Theodore Lidz

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The Person

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e-Book 2016 International Psychotherapy Institute

From *The Person* by Theodore Lidz

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The Therapeutic Relationship

This chapter will move beyond the dynamics of personality development to consider some essential aspects of the therapeutic relationship. The practice of medicine or psychotherapy, or relating properly to a patient or "client" as a nurse, social worker, or clinical psychologist, requires profound knowledge of people, and this book has sought to provide a guide for studying people and learning from relationships with them. Knowledge about persons and their development, however, does not assure a capacity to relate effectively and therapeutically with them. A major difficulty in the practice of medicine, and particularly in the related disciplines concerned with the treatment of people's problems in living, is that the therapist's major instrument is the self. Good physicians, even before their differentiation from medicine man or priest, relied upon their personal powers to help promote healing, and have needed to be students of people. The advances of scientific medicine that have eradicated so many diseases during the past century have not diminished the importance of the physician as a person; and they have made possible the turning of more time and attention to problems of living rather than to the preservation of life. The focusing of increased attention on personality functioning and malfunctioning during the past decades permits a more rational attitude in working with the irrational, and has provided guidelines for assuring more useful therapeutic relationships. As we are not here concerned primarily with pathology or its therapy, attention will be directed only toward an essential aspect of the therapist's relationships with patients that rests upon the understanding of personality development. We shall consider the *transference* relationships between patient and therapist and how they are critical to clinical work in all fields of medicine and form the core of psychotherapeutic activities.

"TRANSFERENCE"

The term "transference" refers to the unconscious tendencies to relate to another person in terms of a prior relationship, basically in terms of a childhood relationship with a parental figure, transferring to the other person attributes of the parental figure or another significant individual with whom he or she is being identified. Although such transferences occur in all important relationships, coloring and obscuring the characteristics of the person with whom one is interacting, they are of particular moment in

medicine where the physician has a unique importance to the patient, and in relationships with any therapeutic figure upon whom a person depends and toward whom the person is apt to feel dependent.

Before discussing the transference relationship, let us consider some rather typical and clear-cut episodes that occurred on the medical service of a university hospital. A third-year medical student has just started his clinical clerkship in internal medicine. His position, in essence, is that of assistant to the intern, learning through active participation under close supervision in the work of the medical service. He is assigned a young woman patient, he elicits a detailed history of her current illness and past health record, and he performs a physical examination. Like all students at the start of their clerkship experience, he is uneasy and rather insecure because he is still hesitant and awkward in carrying out his duties. Nevertheless, after a few days he notes, or others remark, that his young woman patient seems to have improved; at least she has perked up and gained sufficient energy to apply eve shadow and lipstick and arrange her hair carefully each morning. She has her sister bring in her silk nightgowns and a new dressing robe. She always greets the student with a pleasing smile, and recalls some additional information to impart to him. She asks his advice concerning the operation on her heart that is being considered. When the student asks her what the professor has advised, the patient imparts her lack of confidence in the professor's opinion because he is so very busy that he can have little time to think about her and her heart; she places the most weight on the student's judgment. The student tries to stifle his joy at having been assigned a patient who is so astute as to recognize ability when she encounters it. He sits down and offers his considered opinion, based on his experience with one other similar case and his reading in the textbook (written by the professor).

Another student is not so fortunate in the assignment of patients. He helps with the care of a truck driver with severe liver disease admitted late in the evening. The student stays up most of the night with the house staff testing urine specimens, drawing samples of blood, helping to give intravenous fluids, holding the patient's head when he vomits, etc. The next morning he wearily drags himself from bed after a couple of hours' sleep and rushes to the ward, where he is pleased to hear that the patient is doing nicely. He happily walks into the patient's room to draw some blood, and is taken aback when he is assailed by a series of choice invectives from the patient, who wishes to be left alone, and who accuses the student of having collected sufficient blood during the night to support himself for a month. Every friendly approach is met by a renewed outburst in which the patient makes it clear that he despises the

student and his canine forebears. The student begins to feel that the efforts of the previous night had been a mistake, for the man was not worth saving, and he lets the patient know it.

Although these examples may seem to gild the lily, they are actual occurrences that may perhaps have become a bit polished in the telling. It is sometimes difficult for physicians to follow Osier's (1963) advice and retain their equanimity, but recognition of the transference nature of both the young woman's admiration and the truck driver's hostility could have helped both students to keep their feet on the ground and use such situations to gain better understanding of the person they were treating. Neither of these patients knew much about the students, and the woman had little reason to become enamored of one or the man to hate the other. They were relating primarily to symbolic figures in terms of earlier relationships to some significant persons. The young woman with the damaged heart valve was unconsciously seeking security, when she was dependent and rather helpless, by seductively wooing a man to look after her much as she had learned to gain her way with her father. The truck driver carried a chip on his shoulder, for he felt that if he had to be dependent and rely on am man he would be used and victimized just as his father had forced him to work when he was a boy and had appropriated his earnings until he ran away from home. Neither of these patients' responses was suited to the students' behavior, but being sick and dependent had provoked old patterns of reactivity. If therapists recognize the tendencies of patients to identify them with earlier significant figures in the patients' lives, they need not take such reactions personally, but can more dispassionately observe the patients' ways of relating to them and utilize the understanding they gain in the management of their patients.

The ability to utilize the self as an instrument for comprehending and gaining insight into the patient's ways of reacting and relating and for influencing treatment, requires an objectivity about one's own feelings and behavior and knowledge that comes only with experience. It is among the most difficult skills required of a therapist. Still, in the illustrations we have used, it was fairly obvious to anyone other than the students involved that the woman had no logical reason to consider her student-clerk the best physician available, and the student should have been able to realize that he was neither Rex Morgan nor Sir William Osier; and that the man had no grounds for such violent antipathy toward a person seeking to help save his life.

All relationships, particularly new relationships, contain elements of earlier ones. Our judgment of

a new acquaintance is based upon experiences with others of whom they remind us. We size up new persons by consciously and even more unconsciously fitting them into the pattern of someone we have known, or a class of persons we have known. Stereotypes can, of course, save considerable energy and even keep us from knowing persons as individuals. However, an astute observer may gain considerable knowledge about a person by recognizing subtle similarities to others. Transference situations are usually more loaded emotionally. The intense relationships with parental figures in childhood become an integral part of the personality and influence the entire behavioral pattern of a person. Various childhood distortions of the relationship with parents and feelings about them are usually partially corrected as an individual gains maturity and a secure ego identity; but some childhood feelings and perceptions remain, and others are very likely to become reactivated during periods of intense emotional insecurity. The life patterning established by the transactions within the family of origin strongly directs an individual toward fitting new significant persons into the pattern, changing them to fit, or persons are selected to be significant who fit into the life patterning. As has been discussed in the two preceding chapters, there is a fundamental tendency throughout the course of life to pour the new into an old mold; to deal with persons according to past experiences. Such repetitive tendencies are usually more prominent in emotionally disturbed persons or during times of emotional disturbance.

The Therapist's Position and Role

Patients do not consider the therapist simply as another person, and the relationship is not a casual matter to them. Patients come to physicians with needs they cannot manage by themselves, no matter how mature and self-sufficient they may be about nonmedical matters; and persons come for psychotherapeutic or casework help because they can no longer cope effectively. The difficulties are usually worrisome, interfering with patterns of living and threatening the person's well-being. Patients expect that when they place themselves in a therapist's hands, their health and welfare will be of primary importance to the therapist. The therapeutic relationship rests upon the tradition of the doctor-patient relationship; and physicians long held an especially prestigious place in society because, along with the clergy, they were expected to place the patient's welfare on a par with their own. Indeed, they were expected to risk their lives regularly in caring for the sick; and until the serious infectious diseases were brought under control during recent decades, they could give but little thought to their own safety

while caring for the ill. They continue to do whatever they can for a patient—whatever lies within their abilities—not because of their own needs, or because of some personal relationship to the patient, but simply because patients come to them in their role as physicians. As other professions have moved into the healing arts, or become adjuvants to medicine, they have to a greater or lesser degree assumed a similar role. One of the problems has been that few such professions, aside from nursing, have been taught in a similar life-and-death setting which emphasizes the difficulties and burdens of assuming responsibilities. Patients, however, expect any therapist to consider their well-being as a physician would—or should.

THE TRANSFERENCE RELATIONSHIP

The conventions inherent in the physician's role and status help predetermine the nature of the transference relationship in therapy. Patients must place their therapists in positions of authority if they are to feel secure, and they tend to make a therapist as omniscient and omnipotent as possible. They seek to endow the therapist with the qualities of a parental figure who will care for them and protect them. Thus, to a much greater extent than in most relationships, the therapist is regarded as a parental person and the characteristics of one or both parents are often transferred to the therapist, a process which reactivates patterns of interrelating that were used with a parent. The age and sex of the therapist make relatively little difference. The most virile physician may be perceived by a patient very much in terms of the patient's mother, and an aged woman may regard the young intern as she would a father figure. Recognition of such general trends which so often enter into the therapeutic relationship provides therapists with an orientation that guides them in using themselves helpfully. Blindness to the nature of the relationship engenders trouble.

Let us consider an example that is not so gross as the problems encountered by the medical students. A woman who is seriously ill requires considerable attention from the physicians and nursing staff. She is appreciative and complains little despite intense suffering. Then, as her illness comes under control, her complaints increase rather than subside. At times she resembles a whining child and the ward personnel have trouble containing their annoyance and begin to avoid her. The physicians become concerned and repeat several expensive procedures to make certain that she is recovering properly. The head nurse, however, notes that her complaints fluctuate during the day in a way that relates to changes

in personnel rather than in her fever chart. One particular older staff nurse had spent much time with the patient during the critical phase of her illness. If, when this nurse comes on duty, she first sees the patient and spends a few minutes with her, everything goes well; but if she carries out some procedure with another patient first, the woman has many complaints by the time the nurse reaches her. The circumstances become fairly apparent to the perceptive head nurse when this patient occupies a double room with a very ill patient. If the particular nurse pays more attention to the roommate, difficulties arise and the patient becomes petulant and childish. Indeed, she reacts badly when she receives less attention than the other patient from any of the staff, but it is most obvious with her favorite nurse. The patient, as subsequent discussions with the psychiatrist revealed, had again become a child, having regressed markedly as do many seriously ill persons. She again had in the nurse a benevolent mother who was concerned about her and carefully nursed her; she became an envious child as she had many years before when her mother seemed more interested in her younger sister who had been in bed for many months with a chronic illness and required considerable attention. The patient now as in childhood sought to regain maternal attention by emphasizing her own needs in a hypochondriacal manner.

Misuse of Transference Phenomena

Knowledge of the transference aspects of patients' behavior, particularly a little knowledge about transference phenomena, can lead to its misuse by therapists in order to protect themselves from a patient's criticisms. Not all of a patient's misapprehensions, antagonisms, desires to change therapists or to leave treatment, derive from transference problems. Transference difficulties should not be blamed for resentments induced by failures to understand, thoughtlessness, mistakes, or neglect. Hospitals, for example, can provoke considerable aggravation in the bedridden patient. A patient can become annoyed by senseless hospital routine, lengthy waiting for a bedpan, cold and scarcely edible hospital food. A therapist may usefully wonder with the patient why these inconveniences produce such excessive reactions, but time and aggravation can usually be spared by reserving consideration and discussion of transference problems for significant situations for which the therapist's behavior or current circumstances are probably not responsible and the patient's reactions seem inappropriate. In most situations in medical practice, transference difficulties are considered primarily when a patient's behavior appears out of place, exaggerated, or based on misunderstandings.

Transference in Psychotherapy

In medical practice, general social casework, and other situations where the therapist is not specifically trained in the utilization of transference phenomena, they serve primarily as a guide to more effective use of the therapist-patient relationship. But in psychotherapy, transference serves as a major means of gaining understanding of a patient's basic attitudes and ways of relating, and often as a major therapeutic lever in bringing about changes in the patient's attitudes and ways of understanding others.

A psychiatrist who practiced psychoanalytically oriented therapy became ill and canceled his appointments for a day. The following morning, his first patient told him that she was glad to have had the extra hour, for she had been extremely busy at her job and would have needed to remain overtime had he kept the appointment. In fact, she continued, missing the session may have been more helpful as it gave her time to talk to her boss about some of her difficulties and he was very understanding and gave her some sound advice. As the psychiatrist had returned to his practice before he was fully recovered because he believed that this particular patient might become upset if he were ill, he could have become annoyed to hear her say that she was glad he had missed an hour with her and that her boss was able to give advice that the psychiatrist withheld or could not give. However, he simply listens and it soon becomes apparent that the patient is trying to tell herself and her psychiatrist that she will not let herself be hurt by needing someone badly and then be left in the lurch by him. She will make it clear to her psychiatrist that he is not so very important to her. This is an old pattern that has kept her from forming any close relationships and one of the reasons she is still single and turning into a spinster. The psychiatrist eventually comments in an offhand way that he recognizes that she is not angry because he staved home on the preceding day and it does not matter if he or anyone else is really interested in her or not. Tears begin to trickle down the patient's cheeks, and when she tries to talk she finds herself sobbing that she did not really mean that; and, now, she feels for the first time the importance of her denial of her wishes and needs to be cared for and to be taken care of, a recognition which she has managed to evade in therapy except in intellectual discussions which were kept isolated from emotional context. She then goes on to consider her loneliness as a child and how her father was only interested in her brothers, with whom he could fish and hunt.

Another patient had heard that the psychiatrist had been ill. She starts her hour by expressing her

concerns about his health and then tells of a fantasy she had that morning in which she told the psychiatrist that she loved him. In her daydream the psychiatrist was very ill, worried about dying, and needed the solace of the love she could express for him. The psychiatrist does not believe that the patient really loves him, nor does he think he must reassure the patient that he had been home with a relatively inconsequential viral infection. He notes to himself that although the patient has been in treatment for over a year, only in these circumstances has she been able to let herself fantasy being close to her therapist. It is only when she feels she is needed and can be useful because the man is weak and helpless that she can dare to experience affection. As she is married to a semi-invalid, the psychiatrist wonders whether this is a repetitive pattern and just how it had originated. He becomes alert to how the situation may be utilized and simply asks, "You felt that I needed you?" which starts the patient talking about her need to be needed before she can feel affectionate.

As elsewhere in psychotherapy, insight into a patient's misapprehensions or unconscious motives does not call for immediate interpretation; indeed, many experienced therapists rarely give intellectual interpretations at all, but seek to guide patients to reach understandings themselves, and largely through feelings and thoughts engendered in the transference relationship with the psychiatrist. Transference misconceptions may be utilized most effectively by letting them be worked through against reality.

A psychiatrist who had his office in his home received an urgent call from a woman graduate student who asked for an emergency consultation because of her suicidal preoccupations. Although it was evening, he arranged to see the patient immediately. When she arrived, the psychiatrist's sixteen-year-old daughter opened the door and showed her to the waiting room. After several sessions, the patient started psychoanalytic therapy with him. Somewhat to his surprise, the patient referred to his daughter as his beautiful young mistress. He did not correct her misapprehension, which of course led to a rather distorted view of the psychiatrist and his way of life. The references to the imagined mistress gradually became more frequent and central to the young woman's problems. They were transferred from her disillusion in her father, her envy of her father's mistress, her disappointment in her mother, and many other such matters that had long directed much of the patient's fantasy life and distorted her image of herself. After about eighteen months, she suddenly realized that her idea that her analyst had a young mistress was without basis and she began to understand how profoundly a central theme from her childhood was affecting her life.

COUNTERTRANSFERENCE

The patient's transference affects one side of the therapeutic relationship; the *countertransference* —the therapist's tendencies to react to the patient in terms of his or her own earlier significant relationships—is, in many ways, even more important. Clearly, therapists need to view their patients as realistically and as free from distortion as possible. Patients properly must be treated for their own problems and not for some other person's difficulties, including the therapist's. If, for example, a therapist had an alcoholic father who made the therapist's family life miserable, old resentments toward the father may deleteriously color the relationships with alcoholic patients. If a male therapist has idealized his mother and mother figures and been willing to sacrifice himself to gain a token of affection from motherly women, his judgment in his treatment of older women may be faulty.

Countertransference phenomena enter into therapists' attitudes toward patients in many ways simply because therapists are human and their early interpersonal relationships can never be fully excluded from them. Insofar as countertransference enters the relationship, the actuality of the situation is obfuscated. Yet, some countertransference feelings are advantageous, for without such connectedness to prior significant relationships, the therapist might be too aloof and unable to empathize with patients. Psychoanalysts must be thoroughly analyzed themselves, in large part to gain sufficient insight into their own lives and to become aware of the unconscious components of their ways of relating to and understanding others in order to provide assurance that countertransference problems will not seriously influence their work with patients. Knowledge of the self, however gained, is of the essence to anyone engaged in treating people psychotherapeutically. Whether analyzed or not, good therapists continue to learn something from virtually every patient they treat about their own foibles and their tendencies to misperceive patients and what they communicate. Psychoanalysis is purposely carried out in a manner that seeks to heighten the use of the transference attitudes and to minimize the distortions stemming from the countertransference. Patients on the couch do not see their analysts who sit behind them, and patients do not receive cues from their analysts' expressions or comments, which are, particularly during the early phase of analysis, sparse and nondirective, seeking to increase the free flow of associations from the patient. Patients, thus, with little knowledge about their analysts, tend to transfer to their analysts ideas and feelings derived from earlier significant relationships, which eventually become the topic of analytic scrutiny. The analyst's minimal activity lessens the impact on the therapy of countertransference,

for after the patient becomes a more distinctive individual to the analyst, countertransference phenomena are less likely to interfere.

Relatively few analysts, however, adhere rigorously to the style of making themselves a "blank screen" for the patient's transferences and projections. Many analytically oriented therapists seek to serve as what Sullivan (1953) termed a "participant observer," listening to the patient's associations and past and present experiences, while trying to guide the patient into more objective and less distorted perceptions and understanding by-commenting briefly and inserting questions or questioning sounds at appropriate moments. Such psychotherapeutic interventions as a participant observer properly require even greater self-knowledge and ability to manage countertransference phenomena than do more classical psychoanalytic techniques. Perhaps, most analysts work in a style between these two models, varying their techniques to suit the patient and the phase of therapy. Whereas a thorough psychoanalysis is the most effective way for a therapist to gain self-understanding, unfortunately it does not assure it; and there have been gifted therapists, including Freud and many of the early analysts, capable of proper empathy and with deep insights into their own natures and foibles who were not formally analyzed.

Countertransference phenomena cannot be completely avoided or excluded. In customary relationships between a physician, nurse, or social worker and a patient, it is the countertransference excesses that require checking. Therapists become alert when, for example, they find the patient's difficulties provoking strong emotions in them; or when they realize that they are strongly involved emotionally, as when falling in love with a patient or when feeling hostile to a patient. At such times, the danger arises that the treatment will be influenced or even directed toward alleviating the therapist's feelings rather than the patient's problems. Equanimity does not mean disinterest, but it implies that the therapist can maintain a suitable perspective, and that the patient's problems rather than the therapist's emotional needs will guide their relationship.

Countertransference phenomena are, in a sense, part of the larger problem of therapists who are caught up in their own needs while treating patients. They may involve the reasons for the choice of a career. Physicians, or any therapists, may seek power and an opportunity to display it and be unable to countenance any interference with their decisions; or they may seek the love of their patients, leading

them to sacrifice themselves excessively; or they may unconsciously seek to make their patients feel dependent upon them and indebted to them, thus interfering with the goal of fostering patients' development of autonomy. They may desire the plaudits of colleagues more than the well-being of patients; or they may make authoritarian use of their positions in order to gain vengeance on mother or father figures. Good therapists strive constantly to achieve reasonable equanimity and objectivity that permit optimal use of their knowledge and skills for the benefit of their patients. They require ability to learn not only to know their patients as specific individuals and to recognize patients' transference problems, but also to know themselves, their strengths, weaknesses, needs, and repetitive patterns, as well as they can.

It is often difficult for physicians to keep their feet on the ground when they hold the responsibility of dealing with life and death, and also for any therapists who can rightly believe that they can often change the course of a life. When patients idealize them, they can lose perspective and begin to believe they are the persons whom patients think they see. Such exaltation of the self can rebound and bring therapists misery if they expect the impossible from themselves and find it difficult to forgive their own errors. The failure to recognize the transference attitudes of patients breeds trouble, but when therapists see themselves in terms of their patients' transference reactions to them, they are courting disaster.

Although the ability to assess countertransference attitudes competently is essential for psychotherapists, such insights concerning the self cannot be expected from other physicians or from those in related professions. Still, an illustration of how countertransference can be kept from interfering excessively with a therapeutic relationship may be useful. A resident psychiatrist, well along in his training, started to treat a new patient under supervision. He spent a considerable portion of the first supervisory hour discussing his initial encounter with the patient and the feelings and memories it had aroused in him. When he first saw the patient, he felt his heart start to speed up. He noted the reaction and realized that her appearance had surprised him. He had expected a young woman who was seeking help because of marital difficulties, but he had not anticipated the pretty, vivacious, and extremely well-dressed woman who stood before him. He realized that she was a type he had liked to date while in college and bore some resemblance to his wife in the way she walked and talked. When he contemplated his reaction to her, he realized that a connection existed between something in her appearance and his older sister, whom he had idolized in his early childhood. But he also recognized that something in the

patient created an unpleasant feeling in him which he could not fathom, but which he believed would eventually lead him to dislike her. In retrospect he thought it had to do with a smug self-satisfaction which conveyed an assurance that everyone admired her beauty and that any person would be lucky to have her about. The resident felt annoyed, because he did admire her appearance and feel attracted to her. The details are not as important as the therapist's awareness of the feelings that had been aroused in him, and his efforts to alert himself from the very onset of the therapeutic relationship to potential sources of countertransference distortion, of both a positive and a negative character.

The Use of Transference Relationships Outside Psychotherapy

In the practice of general medicine and in other relationships that contain a therapeutic intent or implication, transference relationships are not used so pointedly and purposefully as in psychotherapy; but they often influence the relationship for better or worse even though the therapist may not realize it. Clearly, therapists can use themselves and the relationship more effectively when they are aware of its importance and how it can affect a patient. The simple recognition by therapists that they are, or can be, parental authority figures and potential sources of support to the dependent, often regressively dependent, patient can help the patient to surmount crises. As persons who are capable of countering the internalized superego, therapists, by the power vested in them by patients' transference, can help offset patients' losses in self-esteem. When illness fosters regressive needs for dependency, physicians can permit patients to gain security through dependency upon them until the circumstances change. A patient confronted by a serious operation may feel far more secure if the general practitioner whom he or she has known for years is present in the operating room. The patient may know that the surgeon and the surgeon's assistants are far better equipped than the general practitioner, who could do little, if anything, to help, but the practitioner is a parental figure who, the patient feels, will be personally concerned and protective. It may be irrational, but it is an understandable and an emotionally useful irrationality. Persons who become dejected because they are invalided and no longer self-sufficient may regain self-esteem because of a therapist's interest in them and respect for them. The ramifications are many, and it is such transference phenomena, whether evoked purposefully or accidentally, that account for many unexpected transitions back to health akin to those documented by faith healers.

Sometimes a patient's needs can be met by the controlled use of a transference relationship when

little more specific can be done and with unexpected salutary results. A young woman with severe acute arthritis lay in the hospital feeling hopeless and lost without any family to whom she could turn. Her father, if she had a legal father, had abandoned her mother when the patient was still an infant. Her mother had been a prostitute, but a rather unusual woman with an interest in literature that she had conveyed to the patient, but she was now in a mental hospital, chronically psychotic. The patient had spent her adolescence in foster homes and institutions, but because of her attractiveness, superior intellect, and drive, she had been provided with a college education by a church group. She had repeatedly sought to attach herself to one or another mothering woman attempting to become the favorite child by working inordinately hard to become essential to the mothering person. However, she either became too involved in the woman's family or involved with homosexual women whose advances she rebuffed, so that she never managed to find a permanent home. She had become ill with arthritis while working in a missionary school in the southern mountains after she had been displaced as the woman missionary's favorite and was no longer permitted to live in her home. It had been a severe blow, as she had believed that she had finally found a haven, a mother, and her proper calling.

The attending physician took an interest in the patient and suggested that she become an occupational therapist or nurse. He visited her daily and would chat briefly with her about her life and her many interesting experiences. A rapid shift occurred in the course of the illness, and somewhat to the surprise of the hospital staff she made a complete recovery without any residual deformities. The physician then fostered a long-term relationship in which she came for "checkups" at regular intervals, during which she told him about her progress in nursing school and discussed her plans with him. He was demonstrating that someone was interested in her, and indeed he had become interested in her. As he had consciously developed the relationship to foster the patient's self-sufficiency rather than to permit her to become permanently dependent upon him, he was surprised neither by her seductive efforts to attach herself to him nor by her suggestions that she could be very useful to his wife if permitted to live with his family as a mother's helper. He could retain interest without being frightened away by her attempts to become part of his life, for he had anticipated such efforts from her life story; and he could seek gradually to redirect her energies into channels that held promise for her future.

Indeed, physicians or any other therapists can sometimes be very helpful because of their transference positions, even when they do little more than permit persons to come to the office, where

they listen attentively and empathically to what patients wish to convey. A man who finds little understanding from his wife and children, or an aged person who no longer has any significant person left, may gain much from a therapist's interest, and from being able to talk to someone who listens dispassionately and does not place blame vindictively. All too often physicians believe that they are wasting their own and their patients' time when they simply listen and think that they must *do* something—prescribe medicine, a diet, a vacation, or stop a patient from wasting money on unnecessary visits. Physicians may feel uncomfortable because they cannot offer useful advice concerning a patient's insoluble problems. The patient, however, knows that the problems cannot be resolved and is grateful for the opportunity to ventilate feelings that must be hidden from others, and regains self-esteem because the therapist considers him or her a person to whom it is worth listening.

An understanding of transference and countertransference phenomena provides directives that can greatly improve the therapists' relationships with their patients, but more precise guidelines are gained through interviewing skills with which the therapist helps patients tell about themselves. Patients' anamneses—their accounts of their illnesses and relevant material from their past lives—constitute the most important diagnostic tool in medicine, and form the foundation of most types of psychotherapeutic relationships. The various techniques that help elicit information from patients form a major topic in themselves, and are not part of the subject matter of this volume. However, the capacity to listen to and understand what persons seek to communicate and to note what they do not or cannot say is a major aspect of skillful interviewing. Patients' recognition that the therapist listens, hears, and understands provides an incentive to them to communicate what they consider meaningful. Such capacity to hear and understand what is meaningful in an individual's life rests upon knowledge of psychodynamics—upon knowledge of the epigenetic nature of personality development, of the crucial tasks of each phase of the life cycle and what is likely to be most significant to persons at their stages of life, of the critical importance of interpersonal relationships to everyone—and upon the ability to detect life themes and repetitive patterns. This book has sought to provide a guide for gaining such knowledge; but it cannot be learned from books alone, for it requires responsible involvement with people and a readiness to learn to know the self. What therapists hear from patients about their lives can be disturbing because some of it will surely also apply to the therapists. Yet much of the satisfaction gained from the practice of medicine and from conducting any type of therapy derives from a willingness and ability to

hear and understand. It enables the therapist to gain and grow from each relationship, which in turn makes each patient a new adventure. As the therapeutic relationship ceases to be something given to the patient but rather a situation in which the therapists also receive, they can give of themselves without feeling resentful or drained.

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