ALAN RAPPOPORT, Ph.D.
1010 DOYLE STREET, SUITE 13
MENLO PARK, CA 94025

TELEPHONE (650) 323-7875
E-MAIL: ARAPPOPORT@ALANRAPPOPORT.COM
WWW.ALANRAPPOPORT.COM

The Experience of the Therapist

Alan Rappoport, Ph.D.

In creating Control-Mastery theory, Weiss and other theorists have focused their attention on the patient. The issues that occupied them were the nature of psychopathology, how the patient works in therapy to overcome his or her problems, and what is the role of the therapist is in this process. These issues have been well addressed over the past thirty-or-so years, and a significant body of research and clinical experience has been accumulated supporting the validity of the theory. One of the next steps to be taken is to consider the experience of the therapist, and the quality of the interaction between the therapist and the patient. There has been a great deal of interest in this topic in recent years, which is often included under the general term, "intersubjectivity."

There are a number of areas in which the experience of the therapist is important to consider. For the therapist, the most fundamental is whether he or she enjoys the work and derives satisfaction from it. This is a critical issue for the therapist to face, and it also has great significance for the patient. The patient is very interested in the therapist, because he or she is hoping that the therapist will serve as a model of the kind of healthy behavior that the patient is hoping to become free to engage in. If it is an issue for the patient to be free to enjoy his or her life, which it is for many of our patients, it will be very important that the therapist is enjoying his or her life. The patient will investigate this, by observation and/or by direct inquiry. The patient may wish to know how it is that the therapist feels safe to do so. The therapy may succeed or fail on this aspect of the interaction.

Commonly, the patient's parents were unhappy in some significant way, which resulted in a limitation on the patient's freedom to be happy. Usually there was also some important ways in which the parents were defensive which also limited the patient's freedom. It will be important for the patient that the therapist not have the same kinds of defensiveness. Optimally, the therapist should feel safe and open in interacting with the patient. Therapeutic strategies often masquerade for defensiveness on the part of the therapist. For this reason, when considering how to respond to a patient it is best if the therapist first think of what an ordinary, healthy and natural response would be, and then consider what would be a good "therapeutic" response. An authentic response is very likely to be therapeutic, whereas a "therapeutic" response, if inauthentic, will not help the patient. For example, in my training I was told never to answer a patient's question without first investigating the patient's motivation in asking it. In practice I have found this to be awkward. It can put the patient on the defensive, and it makes the therapist seem defensive as well. Answering the question first and then investigating is more natural and helps the patient feel freer. Often, the patient explains their motivation

spontaneously when the question has been answered, as a result of feeling safer following the therapist's openness.

I find it very orienting to think of myself as modeling the kind of interactional style that the patient would like to acquire, that is, candid, open, empathic, not overly responsible for others, and free to be assertive in my own behalf. When I am considering how to respond in a particular situation, I first guide myself by this principle, and then by my knowledge of the history and dynamics of the patient.

Patients very frequently suffer from an unrealistic sense of responsibility for others. If the therapist is not satisfied with his or her life and does not seem to be enjoying it, the patient may become worried about the therapist and have his or her own progress limited as a result of survivor guilt.

It is as important for the therapist to benefit from the encounter as it is that the patient benefit. Why do we do psychotherapy? There are many ways to make a living; why have we chosen this one? It must have some important personal meaning. Many therapists have, as a result of their early experiences, taken on a sense of responsibility for others, and are expressing it by trying to help others be happier. Many of us have also suffered emotional injury and are taking this route to try to learn how to overcome it. (Some of us feel more comfortable in the role of helper than as the explicit recipient of help, and may be receiving help vicariously.) It is also a way of expressing compassion for others and a potentially rich and satisfying way to be close to others. And, as with any human encounter, it is an opportunity for both participants to express themselves and relate to each other fully and with vitality.

All of this notwithstanding, most analyses of the therapeutic encounter focus on the experience of the patient. The experience of the therapist is typically considered only as it illuminates the patient's psychodynamics or as it becomes an impediment to the treatment process. We usually do not attend to the therapist's personal involvement in the relationship, but think of the therapist as participating solely as a "professional". That is, the therapist's experience of the relationship is not valued for itself, and the therapist is almost not supposed to get anything personal out of it. It is as if he or she would be "using" the patient if this were to happen. The therapist's sole interest is supposed to be the benefit of the patient.

Such a position is absurd on its face. All it leads us to do is to deny or lose touch with our own experience of the process. We can never have an "impersonal" or "professional" relationship in the sense of not having our own experience of the encounter. To the extent we try to act "professional" we become enigmatic, frightening, defensive, and even traumatizing. One thing we are trying to do in helping our patients is to present a model of a healthy relationship, and if we do not include our own experience as a determinant of our behavior we are not doing so. The patient wants to have a personal relationship with us, and a critical part of our professional relationship with the patient is our ability to consider and value the experience of both participants. To the extent that we consider only our own experience we are narcissistic, and to the extent we consider only the other person's experience we are being self-sacrificing (withdrawn, compliant, co-dependent, fearful, defensive). It is not good for the patient for us to interact in these ways, but more to the point, it is not good for the therapist. Such behavior leads to loss of job satisfaction,

getting "stale", burnout, loss of creativity, depression. It prevents the therapist from growing and benefiting from the therapy process.

Every patient wants to be able to contribute to the therapist, to be of value. We therefore can be more helpful to our patients if we allow them to give to us, if we are open enough to receive from them. This has to do with personal openness and vulnerability, that we are willing (indeed, hope and expect) to be changed by each patient we work with. It is the belief that each person has something to give us that will be of value to us, that will make us better or richer in some way. Many of our patient's have low self-esteem because they were not allowed to contribute to their parents' lives. Their parents did not value them and allow themselves to be changed by them, so they considered themselves useless or superfluous. It is very helpful for these patients for us to let them be of benefit to us, and we can only do so if we genuinely participate in the relationship in a personal way, so that they can know who we are, tell how we react, and feel that they are actually in touch with us.

A healthy relationship is one in which each person can both consider and value his or her own experience, and the experience of the other person. Considering only one's own experience is narcissism, and does not allow for the experience of the other person; considering only the other person is "co-narcissism", existing only for the purposes of the other person, and does not allow one to participate in the relationship in a way that has value for oneself.

Passive-into-active

It greatly facilitates passing passive-into-active tests for the therapist to be well aware of his or her experience and free to act on it. Our typical stance is to be empathically aware of the patient's experience and to validate and respond to it. In passive-into-active testing, the more we do this, the more intensely the patient tests, since by being empathic but not assertive we are not passing the test, and so the patient makes the test easier to pass by being more emphatic and making it more likely that we will respond assertively. If the therapist is unduly focused on the patient and not enough on himself or herself, and inhibited about acting on his or her own behalf, he or she will miss the testing purposes of these interactions and simply feel unappreciated and abused by the patient, and discouraged about the treatment.

Control-Mastery theory has been presented as if any therapist, knowing the plan formulation for a patient, would be able to work with that patient successfully. That is, that the therapist's own personality and history do not come into the picture and do not need to be considered. If the therapist knows what the tests are, he or she will be able to pass them and the patient will get better. I do not think that any experienced therapist would believe this to be the case if he or she considered it, but the papers written about the theory often leave readers with this impression. In fact, the extent a therapist is able to pass a patient's tests depends entirely on who the therapist is as a person.

For example, therapists who are nurturing, accepting, and flexible will pass transference tests relatively easily and successfully; therapists who are self-confident and have high self-esteem will be adept at passing passive-into-active tests, finding it relatively easy to

recognize when they are being mistreated and to respond assertively to such challenges. Some therapists are comfortable expressing emotionality and responding to the emotionality of another, others are more intellectual. Some are more comfortable than others with self-revelation. Those who have not overcome past experiences of criticism and rejection will respond defensively to the patient during interactions that recall these experiences. Furthermore, there are vast differences among therapists in levels and quality of training and experience which greatly influence how they understand and respond to patients. In the years I have lead and attended case conferences, I have often been impressed with how obvious and easy a case may be for one person to understand and treat, and how opaque and threatening the same case may be for another person.

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