CHAPTER 9

Acknowledge Your Errors

It was the analyst D. W. Winnicott who once made the trenchant observation that the difference between good mothers and bad mothers is not the *commission* of errors *but what they do with them.*

I saw one patient who had left her previous therapist for what might appear a trivial reason. In their third meeting she had wept copiously and reached for the Kleenex only to find an empty box. The therapist had then begun searching his office in vain for a tissue or a handkerchief and finally scurried down the hall to the washroom to return with a handful of toilet tissue. In the following session she commented that the incident must have been embarrassing for him, whereupon he denied any embarrassment whatsoever. The more she pressed, the more he dug in and turned the questions back to why she persisted in doubting his answer. Eventually she concluded (rightly, it seemed to me) that he had not dealt with her in an authentic manner and decided that she could not trust him for the long work ahead.

An example of acknowledged error: A patient who had suffered many earlier losses and was dealing with the impending loss of her husband, who was dying of a brain tumor, once asked me whether I ever thought about her between sessions. I responded, "I often think about your situation." Wrong answer! My words outraged her. "How could you say this," she asked, "you, who were supposed to help—you, who ask me to share my innermost personal feelings. Those words reinforce my fears that I have no self—that everyone thinks about my *situation* and no one thinks about me." Later she added that not only does she have no self, but that I also avoided bringing my own self into my meetings with her.

I brooded about her words during the following week and, concluding that she was absolutely correct, began the next session by owning up to my error and by asking her to help me identify and understand my own blind spots in this matter. (Many years ago I read an article by Sándor Ferenczi, a gifted analyst, in which he reported saying to a patient, "Perhaps you can help me locate some of my own blind spots." This is another one of those phrases that have taken up lodging in my mind and that I often make use of in my clinical work.)

Together we looked at my alarm at the depth of her anguish and my deep desire to find some way, *any* way short of physical holding, to comfort her. Perhaps, I suggested, I had been backing away from her in recent sessions because of concern that I had been too seductive by promising much more relief than I would ever be able to deliver. I believed that this was the context for my impersonal statement about her "situation." It would have been so much better, I told her, to have simply been honest about my aching to console her and my confusion about how to proceed.

If you make a mistake, admit it. Any attempt at cover-up will ultimately backfire. At some level the patient will sense you are acting in bad faith, and therapy will suffer. Furthermore, an open admission of error is good model-setting for patients and another sign that they matter to you.

CHAPTER 10

Create a New Therapy for Each Patient

There is a great paradox inherent in much contemporary psychotherapy research. Because researchers have a legitimate need to compare one form of psychotherapy treatment with some other treatment (pharmacological or another form of psychotherapy), they must offer a "standardized" therapy—that is, a uniform therapy for all the subjects in the project that can in the future be replicated by other researchers and therapists. (In other words, the same standards hold as in testing the effects of a pharmacological agent: namely, that all the subjects receive the same purity and potency of a drug and that the exact same drug will be available for future patients.) *And yet that very act of standardization renders the therapy less real and less effective.* Pair that problem with the fact that so much psychotherapy research uses inexperienced therapists or student therapists, and it is not hard to understand why such research has, at best, a most tenuous connection with reality.

Consider the task of experienced therapists. They must

establish a relationship with the patient characterized by genuineness, positive unconditional regard, and spontaneity. They urge patients to begin each session with their "point of urgency" (as Melanie Klein put it) and to explore with ever greater depth their important issues as they unfold in the moment of encounter. What issues? Perhaps some feeling about the therapist. Or some issue that may have emerged as a result of the previous session, or from one's dreams the night before the session. My point is that therapy is spontaneous, the relationship is dynamic and ever-evolving, and there is a continuous sequence of experiencing and then examining the process.

At its very core, the flow of therapy should be spontaneous, forever following unanticipated riverbeds; it is grotesquely distorted by being packaged into a formula that enables inexperienced, inadequately trained therapists (or computers) to deliver a uniform course of therapy. One of the true abominations spawned by the managed-care movement is the ever greater reliance on protocol therapy in which therapists are required to adhere to a prescribed sequence, a schedule of topics and exercises to be followed each week.

In his autobiography, Jung describes his appreciation of the uniqueness of each patient's inner world and language, a uniqueness that requires the therapist to invent a new therapy language for each patient. Perhaps I am overstating the case, but I believe the present crisis in psychotherapy is so serious and therapist spontaneity so endangered that a radical corrective is demanded. We need to go even further: *the therapist must strive to create a new therapy for each patient.*

Therapists must convey to the patient that their paramount task is to build a relationship together that will itself become the agent of change. It is extremely difficult to teach this skill in a crash course using a protocol. Above all, the therapist must

be prepared to go wherever the patient goes, do all that is necessary to continue building trust and safety in the relationship. I try to tailor the therapy for each patient, to find the best way to work, and I consider the process of shaping the therapy not the groundwork or prelude but the essence of the work. These remarks have relevance even for brief-therapy patients but pertain primarily to therapy with patients in a position to afford (or qualify for) open-ended therapy.

I try to avoid technique that is prefabricated and do best if I allow my choices to flow spontaneously from the demands of the immediate clinical situation. I believe "technique" is facilitative when it emanates from the therapist's unique encounter with the patient. Whenever I suggest some intervention to my supervisees they often try to cram it into the next session and it always bombs. Hence I have learned to preface my comments with: "*Do* not *try this in your next session,* but in this situation I might have said something like this. . . ." My point is that every course of therapy consists of small and large spontaneously generated responses or techniques that are impossible to program in advance.

Of course, technique has a different meaning for the novice than for the expert. One needs technique in learning to play the piano but eventually, if one is to make music, one must transcend learned technique and trust one's spontaneous moves.

For example, a patient who had suffered a series of painful losses appeared one day at her session in great despair, having just learned of her father's death. She was already so deep in grief from her husband's death a few months earlier that she could not bear to think of flying back to her parents' home for the funeral and of seeing her father's grave next to the grave of her brother, who had died at a young age. Nor, on the other hand, could she deal with the guilt of *not* attending her own

father's funeral. Usually she was an extraordinarily resourceful and effective individual, who had often been critical of me and others for trying to "fix" things for her. But now she needed something from me—something tangible, something guilt-absolving. I responded by instructing her not to go to the funeral ("doctor's orders," I put it). Instead I scheduled our next meeting at the precise time of the funeral and devoted it entirely to reminiscences of her father. Two years later, when terminating therapy, she described how helpful this session had been.

Another patient felt so overwhelmed with stress in her life that during one session she could barely speak but simply hugged herself and rocked gently. I experienced a powerful urge to comfort her, to hold her and tell her that everything was going to be all right. I dismissed the notion of a hug—she had been sexually abused by a stepfather and I had to be particularly attentive to maintaining the feeling of safety of our relationship. Instead, at the end of the session, I impulsively offered to change the time of her next session to make it more convenient for her. Ordinarily she had to take off work to visit me and this one time I offered to see her before work, early in the morning.

The intervention did not provide the comfort I had hoped but still proved useful. Recall the fundamental therapy principle that all that happens is grist for the mill. In this instance the patient felt suspicious and threatened by my offer. She was convinced that I did not really want to meet with her, that our hours together were my low point of the week, and that I was changing her appointment time for my own, not her, convenience. That led us into the fertile territory of her self-contempt and the projection of her self-hatred onto me.

CHAPTER 11

The Therapeutic Act, Not the Therapeutic Word

Take advantage of opportunities to learn from patients. Make a point of inquiring often into the patient's view of what is helpful about the therapy process. Earlier I stressed that therapists and patients do not often concur in their conclusions about the useful aspects of therapy. The patients' views of helpful events in therapy are generally relational, often involving some act of the therapist that stretched outside the frame of therapy or some graphic example of the therapist's consistency and presence. For example, one patient cited my willingness to meet with him even after he informed me by phone that he was sick with the flu. (Recently his couples therapist, fearing contagion, had cut short a session when he began sneezing and coughing.) Another patient, who had been convinced that I would ultimately abandon her because of her chronic rage, told me at the end of therapy that my single most helpful intervention was my making a rule to schedule an extra session automatically whenever she had angry outbursts toward me.

In another end-of-therapy debriefing a patient cited an incident when, in a session just before I left on a trip, she had handed me a story she had written and I had sent her a note to tell her how much I liked her writing. The letter was concrete evidence of my caring and she often turned to it for support during my absence. Checking in by phone to a highly distressed or suicidal patient takes little time and is highly meaningful to the patient. One patient, a compulsive shoplifter who had already served jail time, told me that the most important gesture in a long course of therapy was a supportive phone call I made when I was out of town during the Christmas shopping season—a time when she was often out of control. She felt she could not possibly be so ungrateful as to steal when I had gone out of my way to demonstrate my concern. If therapists have a concern about fostering dependency, they may ask the patient to participate in devising a strategy of how they can be most supported during critical periods.

On another occasion the same patient was compulsively shoplifting but had so changed her behavior that she was now stealing inexpensive items—for example, candy bars or cigarettes. Her rationale for stealing was, as always, that she needed to help balance the family budget. This belief was patently irrational: for one thing, she was wealthy (but refused to acquaint herself with her husband's holdings); furthermore, the amount she saved by stealing was insignificant.

"What can I do to help you now?" I asked. "How do we help you get past the feeling of being poor?" "We could start with you giving me some money," she said mischievously. Whereupon I took out my wallet and gave her fifty dollars in an envelope with instructions to take out of it the value of the item that she was about to steal. In other words, she was to steal from me rather than the storekeeper. The intervention permitted her to cut short the compulsive spree that had taken control of her,

and a month later she returned the fifty dollars to me. From that point on we referred often to the incident whenever she used the rationalization of poverty.

A colleague told me that he had once treated a dancer who told him at the end of therapy that the most meaningful act of therapy was his attending one of her dance recitals. Another patient, at the end of therapy, cited my willingness to perform aura therapy. A believer in New Age concepts, she entered my office one day convinced that she was feeling ill because of a rupture in her aura. She lay down on my carpet and I followed her instructions and attempted to heal the rupture by passing my hands from head to toe a few inches above her body. I had often expressed skepticism about various New Age approaches and she regarded my agreeing to accede to her request as a sign of loving respect.