

The Privilege of Being a Therapist

*A Fresh Perspective from Intrapsychic Humanism on Caregiving Intimacy and the Development of the Professional Self**

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Abstract

The internal world of the clinical social worker looks very different when seen from the perspective of intrapsychic humanism, a comprehensive psychodynamic psychology (Pieper & Pieper, 1990). Adopting this view of development and treatment can remedy one of the most perplexing and pressing dilemmas facing even the most conscientious and dedicated mental health professional – the vulnerability to what Hiratsuku termed “compassion fatigue” (1991) – to feeling stuck with an unrewarding daily clinical experience. The following discussion offers social workers three guidelines that will transform their clinical experience and make it exciting and fulfilling: how to recognize clients’ aversive reactions to pleasure; how to hear both the process and content meanings of a client’s communications; and how to distinguish between the social worker’s personal and caregiving motives. These principles will help all social workers, including those doing brief treatment, long-term treatment, school counseling, and traditional casework.

THE INTERNAL WORLD OF THE CLINICAL social worker looks very different when seen from the perspective of intrapsychic humanism, a comprehensive psychodynamic psychology (Pieper & Pieper, 1990). Adopting this view of development and treatment can remedy one of the most perplexing and pressing dilemmas facing even the most conscientious and dedicated mental health professional — the vulnerability to what Hiratsuku termed “compassion fatigue” (1991) — to feeling stuck with an unrewarding daily clinical experience. The following discussion offers social workers three guidelines that will transform their clinical experience and make it exciting and fulfilling: how to recognize clients’ aversive reactions to pleasure; how to hear both the process and content meanings of a client’s communications; and how to distinguish between the social worker’s personal and caregiving motives. These principles will help all social workers, including those doing brief treatment, long-term treatment, school counseling, and traditional casework.

Compassion Fatigue

Many clinical social workers find that their day-to-

day clinical experience does not produce the glow of satisfaction that was part of the ideal of service that drew them to their profession. Clients who respond to a therapist’s committed caring with unremitting criticism of her clinical abilities, who go long periods of time with no visible improvement, or who demand more from the therapist than what she is providing, often leave the therapist feeling drained, irritable, depressed, discouraged and, not infrequently, driven to illicit sources of self-destructive soothing.

All mental health professionals confront the perennial and seemingly intractable problem of maintaining the enthusiasm that flows from the pleasure of developing and using one’s professional self in the face of the seeming inability to have a meaningful influence on the protracted, immobilizing pain that victimizes those clients who are most in need of one’s therapeutic skills. Intrapsychic humanism offers the therapist a fresh, positive understanding of and approach to the clinical process, which will afford access to a rewarding and stable professional identity. Intrapsychic humanism demonstrates that there is a constructive significance to be found in the negative behavior and seeming lack of motivation and progress exhibited by many clients, and, thereby, enables the clinician

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to uncover the potential for the pleasure of caregiving intimacy in the most seemingly ineffective and incorrigible therapeutic process.

While the most serious form of compassion fatigue, burn out, has captured public awareness, other, less publicized stages of compassion fatigue are more prevalent and more corrosive than is recognized. However, until now, no remedy has been available, and dissatisfaction on the part of those who spend their professional lives offering psychological assistance to others has been accepted as inevitable. From the perspective of intrapsychic humanism, however, all stages of compassion fatigue, up to and including the phenomenon known as burn out, are entirely preventable.

Intrapsychic Treatment

The privilege of being a therapist is the opportunity to do meaningful, helpful work in the context of a unique relationship that affords the therapist the intense pleasure of gratifying the desire to care for others. The therapist's caregiving pleasure can be homologous to the pleasure generated by parental caregiving, which is so compelling that the parent will out of pleasure, rather than out of guilt or duty, choose caregiving motives over personal motives.

Intrapsychic humanism offers social workers a new understanding of child development, psychopathology, and treatment, yet its principles are entirely in keeping with the traditional outlook and values of social work. Intrapsychic humanism views humans as innately disposed to seek a positive, relationship-oriented type of care getting and caregiving pleasure rather than as driven toward antisocial acts that must be thwarted and suppressed. The use of the term *normal development* is reserved for a childhood and adulthood characterized by an inner well-being that remains stable and conflict free no matter what ups and downs life brings. An individual who has experienced an optimal type of development and who encounters a wrenching loss, such as the destruction of her home by a natural disaster, will feel the pain of the loss but will never experience the type of psychic pain associated with shame or depression, will never turn on others, and will never seek physically destructive forms of soothing, such as substance abuse, to ease the pain of the loss. The psychic pain that has been taken for unalterable normality, while typical, in fact represents a heretofore unrecognized form of (alterable) inner unhappiness.

The unshakable well-being that results from an optimal developmental process can also be attained through intrapsychic treatment, which is psychological help based on the understanding of human nature, child development, and psychopathology that comprises intrapsychic humanism. Intrapsychic treatment represents neither a hopelessly naive view of human nature through rose-colored glasses that filter out all evil and illness, nor

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an intellectualized and experience-distant therapeutic process. While intrapsychic humanism posits that fundamental human unhappiness can be prevented and cured, it does not argue that such an outcome can be brought about by social reform or cognitive understanding alone. In other words, intrapsychic humanism does not ignore the internalized nature of human pain and suffering. On the other hand, intrapsychic humanism neither overlooks the individual's interaction with her environment, nor concludes that situational effects are insignificant.

The goal of intrapsychic treatment is not the completion of an incomplete developmental process that began in infancy, but rather the completion of a developmental process that commences within the therapeutic relationship. From the perspective of intrapsychic humanism, conflicted human nature (inner unhappiness) does not result from innately determined, fixed structures, narrative incoherence, or maladaptive reinforcements. Rather, psychopathology represents the developing human's attempt to maintain a viable sense of inner well-being in the face of traumatic caregiving. The finding that the cause of psychopathology is trauma is reflected in the aim and practice of intrapsychic treatment. In contrast, those psychologies that mistake commonly occurring unhappiness for essential human nature assume that even the most successful treatment will leave the client with an intractable type of existential dissatisfaction. To illustrate, Hannah Green chose her analyst, Frieda Fromm-Reichmann's, cautionary statement, *I*

Never Promised You a Rose Garden (1964), as emblematic of her treatment.

In intrapsychic treatment, the therapist has the caregiving pleasure of nurturing the client's heretofore unengaged motives to experience reliable, conflict-free care-getting intimacy. The client's experience of receiving the care getting she needs acquires the meaning of an inner well-being that she causes and regulates. Intrapsychic care-getting pleasure refers not to an affect, but to a meaning structure of effective agency nurtured by the client's experience of causing the therapist to want to give the emotional care the client needs and desires.

The mechanism of therapeutic change in intrapsychic humanism is not insight, but here and now care-getting pleasure produced by the client's experience of causing the therapist to meet her care getting needs. Over time, the superiority of this type of relationship-based self-regulation leads the client to reject as an unnecessary and unwanted loss the type of self-regulation that is based on motives for pain with the unconscious meaning of pleasure.

The therapeutic action in intrapsychic treatment is not hermeneutic; its primary goal is not conflict resolution (it does not rely on transference interpretations of dynamically unconscious psychosexual conflicts); it does not focus on constructing a coherent narrative of the client's life; and it does not concentrate on correcting dissonant cognitive strategies or changing symptomatic behaviors. Just as important, intrapsychic treatment does not advocate any type of unreflective caregiving. Specifically, the practice of intrapsychic caregiving never entails indiscriminate transference gratification, nor does intrapsychic treatment represent a process of reparenting (e.g., it is not a "corrective emotional experience" [Alexander, 1961, p. 213]).

Also, the process of intrapsychic treatment does not depend on empathy — either as perception (vicarious introspection) or as the mode of therapeutic action (Kohut, 1959, 1977). It is manifestly demonstrable that because of the solipsistic nature of introspection, empathy as vicarious introspection represents at best a figure of speech. That is, the act of introspection is not open to the knowing act of another; therefore empathy cannot reliably distinguish between delusion and actuality. In consequence, there is no justification for using empathy as a basis of therapeutic action — there is no way to know whether the experience of affective attunement represents the caregiver's wish fulfillment or compliance with the client's wishes.

There is space only to identify and discuss two kinds

of client behaviors that commonly cause dysphoria in the professional self of the therapist: (1) a client's persistently negative behavior (broadly defined to include emotional withdrawal or a focus on topics that the therapist finds inconsequential) and/or (2) moment-to-moment communications by the client that seem impenetrably opaque and, therefore, frustrating. When social workers adopt the perspective of intrapsychic humanism, however, these client behaviors can become a source of satisfaction rather than loss.

Understanding Aversive Reactions to Pleasure

Persistent negative behavior on the part of the client can result from the client's character structure, from a phenomenon we term aversive reaction to pleasure, or from the client's reaction to losses caused by the therapist's mistake of confusing personal and caregiving motives. Due to space considerations, only the aversive reaction to pleasure, which is the least understood of these causes of negative client behavior, will be considered.

Many of the negative behaviors clients exhibit can be attributed to the phenomenon we have identified and termed the aversive reaction to pleasure. The aversive reaction to pleasure represents the reactive preemption of an individual's motives for genuine, self-caretaking pleasure by learned motives for pain, which have the unconscious meaning to the subject of sought-for pleasure. A common example is the client who forgets a session in reaction to the pleasure of feeling well taken care of by the social worker.

Freud's notion of negative therapeutic reaction and our construct of aversive reaction to pleasure differ in cause, scope, and perceived significance. In *The Ego and the Id*, Freud noted that some clients respond to positive experiences in the therapeutic situation by regressively clinging yet more desperately to their symptoms. He termed this reactive negative behavior a "negative therapeutic reaction" (Freud, vol. 19, pp. 49-50). Freud ascribed this paradoxical behavior to his construct of the death instinct, which he posited as an incorrigible instinctual drive that aims for self-defeat and self-destruction (Standard Edition, vol. 18, 51-54). The death instinct is a cornerstone of Freud's theory and has led all subsequent psychodynamic offshoots of psychoanalysis to be pessimistic about human nature generally and about the possibilities for psychological treatment in particular.

Intrapsychic humanism ascribes aversive reactions to

pleasure to the distorted motive for care-getting relationship pleasure that characterizes all psychopathology. Aversive reactions to pleasure are not limited to the therapeutic relationship but characterize all psychopathology, which intrapsychic humanism defines more broadly than any other theory to include the common inner unhappiness of everyday life. The pervasiveness of the phenomenon of the aversive reaction to pleasure is probably the most common source of clinicians' dissatisfaction with their work.

Aversive reactions to pleasure occur because in a psychopathological developmental process, the child acquires needs for unpleasant experiences, which have the unconscious meaning of deep, care-getting pleasure. While at first this foundational dynamic of all psychopathology may appear maladaptive, it is actually the consequence of the highly adaptive phenomenon that every child has an inborn need to believe that her parents are perfect caregivers who love caring for her. Young children believe that all caregiving, including unstable, inadequate, or abusive caregiving, is ideal caregiving that they are causing and regulating. If parents' caregiving is consistently unreliable, a child will unknowingly attach the meaning of ideal care-getting pleasure to what objectively is the psychic pain caused by unstable caregiving. The net effect is that the child misidentifies a continuing influx of psychic pain as ideal care-getting pleasure and develops unrecognized needs for this discomfort. From an observer's viewpoint, this learned desire for experiences of pain with the meaning of pleasure can also be described as a motive for self-rage, in the sense that it represents a motive to acquire an inferior, growth-inhibiting type of core esteem. This type of core psychopathology underlies all psychopathological symptoms.

Because the learned need for unhappiness is subjectively experienced as a motive for pleasure, it can only be recognized from a perspective outside of the subject. In explaining the process by which humans acquire inner unhappiness, it is helpful to use the analogy of a baby gosling that has bonded to a human "parent." It is by now well known that if a gosling is hatched apart from other geese and tended by a human, that gosling will follow its human caregiver with the same single-minded intensity with which other goslings follow a real mother goose. The imprinted gosling steadfastly pursues the human caregiver without recognizing that the human is not an ideal parent.

This misled gosling will have a less-than-optimal de-

velopment because the human cannot provide the same quality of nurture as the mother goose. From the day it hatched, this gosling has unknowingly developed a distorted concept of ideal parenting. Even if the mother goose is subsequently introduced to its gosling, the gosling does not recognize the goose as its mother but continues to follow the human. The gosling will reject the ideal parenting available from the mother goose and will continue to pursue what a human observer can recognize as the substandard care it gets from following its human "parent." In the same way, aversive reactions to pleasure represent the search for inferior well-being (pain), which has acquired the meaning of ideal inner well-being.

The dynamic of the aversive reaction to pleasure characterizes all psychopathology and silently tinges an individual's existence with the omnipresent threat or actuality of loss in the face of even the most genuinely satisfying pleasure. The aversive reaction to pleasure explains why so many people who achieve immense career success subsequently destroy themselves with addictions, tax fraud, or disastrous relationships. In a milder form, the aversive reaction to pleasure can occur as a feeling of slight unease or a sense that the sought-for and acquired satisfaction was not as rewarding as originally thought, which is illustrated by the saying, "The grass is always greener on the other side of the fence."

In the grip of an aversive reaction to pleasure, a client will unknowingly attach the meaning of loss (pain) to each experience of being well cared for by the therapist, because conscious care-getting pleasure interferes with the client's unconscious use of experiences of relationship unpleasure to satisfy learned needs for unhappiness. The client having an unobserved aversive reaction to pleasure experiences the therapist as a source of pain and trouble rather than as a recognized and available ally.

A clinician began treatment of Mary, a ten-year-old girl², who was suffering from a school phobia and self-destructive behaviors resulting in accidents and broken bones. Over a period of a few months, the child made a very positive connection with the therapist and increasingly sought to communicate her bothersome thoughts. Most of her symptoms abated within two months, and the child began to thrive. Then, inexplicably, although Mary's symptoms remained quiescent in her school and social worlds, her way of relating to the therapist changed dramatically. She became as silent as she had been talkative, brought magazines from the waiting room into the treatment hour and spent the entire session reading

²All names and identifying information have been changed to protect clients' identities.

them or spent the session doing her homework with her back to the therapist.

The therapist considered this a temporary regression, but when a week of this behavior turned into a month and then two months, the therapist became worried. She interpreted to the girl that maybe there were feelings she was afraid to share but that she could feel free to disclose

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anything in her sessions. The girl looked blankly at her. The therapist made other interpretations based on the conviction that the girl was repressing some meaningful association that she could midwife out of her. The therapist asked Mary questions in an attempt to get her talking but was rewarded with monosyllables.

As more time passed, the therapist began to doubt herself. Maybe she had made an inaccurate diagnosis. She carefully reviewed the sessions immediately preceding the girl's withdrawal, but these sessions seemed remarkably similar to the sessions that had come before. In spite of herself, the therapist began to feel irritated with the client, who seemed to be willfully resisting her best efforts. This irritation made her feel guilty and angry with herself. Soon she found herself dreading the interviews with Mary, which made her feel even worse. Finally, she stopped believing that Mary was in a regression and concluded that she had misjudged Mary's potential and that Mary had gotten everything from treatment she could. She conveyed this to Mary's parents, but Mary's resultant termination left her feeling guilty and doubting her abilities.

In contrast, a therapist using the clinical theory of intrapsychic humanism would understand Mary's withdrawal as Mary's aversive reaction to the pleasures of having her emotional needs met by her therapist, of relief at having her symptoms abate, and of her newfound freedom to pursue rewarding activities and relationships. Mary's behavior would not make the intrapsychic therapist uncomfortable, because not only would the aversive behavior make sense, but also the therapist would perceive it as a positive opportunity for Mary's heretofore split-off need for unhappiness to become available to the therapeutic process.

The intrapsychic therapist would respond to Mary's silence with a reflective acceptance in the form of continued, unqualified availability to all of Mary's motives (including motives aversive to therapy), made possible by the secure conviction that, appearances to the contrary, Mary's aversive reaction was evidence of an effective therapeutic process. The therapist's capacity to remain available to and positive with Mary would offer Mary the chance to realize both that the alienation she was feeling was self-caused and also that the gratification she derived from an alienated form of relating was ultimately much less pleasurable than the gratification to be derived from closer involvement in the care-getting relationship with her therapist. This realization would represent an important milestone in the process by which Mary would lose interest in her motives for self-caused unhappiness.

Because the intrapsychic therapist would view Mary's aversive reaction to pleasure as a significant opportunity to help Mary's heretofore invisible pain become available to the therapeutic relationship, the therapist's professional esteem and pleasure in helping Mary would remain undiminished no matter how long the aversive reaction to pleasure persisted.

An eleven-year-old girl who had been in intrapsychic treatment for six months and who was now functioning effectively and pleasurably in all areas of her life entered a period of withdrawal similar to Mary's that lasted an entire year. The girl signaled her emergence from this phase by saying to the therapist one day, "You know, today something happened, and I really wanted to tell you about it, but then I realized I haven't told you anything for so long I don't know how to begin." The therapist responded that the part of the client that wanted to share things with the therapist had been there all along, but it had been silenced by the part of her that felt better by not sharing her experiences and feelings. Within a month, the girl was confiding freely in the therapist, and this openness continued with minor interruptions for aversive reactions to pleasure for several years more to termination.

The previous two examples of aversive reactions to pleasure are taken from long-term treatment processes, but aversive reactions to pleasure occur in short-term treatment as well. Aversive reactions to pleasure occur on a daily basis, and the therapist who is not aware of them can end the day feeling battered or frustrated rather than effective and helpful. An instance is from the treatment of an attorney who had a chronic problem with work inhibition. In his first three sessions, he told his therapist that he was able to begin a project only after the project was due. In the fourth session, however, he mentioned that he

was struggling with an assignment when there remained ample time to complete it.

As the client entered the room for the fifth session, the therapist was still feeling pleasure at the enhanced closeness engendered by the previous session and eagerly anticipated hearing about the steps the client had taken to complete the project. The therapist was thoroughly taken aback when the client angrily attacked the therapist for starting the session two minutes late. When the therapist became defensive and said that he had synchronized his clock with the time signal that morning, the client became verbally abusive and accused him of never being willing to admit an error. When the session ended, the client and therapist were at an impasse, and the perplexed therapist felt a tremendous letdown and concluded that the previous session had not been as significant as it had seemed since the client did not seem to have profited by it.

An intrapsychic therapist would have responded to the client very differently, because she would have anticipated that the intensified pleasure of care-getting intimacy that was signified by the client's timely request for help would stimulate a powerful aversive reaction to pleasure. The client of this therapist would have the pleasant and reassuring surprise of finding that his therapist met his outrage with undiminished availability and focused attention. Rather than doubting the significance of the previous session, the intrapsychic therapist would see the client's aversive reaction to pleasure as corroborating its importance.

Distinguishing Process and Content Meanings

A second way in which the clinical theory of intrapsychic humanism can help the therapist maintain a stable regulation of her professional self-esteem is by alerting her to the distinction between process and content. One of the most important and helpful distinctions the intrapsychic therapist makes is between the content and process meanings of a client's associations during the therapy session. When a client's communications seem obscure, therapists do not have a clear idea of when or in what way to make clinical interventions, and they have great difficulty in evaluating the interventions they make (Piper, Azim, Joyce, & McCallum, 1991). Therapists who find it difficult to track a client's communications consistently tend to feel bored, confused, deficient, or shut out. Alternatively, these therapists may impose a preconceived hermeneutic template on the content of the client's com-

munication in order to evoke a sense of comprehension and of being in control. In contrast, when the process meaning of a client's communication is recognized, it becomes possible to understand all of the client's associations in a dynamic way that leads straightforwardly to meaningful therapeutic interventions.

The process meaning of an association relates solely to the conflict between the client's motives for genuine care-getting intimacy with the therapist and the client's motives to avoid this intimacy and to pursue learned needs for unhappiness. The content meaning of the client's communication encompasses all other significance of that communication besides the process meaning. The distinction between content and process meanings does not

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reflect distinctions between manifest and latent, conscious and structurally unconscious, genetic and contemporary, or transference and nontransference meanings. Rather, the distinction between content and process meanings rests on the significance any association has in relation to the therapeutic goal that the client increasingly acquire the capacity and desire for stable involvement in the mutuality of the caregiving relationship, which signifies an increasingly stable motive for constructive pleasure. This distinction is dynamic in that it is person and situation dependent.

The following is an example of a session in which the clinician first identified and then missed the process meaning of the client's communication. Sarah, an eight-year-old girl, returned to her treatment from a vacation interruption. She entered the session talking about her trip and complaining about how bad the food was. The therapist recognized the process meaning of this association and commented that Sarah had also missed the better "feeling food" that she had in her sessions. The girl nodded. Sarah

then recounted with pleasure that, although she had missed some gymnastic practices while she was away, her mother had arranged for her to make them up by scheduling extra sessions.

The therapist mistook Sarah's association to her positive experience with her mother for the process meaning of Sarah's increasing motive for care-getting pleasure with the therapist. Therefore the therapist commented positively about Sarah's ability to share her feelings of loss with her mother and noted that Sarah must have felt pleased when her mother responded so readily. Actually, however, Sarah was having an aversive reaction to the care-getting pleasure that had just occurred with the therapist. Sarah was unknowingly expressing anger at her therapist for the missed times during the vacation and was couching this anger in the form of an invidious comparison between her mother and the therapist. As a result of the therapist's failure to hear the process meaning of Sarah's communication, the girl's next association continued to be focused on a concrete (remedial) gratification available outside of the treatment. She recounted that she was going to a birthday party and focused on the party favors she would get.

Because the therapist did not understand the process meaning, Sarah's communication had taken on an opaque cast, whereas an understanding of the process meaning would make the girl's associations transparent. If the therapist had seen the process meaning, he would have focused on the loss represented by the vacation interruption and could have said something like, "I can hear you telling me that you are glad we are back together, but that there is a part of you that still feels badly that I can't arrange for us to make up our sessions like your mom did with your gymnastic lessons. Maybe that part of you even feels a little angry about that."

Distinguishing Personal and Caregiving Motives

A third way in which intrapsychic humanism can help clinicians to develop therapeutic skills that will give them a stable sense of confidence and security relates to the distinction we make between the clinician's personal and caregiving motives. As was already discussed, the therapeutic action in intrapsychic treatment is a function of the therapist's capacity to offer the client the stable pleasure of caregiving intimacy, which in time evokes the client's dawning recognition of the superior quality of the pleasure provided by the therapist's caregiving. The suc-

cess of this process depends on the therapist's ability to have stable access to her caregiving motives in the context of having personal motives, which, in turn, makes it possible for the therapist to take pleasure in relinquishing her personal motives or needs in the service of caregiving ideals.

The clinician will not experience the undiluted caregiving pleasure available to a parent because infants are born with unconflicted desires for care-getting pleasure, whereas every client has developed a type of psychic pain that causes her to be conflicted about relationship pleasure. On the other hand, the clinician who understands both the distinction between personal and caregiving motives and also the way in which the client's acquired needs for unhappiness cause the client to be conflicted about care-getting pleasure will experience the satisfaction of recognizing and responding to the client's learned motives for relationship unpleasure and, thereby, bringing about the incremental reawakening of the client's dormant motives for unconflicted care-getting pleasure.

When the therapist does not keep her personal and caregiving motives functionally separate, the treatment and her professional esteem suffer. Examples of personal motives are the wish to talk about oneself, irritation or boredom in relation to a client, the wish to be well thought of by the client, the desire for the client to discuss topics that interest the therapist, and the urge to become unreflectively involved in the client's life through advice, admonishments, etc. When therapists respond to clients from personal rather than from caregiving motives, they are repeating the unstable caregiving that caused the client's psychic pain in the first place.

One of the most well-known and consequential examples of a therapist's behavior being regulated by personal rather than caregiving motives is Freud's decision to have patients lie on the analytic couch facing away from him. Freud explained that he wanted both to establish distance from his patients ("I cannot put up with being stared at by other people for eight hours a day" [Freud, vol. 12, p. 134]) and also to feel free to give himself over to his unconscious thoughts without being concerned that he would influence the patient by virtue of his own facial expressions. Freud's rationale manifests the hegemony of his personal motives (e.g., not to be stared at, not to have to control his facial expressions) over his therapeutic caregiving motives. This nontherapeutic hierarchy of personal over caregiving motives became codified in psychoanalytic theory in such precepts as "the therapeutic regression of the couch."

The iatrogenic effects of the incorporation of caregiving conflicts into psychoanalytic clinical theory remain

disguised because, not understanding the true cause of the client's behavior, the therapist explains the behavior solely in terms of the client's assumed dynamics. For example, when one client began falling asleep on the couch, his analyst attributed this behavior to preoedipal and oedipal conflicts that were being expressed in the transference neurosis (Inderbitzen, 1988). It never occurred to the analyst that the sensory deprivation caused by the imposition of his personal motives that the client lie down and face away from him might be a contributing cause of the client's motive to sleep.

It is currently fashionable in the clinical literature to publish case reports that assert that the negative countertransference feelings aroused in the therapist's conscious mind reflect an unconscious segment of the client's mind that needs to be confronted because it rejects treatment. However, the unpleasurable feelings experienced by the therapist and labeled negative countertransference actually represent the vicissitudes of the therapist's personal (nontherapeutic) motives (e.g., impatience), which are being mistaken for the therapist's separate, internal world of caregiving (therapeutic) motives. This unsound understanding of the therapeutic process is not only antitherapeutic, but it is also counterproductive to the therapist's motive to find a stable, positive pleasure in the exercise of her professional skills.

The therapist's negative countertransference feelings signify that the therapist experiences personal feelings of loss when the client fails to satisfy personal motives the therapist was unknowingly seeking to gratify in the therapeutic process. In one infrequently discussed but not infrequently occurring type of process, a client was mortified to discover that his therapist had fallen asleep. Feeling terribly distressed, he started quietly to leave the room, but just as he put his hand on the doorknob, the therapist awoke and bid him come back. When the client confessed that he was hurt that the therapist had fallen asleep, the therapist responded that it was the client who was responsible. The therapist attributed his drowsiness to the client's resistance, which he said took the form of the client droning on and on. The therapist added that there was much therapeutic value to be had if the client could become conscious of the degree of his unconscious resistance through recognizing the soporific effect it had had on the therapist. The client accepted this explanation and felt ashamed that his resistance had driven his therapist to sleep.

From the perspective of intrapsychic humanism, the therapist's interpretation would never be considered good practice. The therapist's ascription of the responsibility for being kept interested (and awake) to the client

signifies that the therapist was using the client to gratify personal motives. Losses arising from the frustration of personal motives are irrelevant to the caregiving process and would never be the subject of interpretation in intrapsychic treatment. If this therapist's caregiving motives had been operative, the therapist would have realized that her drowsiness and boredom were reactions to the frustration of personal motives and that by dwelling on personal motive frustration, she was missing out on the su-

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perior pleasure of gratifying her caregiving motives. There is no martyrdom or self-sacrificial experience of grim virtue here, only the pursuit of greater professional enjoyment.

A therapeutic process regulated by the therapist's need to gratify personal motives (e.g., to be a good therapist, to be liked, to be entertained, etc.) can only progress on the basis of persuasion and client compliance, because a positive working relationship will be maintained only if the client meets the therapist's unconscious demand for personal motive gratification. The client may initially react with the unconscious pleasure of being cared about by a wished-for parent figure, and this positive feeling can persist for varying lengths of time. Sooner or later, however, the client will either withdraw and cease to improve (which is usually termed "resistance") or will become actively angry, with the result that the treatment will take on a perplexing and frustrating cast that the therapist cannot dispel. In contrast, the litmus test of a genuine therapeutic caregiving motive is whether its gratification depends in any way on the client's behavior. Specifically, genuine therapeutic caregiving motives have only one source of gratification — the therapist's own caregiving ideals to use her therapeutic availability to enable the client to have a self-experience regulated by reflective, self-caretaking motives rather than by dissociated psychic pain. One test of whether the therapist's personal motives have inadvertently taken control is whether the client's behavior causes the therapist to have experiences, such as boredom, impatience, and irritation, which signify the

frustration of personal motives.

Whereas in other treatments, the cause of the therapist's negative feelings about the therapeutic process are frequently ascribed to the client, in intrapsychic humanism, by definition, they bear no relation to the client, but rather signify to the therapist that her internal worlds of personal and caregiving motives are out of joint and need to be set right. Put differently, because in other modalities therapist dysphoria is seen as caused by the client, it is believed to be a function of the therapist's caseload and, therefore, to be at least intermittently inevitable. In intrapsychic humanism, the causes of therapist dysphoria are perceived as endogenous to the therapist and, therefore, therapist dysphoria is conceptualized as a gratuitous loss the therapist can prevent or cure. When the therapeutic process is regulated by the therapist's caregiving motives, the internal world of the professional self of the psychotherapist will consist of a loss-free professional esteem and fulfillment. Correspondingly, the therapist will never be subject to feelings of discouragement or self-doubt, even when the client is in a protracted period of negative feelings about herself, the therapist, and the treatment.

Conclusion

One of the most exciting contributions intrapsychic humanism can make to the therapist's daily experience and internal world is to offer a dynamic, situation-specific and person-specific, comprehensive yet extremely detailed understanding of the therapeutic process. Probably the most common frustration experienced by clinicians is the inability to fully understand the meaning of the client's communications. But without the constructs of personal and caregiving motives, process and content meanings, and aversive reactions to pleasure, the client's experience can never be understood fully. Once the clinician has a satisfying explanation for the client's behavior, she will not only be protected from compassion fatigue but also experience the stable caregiving pleasure that makes it a privilege to be a psychotherapist.

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