Th. In what way?

Pt. That you understand what I'm thinking about and how I feel about things, and so on.

Th. I see.

Pt. And you took me seriously. Whether you believed it or not is beside the point, but you did take me seriously, which is very important to me.

Th. Mm hmm.

Pt. And I felt relieved that you understood me. It's so hard to find anybody who really understands. I realized that the fact that you took me seriously was important to me. If you take *me* seriously then I can take *you* seriously. Not that I didn't think that before, but it gave me a certain base. Then I went further and realized something I had, of course, known before, and that is if a person has faith in me, or believes in me, not me, but in me, that's the biggest compliment they can give me. And then I will do anything for them. It must be I want to have that feeling toward you.

Th. Mm hmm.

Pt. And then I can in turn respond. But I can't give it first. I mean I have to see that my basis for exposing myself emotionally, so to speak, is respected.

Th. Yes.

Pt. So that's how it is. *(pause)*

Th. Apparently you had a suspicion when you came here that I might not understand how you feel, that I might not understand you.

Pt. Yes, I was aware of that, and the reason I felt anxious about it was that I just didn't know if you would reject me. And another thing, when you keep emphasizing that I should tell you about anything I feel about you, whether you do anything in any way to annoy me, I felt, it occurred to me, that maybe you meant that you wondered how I felt about you being Jewish. I don't know if you are or not, but you know it would be a sensible thing to think about. But I wouldn't think two minutes about it. Each time I come it is a good experience. I thought maybe you were referring to whether I had any feelings for, or against, or about Jewish people. *(laughs).*

Th. Do you?

Pt. Why no, of course not.

Th. Actually I didn't have that in mind, but it's important to express whatever thoughts you may have about our relationship.

Pt. That's interesting. I'm very glad.

Th. It is possible that you might have certain prejudices about Jewish people, which are, as you know, common; or, it may be, as you say, that you do not have prejudices.

Pt. Oh, those feelings are nonexistent in me.

Th. Do you have other feelings about me?

Pt. My feelings about you are very good. I have come in contact with other people. I am opinionated. But nothing could have set us on firmer ground than by my walking in here, and you took me as I was. You didn't question, you didn't probe about all sorts of things. I mean my seriousness about it; many things that you could have in the best of faith, but you didn't. That could not have made me feel better. I walked in as a stranger, and you accepted me. I know you are important in your profession, and you have to be selective in a certain sense. I didn't come here with any recommendations. I didn't write you a letter; I just picked up the phone, feeling I've got to do something, and I got an appointment. I walked in and felt very relaxed and very easy. I know that I can feel that way, and I know that I'm not unselective myself. There were things, many things that were bothering me, but you let me choose my words and didn't interfere.

Th. Your feeling is a good one and will help us work more readily with your problem.

Pt. I feel that if a person has faith and respect for me and I can give it back, that I will really be able to get help. I have a full acceptance of you. There are things within me, but they don't concern you. You, yourself, don't cause me anxiety.

Th. Well, if I ever do, I'd like to have you tell me so that we can try to iron out our relationship.

Pt. It's very necessary to keep myself straight in all relationships, and I'm sure it would be doubly necessary with you. I feel I can do it with you although maybe things may happen later on in our relationship. [*It is possible that the patient is anticipating transference, which actually developed quite strongly as we began exploring her problem in the second phase of therapy.]*

Th. What do you think may happen?

Pt. I don't know, *(pause)*

Th. Something I may say or do?

Pt. I have no idea except that anything I would tend to take exception to would be something you would say. *(pause)*

Th. Mm hmm. *(pause)* About you?

Pt. No not necessarily. You seem to be very sensitive, and you seem to have omitted all the little difficulties that could

arise from a person being somewhat insensitive and not being aware of the condition the patient is in, being pretty much on the defensive. You never violated anything like that. And what I like about it is that you act natural, as if you're not putting on an act to get along.

Th. All right, now that we seem to have a good understanding, we can talk about what we will do in approaching and understanding this problem of yours. *[The therapeutic situation is structured for the patient at this point.]*