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The Gift of Therapy

Irvin D. Yalom, M.D.

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AN OPEN LETTER TO A NEW GENERATION OF THERAPISTS AND THEIR PATIENTS

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to Marilyn,
soul mate for over fifty years.
still counting.

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Introduction

It is dark. I come to your office but can't find you. Your office is empty. I enter and look around. The only thing there is your Panama hat. And it is all filled with cobwebs.

My patients' dreams have changed. Cobwebs fill my hat. My office is dark and deserted. I am nowhere to be found.

My patients worry about my health: Will I be there for the long haul of therapy? When I leave for vacation, they fear I will never return. They imagine attending my funeral or visiting my grave.

My patients do not let me forget that I grow old. But they are only doing their job: Have I not asked them to disclose all feelings, thoughts, and dreams? Even potential new patients join the chorus and, without fail, greet me with the question: "Are you *still* taking on patients?"

One of our chief modes of death denial is a belief in personal *specialness,* a conviction that we are exempt from biologi-

cal necessity and that life will not deal with us in the same harsh way it deals with everyone else. I remember, many years ago, visiting an optometrist because of diminishing vision. He asked my age and then responded: "Forty-eight, eh? Yep, you're right on schedule!"

Of course I knew, consciously, that he was entirely correct, but a cry welled up from deep within: "What schedule? *Who's* on schedule? It is altogether right that you and others may be on schedule, but certainly not I!"

And so it is daunting to realize that I am entering a designated later era of life. My goals, interests, and ambitions are changing in predictable fashion. Erik Erikson, in his study of the life cycle, described this late-life stage as *generativity*, a post-narcissism era when attention turns from expansion of oneself toward care and concern for succeeding generations. Now, as I have reached seventy, I can appreciate the clarity of Erikson's vision. His concept of generativity feels right to me. I want to pass on what I have learned. And as soon as possible.

But offering guidance and inspiration to the next generation of psychotherapists is exceedingly problematic today, because our field is in such crisis. An economically driven health-care system mandates a radical modification in psychological treatment, and psychotherapy is now obliged to be streamlined—that is, above all, *inexpensive* and, perforce, brief, superficial, and insubstantial.

I worry where the next generation of effective psychotherapists will be trained. Not in psychiatry residency training programs. Psychiatry is on the verge of abandoning the field of psychotherapy. Young psychiatrists are forced to specialize in psychopharmacology because third-party payers now reimburse for psychotherapy only if it is delivered by low-fee (in other words, minimally trained) practitioners. It seems certain that the present generation of psychiatric clinicians, skilled in

both dynamic psychotherapy and in pharmacological treatment, is an endangered species.

What about clinical psychology training programs—the obvious choice to fill the gap? Unfortunately, clinical psychologists face the same market pressures, and most doctorate-granting schools of psychology are responding by teaching a therapy that is symptom-oriented, brief, and, hence, reimbursable.

So I worry about psychotherapy—about how it may be deformed by economic pressures and impoverished by radically abbreviated training programs. Nonetheless, I am confident that, in the future, a cohort of therapists coming from a variety of educational disciplines (psychology, counseling, social work, pastoral counseling, clinical philosophy) will continue to pursue rigorous postgraduate training and, even in the crush of HMO reality, will find patients desiring extensive growth and change willing to make an open-ended commitment to therapy. It is for these therapists and these patients that I write *The Gift of Therapy*.

THROUGHOUT THESE PAGES I advise students against sectarianism and suggest a therapeutic pluralism in which effective interventions are drawn from several different therapy approaches. Still, for the most part, I work from an interpersonal and existential frame of reference. Hence, the bulk of the advice that follows issues from one or the other of these two perspectives.

Since first entering the field of psychiatry, I have had two abiding interests: group therapy and existential therapy. These are parallel but separate interests: I do not practice "existential group therapy"—in fact, I don't know what that would be. The two modes are different not only because of the format (that is, a group of approximately six to nine members versus a one-to-one setting for existential psychotherapy) but in their funda-

mental *frame of reference*. When I see patients in group therapy I work from an interpersonal frame of reference and make the assumption that patients fall into despair because of their inability to develop and sustain gratifying interpersonal relationships.

However, when I operate from an existential frame of reference, I make a very different assumption: patients fall into despair as a result of a confrontation with harsh facts of the human condition—the "givens" of existence. Since many of the offerings in this book issue from an existential framework that is unfamiliar to many readers, a brief introduction is in order.

Definition of existential psychotherapy: *Existential psychotherapy is a dynamic therapeutic approach that focuses on concerns rooted in existence.*

Let me dilate this terse definition by clarifying the phrase "dynamic approach." *Dynamic* has both a lay and technical definition. The lay meaning of *dynamic* (derived from the Greek root *dynasthai,* to have power or strength) implying forcefulness or vitality (to wit, *dynamo,* a dynamic football runner or political orator) is obviously not relevant here. But if that were the meaning, applied to our profession, then where is the therapist who would claim to be other than a dynamic therapist, in other words, a sluggish or inert therapist?

No, I use "dynamic" in its *technical* sense, which retains the idea of force but is rooted in Freud's model of mental functioning, positing that *forces* in conflict within the individual generate the individual's thought, emotion, and behavior. Furthermore—and this is a crucial point—*these conflicting forces exist at varying levels of awareness; indeed some are entirely unconscious.*

So existential psychotherapy is a dynamic therapy that, like the various psychoanalytic therapies, assumes that unconscious forces influence conscious functioning. However, it

parts company from the various psychoanalytic ideologies when we ask the next question: What is the nature of the conflicting internal forces?

The existential psychotherapy approach posits that the inner conflict bedeviling us issues not only from our struggle with suppressed instinctual strivings or internalized significant adults or shards of forgotten traumatic memories, but also *from our confrontation with the "givens" of existence*.

And what are these "givens" of existence? If we permit ourselves to screen out or "bracket" the everyday concerns of life and reflect deeply upon our situation in the world, we inevitably arrive at the deep structures of existence (the "ultimate concerns," to use theologian Paul Tillich's term). Four ultimate concerns, to my view, are highly salient to psychotherapy: death, isolation, meaning in life, and freedom. (Each of these ultimate concerns will be defined and discussed in a designated section.)

Students have often asked why I don't advocate training programs in existential psychotherapy. The reason is that *I've never considered existential psychotherapy to be a discrete, freestanding ideological school*. Rather than attempt to develop existential psychotherapy curricula, I prefer to supplement the education of all well-trained dynamic therapists by increasing their *sensibility to existential issues*.

Process and content. What does existential therapy look like in practice? To answer that question one must attend to both "content" and "process," the two major aspects of therapy discourse. "Content" is just what it says—the precise words spoken, the substantive issues addressed. "Process" refers to an entirely different and enormously important dimension: the interpersonal relationship between the patient and therapist.

When we ask about the "process" of an interaction, we mean: What do the words (and the nonverbal behavior as well) tell us about the nature of the relationship between the parties engaged in the interaction?

If my therapy sessions were observed, one might often look in vain for lengthy explicit discussions of death, freedom, meaning, or existential isolation. Such existential *content* may be salient for only some (but not all) patients at some (but not all) stages of therapy. In fact, the effective therapist should never try to force discussion of any content area: *Therapy should not be theory-driven but relationship-driven*.

But observe these same sessions for some characteristic *process* deriving from an existential orientation and one will encounter another story entirely. A heightened sensibility to existential issues deeply *influences the nature of the relationship of the therapist and patient and affects every single therapy session*.

I myself am surprised by the particular form this book has taken. I never expected to author a book containing a sequence of tips for therapists. Yet, looking back, I know the precise moment of inception. Two years ago, after viewing the Huntington Japanese gardens in Pasadena, I noted the Huntington Library's exhibit of best-selling books from the Renaissance in Great Britain and wandered in. Three of the ten exhibited volumes were books of numbered "tips"—on animal husbandry, sewing, gardening. I was struck that even then, hundreds of years ago, just after the introduction of the printing press, lists of tips attracted the attention of the multitudes.

Years ago, I treated a writer who, having flagged in the writing of two consecutive novels, resolved never to undertake another book until one came along and bit her on the ass. I chuckled at her remark but didn't really comprehend what she meant until that moment in the Huntington Library when the idea of a book of tips bit me on the ass. On the spot, I resolved

to put away other writing projects, to begin looting my clinical notes and journals, and to write an open letter to beginning therapists.

Rainer Maria Rilke's ghost hovered over the writing of this volume. Shortly before my experience in the Huntington Library, I had reread his *Letters to a Young Poet* and I have consciously attempted to raise myself to his standards of honesty, inclusiveness, and generosity of spirit.

The advice in this book is drawn from notes of forty-five years of clinical practice. It is an idiosyncratic mélange of ideas and techniques that I have found useful in my work. These ideas are so personal, opinionated, and occasionally original that the reader is unlikely to encounter them elsewhere. Hence, this volume is in no way meant to be a systematic manual; I intend it instead as a supplement to a comprehensive training program. I selected the eighty-five categories in this volume randomly, guided by my passion for the task rather than by any particular order or system. I began with a list of more than two hundred pieces of advice, and ultimately pruned away those for which I felt too little enthusiasm.

One other factor influenced my selection of these eighty-five items. My recent novels and stories contain many descriptions of therapy procedures I've found useful in my clinical work but, since my fiction has a comic, often burlesque tone, it is unclear to many readers whether I am serious about the therapy procedures I describe. *The Gift of Therapy* offers me an opportunity to set the record straight.

As a nuts-and-bolts collection of favorite interventions or statements, this volume is long on technique and short on theory. Readers seeking more theoretical background may wish to read my texts *Existential Psychotherapy* and *The Theory and Practice of Group Psychotherapy,* the mother books for this work.

Being trained in medicine and psychiatry, I have grown

accustomed to the term *patient* (from the Latin *patiens*—one who suffers or endures) but I use it synonymously with *client,* the common appellation of psychology and counseling traditions. To some, the term *patient* suggests an aloof, disinterested, unengaged, authoritarian therapist stance. But read on—I intend to encourage throughout a therapeutic relationship based on engagement, openness, and egalitarianism.

Many books, my own included, consist of a limited number of substantive points and then considerable filler to connect the points in a graceful manner. Because I have selected a large number of suggestions, many freestanding, and omitted much filler and transitions, the text will have an episodic, lurching quality.

Though I selected these suggestions haphazardly and expect many readers to sample these offerings in an unsystematic manner, I have tried, as an afterthought, to group them in a reader-friendly fashion.

The first section (1–40) addresses the nature of the therapist-patient relationship, with particular emphasis on the here-and-now, the therapist's use of the self, and therapist self-disclosure.

The next section (41–51) turns from process to *content* and suggests methods of exploring the ultimate concerns of death, meaning in life, and freedom (encompassing responsibility and decision).

The third section (52–76) addresses a variety of issues arising in the everyday conduct of therapy.

In the fourth section (77–83) I address the use of dreams in therapy.

The final section (84–85) discusses the hazards and privileges of being a therapist.

This text is sprinkled with many of my favorite specific

phrases and interventions. At the same time I encourage spontaneity and creativity. *Hence do not view my idiosyncratic interventions as a specific procedural recipe; they represent my own perspective and my attempt to reach inside to find my own style and voice*. Many students will find that other theoretical positions and technical styles will prove more compatible for them. The advice in this book derives from my clinical practice with moderately high- to high-functioning patients (rather than those who are psychotic or markedly disabled) meeting once or, less commonly, twice a week, for a few months to two to three years. My therapy goals with these patients are ambitious: in addition to symptom removal and alleviation of pain, I strive to facilitate personal growth and basic character change. I know that many of my readers may have a different clinical situation: a different setting with a different patient population and a briefer duration of therapy. Still it is my hope that readers find their own creative way to adapt and apply what I have learned to their own particular work situation.

Acknowledgments

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CHAPTER 1

Remove the Obstacles to Growth

When I was finding my way as a young psychotherapy student, the most useful book I read was Karen Horney's *Neurosis and Human Growth*. And the single most useful concept in that book was the notion that the human being has an inbuilt propensity toward self-realization. If obstacles are removed, Horney believed, the individual will develop into a mature, fully realized adult, just as an acorn will develop into an oak tree.

"Just as an acorn develops into an oak . . ." What a wonderfully liberating and clarifying image! It forever changed my approach to psychotherapy by offering me a new vision of my work: My task was to remove obstacles blocking my patient's path. I did not have to do the entire job; I did not have to inspirit the patient with the desire to grow, with curiosity, will, zest for life, caring, loyalty, or any of the myriad of characteristics that make us fully human. No, what I had to do was to identify and remove obstacles. The rest would follow automatically, fueled by the self-actualizing forces within the patient.

I remember a young widow with, as she put it, a "failed heart"—an inability ever to love again. It felt daunting to address the inability to love. I didn't know how to do that. But dedicating myself to identifying and uprooting her many blocks to loving? I could do that.

I soon learned that love felt treasonous to her. To love another was to betray her dead husband; it felt to her like pounding the final nails in her husband's coffin. To love another as deeply as she did her husband (and she would settle for nothing less) meant that her love for her husband had been in some way insufficient or flawed. To love another would be self-destructive because loss, and the searing pain of loss, was inevitable. To love again felt irresponsible: she was evil and jinxed, and her kiss was the kiss of death.

We worked hard for many months to identify all these obstacles to her loving another man. For months we wrestled with each irrational obstacle in turn. But once that was done, the patient's internal processes took over: she met a man, she fell in love, she married again. I didn't have to teach her to search, to give, to cherish, to love—I wouldn't have known how to do that.

A few words about Karen Horney: Her name is unfamiliar to most young therapists. Because the shelf life of eminent theorists in our field has grown so short, I shall, from time to time, lapse into reminiscence—not merely for the sake of paying homage but to emphasize the point that our field has a long history of remarkably able contributors who have laid deep foundations for our therapy work today.

One uniquely American addition to psychodynamic theory is embodied in the "neo-Freudian" movement—a group of clinicians and theorists who reacted against Freud's original focus on drive theory, that is, the notion that the developing individual is largely controlled by the unfolding and expression of inbuilt drives.

Instead, the neo-Freudians emphasized that we consider the vast influence of the interpersonal environment that envelops the individual and that, throughout life, shapes character structure. The best-known interpersonal theorists, Harry Stack Sullivan, Erich Fromm, and Karen Horney, have been so deeply integrated and assimilated into our therapy language and practice that we are all, without knowing it, neo-Freudians. One is reminded of Monsieur Jourdain in Molière's *Le Bourgeois Gentilhomme,* who, upon learning the definition of "prose," exclaims with wonderment, "To think that all my life I've been speaking prose without knowing it."

CHAPTER 2

Avoid Diagnosis
(Except for Insurance Companies)

Today's psychotherapy students are exposed to too much emphasis on diagnosis. Managed-care administrators demand that therapists arrive quickly at a precise diagnosis and then proceed upon a course of brief, focused therapy that matches that particular diagnosis. Sounds good. Sounds logical and efficient. But it has precious little to do with reality. It represents instead an illusory attempt to legislate scientific precision into being when it is neither possible nor desirable.

Though diagnosis is unquestionably critical in treatment considerations for many severe conditions with a biological substrate (for example, schizophrenia, bipolar disorders, major affective disorders, temporal lobe epilepsy, drug toxicity, organic or brain disease from toxins, degenerative causes, or infectious agents), diagnosis is often *counterproductive* in the everyday psychotherapy of less severely impaired patients.

Why? For one thing, psychotherapy consists of a gradual unfolding process wherein the therapist attempts to know the patient as fully as possible. A diagnosis limits vision; it dimin-

ishes ability to relate to the other as a person. Once we make a diagnosis, we tend to selectively inattend to aspects of the patient that do not fit into that particular diagnosis, and correspondingly overattend to subtle features that appear to confirm an initial diagnosis. What's more, a diagnosis may act as a self-fulfilling prophecy. Relating to a patient as a "borderline" or a "hysteric" may serve to stimulate and perpetuate those very traits. Indeed, there is a long history of iatrogenic influence on the shape of clinical entities, including the current controversy about multiple-personality disorder and repressed memories of sexual abuse. And keep in mind, too, the low reliability of the DSM personality disorder category (the very patients often engaging in longer-term psychotherapy).

And what therapist has not been struck by how much easier it is to make a DSM-IV diagnosis following the first interview than much later, let us say, after the tenth session, when we know a great deal more about the individual? Is this not a strange kind of science? A colleague of mine brings this point home to his psychiatric residents by asking, "If you are in personal psychotherapy or are considering it, what DSM-IV diagnosis do you think your therapist could justifiably use to describe someone as complicated as you?"

In the therapeutic enterprise we must tread a fine line between some, but not too much, objectivity; if we take the DSM diagnostic system too seriously, if we really believe we are truly carving at the joints of nature, then we may threaten the human, the spontaneous, the creative and uncertain nature of the therapeutic venture. Remember that the clinicians involved in formulating previous, now discarded, diagnostic systems were competent, proud, and just as confident as the current members of the DSM committees. Undoubtedly the time will come when the DSM-IV Chinese restaurant menu format will appear ludicrous to mental health professionals.

CHAPTER 3

Therapist and Patient as "Fellow Travelers"

André Malraux, the French novelist, described a country priest who had taken confession for many decades and summed up what he had learned about human nature in this manner: "First of all, people are much more unhappy than one thinks . . . and there is no such thing as a grown-up person." Everyone—and that includes therapists as well as patients—is destined to experience not only the exhilaration of life, but also its inevitable darkness: disillusionment, aging, illness, isolation, loss, meaninglessness, painful choices, and death.

No one put things more starkly and more bleakly than the German philosopher Arthur Schopenhauer:

> In early youth, as we contemplate our coming life, we are like children in a theater before the curtain is raised, sitting there in high spirits and eagerly waiting for the play to begin. It is a blessing that we do not know what is really going to happen. Could we foresee it, there are

> times when children might seem like condemned prisoners, condemned, not to death, but to life, and as yet all unconscious of what their sentence means.

Or again:

> We are like lambs in the field, disporting themselves under the eyes of the butcher, who picks out one first and then another for his prey. So it is that in our good days we are all unconscious of the evil that Fate may have presently in store for us—sickness, poverty, mutilation, loss of sight or reason.

Though Schopenhauer's view is colored heavily by his own personal unhappiness, still it is difficult to deny the inbuilt despair in the life of every self-conscious individual. My wife and I have sometimes amused ourselves by planning imaginary dinner parties for groups of people sharing similar propensities—for example, a party for monopolists, or flaming narcissists, or artful passive-aggressives we have known or, conversely, a "happy" party to which we invite only the truly happy people we have encountered. Though we've encountered no problems filling all sorts of other whimsical tables, we've never been able to populate a full table for our "happy people" party. Each time we identify a few characterologically cheerful people and place them on a waiting list while we continue our search to complete the table, we find that one or another of our happy guests is eventually stricken by some major life adversity—often a severe illness or that of a child or spouse.

This tragic but realistic view of life has long influenced my relationship to those who seek my help. Though there are many phrases for the therapeutic relationship (patient/therapist, client/counselor, analysand/analyst, client/facilitator, and the

latest—and, by far, the most repulsive—user/provider), none of these phrases accurately convey my sense of the therapeutic relationship. Instead I prefer to think of my patients and myself as *fellow travelers,* a term that abolishes distinctions between "them" (the afflicted) and "us" (the healers). During my training I was often exposed to the idea of the fully analyzed therapist, but as I have progressed through life, formed intimate relationships with a good many of my therapist colleagues, met the senior figures in the field, been called upon to render help to my former therapists and teachers, and myself become a teacher and an elder, I have come to realize the mythic nature of this idea. We are all in this together and there is no therapist and no person immune to the inherent tragedies of existence.

One of my favorite tales of healing, found in Hermann Hesse's *Magister Ludi,* involves Joseph and Dion, two renowned healers, who lived in biblical times. Though both were highly effective, they worked in different ways. The younger healer, Joseph, healed through quiet, inspired listening. Pilgrims trusted Joseph. Suffering and anxiety poured into his ears vanished like water on the desert sand and penitents left his presence emptied and calmed. On the other hand, Dion, the older healer, actively confronted those who sought his help. He divined their unconfessed sins. He was a great judge, chastiser, scolder, and rectifier, and he healed through active intervention. Treating the penitents as children, he gave advice, punished by assigning penance, ordered pilgrimages and marriages, and compelled enemies to make up.

The two healers never met, and they worked as rivals for many years until Joseph grew spiritually ill, fell into dark despair, and was assailed with ideas of self-destruction. Unable to heal himself with his own therapeutic methods, he set out on a journey to the south to seek help from Dion.

On his pilgrimage, Joseph rested one evening at an oasis, where he fell into a conversation with an older traveler. When Joseph described the purpose and destination of his pilgrimage, the traveler offered himself as a guide to assist in the search for Dion. Later, in the midst of their long journey together the old traveler revealed his identity to Joseph. Mirabile dictu: he himself was Dion—the very man Joseph sought.

Without hesitation Dion invited his younger, despairing rival into his home, where they lived and worked together for many years. Dion first asked Joseph to be a servant. Later he elevated him to a student and, finally, to full colleagueship. Years later, Dion fell ill and on his deathbed called his young colleague to him in order to hear a confession. He spoke of Joseph's earlier terrible illness and his journey to old Dion to plead for help. He spoke of how Joseph had felt it was a miracle that his fellow traveler and guide turned out to be Dion himself.

Now that he was dying, the hour had come, Dion told Joseph, to break his silence about that miracle. Dion confessed that at the time it had seemed a miracle to him as well, for he, too, had fallen into despair. He, too, felt empty and spiritually dead and, unable to help himself, had set off on a journey to seek help. On the very night that they had met at the oasis he was on a pilgrimage to a famous healer named Joseph.

HESSE'S TALE HAS always moved me in a preternatural way. It strikes me as a deeply illuminating statement about giving and receiving help, about honesty and duplicity, and about the relationship between healer and patient. The two men received powerful help but in very different ways. The younger healer was nurtured, nursed, taught, mentored, and parented. The

older healer, on the other hand, was helped through serving another, through obtaining a disciple from whom he received filial love, respect, and salve for his isolation.

But now, reconsidering the story, I question whether these two wounded healers could not have been of even more service to one another. Perhaps they missed the opportunity for something deeper, more authentic, more powerfully mutative. Perhaps the *real* therapy occurred at the deathbed scene, when they moved into honesty with the revelation that they were fellow travelers, both simply human, all too human. The twenty years of secrecy, helpful as they were, may have obstructed and prevented a more profound kind of help. What might have happened if Dion's deathbed confession had occurred twenty years earlier, if healer and seeker had joined together in facing the questions that have no answers?

All of this echoes Rilke's letters to a young poet in which he advises, "Have patience with everything unresolved and try to love the questions themselves." I would add: "Try to love the questioners as well."

CHAPTER 4

Engage the Patient

A great many of our patients have conflicts in the realm of intimacy, and obtain help in therapy sheerly through experiencing an intimate relationship with the therapist. Some fear intimacy because they believe there is something basically unacceptable about them, something repugnant and unforgivable. Given this, the act of revealing oneself fully to another and still being accepted may be the major vehicle of therapeutic help. Others may avoid intimacy because of fears of exploitation, colonization, or abandonment; for them, too, the intimate and caring therapeutic relationship that does not result in the anticipated catastrophe becomes a corrective emotional experience.

Hence, nothing takes precedence over the care and maintenance of my relationship to the patient, and I attend carefully to every nuance of how we regard each other. Does the patient seem distant today? Competitive? Inattentive to my comments? Does he make use of what I say in private but refuse to acknowledge my help openly? Is she overly respectful? Obse-

quious? Too rarely voicing any objection or disagreements? Detached or suspicious? Do I enter his dreams or daydreams? What are the words of imaginary conversations with me? All these things I want to know, and more. I never let an hour go by without checking into our relationship, sometimes with a simple statement like: "How are you and I doing today?" or "How are you experiencing the space between us today?" Sometimes I ask the patient to project herself into the future: "Imagine a half hour from now—you're on your drive home, looking back upon our session. How will you feel about you and me today? What will be the unspoken statements or unasked questions about our relationship today?"

CHAPTER 5

Be Supportive

One of the great values of obtaining intensive personal therapy is to experience for oneself the great value of positive support. Question: What do patients recall when they look back, years later, on their experience in therapy? Answer: Not insight, not the therapist's interpretations. More often than not, they remember the positive supportive statements of their therapist.

I make a point of regularly expressing my positive thoughts and feelings about my patients, along a wide range of attributes—for example, their social skills, intellectual curiosity, warmth, loyalty to their friends, articulateness, courage in facing their inner demons, dedication to change, willingness to self-disclose, loving gentleness with their children, commitment to breaking the cycle of abuse, and decision not to pass on the "hot potato" to the next generation. Don't be stingy—there's no point to it; there is every reason to express these observations and your positive sentiments. And beware of empty compliments—make your support as incisive as your feedback or

interpretations. Keep in mind the therapist's great power—power that, in part, stems from our having been privy to our patients' most intimate life events, thoughts, and fantasies. Acceptance and support from one who knows you so intimately is enormously affirming.

If patients make an important and courageous therapeutic step, compliment them on it. If I've been deeply engaged in the hour and regret that it's come to an end, I say that I hate to bring this hour to an end. And (a confession—every therapist has a store of small secret transgressions!) I do not hesitate to express this nonverbally by running over the hour a few minutes.

Often the therapist is the only audience viewing great dramas and acts of courage. Such privilege demands a response to the actor. Though patients may have other confidants, none is likely to have the therapist's comprehensive appreciation of certain momentous acts. For example, years ago a patient, Michael, a novelist, informed me one day that he had just closed his secret post office box. For years this mailbox had been his method of communication in a long series of clandestine extramarital affairs. Hence, closing the box was a momentous act, and I considered it my responsibility to appreciate the great courage of his act and made a point of expressing to him my admiration for his action.

A few months later he was still tormented by recurring images and cravings for his last lover. I offered support.

> "You know, Michael, the type of passion you experienced doesn't ever evaporate quickly. Of course you're going to be revisited with longings. It's inevitable—that's part of your humanity."
>
> "Part of my weakness, you mean. I wish I were a man of steel and could put her aside for good."
>
> "We have a name for such men of steel: robots. And a

robot, thank God, is what you are not. We've talked often about your sensitivity and your creativity—these are your richest assets—that's why your writing is so powerful and that's why others are drawn to you. But these very traits have a dark side—anxiety—they make it impossible for you to live through such circumstances with equanimity."

A lovely example of a reframed comment that provided much comfort to me occurred some time ago when I expressed my disappointment at a bad review of one of my books to a friend, William Blatty, the author of *The Exorcist*. He responded in a wonderfully supportive manner, which instantaneously healed my wound. "Irv, of course you're upset by the review. Thank God for it! If you weren't so sensitive, you wouldn't be such a good writer."

All therapists will discover their own way of supporting patients. I have an indelible image in my mind of Ram Dass describing his leave-taking from a guru with whom he had studied at an ashram in India for many years. When Ram Dass lamented that he was not ready to leave because of his many flaws and imperfections, his guru rose and slowly and very solemnly circled him in a close-inspection tour, which he concluded with an official pronouncement: "I see no imperfections." I've never literally circled patients, visually inspecting them, and I never feel that the process of growth ever ends, but nonetheless this image has often guided my comments.

Support may include comments about appearance: some article of clothing, a well-rested, suntanned countenance, a new hairstyle. If a patient obsesses about physical unattractiveness I believe the human thing to do is to comment (if one feels this way) that you consider him/her to be attractive and to wonder about the origins of the myth of his/her unattractiveness.

In a story about psychotherapy in *Momma and the Meaning*

of Life, my protagonist, Dr. Ernest Lash, is cornered by an exceptionally attractive female patient, who presses him with explicit questions: "Am I appealing to men? To you? If you weren't my therapist would you respond sexually to me?" These are the ultimate nightmarish questions—the questions therapists dread above all others. It is the fear of such questions that causes many therapists to give too little of themselves. But I believe the fear is unwarranted. If you deem it in the patient's best interests, why not simply say, as my fictional character did, "If everything were different, we met in another world, I were single, I weren't your therapist, then yes, I would find you very attractive and sure would make an effort to know you better." What's the risk? In my view such candor simply increases the patient's trust in you and in the process of therapy. Of course, this does not preclude other types of inquiry about the question—about, for example, the patient's motivation or timing (the standard "Why now?" question) or inordinate preoccupation with physicality or seduction, which may be obscuring even more significant questions.

CHAPTER 6

Empathy: Looking Out the Patient's Window

It's strange how certain phrases or events lodge in one's mind and offer ongoing guidance or comfort. Decades ago I saw a patient with breast cancer, who had, throughout adolescence, been locked in a long, bitter struggle with her naysaying father. Yearning for some form of reconciliation, for a new, fresh beginning to their relationship, she looked forward to her father's driving her to college—a time when she would be alone with him for several hours. But the long-anticipated trip proved a disaster: her father behaved true to form by grousing at length about the ugly, garbage-littered creek by the side of the road. She, on the other hand, saw no litter whatsoever in the beautiful, rustic, unspoiled stream. She could find no way to respond and eventually, lapsing into silence, they spent the remainder of the trip looking away from each other.

Later, she made the same trip alone and was astounded to note that there were *two* streams—one on each side of the road. "This time I was the driver," she said sadly, "and the stream I

saw through my window on the driver's side was just as ugly and polluted as my father had described it." But by the time she had learned to look out her father's window, it was too late—her father was dead and buried.

That story has remained with me, and on many occasions I have reminded myself and my students, "Look out the other's window. Try to see the world as your patient sees it." The woman who told me this story died a short time later of breast cancer, and I regret that I cannot tell her how useful her story has been over the years, to me, my students, and many patients.

Fifty years ago Carl Rogers identified "accurate empathy" as one of the three essential characteristics of the effective therapist (along with "unconditional positive regard" and "genuineness") and launched the field of psychotherapy research, which ultimately marshaled considerable evidence to support the effectiveness of empathy.

Therapy is enhanced if the therapist enters accurately into the patient's world. Patients profit enormously simply from the experience of being fully seen and fully understood. Hence, it is important for us to appreciate how our patient experiences the past, present, and future. I make a point of repeatedly checking out my assumptions. For example:

> "Bob, when I think about your relationship to Mary, this is what I understand. You say you are convinced that you and she are incompatible, that you want very much to separate from her, that you feel bored in her company and avoid spending entire evenings with her. Yet now, when she has made the move you wanted and has pulled away, you once again yearn for her. I think I hear you saying that you don't want to be with her, yet you cannot

bear the idea of her not being available when you might need her. Am I right so far?"

Accurate empathy is most important in the domain of the immediate present—that is, the here-and-now of the therapy hour. *Keep in mind that patients view the therapy hours very differently from therapists.* Again and again, therapists, even highly experienced ones, are greatly surprised to rediscover this phenomenon. Not uncommonly, one of my patients begins an hour by describing an intense emotional reaction to something that occurred during the previous hour, and I feel baffled and cannot for the life of me imagine what it was that happened in that hour to elicit such a powerful response.

Such divergent views between patient and therapist first came to my attention years ago, when I was conducting research on the experience of group members in both therapy groups and encounter groups. I asked a great many group members to fill out a questionnaire in which they identified critical incidents for each meeting. The rich and varied incidents described differed greatly from their group leaders' assessments of each meeting's critical incidents, and a similar difference existed between members' and leaders' selection of the most critical incidents for the entire group experience.

My next encounter with differences in patient and therapist perspectives occurred in an informal experiment, in which a patient and I each wrote summaries of each therapy hour. The experiment has a curious history. The patient, Ginny, was a gifted creative writer who suffered from not only a severe writing block, but a block in all forms of expressiveness. A year's attendance in my therapy group was relatively unproductive: She revealed little of herself, gave little of herself to the other members, and idealized me so greatly that any genuine

encounter was not possible. Then, when Ginny had to leave the group because of financial pressures, I proposed an unusual experiment. I offered to see her in individual therapy with the proviso that, in lieu of payment, she write a free-flowing, uncensored summary of each therapy hour expressing all the feelings and thoughts she had not verbalized during our session. I, for my part, proposed to do exactly the same and suggested we each hand in our sealed weekly reports to my secretary and that every few months we would read each other's notes.

My proposal was overdetermined. I hoped that the writing assignment might not only liberate my patient's writing, but encourage her to express herself more freely in therapy. Perhaps, I hoped, her reading my notes might improve our relationship. I intended to write uncensored notes revealing my own experiences during the hour: my pleasures, frustrations, distractions. It was possible that, if Ginny could see me more realistically, she could begin to de-idealize me and relate to me on a more human basis.

(As an aside, not germane to this discussion of empathy, I would add that this experience occurred at a time when I was attempting to develop my voice as a writer, and my offer to write in parallel with my patient had also a self-serving motive: It afforded me an unusual writing exercise and an opportunity to break my professional shackles, to liberate my voice by writing all that came to mind immediately following each hour.)

The exchange of notes every few months provided a *Rashomon*-like experience: Though we had shared the hour, we experienced and remembered it idiosyncratically. For one thing, we valued very different parts of the session. My elegant and brilliant interpretations? *She never even heard them.* Instead, she valued the small personal acts I barely noticed: my

complimenting her clothing or appearance or writing, my awkward apologies for arriving a couple of minutes late, my chuckling at her satire, my teasing her when we role-played.*

All these experiences have taught me not to assume that the patient and I have the same experience during the hour. When patients discuss feelings they had the previous session, I make a point of inquiring about their experience and almost always learn something new and unexpected. Being empathic is so much a part of everyday discourse—popular singers warble platitudes about being in the other's skin, walking in the other's moccasins—that we tend to forget the complexity of the process. It is extraordinarily difficult to know really what the other feels; far too often we project our own feelings onto the other.

When teaching students about empathy, Erich Fromm often cited Terence's statement from two thousand years ago—"I am human and let nothing human be alien to me"—and urged us to be open to that part of ourselves that corresponds to any deed or fantasy offered by patients, no matter how heinous, violent, lustful, masochistic, or sadistic. If we didn't, he suggested we investigate why we have chosen to close that part of ourselves.

Of course, a knowledge of the patient's past vastly enhances your ability to look out the patient's window. If, for example, patients have suffered a long series of losses, then they will view the world through the spectacles of loss. They may be dis-

*Later, I used the session summaries in psychotherapy teaching and was struck by their pedagogical value. Students reported that our joint notes took on the characteristics of an epistolary novel and eventually, in 1974, the patient, Ginny Elkin (a pseudonym), and I published them under the title *Every Day Gets a Little Closer*. Twenty years later, the book was released in paperback and began a new life. In retrospect the subtitle, *A Twice-Told Therapy*, would have been more apt, but Ginny loved the old Buddy Holly song and wanted to get married to its tune.