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The persecutory therapist

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It would be foolish to imagine that psychotherapy, when it is not beneficial, is merely ineffective. It may do harm – the 'deterioration effect' suggested by Bergin (1966, 1967). This paper draws attention to some types of therapeutic intervention which are likely to do damage.

Research in the complex field of personal relationships in therapy is hardly beyond the stage of formulating principles derived from anecdotal accounts. It is not yet possible to relate reliable measures of the many variables in the therapeutic process to valid assessments of outcome. But observations made over many years, in many situations, can be of value in clinical practice as well as leading to the formulation of testable hypotheses.

The evidence on which our suggestions are based is derived from the authors' own experience; from observations of therapy carried out by others, and from accounts given by patients. By repeated play-backs of audio and videotape recordings, events in psychotherapy have been studied repeatedly by different observers. In a general clinical article an attempt can not be made to present the data in detail. Only a few examples are given to illustrate some ways in which the therapist can cause, or intensify, a patient's sense of being attacked and persecuted.

Reports given by patients are of particular importance. Psychotherapists need to learn from their clients and it is regrettable that, despite a plethora of descriptions of the psychotherapeutic process from therapists, there are relatively few from patients. The authors have collected many such 'accounts' but, for the purpose of this paper, one published work is of unique value. The diary of Anais Nin (1966, 1969) conveys clearly what many of our patients have intimated. In sensitive prose, Nin conveys her experience of successive therapeutic encounters with René Allendy, founder of the French Psychoanalytic Society; with Otto Rank, for many years Freud's special protegee; and with Martha Jaeger, a Jungian analyst.

The main features of therapy resulting in feelings of persecution are discussed under the following headings: intrusion, derogation, invalidation of experience, opaqueness of the therapist, the untenable situation, and the persecutory spiral.

Intrusion

Anais Nin perceives her first, and least successful, therapist as being intrusive:

> He probes, asks questions, sometimes gives up an inquest into a particular theory, surrenders a theme of domination in favour of theme of courting and fearing suffering from love. . . Dr Allendy's statements sound unsubtle. I feel oppressed, as if his questions were like thrusts, as if I were a criminal in court. Analysis does not help me. It seems painful. It stirs up my fears and doubts. The pain of living is nothing compared to the pain of this investigation (1966, p. 82).

This interrogation is experienced as being like that of a prosecuting counsel demanding a speech in defence. It is unlikely to bring into the open the affects and associations underlying his patient's behaviour – emotions and ideas which are associated with guilt, 'fears and doubts'. The technique is in sharp contrast with that of the therapist whose inquiries quietly follow what the patient gives to him; who seems not to be asking questions at all, but rather framing speculations as an invitation to a mutual exploration.

Few psychotherapists of the present day would admit to behaving like Dr Allendy. Nevertheless, such 'probing' and 'questioning' does occur very frequently especially when the therapist's anxiety rises – as is strikingly revealed by detailed systematic study of audio and videotape recordings. The latter give good reason to suppose that an understanding statement is almost always more effective than a direct question in helping the patient to express in 'feeling

language', and to explore further, what he has to say. 'Why?' questions can be particularly dangerous. Either they invite intellectualization or they block the patient, who feels like an examinee or a prisoner in the dock.

Another form of intrusion, which Allendy perpetrated, is still common in therapeutic practice. Many persons are at pains to conceal a system of highly valued and affect-laden ideas which is experienced as a kind of 'core of self' (Meares, 1976). Such precious ideas, often felt as fragile 'secrets', can only be revealed with care. Some therapists are seen by their patients as forcing the confession of these hidden ideas. They can be exposed safely only if there is an explicit or implicit recognition of their value. In the absence of such a valuation and respect, a therapeutic intervention is felt as a mutilation of the confessed experience – as a destructive persecution. Thus, Nin's fourth session with Allendy opens:

> ANAIS: Today, I frankly hate you. I am against you.
> DR A: But why?
> ANAIS: I feel you have taken away from me the little confidence I did have. I feel humiliated to have confessed to you. I have rarely confessed. (1966, pp. 85–86.)

Miss Nin, a remarkable person, has learned not to be cowed by 'Why?' but she conveys how a faulty response may be experienced as inflicting serious damage – damage which, not infrequently, is felt as if it were an injury to, or even destruction of, the body.

Intrusion can occur in another way which is very different from interrogation. A highly intuitive therapist is in danger of making accurate understanding statements too early. Then, at best, the patient is afraid and avoids further exposure; at worst, he, or she, feels invaded and attacked inside by the 'magical' therapist who can control the hidden self which, now, is no longer his 'own'. He can surrender his autonomy and sense of identity in a prolonged dependence upon the 'all knowing' therapist. Such disasters can occur in response to purely non-verbal communications by a 'too-understanding' therapist.

The avoidance of intrusion calls for a balance of intimacy and distance with a continuing respect for the patient's personal, private space. It involves what one of the authors terms a rhythm of 'aloneness–togetherness'. Aloneness is distinguished from isolation, alienation or loneliness; and togetherness is differentiated from a fantasy of fusion and blissful union (Hobson, 1974).

Derogation

The persecutory therapist is often unaware of how he can derogate his patient whilst considering his interventions to be 'confrontations' or 'insight-giving'. Telling a patient that he is angry or that he wishes to dominate, may be a covert way of calling him names. Then, an angry, destructive and manipulative person feels that the therapist is confirming what he, the patient, feels that he is – bad and worthless. Self-esteem is lowered in those for whom it is characteristically low. The mistake may seem obvious but it is by no means limited to the inexperienced and untrained. By subtle means, the patient is made to feel that he is 'bad', 'ill' and 'abnormal'; and, hence, completely different from the therapist. Such patronizing intimations, implying 'It is all your problem which I do not share' induce a sense of alienation.

This is not to say that the therapist should keep his observations to himself. He needs to register, and point out, significant patterns of behaviour. But, it is very important to make 'links' of which the patient might not have been aware – to relate one particular 'piece' of behaviour not only to other such 'pieces' but also to personal perception, images, or ideas. Of especial significance are those which relate directly to those features of the present conversation, here and now, which are analogous to significant relationships in the patient's wider life situation. These links, which approximate to 'interpretation', appear to be of great value in promoting that learning in therapy which can be generalized.

Making links involves an attempt to understand and to convey, in the appropriate language, the emotional correlates of behaviour and images. Surprisingly, anxiety is often neglected despite the fact that orthodox and traditional therapies emphasize its importance in the production of neurotic symptoms. Such disparate figures as Freud (1926), Klein (1963) and Wolpe (1958) have maintained that neurotic symptomatology has the purpose, however ineffective, of reducing anxiety. It is important that the therapist remain sensitive to evasions which have their basis in anxiety, remembering that symptoms can also be conceived as reaping rewards or 'pay-offs' for aberrant behaviour.

Modelling theories represent an important advance in learning theory and in understanding the process of psychotherapy. Yet, some ways of adhering to them may be associated with the therapist's tendency to underestimate the importance of anxiety associated with persecution. An example is given by Rogers & Truax (1967), who argue that 'genuine' behaviour on the part of the therapist is likely to encourage the same kind of behaviour in the patient (see Truax & Mitchell, 1971).

> If I sense that I am feeling bored by my contacts with this client and this feeling persists, I think I owe it to him and to our relationship to share this feeling with him.

'Genuineness' is an important counter to the patronizing, non-sharing attitude referred to above, but a direct statement such as that suggested by Rogers & Truax, can be persecuting by damaging the patient's self-esteem. This is especially so when it is incomplete – in the sense that it does not make appropriate links. In the following example the therapist's boredom was related to the patient's anxiety:

A young woman of 30, whose marriage was failing, was seen for the first time. She related her difficulties in a matter-of-fact way, and her face remained impassive. The story was an ordinary one. She had loved her husband once, but for the last five years she had felt little for him, and although pleasant to each other, they had been growing apart. She had had several affairs. At this point, the therapist realized that he was bored, and wondered why this should be. She had communicated little distress. It appeared that she had responded to the anxiety of seeing a psychiatrist for the first time by controlling emotion, and becoming remote. If this were so, then it seemed possible that she responded to stress in her marriage in a similar way, and this could explain the increasing distance between the marital partners. The therapist began by telling her about his own lack of feeling for her distress, but extended the significance of this by relating it to his speculation about the whole therapeutic and marital context.

This intervention was followed by a significant change in the patient's behaviour during the rest of the session, and by a different attitude towards her husband in subsequent weeks. Later, it became evident that this woman had a very low opinion of herself and that a simple 'feed-back' response of the therapist's boredom could have been devastating. Such a response would have neglected not only the anxiety associated with her manner of relating, but also the fact that the immediate relationship was likely to reflect aspects of other important relationships. The therapist's ability to make such connections may be an important factor in patient improvement (Malan, 1973).

In our view, a central feature of psychotherapy is learning to relate to other persons in ways which, hitherto, have been blocked by anxiety. In elucidating and appropriately lowering anxiety, the patient is able to explore and try out modes of relationship with the therapist, and to generalize this learning in other significant life-situations.

Invalidation of experience

Intrusion or derogation are obvious forms of attack. Invalidation of the patient's experience is more subtle. It might occur when the therapist considers that what his client says does not mean what the latter thinks it does. There is a suggestion that the 'real' meaning lies elsewhere. This is not an unusual situation, since psychotherapy is sometimes characterized as a search for 'deeper' explanations. Yet, such a quest might be illusory, or even destructive. At its most extreme, it involves the assumption that one piece of behaviour, verbal or otherwise, *stands in place of* another piece of behaviour; that what a patient says means *nothing but* something

else – a 'something else' which is regarded as being more fundamental or causative in a particular theoretical framework. Thus, the therapist behaves as if the patient is communicating in a curious kind of code, which it is the duty of the therapist to break. Under these circumstances, the patient finds his words a cage. However, much he strives to find his freedom through them, he is imprisoned behind the iron bars of an explanatory stereotype. The patient may be merely bored or discouraged by this therapeutic response. Miss Nin describes it thus:

> With Allendy, I became aware that each thing I did fell into its expected places; I became aware of the monotony of the design, I experienced a kind of discouragement with the banality of life and character, the logical chain reaction of cliches. He discovered only the skeleton which resembled other skeletons (1966, p. 288).

She feels 'that the mould into which he tried to fit' her is 'an oversimplification' and an appeal for 'normality'. 'Rather than enter this ordinary life, which was death to my imagination', she ends her association with Allendy (1966).

The patient, however, may perceive this interpretative behaviour as worse than reductionism, particularly when interpretations are directed unremittingly to his 'unconscious'. When he protests that he is unaware of the feelings attributed to him and this plea is dismissed as a 'resistance', he may sense a growing failure and unreality – an alienation from his 'own' thoughts. That which he felt he knew is uncertain, and what seemed substantial, a mere figment. He enters a state of increasing bewilderment, despair, and helplessness associated with a sense of unreality.

A patient's statements should always be respected – whatever they may be. It is a good maxim to asume that a person always means what he says but does not always say all that he means. The psychotherapist's job is to *amplify*, to extend awareness not by implying, 'You don't mean that. You really mean this', but rather, 'You certainly mean that, but maybe you *also* mean something more.' If he treats the patient's experience as if it were part of a cryptic crossword he can be destructive in a way suggested by William James:

> Thoughts connected as we feel them to be connected are what we mean by personal selves. The worst a psychology can do is to so interpret the nature of these selves as to rob them of their worth (James, 1962).

Apparently random events do always have some precedent or associations, but a therapist can impose upon them a spurious rationality and purpose. A world structured in this way comes curiously close to psychosis, in which significance is given to coincidence and apparently chance events. Chesterton describes this world (Auden, 1971):

> The last thing that can be said of a lunatic is that his actions are causeless. If any human acts may loosely be called causeless, they are the minor acts of a healthy man – whistling as he walks; slashing the grass with a stick; kicking his heels or rubbing his hands. It is the happy man who does the useless things; the sick man is not strong enough to be idle. It is exactly such careless and causeless actions that the madman could never understand; for the madman (like the determinist) generally sees too much cause in everything. The madman would read a conspiratorial significance into these empty activities. He would think that the lopping of the grass was an attack on private property. He would think that the kicking of the heels was a signal to an accomplice. If the madman could for an instant become careless, he would become sane. Everyone, who has had the misfortune to talk with people in the heart or on the edge of mental disorder, knows that their most sinister quality is a horrible clarity of detail – a connecting is one thing with another in a map more elaborate than a maze. If you argue with a madman, it is extremely probable that you will get the worse of it; for in many ways his mind moves all the quicker for not being delayed by the things that go with good judgment. He is not hampered by a sense of humour or by charity, or by the dumb uncertainties of experience. He is more logical for losing certain sane affections. Indeed, the common phrase for insanity is in this respect a misleading one. The madman is not the man who has lost his reason. The madman is the man who has lost everything except his reason.

The therapist who is obsessed by a need to make explanatory interpretations of 'the unconscious' would do well to recall Keat's stress upon the importance of '*negative Capability*, that is when man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact and reason' (Keats, 1817).

The opaque therapist

A further way by which the therapist may become persecutory is by denying his involvement in a two-person situation. Despite inevitable non-verbal communications, which are always of profound significance, he considers himself to be 'neutral', he takes a role which is opaque and faceless. He supposes that through these manoeuvres he will diminish the contaminating effect of his existence in the production of 'pure transference'. To the patient, however, he may seem unyielding, as if made of stone. This stance has a number of consequences.

Since the therapist believes that he is not there as a person, but merely as a 'blank screen', he may respond to all the patient's remarks about *him* as if they were merely manifestations of other relationships in the past, whether or not elaborated by fantasy. The patient comes to feel that all his productions are unreal distortions. Such a therapist nullifies the patient's attempts to distinguish those responses and attitudes that are illusory from those which are part of an actual situation in the present – certainly affected, and perhaps determined by the therapist's own characteristics. He impedes the patient's movement towards a healthy reduction of his distorted perception of others, by failing to allow him to make this comparison between what is 'illusion' and what is 'actual'. Unless at the appropriate time – and this timing is crucial – the therapist reveals what he is like, the patient has no opportunity to test out fantasy against fact. He is hindered in his efforts to discover his identity. Since all is illusion he can come to believe that all is distortion – his experience of himself and his perception of other people. Then all his emotional responses are 'neurotic'. There is no healthy bit left.

Above all, psychotherapy is concerned with the development of unrealized potentialities.

Failure to reply to direct questions is a characteristic feature of the 'neutral' or 'opaque' therapist. Not surprisingly, this can be construed as being deliberately frustrating since some questions do concern 'reality', at least in part. They may refer, for example, to the structure of the therapeutic situation. This is not to say that direct questions should always be answered immediately for it is often far from clear what is being asked. The problem is how to explore the possibility – and it is only a possibility – that the question is a signpost to a larger area of the patient's imaginative and emotional life (particularly as it concerns the present conversation) and to time the reply without being evasive or rejecting. Simple evasion neglects the fantasy which may underlie the question.

An example of the therapist as a 'blank screen' is given by Anais Nin:

> ANAIS: I am curious about your life. I would like to know whether you get restless, whether you ever stayed up all night, wandered through night clubs, had mistresses, etc.
>
> DR A: I cannot answer such questions; for the sake of the analysis. It is best if I remain an impersonal figure. I must remain enigmatic. An intimate knowledge of my life would not be an answer to your question (1966, pp. 113–14).

It may be appropriate, at this point, for Allendy to point out that a revelation of his biography would not be therapeutic. More frustrating responses might have been: an impassive silence, a mere reflecting back of the question, or a reply such as 'I have asked you to tell me your thoughts, I don't mind if your thoughts emerge as questions.'

Presumably, Allendy considers that he should remain an 'impersonal', 'enigmatic' figure because an 'intimate knowledge' of his life would block Miss Nin's fantasies about him and inhibit her self-exploration by means of 'transference'. In the light of her autobiography, it seems that she is seeking someone like her friend, Henry Miller – who described himself as a 'divine monster' and who was the opposite of an ordinary 'moral' man. Hence, Allendy's reply

requires elaboration in the light of his imaginative apprehension of an image of a fantasy person to whom the question is *also* addressed. Often, a therapist needs to accept such an image for a time before helping his patient to correct misperceptions which are 'unreal' only in so far as they are identified with him. They are 'real' in so far as they help the patient to explore his or her own world. Nevertheless, although details of the therapist's personal life can be inhibiting, an honest feeling response is important if, as the authors consider, psychotherapy is a special kind of conversation. The notion of an *equal* and yet *asymmetrical* conversation is illustrated by Hobson (1974).

The apparent paradox of equality and asymmetry is eloquently expressed by Alice. She is desperate and lonely, her relationships are chaotic and she has made several suicide attempts. But her innocent eye has not been blinded by an excess of classroom education. She writes an account of a therapeutic session:

> I think that I was able to open up to you and express myself so that you could see me raw and all my weaknesses and feelings that torment. I felt obviously that I was opening up myself as much as possible and had given all that I could of my feelings, my truth, but although we discussed them and I saw things in some ways in a different perspective it couldn't go deeper because it was a one-way thing – *I don't want you to tell me all your feelings and thoughts of your own life* but it is difficult when one feels one's giving like one's soul or Being and that it is onesided. Although I felt you understood most of what I expressed, *I wished perhaps you would reveal your real true feelings* and not act out the part of an analyst because I do feel at times that when we are getting somewhere you say the right thing to say instead of what you really feel [italics added].

Alice is tormented by a chaotic sense of badness and weakness. She longs to be able to be open and, at the risk of devastating hurt by being roughly handled, she does her best to reveal her weakness and to expose herself raw. She feels safe enough to begin to emerge from her isolation and venture into the unknown, helped by the sympathetic understanding of her therapist. She longs to go 'deeper', but in order to do so she needs to join in a conversation which is much more than a one-sided 'discussion'. The 'right' words of an analyst (as she understands the label) do not speak to her 'soul' or 'Being'. She has been able to enjoy a new glimpse of herself and a look at the world around her from a fresh viewpoint.

Perhaps she has glimpsed exciting possibilities. But she seeks a more profound and transforming vision. Her preliminary discoveries cannot become insight – a passionate 'new look', with movement into the world of people and things – unless she receives a response of 'real true feelings'. She has a need to give, and offers as a gift the 'truth' of her own life – her feelings which are much more than transient emotions. But she can only do this in an intimate, reciprocal meeting – a giving and receiving, a sharing, with another person who opens himself to her and is not only 'playing a part' (although that part might be necessary sometimes). She asks for a genuine conversation in mutual trust which can free her to explore not only alone but also together with another person. Alice needs to be needed.

She recognizes the special nature of the conversation with its peculiar therapeutic purpose. She states clearly the difference between 'talking about' and 'talking with'. She asks for an equality in the sense of a mutual respect and an honest exchange of feeling in talking *with*, but accepts an asymmetry with regard to what is talked *about*. In order to open herself to new experiences, to emerge from her desolate and yet self-protective loneliness she pleads for help in expressing her need for genuineness, for trust, for tenderness. For love.

Our problem is how to find the appropriate sentences with which to respond to the many Alices who sit in the patient's chair.

The maintenance of the asymmetry (which should diminish over time) without the equality promotes persecution. The therapist is destructive when he tends to invalidate the patient's experience by thrusting his own 'reality' upon him, especially when he assumes a false, opaque mask.

The untenable situation

The therapist may induce feelings of persecution by putting the patient in an untenable position in which he is rendered helpless, not knowing how to respond or to express himself. Four such situations seem to be of importance – lack of clarity about the structure of therapy, imposing impossible requirements, giving conflicting messages, and making conflicting demands.

The structure of therapy

As Frank and his group suggest, there is some reason to suppose that the way in which the therapeutic situation is set up influences the outcome, and that a clear awareness by the patient of his task is beneficial (e.g. Frank, 1961). If this is so, than an opposite state of affairs could be damaging. The patient who sits under the eye of the therapist without a notion of what he is doing, or of what is likely to happen, will feel unnerved, frightened and even under attack. This situation is perhaps rare in pure form. Nevertheless, in a lesser degree, it seems to be exceedingly common.

Frank suggests that the positive effect of giving the patient clear information is due, in a large part, to communicating hope, but an additional possibility is suggested by an investigation by Meares (1973). An experimental therapeutic group was contrasted with a more 'orthodox' group in which, following Foulkes (1964), no specific instructions were given. It appeared that a clear delineation of the therapeutic task in the experimental group promoted the rapid emergence of fantasy images which was not apparent in the 'orthodox' group. It seems possible that this 'fantasy activity' could contribute to clinical improvement in groups.

Impossible demands

Although the therapist might give very clear instructions the patient may be unable to comply with them. This is less likely to occur when patients are highly selected; that is, those who can register an emotional response, verbalize it, and relate it to other experience. Since it is not possible to measure outcome or predict suitability with any confidence, those who cannot cope with an 'orthodox' interpretive psychotherapeutic situation often enter treatment. Then, unless the therapist's technique is flexible, persecutory feelings arise, sometimes to the extent of the development of a 'delusional transference' (Sandler, Dare & Holder, 1970).

Perhaps the most important attitude and skill of the therapist is to be willing and able to *recognize signs that he is wrong*, and to modify his approach in the light of such evidence. Every intervention (e.g. an understanding statement, a challenge, or an interpretation) is an hypothesis to be tested as far as is possible. All therapists long to be right, and detection of mistakes calls for diligent practice with 'negative capability' and an openness to new experience. That is asking a great deal. But it is well to remember that success in therapy might not lie in discovering correct explanations but in *learning how to adjust communication habits* – how to relate to different types of people. This requires a *mutual* adjustment. Harm is done by a therapist who requires conformity to a set pattern without reference to the fact of whether or not this is appropriate for this particular patient or, indeed, whether it is possible for him.

Conflicting messages

A most important, but often subtle, way of putting the patient in an untenable situation is by giving conflicting messages. Human beings communicate through many channels and a therapist can say one thing in words and quite different things by tones of voice, gestures, facial expressions and other non-verbal means – as is apparent from study of videotape recordings. This 'double-talk' is likely to lead to feelings of uncertainty, perplexity, chaos and persecution. It reinforces maladaptive responses resulting from past experiences of inconsistent behaviour by significant persons, especially parents. A therapist is likely to behave in this way when he attempts to practice a 'technique' which is at odds with his feeling for the patient. Frequently,

these 'double-binds' – which indeed can be 'treble' or 'quadruple' – reveal deep-seated personal problems in the therapist. Anxieties, conflicts and avoidance mechanisms of which he is unaware can be touched upon by events in the therapeutic relationship. It is relatively easy to detect contradictory messages and demands arising from such difficulties, especially by audiovisual aids, but it is quite another matter to correct them. It is essential that the therapist should have some therapy himself in order to increase his awareness, but often that is not enough. Some people are not cut out to be psychotherapists and even those who are most suited do not 'fit' with, and can be damaging to, some patients.

Conflicting demands

There are very many ways in which conflicting messages can result in conflicting demands as, for example, when at the same time as encouraging aggression the therapist expresses his fear of it, or when he recommends independence and, owing to his own needs, promotes dependence. These, and similar but very diverse 'binds' have been discussed at length by many writers and, only one, less often noted, will be touched upon in this article. It concerns two modes of thinking, here termed 'linear' and 'associative'.

Linear thinking is logical, problem solving, and goal-directed. Piaget (1959) describes it (using the word 'language' in its narrower sense to mean 'words'):

> Directed thought is conscious, that is, it pursues an aim which is present to the mind of the thinker, it is intelligent, which means that it is adapted to influence it, it admits to being true or false (empirically or logically true) and it can be communicated by language.

Jung, like Piaget, called this type of thought 'directed', and contrasted it with 'fantasy-thinking', which Hobson (1971) summarizes:

> In 'fantasy-thinking' image piles on image, feeling on feeling. The images are usually concrete and are vividly sensed. They show features of condensation and displacement, without a clear recognition of opposites. There is little fatigue in the process, the effortless direction of thought being determined by subjective affect, with association based on analogy, and there is no distinction between subject or object. A great deal of the process goes on in the 'half-shadows' or unconsciously, when it can only be defined indirectly. For adaptive purposes it is seemingly unproductive.

The kind of therapist whom Winnicott has characterized as 'orderly' may set down conflicting rules for the therapeutic conversation by asking the patient to communicate in associative thought, while he, himself, responds only in directed and linear thought. They are speaking in different 'languages'. This somewhat unreal and, indeed, impossible situation may culminate in the therapist remarking, 'I don't think I know what you're saying', to which the patient may legitimately reply, 'I don't know either'.

The 'orderly' therapist is unreceptive and unresponsive to the images of associative thought. Winnicott (1971) writes about this problem in the following way, and in a slightly different context.

> Free association that reveals a coherent theme is already affected by anxiety, and the cohesion of ideas is a defence organization. Perhaps it is to be accepted that *there are patients who at times need the therapist to note the nonsense that belongs to the mental state of the individual at rest without the need even for the patient to communicate this nonsense, that is to say, without the need for the patient to organize nonsense.* Organized nonsense is already a defence, just as organized chaos is a denial of chaos. The therapist who cannot take this communication becomes engaged in a futile attempt to find some organization in the nonsense, as a result of which the patient leaves the nonsense area because of the hopelessness about communicating nonsense... (1971, pp. 55–56, italics added).

The over-rational therapist, who cannot allow himself to use the language of 'nonsense', has a set of rigid expectations based on his beliefs about methods, technique and theory. He does not enter the state of mind advocated by Freud, who suggests that the therapist,

> Surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix

> anything that he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious (1920–1922, p. 239).

This passage suggests that the therapist should allow his imaginative processes to unfurl over the contents of the therapeutic encounter, turning over, in an unfocused way, the matter which is being presented to him. He is not trying to put it into pigeon holes. Freud writes,

> The most successful cases are those in which one proceeds, as it were, aimlessly, and allows oneself to be overtaken by any surprises, always presenting them to an open mind, free from any expectations (1912, p. 327).

Anais Nin puts it from the patient's point of view. She describes with approval, the speech of her most effective therapist, Martha Jaeger.

> She shows hesitations. She does not pretend to know it all. The talk seems wandering, desultory, meandering . . . (1969, p. 248).

Her description of the therapeutic process resembles Freud's:

> There is a most baffling thing about analysis which is a challenge to a writer. It is almost impossible to detect the links by which one arrives at a certain statement. There is a fumbling, a shadowy area. One does not arrive suddenly at the clear-cut phrases I put down. There were hesitancies, innuendoes, detours. I reported it as a limpid dialogue, but left out the shadows and obscurities. One cannot give a progressive development (1966, p. 76).

and again:

> I stopped for a moment to search for the order and progression of our talks, but these talks follow a capricious associative pattern which is elusive. The order made in reality, chronological, is another matter entirely (1966, p. 290).

The 'elusive' associative pattern, intimated by Nin, is consistent with the remarks quoted from Freud and can be elaborated by Winnicott's suggestion that 'if the therapist can not play he is not suitable for the work' (1971). The rhythm and balance of intimacy and distance of aloneness–togetherness, mentioned above, requires a 'space' in which both patient and therapist can allow fantasy forms and themes to emerge. In this 'play' ideas emerge which when reflected upon can result in imaginative activity (Hobson, 1971). Imagination, as distinct from fantasy, is an interplay or 'interinanimation' of linear and associative thinking. Coleridge distinguishes imagination from 'fancy' as a union of 'deep feeling and profound thought', a 'vital' power, which 'dissolves, diffuses, dissipates, in order to recreate', or 'at all events . . . to unify' (Coleridge, 1817).

A therapist needs to have a relatively free access to his own fantasy life together with a capacity to imagine. Lacking these abilities he is likely to be persecutory.

The persecutory spiral

Feelings of persecution induced in the patient may escalate to unendurable levels. An important factor in the production of this persecutory spiral is the therapist's own anxiety which rises in therapy when there is a threat to the view that he has of himself.

The circumstances in which a therapist can feel persecuted are legion and call for a whole paper. Owing to his own personality structure and current problems, he can experience the patient as being intolerably intrusive, derogatory, opaque, inconsistent and over-rational. He responds by overt and covert attack. In varied ways, therapist and patient persecute each other. Only one important feature will be mentioned – the therapist's sense of omnipotence.

In many ways a poor outcome in psychotherapy is easier to define than a good one and casualties can be assembled more readily than successes can be isolated. A study of this casualty group may be a source of important negative information about psychotherapeutic outcome. Yalom & Lieberman (1971) used this strategy in an evaluation of encounter groups. Two-hundred and nine subjects met in 18 groups. Sixteen of these subjects were clearly harmed by

the experience. The damage was particularly evident in groups led by people who were similar in some respects to our stereotype. They 'were intrusive, confrontive, challenging, while at the same time demonstrating high positive caring; they revealed a great deal of themselves. They were the most charismatic of the leaders. They were authoritarian and often structured the events in the group.' Furthermore, they were sectarian, adhering more strongly than the other therapists, to a particular system of therapeutic beliefs. The fact that they were 'caring', were not opaque, and gave a structure to the therapeutic situation is not out of keeping with our suggestions. It has been pointed out how a too rigid structure and obtrusive self-revelation can be damaging, and 'high positive caring' often represents little more than a coercion to conform to the therapist's wishes of getting well.

When intrusive, challenging, authoritarian and sectarian characteristics are overt, the persecutory therapist is not difficult to identify. Frequently, however, his omnipotence is unobtrusive, and he is quite unaware of it. Nevertheless, his implicit role is the bearer of an esoteric system of knowledge which he 'passes down' to the patient, and uses to change him. When the latter fails to improve, is silent, or presents impenetrable defences, the therapist may feel a sense of impotence which he is loath to acknowledge. His anxiety, which he may also fail to recognize, is aroused by the threat to his role and tenaciously held beliefs. He responds by enhancing his omnipotence, and the various modes of behaviour that go with it. The therapist's denial of the two-person situation, together with his opacity and rigidity, is increased. More and more, he emphasizes the patient's 'sickness' and defects. The patient, in turn, experiences growing helplessness. His bewilderment and sense of unreality may become profound. The sense of impotence and persecution, now felt by both members of the dyad mount to dangerous levels.

Sometimes the persecutory spiral is resolved by ending the therapeutic relationship. Usually, this is done by the patient. It is inconsistent with the therapist's view of himself to accept the failure of his method unless he can label the patient as unsuitable for treatment or as being 'unanalysable'. Not infrequently, reports from therapists explain away failures by means of labels attached to patients, which, however fashionably couched in technical terms, can be roughly translated: 'It is all his fault'.

The patient may be unable to leave. His experience of himself at this point is childlike in relation to a dominant parent figure who knows him to be weak, bad and resourceless. Yet, he has come to believe that this figure is omniscient – the only one who can possibly redeem him. He is trapped in an unresolvable situation of extreme dependency associated with hostility and rage often deflected into self persecuting guilt.

The only possible outcome may be suicide.

Summary and conclusions

This paper puts forward, by implication, a model of psychotherapy as a special kind of conversation. An important feature of this dialogue is the emergence of imaginative themes through the interplay of associative and directed thinking. It is suggested that a 'persecutory therapist' can do serious harm to his patients by interfering with the development of, and learning in, this creative relationship. Six main features of a persecuting therapist–patient interaction are discussed.

1. *Intrusion* into the patient's personal space can occur by crude interrogation, by premature intuitive understanding, and by forcing the confession of secrets experienced as a 'core of self'.

2. *Derogation* is a term used to cover various ways in which a therapist can denigrate his patient, seriously damaging his self-esteem.

3. *Invalidation of experience* occurs when the therapist does not respect everything that his patient says, and responds by 'explaining away' or categorizing rather than by elaborating and amplifying affects, images and memories.

4. *The opaque therapist*, in attempting to maintain an impersonal neutrality, denies his involvement in a two-person situation with its rhythm of intimacy and distance.

5. *The untenable situation* renders the patient helpless, confused, and unable to explore and learn. It is promoted by:

(*a*) lack of clarity about the structure of therapy;
(*b*) imposing impossible requirements;
(*c*) giving conflicting messages; and
(*d*) making conflicting demands.

An important instance is when an 'orderly therapist' restricts his interventions to communications in linear logic whilst asking his patient to respond in terms of associative fantasy thinking.

6. *The persecutory spiral* is an escalating destructive interaction in which both therapist and patient are, or feel, persecuted. Potent factors are 'all knowing', authoritarian, rigid, and sectarian attitudes and beliefs regarding psychotherapeutic theory and technique.

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