Words that touch.

Modern concepts on effective psychodynamic interventions.

Hans Wiersema.

Part 1: Empathy, support, holding and safety as conditions for touching.

I will start with a therapy session that is an example of a present day psychoanalytical approach to find words that touch. Look and listen to it and write down your own impressions and comments for later use.
[Gabbard, Erotic transference, 8,5 minutes.]

Besides many other things that can be said about this vignette it is clear that Gabbard adheres to a very strict analytical approach to find words that have a real impact on the patient: first he frustrates the patient's wish to tell her that he finds her attractive. This raises her tension and she redoubles her efforts to force him. This makes him visibly uncomfortable. Then he uses this countertransference to confront her **[pp 3]** that she pressurizes him, which he calls 'steamrolling', and then compares this to the complaints of boyfriends, who had left her.
And after this confrontation of her behavior in the transference and in actuality made her cry, he interpreted the emotional logic for her despotism: to avoid the pain she had experienced as a child when her dad had left her. Also, he showed how this coercion brought about the very problems she had wanted to avoid.
You see how his strict adherence to the classical way of giving interpretations really worked to touch the patient.
[pp 4, 5 Malan's triangles of conflict and of persons.]

For a long time analysts believed that only interpretations are effective to cause personality change. In order to prove this belief the Menninger clinic in 1956 set up a long term research project which resulted 30 years later in a book called **"Forty two lives in treatment**".
This book caused a shock in the psychoanalytic world because it proved that *support* was twice as much responsible for personality change as interpretation and insight. **[pp 6]**

- *45% had reached personality changes that went far beyond the amount of insight* they had reached; a change that was mainly due to the support they had received.
- *Only 24% had achieved a change that corresponded with the amount of insight.*

The success of supportive measures contradicted the classical idea that changes in the personality structure can only be caused by interpretation and insight into repressed conflicts.

In fact the Menninger research confirmed the emphasis **Carl Rogers** had always put on the therapeutic relationship as the most essential element of psychotherapy.
He discerned three elements of the therapeutic relationship: **[pp 7]**

- Empathy
- Unconditional positive regard, and
- Therapist's genuineness, honesty or authenticity.

And later research proved that these were the so called non-specific elements of all successful therapies, and that these elements were responsible for 50% of the therapeutic change.

Now, how can we make therapy more effective than 50 %?
By using our empathy to refine our interpretations. Then you can find 'words that touch'.
The first basic rule is the ancient Hippocratic oath no to do any unnecessary harm to the patient.
We often forget this rule once we discover some pattern the patient is not conscious of yet. In our enthusiasm to share our freshly developed insights with our patients we often forget the difference between diagnostic correctness and tactful therapeutic persuasiveness.

> Recently I lost a patient when I interpreted her rejection of antidepressants, her demand for more sessions per week and her refusal to bring her husband as efforts to do therapy under *her* conditions. What I forgot in my irritation was her defensive *need* to keep me in control. Had I been more empathic with this unconscious need, she would not have felt *accused* but *understood.*

Someone who was very alert on this danger and who focused on expanding our empathic awareness and on giving adequate empathic support in order to tolerate insight was **Paul Wachtel**.

In his book Therapeutic Communication he discussed how often we forget to take the patient's anxiety seriously. After all, much anxiety is created by an inner conflict between a wish or desire and the fear, shame or guilt it causes. And this anxiety is so intolerable that a defense is necessary in order not to feel the anxiety anymore **[pp 8]**(Malan's triangle).

> Take Brenda for instance, who had learned that asking to be loved only ended in frustration. So she developed coercion as an attempt to get what she needed without feeling the pain, which yet came later as a result of her coercion.

Now the classical way to break down the defense is: **[pp 9]** clarification, confrontation and interpretation of the defense, then of the anxiety and finally of the forbidden feeling. By frustrating the defense the wish becomes so strong that it will break through (like with Brenda).
Now Wachtel is convinced that it is not frustration of the forbidden wish, but **[pp 10]** *lowering the anxiety or shame or guilt* about it that makes the defense less necessary. The precondition for the emergence of warded-off content is not frustration, but *safety.*

> In the Greek fable by Aesop the wind and the sun made a bet who would be the first to get a man out of his raincoat. So the wind blew and blew, but the man only tightened his coat. Then the sun warmed the air, and the man took it off.

Now If the person can have the direct experience of safety by the therapist's support and unconditional positive regard when he is exposed to what he fears, his chances for recovery are greatly enhanced. **[pp 10]**
If the crucial question is not anymore: What is the patient hiding?, but: Why is he so afraid, and how can he be helped to become less afraid?, his need for hiding diminishes and he can be exposed to what he had been avoiding fearfully.
And then comments that address the forbidden or painful thought or feeling in a way that does not increase his shame or guilt will make it more likely that he will be able to bear facing what he previously could not.

Now how would Wachtel have dealt with Brenda's desperate coerciveness?

> I suppose that he would have started in the previous session by relieving the shame she had, when she confessed that she had a crush on him. Wachtel would have praised her for her courage to tell him, in a situation in which both knew that it could not be fulfilled. Perhaps he would have used Yalom's phrase: "If everything were different, if I were single, if we

would not have met as patient and therapist, then I surely would have found you very attractive and would have made an effort to know you better." And then he would explore how painful it is that her deepest longings could not be fulfilled in this situation. Probably her coerciveness would not have been necessary anymore to hide her deep hurt and pain. And if it *would* have come, it would have been less painful to confront her with it, because the underlying pain which caused her coerciveness had already become conscious to her.

And how should I have dealt with the lady who wanted to have therapy on her conditions?
I should have registered my irritation and contain it until I could have felt empathy and compassion for her desperate, yet unconscious attempt to keep control, so that I could have interpreted her underlying anxiety of being overruled and becoming utterly helpless.

It is of course not enough to be effectively exposed to what one has been avoiding.
What also is crucial is *mastery* and the *experience of safety.***[pp 10 again]**
For this purpose the patient should be exposed to disturbing material only *gradually* and at his own pace. This contributes significantly to the experience of mastery.
In this process it is essential to help the patient maintain his *self-esteem,* for this is easily threatened by exposure to forbidden or so called 'childish' thoughts and feelings.
So the task is not only to help the patient to "know" more about himself, but to be more *self-accepting.*

Now, how can we help the patient to become less afraid of his forbidden feelings? By giving him adequate support. **[pp 11]**
Instead of the old idea that support was the opposite of insight (reinforcing the defenses versus breaking them down) Wachtel's idea of support is: supporting the patient by building an empathic and curative relationship in such a way that he feels safe enough to have the courage to be exposed to his unwanted aspects. In this view support is an essential part of the process of exploration itself, the condition that makes exploration possible at all !
This means that support does not need to block the access to unconscious material, but rather **that the *absence of empathic support* blocks insight, which is too painful to become aware of without adequate support.** So support is an essential component of the exploratory process of gaining insight.

But does such a support not undermine the patient's autonomy?
The classical analytic opinion is that neutrality permits the patient to find the authority for his actions within *himself*, instead of using the therapist' support as a crutch.
This might apply to highly functioning neurotic patients with strong egos, who are "sick enough to need analysis, and well enough to stand its frustrations".
But even they often experience it as emotional neglect.
And the failure to provide a temporary crutch means that one forces the patient to stand on his own feet too early, which makes appropriate healing virtually impossible.

Therefore the sharp contrast between insight-oriented approaches and approaches in which advice, direction, and support may be employed, is a false one.
Wachtel is convinced that increased self-awareness and self-understanding does not depend on neutrality, anonymity and abstinence, but that only active support gives the patient the courage to confront the fear of his forbidden feelings.
But such a view on the therapeutic process implies a two-person psychology instead of the classical one-person psychology, in which the therapist is not a participant-observer, but only an observer, whilst the patient and his experience of the relationship (the transference) is the object of observation.
Classical psychoanalysts indeed saw the therapeutic relationship as central, but mainly as something to *examine*, not to be *utilized* as a lever for change.
But in fact the therapeutic relationship is a potentially corrective emotional experience in its own right.**[pp 12]**
Besides interpretation it consists of: understanding, listening, sharing, criticizing, comforting, stimulating, moving and allowing oneself to be moved, encouraging, provoking, tolerating; and perhaps above all, being as authentic as one can manage.
Al in all: The therapeutic relationship is an agent for change.

[Another reason for active support is that often insight *follows* change. If one is helped to *live* differently, this change gives a new perspective from which to examine one's life.
As a consequence, new insights are promoted, that are a *product* of change, rather than its cause.
Insights help to consolidate and deepen the changes brought about in other ways.]

Now that I have tried to show you that support is essential for insight and psychic change, it is time to discuss *how* we should give this support. For often our comments and interpretations are experienced as critical by the patient. Therefore Wachtel gives a number of suggestions to lower the patient's anxiety and narcissistic vulnerability, so that insight becomes more tolerable. He works out 5 suggestions: **[pp 13]**

1. formulate your comments in more *permissive* ways,
2. *explore* the patient's feeling, and avoid *interrogating* him,
3. *build on his strengths*, and use *affirmation* of them before he feels safe enough to change.
4. *attribute* feelings he does not have yet,
5. *reframe* his experiences and suggest new ways of acting.

1. Accusatory vs permissive comments.

How we *talk* to patients depends to a large extent on how we *think* about them.

> When I felt irritated by my patient's efforts to do therapy on *her* conditions my comments were critical. If I would have taken time to contain my irritation until I understood her underlying fear, I could have reacted with compassion.

Good interpretations tend to be permission-oriented. They address an aspect of the patient's experience that he has avoided, and they convey the message that it is all right to be more accepting toward that experience. They expand the patient's sense of entitlement with regard to conflicted aspects of his psychic life. They point out to him in one way or another that he has been afraid to acknowledge something about himself, and that perhaps this anxiety is no longer necessary.

> As a student I read about an experiment in which rats were first conditioned to press a handle in order to get food. Then this handle was electrically charged. So the animals preferred starving to touching the handle again. The experimenters had to pick them up and bring them into contact with the handle against heavy protest several times before the animals trusted that the current indeed had been turned off. So our task is to let our patients experience that the current now has been turned off.

Therefore Wachtel gives 4 suggestions **[pp 14] :**

* Try explicitly to couch remarks in a context of permission.

A more permissive reaction to my patient would have been: “You seem to expect something terrible to happen to you if you would not remain in total control of what goes on between us”.

* Look for interpretations that take off the burden of guilt.
  To an adolescent who makes a mess of his room, which creates endless conflicts with his mother, you should not say: “Why can’t you give up resisting your mother?”, but: “I think you really want to please your mom by keeping your room tidy, but have the feeling that nothing will be enough to satisfy her. So you have given up.”

* Use entry phrases like “at least” or “even more” to emphasize the positive instead of the negative pole of what the patient is experiencing.
  Say for instance to a patient who cultivates the role of a victim: “I guess, concentrating on how people mistreat you feels like the best deal you can get. If you can’t have what you really want, *at least* you can feel you have the right to get the sympathy for your suffering”.

* Interpret through questions. This softens your interpretation.
  But avoid the ‘why’ question, which is an accusation.
  - E.g. do not aks “Why are you always avoiding to succeed?” but: “Do you have any idea what makes you scary about success?” By so structuring the question you assume that the patient agrees with your statement. And it is supportive instead of critical because it includes a message of confidence in the patient’s abilities.
  - Another good way of asking is: “Everyone has his way of avoiding things that are uncomfortable. What do you think your ways are?”

2.Exploration, not interrogation. [pp 15]

An essential strategy to gradually explore deeper and deeper is by *first siding with the defense* and then gradually have the patient take more responsibility. Examples of such strategies are:

- Instead of confronting my patient that she wanted to keep total control of the therapy, I could have said: “It strikes me that you seem to find it very hard not to keep control over how therapy is to be done. If that is true, then you must have some good reasons for defending your autonomy towards me.” And then I could have explored these reasons with her.

- To a patient who discovered in his wife's e-mail that she had a lover one should not ask why he did not discussed it with her, but rather: "I guess at this point it feels kind of difficult to bring it up. Any idea what makes it so difficult?"

- Ask patients who say that they 'always' feel anxious: "When is it less? When is it more?"

- *Externalization* in service of insight:
  e.g. to a patient who complains that men always leave her just with a note, you should first ask: "Do you think they do this out of fear that you could not take the confrontation?" ,
  and then: "What do you think they were afraid would happen if they said something to you directly?",
  until you can finally say: "Could it be that you have experienced many times that people did not notice how upset you were, so that the only way to get their attention was to turn up the volume? But now the result is the opposite: they shrink away if you are so upset."

3.Building on the patient's strength. [pp 16]

Instead of saying "You seem to have difficulty talking" say: "Sometimes you talk more easily than at other times".
Or wait for a small improvement and praise that.
Notice small steps in the desired direction.

When a patient is defensive, but less defensive than before, first emphasize that he is less defensive, before analysing what he is defending against.

> To a passive-aggressive patient who failed in his studies and who often came late, missed sessions and did not pay the bill, the therapist interpreted this behavior as an attempt at autonomy. But he also commented that later on he might discover that there are *more* effective ways of asserting one's autonomy.

Never say 'What you *really* want is …', because then you pretend to know the patient better than he knows himself. But substitute 'really' by 'also', for this only *adds* something to what the patient is already aware of.

> To a patient who criticized her therapist that he did not take enough care of the plants in his office, the therapist should not say: "What you really

want is that I take better care of you", but rather: "Maybe you *also* feel that I should take better care of you, just like the plants."

4. Attribution and suggestion.

Attribution means that a feeling is attributed to a patient which he does not have yet, but which is at least within his reach.
It is a way of promoting change by predicting it, or describing it as if it already has happened.
Of course this is a form of suggestion, but it is still in the service of insight.
Such attribution should be embedded in the formulation of a patient's conflict.

E.g. to a patient who is entangled in an enmeshed family, and who is afraid of making independent decisions, because he unconsciously fears that this would be disloyal, one could say: "I can see that you are in a lot of conflict. Part of you feels you don't have the right to go your own way, and part of you starts realizing that you do." The last sentence is suggestive attribution.

Forms of attribution: **[pp 17]**

- Label maladaptive tendencies as 'residuals'.

  "The old ways are still very strong". "You are bound to have some residual anxiety".("Bound to" is normalizing the anxiety)

  To a patient who hesitates to take the next step, don't say: "Now it is time for you to start to take the next step", but say suggestively: "You have already starting moving in this direction implicitly. Now it seems to me that we are at a point where you are ready to start consolidating your autonomy by taking the next step".

- Describe behavior as temporary or transitional.

  "You are heading a difficult stage now that you will have to pass through, in which greater anxiety is to be expected".

- Formulate your interventions in such a way that the patient feels that you are standing beside him, that you assume that he already knows, so that it is common knowledge.

  "As we have both seen …", "As I know you are aware of…", "If I am understanding you properly, what you are saying is …".

  "With all that has been going on in your life, I can understand how you'd feel angry/rejected" instead of: "You seem to feel angry/rejected", because that is only your opinion.

To a patient who got terrible headaches each time her intrusive mother visited her, and who felt too guilty to realize how angry this made her, Wachtel said: “Is there any way you could make her see how angry her intrusiveness makes you?”
This matter-of-factness, took as given that her mother was intrusive and of course provoked anger. This helped the patient to accept her anger as normal.

- Use several attributional comments, one after the other, in order to guide the patient step by step toward understanding and dealing with difficult issues.

  E.g. a girl with a crazy mother, who insisted that the daughter was crazy and needed medication, would feel obliged to defend her mother if the therapist said “There is no way to please your mother. Whatever you do she finds fault with”.
  So instead of trying to persuade her the therapist first said: “It must be hard to know that no matter what you do, you can’t please her.”
  This placed the therapist side by side with the patient instead of opposite to her and suggested that she already knew. It enabled the message to come in through the side door while the front door was heavily guarded.
  The next step was: “It must be hard to have to pretend that you can please her, knowing that that is really impossible”. The ‘pretending’ undermined her belief that it should be possible to please her mother, so it would be her fault if she could not.
  Only after such preliminary work the patient could accept the sentence: “It must be very hard for you to know your mother is crazy”, to which she responded: “I knew it all along but I could not really admit it to myself”.

- Point the patient toward action in such a way that the patient does not feel that you are pushing him. Rather *predict* that you see he is ripe for it, *and* is afraid of it at the same time.

  Instead of saying: “I think you should finally decide to live on your own”, say: “It sounds like what you like to do is to decide to live on your own, but you feel that if you do it will be selfish, dangerous, etc.”
  Such formulation avoids the impression that the therapist is proposing some action, but suggests that he sees that the patient is ripe for it. Moreover it predicts the resistance.

5. Reframing and relabeling. [pp18]

The concept of reframing is very much used in family therapy. It stresses the fact that there is not one truth, but that there are only partial truths that all depend on the perspective one takes.
Interpretation suggests there is one truth; reframing suggests there are several ways of looking at this truth. It is irrelevant and impossible to find the right truth, but it makes sense to construct the most useful one.
Reframing helps to see a situation in a different light.

> To a very self-critical patient who had made some progress but interpreted this as lowering her standards, one could say: "Talking about lowering your standards sounds like a piece of the old (!) self-critical thinking creeping up for the moment. As I hear what you are saying (Not: "it seems to me" for then you put yourself in opposition to the patient!), you haven't lowered your standards; you have let yourself recognize better when you have met them."

Wachtel uses reframing to free the patient from dilemmas, that he has construed in such a way that solution was seen as impossible, by offering an alternative view that points to possible solutions.

> A patient who criticized himself for being confused was so ashamed about his confusion that he quickly turned away from it, with the consequence that he was further alienated from his own experience and further driven to look for cues from others as to what he *should* be feeling and striving for. The result of such efforts was feeling even more confused.
> So Wachtel said to him: "Trying to find out what the others might expect from you only makes you more confused. So it might be more helpful if you recognize that your confusion itself is at this moment a real part of the real you".

Instead of experiencing his confusion as a form of failing, as one more reason to criticize himself, the confusion is now reframed as something real and genuine about him, and therefore worthy of paying attention to. To *embrace* the confusion has the potential to diminish it, and even valuing it as a genuine expression of who he really is.

Reframing can also be used to help point the patient toward a feared action and may contain a suggestive element similar to that of the attributional comments discussed earlier.

> Think of the situation in which the therapist asked the patient "*What makes it hard to tell your wife you read her e-mail?"* We noted then that the question, by implying that it should not be hard, was an implicit accusation, and we examined an alternative: *I guess at this point it feels kind of difficult to bring it up.* The variant I want to consider here is *"It's going to take a lot of courage for you to discuss the e-mail with your wife".*

This comment may also be seen as having an attributional dimension. It attributes to the patient a tendency to address matters that he had not dared to think of yet. In saying "It is *going to* take courage" the comment conveys confidence that the patient *will* take the step, and it frames it in such a way that the patient can feel courageous when he does so.

> One more example of reframing is the following comment to a young woman who regularly came half an hour late to sessions: "What occurs to me is that you come late because you sense that 15 or 20 minutes is all you can tolerate. I think that is because our work together is reaching down into some of the painful things that we need to be reaching, and that is hard; it hurts. But is shows us we are on the right track, and maybe now we can figure out together how to make it easier to tolerate what we are dealing with, how to enable you to bear it longer. Got any idea?"

All these empathic approaches are essential in lowering the patient's resistance against insight and change. They create the precondition that he can let himself be touched.
But this still leaves open the question: **What is it that touches the patient?**
This will be the material for tomorrow's lecture.

Part 2: Authenticity and encounter as conditions for touching. [pp 19]

Yesterday I discussed Wachtel's suggestions to make the patient feel safe enough to tolerate painful or humiliating insights so that he can let himself be touched. Now I come to my central question: **What is it that touches the patient?**

[pp 20] In this second lecture I will try to demonstrate that for touching the patient, the therapist should not only be sensitive and empathic, but also really **authentic**, which is Carl Rogers' 3rd condition besides empathy and unconditional positive regard.
And because an essential part of authentic communication implies the use of **projective identification** I will first describe how this phenomenon works and how a therapist can deal with it.
Then I will compare **two different styles** of authentic touching the patient: the more abstinent psychoanalytical style and the more interactional style promoted by adherents of relational psychoanalysis, like Irvin Yalom. I will use a film fragment to demonstrate the latter approach.

Projective identification.

I borrowed my title from a book by **Danielle Quinodoz**, **[pp21]** a very sensitive Swiss psychoanalyst who died this year. She defined a language that touches as 'one that uses words that can be heard on different levels, emotions and feelings, and bodily experiences as well'.
She started her book with a very important remark:
Before you can touch the patient you should let the patient touch you, which of course is an appeal to the maximum of empathy you are able to have with the patient, even empathy with the parts he does not want to acknowledge to himself.

Now a patient's communication can touch you in three different ways: **[pp 22]**

- First: the patient's *words* can touch you. Then it is relatively simple to touch him too if you are empathic and real. This is the main channel of communication of people with a neurotic personality organization.

- The second channel of communication consists of: *non-verbal*, bodily movements and posture. This channel of communication is used by everybody.

A patient who sweats profusely may manifest anxiety, one who sits upright in the front of his chair manifests at least alertness, someone who moves his chair nearer to yours demonstrates his need for closeness, whilst someone who hangs in his chair with his legs stretched out shows his passive resistance and lack of cooperation.

- The third channel of communication consists of feelings that the patient arouses in you without words, or in between his words, or in spite of his words, the so-called *projective identification* in the *counter-transference*. This is the most important channel of information for understanding people with borderline personality organization, although other people also use it.
  What you experience in projective identification consists of very subtle feelings and sensations that you sometimes are hardly aware of. It can be irritation, boredom or lack of interest, or a sudden feeling of grief, or an impulse to hug the patient in order to comfort him. It can even be such a fleeting sensation, that you only become aware of it when you tell a colleague about the patient. It can even consist of bodily sensations which you hardly notice.
  This is a very rich but also very tricky form of communication, for it is not always clear which part of your counter-transference derives from your own life, and how much is really projective identification with something the patient does not dare or want to feel himself.

    Long time ago I had a patient, a 35 year old unmarried woman who came with complaints of chronic dissatisfaction with her life. She always came dressed in the same unwashed sweater, wore her long brown hair in greasy threads, as if designed to make herself unattractive. Yet she insisted on a special treatment: she wanted that I saw her at 3 P.M. right after she came from work. After I had managed to give her this hour the following pattern developed: She talked in grammatically perfect sentences, but at the end of each sentence I had already forgotten the beginning. Within 5 minutes I felt so sleepy that I could not refrain from yawning.
    So I asked myself: Did I sleep enough tonight, did I not drink too much last night, did I have quarrels with my colleagues or my boss, is there something else that preoccupies me, did I have similar feelings with the previous patients today, or with other patients at 3 P.M., or do I have these feelings only with *this* patient?

It is essential to become aware of these feelings and not to feel guilty about them, or to try to compensate for them by acting nice to the patient. On only should tolerate them before acting on them, and to understand them as a hidden message that should be deciphered, before you can share its meaning with the patient.

In this example I finally realized that the real meaning of what she communicated was not to be found in the *content* of her words, even though her sentences were correct, but in the sleepiness she induced into me, which seemed to be an unconscious desire for a preverbal merging together, against which I resisted by turning off, but in which I also took part by not listening to the words, but by experiencing them as a kind of lullaby in which I lost my alertness and my separate existence.

Now what are the functions of projective identification? [pp 23]

Simple projection is a one-person phenomenon. It occurs when you do *not* experience the feeling the patient attributes to you. In contrast, projective identification is a two-person process.
It has three functions:

1. To *communicate* a preverbal content (normal projective identification which everybody does)
2. To *deny* psychic reality by evacuation of bad parts of the self (pathological projective identification)
3. To *control* the transference object. (pathological projective identification)

[pp 24] The most benevolent form of *normal* projective identification is empathy. This is part of the language that touches, because it is not confined to words, but also conveys feelings and sensations and is intended to communicate that you understand the patient with your mind and your heart.

If the projection is *strong* the therapist may first experience the sensations and feelings as belonging to *himself*, before he realizes that they are projected into him.

This is what happened to me with my 3 o' clock patient.

Excessive projective identification occurs when the violence of the patient's unconscious hate towards an abusive parent is so strong that the therapist is

induced to identify with the projected abusive parent and to act out this induced aggression, instead of simply *experiencing* the induced feeling.

> I once had a somewhat obsessive supervisee with whom I had dealt very carefully because of what I saw as her beginner's uncertainty. In the 11th session she accused me of intimidating her all the time by being authoritarian and dominant. Her unfair accusation made me so mad that I abruptly ended the supervision. Only later I realized that my rage was the result of my identification with her projection, by which I finally *acted* like the abusive parent she had projected into me.

Sometimes however the patient does not project unwanted *feelings* into the therapist, but just *unintegrated bodily experiences*. In that case the therapist will experience in his own body the sensations projected into him. And then he has to become aware of them, to digest them and to discover their meaning, before he can share it with the patient to help him move from sensations to affects, and then from affects to conscious feelings and words for them. This is what we call mentalization nowadays.

> This is what my 3 o'clock lady did to me. And when she commented on my yawning I praised her for her courage, excused myself at length for it, and said that by criticizing me she had restored the contact, which I had lost. And then I asked what we both could do to prevent that loss of contact. In this way I could avoid blaming her for making me sleepy, and I could open up a common exploration of her uncommunicative style and of her need for preverbal merger with me.

How can we use projective identification to touch our patients?

Quinodoz gives 8 recommendations:

1. **[pp 25]** First of all, become aware of your projective counter-identification, instead of acting it out like I did with my supervisee.
Then ask yourself: Do I experience what the patient feels but is not aware of? Or do I experience what he does not want to feel but induces others to experience?
Quinodoz advises not to share one's countertransference with the patient, but to make use of it in formulating an interpretation.

> She describes an analysis in which she felt so incompetent that she considered breaking off the analysis and referring the patient to a colleague. Then she realized that the patient's mother had told him in a matter of fact way that she had felt unfit for motherhood and therefore

had tried to abort him. Then Quinodoz realized that she herself was on the verge of doing the same thing. This made her aware that he had projected into her his own unconscious fear that she might 'drop' him and had made *her* identify with his mother. And only then she was able to interpret to him this unconscious fear that she would drop him. Without mentioning her own reaction!

In my own experience, especially with excessive projective identification, I often do not manage to contain my countertransference feelings, so the patient sees my boredom or irritation. Then it is more honest to confess one's acting out and then to invite the patient to look together at what happened. Sometimes this gives an unexpected opening.

This is what happened with my 3 o' clock lady.

And recently I had a new patient, who had had three previous aborted attempts at therapy, where she always dropped out after the second session. In the first 2 sessions she had only given factual descriptions of her life. So in my third interview I was determined to get more lively descriptions of important others. But instead my mind suddenly became completely blank, unable to think of anything useful to say or to ask. I felt extremely stupid and awkward, felt like sending her home with some kind of excuse, but thought: "Maybe this is my identification with something she did not dare to feel and therefore projected". So I openly confessed how I felt. And then she said: "I did not feel like coming; I felt I had nothing to say. You would only discover how stupid and awkward I am!" We both laughed and knew: This was her only way of sharing with me how stupid she felt.

2. We should listen to our own *bodily sensations*. Because the patient had never been able to integrate bodily sensations (like e.g. stomach pain) into feelings (like anxiety), the only way to share them is by projective identification. Then you experience just the bodily sensation. It is your task to do the translation into feelings. Only then you can return these sensations to the patient, this time loaded with emotional meaning. This translation of unintegrated experiences into meaningful words we now call mentalization.

Think of my yawning and sleepiness with my 3 o' clock patient.

3. For many borderline patients, who are unable to mentalize, especially the *bad parent* often cannot be represented because it is intolerable to bear the idea that the important other hates them and wants to destroy them.

Therefore it is crucial that you can tolerate to experience yourself as the *projected bad parent* in spite of all the care and concern you have for the patient. Not only do you have to tolerate being unfairly *seen* as an sadistic bully (this is the projection aspect), but you even have to tolerate *experiencing* such sadistic feelings or reactions in yourself when the patient induces them into you (this is the identification aspect). If you dare to identify with this bad parent, you can mentalize it, and finally turn it into something that can be spoken about. Only by being represented and mentalized it loses its threat. This is what Quinodoz did to her almost aborted patient.
If you unconsciously resist against this identification, the same thing will happen as with my supervisee.

Another example, which I already mentioned shortly yesterday is about:

> A 59 year old patient, whose mother had died when she was 7. She had to cope with feeling helpless and powerless ever since. She came with complaints of lifelong depression under a façade of strength. She refused to take antidepressants, because she did not want to be identified with her sisters, who had been on antidepressants for years and had been zombies. Instead she insisted on two sessions per week. Then she insisted on 60 minutes sessions. This all gave me the impression that she was insatiable and was trying to dictate me how therapy had to be conducted.
>
> When I asked her to bring her husband once to let him give his view on the whole situation she agreed. But the next time she triumphantly announced that she had decided not to ask him. Because of this triumphant tone I could not hide my anger anymore that she was prescribing me how the therapy had to be conducted. Then she burst out into angry weeping and decided to stop the therapy. Clearly my irritation had been a direct attack on her central defense of needing to have the power in order not to be the helpless victim again. She could not tolerate this attack. And probably I had unwittingly identified with the projected bad parent, that had made her so helpless, and so my reaction was colored by counter-transference acting out.
>
> If I would have dared to tolerate the unpleasant identification with the bully she had imagined me to be, I might have felt and expressed compassion for her deep-seated feeling of powerlessness, before I would have confronted her with her defensive power struggle, in which she wanted me to be the loser. And the therapy might have been saved – at least for the time being, until the next provocation.

4. We should also tolerate the *uncanny feeling* that arises when we are unable to determine the boundary between reality and delusion in what the patient is telling us.

> Quinodoz describes the analysis of a transsexual, who was deeply disappointed in the effect of the operation. For a long time she felt uneasy whether to think of the patient as 'him' or 'her', until she finally realized that this was not the problem, but the answer: the patient was no man anymore, neither a woman, but a unique individual with masculine and feminine traits.

5. **[pp 26]** Do not feel guilty about your absent mindedness or your sadistic feelings or whatever, do not try to compensate for it by being nice, but use it as information about the patient: ask yourself whether it reveals something the patient is not conscious of yet, but which can give crucial information.
Ask yourself: Do I identify with what the patient is not aware of?
Or do I identify with what the patient does to others, because he cannot tolerate the feeling himself? (E.g. when he projects the bad parent into you in order to seduce you to act it out).

[pp 27] And only after you have digested and understood the experience, you should share the result of your inner processing with the patient to help him move from sensation to affect, and then to find words for this affect.
Find a language that appeals both to his healthy part, *and* to his mad part.

6. *Use the patient's* words as the starting point for a language that touches. Use his *metaphors, images, analogies and bodily fantasies,* not yours, as the basis for a common language. Let the patient's words resonate inside yourself, so that you can feel the vibrations set up by all the affects and sensations the patient's words evoke in you. Only when you repeat his words internally in such a way that you will experience the implicit emotional content, he will become aware of it too.
Only then you can create a common language. And this creation of a common language belongs to the language that touches.

> Quinodoz describes a first interview in which the patient had told in a matter of fact way that his mother had often told him that she would very much have liked to take care of him, but that she was too involved in her job and her schedule was too full to look after him.
> When she at the end of the interview proposed psychoanalysis, he said that he would have loved to do so, but that he would not have time for regular appointments. Then Quinodoz acutely felt a great sadness. And

after a time she responded in a voice that betrayed her sadness and repeated the words he had said about his mother being so involved in her job that she had no time for him. Then he fell silent, realized his therapist's sadness and for the first time felt his own painful disappointment in his mother.

7. Because of the value of using the patient's words Quinodoz also recommends that you should *remember his words* for later use. This is what Fonagy calls "keeping the patient's mind in mind'. And it helps the patient to discover that he does not need to keep his memories in the original, frozen state, but that they can be re-used by giving them a new meaning and a fresh twist.
Like the use of humor this will create a surprise effect which might put the patient off-balance, thereby breaking his original rigidity.

8. And finally Quinodoz warns that you should *touch the patient with words and not with actions*.
Quinodoz defines a language that touches **[pp 28]** as 'one that uses words that can be heard on different levels, emotions and feelings, and bodily experiences as well'. 'What matters … is the bridge built between emotions and words'.
In fact this is something every good interpretation should do, in order to be really convincing on all levels.

Authenticity.

Quinodoz's recommendations can be used by therapists of all schools.
It presupposes that one has to be authentic in order to be able to really touch the patient.
Therefore I now would like to contrast two different opinions how a therapist should be authentic, which is Carl Rogers' third essential condition. I will first describe the present day psychoanalytical opinion, as has been recently formulated by the Belgian psychoanalyst Marc Hebbrecht in the line of Danielle Quinodoz, and then the interpersonal psychoanalysis as formulated by Irving Yalom.

Hebbrecht states that authenticity implies that the therapist is his real self in the encounter with the patient, and that he is able to experience feelings and attitudes that come up in him. He should be radically honest towards all the

painful and shameful aspects of his experience. Free association, evenly hovering attention and dreams are in fact authentic phenomena.
Hebbrecht distinguishes two aspects of authenticity **[pp 29]**:
Honesty towards oneself, and on the other hand honesty towards the other, being transparent and using self-disclosure.
According to Hebbrecht psychoanalysis is more concerned with **honesty towards oneself**, being in contact with one's own stream of consciousness, and less concerned with **transparence and self-disclosure.**
He then describes what happens in so called *authentic moments.*
An authentic moment is a moment in which a communication causes an affective resonance in the other. During an authentic moment the self is moving: confusion and boredom disappear; clarity appears, the person feels touched and comes into contact with split-off parts of himself. This moment of authenticity is based on a really experienced feeling and is pleasant for both participants, as if both feel the appeal to their psychosomatic being. An authentic moment signals psychic integration.
Such moments are fleeting. For authenticity is an oscillating and dialectic process, not an achievement that can be reached intentionally or can be forced. Neither is it a constant reality. It alternates with periods of deadness and boredom.

> When I told my patient how stupid I felt, an authentic moment happened.

Hebbrecht himself demonstrated his use of authentic moments in two beautiful vignettes.
In the first, "When my guitar gently weeps", he followed his own free associations until he had analyzed them as a reaction to the patient, and then he communicated his conclusion tactfully to the patient. But he did not reveal his associations to her.

> A 48 year old lady whose husband had an affair used the sessions for endless complaining about trivialities, which evoked a feeling of boredom in the therapist. When his thoughts started wandering he suddenly thought of the song of the Beatles: "When my guitar gently weeps". Then he associated to his own thoughts: the guitar/the woman is not played upon anymore and therefore gently weeps. Then his next association was to the song: "Yesterday; love is such an easy game to play. Oh, I just long for yesterday". He then realized she was just complaining about the lost love. His final association went from 'Beatles', to 'beat', to Woodstock where Jimmy Hendrix beat his guitar until it broke. And he realized that *this* is the aggression his patient is missing.

When she was silent for a moment he told her that she tries to convey her sorrow, but is not able to do so, because she is caught in the same old tune. If she only could sing a new song in which she would protest against her husband's infidelity, instead of destroying her own instrument. She felt that Hebbrecht was moved, felt moved too and started to cry. At home she confronted her husband more assertively and so regained his respect.

In a lecture in Amsterdam this year Hebbrecht told about a transference dream that he used as information about a very independent patient he had analyzed for a couple of years. He thought she was ready for termination even though she never had talked about it. Then he dreamt that the patient lived in a room in his house. She was partly healed but still lost her consciousness a few times daily. He took her into his arms, carried her to his couch and regulated the light to give a warm atmosphere.
This dream made him aware of her unspoken need for further therapy for her unsolved need for belonging and being accepted and cared for. So he continued until they had worked through this need. But he never shared his dream with her. Quinodoz would have said that his dream showed that he had let himself be touched by the patient.

According to Hebbrecht we should not share our associations, for then we interrupt the patient's stream of consciousness and we force the patient to experience us as a separate person, and no longer as the selfobject whose only function is to soothe the patient's pain. So Hebbrecht prefers not to be transparent. If however, the patient would have discovered his boredom, he would have confessed it and asked her what that meant to her, and be empathic with her being hurt.

As you see, Quinodoz and Hebbrecht, like other psychoanalysts, prefer to be as anonymous as possible. They retain their inner authenticity towards themselves, but they avoid transparency and self-disclosure.
The relational psychotherapists, like **Yalom**, on the contrary prefer to be both authentic towards themselves *and* as transparent as possible.

A dramatic example of this attitude is given in the next vignette from the film '**Ordinary people'.** Here the therapist uses many different interventions (confrontations, role-playing, self-disclosure, hugging) in order to touch the patient.

The story of the film is that the oldest son of an upper middleclass family had died in a boating accident, in which the youngest son survived. He develops a posttraumatic stress disorder with alternations of numbness and flashbacks of the accident. He is sent to a psychotherapist without much effect, until he gets into a crisis when he hears that his girlfriend has committed suicide. All the flashback memories of the boating accident overwhelm him and in panic he phones his shrink. When they meet in his office the following scene takes place:

01.34.33 till 01.41.35.
(Please make notes for discussion)

One cannot deny that this therapist is able to touch the patient, by both his words *and* by his actions.
He comes immediately when the patient needs him urgently, shows his real concern, role plays the dead brother in order to confront the patient first with the irrationality of his guilt feelings, then with his underlying anger towards his brother, and finally with the experience of his desperation and powerlessness, and then he is available for comfort ("I *am* your friend") and hugs him.
All these are interventions in the service of real insight in the way Wachtel promotes: he supported the patient to face his terrible guilt feelings, then he interpreted them as a defense against his anger, which itself was a defense against his powerlessness. This was the real underlying feeling, and only then he comforted him in his deepest pain.

But is this the only way? For the drama of the film this is a brilliant example of crisis-intervention.
But if it were not a crisis situation I think Quinodoz and Hebbrecht would prefer verbal ways to touch the patient in a still authentic way.
Irvin Yalom on the contrary would be convinced that this *is* the only authentic way to touch the patient. **[pp 30]**
He points out that the essence of psychotherapy is *encounter*, a caring, deeply human confrontation between two people, one of whom (usually the patient) is more troubled than the other.
According to him your basic attitude should be that the patient and you are *fellow travelers*.
And therefore a real encounter for him implies equality and thus self-disclosure.

Self-disclosure.

Self-disclosure is the external aspect of authenticity, as Hebbrecht mentioned. It means: sharing private information about oneself, which the other only can know if you reveal it.
Yalom agrees with Hebbrecht that therapeutic self-disclosure should be restricted to what is helpful for the patient and what he can cope with and use, but his opinion of what is helpful is broader.
He suggests that you give an example of honesty, in the service of the therapy of course. So give an honest answer to questions whether you are married, have children, your religion, which films you like, whether you felt awkward when you met the patient outside the therapy, etc.
He thinks it does not matter who answers first; your openness will help the patient to be open too.

> An example of therapeutic self-disclosure in the here-and-now of the therapy is my openly confessing my feeling of utter stupidity to my patient, which helped her to confess her feeling of stupidity that had almost brought her to break off the therapy.

Yalom also recommends to take the time to talk about your own experiences, if that helps to put the patient at ease.

> > He would tell a patient who feels guilty about his impatience towards his mother, how he had experienced a similar situation.

Like Quinodoz and Hebbrecht Yalom warns not to feel guilty about your negative countertransference feelings (boredom, irritation, confusion, sexual arousal, feeling excluded) and not to try to compensate for them out of guilt feelings, but to accept them as information about the patient, and to analyze them: When did they start? What did the patient do at that moment?
The difference is that Hebbrecht waits till he can use it as an interpretation to the patient, and that Yalom shares his counter-transference feelings with the patient.

> > E.g.: “In the last several minutes I notice that I have been feeling disconnected from you, somewhat distanced. An entirely different feeling than when you spoke from your heart how disappointed you were in me. That was very painful for me, but at least I felt connected with you. I wonder what is your level of connection to me now. Did you feel the same as I did? Let’s try to understand what is happening.”

Like Hebbrecht he proposes that you acknowledge your errors. Not acknowledging them disrupts the real contact. Comfort yourself with

Winnicott's saying that the difference between good and bad mothers is not the number of mistakes they make, but how they deal with it.

Therefore I openly confessed my yawning and sleepiness to my 3 o' clock patient, so that I could interpret it as a sign that I lost contact.

*Asking feedback.***[pp 31]**

Your self-disclosure should stimulate the patient's self-disclosure. Therefore asking feedback is another aspect of authentic encounter that Yalom insists on. It consists of regularly checking right from the first session how the patient experiences the here-and-now of the relationship.

- "Why did you come to *me*?"
- "Which expectations did you have?"
- "Have they been fulfilled?"

Patients are afraid of intimacy. Either they fear that their inner badness will be exposed, or they fear that they will be swallowed.
You should counteract this fear by checking the relationship in every hour, by asking:

- "How are you experiencing the atmosphere between us today?" or
- "Let's check how things have been going between us today?"
- "What do you think about the way we are working?"
- "What is happening in the space between us?"
- "On your way home how will you look back upon our session? What will be the unspoken statements or unasked questions about our relationship today?"

If patients mention something they have not been honest about, immediately ask if there is something in the therapy too that they have concealed or distorted.

Make a point of inquiring often what the patient thinks is helpful about the therapy process. In contrast to Quinodoz and Hebbrecht Yalom is convinced that quite often it is not your words, but your actions on the relational level that are felt as helpful, actions just outside the regular frame of the therapy (e.g. going to a patient's theatre performance or public lecture), or an exceptional availability of the therapist, like in 'Ordinary people'.
If you are afraid such availability might make him too dependent you may discuss with him what his ideas are how he can be most supported during critical periods.

Giving feedback. **[pp 32]**
Another powerful aspect of therapy as encounter is giving honest feedback about the way the patient interacts with you. For this will reveal his so called blind spots, those aspects of his behavior that he is not aware of, but which disturb his interaction with others. Such feedback helps the patient to get a more realistic self-image.
So explain that relational problems in his life will also manifest themselves in the therapy; search a parallel in therapy for a problematic situation outside, and explain that therefore *complete* openness is required: nothing should be held back, all subtleties of the relation should be explored and accepted in a non-judgmental way.
Like Wachtel Yalom warns to avoid words that may be experienced as critical. So don't say 'You are boring' , but: 'I feel distanced, excluded, without contact'. This expresses your wish to lessen the distance. Speak about *your feelings,* and not about what the patient *does,* for this sounds like an accusation.

Be generous with well-meant compliments, especially if the patient has made a courageous step. (for often you are the only witness).

Place the situation in another context (reframing), so that there is less room for judgement and more room for praise.

> See Wachtel's example of the patient who always came 20 minutes late. Wachtel feared that interpreting this behavior as resistance would have been experienced as critical by the patient. So he said: 'Apparently deep inside you know that you have to encounter *such* painful stuff, that 20 minutes is all you can tolerate'.

Everything is grist for the therapeutic mill. If they cry, or get angry, comment on it and its impact on the relation, but only when the iron is cold.
If a patient has been very shaken and asks for a hug, Yalom hugs her, but always returns to the request of the hugging in the next session.

If the patient openly asks if you find her sexually attractive, Yalom would oppose the way Gabbard used self-disclosure of his feeling steamrolled by Brenda in the film fragment yesterday. And he recommends not to hide yourself behind therapeutic clichés or counter-questions, like "What do you think yourself?", but to tell her: "If everything were different, if I were single, if we would not have met as patient and therapist, then I surely would have found you very attractive and would have made an effort to know you better."

Only after this selfdisclosure you can ask what makes this answer so important for her.
We can discuss whether this approach would be *just* as effective in confronting Brenda with her use of coercion to avoid the pain of abandonment as was Gabbard's approach, or whether in that case such a confrontation is not necessary anymore to touch her with the same intensity.

Yalom mentions 8 conditions that make feedback most effective: **[pp 33]**

1. Agree beforehand with the patient that he will permit feedback, because the way you experience him will parallel the way others experience him.
2. The feedback should be based on here-and-now observations from the session.
3. It should follow the event, that made the feedback necessary, as closely as possible.
4. It should focus on the specific observations and feelings generated in the *therapist*, rather than guesses or interpretations about the *patient's motives or deeds*.
5. It should be specific and explicit. Avoid simply responding to general questions whether you like him, but be specific about *what* you like in him.
6. If you can, use the term 'parts' , for this decreases defensiveness when contrasted to more healthy parts.
7. Strike the iron when it is cold.
   Avoid hurting the patient by comments that may be experienced as critical, but wait till the patient shows more adult behavior, and praise that and contrast it to his previous behavior.
   E.g. "Today I feel much closer to you. As if you are much more real than last time when you hid behind many stories without much feeling".
8. Let the patient check the feedback with others to obtain validation.

All these suggestions help to make your feedback really effective and so to touch the patient.

Conclusion: [pp 34]

It is clear that for really touching the patient one should be both empathic and authentic. I hope I have been clear enough in describing where the classical, abstinent approach differs from the interactive approach, and where they overlap.

My own position is that none of them is better than the other. Both approaches have their own value and they should be applied according to what the patient needs. They reach different levels of the patient's psyche.

The relational psychoanalysts speak about therapy as encounter. They focus on the patient's blind spots, the interpersonal aspects of his personality he is not aware of, but which he manifests in his interactions with others.
After all Yalom is also a group therapist!

Classical psychoanalysts on the other hand seem to be able to reach more primitive levels of the patient's unconscious, the unintegrated 'mad' parts, the preverbal bodily experiences, and the subtle narcissistic needs for a mirror transference, in which the therapist should be available as a holding, soothing selfobject, and not as a real person whom one can encounter.

As far as the patient's personality style is concerned there is an interesting finding by Sidney Blatt. **[pp 35]** He re-used the original data of the '42 lives in treatment' research project I mentioned yesterday, and discovered that the interactive, supportive approach was most helpful to patients who were relation-oriented, and the more abstinent interpretive approach better suited patients for whom autonomy was most important.

As far as your own personality style is concerned, if you have a more reserved personality style, the classical analytic attitude of abstinence and neutrality will fit you best; if you have an more relational style the relational attitude of Yalom, with his emphasis on transparency and interaction will be most profitable. After all, the more natural you are, the more effective you will be to touch the patient in a really authentic way. And don't forget: Theory is a good servant, but a bad master!

Therefore, which approach is most useful depends first of all on what the patient needs to be helped with, which is a question of diagnosis and indication; and in the 2nd place on his personality style (relationally oriented or autonomy oriented), and finally to a certain degree on your personality style, which you should adapt to the patient's needs.
In the next slide I will give a summary where the different examples of this lecture fit. **[pp 36]**

Thank you for your attention.
[pp 37]

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