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The Politics of Psychotherapy: A Gender Issue

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ABSTRACT *Sexual politics is very important in psychotherapy, as elsewhere, and a gender issue which has not been remarked on very much in the literature is therapist narcissism. This seems to be much more prevalent in men, and the present paper gives a good deal of evidence for this, while not claiming that the fault is peculiar to men.*

The essence of such narcissism seems to be a 'stepping outside the circle' set up between therapist and client, in such a way that the therapist becomes a separate ego. Thus it is actually anti-relationship, and therefore doubly interesting. Copyright © 2008 John Wiley & Sons, Ltd.

Key words: Sexual politics; gender issues; narcissism; relationship

One of the prime issues in psychotherapy, it seems to me, is the question of sexual politics. Or as we tend to say more nowadays, gender issues.

One of the ways in which sexual politics impinges on psychotherapy is in the differences between male and female therapists. This has not been studied very much in any systematic way, but one issue that seems fairly obvious is the question of therapist narcissism. This came to my notice in a problem of my own, where I was sued and disciplined and went through quite a process of self-examination as I shall explain later.

Of course there is a good deal in the literature about problems amongst therapists in training. The classic work on supervision by Ekstein and Wallerstein (1972) talks about blind spots, deaf spots and dumb spots among trainees. Dumb spots are those areas where the student lacks the required knowledge and skill in dealing with the client. This is most likely to happen when the trainee is faced with clients who are very different, whether they be poor and disadvantaged, or whether they be other oppressed groups, or indeed if they come from a higher social class. The trainee just does not know enough about what it is to be like the client. But it can happen in other ways too, and is relatively easy to deal with. The trainee just needs more training.

Blind spots are those places where the trainee's own psychodynamics gets in the way of appreciating what is going on in the client. All the phenomena of countertransference

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can come in here. This is harder to deal with, because the trainee may be quite unaware of what is the problem, and the supervisor may be saying something quite new and unfamiliar.

Deaf spots are those where the therapist not only cannot hear the client but cannot hear the supervisor either. These are likely to involve particularly defensive reactions based on guilt, anxiety or otherwise unpleasant and disruptive feelings. Difficulties with authority figures may come into the picture.

What I want to suggest here is that there is another problem, which is better defined by existentialist writers: therapist narcissism. Existentialist writers are much concerned with what they call presence and regard that as a central requirement for any therapist. The essence of therapist narcissism, it seems to me, is that the therapist ceases to be genuinely present for the client, and is off on some pursuit of his own. I want to emphasize that this is not about countertransference and not about projective identification either. It is simply that the therapist has lost touch with the client, in most cases because the therapist has one agenda and the client another. It is a question of the therapist's ego being more important than anything the client might need. And this is not about trainees: well trained and seasoned therapists may fall into this trap. Many readers may have come across the case entitled 'Love's Executioner' in the book of the same name by Irvin Yalom (1989). He says near the end: 'I had, once again, fallen prey to the grandiose belief that I can treat anyone.'

This is explained rather well by the political concept of hegemonic masculinity (Connell, 1995). This is the model of masculinity favoured in a patriarchal society. As Paul Pulé remarks, 'Masculine hegemony is driven by … the *ethics of daring*' (Pulé, 2007), which he contrasts with the feminine *ethics of caring*. Paul Heppner and David Gonzales, in a discussion of men counselling men, say: 'For example, a young male counsellor became frightened by a male client's emotions because he was afraid of "losing control"; as a result the counsellor would consistently change the focus of therapy to avoid his own emotional reactions … Yet another male counsellor had difficulty in being emotionally supportive and tender with other men. He was afraid of being 'too feminine' and thus had difficulty communicating concern and warmth' (Heppner and Gonzales, 1987, 34–5).

In the stimulating book by Jeffrey Kottler and Jon Carlson (2003) they talk a bit about this, and say: 'Therapeutic narcissism is at the heart of so much bad therapy. It is overconfidence, arrogance, and thinking that we know what is best for others that gets us in trouble more often than not.' (Kottler and Carlson, 2003, 130). Some interesting examples of this are to be found in a striking paper by David Winter (1997) entitled 'Everybody has still won but what about the booby prizes?'

DAVID WINTER'S EXAMPLES

Let us first of all recognize two kinds of resistance in the client. The first kind comes from the client's inner conflicts and hidden issues – things that the client has not worked out yet and which are getting in the way of progress. The second kind comes from actual mistakes made by the therapist, which get up the client's nose or make the client feel demeaned or not listened to. This latter kind generally causes more trouble because the therapist's training may have emphasised the first kind of resistance and not alerted him or her to the possibility of the second kind.

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Faced with a resistant client the therapist has several choices. One is to vary the approach in such a way that the client's needs are better met and the resistance diminishes or disappears. Another is to work with the resistance by bringing it to the surface in some way so that it can be brought out and transformed. Both of these can be valuable. A third is to insist on persevering with the original approach, the one that possibly provoked the resistance in the first place. Winter calls this third response the 'heroic' reaction and it seems to me from what he says that it is mainly male therapists who take this course. What I am suggesting here is that such a response is narcissistic rather than heroic.

One therapist (Salter, 1949) suggested that resistant clients 'should be chased from the office with a broomstick.' He goes on to say 'I explain to them that my appointment book is like a life raft. There is room for only a limited number of people, and I do not intend to waste my time trying to convince any of the bobbing heads around me to get on board. There are others drowning who are only too happy to cooperate in their rescue.' This seems to represent a classic way of refusing to learn from the patient. The phrase about 'cooperating in their rescue' is quite suspect in my book. The therapist is not a rescuer and only trouble results from trying to be one.

Winter's next example is the late Albert Ellis, who suggests that resistance may be due to 'the therapist's engaging in … therapy in a namby-pamby, passive way instead of vigorously getting after clients.' (Ellis, 1980). He called resistant clients 'DCs', or 'difficult customers', and accused them of generally 'not listening to others or to their therapists' (Ellis, 1983). What the therapist should do is to 'do violence to' the client's 'resistant thoughts' and to 'search out and destroy … these phony ideas' (Grieger, 1989). It would be hard, in my view, to find a more dogmatic statement in the literature. And it indicates a therapist who is quite resistant to using any of the other approaches to resistance, or indeed admitting that there is anything the therapist can do other than to oppose the opponent. It seems fair to me to label this as therapist narcissism.

The work of the therapist does, of course, lend itself to narcissism because it is unobserved by others, making it possible for a kind of solipsism to take hold. True, clients are taken to supervision in many cases but I suspect that what is said in supervision may also be distorted by narcissism.

Winter goes on to talk about a therapist from the school of Aaron Beck, who gives details of a session where the client admitted that she only filled in her daily homework chart once a week, just before coming to the session, instead of daily as the assignment demanded. The therapist pursues her on this, and 60% of her 247 interventions are about this issue. It seems clear that the client found it a fairly meaningless exercise but the therapist would not accept this. Here is another way in which the therapist can be more narcissistic than the client. (These details were not reported by the therapist but extracted from a transcript of the session.)

Winter's example from psychoanalysis is where a patient was being treated for sexual problems and the analyst came to the conclusion that 'a significant part of his motivation for homosexuality was the danger of the incestuous wish for a castrating and intrusive woman' (Blatt and Ehrlich, 1982, 83). The report goes on to say that this patient was 'unable to curtail the homosexuality' despite being provided with insight into the relationship between his homosexual activity and feelings of loss. In the ninth month of his analysis, the patient showed his resistance by getting up from the couch and announcing that he was

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leaving because the analyst didn't care about him. The analyst responded 'in a somewhat authoritative manner' by telling the patient to return to the couch and continue his associations (Blatt and Ehrlich, 1982, 80). This he did, and continued with the analysis for two more years. But 'in the third year of the analysis, the patient abruptly terminated the analysis.' The analyst regarded this as resistance but the patient regarded this as successfully emerging from a bad experience. My own view is certainly that the therapist here was so convinced of his own rightness that no other possibility even occurred to him. This is therapist narcissism in all its glory.

David Kennard, Jeff Roberts and David Winter (1993) carried out a research study on the interventions of therapists in group analysis. 'The group analysts were presented with vignettes of situations which might arise in therapy groups, often involving what might be regarded as resistance, and asked how they would intervene if they were the therapist' (Winter, 1997, 7). What they found was that on occasion the response would be an interpretation which was more witty than therapeutic, and which could be regarded as self-indulgent or narcissistic. In such cases the therapists' comments on such interventions 'indicated no acceptance of the possibility that clients might genuinely fail to understand their interventions or that these might be too far removed from clients' own constructions of the group experience to be of any value' (Winter 1997, 7). One therapist later commented that he enjoyed making one of these interpretations 'so I get out of the trap of working hard and getting nowhere and becoming irritated and fed up.' I feel that this shows a complete lack of the ability to listen to one's internal supervisor and that therapist narcissism was definitely present.

Hans Strupp (1989), on the basis of many years of researching the therapeutic process, states that interpretations, when used with resistant clients, 'often have a blaming or pejorative quality and are experienced as such by the patient' (Strupp, 1989, 722). He concludes that he sees 'little room for the large array of traditional analytic interpretations. A frequent consequence of these abstract, highly inferential pronouncements may be to antagonize the patient, diminish his or her self-esteem, and merely teach a vocabulary of jargon that may become a weapon to be turned against the therapist' (Strupp, 1989, 723). It takes someone who has as much stature and experience as Strupp to say something like this and be believed but, of course, it is extremely important. If any therapist puts himself into the position of being infallible, it is clearly a form of narcissism. Daniel Wile (1984) makes a similar point in a paper in which he argues that classical psychoanalytic theory 'inevitably leads to pejorative and accusatory interpretations' (Wile, 1984, 355), which may result in negative therapeutic reactions. I am not sure about that but certainly any interpretation or other intervention, which is persisted with in the face of the client's rejection of them can do real harm to the relationship. To quote the account of a client who considered that she had been harmed by her psychotherapist, 'If I disagreed with him about his interpretation of what was happening with me, he very often would not even deal with it, not even entertain the notion that my interpretation might be valid. As he said – 'Do you want to listen to me? I'm the therapist. If you don't want to listen to me then I can't help you' (Striano, 1988, 68). This is a good example of what I mean by therapist narcissism, the therapist's ego defences in full bloom.

Hugh Gee (1998) gives an interesting example when an experienced therapist in supervision described an interaction with a client. 'She was feeling a bit fed up with her patient.

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She went on to describe how the patient had arrived at a session and having sat in silence for some time he then reported that he had no feelings and no thoughts at all. The supervisee had then asked the patient a number of questions, 'why do you think you are in this state?' and 'what do you think lies behind this state?' (Gee, 1998, 16) These are clearly persecutory questions, coming from the therapist's anger at the silence of the patient. The patient's resistance is matched by the equivalent narcissism of the therapist, who had clearly departed from the rubrics of good practice. Hugh Gee sums this up very neatly by saying 'When resistances in the patient are matched by a similar resistance in the therapist, a vicious circle is introduced' (Gee, 1998, 31).

One example that actually became a whole book is reported by Anna Sands (2000). Her therapist and she engaged in an unprofitable and agonizing dance, in which her suffering steadily increased. Of course we cannot be sure of what actually happened. Even if the therapist's story had been available it would still be just another story. But it certainly appears as if the therapist's narcissism came into the picture. Much clearer is the account by Ellen Plasil (1985) where the therapist was clearly not only resistant but completely out of order and sexually exploitative. And this has been commented on by Carl Goldberg (2001), a long-time researcher in this area, who believes that such behaviour is on the increase. He says:

> I believe that the psychotherapy crisis today has primarily to do with the high incidence of practitioners who inflict harm on their clients because they are even more emotionally unstable than their clients. Many of them may try to help their clients but cannot; still others wreak damage because they disdainfully prey upon their clients' vulnerabilities for their own personal gain. No small number of these toxic practitioners are highly prestigious members of the psychotherapy profession … (Goldberg, 2001, 107)

He gives details of a case that is too long to quote here, but is almost unbelievable in its hostility and damage to the client.

There are some interesting examples in the book edited by Rosemary Dinnage (1988) and it is very clear from this book how powerful the resistance of the therapist can be. One therapist intimidated the patient and she fought with him for 11 years. Another therapist would suddenly make a putdown remark and never seemed to help in any way; she stayed with him for three years, three times a week. A third therapist saw the patient five times a week for three years; the patient eventually came to the conclusion that the therapist was afraid of her. She was a very difficult patient and the analyst eventually referred her to someone who could handle her much better, but it would have been preferable to have arrived at this conclusion sooner. Another patient had an analyst, again five times a week, who started to have a drink problem but would never admit it or even mention it. It seems very clear to me that therapist narcissism is a very real and not particularly uncommon problem. Certainly the well-known book by Jeffrey Masson (1990) has plenty of warnings about this.

A more recent book contains many examples of therapists who get it wrong in various ways. The chapter by Alessandra de Paula contains this humorous advice: 'The best way to deal with your therapist's narcissistic tendencies is to agree with her and move on as quickly as possible. If you show embarrassment, you may have problems in later sessions' (De Paula, 2006, 110).

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One of the best books on this whole area is the text by Dave Mearns and Windy Dryden (1990), which not only contains many more examples but also some interesting and valuable research on success and failure in therapy. They speak of the therapist's insecurity, as does David Collinson: 'The tendency to become preoccupied with seeking to secure clearly defined and coherent masculine selves may in itself be highly paradoxical, likely to reinforce, rather than resolve, men's deep-seated sense of insecurity' (Collinson, 2007).

MALE CONSCIOUSNESS AND THERAPIST NARCISSISM

Now I would like to raise the question as to whether there is more therapist narcissism among men than there is among women. Although there do not seem to be any well-researched statistics on this, it is obvious at once that most of the examples I have found so far do involve male therapists. There are, of course, also many examples of narcissistic female therapists and I do not want to make any kind of a case that this is an exclusively male preserve. Nevertheless, there are good reasons to suppose that this is a greater problem area for men than it is for women. Let us look at one or two of them.

The first is the well-known fact, checkable from virtually every training programme on offer, that most of the people who come forward for training as therapists are women. It is largely a women's profession, although as in other professions the most eminent and prominent and best-paid exponents are men. This immediately tells us that men have some kind of difficulty with the demands of being a therapist. And the most obvious of these, noted many times in the area of being a client, is that men tend to steer clear of the realm of emotions and of empathy. Hence this is something they have to learn. Mostly this is learned through the experiential part of their training, whether it be in one-to-one therapy or in experiential exercises or in an experiential training group. And of course this is the hardest part to control or to measure: some people get a lot out of their own therapy experiences and some do not. I met one therapist who had been through 12 years of training, largely experiential in nature, and who still had great difficulty in communicating on an emotional level.

The second is the equally well known fact that men are brought up to suppress emotions, just as women are brought up to express them. Every book examining male psychology tells us this. Perhaps the clearest analysis comes from the political writer Bob Connell (1995), who has given us the concept of 'hegemonic masculinity' – a kind of masculinity that is culturally dominant and comprises a set of rules for how men should be. The big compendium edited by Ronald Levant and William Pollack (1995) is full of research telling us this in field after field: 'At a normative level, narcissistic character styles are prevalent among men and are associated with self-involvement, self-importance and emotional distance' (Krugman, 1995, 113). The journal *Men and Masculinities* brings us more information, quarter by quarter, confirming that this is still the case. Men tend to think that emotions weaken them. Even Warren Farrell (1990), who is much concerned to set the record straight on male psychology in opposition to feminism, does not deny this but simply puts a more favourable construction on it. He points out, for example (Farrell, 1990, 294) that in a road accident it is very valuable to suppress emotions until the emergency is dealt with and the necessary action has been taken. However, in the role of therapist a man has to be in touch

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with his feelings if he is to be any good at all. And this is just more difficult for men than it is for women, in general and on average. It can of course be done, as I can testify!

One of the things that have to be done in therapy is to get the client to own up to his or her own feelings and inner conflicts. We have only to remember Freud's original statement that the therapist can only move the patient to the limit of the therapist's own resistances. If the therapist has difficulty getting in touch with his own inner world he is thereby less able to help the client to do the same. If the therapist is warding off some of his inner experience he is going to have difficulty encouraging the client to encounter that same material. And this means that the therapist may actually get in the way of the client reaching into some of the more difficult regions of his or her experience. There are some interesting examples of this quoted in the Mearns and Dryden (1990) book already mentioned.

And I could think of an example of this from my own work in therapy. It concerns a teacher, a man in his forties, who met a most beautiful girl who worked at the same school and who he saw every day. They started going out together and he started to fall in love with her. She sometimes stayed at his flat but more often he stayed at hers.

She came from a different culture. He invited her to meet his brother, but she did not invite him to meet hers. He was afraid of being found out because that might affect his position in the school; she was afraid of that, too, but was also afraid of the reaction of her friends and relatives if it were known that she was seeing a white man. As he grew closer and closer to her, he became more and more agonized and conflicted. Emotionally and sexually she meant more to him than anyone he had ever met before.

He was quite a heavy drinker, and tended to visit the pub every night; she did not like pubs. He was quite a heavy smoker and smoked many cigarettes in the course of a day; she did not smoke. He liked to spend the weekend with his brother. She did not like the brother very much. He agreed that these things got in the way of the relationship. But he was not prepared to change his habits in any way. They had great rows, which they made up affectionately and explosively. The strain grew. They went on a week's holiday together and this led to further stress rather than resolving anything.

I came to the conclusion that unless he cracked and gave up some of his habitual actions, he would lose the opportunity to achieve greater happiness than he had ever had before. In his previous relationships he had always been in charge, it seemed to him. But here he was not in charge at all. It was disconcerting. He agreed that nothing very terrible would happen if his school did find out. It could be handled. But he still would not let go, would not move.

In an attempt to get through to him, I told him the story of the Skeleton Woman (Estes, 1992) who is caught by a fisherman and taken home by him. As he sleeps, a tear comes from his eye. She drinks it and revives. She reaches into his body and takes out his heart and bangs on both sides of it, and it makes a sound like a great drum. She sings, and as she sings her flesh fills out, her hair comes back, and her eyes, and her breasts and her sex. She drums his clothes off and slips into the bed with him, and returns his heart to his body, and that is how they awaken, wrapped one around the other. Then she and the fisherman went off together.

He could not see the point of this story. I became more and more frustrated. I felt I knew the answer but he was so obtuse that he would not see it. He needed to learn how to trust,

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how to give in. I became so sure that this was the answer that I became quite boring to him. He could not take it. He felt that he had nothing more to gain from me and left the therapy.

I thought at the time that the hard-earned lesson here was that I must not take things to heart – not let insights involving the client have such an effect on me that I would take them on as my own. I thought that the moral of it was that *authenticity is not enough*. But now I see that it is deeper than that. I had actually broken the unity that we needed for the therapy to work. I had allowed my ego to break free and assume an independence that was isolating.

I now think that the moral of all this is that the therapist is only efficacious and positive to the extent that he (or she) abandons the notion that he is a separate ego. It is better to think in terms of a team, or an alliance, or a dual unity, or an interpenetrating mix-up – anything rather than a separate ego. There must be some kind of awareness that there is not only the dreadful danger of thinking that I am right – there is the even worse danger of thinking that I am separate.

Of course I am separate, in the sense that at the end of the hour, the client goes one way and I go another. But during that hour, we both form part of a greater whole; and if we do not, terrible things can happen.

Of course I am a separate person, with a separate history, a separate home and a separate bank account; but during that hour I am linked inextricably with the other. As soon as that link is broken, the therapy ceases to work. And what is most likely to break that link is my narcissistic ego.

As soon as I think that it is *me* doing it, as soon as I think it is *my* responsibility to put things right, as soon as I think that the client is wrong, I step outside the healing circle.

Perhaps that is a good way of putting it. In good therapy, a healing circle is created. As soon as the therapist steps outside that circle and wants to be right in contrast to the client, a destructive form of interaction is set up. It is in that situation that therapist narcissism can enter in most readily. It is not countertransference because very little of it is below the level of ordinary consciousness: it is available for inspection at any time and the client is just as likely to notice it as the therapist himself.

The point is well put by John Murphy (2005) who says: '[This case] taught me not to fall in love with my solutions or try to impose them on others, because to do so carries the risk of running roughshod over the more important task of establishing and maintaining a respectful relationship with clients' (Murphy, 2005, 145).

CONCLUSION

In conclusion, I would just like to say that it seems clear from all this that therapists are often subject to several different kinds of emotional blocking and find it hard to meet their clients where they really are. The most worrying of these kinds of blocking is what we may call therapist narcissism: the way in which the therapist's own personal sense of a separate ego can get in the way of the work. Of course I am not saying that there should be a kind of symbiosis between therapist and client: the aim is for both of them to be able to be genuinely present, both in the consulting room and outside it.

In this article I have concentrated on men because it seems to me that gender issues are highly political, and that the more we understand about them the better. But of course

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women have characteristic faults too: the book by Yvonne Bates (2006) makes it clear that they are not innocent. Their faults are mostly about too much closeness, it seems to me, whereas men's faults are mostly about too much distance. But to explore that would be another piece, written by a woman.

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