Legitimate Gratification of the Analyst's Needs

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Perhaps no topic is more controversial than that of the analyst's needs being met in the course of treating the patient. Prior emphasis has been placed on satisfaction derived from the patient's progress, with frequent warnings regarding the analyst's inappropriate pursuit of her narcissistic needs. The author readily acknowledges that all manner of inappropriate gratification does exist and harms both analyst and patient. Yet the major thesis presented in this paper states that mutuality is a driving principle in all human relationships. If this is true, then anything that is essentially harmful to the patient is also harmful to the analyst. But it also means that if the analytic relationship facilitates self-discovery and therapeutic transformation of the patient, while providing a sustaining level of affirmation, safety, and well being, similar benefits will occur for the analyst.

Legitimate gratification of the analyst's needs is both difficult to define and controversial. That we are gratified in our work is self-evident, and has been discussed in numerous ways. When it comes to legitimate gratification, however, the favored emphasis has been on seeing the patient change or on vicarious gratification derived from the patient working through conflicts and expressing intense feeling. The notion of any ongoing gratification for the analyst as an inherent part of a successful treatment, especially the notion that the patient helps the analyst to change, or provides emotional or intellectual sustenance for the analyst, remains foreign. Although I use the term gratification throughout, I am referring not just to immediate pleasure, relief, or satisfaction.

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am referring primarily to a deeper experience of personal growth, fulfillment, and transformation within the analyst as a requisite aspect of the analytic process.

The analytic literature speaks endlessly about all manner of illegitimate gratification and how to avoid it. The old portrait of analytic work depicted the analyst as self-sacrificing, putting her needs aside so that the patient's needs could be addressed. The counterpoint to the self-sacrificing analyst is the newly coined self-indulgent, self-disclosing analyst associated by some with the two-person approach. Current controversies about the uses of therapist self-disclosure focus on unseemly gratification of the analyst's narcissistic needs, (Bernstein, 1999; Layton, 1999; Hirsch, 2001). And we certainly are all familiar with the term “slippery slope” as it pertains to the occurrence of mutually gratifying events in treatment (Gabbard & Lester, 1994). It was not so long ago that the analyst used the presence of any form of emotional gratification, or the longing for emotional gratification, as a sign of pathological countertransference. For all the conversations about the inevitability of the analyst's participation as a human being, we are still preoccupied with fears of losing control, of being too needy, or being narcissistic and self-indulgent. What seems odd to me is that for all the emphasis on mutuality in current theory, we do not seriously contemplate that it might be necessary for the analyst to get better if the patient is to get better. And we seem to live in fear of our neediness spilling out uncontrollably and ruining the treatment. Does the extent of this fear reflect on just how needy we really are and how much we deny it? If so, perhaps a more realistic assessment of our own mental health and motivations for doing treatment (Searles, 1979; Brenner, 1985; Sussman, 1995; Maroda, 1991) must precede any serious consideration of legitimate gratification.

Ferenczi (1932) openly discussed the analyst's need for the patient. But his discussion of the topic has received little attention, even with the resurgence of interest in his work and the expunging of his blackened reputation in the analytic community (Aron & Harris, 1993). It seems that talking about having our needs met by our patients makes us queasy. Bacal and Thomson (1998) represent two of the few voices that have taken up the notion of the analyst's gratification and need for emotional support within the treatment. They point out that traditionally we were not supposed to need our patients' responsiveness, and, out of our shame for having our needs met, we disavow that we even receive anything substantial from them. They say,
We believe that analysts regularly expect patients to respond in a number of ways that are, in fact, self-sustaining or self-enhancing. And our patients ongoingly meet a number of psychological needs that enable us to go on treating them. For the most part, we are unaware that this is happening. … The analyst's experience of the patient's unresponsiveness is in essence no different from the patient's experience of the analyst's unresponsiveness. When the patient experiences this, we call it a disruption. When the analyst has this experience, we call it countertransference. [pp. 253-254] Wolf (1998), writing in the same volume edited by Bacal, speaks of the inevitability, not only of the analyst serving as the patient's selfobject, but also of the patient serving as the analyst's selfobject. Although these authors do not use the term “mutuality,” clearly this is what we are discussing.

Aron (1996) notes that the literature on therapist gratification is sparse, conflict-filled, and remains outside the mainstream. He cites specific analysts from Ferenczi to Winnicott, Jung, Searles, Fromm, Thompson, Tauber, Singer, Levenson, Wolstein, and Bacal, all of whom make some mention of the therapeutic benefit for the analyst. I would add Bellak and Faithorn (1981) to that list, as well as the aforementioned references to the work of Wolf. And I am sure there are others. The observation that the patient cures, heals, gratifies, and soothes the analyst, as well as frustrating and upsetting her, is certainly not a new one.

But it appears that the analyst's gratification is something we are more comfortable with in theory than in practice. Even Aron does not get into specifics when he speaks of the inevitability of emotional gratification for the analyst. Mitchell (1997) says,

> not only is psychoanalysis a powerful, transformative experience for the patient, it also provides an extraordinary experience for the analyst. It is only in recent years, with the increasing openness in writing about countertransference, that it has been possible to acknowledge how absorbing, personally touching, and potentially transformative the practice of psychoanalysis can often be for the analyst. [p. 35, emphasis mine]

So Mitchell is intensely aware of analysis as a mutually transformative process, but does not go so far as to confirm my view that some degree of transformation for the analyst must occur in a successful treatment.

Szasz wrote the only article that directly speaks, at least theoretically,
to the inevitability of mutual and deep gratification in the analytic relationship. Szasz (1956) also speaks to why we tend to deny our knowledge of mutual gratification.

The fact remains … that while this “knowledge” about the analyst's gratifications “exists,” it is at best latent and is unacknowledged officially. It seem to me fair to assert, first, that little emphasis is placed in our theory in general, and in discussions of techniques in particular, on this aspect of the analytic situation; and secondly, that on the contrary, we frequently encounter authors dwelling at great length on the emotional hardships to which the analyst is subjected by the nature of his work. Is it not possible that from the point of view of psychological science this socially condoned position of the analyst is not altogether honest? [pp. 210-211]

As usual, Szasz was ahead of his time in his insinuation that the analyst is not fessing up to the full realities of her personal involvement in the analytic relationship. In fairness, I think the self-sacrificing aspect of the analyst's role receives less emphasis today than it did in 1956 when Szasz wrote his comments. Nonetheless, I think much of what he has to say still applies to the analytic situation today. He talks about the quandary we face when attempting to answer the question, “Who needs whom, and how much?” (p. 212). While he considers this question inherently unanswerable, he warns us against the passive acceptance of the patient as the primary beneficiary of the analytic process.

Szasz likens the analyst-patient relationship to the parent-child, clergy-worshipper, leader-follower, and other “fundamental paired systems” that rely on the attribution of neediness to one person in the pair providing power and prestige to the other. He labels the belief that one member receives gratification while the other is self-sacrificing as “the great oversimplification.” He cautions us that there is no safeguard against the hazard of the patient re-experiencing in his relationship with the analyst a human interaction significantly similar to that between a child and a masochistic, “self-sacrificing” parent. The burdens and inhibitions which such a relationship can place on the developing child's ego are familiar enough to us and do not require further comment. [p. 221]

I agree with Szasz that the answer to the question, “Who needs whom, and how much?” is unanswerable even in the general sense, let alone
with regard to each unique analytic pair. But so much of what we do is unknowable. Yet we still struggle to be as aware as possible of what is happening in the treatment relationship, accepting that our knowledge will always be imperfect. We also know that the price for denial can be substantial. I think Szasz is right when he says that the long-suffering analyst poses as much of a threat to the patient as the long-suffering parent did.

Current discussions of ongoing, rather than momentary, gratifications in analytic work are almost nonexistent. A review of the recent literature produced only one article on the topic of legitimate gratification, “On Gratitude and Gratification” (Gabbard, 2000). He provides a case example of a patient who made a point of negating Gabbard's influence over him, and withholding any expression of appreciation or gratitude, which frustrated Gabbard. Generalizing beyond the scope of his work with this patient, he says,

Indeed, our contemplation of the patient's gratitude leads us directly into considerations related to the analyst's gratification. The wish for something in return from our patients, and the longing for expressions of gratitude and appreciation, is related to our unconscious motivations for choosing a career as an analyst. In addition to our altruistic intentions, most of us are searching for some form of healing in our work.... We offer understanding, caring and affirmation, but we hope to receive gratitude and appreciation for our efforts. [p. 698]

First Gabbard says we are seeking to be healed, then says, “we hope to receive gratitude and appreciation.” Is that how we are healed—through the patient's gratitude and appreciation? I doubt it.

Obviously Gabbard is on to something when he says we need something from our patients, but I disagree with his conclusion. I think we often settle for gratitude, seeking it or complaining about not getting it only when our deeper needs for affirmation are not met. Focusing on gratitude is what you do in an interpersonal relationship when you feel someone owes you something. Implicitly it means that the relationship is tilted out of mutuality. When both people's needs are being met, gratitude, while it may be present, is not at the forefront.

Having some idea about how our needs are being met in the analytic process is invaluable to the work we do. I believe that it is our frustrated needs and lack of overall gratification with individual patients that lead
us to improper or untherapeutic attempts at gratification. Casement (1985) is one of the few therapists willing to describe his actual experience with patients, including his errors and neediness. Naturally, I admire this very much and have taken one of his case examples from *Learning From the Patient.* Although Casement's focus in this example is on his failure to listen to his patient, his self-described motivation for this behavior relates to what he needs from the patient at the time. For my purposes, I am using this example and emphasizing his ongoing need to receive something from this woman he is treating.

Casement's patient comes to her session delighted at having found a new dentist, and he asks her to give him the name of this dentist. Not long after, the patient comes to another session stating that she has found a wonderful cure for her insomnia—a relaxation tape. Again, Casement asks her to share this with him. On this issue he reports,

> My listening has veered completely away from the patient. As with the earlier reference to her good dentist, I am responding like an envious child. Each time Mrs. A indicates that she has something good, I have wanted some of it for myself and I have asked the patient to provide it for me…. She may be wondering whether I am telling her that I too am having sleeping problems, as I seem to be asking her obliquely to help me with this. My countertransference gratification is clearly evident. [p. 62]

He goes on to say that the patient came to her next session with the tape, but left saying, “I don't know why, but today doesn't seem to have been as helpful as I had hoped.” At the next session she reported having had a terrible week.

Casement is candid and nondefensive about his countertransference envy and the obstacle this creates to “listening to the patient.” But he focuses on how his countertransference interferes with his ability to listen well, which is the point he wishes to illustrate. For my purposes, however, I want to focus on the issue of why he seeks this gratification from the patient at this time. I wish he had spoken more about his feelings about this patient, including how he might have been frustrated in his attempts to reach her. Why did he need something from this particular patient, what was it that he needed, and why now?

It is common knowledge that narcissistic patients need to inspire envy in others, including their therapists, as a way of shoring up their sense of self. They settle for envy rather than taking the risks that come with
vulnerability. Opening themselves up to their therapists is difficult and risks unbearable narcissistic injury. Granted, some patients do seem to be very good at finding the best of everything for themselves, but I do not think that Casement would have been so caught up in his envy and wanting to get something from this patient unless he was significantly thwarted in his attempts to connect with her emotionally.

He clearly sees her as a powerful and resourceful person, in spite of her pain. He needs something from her, but what? Certainly not the name of a good dentist. Casement hints at being in pain himself when he asks for the relaxation tape. Is there some way for him to be soothed and comforted by his patient in the course of doing good therapy and responding appropriately?

Barring the presence of characterological envy and greed in the therapist, illegitimate gratification emanates from the therapist's immediate frustrated emotional needs in relation to the patient. Although there is no hard data on this issue, Gabbard (1996) has documented the frequency with which sexual relations between therapist and patient occur following a stalemate in the treatment. And Searles's (1979) description of analysts wanting to magically heal their patients through sex implicitly acknowledges that both patient and analyst were currently frustrated in their mutual healing process when the sexual relations occurred.

So my hypothesis states that illegitimate gratification results from thwarted legitimate gratification, which brings up the interesting notion that patients who actively seek sex, late-night phone calls, vacation contact, and other questionable gratifications from the analyst, may be settling for these things because they cannot get what they really need. Just as Casement settled for the name of his patient's dentist and her relaxation tape, how many patients settle for extending the session a few extra minutes, or calling the analyst at home, when they feel they have not been heard or adequately responded to? I have always wondered why some therapists get incessant phone calls and demands for special favors from their needy patients, while others get few or none. Whereas this phenomenon may be explained, in part, by the patient's knowledge of what the analyst is or is not willing to do, or what the analyst has or does not have, to give, I think it may also be a function of what the patient is actually getting in the sessions.

The difficulty in pursuing the notion of legitimate gratification harkens back to the aforementioned fears of illegitimate gratification. How can we know when our pleasure and satisfaction occur in tandem with the
patient's transformation, or at his expense? It is safe to say that any form of gratification that violates the boundaries of the professional relationship cannot be considered legitimate and in the best interest of either participant. It is easy to name some clearly defined instances of therapist abuse, such as repeatedly telling one's personal problems to patients, making any business deals or taking insider stock tips from patients, having extra-analytic contact with patients, and having intimate physical contact with patients.

We may try to "get something" from the patient through therapist-initiated phone calls or appointments, therapist-initiated emphasis on the positive transference (including the erotic or loving transference), or focusing on any topic within a session that may catch the therapist's interest, but not be really important to the patient. Or we may fail to support the patient's attempts to cut down on sessions or set a termination date, be chronically late for sessions, frequently reschedule sessions, or take nonemergency phone calls during sessions. If these behaviors are anomalies (and not due to some personal crisis in the analyst's life), I would ask how and why the analyst feels personally or professionally frustrated in relation to this particular patient at this time. If these behaviors occur across patients, I would suggest that this analyst has unresolved issues that motivate her to seek power and personal convenience at her patients' expense.

Crastnopol (1999) and Aron (2000) have also written about potential intrusions into the treatment through the analyst writing about patients. These analysts note that writing about patients can be a form of legitimate gratification as well, just as suggesting an extra session may be in the patient's best interest during some difficult time.

Defining legitimate gratification within the parameters of the relationship presents even greater difficulties. The gray area that Gabbard calls "boundary crossings," temporary alterations in the professional stance, such as hugging the patient, that may be therapeutic, can be the most difficult to assess. We can legitimize emotional gratification for the analyst while still maintaining the old standard that the analyst's behavior should be responsive to the patient's need. What we speak less of is that even if the patient initiates the hug, it must be a positive experience for the analyst as well. Otherwise the analyst is avoiding one pitfall—the narcissistic injury suffered by the patient when a hug is refused (McLaughlin, 1995)—while falling prey to another: the tension and implicit rejection of the contact communicated by the analyst's discomfort. In
order for the encounter to be therapeutic, both parties must feel comfortable. And sometimes we have to make a mistake before we know what works, and what does not, with a particular patient.

When I was presenting at a conference recently, a therapist in the audience asked me about a patient she was treating who was hugging her hard at the end of each session. The therapist perceived this patient as easily wounded, so she did not bring the hugs up for discussion to avoid humiliating her. The therapist assumed the hugs were temporary and that the patient would broach the topic at some point in the treatment. She stated it had now been two months, and there was no end in sight. What did I think?

I advised her on two fronts. First, what happened two months ago? The question of “why now?” is rarely out of my immediate consciousness. Second, if the goal is emotional honesty, and if the therapist believes in mutuality, then how can she continue to accept the hugs? Isn't her increasing discomfort the proverbial elephant in the room? So I encouraged her to gently tell the patient at the start of the next session that she was wondering about the hugs and what she might be needing from the therapist and not getting. I also encouraged her to engage the patient as a consultant on her own case, asking what she thought about what might have happened between them two months ago that made the patient feel the need for this fervent physical contact.

I think there are two principles that can guide the analyst in making good decisions. The first guiding principle is the aforementioned mutuality. I believe that it is virtually impossible to do or say things over time that are bad for the patient but good for the analyst. Analysts who gratify themselves at their patients' expense invariably feel guilt and shame and know that things are not as they should be. Past permissions to write off the patient's complaints or symptoms as transference only facilitate the analyst's denial that something is awry. Sadly, the analyst may not become aware of what she is doing until disaster strikes. Serious boundary violations carry the threat of ethical or criminal charges, painful lawsuits, and public humiliation for the analyst.

I want to reemphasize the aspect of over time with respect to what is mutually beneficial. Certainly all of us do satisfy some immediate need or desire at the other person's expense in any relationship—and sometimes for good reason in terms of our own survival. And we are equally familiar with the frequency of competing needs in any relationship. Stand-offs inevitably occur when both parties are needy, and in an incompatiable
direction. So I approach the topic of mutually beneficial, growth-producing therapeutic relationships with the knowledge that this must be a relative concept. The therapeutic relationship cannot transcend the limitations of all human relationships, which necessarily include periods of insensitivity, neglect, power-seeking, and even some degree of exploitation. The point of this paper is not to create an unattainable ideal, but rather to point out that a certain amount of therapist gratification, both superficial and deep, necessarily occurs in tandem with the patient's improvement.

An ongoing obstacle to the analyst trusting her feelings of unease, guilt, or shame over what is happening in the therapeutic relationship is the irrational guilt and shame discussed by Bacal and Thomson. If we feel guilt and shame about having any of our needs met, if we feel guilt and shame over enjoying the patient and laughing at his jokes, or looking forward to seeing him, if we feel guilt and shame over discovering a part of ourselves that we have never really known before, then guilt and shame no longer serve as reliable signals that something is awry in the relationship. Many therapists still feel guilt and shame over having any of our needs met, if we feel guilt and shame over enjoying the patient and laughing at his jokes, or looking forward to seeing him, if we feel guilt and shame over discovering a part of ourselves that we have never really known before, then guilt and shame no longer serve as reliable signals that something is awry in the relationship. Many therapists still feel guilt and shame over having intense feelings about a patient, particularly sexual ones, or over having felt better as a result of being with the patient. I believe that this has to change.

Therapists who act out destructively with their patients have often been unbearably frustrated in the relationship for some time and cannot find their way out. They settle for what they can get, or they allow an abusive patient to get away with behaving badly, not paying the fee, or harassing the analyst during his private time outside the sessions. If they cannot feel competent, they may settle for feeling desired.

Consultations may fail to help the situation because they rarely focus on the true needs of both analyst and patient. From my experience, consultants usually provide well-intentioned support for their colleagues' insights and feelings. Historically, we have not asked, “What does the analyst need that he or she is not getting?” and can this situation be changed in a way that is therapeutic for the patient? If not, how can the therapist attend to her emotional needs outside the analytic relationship so that she is in a better position to facilitate the treatment?

Therapy relationships, like all relationships, tend to be mutually gratifying or mutually frustrating, either in the general sense or at any point in time. Whether the difficulty is ongoing, intermittent, or rare, I think it
is vital that the analyst be able to say to herself, without guilt or shame, how am I emotionally frustrated in this relationship? How is this patient not functioning as a selfobject for me? And how am I failing to function as a good-enough selfobject for the patient? Are either of us denying our need or feelings for each other? Does this patient have a history of not giving over to others? Do I have a history of not making myself vulnerable? How is each of us contributing to our mutually frustrated state and what needs to happen to create or restore our mutual selfobject status?

I have stated (Maroda, 1999) that it is often the analyst's reluctance to emotionally surrender to the patient that creates impasse and mutual frustration, anger or hopelessness. Frequently, the patient is overtly asking for an affective response from the analyst, either directly or indirectly, and the analyst does not provide this, believing that to do so would be nonanalytic and self-indulgent. What typically ensues is impasse and mutual frustration. I encourage therapists to be freer with their affective disclosures to patients, provided that the patient is seeking this response.

This leads us to the second principle that can help us to decide whether we are indulging ourselves or responding to the patient. Has the patient taken the initiative or has the analyst? Everything from selfdisclosure to physical contact to advice-giving has been shown to be therapeutic primarily when the patient rather than the analyst initiates it. Granted, when we are talking about projective identification, the notion of who is initiating can be very difficult to ascertain. I think the best we can do is simply ask ourselves, “Am I doing this in response to the patient or is my behavior born out of my own curiosity, opinions, neediness, or defensiveness?” Knowing that we have unconscious motivations that preclude us from certainty should not deter us from pursuing self-awareness and self-analysis.

Here is an example from my own practice, illustrating the perils of initiating a response that the patient was not seeking. I call the patient Phyllis. At this particular point in the therapy she began to find fault with me, which frightened her. In accordance with Szasz's commentary, she was initially comfortable with me as the all-knowing, self-sacrificing, parent-therapist. Even though this repeated the repressive dynamics of her early childhood, she felt safe thinking of me this way. Phyllis's father had dominated the household and she and her siblings catered to his every need. In exchange, he gave her advice and approval. She felt grossly inferior to him, and she feared criticizing him and invoking his
wrath and rejection. The only safe position was that he was always right and superior, and she was always wrong and inferior.

Most patients need to go through a period of idealization of the analyst and, as Kohut (1977) pointed out, to refuse this idealization is to interfere with the patient's growth and development. But too long an idealization often represents the patient's need to maintain Szasz's "great oversimplification."

Phyllis had asked me for relationship advice on several occasions, which I provided only after she convinced me that she needed it in the interests of her psychological education. She made it clear that even though she sought help too often from others, I needed to meet her where she was and give some needed advice. Each time I gave it, she pondered the advice and found it helpful. One day, after giving her some advice that I thought she was seeking, but had not directly requested, I noticed that Phyllis looked irritated. I asked her what was bothering her and she declined to answer. I pursued it and she admitted that she did not like being "lectured to." She said it made her feel bad about herself and got in the way of her making any meaningful emotional connection to me. She expressed real emotion when she gave me this feedback, and it made an impression on me. In that moment I realized two things: One, I had fallen into repeating the relationship my patient had, not only with her father, but also with most other people in her life. Everyone gave her advice and patronized her in response to her neediness and acting helpless. In those moments when I behaved the same way, I only hurt her instead of helping her.

But I also realized that it was easy for me to be somewhat of a know-it-all and be too patronizing—not just to her, but to others as well. Her gentle, but effective, confrontation made me realize I had to change. I was moved by this encounter and have had several others with her that provide compelling evidence that I must change in order for her to change. And this is a form of gratification, even though it is very different from our earlier "feel-good" exchanges. This encounter was somewhat painful and embarrassing for me, but it helped me to face the truth about myself. Obviously, it also provided my patient with the opportunity to repeat the past, but then to change it.

I should add that she was quick to point out that her acting helpless about everyday matters stimulates advice-giving in virtually everyone she knows, but she needs me to refrain and help her to change, rather than fall into this same pattern. She made it clear that when she needed my
advice, she would ask for it. As I (Maroda, 1999), Chused (1996), and others have pointed out, when the patient makes the interpretation, as Phyllis did, it is far more effective and meaningful than when the analyst makes it. Insight gained in the current relationship with the analyst often leads to the patient making genetic interpretations.

When the analyst reaches out in some way, out of a deep empathic connection to the patient, do we call this patient-initiated or therapist-initiated action? I would say it was patient-initiated, but I can see where others might call this hair-splitting. The notion of patient-initiated action is certainly not black and white and calls for difficult judgment calls when based on empathy or the receipt of unconscious communication. One of my early supervisors advised me that if I was unsure of my intervention, no matter what it was, I should look to the patient's response, both immediate and at the next session. Just as with Casement's patient expressing her distress and displeasure, I find that my patients show distress when I make a mistake. When my interventions are helpful, their response is to move deeper and more meaningfully into their personal experience. The aforementioned example showed how the patient became quiet and sullen when I made the error of giving her unsolicited advice.

I want to provide another illustration of mutuality and concurrent gratification through the case of Paul. Paul began therapy on a very skeptical note. He said he was coming to see me only because I was highly recommended by a family friend who is a psychologist. Starting out with very little money, he made a large personal fortune by the time he was thirty-five years old. He had been in therapy before, for four years, with no positive result. When I asked him how this came to be, he said his therapist was fascinated with his Midas touch and routinely talked to him about his business acumen and how to acquire wealth. He admitted that he settled for the admiration and position of power he held with this therapist, but regretted having participated in such a shallow relationship. He also was very resentful of all the money he paid the therapist for the privilege of educating him about business and stimulating his envy.

As I work with this patient, I also am gratified, in ways both similar to and different than that of his previous treatment. He wants me to admire him and acknowledge that he is enormously talented—something his critical mother never gave him. And I do. I ask him questions about his businesses only to the extent that I need to so that I can understand what
he is trying to tell me. He also likes to throw out things that he knows I will not immediately understand, so that I must ask questions and defer to his greater expertise. An example of this is when he told me that he bought a particular business that makes no money but will obviously be worth a fortune in a few years. I ask him what makes this so. He tells me that the land it is on will be ripe for development in five to ten years and will be worth at least ten-times what he paid for it. In the meantime, the business does not make money, but does cover all costs involved in holding the land. I say, “very clever” and he smiles. This is what he wanted from his previous therapist—admiration and affirmation. Unfortunately, his previous therapist got stuck in his countertransference idealization of the patient's financial success.

When he talks about business with me it is always quite brief, and I make a point of doing what he told me he wished his previous therapist would do—let him talk about business for a few minutes, but then get him on track with his feelings. He is not easy to direct, but he is a very emotionally intense person who has broken down in tears several times in the year we have been working together. When he cries I am always deeply moved. I sometimes tear up myself. I identify with his love of his family, his desire to be a good person, his ambition and sense of personal power, and his disappointment that he is not always the virtuous person he had hoped to be. When he cries, I feel relief and, also a sense that something good has happened between us. He knows I respect him and like him and enjoy working with him. And I know he feels the same about me.

Deep emotional gratification with a patient does not preclude other gratifications that may be secondary, or even superficial, but pleasurable nonetheless. The aforementioned patient is reasonably nice looking, lives an exciting life that I enjoy hearing about, is very high energy and stimulating, intelligent and confident, and has a good observing ego and sense of humor. He is exciting, fun, and lovable. He enlivens me. All of this happens while I respond to him therapeutically.

Surely it is possible for an analyst to feel too much for a patient, either positively or negatively. If we cannot manage our own affect, then we cannot treat the person who has come to us for help. But I do not think this happens very often. Rather, we take quiet pleasure in the sight of a good-looking patient. Or we feel relief when someone feels deeply and is not afraid to show it. We feel proud and affirmed when the patient is
insightful and runs with whatever we give him. We may feel sexually attracted to, or even sexually aroused by, some patients. We may feel excited and hopeful when the patient observes something about us that we know is true, but that no one has stated before.

We feel needed, important, and take vicarious pleasure when we share in our patients' deep pain and help them to find relief and acceptance. We may feel unbounded exhilaration when a patient subsequently finds a way to use or transcend his pain to become creative, productive, or even famous. We revel in our patients' transformations and are deeply gratified by this process, even if we envy them at the same time.

This mutual gratification, mutual mirroring, mutual giving over is at the heart of the analytic enterprise. To what extent will a patient give over if he does not sense that the analyst is experiencing something similar? Is unilateral transformation possible? Can we posit that the patient had a life-altering, deep emotional experience in analysis when the analyst did not? Or must analyst and patient transform each other to a great degree? The case examples I provide here are necessarily brief and do not do justice to the deep shared experience that has always been a part of the analytic process.

Again, I want to emphasize that writing about this topic is new, not the phenomenon itself. Searles (1959) talked about falling in love with every patient at some point, be they male or female. He freely discussed fantasizing spending the rest of his life with almost all of his patients. He accepted this as a normal part of the process. I might add that he was not compelled to share this with his patients.

I am convinced that every successful treatment was inherently a mutual event that irrevocably changed, gratified, pained, and enlivened both participants. And every failed treatment or instance of abuse equally leaves a lasting mark on both analyst and patient. The treatment relationship is essentially asymmetrical, but also essentially symbiotic. It is my hope that we can reduce the incidence of abuse and countertransference dominance (Maroda, 1991) through admitting that we need our patients and that they potentially enhance and transform our lives.

References


