Interview with Professor Sidney Blatt

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The focus in this presentation is on aspects of Sidney J. Blatt as a clinician and therapist based on an interview conducted a number of years ago. An account of the personal and more general professional development of Dr. Blatt is available in an 2006 article in the Journal of Personality Assessment 87: 1–14, titled A personal odyssey.

LD: Can you tell me more about how your interest in doing therapy began?
SB: Reading Freud's Introductory Lectures when I was seventeen had a profound impact on me. A capacity for caring and compassion were there from an early age and a desire to help others has always been important in my life.

LD: When you were young, did you have fantasies of what you’d do when you grew up?
SB: I had an uncle who was a physician and when I read Freud in my late adolescence, I decided that was the kind of doctor I wanted to be.

LD: Did anything in your social or religious background lead to your interest in therapy or healing?
SB: It’s more personal, the sense of compassion, the need to do something significant with my life, feeling my father was burdened by the work he had to do to earn a living but that he resented. I decided that I wanted to do something productive and meaningful from which I could gain pleasure, but not just to earn money. Those attitudes, combined with my capacity for concern and compassion, made therapy a natural for me. I can be tough and sometimes forceful in interpretations with my patients, but I generally feel quite maternal as a therapist and by-and-large my patients seem to view me as a loving and compassionate person.

LD: Is that also linked to your feelings towards your father?
SB: Yes, though we didn't get along well. But going to the cemetery with him each fall to visit the grave of his mother, whom he lost at the age of 5 or 6, and sharing his pain as he relived that loss, is a vivid memory for me. My awareness of the importance of depressive affect, especially depression focused around a loss, stems from my experiences with my father.

LD: Were there personal transformations as you’ve done therapy?
SB: With each patient I feel I rework to some degree a facet of myself that I haven’t articulated before, issues the patient provokes in me. I think we often underestimate the importance of this “fringe benefit” in our work! The very process of doing therapy is a growth experience. My analysis also was transforming. My analyst became the father I wanted and never had, someone who appreciated the subtleties of my mind and soul. For my father I was a sissy, too sensitive and philosophical. My analyst was a powerful male authority figure who appreciated me for what I was, allowed me to be soft and caring and at the same appreciating my intellect.

LD: Have you ever had doubts about continuing to do therapy?
SB: No. I have an academic and research career, but I devote at least twelve hours a week to doing therapy, and it’s been a very important part of my life. It’s given me a great deal of personal satisfaction of closeness and caring that’s hard to get in academia. It has turned out to be an endless source of ideas for my research and writing. I’ve learned an enormous amount from my patients. Therapy has been a way of being intellectually active and discovering, and at the same time caring and compassionate. I couldn’t think of a better profession.

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LD: Which theoretical models influenced you the most?
SB: Freud’s case reports, his descriptions of the functioning and subtleties of the mind, but also my personal experiences with Carl Rogers and his emphasis on taking the perspective of the other, the unconditional positive regard for my patient as well as the importance of empathy which later became congruent with my involvement in an object relations perspective. One needs to be aware of drive derivatives for understanding patients, but it is vitally important to appreciate that we evolve and live in an interpersonal matrix. Insights and interpretations have therapeutic power, but only in the context of an understanding, empathic relationship. The therapeutic relationship is vital. It is augmented and enriched by the sensitivity and understanding that is communicated in sensitive and thoughtful interpretations. So I try to combine the empathic, person centered approach I learned from Carl Rogers with Freud’s knowledge, insight and understanding of psychodynamic development. I try to integrate Freud’s intellectual power with Rogers’ humanistic quality in my work as a therapist.

LD: What is so unusual about your work is the combination of the clinical, theoretical and empirical.
SB: Research without understanding the complexity of people and their feelings and their interpersonal relationships can be hollow and devoid of meaning and relevance. And likewise, clinical work without being critical of what one does tends to be ritual adherence to dogma without understanding and appreciation of the complexities of the human condition in life and in the therapeutic process. The blend of the two, of clinical work and scholarship and research, has given meaning and enriched my work as therapist, and doing therapy has enriched my personal life and my research.

LD: How much have you learned from external sources and how much from inner processes?
SB: Much of my knowledge has come from inner sources. In the treatment hour, I try to imagine myself in some temporary way in my patient’s life. I try to feel what they feel and to give voice to what I think they’re trying to say but what they can not or are reluctant to say. I try to give voice to their experiences, not as an outside observer objectively commenting on what I observe, but rather what I think they are doing, thinking or feeling. I use myself very much in that process. I try to experience what they are experiencing, try to feel my patients’ feelings. This process makes the work productive, but also it can make it at times painful. I feel my patients’ joys as well as their anguish. Caring compassion and empathy is what makes my therapy creative. I learn mainly from my experiencing of myself and my patients and not from the external, theoretical kind of thing. Then I try to find a theoretical frame to help me understand more fully what has been going on, but the understanding and insights come from an experiential base.

LD: What’s your earliest memory?
SB: When I was three, swinging on a porch swing on a summer day. I think I also remember lying in a crib, looking out through the slats. But that is less certain than the early memory on the swing. The swing memory is confounded by many later memories. About that time, during the great economic depression, my father was a milkman. He’d go out very early each morning with a horse and wagon to deliver milk. On occasion he would take me with him. Somehow the memory of the swing is linked to riding on the horse and wagon with him.

LD: That swing somehow represents togetherness with your father in the sadness and difficulty?
SB: Yes. He lived a sad life and always felt unfulfilled. He was not clinically depressed, but I always felt a pervasive sense of underlying dysphoria. Not a clinical depression, but a sense of sadness and a lack of personal fulfillment. He always felt vulnerable that things would be taken away from him, based in part I assume of the loss of his mother as a young child and of bankruptcy of his first business venture as a consequence of the economic depression that began in 1929. The memory of being with him and sensing his underlying dysphoria was very important in my development.

LD: It could have led you to be angry at him, yet there’s a flavor of being with him in his sorrow.
SB: I was often angry at him, and he with me at times. And I often had the sense of his being disappointed with me. But I was also understood him emotionally, yet I think he wasn’t really aware of his feelings or my concern for him. I don’t think he ap-
preciated my compassion or sensitivity, but I felt concern for him — for his difficult early life and his having to work in ways that were unfulfilling. But I also felt his competitiveness with me, and I felt competitive with him in return. But being with him was a very important experience for me. I sensed his pain. I wanted to help, but could not very much.

LD: Some therapists say therapy is lonely work. Do you feel that?
SB: It is lonely in some ways, but profoundly intimate in others. I feel very close to my patients. When they leave I think about them. I don’t want to hear from them after termination because I hope they can manage without that contact. Yet I know what they have suffered and on occasion wonder how they are doing. Therapy is a process of alternating loneliness and intimacy for both the patient and the therapist.

LD: Do you feel a sense of belonging to a particular social, religious or ethnic group?
SB: I feel deeply Jewish, though not in a ritual sense. I feel very much part of the intellectual tradition of Judaism. Unfortunately, I always thought of Judaism as a religion of deprivation — of things one should not do. My parents never really appreciated or shared the beauty of Judaism with me, and I now regret that. Unfortunately I had not developed these feelings earlier in life so I did not communicate that to my children because I only discovered its beauty later in life. I feel very much involved as a Jew, historically, culturally and intellectually. Being Jewish has been an important part of life, including being a therapist. That sense of compassion and responsibility for one’s fellow man isn’t exclusively Jewish, but it’s an important part of Judaism. But the field has changed in recent years. Now people “medicate and manage” and no longer seem to care or feel or identify with people, they focus primarily on reducing symptoms. I feel privileged to have come into the field when it was still in a more compassionate, caring, experiential, yet thinking mode.

LD: I gather you also have a strong sense of identification with Israel.
SB: Yes. I thought of settling in Israel. We never had the financial resources to do so. Also I have difficulty learning languages, a problem related to a mild auditory dyslexia. I thought it would be impossible to be in Israel and not speak Hebrew. I have visited Israel as often as possible and have tried to be of assistance to Israel scholars and professionals because I feel a profound commitment to the state.

LD: Are you motivated by a need to compensate for early childhood experiences?
SB: In addition to issues relating to my father’s depression, it’s mainly wanting to make my life meaningful and not spending my days doing something just for survival. I enjoy the recognition and success, but what drives me has always been wanting to do a good job.

LD: Has your family contributed to or hindered your therapeutic work?
SB: I have learned the power of the unconscious and of developmental issues from being a parent and grandparent. Raising children has made me recognize how complex and difficult a process parenting really is. Children eventually have to go their own way and parents can direct but not control their children. I remember how my daughters in their late adolescence and early adulthood had to maintain distance from us until they established a firm bond with a man whom they felt was going to be the man of their life. I’m glad I didn’t get angry or impatient with their adolescent struggles, but remained there, dealing with my feeling of concern and pain. But not losing my cool has allowed them to come back into our family in redefined and remarkably new ways. That’s why I appreciate the complexity of the adolescent period, how tough it is on parents. You learn enormously from your family. Life experiences are very important in becoming a good therapist, in recognizing your own limitations, and in learning that people have to work out their own problems but you have to be there for them.

LD: Have you felt that the drain on you from patients has made it difficult for you with your family?
SB: No, by and large my patients’ problems don’t impinge on our lives that way.

LD: What parts of you are gratified more in therapeutic work than in your family or other settings?
SB: Clearly more personal needs are expressed in one’s family, but there is something about doing therapy that is similar to good parenting. They’re interrelated but not competing. I use my clinical skills and
understanding with my family only in the sense of trying to understand more fully the issues with which others are struggling. It’s a mistake to try to be a therapist with one’s own family or friends. One should use clinical insights to be a more understanding and appreciative parent and spouse, but never to interpret to your child or spouse what you perceive to be his or her underlying unconscious motivations.

LD: What major traits do you bring to therapy?
SB: Compassion, empathy, the ability to understand and feel what another person is experiencing without imposing my own meaning on it. I’ve seemed to have had that talent all my life. Part of my growth has been recognizing that this capacity is a very important gift, one that I should not take for granted, but use in my work. I now view those capacities as a very special gift, like a musician who has perfect pitch.

LD: Can you think of qualities you have that are problematic in doing therapy?
SB: It took me time to learn not to tell the patient what I thought was the correct answer or the facts. I have learned instead to ask questions that enable the patient to discover the facts for him- or herself. Also, though I don’t avoid anger in the treatment process, I do not focus on it as much as I should. Anger is an important part of the treatment process and sometimes efforts to be compassionate and understanding interfere with my patient’s capacity to express anger at me and in the treatment process.

LD: Are you saying your compassion at times doesn’t allow the patient to be justified at being angry?
SB: Yes. Sometimes I do not give my patients enough space to be angry with me because I’m too caring. Though empathy and compassion are important, sometimes they do not allow the freedom to be angry. When they do express anger or I think it is an issue, I don’t try to avoid it or tone it down by attributing it to transference prematurely. But sometimes anger does not emerge as readily in my treatments as much as it should.

LD: With which kinds of patients do you work better and with which worse?
SB: I haven’t treated many psychotic patients. But I can work with a wide range of patients, adolescents or adults, male or female. I have a problem primarily with manipulative, psychopathic patients. I emphasize too much being able to understand patients’ experiences, but, because these kinds of patients are often so well defended and out of touch with their experiences, I find it difficult to work with them unless they shift into a more psychological mode, and can share their suffering with me.

LD: You spoke of a special gift of compassion and understanding. Do you feel special in other ways?
SB: No, that’s the primary uniqueness I think that I have. I feel fortunate and grateful for it.

LD: Are you talking also of conveying the understanding in meaningful language?
SB: I try to work in feeling, empathic, experiential terms. For example, if a patient says, “I am feeling anxious,” I may say, “What do you mean by anxious?” I try to stay away from technical jargon completely. It’s a defense.

LD: Do you see yourself as charismatic?
SB: People see me as powerful and articulate, but I don’t feel that way. Yale is a very special place and there’s a lot of arrogance here. I try not to get caught up in that quality and try not to enter into the power game. I came from a humble background. My life could have been very different had I not had the opportunities I had. I’ve worked very hard. I’ve been successful and very lucky. But I’m very appreciative of that luck and the help that some people have provided me along the way.

LD: I suspect the lack of arrogance comes from a deeper place than just the background.
SB: I don’t know where it comes from. I grew up in a neighborhood close to the city dump. I know what it is to be poor. I can’t be arrogant. What makes me not want to lose touch with that? Maybe it comes from a deep appreciation for what has been given to me. Early in my career, when we really had no money, I had an “analytic sibling” who came from a wealthy family and I once said to my analyst how envious I was of this person. He had all the financial support and a sense of confidence and assurance, things that I felt I lacked and envied very much. My analyst said, “But you know that you have earned what you have and that no one has given these things to you.” That was a very important interpretation. Hard work and struggles take their toll, but you also know you’ve
done it on your own and are appreciative of what you have.

**LD:** Do you feel an attraction to or curiosity about hidden, irrational, psychotic content?

**SB:** Yes. But I have usually found that it is not as irrational as it initially seemed on the surface. If you listen carefully, there is usually a logic and purpose to irrational thought. Delusional material is a way of trying to make meaning and sense out of crazy experiences. I pay careful attention to it. It’s irrational in some ways, but from the patient’s point of view, I find these thoughts sometimes can be highly rational.

**LD:** What changes do you see as important to bring about?

**SB:** I try to enable my patients to reflect on themselves, to try to understand themselves, but to do so with compassion and not with harsh judgment. My goal is to enable people to take responsibility for their lives and to feel they can live different types of lives if they want to and have the courage to do so. The specifics of the kind of life an individual should live, however, varies greatly with each patient and depends on his or her own values and talents.

**LD:** Do you at times feel you live out some of your own aspirations vicariously with patients?

**SB:** No, I don’t feel I have the right to tell people how to live their lives. There are many ways of being, and everyone has the right to live their own life. The only aspiration I have in therapy is that my patients will feel that their therapeutic experience with me helped them become the kind of person they want to be. I hear about their successes and take personal and professional pleasure in them, but I would be just as happy if they are successful in ways that are meaningful and gratifying for them. The only value I really emphasize, other than leading productive, meaningful, satisfying lives, is the importance of being able to have an intimate, mutual, reciprocal relationship with somebody.

**LD:** Do you identify parts of yourself as unwelcome, and how are they involved in doing therapy?

**SB:** It relates to what I said earlier, whether I can give my patients enough room to be angry with me. Being too understanding can be a problem for some patients, like trying to be too nice a parent and not letting a child get angry with you or moving away from you.

**LD:** What confirms you as a good therapist in your own eyes?

**SB:** When patients tell me things like, “You really understood,” or “That was a very important experience for me.” The confirmation is in seeing the change. Tomorrow I’m terminating with a patient who over a number of years had gone to four well known therapists before. She said that one therapist told her that she was a “masochistic exhibitionist.” While I thought that formulation was reasonably accurate, I would never use diagnostic terms like that with a patient. I’d say something like, “You are self-destructive in your repetitive involvement in relationships in which you get hurt.” Earlier this week she commented in beginning to say goodbye that “What this treatment has meant to me has been remarkable.” My response to her was, “You did a lot of work on your own that enabled us to do constructive work together,” trying to share the credit of her gains and pointing out that she was capable of considerable psychological work in her own right. I think she found those remarks personally confirming and encouraging in their emphasis on her more adaptive potentials.

**LD:** What aspects of countertransference do you identify in your work?

**SB:** I find that most of my countertransference reactions provide me with considerable insight into the experiences of my patients. I have learned to allow myself to engage in fantasies, and often I find they are provoked by something in the hour. One has to have been analyzed and have worked through most of one’s own personal issues to a reasonable degree to allow oneself to focus on that level, but these fantasies can be an immense source of creativity insight in the treatment process. When I take my patients’ point of view, I’m feeling what they’re feeling; and through those countertransferential reactions I often gain considerable insight into the experiences of my patients. As long as I am able to contain the fantasy, not act on it, but rather reflect on what it may mean and why that fantasy has been provoked in this phase of the treatment process, it can be a creative aspect of the treatment process.
LD: Have you felt doubt about your own ability to offer healing because of your own limitations?
SB: I have doubt whenever I start something new, whether it is with a new patient or a new seminar. Once I begin to sense a flow with a patient or in a new seminar, as we begin to talk and communicate, I get over my initial doubts.

LD: What does pain or distress arouse in you?
SB: Anguish — but if there's no pain in the treatment it hasn't gone anywhere. And if I cannot enable the patient to contain the anguish and learn to work with it, the therapy hasn't accomplished very much.

LD: How do you use the motherly and fatherly aspects of yourself in therapy?
SB: I think the patient constructs the therapist and creates the conditions to experience the therapist as both mother and father and some amalgam of the two.

Perhaps I'm more able to allow myself to be more maternal than most male therapists. The caring relationship has to be built on the basic paradigm of the original caring relationship, but any caring relationship has maternal and paternal dimensions, both for the person being helped and the person providing the help.

LD: What do you see as maternal and what as paternal?
SB: Maternal is nurturing, supportive, but also depriving and frustrating. Paternal is more a voice of reality, of separation and judgment. In a sense, the therapeutic relationship is more the maternal function and interpretations more paternal functions. And in any successful treatment, I think you have to be able to provide both.

LD: And those both reflect different aspects of you in the larger framework of your career.
SB: Yes. I've tried to be a compassionate, caring therapist. I also want to reflect on what I'm doing and be critical and understanding of what I am doing in the treatment and why. It's interesting. I hadn't thought about it that way before.

What is so important and gratifying for me in therapy is that it allows me to have a certain intimacy with people who see me in ways nobody else sees me. I'm at my best as a human being with my patients in that I can transcend my own particular needs and neurotic concerns. I can be empathic and caring with my patients because there's nothing at stake except being a good therapist. That is what is so remarkably exciting. It allows me to be the kind of person I would ideally like to be all the time.

LD: What have you enjoyed doing most in therapy and what least?
SB: It's a privilege to participate in enabling people to gain some perspective on what they've been doing and why, and to gain a measure of satisfaction and control in their lives. For me the most difficult part of the treatment process is termination. If the treatment has been successful, you should not hear from the patient again. In treatment you become intertwined with patients' lives and so saying goodbye is difficult, especially not ever knowing how eventually things work out.

LD: It's a kind of loss. It's paradoxical, isn't it, that a real gain becomes a loss.
SB: You're right. It's like a loss. And you take pleasure ultimately, as you do in grieving, by saying that what we did together was worthwhile. It's a grieving process in which ultimately both patient and therapist grow. For me it's the most painful part of therapy.

LD: Have you ever had thoughts of leaving it all?
SB: No. I have other interests, but I couldn't imagine a more satisfying lifestyle. The combination of being an academic and a clinician has been extraordinarily satisfying. I only regret where the field is going now, the changes in treatment, the emphasis on medication and brief manual directed treatments, the seeking of quick solutions to complex problems, to focusing on symptoms and their reduction rather than working with people. The field has changed and, in my judgement, not for the better; but I have not been seriously impacted by these changes. I do clinically what I've been doing all along. I can discover, I can be a scholar, I can be creative in research, I can work with patients, and I can go back and forth between all of these. I learn a great deal from my patients. Much of what I have written stems directly from my work with my patients. Many people view my major contribution to be my 1974 paper on depression. What I learned from two patients presented in that paper has guided my theoretical and
empirical contributions for more than the past twenty years.

LD: It’s a wonderful paper. It really opens up something.

SB: Yes, it was a real discovery. That’s what’s so exciting about clinical work. I don’t try to impose a theoretical model on patients. While there are certain basic principles in analysis and analytic theory and fundamental concepts through which we understand people and their evolution and pathology, but I’m always fascinated by the variations from classic theory. It is fine when clinical experiences confirm the classic theoretical model, but what is really exciting is the discovery of deviations or variations from the basic theoretical model. It is fine when observations confirm basic theory, but when observations don’t confirm basic theory, you can learn something new that allows you to revise and extend the basic theoretical model, at least to some degree. Patients can teach you an enormous amount if you’re open to it.

LD: Could you describe a peak therapeutic encounter?

SB: I’ll describe encounters with two patients around termination. The first, as she got off the couch in the last session, said, “I will always remember you as the gentle voice.” That was deeply touching. The second was with a patient who was losing her hearing over the several years of the treatment process. When I started the analysis with her, I established a rule for myself that I would never interpret any misperceptions she would have of what I had said. To do so would have made unfair use of her disability. I also had to speak uncomfortably loudly in the treatment sessions, and, if she said she didn’t hear clearly what I said, I would repeat or rephrase my comments without any assumption that the failure to hear might represent some defensive process. Towards the very end of an extended and I think successful treatment process, in the closing days of the analysis, she commented that I had been remarkably sensitive to her hearing difficulties, more so than anyone she had ever met. And she then asked “How come you were so sensitive to this issue?” Her question was profound because it brought to my awareness a countertransference issue that had been present in the analysis but of which I had not been consciously aware, namely my father’s loss of hearing when I was an adolescent and how my sensitivity to my patient’s hearing loss may have been an enactment for me of a sensitivity I now thought I should have had for my father, which to some degree I did not express in my adolescent years with him. I generally don’t reveal aspects of my life to patients, but I told the patient that my father had lost his hearing when I was in early adolescence and for the first time I explicitly realized that my sensitivity to my patient’s hearing loss was a working through for me of the issues I had experienced in dealing with my father’s hearing loss. In being a good therapist to her I think I was working through what I should have done for my father as a thoughtful and sensitive son.

LD: Your father’s impact on you professionally is remarkable, given the nature of the relationship.

SB: Yes, his hearing loss and his depressive reaction to the losses in his life and his lack of appreciation of my interest in education because of his own lack of education were all important issues in my development. We are truly, at least partly, always residuals of our experiences with our parents. Those relationships are the powerful templates that shape our lives, some of which we are never fully aware.

LD: It’s remarkable when one can use that to the good and not to the bad.

SB: The job of therapy is often to work out the pathological, distorted, destructive segments of the identifications in order to free the more adaptive parts. In all of us there are both adaptive and destructive aspects. I see therapy often as a freeing up of the individual from those pathological internalizations and introjects, and at the same time liberating within the patient the capacity to establish more adaptive aspects of these internalizations. That for me has been a very important recent discovery. For a long time I thought of treatment as a freeing up of the pathological introjects, and then internalizing the therapist as a new introject and of aspects of the analytic process and its values of being reflective and accepting of oneself. I’ve recently begun to think, however, that we focus too much on ourselves as new constructive objects for the patient. I don’t think patients internalize us, but now believe that the patients often have within themselves adaptive structures which they have sought all of their lives to attain but which have
been unexpressed because they've been caught up in pathology. We free those adaptive elements, and then patients seek in the therapy and the therapist elements that are congruent with their undeveloped adaptive potential. We don't become a new constructive object but rather we free up the adaptive internalizations that have been unexpressed within our patients. The patients find aspects of those more adaptive capacities in their interaction with us and in the treatment process use the relationship with the therapist to consolidate these adaptive potentials that have been there in latent and undeveloped form.

**LD:** How much of yourself are you willing to disclose to patients?

**SB:** Relatively little. It's not that I mind their knowing about my life. But I am not a real object in their lives, but an unreal, idealized figure. I think their curiosity about me is part of the transference and that it is important to try to understand what and why they are interested in that facet of my life. Their curiosity often has important relevance for the treatment process. I am only a transitional object who facilitates patients finding appropriate figures in their own lives. Therefore I have to impinge as little as possible as a person on my patients, but rather to free them so they can construct their own lives with appropriate figures. My task is to free them up to develop and to discover how to live their lives. My task is to liberate them rather than have them be like me. I feel it's an intrusion to talk about your self in treatment unless it's directly relevant, like when I told the woman who was losing her hearing how my functioning in this aspect of the treatment was a derivative of my experiences with my father's hearing disability. Even then, I told her about this only in response to one of her questions in the closing hours of the analysis.

**LD:** To what extent have power or the wish to influence been motivating factors in doing therapy?

**SB:** Relatively little. I have a fair amount of administrative responsibility in my job as head of a section, but I've rarely used it as a power base. I get involved in power politics only to protect myself, to be able to do what I want to do, but I don't accrue power. Recognition by my patients saying I do good work, that I've been helpful and caring, is more of a motivating force.

**LD:** Could you talk about the role of sexuality in your therapeutic work?

**SB:** Sexuality is a central and enormously powerful force in everybody's life, and I talk with my patients about their sexuality in frank, direct and explicit terms. In my countertransference responses, I allow myself to feel sexuality towards my patients, and even to entertain sexual fantasies, because I think it's an important part of the process. But the hour always ends promptly, and the limitations on the relationship are very clear. In therapy we talk, think, feel and fantasize, but we don't act. You have to be very careful with sexuality. I see the parallel in childhood. The child and parent should feel oedipal feelings, but if the incest taboo is violated it is destructive for everyone involved. Oedipal feelings give momentum for the person to leave the family to find someone like the parent, but different from them, someone who they have on their own. That's true for treatment too. You need the oedipal strivings, but you set limits so that they don't destroy.

**LD:** Some therapists have a great need to be alone with themselves. Is that true of you?

**SB:** No. I love to be with people. But I usually see patients only from eight to twelve each morning, and then have a full day of other activities. People who see patients all day long may need time to decompress and therefore may need some time alone.

**LD:** What are the main contributions you've gotten from patients for your own personal growth?

**SB:** I've learned an enormous amount about people's functioning and pathology and their capacities for adaptation. As I said before, much of my theoretical work derived directly from my experience with my patients, so my academic career has been enriched substantially by my clinical work. What I've also gained is the realization of what ideally I am capable of being at my best as a person, and in a sense wanting to be that way as much as I can. I wish I could be that way more often with my wife and friends, being able to listen carefully, not feel threatened or vulnerable, and respond adaptively and constructively. Probably the most important thing I've gotten out of therapy and being a therapist is recognizing who I can be and in my life trying to be that person as best I can. Your questions do put one in touch with feelings!
LD: To what extent do you try to talk patients out of erroneous assumptions?
SB: Never. I assume these assumptions have meaning that I and the patient may not yet understand. From the patients’ point of view, the assumptions are logical conclusions, but you’ve got to know the meaning structure behind these assumptions and how the patient arrived at these assumptions. Once you and the patient understand the motivations, forces and life experiences that are the basis for the assumptions, recognize the dynamics entering into them, then you and the patient will see them as erroneous, but in an emotional rather than just an intellectual way. Understanding the motivational forces behind these assumptions is the only effective way of dealing with them.

LD: Did you re-enter therapy in the wake of difficulties arising from practicing therapy?
SB: No, but for several years I belonged to a group of senior clinicians who met weekly to talk about their experiences, particularly countertransference problems. That was helpful. Also I maintain close friendships with two clinicians here and occasionally talk with them about a problem I am experiencing in a treatment process. But I have not experienced a problem in therapy with a patient that I felt I needed to work out further in additional treatment or analysis.

LD: Would you do it all over again?
SB: I couldn’t imagine any other life. It’s wonderful. It’s just been amazing. I consider it a privilege.

LD: What are the main personality characteristics required for the analyst to do effective treatment?
SB: I think a capacity for empathy. Of course one needs a certain amount of intellect, theoretical sophistication, insight and supervised training. But without empathy and compassion for the multitude of ways people struggle to find meaning and purpose in their lives, I don’t think you can really hear, appreciate and understand what patients are feeling and thinking and struggling to put into words or to be able to communicate to themselves and to the therapist, and then to communicate that understanding and appreciation to the patient. You can be right theoretically, but without empathy and compassion it is difficult to communicate these painful feelings and thoughts with tact and sensitivity to the patient in ways that can facilitate their working with this new understanding. You need empathy, insight, compassion, understanding and a collaborative relationship for the treatment process to proceed.

LD: How much depends on the therapist’s intuition, and how much on his professional knowledge?
SB: It’s always a blend of the two. If I have an intuitive sense of something, I also need to understand it in some intellectual or theoretical way to place in a broader matrix of the other processes within the patient. The professional component is like a language. It’s always an interactive process. Intuition is refined by professional knowledge and vice versa. The two perspectives, intuition and theory, are intertwined in complicated ways.

LD: What are the relative weights of who does it and how he does it?
SB: Aspects of technique seem relatively superficial to understand the mutative factors in the treatment process. We are now reanalyzing the NIMH study of the treatment of depression (the TDCRP as it is known) comparing four different types of brief treatments for depression and have found no significant treatment effects. We are finding that it is the quality of the patient’s perception of the therapist’s capacity for empathy that is significantly related to outcome across all four treatment conditions. It’s not what the therapist is doing technically that matters, but how the therapist is perceived and experienced by the patient that matters.

LD: To what extent do you think the therapist should be enthusiastic or restrained?
SB: I would say “optimistic” rather than “enthusiastic.” You have to be both. You have to have some belief in what the patient is potentially capable of being, a belief that they do not as yet have for themselves. But you cannot generate that optimism for them and therefore have to be restrained and find ways to enable the patient to develop this belief in themselves.

LD: Otherwise you’re imposing it on them.
SB: Yes. It has to emerge from the patient’s experiences in the therapeutic relationship. I see therapy as a re-initiation of a natural developmental process that has been thwarted. Our task is to free the patient’s natural tendency and potential to become who
they are capable of becoming, like the mother with
the developing child.

LD: Should role playing be used?
SB: I am very much in Rogerian tradition and so
think that the authenticity of the therapeutic rela-
tionship is central. I see myself as giving voice to my
patients’ experiences. I think techniques like role
playing interfere with the reality and the authenticity
of the relationship. Therefore I never use it.

LD: What are the main roads into the defended parts
of the patient?
SB: It’s empathy on two levels. One is to allow your-
self to identify with the patient and feel what he is
feeling. The other is to allow yourself to feel what the
patient is trying to make you into, how they are using
you and the therapeutic relationship. Empathic re-
sponse and the introspection and insight into one’s
feelings in response to the patient facilitates recog-
nizing the patients’ feelings behind what they are
saying and the feelings they are impinging on you.
Dreams, free association, and slips are very useful,
but for me the real insights occur in the dynamic ebb
and flow of the treatment process and in the transfer-
ence and countertransference expressions.

LD: Do you think manipulation should be used?
SB: Never! I don’t tell patients how to live their lives.
That’s an impingement.

LD: Overall, do you think therapy is more art or sci-
ence?
SB: To find the right phrasing for what you’ve under-
stood, so that the patient can hear it and work with it,
and to know when to say it, is an art. Yet there are
awful things we know about the human psyche and
the developmental struggles inherent in the human
condition. The blend of art and knowledge makes
the profoundly creative therapist. Understanding
and knowing theory, and knowing how and when to
say what you understand about the patient’s experi-
cences, is a complex process that emerges with clinical
experience and good supervision. You have to be
able to say what you understand about the patient
and his or her experiences, but to say it with respect
and compassion.

LD: Should the therapist be committed to telling all
the truth and nothing but the truth to the patient?
SB: My task is not to be truthful, but to be therapeu-
tic. I have to gauge carefully what and how I say
something. One skill in treatment is being master of
innuendo, being able to say something using a word
that has other, more latent, meanings that can sug-
gest implicitly to the patient something that may be
in his experience but which he is not quite ready to
consider. But the latent or secondary meaning of the
words you select can communicate and provoke in
the patient issues that he may follow if the lead of-
fered by the suggestive phrase is accurate and if he is
ready to hear it and work on it.

LD: You’re saying that what you say is true, but isn’t
all the truth.
SB: Right. You have sins of omission, not commis-
sion. You have to gauge what can be assimilated and
worked with constructively by the patient and when.

LD: To what extent should therapeutic technique ad-
here to theory?
SB: Theory should inform technique but not domi-
inate it. But what is exciting about therapy is the dis-
covery of variants of theory in the unique
experiences of patients, so sometimes clinical experi-
ence can enable us to revise theory. All of us who are
clinicians and therapists as well as investigators try to
revise and extend theory as a consequence of our
clinical experience.

LD: What emphasis should be put on symptom re-
moval and the alleviation of immediate distress, and
what on the broader goals of growth?
SB: The long range goals of growth for me are always
essential. One of the temptations young therapists
face is the wish to alleviate suffering. When someone
is suffering, one of the most difficult things is not to
reassure him or offer relief of that immediate dis-
tress. But they and we as therapists may have to expe-
rience and live with anguish before we do something
constructive about it. The attempt to seal off painful
feelings is sometimes as much due to the therapist’s
own discomfort with his own anguish, which is re-
lated to the patient’s anguish, as it is to alleviate the
patient’s suffering. Sometimes you have to psycho-
logically hold a patient’s hand in a crisis and seek to
reduce symptomatic distress, but it’s always a com-
promise. There will be anguish in the patients’ lives
after treatment too, and patients have to develop
ways of coping with symptomatic distress. And they can do that best if they initially experience dealing with pain, difficulty and anguish in the treatment process with the therapist. So symptom reduction is not my primary goal in treatment, rather the goal is to understand the symptom and to find ways of dealing constructively with it.

LD: What, for you, are the positive criteria of mental health?
SB: Two things. One is the ability to establish a meaningful, really reciprocal, mutually enhancing relationship. The other is to have an effective, realistic, essentially positive view of one's self, of one's shortcomings and limitations as well as one's skills and strengths.

LD: What could be the role of humor in therapy?
SB: [laughs] It depends on when and how, but the ability to be playful is a vital part of the process. Humor can get through defenses, highlight what is essential and give a sense of perspective. When treatment becomes playful without becoming frivolous and defensive, it has entered a new phase.

LD: Since therapy focuses on the patient's narcissistic needs, could it reinforce egocentrism?
SB: That's a problem for the therapist as well as the patient. I think you have to be careful when a patient's narcissistic needs are being fulfilled in the indulgence of having someone listen so carefully to everything he says. So the treatment process can be used by the patient for narcissistic gratification. But equally important is the fact that one of the dangers in this business is that the therapist loses perspective and begins to believe that he is in fact the embodiment of his patient's positive transferences. Patients deify you. One of my patients started off an analysis by saying, “You are going to be my savior.” I said, “No I'm not.” And she asked why not and I responded, “because saviors usually get crucified.” Therapists have to be careful of the gratifications they get from the intensity of the positive transference. Analysts often take themselves too seriously and believe they are omnipotent and can do no wrong. Arrogance is a potentially occupational hazard for therapists, a quality that can be harmful and destructive to their work with patients as well as in their relationships with colleagues and in the profession more generally.

LD: Do you think talking is enough in therapy?
SB: It's all we've got. We want our patients to symbolize, to put into words and not enact. So the words, though they have limitations, are essential for what we are trying to accomplish.

LD: The therapist has at times been seen as a secular moralist, replacing religious authorities. Do you agree?
SB: An important part of our work in therapy is establishing for individuals an effective moral code, but I don't see this as a replacement for religious authority. We want our patients to live in a societal world in which they respect others and expect others to respect them. That's a here and now kind of morality, how one conducts one's life based on one's feelings about oneself and one's relationship with others. But I don't see that as replacing religion. Though we get into moral issues in therapy, it's not quite with the profundity of religion. Religiosity talks not about psychological origins, but of cultural origins and one's expectations beyond one's corporeal existence. Though we deal with morality in a secular sense in treatment, it's not a replacement of religiosity. For some people, religion is a vitally important part of their lives, and it is to be respected.

LD: What is the role of doubt and skepticism in therapy?
SB: Therapy is a constant process of exploration, so it always lacks a degree of certainty and involves some degree of doubt and skepticism. But these feelings are usually balanced by a wish and the expectation for discovery, and the potential for growth which engenders feelings of excitement within oneself and the patient.

LD: We've talked about this, but we may as well summarize it. What use can and should be made of transference, and what is the constructive role of the real relationship?
SB: The real relationship, the sense that I care and want to help, is an important part of what makes the treatment go. Transference is an enormously powerful force, as is countertransference. It's important to let the transferences evolve and through the transference, discover important, usually unconscious, aspects of the patient. Even more important, the relationship gives the patient the sense of the authen-
ticity of the process, that what they’re feeling in the here-and-now is authentic but also is linked to their early life experiences. But the expressions of some of these issues in the transference gives them an immediate vitality that is essential for the understanding of these issues to have therapeutic effect.

LD: How can you ensure that the therapist doesn’t use the concept of transference defensively to ward off legitimate feelings the patient may have?

SB: You can only ask that the therapist evaluate himself or herself as they ask the patient to reflect on himself. The therapist needs to recognize and acknowledge limitations in his own life and try to be aware of when he’s using the patient for fulfillment of things lacking in his own life. The quality of arrogance that can occur in the therapist, that we discussed earlier, is a major impediment to this process of self-scrutiny by the therapist of his experiences in the treatment process. It can be an important problem for some therapists.

LD: The final question — What are your main suggestions for young therapists?

SB: First, to have as intensive a treatment yourself as possible, because the major skills in treatment involve the constructive use of your own feelings to understand the complex and subtle feelings of others. But you have to be sure that your feelings in the treatment are authentic and related to the experiences of the patient and not expressions of your own unresolved neurotic needs. So one’s own personal treatment is important; that one has to a reasonable degree analyzed and confronted one’s own personal issues and resolved them to a reasonable degree, though not necessarily resolved them fully, which one can never really do. The other advice is to maintain a sense of integrity regarding what they believe is therapeutic. The field is continually dominated by current fads about the nature of treatment. Some of these fads often bring with them a temporary and transient sense of power and glory, to be in vogue with new and modern ideas. There are also more realistic professional temptations to go with the dominant theme in the contemporary definition and the current popular fad in treatment. But if you’re going to do good clinical work, you have to follow what you believe, even if it is currently unpopular. So I think one’s own therapy plus a sense of commitment to certain principles of treatment are vital.

Since this volume is published in Professor Blatt’s honor, I feel moved to comment briefly on my reactions to our meeting. This interview was one of a series of in-depth interviews with eminent psychotherapists of various theoretical persuasions. Though I adhered to the long list of questions asked of all of the interviewees, when I met with Professor Blatt I almost immediately felt there was a spontaneous flow to the conversation between us, a sense of ease and comfort. Throughout I was deeply impressed by his understanding of people and his ability to convey that understanding in both theoretical and real life terms, always with empathy, caring and concern. As noted, when asked which theoretical models have influenced him the most, he replied that he has always tried to integrate Freud’s intellectual power with Rogers’ humanistic quality. Clearly, this is a combination that is by no means easy to achieve. However, my impression is that he has indeed succeeded in doing so. In addition, he has, of course, also made extremely important contributions to clinical research.