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.

inclined, for example, to let you matter or get too close because of fear of suffering yet another loss. Hence the investigation of the past may be important not for the sake of constructing causal chains but because it permits us to be more accurately empathic.

CHAPTER 7

Teach Empathy

Accurate empathy is an essential trait not
pists but for patients, *and we must help p*
empathy for others. Keep in mind that ou
erally come to see us because of their lack of su
oping and maintaining gratifying interpersonal
Many fail to empathize with the feelings and
others.

I believe that the here-and-now offers therapi
way to help patients develop empathy. The strat
forward: Help patients experience empathy with
will automatically make the necessary extrapola
important figures in their lives. It is quite comm
pists to ask patients how a certain statement or a
might affect others. I suggest simply that the the
himself in that question.

When patients venture a guess about how I fe
hone in on it. If, for example, a patient interprets