What Is Therapeutic in Clinical Relationships?

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"We can do a lot of things these days, but it is another matter whether we actually help the patient."

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Introduction

"The most important part of the music," said composer-conductor Gustav Mahler, "is not in the notes." And Arturo Toscanini admonished the members of his beloved NBC Symphony to "play with your hearts, not your instruments." Just as one cannot make music without notes or instruments, one cannot do therapy without guidance by knowledge, theory, and skills. And, just as musicality transcends notes and instruments alone, so is therapy something more than a repertory of clinical concepts and procedures. Here I shall take the importance of reading and playing the notes for granted and turn my entire attention to that music which so often fails to be musical even when all the notes are played accurately. My subject is that nebulous realm of clinical interaction and outcome that currently goes by the scientifically doleful name of "nonspecific," the *sine qua non* of therapeutic effect.

Doctor as Therapist

From some 13 years work with psychiatry and family medicine residents, I have frequently been the object of anxious and angry outcries: "Too much analysis is just paralysis... don't just help me to understand the case... tell me what to do, so that I can get in there, intervene, make things better quickly, and finish... all you leave me is impotence ...this sort of analysis just makes things worse... I would rather not know so much... you end up not being able to do anything."

Many residents have protested to me and to other behavioral science colleagues over the years that they went to medical school and into residency training to become doctors to cure disease, not to become therapists or counselors. The very terms "therapist" and "counselor" often feel inimical to the self-perception and identity of a physician — not only in what he does in the role, but what sort of person he is in that role. For many, the appurtenances of the medical profession are used as a form of protection against being too disturbed or touched by the patient (or rather, by what the patient represents in oneself and one's past). In essence, doctoring for many is a role-implemented defense against the dangers of being in a therapeutic relationship.

One young family physician, having successfully gotten his patient into and through surgery, said as much from sheer relief as from pride: "Finally I found a real disease I could do something about.... The more you get into areas you can't do anything about, the more frustrated you get." Values of mastery, doing, curing, winning, simplifying, and conquering are all part of the physician role which students and residents have in mind.[1] Conversely, they regard values associated with the therapist and counselor roles as more interpersonal and reflective; as more involved with being and becoming than sheer, aggressive doing; as emphasizing listening, empathy, comforting, and communication rather than action; and as involving a more intimate knowledge of and association with the patient and the family than the instrumental role of the physician requires. Therefore, they find these values only of limited use, overemphasized, uncomfortable, and occasionally repugnant. They do not want to stand back, look, feel, analyze, and wait.

Although in our culture physicians seem to draw a distinction between the practice of "real medicine" and that of "therapy" or "counseling," the deeper contrast should be between what is therapeutic and what is antitherapeutic in any form of communication. The question is: "Is the relationship itself therapeutic or antitherapeutic?" Thus the presence of therapy lies not in the name or the clinician's role and qualifications, but in the character of the relationship itself — whether we stretch ourselves toward another, or withdraw from others and hide behind theory, procedure, or technique. To be clinically therapeutic with a patient, for instance, one must find the patient interesting in his or her own right, not merely the container of an interesting disease or an intrusion to be gotten rid of as soon as possible. Measures to reduce the amount of time and personal involvement with a patient have taken root throughout modern medicine. Yet it is personal commitment that is the bedrock of all that is ultimately therapeutic — "For thou art with me," says the Psalmist in his darkest moment.

One is either therapeutic or antitherapeutic in any kind of relationship or situation, and learning to hone the distinction takes at least a lifetime. We either heal or we injure, nurture integration or sow the seeds of fragmentation, foster maturity or regression, treat the other truly as another (as a subject) or treat the other as some extension of ourselves (as an object and receptacle). We can allow ourselves a growing sense of intimacy with our own inner recesses and thereby increase the ease of our intimacy with patients, family, colleagues, residents, and students; or we can use the teaching

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and practice of medicine as a defense against ourselves and others.

Self and Subject

Since what we do is inseparable from who we are and what we mean, either unconsciously or consciously, it behooves us when considering the clinical relationship to incorporate an interest in the physician's own identity and meanings. Whether our intervention will be therapeutic or antitherapeutic depends upon what we do with our anxiety. To be therapeutic, we must have access to data about ourselves that will permit us to have access to similar data in patients, residents, staff members, and students. This does not supplant biomedical knowledge and skills, rather it supplements it with a different level and type of knowledge. Without the latter, one may inadvertently misuse official knowledge and skills in what Langs[2] calls a "therapeutic misalliance."

We Americans have an on-going love affair with efficiency, brevity, streamlining, and paring things down to size. These attitudes and sometime virtues have taken us far. In medicine such attitudes may unwittingly lead us to diminish and dishonor patients, families, doctors, and staff alike. Medicine risks becoming something of an unfeeling assembly line, the primary goal of which is to "move 'em up and move 'em out." In our brave new world of DRGs and PSROs, I suppose that the resulting clinical shortcut could be "evaluated" to be effective. But it should not be confused with anything therapeutic, since the care of the patient no longer occupies the highest priority. Therapy, on the other hand, takes time, money, and commitment. Disingenuously, shortcuts rationalized according to the logic of briefer and briefer therapies only short-circuit therapy by disavowing maturity as a worthy goal and compassion as a worthy attitude.

I have heard countless physicians say, both in fact and in essence: "I should be able to change the patient; I have an obligation to change the patient; the patient should be willing to change, otherwise why does the patient come to the doctor; and if I can't change the patient, I'm a failure." We are preparing our young doctors for an unrealistic attitude toward themselves and their patients, and the failure of realism is antitherapeutic. To expect and train a physician to be infallible, totally responsible, omniscient, omnipotent, omnibenevolent, absolutely certain, and always decisive is dangerous to the health of doctor, patient, and society alike—even if society demands perfection from its physicians. To be in a therapeutic position, the physician can empathetically acknowledge the wishes and expressed needs of his or her patient, but must at times frustrate and fail to satisfy many of them in the service of the greater maturity of all participants.[3] The effort to be "patient pleasers" on the one hand, and to exact "compliance" from patients on the other hand, are twin countertherapeutic seductions of modern medicine.

In his essay on "Dialogue," Martin Buber[4] wrote:

"Genuine responsibility exists only where there is real responding.

"Responding to what?

"To what happens to one, to what is to be seen and heard and felt.

"Each concrete hour allotted to the person, with its content drawn from the world and from destiny, is speech for the man who is attentive."[4]

In *I and Thou* Buber also noted that "Magic desires to obtain its effects without entering into relation, and practises its tricks in the void."[5] The relationship between doctor and patient always stands at risk of subversion by the patient's wish to receive, and the physician's desire to produce, a magical prescription that dissolves relation into substance or technique alone. Now, what separates scientific prescription from magical prescription is not the pharmacological content but the implied intention of the act. When antibiotic or advice is administered or presented as a "magic bullet," doctor or patient or both have forsaken the realm of science for magic, the presence of I and Thou for the manipulations of one It to another. The "patient compliance" or "patient satisfaction" thus achieved are fleeting bursts of infantile omniscience, omnipotence, (received or bestowed) omnibenevolence, and infallibility. Such magic "exists" only in the earliest mental world where gesture commands the world that is its extension. In this world there are only deeds, not people. The physician can understand this regressive pull both in himself or herself and in the patient—but to indulge it is to forsake people for things. Medicine which heals—not which tricks—is always contained within the clinical relationship.[6] The relationship itself is the act of healing; the healer, who has learned to forego magic, helps the patient to become healed or reconciled to life's irreversibility and loss's irrevocability by first declining to comply with the patient's request for magic. The physician's prescription and presence need not be antithetical, so long as they serve reality while fully acknowledging Wish. The more physicians can trust their disclosure of presence, the less they will feel called upon, by themselves or by patients, to outwit patients rather than address them. Clinicians must be constantly prepared for unexpected symbolic turns of meanings; for patients or families will be able to endure, feel, and understand their own anxiety and defenses only to the extent that they believe the clinician feels safe enough with this unsettling material. The physician must thus be willing to accompany and let go of the patient, as much as to lead and direct the patient when the occasion calls for it.

Technique and Defense

In medicine our watchwords include being "in control" if not being "in charge." Yet a decade and a half in graduate medical education—much of which has been spent "on the front lines" with psychiatry and family medicine residents, their patients, families, and staffs—has taught me also the courage of chaos, of ambiguity, of uncertainty, of waiting. Each time I listen to a resident or see a patient (or family) and resident together, I bring

with me everything I believe I know, and attempt to listen afresh as if I know nothing. For the truth of the matter is that we never know beforehand what it is that we need to know or look for or hear, let alone do. If a resident is to have the courage of chaos for the sake of the patient and trust that order will ultimately emerge, then I too as educator must learn this same dauntlessness for the sake of the resident (and secondarily the patient or family). It is as if medicine is created anew with each patient encounter and physician consultation. It is not enough, I have come to teach, to merely "practice" medicine if by practice we mean the application of what we know as "the state of the art." Technique must be responsive to our capacity to learn something new from reality, which includes the patient, our best teacher. Simplified diagnoses and automatically applied techniques are our signs and symptoms of defense against what we fear to know about ourselves in the guise of the patient.

I have no quarrel with technique per se (from surgery to medication to confrontation to paradox). Yet even here technique is inseparable from the conscious and unconscious uses for which it is invented in the first place and later applied. At issue in clinical and research matters alike is "the unconscious use of sound methodological devices primarily as defense mechanisms and only incidentally as (sublimatory) scientific techniques."[7] The authentic healer is not the one with the answers before the questions are posed, but the one who can bear the anxiety of pursuing questions rather than rushing to answers. This healer is not the Aristotelean unmoved mover, but the most moved mover. One who can heal is one who can first allow oneself to be moved, touched — nay, wounded — by the patient. In fact, as in etymology, to be a patient is to suffer. To heal is first to acknowledge that suffering.

The Wounded Healer

In the Blanchard Lecture, Stephens argued that:

> "Pellegrino[8] has written that the fundamental characteristic of clinical medicine is wounded humanity seeking cure at the hands of a physician. This is not the same as a consumer purchasing a commodity. The therapeutic relationship has never been equal. Woundedness makes the difference. The contract is not enough, there must be a covenant that goes beyond what anyone has a right to demand and that cannot be compensated with money."[9]

Now, the allegory of "wounded humanity" has as its parallel the image of the archetypal physician Asklepios as the "wounded healer," that is one who is capable of being profoundly moved by the patient's suffering and is thereby able to address its depth.[10]

During the past decade the consumerist, or patients' rights movement, on the one hand, and the industrialization, or corporatization of the medical profession, on the other, can in part be understood to be a retreat on the part of patients, practitioners, and public alike from the vulnerabilities of "wounded humanity." They approach medical care as though it were a commodity to be traded for, the human body a machine, the human mind a computer, and the clinical relationship an impersonal exchange of computerized information. Dissatisfaction with an emotionally if not functionally hierarchical relationship has led not only to an emphasis on individualism and a demand for a more equal "partnership" in the clinical relationship, but to an adversarial competition for "one-upsmanship" in the guise of equality.

The exercise of authoritarianism in the guise of individualism,[11] and the resort to what Bateson called "symmetrical"[12] escalations in one's approach to problem solving, are hardly limited to medicine and its constituency, but in fact are American cultural patterns. The history of management and labor, and of various ethnic groups vying for "equality,"[13] reads much like the recent history of medicine in the U.S.A., each component feeling a sense of entitlement for various grievances, each wishing for vengeance for having been wronged, and each going on the defensive and offensive to protect what it sees as its endangered interests. There can be no common ground when both sides of the ideological tracks come to see each other as personifying evil. Each protects rather than exposes his/her wounded humanity.

Life is deep and therefore so must be medicine. Work in family medicine and psychiatry departments has brought me daily face to face with my own subjectivity, and how everything I do and say bears the footprint of my biography. Rather than recoil from that fact I try to gain increasing access to it and to use it. I attempt to reach outward toward a resident or patient by being able to reach inward without fearing loss of reality or of my self. I have had to learn to trust that which my childhood, family, and education had trained me to forget. I have learned that the more I permit myself to reclaim of my past, the more I can permit a patient or student to "have" of their past. We talk sloppily and glibly about maintaining a therapeutic position, of meting out acceptance and reassurance, reframing and paradox, as if posture were equivalent to statute, as if a false mask could ever pass for a true face. But only one who can truly take a stand can help another stand as well. The ability to meet a patient face to face rests upon the ability to face oneself in the mirror of one's memory, and as the patient mirrors oneself as well. One can truly recognize a patient only if one is willing to recognize oneself in the patient — to use projective identification in an empathic, rather than rejecting, way.

The physician's power does not reside in the command of technique alone, but in the ability to comprehend the depths of the patient's life, which enables the physician to understand in turn the significance of the illness to the patient. Any formulation of "comprehensive care" which omits the dimension of comprehending the patient omits the whole of the patient's life and reduces it to fragments — even if the heap of fragments is deceptively immense. It is not only that we have so much to do to patients, but that we have so much to learn from them that, in turn, alters the face of assessment,

diagnosis, treatment, and outcome. I can only claim this from having learned to bear witness to it in myself. I learned to teach by learning to listen to residents rather than rushing to be their provider with answers or formulas. Paradoxically, answers can be part of the problem and often prevent us from peering more deeply and broadly into the abyss. Increasingly, I have come to teach residents —and through them, perhaps, patients—what the residents have unwittingly just taught me. The inventor of the stethoscope, Lannec, is reputed to have admonished his students: "Listen to your patient, he is telling you what is wrong with him." Patients may grievously err in their interpretation of their symptoms, but if we follow their symbolic pathways as diligently as we do neurological ones, they cannot but lead us to where we both may have feared to go.

A therapeutic environment, then, is not one which stereotypically relies upon "doing," in our cultural sense of aggressive intervention, but rather is one which is also capable of integrating within the clinical repertory the ability to accompany and follow the patient's lead into the patient's own life situation and meanings. One resident wisely said that "one of the hardest things to know is when to do nothing." Of course here, "doing" gains its meaning from a larger frame of reference. In avoiding the trap imposed by oneself, one's family of origin, one's medical education, and one's patients to "do something" simply because one is the doctor, one can instead withstand and absorb the patient's anxiety rather than act in order to rid oneself of it. Attentive to the patient's needs, the doctor provides a safe, protective "holding environment"[14] in which the patient feels understood. Whatever else one may elect to do clinically, the "listening process"[2] and its attendant "regression in the service of the other"[15] remain the foundation of the entire clinical edifice.

Cultural Issues

In this final section I address the thorny issue of the relationship between culture and healing. I take the nonrelativistic position that all that goes by the name healing in whatever social group is not necessarily therapeutic for the patient, clinician, or the group itself.

In a courageous paper, "Approaching Cross-Cultural Psychotherapy," Boyer[16] discusses the "discrepancy between the patient's and the therapists's therapeutic goals," based upon his 35 years of practice as a psychoanalyst in the San Francisco area and 25 years of research among the Apaches. Communication style and culturally patterned expectations often differ between patient and therapist. Boyer identifies elements in Apache shamanistic philosophy which are widely shared in faith healing beliefs and practices of all groups: the interlacing of religion, medical practices, mythology, and folklore; the capacity of the shaman to use his supernatural power for good (healing) or for bad (witchcraft to bring harm to others); the use of laying on of hands, administration of herbs, prestidigitation, etc., which "serve essentially to enhance the patient's belief in the curer's omnipotence. In many cultures hallucinogens and consciousness altering drugs are used for that purpose and to reduce the patient's capacity to think logically."

From a cross-cultural point of view, La Barre[17] writes that a shaman's treatment of disease caused by "possession" by an alien spirit is exorcism. "The Navajo night chanter uses a ground painting in which to cast the disease spirit, and afterward the painting is destroyed." Once the painting is erased, the malevolent cause of disease is magically dispelled and dispersed. While the conscious representation of the repressed is temporarily effaced, the unconscious conflict remains, requiring subsequent visits to the putative curer. True, such curing rites reintegrate the individual into society; but since the devils that have been cast out remain latently and valently within (where they have always been a split-off part of the self), they are prepotent causes of further stress, necessitating subsequent treatment and the permanence of the curing role. Likewise, despite the financially costly and often physically painful process of reassurance, the patient who began by the conversion of anxiety into imagined or real somatic pain retains the source of anxiety that has gone unattended by a ritual aimed at avoiding the shared unconscious source of the conflict. Ritual cure can therefore never resolve conflict since it is dependent on the persistence of the conflict it aims to remove.

A number of psychoanalytic researchers have noted how therapies tend to be culturally fixed in the vicious circle of pathology and symptom remission. On the basis of Opler's[18] work among the Apache, Devereux[19] comments that "Apache shamans can cure 'tics' (which are notoriously resistant to psychotherapy) by substituting a taboo for the tic. ...What seems to happen in such 'cures' is simply a changeover from idiosyncratic conflicts and defenses to culturally conventional conflicts and ritualized symptoms, without any real curative insight."

Boyer compares and contrasts faith healing and insight-oriented psychotherapy. He argues that in faith healing, diagnosis is irrelevant and reliance upon supernatural force essential, while in western psychiatry diagnosis is essential. The insight-oriented therapist relies on evidence that emerges from the data and from the therapeutic alliance rather than from belief that in turn is used to confirm preexisting belief. "He sees the patient's wish to view him as omnipotent as part of transference phenomena and his aim is to free the patient both of transference distortions and of his relationship with the therapist. He knows that abrupt symptom removal frequently disguises underlying psychopathology. He views suggestion therapy to be not infrequently a manifestation of countertransference problems."[16]

Boyer urges that the therapist be interested in and cognizant of "the style, content and implications of (the patient's) verbal and nonverbal communica-

tions," and be especially attentive to culturally based discrepancies between the therapist's and client's expectations, for often the "patient hopes for cure through faith healing."[16] Successful therapy "requires mutual understanding of verbal and nonverbal messages by the therapist and the patient."

The significance of Boyer's paper for family practitioners and other physicians lies in the continuity of certain aspects of "faith healing" within the biomedical tradition, not merely historically preceding or outside it. One can think of many powerful vestiges of the magical in modern scientific guise: the "routine" B-12 and penicillin shots given to patients upon demand; the aura of the sacred which patients and physicians alike confer upon the high technology of medicine; the expectation of instant cure by the "magic bullet" which must be ritually prescribed at the conclusion of the office visit; the medical equation of symptom removal with cure; frequent reliance upon suggestion, optimism, and reassurance to mobilize a patient's hope and generate patient compliance and satisfaction; the significance to patient, family, and medical staff alike of medical symbolism that heightens clinical authority.

Boyer's paper serves as a timely reminder of how in all medicine the wish to heal and the wish to be healed interact. While physicians in the biomedical tradition are not merely contemporary shamans, the many parallels in expectation and function are too great to discount. Boyer's brief but synoptic article contributes to our understanding of the psychodynamics of any clinical relationship, and therefore to the current debate over what is precisely therapeutic.

My only cavil with Boyer is with his view of diagnosis, for intrinsic to all healing endeavors is the identification or labeling and explanation of the malady.[20] Action always follows naming. In faith healing, diagnosis is never entirely absent and irrelevant; rather, diagnosis is not allowed to penetrate the symbolic veneer to the core of the pain. Diagnosis colludes with patient, family, and community not to penetrate it but only to manipulate and resymbolize it in ways that reaffirm everyone's defenses.

In critically evaluating any clinical decision-making process—the biomedical included—one must inquire into what types of data serve as evidence and what types are excluded and why. In faith healing, the symbolic reality and authority of the healer must be upheld. In psychodynamically-oriented healing, which ideally also includes the physician, the symbolic reality of both healer and client are constantly explored for their latent meanings. With benevolent skepticism, the insightful physician asks himself/herself what the faith healer cannot tolerate asking: What is diagnosis for? Whom does the diagnosis (and treatment) serve? Diagnostic belief on the part of patient, family, and clinician alike can easily be a rationalized form of resistance to self-knowledge, which obscures the pathological process occurring in the patient in the guise of illuminating it. What Boyer so lucidly describes as a contrast between two types of healers, characterizes, I believe, an inner polarity within modern scientific medicine itself.

On the basis of the ethnographic record, it has become a truism in anthropology that the medical component or system of a culture is enmeshed in the ethos of that culture, which pervades all institutions. For instance, writing of "Morita therapy" in Japan, Kiefer observes that:

> "Morita Therapy is...a kind of cultural institution, subject to the same influences that shape other institutions, in this society...Even the types of neurotic disorder for which the technique is most often used...are the sort which one would expect to flourish in the Japanese social atmosphere. In short, the study of a treatment modality tells us a surprising amount about the society in which it is practiced."[21]

The structure of relationships in healing settings parallels the preferred structure of relationships in other social institutions as well, e.g., family, religious, political. Thus, Draguns[22] argues that cultures with authoritarian political systems tend not to have much individual psychotherapy as preferred modes of treatment. And Wintrob[23] argues that societies with strong authority structure tend to use magic to explain and treat mental disorders. What can be said to characterize supposedly whole cultures can also be said for different historical eras in the same culture. Currently in the U.S., the nostalgia for the past, the quest for religious and political absolutes, the search for family stability and social order, the frightened call for "back to basics," percolate into the clinical relationship as well. Culture crisis creates the demand for authority to wrest order from chaos; the danger is that clinicians and politicians alike "comply"—for reasons of their own—with new rigidities borne more of anxiety than of comprehension.

Our conventional understandings of therapy, healing, cure, and the like, as much from within anthropology as within orthodox biomedicine, hold that disease or pathology is a departure of deviation from the social norm and that the goal of treatment is to restore the individual (insofar as it is possible) to the condition prior to falling ill (premorbid) and return him/her to society. Here, both the sanctity of the social norm and its supposed existence above the process which led to pathology in the first place are accepted uncritically. Yet, both theoretically and clinically, this position is incorrect, for the norm, deviation from it, and treatment alike are all part of the same social system.[24] Culturally, the goal of treatment is to change symptoms which its members as a whole dislike and which make them anxious, and to replace them with symptoms which its members like and which make them feel reassured. Cultural treatment is thus often symptom substitution.

Genuine therapy, on the other hand, is meta-cultural. That is, it is a form of inner liberation, not social conformism, for its aim is to help those who suffer to know their suffering, not simply to help

them to find relief ("feel-good" remission) from it. Genuine therapy identifies and ultimately gives the patient the courage to challenge the frightened, unthinking consensus that has often contributed to and culminated in the pathology. I define bona fide therapy as breaking the vicious cycle of pathology that includes one's defenses and symptoms. Therapy includes a deeper understanding of the conditions that produced these symptoms and how one unwittingly conspired with those circumstances. Therapy in this usage of the term is synonymous with inner liberation.

Our cultural definitions of therapy, however, have led us to embrace greater and greater specialization and the creation of a widening cornucopia of "units" of care. The proposed role of "the family" in family medicine is only the latest in this unfolding. Yet even this purported solution may share in the problem of the fragmentation of medicine and life. For the proper antidote to specialization is not more specialization, but contextualization. What Sander writes of Jay Haley's strategic family therapy could well apply to much of the biomedical clinician's worldview, which the family therapy movement ideologically repudiates. He points out that many family therapy techniques "sound like attempts to outsmart the patient and terminate the contract as quickly as possible. This approach leaves unanswered the question of how long-lasting the changes brought about will be and what the basis of these changes are.... The family systems paradigm assumes that significant portions of human behavior and experiences are (to degrees never fully realized) overdetermined by the social field and has demonstrated that as a modality it too can achieve symptomatic improvement. But to embrace behavioral change as a raison d'etre of family therapy will doom its further development."[25] The place where we must begin to break the vicious cycle of repetition lies not in patient care but in ourselves — practitioners, teachers, and administrators of medicine.

Patients are always trying to tell us something through their symptoms, diseases, and resistances. They are trying to tell us their inner story even when they disguise it and present us only the symptoms they feel safe enough to disclose. They are trying to tell us something even in the act of trying not to say something. Nurnberg and Shapiro,[26] for instance, offer the concept of a "central organizing fantasy" as an assessment tool that can help orient the clinician to the clinical situation. Not only can we understand how people become ill from the way they form their fantasies, but "if the meaning an individual gives to his life and experiences has bearing on what makes him sick in the first place, it would seem that an effort to understand the dominant fantasy can offer an important insight into patients."

The Clinical Equation

We highly pragmatic, empiricistic Americans are so entirely attuned to happenings in the external world that in attempting to explain illness etiology we concentrate almost exclusively on precipitants, if not causes, in the form of events rather than meanings. One thinks immediately of the Holmes and Rahe[27] "Social Readjustment Rating Scale," for instance. However, "An event becomes a trauma and results in symptoms because of the unique meaning of the event to the affected indivdual."[26] It is as important to unravel the complex inner meaning of "what happened" as it is to uncover the often repressed and veiled experience of precisely what did happen.

So, in conducting a history, physical exam, and laboratory workup, physicians often are so eager to piece together their own story about what is wrong with the patient (which is important to do) that they unwittingly neglect to elicit the patient's own story — one which usually can be pieced together only over many episodes with individuals and combinations of family members. Developmentally, an organizing fantasy "refers to what the patient might say if he had full access to what is ordinarily unconscious about the way he tends to see himself and his world, how this view developed out of his experience, and how it influences his behavior and his fears."[26] If medicine is truly to be "meaning-centered,"[28] the physician must become better aware of those meanings which he/she brings to the clinical encounter, those meanings brought by the patient, how one perceives and feels about the patient, and therefore what one wishes to see and not to see in the patient. Only by gaining greater familiarity with one's own personal and professional story can one become increasingly adept at eliciting and hearing the inner story that the patient and family is trying to tell the physician through the symptoms and history.

Child psychiatrist Alice Miller[29] writes:

> "It is a fascinating experience to accompany a patient on this journey (of discovery) — so long as we do not try to enter this new land with concepts that are familiar to us, perhaps in order to avoid our own fear of what is unknown and not yet understood. The patient discovers his true self little by little through experiencing his own feelings and needs, because the analyst is able to accept and respect these even when he does not yet understand them."

I see no reason why learning to embark on this journey should not constitute part of the professional training of all physicians. If we as medical educators offer future providers only socially approved defenses, we shall succeed only in rendering virtually inaccessible not only the inner pain of the practitioner to himself or herself, but that of the patient as well. In the guise of a "therapeutic position," one will be deaf and mute to deeper stirrings that can thus only be acted out as defenses.

"The psychiatrist," writes La Barre,[30] "must know himself, through a rigorous and often painful didactic analysis, for he will not be able to see in his patients what he cannot afford to see in terms of his own defenses. He must constantly ask 'What am I doing in saying this or asking that?' — that is, he must carefully watch his own countertransference to the patient." Lamentably, such disciplined self-awareness is not only no longer an inexorable part

of psychiatric training, it is virtually absent from biomedical training. Thus, for the most part, even behavioral scientists direct all their own (and medical students' and residents') attention to the patients' and now families' behavior, and studiously avoid inner meanings of behavior in themselves, in patients and families, and in those whom they are teaching. We search for formulas about ethnic behavior and family interaction as eagerly as physicians rely on formulas about the efficacy of mastectomy and antibiotics.

Yet, for physician and behavioral scientist alike, to peer inward is an invaluable—nay, essential—tool for looking outward. One can be therapeutic, irrespective of the name of one's specialty, only as one is capable of hearing and feeling what the patient is trying to say or not say. We must be capable of being moved by the patient and aware of precisely how we are moved. Observing the outside alone can function as a profoundly powerful defense against looking within—and thereby distorting what is outside as well. The question of whether to order this test, to do that procedure, or to interpret some result in one way rather than another must always be partly answered in terms of what we do so for in terms of our unconscious meaning. The unexamined life is one which observes and interprets what to a large degree it first projected.

In his still revolutionary essay, "The Golden Rule in the Light of New Insight," Erik Erikson[31] defined mutuality to be "a relationship in which partners depend on each other for the development of their respective strengths." He then proceeds to reformulate the golden rule in the light of a psychoanalytic understanding of human development: "Truly worthwhile acts enhance a mutuality between the doer and the other—a mutuality which strengthens the doer even as it strengthens the other."[31] Erikson then specifies "a mutuality of divided function...a professional, and yet relatively intimate one: that between healer and patient." "This," he says, "permits the medical man to develop as a practitioner, and as a person, even as the patient is cured as a patient, and as a person." One is thus most capable of being therapeutic—responding to the depth of the patient—not when one writes oneself out of the clinical equation (for no sooner does one dissociate one's personal self from the clinical situation than one makes the patient likewise into an inanimate object) but when one can recognize that one is always a part of the clinical equation.

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