A Primer for Psychotherapists

THE THERAPIST

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If we were to describe the requirements and qualifications of a good psychotherapist, they could perhaps be listed as follows. He should have:

1. A body of knowledge concerning normal and pathological thought and behavior in our culture.

2. A logically cohesive group of theoretical concepts which are convenient in understanding this thought and behavior.

3. Technical experience in therapeutically integrating observations with concepts through clinical work with patients.

4. Intuition as a practiced and controlled ability to read between the lines and empathically grasp what the patient means and feels beyond the face value of what he says.

5. Awareness of his own inner wishes, anxieties, and defenses and their influence on his therapeutic techniques.

Knowledge, theory, experience, and intuition are matters of learning plus talent. Self-awareness is gained only through frequent and honest consideration of our own psychological operations.

The patient never forgets, nor should we, that he is talking to another person and what he thinks about this person determines to a large extent what he says. Some of his opinions are transferences, while others may be justified by what the therapist is in reality. Obviously the therapist should be in a position to judge which is which. Hence we will pay some attention to the therapist as an integral determinant in the climate of therapy.

His Past

We might begin, as with the patient, by discussing the therapist from the three perspectives of organism, ego, and cultural environment. But since he can be evaluated in these respects like any patient, we cannot add much to what has already been said in the preceding chapter.

Yet there is one decisively formative experience in the therapist's past which warrants mention in that it has great bearing on his fitness as a psychotherapist. This is his medical training, with both its good

and its bad consequences. The good ones are celebrated often enough without honoring them here. The bad ones can bring complications into the therapist's career, and he should be aware of these possibilities.

Outstanding among educationally induced handicaps are the detachment and dehumanization achieved in medical school. One learns to become interested almost entirely in diseases per se rather than in the people who have the diseases. A once-active imagination may become stunted in the name of a false scientific objectivity. The traditional medical single cause-and-effect concept of disease narrows the observation and sympathetic understanding of inter-human processes. For example, a patient in the terminal stages of a carcinoma of the pancreas, shown briefly to two groups of students, was described by senior medical students in terms of icteric index and metastasis, while senior college students readily grasped the heart of the matter—the man was dying. In matters of treatment also, medical education directs the axis of the student's interest toward mechanisms that can be seen and touched. It is only through repeated therapeutic experiences with patients that his educationally ingrained distrust of treatment through verbalized ideas becomes surmounted.

Undoing these tubular views becomes one of the problems in the metamorphosis of the beginning psychotherapist. Some, though for reasons other than exposure to medical school, never seem to achieve such a rehumanization. Fortunately most therapists can overcome this limitation in much less time than it took to acquire it.

His Present

A psychotherapist is first a human being and only secondly a technician. He has become a psychotherapist as a result of the interactions of his life experiences and his own wish-defense systems. In therapeutic work, sexual and aggressive wishes mesh with ego and superego defenses in such a way as to bring emotional satisfaction and to earn a living for the therapist, now or in the future.

Each therapist has his own particular character structure, and it is of course impossible to generalize about the unique aspects which these structures present. Still there are some general emotional problems which therapists share in common as potential interferences in careful therapeutic

work.

Fenichel has said that the patient's wish to be cured by a magician may be equaled by the therapist's wish to be a magician. A diplomaed authority may be unaware that he is magically convincing himself of his own omnipotence. Too, there is in every healing profession the temptation to play God, and an all-wise, all-powerful-acting therapist may soon run into unpleasant difficulties, just as new-found powers proved heady for the sorcerer's apprentice. A psychotherapist is really not God, nor even a close relative of his.

Every therapist naturally wants to cure his patients. But this wish may obscure the reality possibilities of cure or the length of time a cure will require. Overambitious therapeutic eagerness is something the beginner contends with until experience tempers his wishful concept of the quick and complete mutability of neurotic processes. When frustrated, the urge to get results may lead to countertransference difficulties.

Most beginners are aware of the sexual feelings which may arise in psychotherapy. Some recognize their hostile and aggressive attitudes toward the patient. More difficult to realize are the narcissistic needs and defenses which the therapist has at stake in the therapeutic process. When one has spent years of hard work at training to become an expert and has achieved a rather special status in our society, it may not be easy both to hold a favorable opinion of one's self and to be reminded of weaknesses, mistakes, and failures. Patients quickly learn whether or not they can produce a response when they openly doubt your knowledge, experience, or ability to help them. Those youthful in appearance have the additional problem that this characteristic may be seized on by the patient as a visible target for bombarding the therapist's self-esteem. The danger is a defense of overcompensation wherein the therapist tries too hard to demonstrate his ability, usually through over-interpretation.

The therapist may struggle with the temptation to impress the patient, perhaps by showing him how knowledgeable he is or even by attempting to maintain a papal infallibility. However, one cannot long remain infallible, since there are plenty of mistakes to be made in psychotherapy and everybody (not only beginners) makes them. Your work will never be flawless. The important thing is not that we have some degree of narcissism or that we want to be perfect, but that we are aware of when it is a

narcissistic blow that is determining our reaction to the patient and when we have made a technical error.

Problems of earning a living, of his position in the community, and of his own love relationships have bearing on the therapist's professional activities. He must have some realization of how these personal factors influence his attitudes toward patients and of the fact that his own values in these areas may unduly impress him as the values others "should" have.

His Task

The therapist's task is to help the patient understand himself by bringing unconscious ideas and memories into his consciousness through the verbalization of them. It is not the job of the psychotherapist to give love, to offer himself as an example of a normal or model person, or to instruct the patient on how to live a proper life. The patient has had people for many years telling him what he should do and exactly how he should do it. For him to talk to someone who does not nag and moralize is a special experience which can permit him to grow to feel that he is a responsible adult rather than a naughty child.

In carrying out his task, the therapist's general interview attitudes are of great importance. A consistent bearing of calm, friendly, but firm gentleness proves more useful than an iron sternness, a forced joviality, or cyclic variations between the two. Although a warm, patient, and quiet good-naturedness involves risks of coddling or condescension, in the long run of work it provides the smoothest course. Kindliness does not need to mean that one avoids confronting the patient with conflicts unpleasant to him. In his recommendations for those who treat the mind, Plato wisely included knowledge, benevolence, and boldness.

Maintaining the above-described attitude for some therapists may come close to forcing one's self to play a role, and if so it carries certain disadvantages. It is unsound to try to impersonate a psychotherapist. If the way you act as a therapist is greatly different from the way you are as a person, then the façade will drain energies needed for other aspects of therapy and your patients will soon learn of this artificiality. In this connection the therapist should not attempt to "manipulate the transference,"

for example, acting like a father with one patient or like a brother with another. The patient must be left as freely as possible to develop spontaneously those reactions determined by his childhood experiences.

To remain serene in the face of transference aggressions and to treat patients with a gentle benevolence requires that the therapist himself be in good physical and emotional condition. If you have a pain or feel sleepy or "hung over," then you should not see patients until your malaise has cleared. Likewise, if some personal emotional problem is making a therapist uncontrollably "crabby," anxious, or depressed, then he is in no shape to do his best for the patient. Like an athlete, the psychotherapist has to keep himself in an efficient working state.

Some therapists advocate that we discuss our own feelings with the patient in an effort to demonstrate how he affects people. I cannot recommend this for beginners, who have enough trouble evaluating whether their feelings are realistic or are countertransferences. Naturally a therapist *thinks* about himself and his reactions to the patient, but this does not mean that he must *tell* the patient about his emotions. The less the patient really knows about you the greater chance he has to make transferences, which are precious material for the therapeutic process. Other devices can be more advantageous to show the patient how he operates in interpersonal relationships.

The beginner may doubt that he can be a good psychotherapist, since the whole business at first looks hopelessly complex, requiring the intellect of a genius, the talents of a master, and the emotions of a paragon. Actually it requires only average human qualities and a slightly above- average interest in using one's intellect and intuition to help others. Study and growing experience soon increase the beginner's confidence and put him more at ease in his everyday work.

Countertransferences

It is useful to pide the therapist's emotional reactions into those justified by realities in the therapeutic situation and those determined by his own inner conflicts. For example, it is natural to feel annoyed when a patient repeatedly mistreats one's furniture. But when a therapist feels outraged if a cigarette is dropped on the floor, his disproportionate response signals a countertransference problem.

When used loosely, the term "countertransference" refers to all the therapist's feelings and

reactions regarding the patient. But in its limited and more accurate sense it concerns those moments when one *unconsciously* reacts to the patient as if he were some important figure in one's own psychological past. Of course the therapist's reaction does not literally "counter" the patient's transference. Hence the designation "collateral" or "reverse" transference perhaps conveys more of the intended meaning.

Being aware of his own feelings during an interview gives the therapist a chance to evaluate and check their expression. Countertransferences become unwanted complications when the therapist cannot control his unrealistic feelings, and in most such cases he cannot control them because he does not even realize their presence and effect.

The multiple variety of countertransference reactions might be grouped by a therapist from the standpoint of two questions which he can put to himself: (a) Who am I to myself in relationships with patients—a father, a mother, a curious child, a sibling? (b) Who are my patients to me—children, rivals, love-objects, myself? Sexual and aggressive impulses and their particular defenses interplay in all these instances. Therapists with sexual conflicts may unwittingly influence the patient to talk only of sexual matters. Therapists with anxieties concerning aggression may avoid dealing with similar material from the patient or counter-phobically prod the patient into behaving aggressively toward them.

Unknowingly treating the patient as a projected part of one's self is perhaps the most common countertransference problem in beginners. Through a defense of externalization the patient may come to be unconsciously regarded by the therapist as his "bad self" who needs reforming.

A final factor to be considered by a therapist in examining his own emotions is the ability of some patients to make him feel as they wish him to feel. For example, the anxious patient who attempts to infect you with anxiety until you likewise become frightened. Or the depressed patient who describes his hopeless plight in such a way that you begin to feel just as overwhelmed and defeated as he does. Indifference and boredom felt by the therapist may be produced by a patient whose characteristic defensive maneuver is to put psychological distance between himself and the therapist and lull opposition. Such emotions experienced by the therapist are not countertransferences in the strict sense but reactions produced by the patient in the therapeutic relationship to satisfy some definite

interpersonal need.

All the mechanisms thus far discussed are extremely important for the therapist to know about and to consider seriously in relation to himself. Perhaps here it would be convenient to mention the dusty controversy over whether every therapist should be psychoanalyzed. Any psychotherapist can profit from an analysis or long-term psychotherapy, and ideally every therapist should be analyzed. But for all sorts of reasons, many will not in reality have this experience. Certainly if the beginner has frank neurotic symptoms, a perversion, or some other severe character problem, he should make every effort to be analyzed. Those who do not obtain therapy for themselves can only make frequent and sincere attempts to think at length about their own psychodynamics in an effort to understand them better than those of their patients.