Perspectives on different kinds of therapeutic process and therapeutic action:
A discussion of interviews with and by Paul Wachtel

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Paul Wachtel’s interview with Louise, who is in an ongoing therapy with someone else, is very moving. At the end she is effusive in describing her feeling that she has achieved great insight and thanks him profusely.

Watching this video has stimulated my own thinking in the direction of considering the impact of the choices we make from moment-to-moment as we engage with our patients, not only in a consultation such as this but in long term work as well. I will try to spell out some thoughts about this here. First, however, I will focus on some questions of definition raised for me by Paul’s comments about how he works.

Paul gives a brief outline of his clinical perspective, which he calls “integrative relational psychotherapy,” and which he describes as involving the integration of behavioral approaches, psychoanalysis, family therapy approaches, and of cyclical psychodynamic systems theory. He tells us that he sees himself as grounded in a relational analytic approach, but that he sees the strength of behavioral therapy in the attention it pays to what we do with other people. He suggests that this is the opposite of the focus on here-and-now of relational approaches.

It is not clear how Paul is defining “relational” approaches since “relational” includes diverse perspectives ranging from interpersonal, object relations, self-psychology, gender theory, and other points of view (Ehrenberg, 2006). These are not only diverse but also sometimes incompatible perspectives. Furthermore, there are also major differences between those within the same relational tradition.

Paul tells us that behavior therapy helps people become less afraid of external things through the opportunity for exposure without anticipated consequences. He seems to
believe this does not occur in “analytic” work. In my view this is integral to analytic work. Winnicott’s (1969) emphasis on the importance of the analyst surviving destruction comes to mind. I have expanded on how this becomes a bi-directional issue as well, and how discovering one’s power to impact on the other and to survive the impact of the other also can be powerful revelations (Ehrenberg, 1974-2010).

Paul’s view is that working in the here-and-now between patient and analyst, as he assumes relational analysts do, excludes dealing with what goes on between the patient and others in the patient’s life. I think this provides an opportunity to clarify some important misunderstandings. First, relational analysts do not only work in the here-and-now. Second, where a patient has no awareness of what goes on or has gone on in his or her relationships with others, focusing on the here-and-now can become a very effective way to clarify what goes on and what has gone on in the patient’s life outside of the analytic room which the patient may have no awareness of and no other way to communicate. I have presented extensive examples of situations where working at what I call the “intimate edge” of the relationship and deconstructing what was going on between patient and analyst in the interactive moment, often without awareness, was useful toward this end. Not only can it help to detoxify the moment, and to prevent potentials for toxic developments from escalating to dangerous proportions, it also can help to clarify the interactive patterns and specific boundary issues that are the basis for a patient’s difficulties in relationships outside of the treatment situation, past and present (Ehrenberg, 1974, 1992, 2010).

Though Paul tells us that being confronted with a “reality check,” as in “behavioral approaches,” can help relieve a person’s fears, I believe that the opportunity to see what one is projecting or introjecting in the kind of tangible and live way that can occur in the process of “analysis” can constitute an important kind of “reality check” that allows for then looking at conflicts about knowing, feeling, seeing and, most importantly, for working these conflicts through.

Paul talks about the importance of exposure to what we are afraid of - like desensitization
to a phobia - of behavioral approaches. He also elaborates that his way of working differs from the kind of psychoanalysis that he sees as an “accusatory discipline” (he cites Daniel Wile) that involves the analyst “stripping away illusions - showing people what they are doing wrong - where they are defending or where they are primitive or archaic.” He feels this is not helpful. Rather, he tells us, his goal is to help his clients to re-appropriate their feelings and thoughts that have become frightening. I have questions about his definition of “analysis” here as well as about his idea that re-appropriating feelings and thoughts that have become frightening is not something that analysis would try to achieve. I believe this suggests a version of psychoanalysis that not only relational analysts but many traditional analysts would not feel represents what they do and would be critical of. In addition, when Paul talks about behavioral approaches being more “experiential” than analytic ones, I find myself especially puzzled since analysis is always focused on “experience.”

Paul stresses the importance of making it “safe.” I am in total agreement that this is always essential. But how is he defining what keeps it “safe”? Paul is supportive and affirming and focuses on the “positive,” and this seems to be very effective. Nevertheless, in my view, even in a consultation, establishing that this is a place where we can look at both the positive and the negative, without having to minimize or overemphasize either, need not be threatening, challenging or unnerving. Rather, it can be reassuring precisely because it conveys that this is a place where we can look together at both the patient’s limits and problems and the patient’s strengths, and where the patient can get help dealing with what is troubling to him or her. What I am suggesting is that part of making it “safe” involves creating a space in which “badness” and ambivalence, weakness and fears, fragility and confusion can be owned and acknowledged and seriously looked at and addressed, rather than judged. Conveying our interest in knowing about and helping a patient to talk about feelings that he or she might be ashamed of can be especially reassuring. It can help to establish that it is OK to have negative feelings, and safe to talk about one’s failings, limitations, and the times one “loses it” and/or may even enjoy hurting others, about the times one may have experienced (and continues to experience) irrational anger and rage, about the times one was and can be “mean” and can
be “out of control,” about what is unnerving and about one’s real vulnerabilities, including ways he or she may feel at the mercy of others’ “goodness” or “badness” and unable to handle disappointments.

Being sensitive does not mean that we must stay clear of problem areas. The challenge, as I see it, is to find sensitive and constructive ways to be able to engage what is problematic. Paradoxically, handling patients with “kid gloves” and avoiding “hot spots” can convey the message that we think the patient is too fragile to deal with his or her issues in a constructive way, or too toxic for us to deal with. Either can affirm a patient’s worst fears. Sometimes allowing things to get “messy” provides an opportunity to see how things go awry, in contrast to keeping things too “clean,” which can leave the work sterile. Furthermore, creating a context in which toxic potentials can be embraced and engaged, before they escalate to unmanageable proportions, allows for potential time bombs to be defused. This achieves a different kind of safety than avoiding the danger zones could achieve.

Though in some instances avoiding “ruptures” or being able to “repair” them can be essential, there may be other times when zeroing in on “ruptures” or on the potential for “ruptures” or even “explosions” allows for deconstructing the ways in which things become problematic. Being able to defuse the potential landmines by demystifying the unconscious enactments and collusion and the projections and introjections that account for escalating toxicity and even “paranoia” then can take the work further in ways that can be liberating. Particularly where the issues are deeply internal, demystifying confusions between what is internal and what is external can be the most powerful kind of “reality check.” What comes to mind is a mother in a post partum depression who feared she might hurt or even murder her child. Helping her to work through the conflicts and feelings she was struggling with internally was essential here.

Experiencing growth and change is ultimately what is most affirming. Each time growth and change occur, psychic space opens in potentially powerful ways. The question then is how can this best be achieved with each specific patient at each specific moment.
Let’s turn to Paul’s clinical interview with some of these concerns in mind.

Clinical considerations about options and choices in the interactive moment

My effort here will be to use Paul’s interview with Louise as a springboard for a more general discussion about how the moment-by-moment choices we make as we engage with our patients, whether in a consultation or in short or long term work, can generate different kinds of therapeutic process and lead to different kinds of therapeutic action. I am well aware that Paul’s interview with Louise does not reflect how Paul might work if this meeting were to be the beginning a potentially long-term treatment relationship, and also that there is no way to know how any of us might react in the actual clinical moment, no matter what our theory, given the power of what goes on unconsciously between patient and analyst. Nevertheless, I would like to look at some of the moment-by-moment choices made here and consider their impact as compared to the potential impact of other possible choices, to emphasize that different kinds of responses can take the work in different directions.

Paul does not ask Louise why she has agreed to be interviewed and how she feels now, sitting in the room with him. Nor does he ask whether there are issues she feels she is not able to get to in her ongoing to treatment that may have contributed to her agreeing to meet with him. Rather, he focuses on Louise’s family issues and on helping her to solve practical problems. How might the trajectory of the work proceed if one were to open it with any of these other questions? Or, even, in keeping with his decision to focus on her issues with her husband’s family, what might have happened if he had done so in terms of her internal issues about this, including her possible conflicts about working things out with her husband’s family? I note this to emphasize that each choice we make impacts on the direction the work will take.

Consider the moment where Paul reassures Louise that her friendships are solid and that she has achieved her goals in terms of having friends. It is clear how delighted and
affirming this turns out to be. She is glowing in response. Would her good feelings have been diminished if Paul had also asked her to give more details about what she thinks are the good things in these relationships, what were the important turning points for her that she feels most proud of, and in what ways might there may still be problems to work on? What would be the impact of conveying that there is room to explore her weaknesses or where she still struggles and that it is possible to share whatever doubts, fears, concerns, hopes she might still be experiencing, along with her pride in her achievements and the things she feels proud of? What might be the impact of helping her to begin to get more perspective on the complexity of her experience, including on what allows her to function well and what brings her “down”?

Consider also the moment when Louise indicated very explicitly that she had to increase her medications because she had a “paranoid” reaction. Would exploring this in some depth, given how frightening this must have felt to her, allow for zeroing in on her concerns about her own emotional and mental fragility? What about exploring exactly what had set her off in that moment? Does she understand what tipped the balance for her? What anxieties might she have about whether she can trust her own perceptions, including her perceptions about who and when to trust?

What I am suggesting is that affirming what she has achieved does not preclude also exploring where she feels at risk, or deconstructing the ways she still may be disavowing her own power and agency and wanting and needing affirmation, as it may be playing out in general or in the moment. Choosing either option leads to different process and also to different potential outcomes. Might clarifying projections and introjections and disavowals of responsibility in the immediate moment help illuminate choices not to know, not to take responsibility or to take too much responsibility? Could this help to zero in on fears of or conflicts about empowerment or helplessness and about “knowing” and “not knowing” and conflicts about issues of being competent or not, as well as conflicts and issues about desire? Could helping her to see the choices she makes and why, and the ways she may be acting and reacting without a sense of choice or awareness, be useful? What about attending to what transpires emotionally and
nonverbally as this proceeds and bringing into focus disjunctions between what is said and what seems to be going on affectively? I think each such choice might have different impact on what might develop.

Being reassuring, without exploring the impact of our doing so, can play into a patient’s need for approval at the expense of helping her to explore what she gives up in relying on the approval of others. For example, this may not allow for looking at a patient’s doubts about being able to see, know, or trust his or her perceptions and difficulties making decisions and taking action.

Monitoring for the impact of whatever we do also allows for clarifying when reassurance might feel patronizing and not reassuring at all, or when deconstructing what is in play can be threatening or helpful, or both. In my experience, this kind of attention to and sensitivity to the specifics of how we are impacting on our patients and being impacted on by them from moment-to-moment takes the work in a different direction than if this is not explicitly explored.

Other things we might consider include:

For Louise, who never had a father who was able to protect her or help her in the kind of way Paul seems able to provide, could his efforts to help her have been what mattered most? If so, would being able to bring this into explicit focus allow for taking the consultation to another level of “helpfulness”?

Picking up on Louise’s comment that she is a people pleaser and is getting better at not being that, Jon Carlson, the interviewer, asks Paul if he thinks she was trying to please him. Paul concedes very graciously that he never explored that with the patient or himself. What would have happened if he did try to explore this with her in that interview or if he had tried to explore what she might have been acting out in this interview in relation to her therapist and also in relation to both her husband’s and her own families by “telling all” about her issues in this public way?
Jon Carlson notes that in fact Louise doesn’t seem to please people, rather the reverse. Paul replies she is a people pleaser who doesn’t always please people. Jon Carlson laughs and comments that Paul seems to be trying to put a “positive” spin on this at all points. A question here is, how do we define “positive” or “negative.” Are there times when putting a “positive” spin on things can be “negative” and close off a chance to explore negative feelings and/or the complexity of what might be involved? My hunch is that exploring when and why she is a people pleaser, and when and why not, can open the work without compromising “safety.” In fact, asking her to think about how aware she is of what accounts for her choices to please or not to please others can be freeing rather than threatening. This could then open onto other important questions such as: Why does she say “yes” when she does? When can’t she say “no” and why? Does it ever give her joy and pleasure to be able to please others? Is it ever done freely and with love? This could open a rich exploration of the ways in which she suffers and struggles, and the ways in which she feels coerced and resentful, and blames others for her situation, without any sense that she is the one making the choices she does. Is she feeling coerced because she feels she must please the other and that there is no option to say “no” or to consider her own feelings? Does she try to please people because she cares about their feelings, or does she do this because she fears disapproval and is afraid of how they might react to her if she doesn’t please them? How does this work with her friendships, her family, then, now, here in the room now, or with her therapist? How does this relate to why she is with Paul now? Helping her to look at when she feels she has found her true voice and when not, and why, and at whether finding her voice leaves room for recognizing the feelings of others, also could then be explored.

Similarly, helping her discover the ways in which her sense of possibilities may be unnecessarily limited, and her imagination foreclosed, including the extent of her own role in her own self mystification can be liberating in ways that might not be achieved otherwise. This can allow for reaching to new levels of creativity and imaginative and emotional freedom and also for exploring her capacities for playfulness and humor. Where these seem to be especially limited, deconstructing why this might be so can open
the work in yet more ways.

I am well aware that the issues I am raising go beyond the question of what is possible in one interview, and also that even within one interview, there is no way to generalize as the work always will be specific to the moment-by-moment interactive experience as it is lived by the participants of each specific dyad. I have simply tried to highlight how different ways of engaging in the moment can generate different kinds of therapeutic process and can lead to different kinds of therapeutic action, whether in consultation or in short or long-term work.

References


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