

## ENDANGERED BY INTERPRETATIONS

### *Treatment by Attitude of the Narcissistically Vulnerable Patient*

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Some narcissistically impaired patients present a particularly difficult therapeutic challenge. They often cannot tolerate interpretations because they view interpretations as humiliating evidence that they are shamefully defective. For these patients, “treatment by attitude” and without significant interpretation may be the only way they can feel safe enough to allow the therapeutic process to unfold. Two cases are discussed. In the 1st case, the usual therapeutic attitude of nonjudgmental acceptance was sufficient. The 2nd case was counterintuitive because the patient needed the therapist to demonstrate a complete lack of worry about the patient for her to make progress. Although the therapist’s attitude is part of every treatment, it may be particularly important in the treatment of more severely disordered patients.

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Psychoanalytic treatment has always assumed that interpretation must play an important role in the exploration and resolution of unconscious conflicts, but one type of severely narcissistic patient can feel humiliated, and thus endangered, by interpretations. The inability to tolerate interpretations can appear to be an insurmountable barrier to an analytic process. But by developing a stance that allows the patient to feel safe in the treatment, the patient can develop insights on her own, even in the absence of interpretation. This paper discusses the role of the clinician’s attitude as one aspect of helping the patient feel safe enough to allow the therapeutic process to unfold in psychoanalytic psychotherapy.

The role of the therapeutic relationship and the clinician’s attitude has never been totally absent from clinical awareness. Freud (1958a) discussed the powerful feelings that

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can occur in transference love. His technical recommendation for dealing with transference love was to maintain an attitude of analytic abstinence. Freud could be warm and friendly with his patients (Roazen, 1995). However, his writings emphasized the need for abstinence and neutrality on the part of the analyst (Freud, 1958b). For many early analysts, despite Freud's personal behavior, interpretation was more important to therapeutic progress than the person of the clinician.

Later analytic theorists who stressed the importance of object relations gave a more prominent role to the mutative aspects of the therapeutic relationship, and thus the analyst's attitude took on a more central role in treatment. Loewald (1991) explained how the analyst becomes available to the patient as a new object through the interpretation of transference distortions. The interpretations would need to include an attitude of "love and respect for the individual and for individual development" (p. 25). Modell (1976) also discussed the importance of aspects of the idealized mother-child relationship in the analytic relationship. Inherent in that relationship is the analyst's attitude of reliability and acceptance of the patient.

Relational theorists (e.g., Mitchell & Aron, 1999) stressed the centrality of the therapeutic relationship and, in particular, the therapist's influence on the patient's experience. Relational theorists contend that the therapist cannot remain opaque; it is, in part, the patient's exploration of the therapist's subjectivity that is mutative. Thus, the therapist's attitude of openness and authenticity is important to therapeutic progress. This emphasis on the importance of the therapeutic relationship includes, either explicitly (in object relations theories) or implicitly (in classical theory) the idea of a reliable analyst who maintains an attitude of responsive acceptance toward the patient. The importance of this attitude has also been supported by research on nonanalytic therapies (e.g., Beutler, Machado, & Neufeldt, 1994).

Although Sandler (1960) was explicit in referring to the "background of safety" that is necessary for therapeutic progress, the importance of the patient's ability to feel safe in the therapeutic relationship in order to make progress is contained in many analytic ideas (e.g., the "holding environment" of Winnicott). The usual understanding is that the clinician's reliability and acceptance will help the patient tolerate the difficult work of uncovering and working through painful traumas and unconscious conflicts.

The question of how one creates conditions of safety in the therapeutic relationship is a central concern of control-mastery theory (Weiss, 1993; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986; see also, Silberschatz, 2005). The theory assumes that psychopathology originates in unconscious pathogenic beliefs that are the result of traumatic experiences with parents or other significant loved ones. Pathogenic beliefs are similar to the internal working models of attachment theory (Shilkret & Silberschatz, 2005). Children are powerfully motivated to adapt to the reality of their interpersonal environment because it is necessary for their psychological and physical safety. Because attachment to the parent is crucial to the child's safety and well-being, the child views the parent as the ultimate authority on what is right. Therefore, the child comes to believe that the way he or she is treated is the way he or she deserves to be treated. Patients without a significant trauma history bring to the treatment a belief that the transference relationship will be generally safe because they have received, and therefore deserve, good treatment. However, patients who have been traumatized enter treatment with no such conviction. It then becomes part of the therapist's task to try to create a situation within which the patient can feel safe enough to allow the therapeutic process to unfold. Although there is a continuum of feelings of safety, I will focus on the extreme situation of patients who cannot feel safe in the usual treatment relationship.

The creation of conditions of safety is particularly important when treating one type of narcissistically vulnerable patient. These are patients who have traumatic histories of having been humiliated and shamed. Thus, they often react to interpretations as if they were shameful narcissistic humiliations. Treating them can be exceptionally difficult. A therapist cannot tell them anything new because they react as if a shameful deficit in their self-understanding has been exposed. In addition to his view of the general importance of safety for all patients, Sandler discussed the particular importance of a sense of safety in order to cope with the pain of narcissistic disappointment (Joffe & Sandler, 1987). Rosenfeld (1987) referred to these patients as “thin-skinned” narcissists who are “hyper-sensitive and easily hurt in everyday life and analysis” (p. 274). Rosenfeld distinguished them from “thick-skinned narcissists,” whom he described as “insensitive to deeper feelings” (p. 274). He recommended that thick-skinned narcissists be confronted repeatedly with their narcissistic attitude. In contrast, thin-skinned narcissists would be traumatized by this approach.

Despite their emphasis on the therapeutic relationship and the importance of the clinician’s attitude, most analysts and analytically oriented therapists believe that interpretation is necessary for a complete treatment. For example, Winnicott (1971) described deliberately not interpreting to allow the patient to be creative and make her own interpretations. However, there was “interpretative work that the analyst must do” (p. 87) in order to help the patient develop the capacity to use objects. Modell (1976) laid out 3 phases of the psychoanalytic process in treating narcissistic character disorders. In the 1st phase, the “cocoon transference,” the patient maintains an “illusion of self-sufficiency and disdainful aloofness. . . .” (p.295). In the 2nd phase the analyst confronts the patient’s attitude, which results in intense rage, but it eventually begins to decrease the patient’s grandiosity. The 3rd phase resembles a more typical analytic process with a transference neurosis and focus on oedipal dynamics. During the 1st phase, interpretations are not useful, except to convey the analyst’s attitude toward the patient. However, interpretations are an important part of the 2nd and 3rd phases of treatment.

The importance of interpretation is also an integral part of self psychology. This is sometimes overshadowed by the emphasis on empathy in writings on self psychology. Kohut (1984) stated that treatment consists of 2 parts: understanding and explaining. The understanding phase includes the therapist’s conscious and unconscious empathic experience of the patient’s affective state. The explaining phase still maintains the empathic bond, but it includes the therapist’s more objective interpretations of the patient’s dynamics and history. From the perspective of self psychology, Rosenfeld’s “thin-skinned narcissists” could be described as having deficits in the area of mirroring. The weakened structure of the self leaves the person vulnerable to feeling easily humiliated and shamed. If the clinician maintains an empathic attitude toward the patient, the patient is able to use the therapist as a selfobject and begin to repair the damaged structure of the self. The patient comes to feel understood by the therapist’s demonstration of accurate empathy. Feeling understood then allows the patient to tolerate the explaining phase of treatment. In cases of severe narcissistic pathology, the understanding phase may need to be very lengthy, but the explaining phase is eventually possible and is necessary for a complete treatment.

However, as mentioned above, severely narcissistic patients often react to interventions as if they were shameful humiliations. In addition, if the clinician tries to investigate their sense of shame, or even just to empathize with their reactions to interpretation or investigation, they may feel increased shame because the investigation and the empathy further highlight some humiliating lack in themselves that they did not already know.

Their expectation of humiliation may be so entrenched that all interventions are experienced in that way. The more the clinician tries to be helpful, the worse such a patient can feel, and the more “stuck” the treatment seems to become. With this type of severely impaired narcissistic patient, I have found that a successful treatment can be carried out “by attitude” and without significant interpretation.

Treatment by attitude has been discussed by Weiss (1993) and Sampson (2005). The concept of treatment by attitude was introduced in Alexander’s discussion of the “corrective emotional experience” (Alexander & French, 1946). Although controversial at the time, aspects of the corrective emotional experience have now been accepted into analytic practice (e.g., see Jacobs, 1990; Miller, 1990). Although there are some similarities between the corrective emotional experience and treatment by attitude, Sampson (2005) has pointed out a number of differences. The corrective emotional experience is usually understood as a consciously utilized technique. Treatment by attitude is an interactive process and not simply an adoption of a general attitude that is then imposed on a passive patient. Although he or she may not be able to articulate it, the patient is actively involved in trying to assess the therapist’s attitude toward him or her in order to help disconfirm the patient’s pathogenic beliefs. The patient may even “coach” the therapist (Bugas & Silberschatz, 2000) by presenting material to increase the likelihood of the therapist responding in a helpful way. The particular attitude that is most helpful for a given patient is not a generic one but is always specific to the unique patient-therapist dyad.

The therapist may be conscious of having a particular attitude toward a patient, based on the therapist’s understanding of the patient’s history, traumas, or reactions to the patient, or the attitude may occur out of the therapist’s conscious awareness. If it is out of awareness, it may become conscious through the therapist’s self-observation or as a result of comments by the patient or by a supervisor. Or it may remain unconscious. When the usual therapeutic attitude (e.g., reliable, respectful, noncritical acceptance of the patient) is sufficient for therapeutic progress, the importance of the therapist’s attitude goes unremarked upon, if not unnoticed. It is only when the case is an unusual one that the therapist’s attitude may come to the fore. For example, Weiss (1993) discussed a patient who acted in a provocatively casual manner in his treatment despite significant problems, including an inability to work at his job. When the therapist decided to reciprocate the patient’s casual friendly attitude the patient began to improve. Once he assured himself that the therapist would not insist that he work hard, the patient then went on to analyze his pathogenic belief that he did not deserve to enjoy his life because his parents had been rejecting and controlling.

Kantrowitz (1995, 2002) has examined the style of the analyst, including the analyst’s general attitude in her explorations of the importance of the patient-analyst match. She found that “when an analyst had a characteristic that compensated for some deficit in the patient or which aided in disconfirming some aspect of the patient’s transference, the analysis was facilitated” (1995, p. 301). These characteristics of the analyst were not necessarily conscious or, if the analyst was aware of them, they were not used intentionally in the analysis. For example, one very difficult patient was helped, in part, by his analyst’s calmness and ability to tolerate the patient’s extreme self-hatred (Kantrowitz, 1995).

In treating patients who cannot tolerate interpretations, the clinician demonstrates an attitude that disconfirms the patient’s unconscious belief without interpreting to the patient what the belief might be. The clinician is tested in the day-to-day interactions between patient and therapist as the patient scrutinizes every interaction to determine the therapist’s attitude toward the patient. Since the patient’s overwhelming priority is to protect oneself

from any experience of shame, the patient is constantly on the alert for any hint of criticism and is prone to overreact to anything perceived to be potentially humiliating. This occurs in the patient's daily life, as well as in the therapy. Thus, the therapist may be presented with numerous examples of the patient behaving badly (e.g., being rude, obnoxious, or self-defeating in a variety of ways) which cannot usefully be explored. Given the severity of the narcissistic pathology, the fragility of the patient, and the therapist's inability to use the usual techniques of exploration and interpretation, these therapies progress very slowly. Therefore, treatment primarily by attitude is usually a "last resort," after it becomes clear that the patient reacts badly to interpretations.

The following 2 examples of patients seen in weekly psychotherapy demonstrate treatment by attitude. Both patients had previously been in unsuccessful therapies. Despite their difficulty tolerating interpretation, both wanted "in depth" treatment and an understanding of their pathology and not merely behavior change. Both therapies were slow-moving and lengthy (10+ years). The 1st patient was able to make use of the usual therapeutic attitude of nonjudgmental support. However, the 2nd patient required a rather different and somewhat unusual attitude.

### Mary

Mary began therapy in her 40s, complaining of multiple dissatisfactions in her life. She had graduated from a prestigious college but was working at a low-level job. She was overweight and felt unable to control her eating. In every area of her life, she felt dissatisfied but unable to make changes. My discussion will focus primarily on the difficulties in her work life, but the therapeutic process was similar when we addressed other areas of her life.

Mary was the only child of working class parents. Her mother had a chronic illness that was a source of concern in the family. Her father owned a small business, but there was often dissension in the household because he was not a very successful businessman, and money was often tight. The belief that one cannot challenge fate was pervasive in the family. Her mother's illness truly was not curable, but it also became the handy explanation for why she did not do things that she could do but did not care to, such as visit her in-laws. Mary's father seemed rather hapless but also passively resigned to his fate. His attitude was that one could not expect to make any more money at his type of business. It was many years before I learned that he had bought the business from another relative who had been quite successful, which suggested that her father had not done all he might have to make the business a success.

Mary viewed herself as too weak to cope with the world. This was both an identification with her sick mother and also a compliance with her mother's extreme overprotectiveness. As a child, she was discouraged from playing with other "rough" children in the neighborhood, and so she had few friends. She was deeply ashamed of her relative friendlessness and humiliated by the feeling that she was not strong enough to compete in the world, which she later defended against by "coming on too strong" with others. Although bright, she was discouraged from going to college, in part out of loyalty to her working class origins (no one in her extended family had attended college) and in part to keep her close to home. She went to work as a secretary, but she had always longed to see more of the world. After a few years of secretarial work she joined the Army. Her parents were extremely upset and disapproving. After a few months in the Army, her mother died somewhat unexpectedly, and her father told Mary it was her fault because her mother's

heart was broken. Although deeply shaken, Mary stayed in the Army for many years. However, she chafed at the discipline, and numerous times she came close to getting into trouble by her complaints, which bordered on insubordination.

After she left the Army, Mary realized she could use her benefits to attend college. She was accepted at a prestigious college, and she flourished. She enjoyed the academic atmosphere where dissent and discussion were encouraged. However, once she graduated, she began to have difficulties at the jobs she obtained. Sometimes she was fired from her jobs, and sometimes she decided to quit. When she finally began therapy, she had been “downwardly mobile” for a few years and was working as a secretary in a family-run business.

Mary’s therapy was a litany of complaints. Her employers were exploiting her; her boyfriend was mistreating her; her upstairs neighbor was making too much noise, and the landlord was unwilling to do anything about it, and so forth. She gave me enough information so I could tell that there was some validity to all her complaints (she was not paranoid). However, she remained passive and unable to make any changes in her situation, and she seethed with humiliation at the injustices that she was suffering. Whenever I tried to intervene, either to investigate or to make a suggestion, she would go on at length telling me why it was useless. If I tried to empathize with her, she ignored what I was saying. I began to feel increasingly hopeless about her situation and about my ability to help her.

As I examined my reaction of hopelessness, I realized that Mary had identified with her hapless and hopeless parents. The operative pathogenic belief in her family seemed to be that nothing could ever be solved or improved. You just had to suffer with your problems because you were too weak to effect changes. This was the case with her father’s business. The medical problems that led to her mother’s early death were no one’s fault, but they intensified the belief that problems were unsolvable. This family dynamic was now being played out in the therapy. Although Mary consciously tried to improve her situation, her unconscious belief was that nothing could ever be done to change her situation and that it was too dangerous to try. Even though she knew the realistic cause of her mother’s medical problems, she believed that her assertiveness had damaged her mother and caused her early death. In addition to feeling hopeless, she burned with feelings of shame at being in the humiliating position of being weak, a loser in life, which she fought against by her rebelliousness and her sarcasm. She had no recognition of her identification with her “loser” parents. She could not hear any intervention from me because it reinforced her view of herself as a loser who had to be told humiliating things about herself. Nor could she tolerate any empathic statements on my part because they, too, conveyed to her that she was a loser, someone to be pitied. Her general response to my comments, including my attempts to explore her reactions to my comments, was to shut down and become unable to think.

When I recognized that my feelings of hopelessness were a reflection of the unconscious pressure to comply with her family’s belief that life was hopeless, I was able to regain my own sense of hope about the usefulness of therapy. Since I was aware that she was unable to make use of the interventions that I did make, I decided that the most useful way to treat Mary was to maintain a positive attitude, especially when she acted as though nothing could ever be done to solve her problems. This often meant that when she complained about how awful her life was, my only reaction was to agree that it was difficult, but that perhaps we could figure out some small ways to improve things. In the beginning of therapy, she often insisted that it could not be done; however, much later on in the therapy,

she became interested in how changes might be made. Whenever she did try to change her situation, I remained positive even when I was doubtful about her technique.

Early in the therapy Mary focused on her job situation. She left her original job and soon found a better job and reported feeling happier. However, at her 1st evaluation, there were complaints about her negative attitude on the job. She insisted she did not know what they were talking about and resisted any attempts to explore her feelings about the complaints. She left that job and took another. The same pattern repeated itself. She was happy at first, but she then developed personality conflicts with her fellow employees. She was unable to be specific about the nature of their complaints about her, except that they had unreasonable expectations of her and that they excluded her from their discussions. However, she did reveal that her coworkers viewed her as negative and uncooperative. After a few years, she left that job shortly before she probably would have been fired. She then took another job, and the pattern repeated itself: her boss was unreasonable, other people excluded her from meetings, and people were not friendly, despite how hard she tried.

Over the intervening years as she began to trust that I would not criticize or humiliate her, Mary began to reveal a bit more of what actually went on at her jobs. She was extremely sensitive to any comment or activity that felt to her like a narcissistic humiliation, and she would react sharply, with a complaint or with sarcasm, to any perceived mistreatment. For example, if her boss invited a coworker to lunch and did not invite her, no matter what the reason, she would become petulant, neglect her work, and make insulting comments about her coworker and sometimes about her boss. Needless to say, this did not endear her to her coworkers, and they increasingly ignored her. This intensified her feeling of humiliation; she would make more such comments, and the relationships in the office would become worse and worse. She could not usefully examine her beliefs about her coworkers or about me. Any attempts to explore those relationships were too painful to be tolerated. She would angrily insist that people were mistreating her, and she would talk over me if I tried to comment on what she said. I could say only that, of course, it hurts to be left out of office discussions, but that these things can be managed, and perhaps we could figure out some ways that she could improve her relationships with her coworkers. She began to feel encouraged that she could take some small steps to improve her work life, and she started to react a bit more calmly to perceived narcissistic insults. However, her department was abolished in a company reorganization, and she lost her job. (It is possible that if she had created more good will in the company, another job might have been found for her, but by then enough people were annoyed at her that no such effort was made.)

Mary then decided to go into business for herself as a dressmaker. She had been making her own clothes for many years and had wanted to do this professionally, but she had always been discouraged from doing so, first by her family and later by her husband, because it did not seem to be a secure way to support oneself. I continued my attitude of being supportive of any activity she did for herself. At first, she began in a predictable way. She complained about suppliers and made negative comments about professional groups she joined. She reacted with exaggerated concern to her clients' comments, even those that were just questions rather than criticisms. However, after many years of therapy, she had begun to identify with my attitude that problems were not shameful, but that they could be overcome. This resulted in 2 changes. First, she felt safer that I would not criticize her, and thus she allowed herself to reveal more of what was going on between her and others. She was then able to ask my advice about how to deal with others, and for the first time we began to explore in a more meaningful and collaborative way how

vulnerable she felt to feelings of humiliation. Second, she began to recognize patterns in her behavior and recognize that her negative responses to others were reactions to her feelings of humiliation.

One day, Mary began a session complaining about some colleagues. She then stopped and said, “You know, I don’t think it’s them. I think I’ve been causing the problems I’ve had at work. Maybe the only way I could cope was to be in business for myself.” She then became increasingly able to look at her ideas about other people and how humiliated she felt viewing herself as a loser. As she became more professionally successful, she began to realize that she had identified with her unsuccessful parents and that she felt guilty being a better businessperson than her father had been. Although I had previously tried to discuss this identification with her, it had gone nowhere. Either she would agree and change the subject or she would feel attacked and humiliated and respond defensively to demonstrate that I was wrong. It required many years plus some experiences of success before she felt safe enough to tolerate revealing the true extent of her feelings of weakness and humiliation. At a later point, she mentioned the fact that I, too, was in business for myself, and she tentatively began to explore her thoughts and feelings about me, and what she imagined I might think about her.

I think the reason we do not usually label this kind of therapy “treatment by attitude” is that it is similar to what we do with many patients—presenting a supportive, positive attitude toward the person. What makes this case unusual is that it was almost all I could do with her since she could not tolerate anything more active on my part. Her extreme feelings of shame and her vulnerability to feeling humiliated made almost any intervention dangerous to her fragile self-esteem. Therapies such as this will be extremely slow-moving and lengthy—in part because the patient is so fragile, and in part because if the therapist cannot make any interpretations, it takes longer to help the patient understand, and thus resolve, his or her unconscious beliefs and transference distortions.

Although many theories might recommend a positive, supportive attitude, treatment by attitude does not always mean being openly supportive. In the next example, the attitude that the patient required was more unusual.

### Dolores

Dolores began therapy in her early 40s because she felt like a failure. She was unable to sustain a relationship or maintain a job. She grew up in a middle-class home and both her parents had white-collar jobs. She was the younger of 2 sisters. Her older sister was a successful lawyer, married with children—in short, everything that Dolores was not, as her parents often pointed out. Her parents were extremely critical and unable to appreciate her genuine accomplishments. Dolores was an elementary school teacher who changed jobs often. She seemed to be a good teacher, but she could not get along with her coworkers. She was chronically short of money, not surprising since teachers are not highly paid. However, unlike some people who take second jobs or try to advance in their careers to make more money, Dolores impulsively went from one school district to another when she was criticized (or thought she was about to be criticized), often taking a pay cut to change jobs. Her intimate relationships were similarly chaotic. She had had numerous boyfriends, but the relationships always ended disastrously and often abruptly. She often became enraged at a perceived narcissistic humiliation and cut off contact with a boyfriend. Or he would get tired of her rages and erratic behavior toward him and he would end it. She had been in therapy on and off since her adolescence with some small



gains. Interestingly, she chose me as her therapist after accompanying a therapist friend to a talk I gave which included a description of the treatment of a very difficult patient. She said I seemed like someone who would not be intimidated!

Dolores began therapy by complaining about her current job. The principal was stupid; the things she required of the teachers were ridiculous, and so forth. After complaining for a while, she sometimes asked my opinion, but she never gave me enough information to venture an opinion, even if I wanted to. When I tried to investigate her thoughts or feelings, the session would get increasingly confusing. Either she ignored my questions or she appeared to respond, only to go off in another direction while I was left trying to figure out how her responses related to the questions I had originally asked. Often, I could not even remember what I had asked. Even when we began to discuss a topic together, she frequently changed the subject before we could deepen the discussion. The changes could sometimes be abrupt. For example, she began a session complaining about her job difficulties, her immature coworkers, and her lack of money. She then talked about ways to make more money, some reasonable, some not. After an extended discussion of her finances, she began to obsess about the weather until she became quite panicky about it. Her concerns with the weather were not the more typical ones, for example, will we get a bad thunderstorm or snowstorm. Instead, she obsessed about things like earthquakes. She became preoccupied with the likelihood of an earthquake, and there was very little I could do in response. If I tried to investigate her panic, she felt I was not taking her concerns seriously enough, that is, I was treating her panic as something to be understood, not a reality issue. If I tried to discuss the reality aspects of her concerns, that is, the unlikelihood of such an event, she used that as proof that an earthquake was imminent because it had not happened in a long time. If I tried to empathize with her feelings of anxiety and impending doom, she felt I was just avoiding discussing the hard reality that the only way to cope with such an event was to move away from this area as soon as possible. If I tried to discuss the progression of the hour by pointing out that she had gone from topic to topic, she felt humiliated that I was saying there was something wrong with her. And if I tried to explore her feelings in the transference that she had a therapist who could not do anything right, she would just agree and say she already knew that and it was not helpful. Any attempt on my part to analyze anything in the session resulted in her becoming increasingly annoyed at my incompetence and lack of empathy for her situation.

Given what she had said about her parents, I felt fairly confident that she was identifying with her parents' treatment of her and was criticizing me as they had criticized her. However, I learned that there was no way to investigate or interpret that. As with Mary, Dolores either seemed to agree and then changed the subject, or she defensively disagreed and got increasingly angry with me for not understanding her. I realized that she had complied with her parents' (especially her mother's) extreme criticisms of her and felt deeply ashamed of any evidence that she was not perfect. Any attempt to investigate her problems, even problems that she brought up, was felt as my "rubbing her nose" in her deficiencies. And the attitude that often works well with patients such as Dolores, a positive, supportive, empathic attitude, did not seem to result in much progress. Again, I later learned that she viewed empathy as a humiliating sign that she was defective, that she had a problem.

Partly by trial and error I discovered that the attitude that was most helpful to her was for me to be unbothered and undismayed by whatever she said. (I should have paid more attention to her initial "coaching" of me when she first told me she had chosen me as a therapist because she felt I could not be intimidated.) I became interested in whatever she chose to discuss, and I encouraged her to explore her thoughts about the topic. However,

if she abruptly changed topics, I did not comment. I listened respectfully to her panicky worries about the weather, her finances, me, and so forth, but I did not act particularly bothered, and often I did not investigate at all. This is an unusual attitude for a therapist to have, and at times I felt that I was not being very therapeutic. However, over several years, she began to identify with my unbothered attitude. She then began to discuss her mother in more detail. She had reported from the beginning of therapy that her parents were both very critical of her. However, it took several years of therapy for her to become aware that her mother had another aspect to her personality besides the critical, superior know-it-all. Her mother sometimes became extremely panicky for reasons that were not clear to Dolores. For example, one time she and her mother were having a reasonable conversation when her mother suddenly started worrying that she (the mother) would not have enough money to pay the mortgage. She implied (and sometimes stated directly) that this was the patient's fault because it cost so much to raise a child. In retrospect, these worries of the mother's were always untrue. But as a small child, Dolores had no way of knowing that. She became panicky along with her mother and then shameful, feeling that her needs were the cause of the problems in the family. Her mother eventually calmed down and then behaved as if nothing had happened. If Dolores tried to discuss any of this with her mother, her mother denied Dolores's perceptions and accused Dolores of causing problems.

Dolores did not realize that she had identified with her mother's attitudes. Since we could not discuss any of this for several years, the only way to disconfirm her unconscious belief that the world was unpredictable and that she was responsible for dangers that could erupt at any minute was to remain completely unbothered no matter what the topic. Early in her therapy, she often began an hour with a dramatic announcement of an impending crisis, for example, she was about to be fired, and she felt like killing herself. I would ask her to tell me more about her feelings, but I would not pursue it when she changed the subject (as she invariably did). She occasionally returned to her initial topic at the end of the session, insisting that something had to be done. I would end the session by saying that she had been through things like this before and that we would continue to try to figure it out. By the next session, her focus was on something else, and I often did not learn the outcome of the original crisis unless I asked her. Later in the therapy, the impending crisis often involved our relationship, for example, the therapy was making her worse because I was so incompetent and did not understand her. However, the process remained the same. I tried to investigate her complaints; she changed the subject and ultimately moved on to another worry.

Over many years, Dolores identified with my attitudes: my confidence in myself (demonstrated by my not acting bothered when she criticized me) and my lack of worry (demonstrated by my minimal investigation when she became panicky). As she felt safer, she became more tolerant of the events in her life (e.g., if a coworker criticized her) and also toward herself. She began to remember with greater clarity how her mother frightened her. She could recognize it in the present and deal more calmly with her mother's perpetual anxieties and accusations. She also became able to explore our relationship. Unlike her initial, externalizing presentation, she became thoughtful about the nature of our relationship. She began to analyze her thoughts and feelings about me and to make connections between her relationship with me, her relationships with others, and how all of these relationships reenacted her conflicts with her mother. She then became increasingly able to discuss her fears of having a psychologically intimate relationship with me.

## Discussion

Both patients were treated primarily by attitude for many years. The main emphasis with Mary was on maintaining an overtly supportive attitude toward her even when she reported things that were self-defeating. For example, she might proudly report how she “wasn’t going to take any more crap” from her boss and then report what she had said to him. I was in the position of knowing that a person could not say things like that to one’s boss and expect to keep one’s job. However, exploration of her thoughts or feelings left her feeling criticized no matter how empathically they were framed. Therefore, I had to be supportive no matter what and remain positive despite her self-defeating behavior and the exceedingly slow pace of the work. By remaining optimistic, I demonstrated that I did not accept the pathogenic belief that she had grown up with—that things were hopeless and you could only stand by and passively worry. Later in the therapy, she began to be able to tolerate the exploration of her feelings, but it took several years for her to get to that point. One of the reasons the therapy proceeded so slowly was her belief that her assertiveness was responsible for the illness and death of her mother. Thus, she could not take a chance that assertiveness in her current life might severely hurt someone she cared about, for example, her husband or me.

Similarly, Dolores suffered from the belief that she was the cause of her mother’s intense worries, so she could not allow herself to make progress very quickly lest someone close to her be driven crazy with worry. I maintained a consistent attitude of not worrying for many years before interpretations were useful. However, although I would say my attitude was supportive, I am not sure that she would, at least not for a long period of time. Being overtly supportive would risk confirming her pathogenic belief that there was something overwhelming to worry about. Therefore, I just tried to listen respectfully and say little about her worries. When she was critical of me, I took the attitude that I was sorry, but that “no one’s perfect,” and I could not always do or say exactly the right thing. Over time, she was able to identify increasingly with my unbothered attitude, and she ultimately became able to analyze her mother’s critical and panicky approach to life in which everything was terrible and it was all Dolores’s fault. She had not been aware that she identified with her mother and lived her life in accordance with her mother’s pathogenic belief that she was a demanding child who made her mother’s life difficult. When I did not accept the idea that I made the patient’s life difficult by depriving her of things (like the time and money she spent on the therapy), it helped her to disconfirm the powerful unconscious belief that she had deprived her mother of things. However, for many years of the therapy she could not tolerate any direct exploration of these ideas, and much of the therapy was conducted by attitude.

Although they required somewhat different attitudes for the therapy to progress, both Mary and Dolores shared a feeling of intense shame for being weak and/or defective, which they found humiliating. Mary’s feelings arose in part from being treated as too weak to cope with the world, while Dolores’s feelings were the result of constant experiences of public criticism. One additional factor that I believe made interpretation hard to tolerate and slowed the pace of the therapy was the intense worry that both women lived with as a result of the pathogenic belief, “If I change my life, something terrible will happen to my mother.” Mary struggled against the belief (intensified by her father’s comments) that her independence killed her mother. Dolores believed (encouraged by her mother’s behavior and her father’s acquiescence) that her success would literally drive her mother crazy with worry.

Each patient required a different attitude in treatment, but neither attitude was

inauthentic. For each patient, my attitude developed from my understanding of the patient's unique history, traumatic experiences, and pathogenic beliefs as well as genuine positive feelings toward each patient that developed in the course of the therapies. Although my own (conscious and unconscious) style contributed to the attitude that I conveyed to each patient, the patient's unconscious search for an attitude to disconfirm her pathogenic beliefs placed limits on the range of therapeutic attitudes that could be useful to her. Dolores could not use the more typical therapeutic attitude of nonjudgmental interest and investigation. Based on her rigidly held belief that affective interactions always lead to uncontrollable worry and panic, the therapeutic attitude that allowed her to feel safer might appear to an outside observer as almost disinterest in her problems.

One question that might be asked about both therapies is whether they were truly psychoanalytic since there were almost no interpretations. One hallmark of an analytic process is the ability to develop insights into one's conflicts and defenses. Over time both patients became able to do this to varying degrees. Dolores could discuss the transference and explore her fantasies about me, where they originated in her early history, and the variety of defenses she used to keep her beliefs and fantasies unconscious. Mary developed increasing insight into her conflicts and the defenses she used to ward off the painful feelings of shame and humiliation. However, she was still rather tentative in discussing the transference or her fantasies about me. In contrast with Dolores, Mary did not exhibit the 2nd phase of intense rage predicted by Modell (1976). It is possible that this reflects the greater danger and sense of omnipotence that she felt in relationships. After all, her mother's death was her fault (according to her father). In contrast, despite all the threats and drama, Dolores's mother survived. But once the therapeutic situation was made safe enough, both women were able to develop genuine insights into their pathology that went beyond compliance or behavior change.

The therapist's attitude is an important element of most therapies. However, it becomes a central mutative factor the more impaired the patient. These 2 patients were similar in their deep sense of shame that made it impossible to tolerate any intervention that suggested that they had any problems. However, patients with other types of pathology can be treated by attitude as well. Pryor (2005) discussed the treatment by attitude of a severely traumatized woman with an eating disorder. Gassner (2004) reported on her treatment of a woman suffering from agoraphobia and panic disorder. One important aspect of the therapy was Gassner's ability to remain "steady, calm, assured, nonworried, noncatastrophizing, separate, and available" (p. 239). (See also, Barish, 2004, for a related discussion about the importance of affective engagement in psychoanalytic child therapy.) It may be that one element that makes different analytic therapies mutative is the common background of safety, the therapeutic attitude of nonjudgmental acceptance that underlies most therapeutic approaches. It is only when the patient requires a more unusual attitude, or when nothing other than the therapeutic attitude itself is mutative, that the role of the therapist's attitude comes to the fore.

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