CHAPTER 1

Rethinking the Talking Cure

The Therapist Speaks Too

In the practice of psychotherapy, words are our primary medium. This is the case whatever orientation we practice from. The words (and the thinking behind the words) may be different from the vantage point of each approach, and systemic or cognitive-behavioral therapists may not think of themselves as engaging in "the talking cure" the way psychodynamic or humanistic–experiential therapists do; but even if one's focus is on initiating behavioral interventions or restructuring the family system, the medium for doing so is primarily our words.

Words are also the medium of relationships. Although the exact contribution of so-called specific and nonspecific factors remains a hotly contested issue (cf. Siev & Chambless, 2007; Wampold, 2009; Hubble, Duncan, & Miller, 1999; Duncan, Miller, Wampold, & Hubble, 2010; Shedler, 2010; Norcross, Beutler, & Levant, 2006), one finding that consistently emerges from the research evidence is that the therapeutic relationship accounts for a noteworthy portion of the therapeutic change that is achieved (Norcross, 2002, 2010). Even in relatively structured, manualized treatments, establishing a strong therapeutic alliance is almost always an important goal, and what we say to the patient or client constitutes more than "interventions"; our words and phrases, offered continuously in multiple reciprocal exchanges, powerfully shape the climate of the relationship and the tenor of the alliance. As I will

elaborate in great detail throughout this book, even slight variations in what we say and how we say it can have far-reaching implications for the patient's experience of the relationship, of the work, and of himself and his potential for change.

Given this critical role of the therapist's language for the development of the alliance and the progress of the therapy, it is surprising how little has been written about the principles that can guide the therapist in framing her comments to the patient in ways that facilitate therapeutic change or about the implications of different ways of communicating her ideas and observations. Often, both in supervision and in case discussions in the literature, the patient's or client's words are examined for subtle nuances of meaning and inflection, but the *therapist's* words are given much less attention. Supervisees and students in practicum seminars over the years have often noted that most of their supervisors concentrate on listening to and understanding the patient—needless to say, a crucially important focus for good therapeutic work—but that they give little guidance as to what the therapist *should say* based on the understanding achieved. The assumption seems to be that if one truly understands, what to say will follow more or less automatically. These students and supervisees have responded with gratitude (and surprise) when I have not shared that common supervisory assumption, but rather have examined with them in some detail what they have said, what they *could* say, and the implications of each of the choices.

Often, they have commented that paying attention to finding the right words to say something they want the patient to hear has enabled them to say things to the patient that they previously could not. Implicitly—to anticipate what will be a key point throughout this book—they have recognized that the way they had thought to put their understanding or observations into words would likely feel *accusatory* to the patient, would leave him feeling "caught" by them in something shameful, and consequently would not be helpful. But without a better alternative in mind, they have kept their observation to themselves. A central aim of this book is to enable the therapist to find more effective and more empathic ways to put her observations into words, so that the therapist is empowered to *say* what she sees, and the patient is enabled to integrate the therapist's observations into a larger, more expansive sense of self rather than feeling humiliated or diminished by what the therapist has noticed.

Of course, this book is not just about words. First of all, much of the important communication that goes on in the session is nonverbal, con-

veyed in gesture, posture, tone of voice, and the like. Moreover, words derive their meaning not just from syntax and vocabulary but from the social, emotional, and behavioral context in which they are uttered. The words we speak in the therapy room are, in important ways, inseparable from the feelings we feel in being with the patient and from the totality of the ways that we and the patient have interacted. They reflect as well how we *think* about the patient and his anxieties and conflicts. Thus, another central aim of the book is to present a theoretical perspective in which nonaccusatory, nonpathologizing formulations come readily to mind, and do so not as an evasion of the difficult issues the patient faces but as a reflection of an *alternative understanding* of those issues.

These considerations notwithstanding, however, this book is certainly very centrally concerned with the words we use as therapists. The words and phrases we choose to express what we want to convey to the patient do matter. They matter, in fact, a great deal, and it is my intent in this book to illuminate how even subtle variations in the way we say things can have significantly different implications for the therapeutic work.

Over the years I have become convinced, both from my work with students learning to do psychotherapy and from observing my own behavior as a therapist, that what to say does *not*, as is frequently assumed, follow automatically from one's understanding of the patient. The framing of therapeutically effective comments is a skill, just as achieving proper understanding is a skill; and although the crafting of therapeutic comments is obviously not independent of one's understanding of the patient, it is far from completely determined by that understanding.

I am also persuaded by my experience that creating therapeutically helpful comments is a *teachable* skill. Both beginning students and seasoned practitioners can benefit from paying more attention to just how they phrase what they say to patients. After a time, one begins to get a feel for ways of saying things that are significantly less productive of resistance and significantly more respectful of the patient's self-esteem. And this not because one pulls one's punches or avoids painful realities but because how one gets one's message across is as important as what that message is.[1]

[1]Indeed, the "what" of the message and the "how" of the message are not really separable. To a significant degree, how one gets the message across determines what the message really "is." In the terms introduced next, the meta-message is an intrinsic—and crucial— part of the overall message conveyed to the patient.

FOCAL MESSAGES AND "META-MESSAGES"

Central to the argument of this book is the idea that every overt message that the therapist intends to convey, every communication of a particular understanding of the patient's experience or dynamics (what I will call the "focal message"), carries with it a second message, a "meta-message," if you will, that conveys an attitude about what is being conveyed in the focal message.[2] It is often in this meta-message—frequently unnoticed or unexamined—that the greatest potential for therapeutic transformation (or therapeutic failure) lies.

It is by now widely recognized that, when listening to a patient, it is at least as important to notice *how* the patient communicates as to hear *what* he says—indeed that very often the "how" is the most important "what" that the astute listener can pick up (see particularly, Reich, 1949; Shapiro, 1965, 1981, 1989, 2000). But a corresponding literature on the how of the *therapist's* communications is scarcely to be found. When standard texts approach the topic at all, it is most often under such rubrics as tact or timing. The focus of this book does overlap in certain ways with what is commonly conveyed by the concepts of tact and timing, but its concerns go well beyond those limited conceptualizations.

Indeed, it might be said that some of the recommendations made here can be seen as suggesting an *alternative* to tact—not, I hasten to add, in the sense that I advocate being tactless; but in the sense that in ordinary social discourse being tactful at times implies a degree of evasion of difficult issues, a skillful avoidance of an uncomfortable truth. What I hope to show, in contrast, are ways *to address* the disagreeable matters whose evasion is often at the heart of the patient's difficulties—but to do so in such a way that the patient will be able to take in what is said and will feel more able to deal with the issue rather than to find new ways to ward it off.

A comment whose focal message is accurate but whose meta-message is poorly wrought can have an effect similar to that of a potentially curative organ transplant that is rejected by the patient's body because it is registered as alien. Such a comment is potentially healing in principle

[2]My use of the term "meta-message" may call to mind for some readers Bateson's (1972, 1979) discussions of metamessages and metacommunication. His approach, however, has rather different emphases, deriving from his interest in Whorf's (1956) theory of language and Whitehead and Russell's (1910–1913) theory of logical types.

but unhelpful in actual effect because it is experienced as a dangerous intrusion of alien material. Like the needed organ, it too is rejected and thereby prevented from exercising its curative potential. "Tissue rejection," one might say, is an issue in the psychotherapeutic process as well.

For that reason, I will concentrate a good deal on the larger meaning of the therapist's message—on what view of himself it induces in the patient; whether it elicits cooperation or resistance; whether it enhances the patient's self-esteem; whether it leads to conflict-resolving or fear-reducing or skill-enhancing action; what it conveys about the therapist's view of the patient; and so forth. It is striking how often in the literature basic details are omitted regarding what the therapist actually says, with the consequence that the full implications of what is said remain unexamined. Even many seemingly concrete and communicative reports, whether in the literature or in supervisory sessions, can be seen, on closer inspection, to leave a crucial ambiguity about what was actually said and, hence, to be considerably less useful or revealing than they might first appear. When a supervisee reports, for example, "I told the patient that I thought his forgetting was related to his anger at his wife," his actual comment could have been anything from *You were angry at your wife, and you tried to hide it by forgetting*, to *You've told me about a number of things your wife did that I would imagine made you angry; perhaps you forgot because you were trying so hard not to be angry at her.* The tone and meaning of these two ways of "telling him his forgetting was related to his anger at his wife," the meta-messages they convey, diverge quite substantially. Unless one examines the actual comments in their concrete detail, one's appreciation of what transpired will be incomplete and potentially quite misleading.

ATTENDING TO THE PATIENT'S EXPERIENCE OF THE THERAPIST'S REMARKS

In considering the implications of the ideas and examples just discussed, it is essential to be clear that the meaning *to the patient* of the therapist's comment is not objectively given in the comment itself. The patient will inevitably experience the comment "in his fashion," filtering it through his past experiences, expectations, needs, fears, and working models of human relationships. Put differently, the ubiquitous phenomenon of transference will make it likely that the patient's experience of the com-

ment will differ in certain respects from what the therapist thinks she is conveying.

The ramifications of this understanding of the communicative process are substantial and will be explored in various ways throughout this book. It is important, however, that appreciation of the crucial role of the patient's subjectivity in determining the meaning of the therapist's remarks not mislead one into downplaying the importance of what the therapist actually says. As discussed in Chapter 6, transferential reactions, though idiosyncratic, are far from arbitrary. They are significantly shaped by the actuality of the situation, even as they give a particularized meaning to that actuality (cf. Aron, 1991a, 1996; Gill, 1982, 1983; Hoffman, 1983, 1998, 2006). The way the therapist chooses to phrase her communication will not completely determine how the patient experiences it, but it is highly relevant to that experience. Though the vagaries of transference will render the impact of the comment probabilistic and partially indeterminate, the *likely* impact—and especially the *range* of likely impacts—can be usefully estimated, especially as the therapist gets to know her patient and the patient's particular way of construing experiences.

It is absolutely central to the point of view presented in this book that the therapist must not simply *assume* how the patient will experience the comment and that she must be constantly alert to the meaning *the patient* gives to the remark. However, the therapy will be much the worse for it if this important truth is used by the therapist to obscure the equally crucial reality that the particular way one says something has a powerful impact, and that, when the therapist has learned to pay attention to the meta-messages embodied in her remarks, the probable impact can be estimated with a reasonable degree of accuracy. If the fact that each patient gives individual and somewhat idiosyncratic meaning to what is said becomes a nihilistic cliche, justifying the therapist's lack of attention to how she phrases her comments on the grounds that they will mean something different to the patient than the therapist intended anyway, the therapist's ability to be genuinely therapeutic is notably impoverished. Throughout this book, I intend to weave together the implications of two important realities of the therapeutic process and relationship—on the one hand, that the meaning of the therapist's comments is ultimately the meaning as experienced by the patient; and on the other, that that experience is significantly determined by the actual shape and tone of the therapist's remarks.

"THERAPIST NOISES"

Critical or countertherapeutic meta-messages are often not easy to detect. Psychotherapists have developed a variety of commonly used forms to carry their messages, and these forms are often quite effective (at least initially) in disguising the meta-message that is being conveyed. Indeed, that is in large measure their purpose.

Consider, for example, the following brief interaction between a patient, Linda, and her therapist. The therapist described Linda as someone who frequently put her off balance, who asked questions that she did not know how to respond to. On one occasion, for example, Linda asked her, "You're not Jewish, yet you're married to a Jewish man. How come?"

The therapist, feeling flustered and uncertain, called upon a kind of comment that will probably sound familiar to almost all readers. "It's interesting," she said, "that you ask so many questions."

"Interesting" is one of those words that seem to convey the neutrality that many therapists believe is the proper stance for the therapist to maintain. By commenting that the patient's behavior is interesting, it may seem we are simply calling attention to it, attempting to stir the patient's curiosity about his own mental processes. But is "interesting" in this instance neutral? Most of us are usually pleased when we are told that something we have said or done is interesting. Would the present comment produce the same self-satisfied glow? I doubt it.

It is not difficult to detect that the real message conveyed by this expression of interest is disapproval. Calling the patient's behavior "interesting" in this context puts her in her place and affirms that she is a clinical "case." We all have images of therapists in bad movies saying to the patient, in a heavy Viennese accent, "verrry interrressting," and again we know that this is not meant as a compliment.

Such locutions are what I call "therapist noises." They are the familiar phrasings that therapists call upon when uncertain, phrasings that at once convey a bolstering sense of professionalism and serve to protect the therapist from further revelation of what she is thinking or feeling. It is difficult for me to imagine any therapist (myself included) doing entirely without these forms of protective coloration. Doing therapy makes one too vulnerable to give them up completely. Moreover, their close relatives are perfectly legitimate expressions of the stance of participant observation (Sullivan, 1953, 1954), the odd combination of engagement and reflectiveness that characterizes psychotherapy at its

best. Indeed, sometimes the very same phrase can be in one instance a "therapist noise" and in another an expression of the therapist's competent professionalism. That is, after all, why such phrases actually do soothe and protect us. They would not *feel* competently professional if they were not versions of something that on other occasions really *was* competently professional.

If one is attuned to the idea of therapist noises, however, they are not hard to detect. When one is making therapist noises, one has a characteristically hollow feeling, a sense of discomfort, fraudulence, or stiltedness that, subjectively, is painfully obvious, however hard one tries to keep it from being noticed by the patient. One is aware, and not in a positive way, of "sounding like a therapist." When I have introduced this concept to students, they have had little trouble recognizing instantly what I was referring to and have indeed noted that it was an all too common accompaniment of their efforts to take on the therapist's role. One gauge that I have only half jokingly suggested to students as a rough indication of whether they are drifting into making therapist noises is to keep track of their *perhaps-to-maybe ratio*. When one is in the stilted, "therapist noises" stance, one is likely to use rather frequently the word "perhaps" ("perhaps you're feeling such and such") rather than the more informal "maybe." Such subtleties of tone can be useful in alerting the therapist to what can be a rather important dimension of her interaction with the patient.

Phrases such as *I wonder what you mean by that* or *I wonder why you're asking me that* or *What do you think you should do?* or a host of others all can be appropriate and facilitative of the therapeutic process; completely excising them from our therapeutic vocabulary would impoverish our work very substantially. But they can also be stultifying cliches that keep the patient at bay, protect the therapist's fragile sense of expertise, and prevent real life from entering the interaction between patient and therapist. The discussions in this book are designed both to help the therapist become more aware of when her communications take on this quality and to help her build a repertoire of more genuinely therapeutic comments that can obviate the need for "therapist noises" and promote contact rather than uncomfortable self-protection.

CONTRIBUTIONS FROM THE LITERATURE

Although there is a general paucity of writings on the crucial details of technique addressed in this book, a number of writers have seen clearly the importance of the topic and have made valuable contributions. The

original impetus for this book derived from concerns and dissatisfactions that I had with psychodynamic modes of communication in the session and with a sense that it was possible to utilize the important insights of psychodynamic thought in ways that were more facilitative of therapeutic change. Hence the literature I will discuss here is primarily focused on this perspective, because it is the literature in relation to which the ideas I am presenting evolved. Over the years, however, when I have presented the ideas in this book in workshops in many locales, participants have often been struck by the convergences between my emphasis and that of systemic and narrative therapists (e.g., White & Epston, 1990; White, 2007; O'Hanlon & Weiner-Davis, 2003; Zeig, 1994; Zeig & Lankton, 1988; Watzlawick, 1978). Other participants have noted similarities to the cognitive and cognitive-behavioral approaches depicted by writers such as Judith Beck (e.g., 1995, 2005) and Robert Leahy (e.g., 2001, 2003; Gilbert & Leahy, 2007; Sookman & Leahy, 2010) and with experiential approaches (e.g., Johnson, 2004; Greenberg & Johnson, 1988; Greenberg & Watson, 2006; Fosha, 2000). I will discuss these perspectives on the therapeutic process at various points in this book, but in this chapter I will concentrate on the writings within the psychodynamic tradition that most directly bear on the issues in response to which the clinical guidelines described in this book evolved.

Leston Havens (1986), writing on matters of wording and phrasing from a perspective that combines existential and interpersonal points of view, offers a rather elaborate taxonomy of types of therapeutic statements, which he broadly categorizes into empathic language, interpersonal language, and performative language. Much like the present volume, his book is filled with detailed examinations of particular ways of saying things and their implications for the therapeutic process. I will have occasion in a number of places in this book to draw on his interesting observations.

Ralph Greenson, in his authoritative text on psychoanalytic technique, shows considerable interest in and thought about the wording of comments to patients and discusses his choice of words in some detail. As he puts it,

> My language is simple, clear, concrete, and direct. I use words that cannot be misunderstood, that are not vague or evasive. When I am trying to pin down the particular affect the patient might be struggling with, I try to be as specific and exact as possible. I select the word which seems to portray what is going on in the patient, the word which reflects the patient's situation of the moment. If the patient

> seems to be experiencing an affect as though he were a child, for example, if the patient seems anxious like a child, I would say: "You seem scared," because that is the childhood word. I would never say, "you seem apprehensive" because that would not fit, that is a grown-up word. Furthermore, "scared" is evocative, it stirs up pictures and associations, while "apprehensive" is drab. I will use words like bashful, shy, or ashamed, if the patient seems to be struggling with feelings of shame from the past. I would not say humiliation or abasement or meekness.
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> In addition, I also try to gauge the intensity of the affect as accurately as possible. If the patient is very angry, I don't say, "You seem annoyed," but I would say, "You seem furious." I use the ordinary and vivid word to express the quantity and quality of affect I think is going on. I will say things like: You seem irritable, or edgy, or grouchy, or sulky, or grim, or quarrelsome, or furious, to describe different kinds of hostility. How different are the associations to "grouchy" as compared to "hostile." In trying to uncover and clarify the painful affect and the memories associated to that specific affect, the word one uses should be right in time, quality, quantity, and tone. (1967, pp. 108–109)

Warren Poland, another analyst who has appreciated the importance of what the therapist or analyst actually says, shows as well how certain assumptions of standard psychoanalytic thought can obscure and constrain that appreciation. Poland, pointing in his own way to the dimension I addressed above in terms of the distinction between the focal message and the meta-message, notes that "The analyst's music carries messages as important as those in the manifest words." He alerts the reader to "buried messages," to the fact that "Even simple remarks carry implied messages beyond the manifest" (1986, p. 248).

In a more critical vein, Poland notes the ways that the psychoanalytic literature has often attempted to deny or obfuscate this dimension of the therapeutic exchange. He cites as an example of the conceptual confusions that can arise the claim by the highly respected analyst Rudolf Loewenstein (1956) that the well-functioning analyst excludes from his speech any appeal or effort to affect the patient, "limiting himself specifically to the cognitive function in relation to facts concerning his present addressee: the patient" (1956, p. 462).

"Such tidiness of concept is appealing," says Poland, but "unfortunately" such a model, in which "the patient reports his inner world and like an objective outside observer, the analyst interprets," does not square with experience. The idea of "simply saying," of speech that is not also "an action upon the other," seems to Poland highly questionable, and he states quite explicitly (and correctly, I believe) that

> the analyst speaks for effect. No matter the analyst's desire to see his role as that of an impartial researcher helping catalyze the uncovering of buried truth, the analytic work is done for purpose. If the analyst were to have no impact on the patient and the analysis … then the analyst and the analysis would be meaningless. (1986, p. 264)

Poland provides a number of interesting illustrations of how language may be used, when the therapist or analyst is aware, to enhance the likelihood of getting through to the patient. One of my favorites involves an instance in which a patient presented to him a dream in which "the manifest content repudiates an urge, one the patient would prefer to disown." In speaking about the dream, the patient adds that he "would never do anything so outrageous as the dream suggests." To this Poland replied, "You wouldn't even dream of such a thing" (1986, pp. 246–247).

Poland's way of framing his comment provides a potential opening that a more direct confrontation would likely fail to provide. The paradoxical quality of the comment (both acknowledging the patient's claim that he wouldn't dream of such a thing and pointing out that he just did) provides a gentle nudge, and, as Poland notes, the patient can choose to hear it in whatever way he is ready to. Not only is such a comment less heavy-handed than something like *You say you wouldn't do such a thing yet you went ahead and dreamt it*; it also creates a tone in which analyst and patient are standing side by side rather than facing each other as adversaries. Poland is giving the patient credit for being able to see the humor and paradox in his comment, and they can both appreciate it together.

Poland further notes that the analyst's style of speech can have as significant an impact on the patient as do the words. In a fashion similar to the approach taken in the present book, Poland points to the "how" of the therapist's comment as well as the what, its "official" or manifest focus. With regard to the "you'd never dream of it" comment, he points out that "spoken with regard to the patient in his struggles, the statement is helpful. Spoken with an edge of sarcasm, it ridicules and belittles. Interpretations … are undermined if the message itself is not truly respectful and nonprovocative" (1986, p. 264).

A somewhat similar strategy of communication is illustrated in another of Poland's descriptions: a woman patient, whom Poland perceived as having considerable conflict and anxiety over sexuality and body damage, described to him her fears of her male supervisor's comments. Poland's comment—"You're afraid of a penetrating remark"— differs quite considerably from a comment such as *You're afraid he's making a sexual advance.* Apropos the main argument of this book, the latter com-

ment derives from the same understanding as Poland's, but its potential effects could be quite different. Poland's comment permits the patient to take it at whatever level she is ready for. If she wishes, she will hear what he is implying; if not, she can ignore it (at least temporarily)—yet also let it have an impact unconsciously. This is a tactic that is probably used often by skilled therapists but is rarely explicitly addressed in the literature. When done appropriately, and with sufficient respect for what the patient is capable of dealing with, and—apropos Poland's aforementioned caveat about tone—when not employed in a superior or judgmental way, it can diminish considerably the likelihood of "tissue rejection."

Not surprisingly, Harry Stack Sullivan also provided a rich store of guidelines for the effective framing of therapeutic comments. From Sullivan's perspective of "participant observation" it was very clear that what transpired in the therapeutic hour was not the simple unfolding of something from within the patient while the therapist merely watched (cf. Wachtel, 1982). The experience of the patient was a joint product of the patient's past history and present characteristics *and* of the therapist's participation in that history. That "the therapist speaks for effect" did not have to be told to Sullivan (see also in this connection Aron, 1996; Mitchell, 1988, 1997; Hoffman, 1998; Frank, 1999; Wachtel, 2008).

Numerous accounts, both by Sullivan and by others describing his work, illustrate his keen appreciation of the impact on the patient of precisely what he said and how he said it. As A. H. Chapman put it in his volume *The Treatment Techniques of Harry Stack Sullivan,* it was Sullivan's view that since words "are the implements with which therapists work, attention to their most effective use should be included in teaching psychotherapy" (Chapman, 1978, p. 17). In this context, Chapman goes on to comment that "It is an odd fact that most distinguished psychiatric innovators have paid little or no attention to *the precise verbal and nonverbal techniques* that therapists use to obtain and convey information with patients" (Chapman, 1978, p. 17; italics in original).

Chapman stresses Sullivan's concern that one must not pursue the task of therapeutic inquiry in ways that will lower the patient's self-esteem, and he provides numerous examples illustrating Sullivan's careful attention to the impact of the particular way of approaching any topic. He suggests, for example, that

> in discussing with a patient a problem she has with her husband, it may be an error to ask, "Have you talked this over with him?" If the patient has not discussed the subject with him, she may feel that the therapist's inquiry implies that she has blundered by not doing so. Indirect questions which do not undermine the patient's self-esteem

> may be much better. "What does your husband think about this problem? Has he brought the subject up with you? Has he in other ways made his feelings clear on this point?" (1978, pp. 16–17)

In this example, casting the inquiry initially as one in which the *husband's* behavior is first examined, in which *his* responsibility to discuss the issues between them and to share feelings is the focus, enables the topic to be addressed without directly confronting the patient's vulnerabilities. As the inquiry proceeds, it gradually shifts toward enabling the patient herself to take responsibility for communicating. Thus, the series of questions ends with "Do you think it would be advisable to get this problem out into the open between the two of you?" (Chapman, 1978, p. 17), but this point is reached only after preliminary work designed to protect her self-esteem and, we may add, to enable her really to hear what her therapist is saying.

Alexander and French (1946) also showed an uncommon appreciation for how the specific features of the therapist's communications can influence their therapeutic impact. Although endorsing the commonly held goal of avoiding both criticism or praise in what is said to the patient, they note that we "deceive ourselves … if we hope thereby to keep the patient from reading praise or blame into our interpretations." And they argue that although transference influences certainly account for a good part of this tendency on the patient's part, "It is not only as a result of such transference mechanisms that the patient may get an impression as to how the therapist evaluates the motives he interprets" (p. 93). By way of illustration, they offer the following example:

> If … a young man has just formed an attachment for a young woman, who in many ways resembles his mother, and if his therapist decides to call attention to this resemblance, it is by no means a matter of indifference just how he shall go about it. If he tells the patient that he is attracted to the young woman because she represents his mother, the implication will be that the patient should inhibit any sexual impulse toward the young woman as he would toward his mother. On the other hand, if the therapist waits until the patient has already begun to react with guilt to his sexual impulses toward the young woman and then points out to the patient that he feels *guilty* because he identifies the girl with the mother, the implication of this interpretation will tend to diminish the patient's guilt feelings because the patient will feel that the therapist is reminding him that the girl is really *not* his mother. It is evident, therefore, that it is a matter of great importance to the advancement of the therapeutic process in which way the therapist chooses to make the interpretation. (1946, pp. 93–94; italics added)

THE CONTRIBUTION OF THE THERAPIST'S FEELINGS, WITTING AND UNWITTING

The nature of the meta-messages conveyed to the patient is rarely a matter of technique alone. It is crucial that the therapist be alert to her emotional response to the patient's communications and to what has transpired between them. One's attitude is conveyed not only in one's words, but in one's tone, rhythm, posture, and so forth, and it is virtually impossible to disguise over the long run how one feels about the patient or about what he is saying. Especially if a therapist consistently makes comments to a patient that, however accurate, convey critical meta-messages, an examination of the therapist's personal reactions to the patient, of how the patient evokes feelings in her that stem from her own past or from her own unresolved conflicts, is clearly in order. Nothing in this book's agenda is intended to slight this critically important task of self-examination by the therapist.

It is important to be clear, however, that countertransference considerations and the considerations of proper phrasing and therapeutic communication that are the primary topic of this book do not constitute two clearly separable realms. On the one hand, the feelings evoked in us by the patient are a function not only of our personal history but of our set as we approach the patient and the therapeutic task. This set, in turn, depends on how we conceptualize the nature of psychological difficulties and the therapeutic process. Whether we experience the patient as manipulative, for example, depends as much on our theory as it does on more personal and idiosyncratic influences. For some therapists, behavior that might be described by others as manipulative is understood quite differently—as the patient's trying, indirectly (and largely self-defeatingly), to find a way to express and gratify his needs in the face of a long history of finding that when he expressed those needs in direct fashion it led to frustration, humiliation, misattunement, or other punishing experiences.[3]

Moreover, how manipulative, or resistant, or hostile, or inaccessible the patient feels to the therapist will depend as well on how competent and prepared the *therapist* feels. When one feels competent in the pres-

[3]As I will elaborate in later chapters, often the consequences of early problematic experiences are perpetuated by ironic vicious circles, in which the habits learned to cope with painful experiences end up generating still more such experiences, and hence still further strengthening of those very habits. When the patient elicits from the therapist a problematic response that is similar to those he encounters in others, such a process is usually in operation.

ence of a patient, when one feels one knows what to say and how to be therapeutically effective, the patient is likely to seem more likeable, and it is easier to empathize with whatever emotions he is manifesting. The many clinical examples offered in the second half of this book are designed in part to enable the therapist to feel precisely that sense of competence, of "knowing what to say," that will enhance the likelihood that she will like the patient or feel comfortable and receptive toward him.

On the other hand, in a field such as ours, one's theory itself is far from independent of who one is. That is, the same background personality factors and life experiences that are the soil for specific countertransference reactions to the patient provide as well much of the basis for our choice of a theory. With so many competing theories, there are many justifiable ways of conceiving both the therapeutic task and the psychological foundations of our patients' problems. Which one we choose to ally ourselves with will at least in part depend on which fits our personality and our own life experience (Stolorow & Atwood, 1979).

Thus it is never an either/or question of whether one's reactions result from countertransference or not. Certainly the therapist must continuously monitor her participation in the therapeutic process with the patient and attempt to understand the contribution of her own history and vulnerabilities to what is happening and to how she understands it. But it is important to appreciate as well that the degree to which countertransference influences will markedly skew the therapeutic process can depend quite substantially on the kinds of considerations at the heart of this book. By closely studying effective modes and structures of communication, by making them "second nature," the therapist can at least temper the distorting role of countertransferential reactions.

In general, the influence of unconscious conflicts and of residues from one's early history is most evident where ambiguity is greatest. Structure, in turn, helps to keep such influences in check and to create a relatively conflict-free zone. This is true as well for one's functioning as a psychotherapist. Attention to the phrasings and communicational strategies described in this book is no substitute for the therapist's continuing examination of her emotional reactions to the patient's characteristic ways of experiencing and interacting. But it can provide a structure that can help keep untoward reactions within reasonable limits as well as provide a further dimension of skillfulness in the conduct of the therapeutic work. As Poland (1986) has suggested in a somewhat different context, when one reaches for something to say to the patient, one is likely to "pull from the top of the pile." My intention in this book is to spell out the principles of effective therapeutic communication and to

provide sufficient examples of those principles in such a way that therapeutically facilitative phrasings are naturally at the top of the pile.

To be sure, many therapists achieve a fairly good sense of these principles intuitively and, without giving the matter too much thought, come up with therapeutically helpful phrasings a good deal of the time. But because it is not based on the same kind of reflection and careful study that other aspects of their therapeutic skills are, this capacity is particularly vulnerable to the winds of countertransference and to the stresses and pressures that are an inevitable part of therapeutic work. Moreover, for the same reason, this aspect of therapeutic functioning is more likely to be influenced without the therapist's even being clear that such influence has occurred.

A key aim of this book is to help the reader be more focally aware of the words she chooses in communicating her observations to the patient. I hope to bring to the reader's attention considerations that, even if frequently successfully negotiated in an intuitive fashion, have not been submitted to close study and reflection. I aim as well to provide a host of concrete examples that can provide the reader with a kind of warehouse of well-honed tools for clinical work.

Some of the examples will feel quite familiar to the experienced therapist. They will evoke a sense of "Yes, I do that," perhaps even an impatient sense of "I *already* know how to do that." They are representative of the ways we learn over time, in the intuitive fashion referred to above, to communicate effectively and therapeutically with our patients. But though familiar, they nonetheless merit close attention. When we can explicate to ourselves more clearly the principles that underlie what we do intuitively, we can increase the likelihood of the most helpful phrasings and messages coming to mind when they are needed (and often they are most needed when we are facing the most challenging clinical moments, the very moments when our intuitively developed skills are most likely to be disrupted).

The need for continuing work on these skills and these principles is underlined by a second sense of familiarity that the reader is likely to experience: The "bad" examples that are the starting point for a number of the discussions in the book are likely also to feel familiar. It is virtually impossible to do therapy day in and day out without finding oneself periodically making problematic comments to patients of just the sort I will focus on here. And this not because one is incompetent or sloppy but simply because the work we do is difficult, and it never can be perfect. Indeed, as I know from looking at my own clinical work, even after engaging in the kind of intensive scrutiny provided by the analyses pre-

sented here, the reader will not completely eliminate such unfortunate phrasings. I do hope, however, that their frequency can be considerably reduced.

I hope as well that calling the reader's attention to these issues will enable her to better recoup after a problematic comment rather than compound the difficulty. There is accumulating evidence that a key element in successful therapeutic work is attention to and repair of "ruptures" in the therapeutic alliance (Ruiz-Cordell & Safran, 2007; Safran & Muran, 2000; Safran, Muran, & Proskurov, 2009), and the problematic implicit messages to which this book calls attention are a major source of such ruptures. These ruptures are not just "errors" made by poor or inexperienced therapists; their occurrence and repair are, in important respects, part of the very "stuff" of good therapeutic work. But in order to deal with them effectively, one must be able to *notice* that a rupture has transpired. At times, we detect this because there begins to be an "uncomfortable" or unproductive feeling in the room, or even because the patient explicitly says that something is wrong. But it helps to have a kind of early warning signal that one is getting into hot water.

In my own work, I have found that my interest in and attention to the qualities of phrasing discussed in this book have often served to alert me to noticing something I have just said that may not yet be causing waves but which I realize is potentially problematic. I am then in a better position to change course or to begin the process of repair before it has compounded to an unproductive degree. In a related vein, similar attention to one's words and phrases can also serve as a sensitive indicator of developing countertransference feelings of which the therapist is not yet aware.

Not all of the examples in this book will have either version of the ring of familiarity to which I have just been referring—the sense, experienced with either satisfaction or chagrin, that "Yes, I say things like that." Some may feel more like examples of the kinds of things the reader has *tried* to say in sessions, perhaps has groped toward but has not quite been able to articulate. Still others may seem rather novel to most readers, forms of therapeutic discourse that had not occurred to the reader as a possibility before encountering them here. They are the result of many years of active reflection on the implications of different forms of communication in the therapeutic work; they are the product as well of being stimulated and encouraged in these reflections by students and supervisees who found this focus both intriguing and a useful supplement to the perspectives that more typically occupied their supervisory experiences.

The different chapters of this book do not address completely inde-

pendent topics. There is overlap in the examples and principles discussed from one chapter to another, because the principles that guide good therapeutic work are intertwined and interactive. Principles focused on in one chapter contribute to the effective formulation of the kinds of comments or the dimensions of communication that are the central concern of another. The division of the discussion into different types of comments or different principles of formulating comments reflects the necessities of the linear nature of books, but effective therapeutic communication is all of a piece. This caveat notwithstanding, I discuss in each chapter a somewhat different aspect of the process of communicating one's understanding to the patient in a therapeutically useful way. If the reader is aware that many of the examples offered, although discussed under one particular rubric, in fact reflect *several* of the principles addressed in this book, he or she will gain a richer understanding.

Although this volume is richly illustrated with concrete and detailed examples—a necessity, in my view, if the reader is to translate the points I am making into her daily clinical work—my most fundamental concern is with the clinical strategies and principles that lie behind the examples. It is in understanding the *thought processes* that underlie the examples offered that the reader can best take in what I am describing in a fashion that enables her to creatively generate versions that suit the particular patient and the particular clinical moment.

In the chapters that immediately follow, I consider first the theoretical and empirical foundations of therapeutic work and the underlying principles that give coherence to the diverse clinical examples that constitute most of this book. Having done so, I then turn in Part II to the specific challenges encountered in therapeutic practice and to the examination, via detailed clinical illustrations, of the various options available to therapists in meeting those challenges. Even more than in the first edition, my aim is to offer clinical guidelines and recommendations that are relevant to the practices of therapists from a wide range of orientations. It is through the encounter between different points of view, via respectful yet challenging examination of the assumptions and practices of thinkers who approach the therapeutic process from multiple vantage points, that I believe our field is most likely to progress. I hope the reader finds that this book embodies such an integrative and open-minded spirit, and that the reader's own active participation in the reading enables her to be a participant in the ongoing dialogue that constitutes our work, both with our patients and in relation to each other.