THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

To Students Interested in Becoming Psychotherapists

DR. MAX HAMMER

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MAX HAMMER, Ph.D.

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Be not like the lame selling crutches;

And the blind, mirrors.

Kahlil Gibran

THE CURRENT STATE OF THE ART

From many recent studies, it has become clear that the primary determinant in regard to therapeutic effectiveness is the therapist himself. Certainly it is helpful if the patient is subjectively uncomfortable, highly motivated for change, intelligent, verbal, in relatively good contact with reality and non-impulsive in a sociopathic sense; but most of all, the kind of person that the therapist is will be the primary determinant of whether or not there will be therapeutic results. This fact has been well documented by the research findings over the last few years. Consistently, researchers have pointed out that successful outcome in therapy is related to the empathic ability and understanding of the therapist. There appears to be a direct relationship between the effectiveness of therapeutic outcome and the personal psychological health of the therapist. These studies point out essentially that the therapist who is more anxious, conflicted, defensive or generally “unhealthy” is least likely to promote change in his patients. Other studies have determined that therapeutic results tend to be most favorable

when the therapist is warm, genuine, congruent and one who sincerely likes his patient.

Other significant studies relating the characteristics of the therapist to therapeutic outcome confirm that in general, the more

experienced the therapist is, the more effective and successful he tends to be; inexperienced therapists may actually cause their patients to deteriorate. All these studies plus the studies relating effectiveness of therapeutic outcome to various techniques, systems or schools of psychotherapy lead to the obvious conclusion that positive therapeutic change by the patient is not related to any particular kind of school, technique or theory of psychotherapy but is definitely related to the therapist's own psychological health and capacity to understand his patient regardless, apparently, of whether this understanding is a function of some natural empathic ability or comes through years of experience as a psychotherapist. One can assume that it is probably not just the number of years of experience, as such, that leads a therapist to develop the empathic ability to understand his patient but likely those that had this ability to begin with are more successful and remain longer in the career of psychotherapist, whereas the less empathic and less successful therapists are more likely to move into other than psychotherapy positions such as administration, research or teaching.

HEARING: THE ESSENCE OF PSYCHOTHERAPY

At this point, it should be clear to the student that being an effective psychotherapist does not involve a specific kind of doing or performance, such as a role that one has to play or a formula of some kind that has to be followed and mastered. Psychotherapy is not a recipe that is recited, rather it involves the therapist's capacity to be sensitive enough to clearly and deeply hear and understand in the patient those rejected truths that have become disassociated from himself and have caused his disintegration and which, when heard and understood by the patient, lead to his reintegration, growth and liberation from his conflicts, fears and tensions. This kind of sensitivity in the therapist, which is basically a keen sense of awareness and contact with reality, is developed as a function of the therapist's openness to his own moment-to-moment experiential reality. This, in my view, is really the essence of the psychological health process and the antithesis of the pathological process which is essentially the escape from the actuality of one's personal experiential reality and the pursuit of what one ought to be, conceptually and ideally. This kind of sensitivity and openness comes as a function of just practicing a continuous nonjudgmental and non-analytical self-awareness.

Being an effective psychotherapist then requires that the therapist himself be psychologically healthy, which means being non-defensive and

totally open to the moment-to-moment reality of himself. This kind of sensitivity liberates him from the distracting tension and self-preoccupation which exists ordinarily when one is in conflict trying to escape from some inner truths. A mind that is quiet and not distracted by one's own conflicts or by needing to move somewhere (because the therapist is ambitious for the patient to achieve some kind of predetermined objective or goal) is able to hear with enormous sensitivity. This capacity for awareness enables the therapist to be in a state of communion with his patient—a state in which he is totally present and fully attuned at all levels to what the patient is trying to share or avoid. This is the essence of empathy, understanding or what I refer to as the ability to hear. It is this kind of empathy or hearing which produces what is called *movement* in therapy and which ultimately leads the patient to self-discover and commune with those rejected and painful experiential realities of himself which culminates in that self-integrating, healing and liberating effect which is called *growth.*

Hearing really involves two basic elements. It includes empathy but also goes beyond it. First, there must be the clear and full *awareness* of the patient's subjective reality, which is called empathy. However there must also be the additional factor of the immediate perception and *understanding* of the *why* of that particular moment-to-moment subjective reality. Empathy involves being totally attuned, or one with, the patient's *individual* moment-to-moment experiential reality, but hearing also includes the immediate

integrative perception and understanding of the thread which ties together that complex of thoughts, feelings and behaviors with which the therapist has been individually empathic. It is that basic experiential truth or thread which gives rise to the individually manifested thoughts, feelings and behaviors and which must be understood for there to be a liberating effect. This kind of understanding cannot be obtained through logical deduction. It involves a total, direct and immediate perception of the whole of the thing as a result of a mind which is passively and creatively open and uncommitted and in a state of communion with the moment-to-moment experiential reality of the other person. This capacity for total and integrative perception which is called understanding is the essential ability of which the therapist must be capable, if he is to be effective as a psychotherapist.

To really hear, a state of communion must exist between the listener and the verbalizer, between the observer and the observed. It is the therapist's own self-preoccupation that prevents his total absorption in the patient (the state of communion) and instead fosters the state of duality which separates and isolates one behind his own self-enclosed ego boundaries. When awareness of the sense of self is absent then the observer and the observed merge into a state of true communion. The potential for producing a state of communion and hearing the patient is optimal when the therapist has transcended his identification with all self-concepts and images and therefore is one with his moment-to-moment awareness. Being no entity

self and having no sense of self-awareness, he then is fully attuned to whatever is in his awareness. This permits him to be in direct communion with whatever the patient is saying and feeling. A self-concept demands constant self-attention and efforts toward confirmation of that self-concept. As a result the therapist's attention becomes split and the patient receives only part of the therapist's attention while the other part of the therapist's attention is on himself, devoted to confirming some image of himself, such as being an effective therapist. When there is no identification with a self-concept, then attention upon the self is reduced and the therapist can then become locked into the patient's moment-to-moment experiential reality with unwavering attention (for that is his only awareness) and thereby be in a position to hear every subtle nuance of the patient's thoughts and feelings.

This state of communion is necessary, not only for the therapist to really be fully attuned and hear the patient but also because it is the basic therapeutic state or state of integration which may be referred to as the state of *quiet mind* which the patient must be in relative to his own experiential realities, if he is to make the full contact with himself which yields self-understanding, self-integration and growth. This state comes into being when there is no longer an active or deliberate thinker that is attempting to initiate, judge, control or direct the content and movement of thought—that is, when one just permits thought to come to awareness and watches it without any kind of interference. Then the thinker becomes merged into thought and

there then exists only the process of *thinking,* which I refer to as the process of *free-flowing consciousness* or the *state of creative understanding.* In this state, because it is unimpeded by the existence of any counter-cathecting censor, in the form of the deliberate thinker, and because in this state of psychic integration there is no longer any sense of duality, internal contradiction or opposition to prevent the integration of rejected truths, thought flows directly to its source of most immediate conflict and liberates itself. Awareness of the truth which liberates is immediate because there is no active thinker present to serve as an influence to distract attention away from the direct perception and understanding of the contents of consciousness.

In essence then, when the deliberate thinker is unactivated and quiet—that is to say, when the ego, in its role as deliberate thinker, is not deliberately or purposefully introducing conscious thought in order to capture the mind's attention—there is no chattering noise on the surface of consciousness to superimpose itself upon and distract the mind's attention away from clearly hearing and following the soft whisperings of unconscious thoughts, feelings or impulses. The ego, in its role as the deliberate thinker and defender of its own sense of integrity, acts as the censoring wall of separation and division between consciousness and unconsciousness and prevents the free flow of consciousness from integrating material from the repressed unconscious into conscious awareness. The most basic drive of consciousness is to flow freely and to heal itself by making itself integrated and whole. The contents of

consciousness which are repressed always push for intrusion and discharge into conscious awareness in order to drain its pent-up energy and tension; therefore, psychopathology develops when the ego, as deliberate thinker and censor, invests psychic energy toward the goal of inhibiting that free flow of consciousness. When the ego, as obstacle, is absent, then consciousness is free to integrate itself and reduce the tension accumulated through the repression of unconscious material and its accompanying psychic energy, and so it flows freely to the source of conflict and repression or, to put it another way, the source of conflict and repression is free to flow directly to the surface of conscious awareness. For example, a rubber ball, kept submerged under the water through the counter-cathecting force of your hand, flows freely and directly to the surface as soon as the obstacle of your hand is removed. Thus, no purposeful pursuing of insight or understanding is necessary; it comes of its own, immediately and directly, to your conscious awareness, if you just do not purposefully activate the deliberate thinker. Essentially then, psychotherapy is not the process of the active pursuit of the repressed but rather is the result of the elimination of the barrier between conscious and unconscious awareness which then permits that which is repressed to surface of its own accord.

Freud tried to create this integrated psychic state and free-flowing consciousness process with his method of free association, but he apparently failed to recognize that in his process of free association, thought is quite

often not really free because it is not free of the influence and control of the ego. The ego, operating as the entity of the thinker, is still in a position to be outside of and separate from its thought and therefore still in a position to have an element of control over thought which prevents a true sense of integration from developing and prevents the energy of consciousness from having the opportunity to flow freely to the source of its own conflict and inhibition and thereby resolve it. Furthermore, in free association, because the ego is still in control of thought, the ego can use thought as the means of defense and escape from contacting the rejected experiential realities through the means of presenting to awareness distracting concepts or intellectual insights.

What does self-understanding or self-integration really mean then? It should be obvious that it does not refer only to an intellectual comprehension. Rather it refers to a state of realization in which one makes real or brings into concrete existence formerly rejected aspects of self. It is knowing by becoming one with, as the word “knowing” was used in the scriptures to mean having intercourse with. One must have a true intercourse with the rejected aspect of self, by becoming one with it, in order to really hear, know or understand himself. He must be in immediate and direct contact with himself. This is the essence of integration which produces liberation from conflict.

Liberation involves resolution and is not to be confused with the seeking of a solution to a conflict or problem as a means of escaping from it. A solution can bring about a superficial *change* by altering one's awareness through some form of distraction, but only resolution can result in liberation and *growth.* Liberation cannot be the result of any solution which involves forms of escape such as suppression, distortion, avoidance or withdrawal. Rather it involves resolution and transcendence. Thus, for example, if I feel an intolerable sense of loneliness, one way that I might try to solve this problem is by attempting to escape from my awareness of it by going to the movies or taking a drug. However, as soon as the movie ends or the effects of the drug wear off, my awareness of my loneliness as a problem returns. I have not resolved or transcended the problem and will not until I fully understand why loneliness to me is intolerable and why it is interpreted by me to be something more than just aloneness; for example, do I feel abandoned? empty? worthless? vulnerable? unaffirmed as a particular identity such as a male? and so forth. To really understand and resolve this problem, I must permit myself to be one with the loneliness instead of running from it by one means or another.

Thus, resolution of a problem lies only inside of the problem and never outside or away from the problem. By remaining inside the problem the kind of total perception and understanding which liberates can come; but by seeking some kind of solution away from the problem, there results only a

kind of transitory distraction of awareness away from the problem but the problem, as such, is still preserved. Understanding is its own sufficient action to bring liberation, but no amount of effort away from the problem can bring liberation. One does not become released from a problem by the effort and struggle to free oneself through some form of escape from it. Rather, the problem must be confronted and faced head-on and not just glanced at as though through the comer of one eye, and then, through the contentedness just to be fully immersed in communion with it, the kind of total perception and understanding of the problem that brings full release and transcendence of the problem will come.

Thus one should learn to totally explore and understand the problem or question and in that total understanding of the question lies the answer. The answer or resolution to any question is never the result of a solution which is brought to it from outside of it but rather lies just in the total understanding of the question. A problem is just the result of an incomplete perception and understanding, and when it becomes focused into direct and total perception, the problem disappears.

Understanding leaves no trace remaining of the problem, and therefore there is true liberation from the problem; on the other hand, solutions and escapes keep you tied to the problem because they leave a trace of bound-up energy tied to the parts of the problem not yet acceptable, revealed or

understood. In seeking its release, that bound-up energy captures thoughts in the attempt to gain some expression and discharge into awareness and as a result you cannot be free of the problem or its preoccupation. Understanding is its own action, sufficient to bring release from the problem because it brings the full release of the pent-up energy, as the rejected truths which contain it are released into awareness.

Therefore, helping the patient learn how to inquire into himself for the truth of himself is more essential than providing him with any solutions or answers to his problem which he finds intolerable and from which he wants to escape. Such solutions only take him away from his problem, and even worse, they teach him to look outside of himself and away from his problem for its resolution. They condition a process of escapism which is the essence of the pathological process and which is the essential thing that the patient learns from that kind of "therapy." On the other hand, self-inquiry provides the self-integration which itself is therapeutic. It is both the process and the outcome of therapy. It is both the means and the end of therapy. It is the necessary self-integration process that leads to the self-integration outcome referred to as growth.

Thus, the patient is in the state of creative understanding when he comes to recognize that he *is,* for example, his anger, his fear, his depression or whatever the experiential reality happens to be and not just the *observer* of

these from the outside. Then the observer has become the observed and the basic pathological state of duality and self-disintegration is transcended. In this integrated state of creative understanding, insights come to you in flashes of vivid clarity without any effort to seek them out. Therefore, the state of creative understanding is the basic self-healing state of integration that the patient needs to learn before he terminates psychotherapy for it is the means by which he learns to heal himself in the future rather than having to keep coming back to the therapist for "patchwork" every time he finds himself in an uncomfortable conflict.

The process of therapy must have as an intrinsic part of it the means of achieving the ends desired. If therapy seeks as an end the greater integration and growth of the patient, then the process by which this is to be achieved must also permit integration. The means and ends of psychotherapy are not really separate. If the process of therapy always keeps the patient outside of himself, then it cannot expect to lead to the patient being integrated in the end. The patient must come to recognize that his symptoms are not something that must be studied and explained away but rather they are aspects of himself with which he must have communion. He must blend himself into the symptom and be one with it, and in that process lies the essence of liberation, healing and growth.

In addition, to really be effective, the therapist needs to know from

personal experience what the "path" is that leads from internal conflict and contradiction to liberation. If you do not know how to liberate yourself from an internal conflict, fear or pain, then you are not in a position to help others do it either. If what you do does not work for you, it will not work for the patient either. What right does the therapist have to ask the patient to face his rejected truths and anxiety and to take risks in terms of exposing himself and making himself vulnerable, if the therapist is not willing or able to do so? You cannot instruct a patient to be vulnerable. You can only be the model for that kind of vulnerability through your own openness and spontaneity. The therapist must know from personal experience that honest self-confrontation leads to growth and liberation; otherwise his encouragement of the patient to confront himself will not be genuine and will certainly lack conviction, and the patient, at some level, is bound to be aware of that and no growth will take place.

In essence then, the two basic factors which distinguish the therapist from the patient is the therapist's ability to be open to hear and accept painful realities without resorting to some form of suppression, disguise, withdrawal or escape and his ability to permit himself to be vulnerable and take risks for growth. Because of these factors the therapist is continuously becoming more and more open to and in full contact with all the internal and external realities which confront him, so that he is constantly self-integrating and growing, whereas the patient is not.

The patient cannot grow unless he is willing to take the risk of making himself exposed and vulnerable. Only then can greater integration take place with that which is real, but rejected, within **him**. Fears of being vulnerable usually are related to the concern of there being a threat to the dissolution of the sense of integrity of the ego. The loss of that feeling of integrity is experienced, subjectively, as the psychological death of self.

Threat tends to be experienced as being greatest when one feels helpless and vulnerable in the face of emotional or physical pain, which the ego fears will overwhelm it and destroy it, and also when the ego is in the position of recognizing rejected truths about itself which have been disassociated from the ego because they were experienced as being in contradiction to the feeling of consistency and integrity of the ego's sense of identity; and were they to become conscious, they would also threaten the ego with dissolution. Thus, for example, if I am basically identified as a "male," then I reject and repress all aspects of myself which I consider to be "female"; and therefore because all that I am aware of about myself I consider to be "male," I feel a sense of being an integrated and consistent personal entity self. However, I feel severely threatened if I am confronted with aspects of myself which I label "female" for how can I be both "male" and "female" at the same time? Thus if I were to accept these "female" traits as really being part of me, I then would become very frightened that perhaps I was not really anything at all in terms of a consistent and integrated psychological identity.

This would threaten me with psychological extinction.

Thus, the term “ego strength” really represents the ego’s capacity to tolerate inconsistency and contradiction within its own sense of identity, and the tension and pain which results, without feeling threatened with anxiety which is essentially the ego’s reaction to feeling threatened with extinction. In the face of inconsistencies and psychological pain, ego strength is reflected by the ego’s ability to say, “this, too, is me.” Therefore ego strength is basically the ego’s capacity to confront and endure psychological pain without having to distort or escape from the source of that pain for fear that the pain will overwhelm and destroy the ego. Where there is psychological growth, ego strength has been enhanced. There can be no real growth without it. Thus the reader can see that ego strength is not enhanced through intellectual awareness, alone, but only when the ego is confronted with the painful aspects of its rejected self in the form of repressed memories, feelings, emotions, impulses, etcetera. It should be clear from this discussion that psychological pain exists only where there exists an identification with a self-concept which feels threatened with being diminished or extinguished.

Thus, it is a clear psychotherapeutic principle that *regression always precedes real progression or growth.* All other forms of “growth” are only conceptual in nature—that is, one feels oneself to be making progress toward becoming some kind of conceptual self or imaginal ideal and concludes,

therefore, that he is growing. In reality, however, it is only through that form of regression in which the patient first takes a backward step, so to speak, by permitting himself to enter into full communion with those repressed and painful aspects of his rejected self which then permits the forward advance—in terms of a greater sense of integrative wholeness, liberation or growth—to really take place. It is only when the patient recognizes that he is nothing more than just his moment-to-moment experiential self, that he then is in a position to permit himself to immediately become sensitively aware of and one with that moment-to-moment experiential reality as soon as it arises and thereby live in that integrative and psychic energy liberating process which may be referred to as the process of *growing* or *psychological health.* In this way nothing lingers unresolved in the mind to become repressed into unconsciousness and thereby distort the functioning of consciousness and its contact with reality.

However, as long as he is identified with some kind of fixed conceptual or imaginal entity, he must be faithful to that conceptualized entity self and reject and repress from conscious awareness other aspects of himself which appear to be inconsistent with and in contradiction with that particular self with which he has become so strongly identified. It is identification with such imaginal selves which is really the essence of the pathological process because it is the essence of what produces a state of disintegration and schisming of the self. Thus, the patient is not fully integrated and healed until

he has transcended his identification with any and all conceptual and imaginal selves, even those which he judges to be highly positive in nature, and is content to be nothing except his moment-to-moment experiential reality.

Another basic reason why the patient fears being vulnerable is that the realization of his vulnerability feelings will also trigger the awareness of the weak, helpless and fearful child in himself which he has tried to deny is a reality in himself through repression, escape and various means of distorting this reality. Through past experience he has learned that being a vulnerable child is associated with being helpless in the face of intolerable pain which produced, and still does produce in him, an intense state of apprehension, anxiety or panic. Therefore, he maintains an unconscious inner commitment to avoid, at all costs, ever realizing that he is truly in a vulnerable position. His compensatory attempts at power and need to deny his helpless vulnerability is a basic contributor to what is referred to in psychotherapy as the problem of *resistance.* Resistance is a phenomenon, which is encountered either directly or subtly in probably all systems of psychotherapy, in which the patient seems to consciously or unconsciously resist the therapeutic overtures of the therapist. In essence what is occurring is that the patient is resisting relinquishing control of the interaction to the therapist in order to resist acknowledging himself as being vulnerable and so he tries to deny his feelings of vulnerability and gain a compensatory sense of potency by

entering into a kind of power struggle with the therapist and defeating him by not permitting himself to be influenced or changed by the therapist. This usually takes the form of resisting confronting his own real feelings and of denying the truth and appropriateness of the therapist's insights or suggestions. By so doing, the patient is also preventing the therapist from understanding him because he feels being understood is extremely threatening—the same as the therapist having penetrated his defenses—and therefore it makes him feel exposed and very vulnerable. Therefore, when resistance exists, psychotherapy becomes basically a fencing contest in which the patient parries every thrust that the therapist makes.

Essentially the patient is resisting being vulnerable because he is committed to resisting being confronted with psychological pain due to the fact that he is inwardly convinced that his ego is too weak to endure such pain and therefore his ego would be overwhelmed and destroyed. At some level the patient understands that the goal of the therapist is to make him confront the pain from which he is trying to escape and therefore he feels that he must resist every overture on the part of the therapist to remove his defenses against the experiencing of that pain. Most patients really do not come for psychotherapy to face the painful realities from which they are escaping but really they come hoping to find some new gimmick which they can use to insure that their escape and their defenses against such pain will be more effective. When they come to the therapist for help, they tend to have the

same expectations which operate under the medical model in which one goes to the doctor when one has pain and is given something for the immediate removal of that pain. Most patients come to psychotherapy hoping to learn how to gain a sense of mastery over psychological pain. They want a sense of confidence of having power and control over pain so that they will be able to conquer it at will. In essence they are hoping to attain a form of psychological invulnerability and omnipotence.

Unfortunately many systems of psychotherapy attempt to supply the patient with forms of escape from having to experience his psychological pain, but in actuality this form of “treatment” really encourages the intensification of the pathological process. The essence of psychopathology is the process of attempting to escape from one’s own psychological pain by rejecting and repressing particular realities about oneself which threaten to bring pain. This produces a state of psychic disintegration and an inner conviction that one is weak and unable to endure pain without being overwhelmed, and so the ego builds defenses in its struggle to escape from feeling helpless and vulnerable in the face of pain. The defenses operate to distort not only one’s contact with the rejected and painful inner experiential realities from which one is trying to escape but also operates to distort those various aspects of the external reality which could possibly trigger the repressed painful inner realities if they were given full conscious recognition. Thus, if one can face pain and no longer hide the truth from himself, then it is

no longer necessary to distort and escape from reality and the pathological process is ended.

Growth, therefore, depends on the ability to risk facing pain and results, in essence, from the patient's greater capacity to confront and endure painful reality without having to distort or escape from it in some way. Intellectual insight alone, if it does not lead to the arousal of rejected painful feelings and the conscious confrontation and integration of those painful feelings by the patient, can never be effective in producing a sense of liberation and growth in the patient. Thus what the therapist has to essentially hear and help the patient integrate with are not just the intellectual truths which the patient must deny to himself but rather those feelings which are the consequences of accepting the reality of those rejected intellectual truths. It is the experiential reality rather than the verbal reality that needs to be the focus of integration.

Therefore it should be clear that analysis of the patient's problem can have no real therapeutic effect because analysis is only an interpretive theoretical hypothesis applied to the patient's problem from outside the patient by the analyst who is trying to bring an intellectual understanding and synthesis to the problem. But the patient's real problem, most basically, regardless of how it is verbally presented to the therapist, is his inability to confront and integrate with the painful rejected realities of himself from which he is committed to running. That is the essence of his psychopathology.

Analysis is intellectual in nature and only serves to carry the patient away from contact with the painful subjective realities which he must confront in order to grow. Knowing *about* oneself is not the same as knowing oneself. Knowing oneself comes about through direct perception and experience, by actually being there at the place where the pain is at and being totally immersed in it. Then, instead of speaking for the pain or symptom as analysis would do, the patient through his reuniting and integration with the pain permits the pain to speak for itself until it runs its course to the end and exhausts itself. By reuniting and integrating himself with his pain, instead of identifying himself as just the observer or controller of it, the patient has taken the first essential step that leads to his becoming integrated with those former aspects of himself which he has rejected and repressed because their acknowledgment brings him pain. This greater sense of wholeness and integration is what is real psychological growth. Thus, for example, by being with the pain of what I call my loneliness, I am then in a position to integrate with that rejected part of me and essential reality which lies beneath that label of loneliness which may be, for example, the child in me, which feels so helpless and vulnerable and is so frightened of abandonment when left alone, and which I have longed repressed and denied is really part of my self.

In essence then, the basic commitment that the patient has to make to therapy involves the recognition that he is not coming for assistance by the therapist to help him escape from pain or help him discover some means of

mastery over it, but rather the commitment must be to face the pain of one's rejected experiential realities because he understands very clearly that it is the only means of really growing and liberating himself from the pain and therefore liberating himself from the pathological process which involves his need to distort both internal and external reality in order to escape from the threat of experiencing what he believes to be the annihilating capacity of that pain. Thus, it should be readily apparent to the reader that the therapist who cannot face his own psychological pain is really not in the position to ask the patient to accomplish something which in the therapist's own personal experience is not accomplishable.

Another essential factor that can help the patient to expose himself and permit himself to be vulnerable to the experiencing of psychological pain is the patient feeling a deep sense of trust toward the therapist. This sense of trust convinces him that should he permit himself to be vulnerable, the therapist will not take advantage of his vulnerability to hurt him. More specifically he must have trust that the therapist will not make him confront painful realities and then abandon him emotionally to face this threat of annihilation alone. It is this factor of lack of trust, probably more than any other, which serves as the basic deterrent to successful therapeutic outcome. It is the patient's clear conviction that the therapist is trustworthy which ultimately brings an end to the therapy-defeating process of resistance.

There are several basic ingredients which contribute greatly toward the patient feeling the kind of trust toward the therapist that will permit him to lower his defenses, feel vulnerable, confront pain and therefore to grow. One major factor is the therapist's own ability to take risks and make himself vulnerable when he is with the patient through his own openness and spontaneity of his own thoughts and feelings without concern for the preservation of any idealized image of self. Another factor is the honesty and sincerity of his responses to the patient. A third factor is his ability to really hear the patient which forms a bond of alliance with the patient and also tells him that he is really understood and appreciated. I find that compassion or love is the natural and spontaneous consequence of being in communion and really understanding the other person. Love is not a volitional act on the part of the ego but rather is, on the contrary, the result of the loss of the sense of self-awareness and is the natural consequence when one makes full contact with another human being even if at the moment of communion the patient is expressing extremely negative feelings. If the therapist is free of any self-concept identifications for himself and enters into the relationship with the patient as an unlabeled whole, then he will find that without it being a volitional act, feelings of compassion will flow spontaneously from him toward his patient. This is for me the true meaning of what some refer to as having unconditional positive regard for your patient or what others call the I-Thou relationship. This land of communion relationship is not only the

essence of what produces optimal hearing of the patient's moment-to-moment experiential reality by the therapist but is also the essence of what is necessary to produce the kind of therapeutic atmosphere and therapeutic alliance between the therapist and patient which has to exist for the patient to venture forth into his own self-exploration.

The kind of love that brings security to the patient is not to be confused with giving the patient a strong feeling of being valued or liked. These latter feelings are the result of an evaluative personal judgment of only some part of the patient. The patient, as an unlabeled whole, cannot be valued or judged. The patient intuitively knows that such evaluative judgments by the therapist are really subtle forms of rejection of him as a whole and it makes him feel very insecure because he knows that such positive judgments can quickly turn to negative evaluations if the patient ceases to personally satisfy the therapist and therefore they cannot produce any real sense of security and trust. But a nonjudgmental, compassionate form of love which flows as the natural consequence of fully understanding or knowing the patient contributes significantly to his development of a real sense of trust. The patient now feels free to be even his most negative self without the threat of being condemned or rejected. There is a real sense of security in knowing that the therapist has heard him and seen his most negative and rejected self and has not disliked him or used it against him; so there is no longer a great need to defend himself and therefore he is free to explore himself more fully.

However, the therapist’s capacity to hear and accept the rejected in the patient depends upon his openness to the negative in himself. If the therapist cannot bear to face his own psychological pain, then he is not in a position to hear and be empathic with the patient’s pain, for that empathy would only serve to trigger his own pain and threaten him with being overwhelmed. Therefore in running from contact with his own psychological pain he must also run from full contact with the patient.

One other major factor that probably contributes more than any other to the mistrust of the therapist by the patient is the patient’s recognition, at whatever level of consciousness, that the therapist himself is emotionally disturbed and needful in regard to the patient. This recognition is very threatening to the patient and makes him fearful that if he does not defend himself at all times that the therapist will manipulate him and use him for the gratification of his own needs. This makes it impossible for the patient to ever permit himself to be vulnerable and therefore it closes the door to the possibility of his achieving any real growth. Thus, it is absolutely essential that the therapist be free of any major psychopathology and of any need to use the patient as an object for attaining his own gratification or elevation in his self-esteem. Quite often students choose psychotherapy as a career precisely for these reasons. If the student is to really be an effective therapist it might be well for him to honestly explore his basic motivations for becoming a psychotherapist and thereby be in a position to prevent his

inappropriate needs from having a deleterious effect in therapy. It is toward this end that the next section is presented.

MOTIVATIONS FOR BECOMING A PSYCHOTHERAPIST

For the most part, students choose a career in the field of psychotherapy for honorable and noble reasons. They tend to have a deep sensitivity and empathy for persons who are experiencing psychic pain and difficulties in living. Most of these students also feel a sincere yearning to personally involve themselves in the process of helping to relieve these persons of their suffering and difficulties. Their sensitivity and empathy frequently grows out of their own related personal experiences, and also, in the Jungian sense, they tend to be persons to whom the assuming of the archetypal roles of the nurturant parent, teacher and healer comes easily and naturally.

However, in assuming these roles the student is frequently unwary of the many pitfalls and traps that he may inadvertently permit himself to fall into as a function of his individual personality and needs. As a result, in many cases in which psychotherapists attempt to help patients with their problems it becomes a matter of the "blind leading the blind." As the Scriptures (St. Luke 6:39-42) admonish: Can the blind lead the blind? Shall they not both fall into the ditch? The disciple is not above his master. . . . And why beholdest thou the mote that is in thy brother's eye, but perceivest not the beam that is

in thine own eye? . . . Thou hypocrite, cast out first the beam out of thine own eye, and then shalt thou see clearly to pull out the mote that is in thy brother’s eye.

In the same vein we need to recognize that the patient probably cannot grow beyond that level of emotional health and maturity achieved by his therapist. What the therapist cannot permit himself to be aware of in himself, he likely will also not be able to be aware of in the patient. Having conditioned himself to be insensitive and defensive toward himself in order not to have to confront certain unacceptable aspects of himself, the therapist then tends to carry over this conditioned insensitivity into his relationships with others. If the therapist is really to be effective, he must first eliminate those psychological problems within himself which are likely to result in distorted perceptions of his patient and of his psychotherapeutic endeavors.

After working closely for a long time with students in training to become psychotherapists, I have come to recognize some basic personality needs in students that are more likely than others to lead the student into the kind of pitfalls and traps that make it difficult for him to utilize the constructive motives that originally led him to choose to become a psychotherapist. These needs tend to make it extremely difficult for the therapist to be effective in his therapeutic endeavors with his patients.

The Need To Dominate

Some students have been so severely dominated and controlled by their parents that they seek a career that will offer them opportunities to be in the dominant and controlling position. They envision patients as being very needful and dependent, which they feel will offer the therapist a great opportunity to gratify his own basic need to dominate. These students are determined to be the superior one in a relationship, and they equate the inferior role with humiliation. They are trying to undo all of the humiliation they felt toward themselves for submitting and permitting their parents to dominate them and for this reason they harbor a secret revulsion toward all their patients for putting themselves in the inferior position of having to ask for help.

These therapists frequently become extremely antagonistic toward their patients, especially toward those in whom they expect to put some "backbone," and it is not unusual for them to quite often ridicule those patients who continue to remain passive and dependent. Some of their revulsion toward passive-dependent and submissive patients is usually related to the fact that these students have unconsciously come to equate submissiveness with femininity and dominance with masculinity. Those persons whom the student feels are trying to dominate him he also feels are trying to "castrate and feminize" him and by the same token he is

unconsciously perceiving all submissive persons as being castrated; for this reason he is revolted by them. This kind of therapist finds it almost impossible to endure silences during therapy or any other behavior on their part which they could possibly construe as being passive; for this reason they tend to be almost compulsively active and penetrating in their therapeutic approach toward their patients regardless of the therapeutic system or school to which they say they adhere.

The need to dominate is also observed in students with strong sociopathic and/or paranoid tendencies. Their need to control, manipulate and exploit others is basically a function of their worship of power. This craving for power and superiority which contributes toward their motivation to become a psychotherapist serves basically as a compensatory defense against their own despised feelings of weakness, fearfulness and vulnerability and also serves as a defense against their basic inability to trust and relate meaningfully and deeply with people.

In essence then, these students are busily engaged in a one-upmanship game with their patients. If they feel successful in influencing the patient and getting him to submit, then they feel that their compensatory need for power, which is used to offset their more basic feelings of weakness, helplessness and vulnerability, has been confirmed. If they cannot influence the patient, they become very upset because unconsciously it tends to confirm their more

basic conviction of their impotence and vulnerability. The methods they adopt for therapy usually are consistent with their need to influence and tend to offer them an opportunity for almost absolute control over their patient. Because the therapy relationship to most patients reflects a parent-child relationship, most patients tend to be very sensitive in regard to being overpowered and influenced because it confirms, for them too, that they are weak, helpless, vulnerable and impotent. It is for this reason that this kind of therapist usually is confronted with a great deal of resistance in his patients throughout the course of therapy.

Should the student who needs to dominate be confronted with a very aggressive patient and one who, similar to himself, needs to dominate, then the therapeutic interaction becomes extremely competitive and the therapist may utilize every possible interpretation and device in order to disarm the patient and make him finally submit. If the therapist cannot achieve this victory he will usually discharge the patient with some type of admonition that he had not been a good patient and probably cannot be helped in psychotherapy by anyone.

I find that a great many students are attracted to the field of psychotherapy out of a need for power. This need for power makes them become very hard and insensitive people, which destroys their capacity for hearing and truly empathizing with their patients. They essentially become

manipulators of their patients and are incapable of really caring about them or seeing any beauty in them.

These students find it extremely difficult to accept supervision or undergo their own personal psychotherapy because they perceive these relationships as involving a forced passivity on their part which makes them feel extremely anxious and vulnerable, and as a result they tend to aggressively resist these kinds of forced passive or submissive relationships.

The Voyeurist

Some students seek to use the therapeutic relationship as a way of peeking into the private lives of others. They are especially interested in sexual matters, but any kind of secret may hold erotic excitement for them. They are forever looking for such secrets in the patient's life, and the way they conduct therapy reflects their morbid curiosity. They frequently ask prying questions usually related to highly erotic and perverse sexuality. They usually become quite bored with patients who do not provide them with such discussions.

This kind of morbid curiosity may often stem not only from sexual voyeuristic tendencies but also from an environment in which parents habitually withheld certain information from the student when he was a child, which led to his feeling very insecure unless he "found out what was

going on." Not knowing becomes equated with helplessness and vulnerability and in order to reduce anxiety the student grows up with a morbid curiosity and "need to know" which eventually moves him in the direction of seeking a career as a psychotherapist.

The Exhibitionist

There are some narcissistic students who are so identified with and enamored by their physical appearance that they need to display themselves to others and require a steady stream of patients who, because of their needful state, will usually supply the therapist with an over-exaggerated reaction as to his desirability. There are other therapists who attempt to exhibit themselves via their wisdom and intellect and are unconsciously equating the potency of the head with a kind of phallic and masculine potency.

These therapists are forever offering interpretations to the patient and expecting him to reflect to them their admiration of their wisdom and potency of mind. They are unconsciously quite competitive with their patients because when the patient is talking, the therapist projects his own needs onto the patient and feels that the patient is trying to display himself. The therapist can hardly wait for the patient to stop talking so that he can have his turn to talk and thereby display himself again. The therapist is therefore quick to

interrupt the patient, which in a sense, by abruptly cutting him off, is a kind of castration of the patient; at the same time the therapist is really unconsciously "knocking the patient off the stage" and assuming the spotlight for himself. This kind of therapist also enjoys group therapy a great deal because the larger the audience he has, the more he enjoys displaying himself.

A Need for and Fear of Intimacy

I have progressively become more aware that there are many students and therapists who crave intimacy yet fear it, either because they are greatly apprehensive about emotional involvement for fear of getting hurt or because it is equated with union and therefore loss of self. Because their own identity or sense of self is not clearly established they unconsciously fear that intimacy will produce a state of fusion which will result in the loss of their individuality. The therapeutic relationship, they feel, will offer them a controlled type of intimacy. They envision that they will be in full control of the relationship which they expect will permit them to satisfy their need for intimacy and yet, because they control it, will prevent the over-involvement or loss of self which they fear. They cannot handle intimacy unless it is this controlled type of intimacy.

For those therapists in whom the *fear* of intimacy is greater than their *need* for intimacy, the therapist's stance in his role as a professional, rather

than as an involved other, limits the degree of intimacy and puts the control of this factor in his own hands. Other therapists, whose *need* for intimacy is greater than their *fear* of intimacy, tend to become overinvolved with their patients and lose the distinction between self and other and thereby become overly identified with the patient. They tend to suffer when the patient suffers and in general become overwhelmed with all kinds of countertransference feelings toward their patients. This distorts their perceptions of reality and greatly hampers their effectiveness as a psychotherapist.

Much intimacy of a sexual nature also goes on at the fantasy level with patients of the opposite sex which, for some students, provides a kind of vicarious sexual relationship which is highly erotic and stimulating. Some need this kind of sexual intimacy in order to confirm a sense of masculinity and sexual potency which they are unconsciously questioning in themselves, and they see all positive transference and valuing of the therapist by the opposite sex patient as such confirmation.

The Omnipotent Healer

Some students are unconsciously driven into choosing psychotherapy as a career by what may be called a “savior complex.” The “savior complex” is based primarily on an unconscious striving for a sense of omnipotence which is a reaction to an enormous inner feeling of fearfulness and helpless

vulnerability. They have a great need to exert their potency and prove their power by influencing others. They perceive themselves as being able to heal all those who come to them for help. Sometimes the first patient confronted who does not respond in a positive way or does not grow or change can traumatize the student seriously because he has come to identify himself with this role of omnipotent healer. The failure to fulfill the role can make him doubt the substance of his own identity and existence. Without this ideal to live up to, his life is disrupted immeasurably.

Many of these students will project the blame for the lack of therapeutic success onto the patient for having no capacity for growth rather than accept the reality that perhaps their capacity to help has some limitations. To some students the reality of the first non-growing patient can be extremely disturbing because they have the need to maintain the illusion of their own omnipotence which they unconsciously hold as being essential in order to feel a sense of security. These therapists envision therapy relationships as providing them with an opportunity, via the patient's adoration, reverence and growth, to substantiate the illusion of their own personal worth and omnipotence. Their need for omnipotence may also be revealed in their need to demonstrate to the patient that they have all the correct answers and also in their need to be able to condition and influence the patient's thinking and living. Many of these therapists also indulge their need to feel omnipotent by maintaining the attitude that the fate of their patient's psychic life and

happiness lies in their hands.

Another aspect of the “savior complex” found in some students and therapists is the belief that all the patient requires to get well is love and that they have this healing, loving capacity. I find that many of these students have come to believe that the only reason they were unhappy in life is that their parents did not love them enough. They therefore conclude that all anyone needs to be happy is sufficient love. When some patients fail to grow, in spite of the student’s “love,” the entire thread which has woven the meaning of his life together begins to unravel and he responds with great emotional disturbance.

The People Addict and the Lonely One

Some students in psychotherapy have led very lonely lives as children. They may have been an “only child” who always longed for companionship or lived in a neighborhood where friends were scarce. These people tend to grow up with an intense hunger for companions. They are constantly on the lookout for a pal. They tend many times to make personal friends of their patients and project that it is the patient who needs it and that the patient cannot grow without it. They envision a career as a therapist as providing them with a constant source of interpersonal relationships to relieve their panic of being lonely and isolated. Basically they need to use others as a

confirmation of their own worth and existence. When one has had for many years no significant other to relate to, unconsciously one comes to question the worth and viability of one's own existence.

The same thing is basically true of the "people addict" who also unconsciously feels that without someone to relate to, he does not exist. These are people with a poor sense of self because they were either always surrounded by a large number of family members and felt "lost in the shuffle" or else they always had to please some significant other, usually a parent, in order to feel safe and secure, and they thereby learned to localize the sense of self in the other instead of within themselves. For these kinds of students, to be alone is their greatest fear and they perceive the role of the therapist as being perfect for filling this basic need for a constant flow of interpersonal relationships.

The Need To Hurt and Be Hurt

I have encountered many student therapists with strong sadomasochistic features to their personality. Some are attracted to the field of psychotherapy because of their own heightened state of fearfulness which makes them unconsciously want to see other more frightened people than themselves and in some cases even contribute toward the intensification of the patient's fearfulness. The sadist is particularly attracted by helpless and

vulnerable persons, which makes working with emotionally disturbed people so attractive to him. I have seen many students rationalize their destructive anger toward their patient by calling it “good clean anger” and therefore insist that because it is honest, it is therapeutically helpful. Essentially they are trying to control and make the patient feel frightened of them in order to try to cloak their own interpersonal fearfulness.

Other more masochistic therapists tend to provoke their patients into abusing them. They invite attack by the patient upon them in numerous ways. Typically they will invite attack by their unconscious but deliberate failure to understand the patient, which makes the patient feel much more confused and frustrated, which then tends to make the patient direct his exasperation and anger onto the therapist. In essence, these therapists tend to provoke and encourage the negative transference. Some therapists achieve masochistic gratification by suffering along with the patient when the latter is suffering. This, of course, makes it impossible for the patient to “let himself go” and confront all of his own repressed feelings because he is afraid that the therapist will not be able to tolerate it. The patient then has to become concerned with protecting the therapist from hurt and is therefore unable to grow.

As is true in the field of nursing, medicine, social work and other related professions, students choose psychotherapy as a career because it is one of

the “helping professions,” and in so doing, they can, via reaction formation, deny to themselves and others their basic sadistic need to hurt others.

The Need To Be Loved and Needed

Some students who desire to become therapists are trying to compensate for very low feelings of self-esteem related to unconscious feelings of worthlessness which were usually precipitated by the fact that they never felt loved or valued by their parents. As their sense of self-esteem drops, their feelings of worthlessness increase and the unconscious equation that they make is that being totally worthless is the same as being totally nothing, and therefore a severe threat to their self-esteem is really a threat to their feeling of existence as a psychological self. They envision being a therapist as the optimal means of gaining love and thereby boosting their self-esteem. Such therapists tend to overly encourage the positive transference by continuously offering supportive, reassuring and complimentary remarks to the patient hoping that these will make the patient feel obligated to return to the therapist some kind of mutual admiration and affection.

Just as some students have a compulsive need to receive in the form of being loved, there are other students who have a compulsive need to give of themselves to others in the form of some kind of nurturant assistance, and therefore they have an intense need to be needed. This kind of student quite

often uses his image of himself as the “unselfish giver” as the primary means of elevating his low sense of self-esteem. He basically becomes the prototype of the nurturant mother who takes in and protects all the strays and underdogs of the world. This kind of therapist also tends to have a history of being unloved by parents and quite often what he is doing is identifying with his patient and giving him the kind of nurturance and love from a loving parent that he never received. By so doing, he feels as though he is making up for his own early years of deprivation. I have also observed this need to be the nurturant parent in students who have identified with an overly loving and doting parent.

As a result of his need to be needed, this kind of therapist unconsciously tends to keep his patients quite dependent and needful by continuously and forcefully offering the patient advice and suggestions. He is forever coming to the patient’s “rescue” when he is having difficulty with some aspect of his life or is very uncomfortable. To do for another what he is capable of doing for himself prevents the patient from ever growing and becoming aware that he is capable of dealing with life effectively on his own. These kinds of students become therapists because it is a “helping” profession and although they consciously are quite devoted to helping their patients to grow, they guarantee that just the reverse occurs through their compulsive ministrations of “help.”

These therapists can never satiate their need for self-esteem, for it only seems to be as high as their last success, and therefore, because it is so tenuous and precarious, their need for it becomes compulsive and insatiable.

The Self-Cure Seeker

There are many students who desire to become therapists because they feel that in the process they will learn enough about themselves to cure themselves of their own emotional disturbances. They secretly hold the conviction that they are severely disturbed and they are afraid to reveal their problems to anyone for fear that this illness will be exposed. They are determined that they can cure themselves and somehow they convince themselves that they can do so if only they can gather enough information in the area of personality, pathology and psychotherapeutic theory. When they find that they are unable to cure themselves just by the use of the intellectual knowledge which they have accumulated, they then unconsciously seek to work with patients similar to themselves and hope that by curing these patients they will somehow have found the cure for their own problems.

In many ways they are similar to the medical student who chooses to become a physician in order to deny and counter his unconscious but intense fear of death. The fantasy that is being acted out is the one that holds that if he can keep a patient from dying then maybe he will be able to do the same for

himself. Some students of psychotherapy are living out a similar fantasy in regard to mental illness.

The Need To Escape from Oneself

Another prevalent need found in many psychotherapists is the need to escape from their own unpleasant thoughts and problems. Similar to the gossiping neighbor, the therapist seeks to get involved in the problems of others as a way of escaping from the confrontation with his own very unpleasant existence. His life lacks meaning, sensitivity and intensity because he fives only on the surface of his own consciousness, always afraid to confront himself in regard to his own realities, so his mind becomes dull and insensitive. Needing to feel a sense of vitality, intensity of experience and meaning to his life, he becomes absorbed in the intensity of life of his patients and lives vicariously through their experience.

As a result of their alienation from themselves, the sense of identity in these therapists is very vague. Consequently they become overly identified with their role as professional psychotherapist, to the relative neglect of almost all other aspects of their lives, in order to fill their own inner emptiness. Their professional commitments usually become overly extended and they lose themselves in their professional work and in their patients; this kind of escape may become the basic pattern of their fives.

THE IMPORTANCE OF A PERSONAL GROWTH EXPERIENCE

Ideally, the most constructive and effective therapist is one who has gone through a meaningful growth experience of his own and knows directly the joy and peace that comes with liberation and the deep beauty that is within oneself and in one's capacity to love. Then there results a great unselfish need to want others to also have such an experience and to want to contribute in some way toward others achieving such a similar experience. The existence of any other selfish need will tempt the therapist consciously or unconsciously to use the patient for the gratification of the therapist's own needs. This does violence to the patient because it makes of him an object which is a form of destruction of him as a person.

Even if the therapist does not use the patient to fill his own unmet needs, these needs will probably still serve to distract **him** and thereby severely impair his capacity to be totally present to, and hear, what the patient is really trying to communicate. When the therapist with strong unmet needs becomes aware of a strong emotion or impulse within himself, he cannot be sure whether he is reacting to something in the patient or something solely in himself. The therapist is not in a position to trust himself, and therefore he cannot trust what he is hearing in the patient.

Thus, for example, if a therapist has strong doubts about his masculinity he will probably need to have his masculinity confirmed by the admiration of

his attractive female patients. Consequently, if he finds himself experiencing strong sexual feelings toward one of his female patients, he cannot be sure if it is an indication that he is surrendering his controls in regard to his sexual needs or if it is rather an indication that the patient is really deliberately trying to seduce him as a function of her own particular needs. Not being able to trust himself, he will not be sure of what is really happening and as a result of his confusion he will likely repress or consciously ignore awareness of the entire issue and thereby not have to deal with it in the patient or in himself. This impaired capacity to be aware of certain truths must then serve as a severe obstacle to the likelihood of a successful therapeutic outcome.

For these reasons I recommend that any student or therapist who recognizes that he is burdened by some kind of incapacitating need or problem or anyone who has not himself ever achieved a meaningful growth experience should consider getting involved in a personal psychotherapeutic experience if he is ever to become a truly effective psychotherapist.

PATIENT TRAPS

Just as the therapist's needs can serve as a trap which can ensnare him in a net of resistance and nonconstructive interactions with his patients, so too can the patient's needs. The therapist must be alert to the fact that the patient has a devotion and commitment to obtaining basic gratifications that

have long gone unsatisfied and of reviving previous traumatic situations in the hope that by reliving and re-experiencing the emotional event he may achieve some kind of mastery, resolution or integration of certain feelings which at the time they occurred were intolerable. Over and over again, they subtly force persons into playing certain roles with them and try to arouse certain behaviors, reactions or feelings in these persons which enables them to react in a way which they hope will resolve the situation, but unfortunately they usually tend to react in the same old way and so they are compulsed to repeat this event over and over again.

The therapist should learn to be alert to these forms of what may be called transference and repetition compulsion, because unless he is sensitive to what is happening he can frequently end up aggravating the patient's pathology. The student should not be misled into believing that these reactions by patients occur only to therapists who are pathological themselves or who are themselves involved in some kind of countertransference reaction to the patient. Even a therapist without large areas of significant pathology in himself can fall victim to these kinds of maneuverings by the patient.

The therapist should be constantly watchful and sensitive to what is happening within himself as a clue to what it is that the patient may be trying to accomplish with him, which probably relates to the patient's basic

problem. What is happening in the interaction between the patient and the therapist is quite often more important and significant than the content of what is being discussed, which is quite often used by the patient as a diversionary vehicle for camouflaging what he is really saying or doing to the therapist, such as making the therapist feel, for example, like a child, like a parent, angry, fearful, sexually aroused, stupid, impotent, neglectful, rejecting or elated.

The therapist should also recognize that not only might he fall into one trap with one patient and another trap with a different kind of patient, but even for any one patient his various needs and the various needs of the patient can entice him into many different traps and if he is not alert to these, then therapy can never be effective for it only encourages the perpetuation of the irrational acting-out that is taking place.

IS PSYCHOTHERAPY AN ART OR A SCIENCE?

An issue which is much discussed and frequently fought over, not only by students but also by faculty members and clinicians, is whether psychotherapy is really an art or a science. The answer to this question seems vital to many people in the field of psychotherapy because it seems to determine the way students are trained and the psychotherapeutic methods and philosophy that students will use. Quite often the stand that one takes in

regard to this issue is not based so much on what the individual has personally explored and found to be really true but tends rather to be based much more on the particular individual's need to be consistent with his particular conceptualization of the nature of man and life, which itself quite often stems from more basic personality needs. Thus, for example, those who need to see life as something to be mediated through the mind and senses and as something that is to be mastered and controlled tend to react to man in general and patients in particular in the same way; and those who need to conceptualize life as a work of art will tend to react to man and patients in terms of the pleasure of immediate experience and appreciation.

Probably both of these rather exclusive and absolute conceptualizations are a gross oversimplification of what is really true. I would have the student consider the likelihood that both are necessary and complementary to provide a full and complete understanding of any phenomenon. For example, the scientist will contribute a great part toward the understanding of the nature of an apple by studying its size, shape, color, texture and its other physical characteristics, and the artist will contribute too, but his approach to understanding the apple may be to take a bite out of it and taste it; this analogy applies to psychotherapy as well.

Unfortunately, not all those who purport to identify with the scientist's stand are really scientific and not all those who purport to identify with the

artist's stand are really artistic, but rather each tends to use his approach to life and man as a way of confirming an image of himself with which his personality needs require that he strongly identify. The student of psychotherapy who needs to identify himself as being an absolute scientist is usually one who needs to see himself as being powerful, masterful, intellectual, self-controlled and masculine, rejecting all traits of weakness, passivity and emotionality. He is usually someone who values having a strong will and enjoys feeling capable of doing battle with life and being victorious over it and in some cases superior to it as though looking down upon life as if from some godly perch. He unconsciously uses this illusion as the means of gaining a sense of security by identifying with a sense of being an omnipotent power. He basically feels that life and man are objects which have to be subdued and conquered, and he has to see himself as the conqueror in order to maintain the illusion of great power and deny his more basic conviction of great weakness and vulnerability or, perhaps, femininity, and so he uses the discipline of a science as the vehicle for domination and control over the elements in his life and for the purpose of self-concept confirmation.

On the other hand, the student who has strongly identified himself as the absolute artist tends to try to gain a feeling of personal superiority by trying to confirm an image of himself as someone who is tender, gentle, affectionate, emotional, sensitive, intimate, non-combative, esthetic, altruistic and nonmaterialistic. He identifies with all of these feelings as a value but

does not really experience them or live them as a reality. One is not an artist in the true sense of the word without having an inner sense of beauty and inspiration which serves as the generating source for artistic creations. Most of these students do not possess any significant degree of such feelings. In fact, quite often this identification serves as a cover for, and denial of, more unconscious and unacceptable destructive impulses. But in its absolutism it is similar to the absolutism of the scientist in its goal of attempting to achieve a sense of security through the pursuit of a form of omnipotence, but it differs in its identification with the loving attributes of godliness rather than the power attributes, which is the case for the absolute scientist.

Obviously psychotherapy must involve more than just the artistic component because it is not sufficient just to fully appreciate a person in psychic pain, whereas for the artist it is an end in itself just to be totally sensitive to and in full contact with the reality of that person and his pain. The therapist goes beyond just the artistic when he concerns himself with an understanding of the process of growth and makes a commitment to being in a profession which is devoted to helping the person who comes to him with a desire to achieve a sense of liberation from his pain.

To the degree that psychotherapy is an art, it is a creative art rather than an imitative or interpretive art. An analogy would be in the field of music in which the creator of a composition engages in a creative art, whereas the

concert pianist who plays the composer's work, however masterfully, is engaged in an imitative or interpretive art in the sense that his self-expression is primarily dominated by a patterned, external influence, whereas for the composer the self-expression is primarily a manifestation of his own creative inner experiential reality.

I see creativity essentially as being that *state of mind* in which there exists the absence of the deliberate thinker. It is that state of mind in which consciousness is free flowing without the intrusion or interference of a censor which initiates, controls or attempts to direct the content and movement of thought and feeling. It is also that open and passively receptive state of mind in which consciousness meets a confronting challenge without a rehearsed or predetermined conditioning, expectation or commitment to that challenge. It involves permitting the stimulus to operate upon you and trigger in you whatever it will, without any interference on your part to predetermine what your reaction or response should be.

When consciousness is uncommitted or not put in a mental straitjacket, then it is open and receptive, not only to all kinds of influences from the outside but also influences from the unconscious; and as a result, one has available, to meet any challenge or problem, relevant elements from both consciousness and unconsciousness. When one's consciousness alone is brought to bear on a challenge or problem, then the ability to deal with it is

always incomplete and fragmented. It would be as though a ship traveling at night were to consider only the surfaced part of an iceberg to be a relevant threat but take no account of the submerged aspect of the iceberg. Thus, when you are in a creative state of mind you are bringing more of yourself than your conscious awareness to every problem and challenge in life. You come to every situation with a potential for integration of both conscious and unconscious relevant factors.

When the mind is pre-committed, then it is a closed mind and unreceptive to a wide variety of relevant external stimuli and also closed to elements from the unconscious that could also possibly be relevant to the situation. The mind is uncommitted only when consciousness is not trying to move to get somewhere. It is not committed to becoming or achieving any special thing. Therefore, approaching a situation with the hope of attaining some kind of specific goal or objective prevents a creative interaction with that situation.

You cannot be taught to be creative and spontaneous any more than you can be taught to be sensitive or to love, for these states exist only when the mind is not rehearsed or patterned in any way. So no path, method or formula can ever lead you to creativity and spontaneity. No one can teach you the loss of the sense of self-consciousness in the absorption of communion with the moment-to-moment actual reality, which is necessary if one is to be creative

and spontaneous in living. It can never be the result of some deliberate or contrived act for all such acts stem from the self as the one who acts (that is, the doer) which only serves to arouse and heighten self-consciousness. For that reason the more effort you make to be creative, the less creativity can result. Creativity is not something that can be pursued, but rather it is something which *comes to you* when all effort-making and pursuing ends, for only then is the sense of self-consciousness put to rest.

Effective psychotherapy is creative in the sense that reality is created from moment to moment as a function of the non-contrived and non-predetermined interaction between the therapist and the patient. The therapist never knows in advance what the patient is going to say nor does he know in advance what his reaction will be, and in that sense reality is created from moment to moment and from that creative reality comes real hearing, understanding and integration.

Many therapists hide behind their professionalism as a way of avoiding a real creative human encounter with the patient. Because of his "professionalism" he conceptualizes his role as a master technician and tends to be more interested in the "case" than the person, more interested in following his formula to the letter than in the challenge of the patient's problem and moment-to-moment reality, and more interested in *his* truth than in *the* truth. When the therapist is lacking an affective appreciation of

what the patient is experiencing and has only an intellectual appreciation, there tends to result a basic intolerance for the patient's suffering and his understanding of the patient must always be incomplete. He is always outside the patient's range of contact. The therapist may say "I understand you" or "I care about you," but the patient could make the same response as the boy did to his father who while spanking him reflected, "This hurts me more than it does you." "Yes, but not in the same place," was the boy's reply.

Psychotherapy cannot be absolute in its scientific or artistic aspects because man is not. The patient is a synthesis of intellectual, sensory and experiential components and psychotherapy must correspond and be the same. It cannot treat only part of the man and hope to be a real, effective therapy. A whole, integrated man cannot be the end, if the means involves only dealing with the partial man. The therapist must come to his patient as a blend of the artistic substance and the scientific form. As any artistic creation is the result of a blending of the artist's deep inner feelings of beauty and inspiration which serve as the substance, essence or source of the creation, as well as his training in theory and practice which serves to mold the specific form and manifestation of the creation, so too must the psychotherapist and psychotherapy be a blend of these same aspects.

To be able to be fully attuned and sensitive to the patient in order to really hear and understand him, the psychotherapist must have his theories

of psychodynamics, psychopathology and psychotherapy as well as an inner sense of inspiration, beauty and warmth, but these all must be synthesized into a creative whole from which then flows his spontaneous responses of that which he creatively hears. Ideally, the therapist should be not only a synthesis of what man is but also participant in the highest of what man can be so that he will know how to arouse and elicit the highest in the patient.

In psychotherapy, as with any other art, when the quality of feeling is lacking, the art is then prostituted; for example, for an artist to paint a picture of a tree without having some kind of deep inner feeling of beauty or love for that tree or toward what trees in general represent to him prostitutes the work, for then his painting is little more than a picture of a tree that can be captured accurately in its formal qualities with just a camera. The same is true for some therapists who work with patients and have not the available capacity to love them or see beauty in them but rather mechanically attempt to dissect the patient in order to understand him intellectually. This is a prostitution of the art of interpersonal relationships and psychotherapy because his intercourse with the patient is without real affective investment. He is just going through the motions of relationship.

Just as painting, music or poetry requires some kind of inspiration as the source for these artistic manifestations, in order to be considered as creative and meaningful, so too psychotherapy requires inspiration on the

part of the therapist to be creative and meaningful. This inspiration is based on the therapist's capacity for loving and possessing an inner sense of beauty. To sing, one must have a song in his heart. To help the patient to have his own "song" requires that the therapist have one of his own. The therapist's own inspirational feelings, more than any other factor, contributes toward arousing that same thing in the patient. Beauty begets beauty and warmth begets warmth.

It is from such a state of inspiration that the total action of all therapy needs to emanate. Unfortunately most training centers in psychotherapy concentrate mostly on teaching therapists what to *do* because they are at a loss as to how to teach a therapist how to *feel.* They are not in a position to inspire and elevate the therapist because they themselves are basically uninspired.

Many universities offer courses in art appreciation but can the appreciation of art really be taught? For an appreciation of art to be taught one must be able to teach the appreciation of beauty. But just the intellectual appreciation of form, structure and composition is not the appreciation of beauty. Beauty emanates from love and inspiration and that cannot be taught but it can be developed as a result of continuous self-sensitivity. Art is beauty, shared or made manifest, but beauty is never the manifested but only that which gives rise to the manifested. As Gibran puts it, "Where shall you seek

beauty, and how shall you find her unless she herself be your way and your guide?”

Without those inspirational feelings of beauty the therapist enters into the human encounter with his patient deprived of his most basic and potent tool. In the training of psychotherapists we must become more interested in helping our students to be beautiful people, in the true sense of the word, and then maybe they will know something of how to help others really be happy. Psychotherapy must amount to more than just being a process for symptom removal; it must begin to study and understand the essence of the nature of joy, beauty, and warmth and the inspirational mother of these offspring—love. If *we* do not do it, who then will?

This entire discussion is succinctly yet profoundly reflected and summarized in a simple poem by E. E. Cummings, which reads as follows:

While you and I have lips and voices which are for kissing and to sing with who cares if some one-eyed son of a bitch invents an instrument to measure Spring with.

PSYCHOTHERAPY: THE ART OF THE INTERSUBJECTTVE

Basically, psychotherapy may be defined as the art of the creative intersubjective relationship. In contrast to the intersubjective relationship is

the interpersonal relationship. An interpersonal relationship involves just an objective interaction between two persons. The word “person” comes from the Latin word “persona,” meaning mask. An interpersonal relationship then is one in which each of the two members of the relationship is relating to the other *as* the mask or social role which he displays to his interpersonal world; he is relating only *to* the mask or social role of the other.

On the other hand, in the true intersubjective relationship each is relating to the other with what is subjectively most real in himself and to what he sensitively feels to be most subjectively real in the other. The intersubjective is a getting-through to the other’s deepest aliveness. The intersubjective is the light, heat and energy generated in the interpersonal. If someone goes into a store and asks for a container of milk, that is interpersonal; but if he senses that the clerk feels depressed and says something supportive to cheer him, then that is intersubjective. It is the difference between seeing only the grades or seeing also the eyes of the child who is presenting his report card.

Two friends may meet, both smile sweetly, each asking about how the other is, each replying “fine”; they are only just going through the motions of relationship for it really is more an interaction than a relationship, no matter how long they have known each other, because the intersubjective has not been stirred. Yet it may be that the eyes of strangers may meet only

momentarily and it is immediately clear that the intersubjective has been awakened and involved. There is an old Chinese story about a man who asked his friend

"Do you love me?"

"Yes, of course, I love you," said his friend.

"Do you know what's bothering me?" the man persisted.

"No, how can I?" demanded the friend.

"Then you don't love me," the man said sadly.

In the same way patients in psychotherapy equate caring and concern on the part of the therapist with the therapist's being sensitive to his (the patient's) subjective. The basic concern on the part of the patient (and the Chinese man in the illustration) is not so much, "Do you know what's bothering me?" but rather "Do you *care* to know what's bothering me?" To really care about another is to hear the subjective of the other. One cannot hope to demonstrate concern and caring for another by just the giving of supportive and flattering words but only by the intersubjective hearing of the other. As the therapist hears and speaks to the subjective of the patient, the patient learns to be sensitive to and hear his own subjective, and by so doing,

he comes in contact with that which is most real in himself and integrates himself as a real person instead of some imaginal or conceptual ideal.

In both casual contacts and established relationships, intersubjective caring is the step out of our narrow, egocentric preoccupation and turned-off isolation. Both for the carer and cared for, it redeems the world in all the little daily transactions. Intersubjective hearing and caring is the first step out of solitary confinement and is the essence of the therapeutic relationship.

Therefore, a meaningful definition of a good therapist is not just one who has published a large number of books and articles or one who has given many therapy workshops or one who has received many awards or holds high office in professional organizations, for the capacity to be therapeutic is not related to how renowned one is but is much more related to how sensitive one can be to the truth of the patient's moment-to-moment subjective reality. Regardless of the profoundness and uniqueness of one's theories and techniques, you will never be effective as a therapist if you cannot hear the truth of the patient's moment-to-moment subjective reality. Therefore, the judgment of whether or not you are a good therapist is one that can be made only at any given moment in therapy and is not some kind of an absolute, enduring or final judgment. This means that at any given moment in therapy, even the most naive student, in terms of degree of experience, can be better than the most experienced and "sophisticated" therapist if he can be

fully attuned and clearly and precisely hear the truth of the patient's moment-to-moment subjective reality and has the sensitivity, openness and courage to respond honestly with his own subjective reality. At that moment he is the very best therapist that anyone can possibly be, and therapy is as effective as it can possibly be.

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