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ON BEGINNINGS

The Concept of the Therapeutic Alliance and the Interplay of Transferences in the Opening Phase

The opening phase is a crucial time in treatment. Attitudes that patient and analyst develop towards each other in that early period, although colored by initial transference feelings and fantasies, can have an enduring effect on the treatment. While these first impressions can, and often do, undergo change as patient and analyst learn more about each other and transferences deepen, not infrequently the emotional tone set early on influences all that happens thereafter.

The phrase "therapeutic alliance" has been used to designate a particular attitude on the part of patient and analyst. It is one characterized by a spirit of mutual regard and friendly feelings, together with a commitment on the part of both participants to work together on a joint project; exploring the inner world of one individual, the patient, in an effort to help him overcome the emotional problems that have hampered him in his journey through life.

The so-called therapeutic alliance, however, is far from a single entity. It is, in fact, one highly complex phenomenon, composed of a variety of intersecting and intertwining elements. Primarily for that reason, and because transference inevitably plays a major role in its formation, a number of colleagues, Abend (1997), Brenner (1979), and Hoffer (1997), maintain that it is a term without meaning. For them, the therapeutic alliance is a compromise formation composed primarily of the positive transference, to which other elements of the personality make a contribution. From this perspective, then, no new term is needed to designate this compromise formation. What is needed, rather, is thorough analysis of it; a task that can be overlooked when the therapeutic alliance is simply accepted as a reality-based nonconflictual entity.

For Zetzel (1956), Stone (1961), and Greenson (1965), on the other hand, the therapeutic alliance is more than a composite of forces that require analyzing. It is a phenomenon that is based, in large measure, on

certain accurate and undistorted perceptions of the patient's, as well as on other aspects of his ego functioning that are relatively conflict-free. Thus, the patient's positive view of the analyst and his willingness to cooperate with him represents more than the manifestations of positive transference. While clearly containing such transference elements, they involve aspects of judgment, thinking, and evaluation not primarily based on transference distortions.

My own view is that the therapeutic alliance is, inevitably, a compromise formation that involves a number of elements, including transference, fantasies, memories, and projections of self and object representations. Included in this mix, however, I believe—and to this extent I agree with Stone (1961) and Greenson (1965)—are quite accurate perceptions of the analyst; perceptions that exert a substantial influence on the patient's responses. While, clearly, these perceptions are not totally free of transference, often they are accurate enough to give the patient an essentially undistorted reading of certain aspects of the analyst and of the treatment situation. That all of the patient's perceptions should, however, be the subject of analytic investigation goes without saying.

Because the concept of the therapeutic alliance is so complex and controversial an idea, and because in the crucible of the analytic encounter analysts have little opportunity to sort out such niceties of theory, I have developed, and offer the reader without cost or obligation, a quick, foolproof method for determining whether, in any given treatment situation, the set of attitudes and feelings commonly designated as a therapeutic alliance are, in fact, present.

My method involves a test that is simplicity itself. For want of a better name, I call it the *gesundheit* factor. It requires no extensive experience, no knowledge of analytic theory, not even a personal analysis—only a handkerchief and an occasional head cold or allergic episode. Let me illustrate with an example from my practice.

Mr. K, an aspiring young comedian with whom I have been working, is in a fit of pique. He is furious because I have not given him my opinion of his manager and whether or not that individual is ripping him off. As a result, he maintains that I am putting him in jeopardy, allowing him to remain in the hands of a con artist, and very likely causing him to lose a great deal of money. What kind of analyst am I anyway? he demands. He knows that I have no intention of being human, but he supposed that, once in a while, under extreme circumstances, I might develop a few humanoid qualities. Now he sees that this is impossible. Clearly, I am tied like a tethered goat to my Freudian method, antiquated and out-of-date as it is. I am, in fact, a phenomenon, a genuine anachronism. With a little pull, he could probably get me a booth at Ripley's Believe it or Not! museum.

Mr. K has said much the same thing before. He is, in fact, quite regularly on the attack, chiding me, mocking me for my old-fashioned ways, trying

to knock me off my analytic stance. In one session, after I had made what I thought was a particularly meaningful interpretation, linking a particular quality of his with certain long-forgotten attitudes of his mother's, Mr. K responded, not with insight, but with an observation.

"You have hit the mark again," he said. "Your interpretations are uncannily accurate. In fact, there is no question about it: you have one of the finest minds of the thirteenth century."

Today he is in high gear, launching an all-out attack. As I listen, flinching a little inwardly and beginning to wonder if, in reality, I have become an old fuddy-duddy, the analytic equivalent of the nearsighted Mr. Magoo, my nose begins to itch. I try to stifle the approaching sneeze, but it is too late. I sneeze rather loudly and the sudden sound breaks into Mr. K's tirade. Scarcely missing a beat, he pauses, offers a hearty "God bless you," and continues the attack with a laundry list of my shortcomings.

What is happening here, I realize, has much to do with the therapeutic alliance, at least as I understand what Stone (1961), and others who value the concept, mean by it. Mr. K's quixotic behavior clearly reflects certain important underlying feelings that he has about me. His response to my sneeze is a sign that there is a bond between us; a bond composed of accurate, as well as transference perceptions, that helps carry the treatment forward and that helps him weather my mulishness, his rages, and all the tensions and misunderstandings that our peculiar enterprise is bound to encounter.

Of course, it is more than Mr. K's words that are important. Theoretically, in offering his blessing, my patient could be speaking sarcastically or with mockery, and secretly might be hoping that the sneeze would turn into a bad case of the flu. In my experience, however, such hostility is rarely concealed behind this particular expression of goodwill. Mr. K's spontaneous offering suggests, rather, the existence of a wellspring of positive feelings towards me; feelings that are sustained despite the eruption, from time to time, of anger and resentment.

The positive regard that my patient feels for me, of course, contains all the elements that I have mentioned. In his case, the core of warm feelings that, as an infant, he felt towards his mother is at the base of the positive transference. Added to this are not only a mix of transferences displaced from early perceptions of his father and a sibling, but fantasies involving a wished-for self and wished-for parents. Included, too, are a set of imaginations concerning my relationship with him; imaginations that involve our being soulmates as well as enduring friends.

Not all of Mr. K's perceptions, however, are infused with fantasy. In this treatment, as in many others, the therapeutic alliance derived much of its intensity from the patient's intuitive and accurate perceptions of his analyst.

From my tone and manner, as well as from nonverbal clues transmitted to him, Mr. K knows that I like and admire him. He knows, too, that I am on his side and senses that I share with him the wish that he better

resolve the conflicts that are at the root of his troubles. He has tested me and knows that I won't retaliate against him for his rages, nor will I drop him because he is nasty, and even abusive, at times. He knows that I am in for the long haul. He also knows that, in setting the fee I have tried (though in his eyes not always successfully), to be fair to both of us. And, in the matter of arrangements, paying for missed appointments and the like, he has seen that I have attempted to take his reality, as well as my own, into consideration. When, for instance, for compelling reasons having to do with the demands of his career, Mr. K has had to miss sessions, I have made an effort to rearrange his appointments. When this has not been possible, and his hours have been filled by other patients, I have not charged him. I am well aware of the problems inherent in this arrangement, including the potential for acting out of fantasies and conflicts on both sides of the couch, but on balance I believe that it is more important, from the outset of treatment, for the analyst to behave in a fair, reasonable, and considerate manner. When we have occasion to refer someone close to us for analysis, we look not only for a skilled and experienced person, but for someone who is a *mensch*, a mature individual with sound values who can relate warmly and empathically to another human being.

There are, of course, a number of factors that contribute to the development of rapport between patient and analyst. Among these is the kind of match of personalities and styles that takes place initially (Kantrowitz, 1986); the analyst's theoretical orientation, his experience, skill, capacity for empathy; and the nature of the transference-countertransference interactions that unfold. As important as these factors are, however, in and by themselves, they do not fully account for the particular quality of an analytic relationship. The character of the analyst—the *mensch* factor—operating as an unspoken, but ever-present, factor in the mind of the patient, influences all that transpires.

No matter what qualities we bring to analysis and no matter what approach we use, our attitudes and behavior will stir memories and fantasies in the patient that are based on the inner world that he brings to treatment. These are the transference reactions whose exploration forms the core of our work. But patients also respond to certain realities about their analysts, including the attitudes and values that they convey. Transferences take root from these accurate perceptions, not only from distorted ones. The transferences that a patient develops in different treatment situations, as we know from reanalyses, are not identical. While, clearly, certain transference paradigms are the same, or nearly so, others are not. Not all aspects of an individual's psychology are mobilized in a given treatment. What does appear is, to some extent, determined by particular qualities in the analyst and his manner of interacting with the patient, both of which the latter views through the lens of his unique personal history.

What, in short, I wish to convey is that, however we think of it and however we define it, the concept of the therapeutic alliance contains the fundamental idea of a bond between two people; a bond involving feelings of trust on the part of the patient that, to a considerable degree, take root from his accurate assessment of certain qualities and attitudes of his analyst's.

In this connection, Roy Schafer (1983) raised an intriguing question in a paper of his written some years ago. Every analyst, Schafer pointed out, puts on the mantle of his working self when he steps into the office. In taking on the role of the analyst, he keeps his more personal side under wraps. That being so, Schafer wondered whether it would be possible for someone who did not have a good character—who was, for instance, a small-minded or nasty individual—to be a first-rate analyst.

I had the privilege of discussing this paper and I remember that my answer was yes—and no. Yes, up to a point, I said, I thought that it was possible for certain not very praiseworthy people to check their worst features at the door and to function quite effectively in their offices. We all know some pretty skilled analysts from whom we would not necessarily buy a used car. While in these individuals the discrepancy between their working selves and the selves that their friends and family know is greater than the norm, it is not so great as to make them unsuitable as analysts.

There is a point, though, I thought, when the stretch becomes too great. If someone is truly a mean-spirited person—self-involved, devious, greedy, or lacking in empathy for others—sooner or later patients will know this. They may not be fully conscious of what they sense and may not be able to put their perceptions into words, but they will grasp the truth. Although patients may not be privy to the facts of our lives, they come to know the essence of ourselves. And, sensing the truth about such an analyst, patients will be on guard. While on the surface they may seem quite open and spontaneous in sessions, a core part of themselves will be withheld. Not completely trusting the analyst, they will not allow themselves to become wholly vulnerable.

Whether or not we endorse the concept of the therapeutic alliance, then, one thing seems clear. Insofar as that term designates the existence of a reservoir of positive feelings for, and trust in, the analyst, it points to an element of the greatest importance in treatment. This is not to say that the patient's attitude towards his analyst must remain consistently positive for the analytic work to be effective. Quite the opposite is the case. The surfacing and working through both of negative transferences and negative feelings based on other factors is indispensable to a successful outcome. Dr. Martin Stein (1981), in his seminal paper on the unobjectionable positive transference, pointed out that not infrequently a seemingly uncomplicated positive attitude towards the analyst conceals and screens out covert negative feelings that have the power to undermine the analysis. Access to such negative

transferences, however, is frequently difficult. The patient may dread the confrontation and the threatened object loss that, in fantasy, accompanies the exposure of such feelings. Often it is only after a basic attitude of trust in, and positive regard for, the analyst has developed that patients can truly expose their rivalry, rage, and other negative emotions. And as we know, exposure of this kind is essential to progress in analysis, for it is only by means of such openness that understanding and working through of these powerful affects can take place.

It is not surprising, therefore, that at the outset of treatment, evaluation of the analyst takes place alongside that of the patient. On the surface, this may take the form of the patient asking questions about our background, training, affiliations, and the like. While surely patients are interested in such matters, their fundamental concern is with something else. They want to know what kind of people we are. Are we honest, intelligent, reliable, and trustworthy? Are we introspective enough to examine our own reactions as well as theirs? Can we own up to our mistakes without being defensive and attributing blame elsewhere? Can we tolerate aggression directed towards us, as well as depression and despair in our patients? And do we have the capacity to get outside our own skins and put ourselves in the shoes of another? These are things patients want to know and when—on the basis of what they have observed, the answer they obtain is a positive one—the therapeutic alliance is born.

This is a good beginning, the kind of beginning that often launches an effective analysis, but it is only a start. The opening phase of treatment, as we know, is fraught with difficulties. It is a vitally important time, though, because what happens early on often sets the tone for much of what is to follow. It is true, of course, that some marriages—and some treatments—that get off on the wrong foot right themselves and go on to become productive and satisfying. But many do not. Often they carry the scars of troubled beginnings throughout the relationship, and sometimes those scars never heal.

Just as in air travel, it is the take-off and landing that are the most hazardous parts of the flight and require most pilot skill, so for both patient and analyst it is often the beginnings and endings that pose the greatest challenge and that are the most difficult part of the journey to traverse. This is because, for both participants, as for most of us, beginnings and endings have special psychological significance. They have a way of evoking trouble-some ghosts.

Every time we begin a treatment, a host of memories involving previous beginnings that have been important in the lives of both patient and analyst wait in the wings, ready to come on stage and to influence the action. These memories involve the most diverse experiences: the first day of school, meeting new friends, moving to a new neighborhood, first dates, first sexual experiences, and so on. The range is infinite and, because endings are inevitably

associated with memories and fantasies involving loss, separation, and death, their evocative powers are equally great. Unconsciously, these memories, the experiences that give rise to them, and the fantasies connected with them, operate silently to set our expectations in a particular direction and to color our vision.

Because it is pertinent to this point, I will relate again a story that I recounted in a previous communication (Jacobs, 1991). It concerns a very short analyst, no more than 5 feet, 2 inches in height, who walked into his waiting room to greet a new patient. There he encountered a Paul Bunyan of a man standing fully 6 feet, 8 inches tall, weighing 280 pounds, and wearing cowboy boots and a ten-gallon hat. For a moment the analyst stared unbelievingly at the newcomer. Then he shrugged his shoulders. "Come on in anyway," he said.

As an illustration of the way in which the interplay of transference between patient and analyst can affect not only their emerging relationship, but the entire opening phase of treatment, I would like to cite a clinical example that, in its essentials, will be familiar to many colleagues.

Some years ago, after I had finished my residency and had just entered practice, I received a most welcome phone call. A highly respected and much admired teacher of mine was on the line.

"I've got a great case for you," he exclaimed in his typical enthusiastic, high-energy manner. "Just up your alley. A remarkable lady—a poet, teacher, scholar and wit. I've spent two delightful hours in consultation with her. She's fascinating, has neurotic hang-ups, and was in a bad treatment that ended abruptly. She's ready for something good this time around. I've told her all about you and she's anxious to meet you and to get started. She can't pay a whole lot, but listen: this is a terrific case. I'd take her myself if I had time."

"Sounds great," I said. "Just happen to have a couple of openings at the moment."

"I thought you might," my friend replied.

"Well, okay, I'd be interested. You say she's neurotic? What problems is she having?"

"Depression mostly. There's a lot of repressed anger and some self-destructive fantasies, but nothing that is unworkable. I have no doubt that you can help her. In fact, you two should get on famously."

You can imagine the excitement I felt when I hung up. I had gotten a great referral and a vote of confidence from a highly valued teacher. I was walking on air and was looking forward with high expectation to meeting this remarkable woman—a patient who, incidentally, would constitute the first bona fide neurotic case in my fledgling practice. My fantasies about the patient were further aroused by my speaking to her on the phone. She had an attractive voice, soft and resonant, and was clearly a cultured and intelligent person. I had visions of meeting a young Mary McCarthy or, if it was true that she

suffered from longstanding depression, a Virginia Woolf-type whose tragic fate I could prevent by means of my effective and deeply empathic treatment.

The patient whom I encountered in the waiting room resembled neither of these literary ladies. Sighting the large and imposing figure perusing my bookshelf with what I took to be an expression of amused disdain, I had to fight off the flood of memories of disappointing blind dates that suddenly cascaded in on me. The patient turned, looked at me quizzically, and waited for me to speak. I imagined the disappointment was mutual. Trying to compose myself, I smiled and looked as welcoming as I could.

"Ms. S, I'm Dr. Jacobs," I said pleasantly. Apparently my bright tone did not conceal my true feelings.

"Who did you expect?" she asked. "Catherine Deneuve?"

Not being a foreign film buff at the time, I had only the vaguest idea of whom she meant, but I covered up my ignorance.

"Actually, Dr. Y. told me a good deal about you." I put in quickly. "Won't you come in?"

Slowly and quite reluctantly, she entered the office and sat on the edge of the patient's chair, looking distinctly unhappy.

"I thought that you'd be a good deal older," she remarked. "Not someone just out of school."

"You had some idea of me in mind, then," I replied, trying, as I had been taught, to explore the inner world of fantasy.

"Actually, I did," Ms. S said. "I imagined, since you were recommended by Dr. Y, that you might look like one of Freud's younger colleagues, perhaps Rank or Abraham."

I knew then that I was in big trouble. This lady knew more about Freud's inner circle than I did. Although I had heard the names of these early analysts, at that point I knew very little about them. In fact, on that score, they were pretty much in the same boat as Catherine Deneuve.

I looked at this new patient sitting across from me and I felt tense and anxious. What was I to do with this formidable Freudian scholar who promised to be a lot more, as well as less, than I bargained for? Ms. S stared back at me as though I still had a face full of acne. I imagined that she was thinking of me as the analytic equivalent of Andy Hardy or Henry Aldrich, a disconcertingly pubescent therapist.

Clearly Ms. S and I were unhappy with each other. Although there was a good deal more to it, initially my disappointment had to do with the disparity between the patient whom I expected and the patient who arrived in my office. Ms. S was not the ideal patient of my imagination, and it took some time for me to sort out the personal elements concerning my wish for a particular kind of woman in my life that had suffused my initial perceptions of her. Ms. S's disappointment, I came to understand, was connected with certain experiences both of the recent and more remote past. Although for quite some time she said nothing about it, the combination and sequence of recent

events in Ms. S's life, including the abrupt ending of her prior therapy, the consultation with Dr. Y, and the referral to me, stirred up a host of memories that colored her initial responses to me and nearly capsized the treatment.

Ms. S was the daughter of a ne'er-do-well father, a compulsive gambler, who abandoned the family when the patient was 18 months old. Being married and supporting a child, he decided, was not for him. Although there were occasional postcards from places like Las Vegas and Tahoe, Ms. S saw her father only once more. A brief visit was arranged when she was 8 years old. In her mother's eyes the father was a pariah, the devil incarnate, who had wreaked havoc on the family. Ms. S was not to think about him or even to mention his name.

Under these circumstances, the girl did as she was told. She suppressed all thoughts about her father, including the wish that he return one day, and, instead, turned for love and support to her stepfather, a clever, outgoing, and successful businessman. Although he possessed much in the way of charm and charisma, the stepfather was actually a vain, self-involved individual who avoided intimacy and related to Ms. S in a cool, arm's-length manner. Not understanding his need to maintain distance, she experienced his behavior as a painful rejection.

The one male with whom she had close ties, and highly ambivalent ones at that, was a brother four years younger than herself. The product of her mother's second marriage, this boy was the golden child, the son who carried the hopes of the family. He was designated to become a shining star, a noted physician or scientist, perhaps, while Ms. S was regarded as a nice enough, but undistinguished, girl from whom little could be expected. D, the brother, was sent to a prestigious prep school and an Ivy League college, while Ms. S went to the local high school and a nearby branch of the state university.

In childhood, and for years thereafter, Ms. S was consumed by feelings of resentment towards, and envy of, her brother. There was little that she did in life that she did not compare with his achievements. Listening to her, one had the impression that she was obsessed by such comparisons.

From the first session on, it became clear that a brother transference would be a central feature of the treatment. What I did not realize then was that the sister-brother scenario that was to unfold was a multifaceted one that involved not only aspects of Ms. S's history, but of mine as well.

Ms. S's therapist had decided to retire from practice on rather short notice. For Ms. S, his abrupt departure stirred memories of her father's sudden abandonment of the family, and she handled the current loss as she did the earlier one: by suppressing her loving feelings and focusing on the negative ones. Her therapist was dull, predictable, and not very intelligent, she claimed. She had learned little from him and was not sorry to see him go. The deep attachment that she had to this man, an attachment that surfaced only gradually in treatment, was denied and initially was not available in consciousness.

To Dr. Y, my old teacher, Ms. S reacted as she did to her stepfather. She viewed him as the same kind of man: successful, personable, and outwardly friendly, but ultimately rejecting. She felt hurt and put down by his sending her away. In typical fashion, however, she kept those feelings to herself.

In Ms. S's mind, I was immediately linked with her younger brother, the golden boy who was Dr. Y's protégé and his favorite son. I was the privileged one who, given every advantage, had become a doctor, and believed myself superior to her. From the opening gun she wanted to show me up, to defeat me, and thereby to prove that she was not only my equal, but, in fact, had more ability and a keener intelligence than I. At the same time, she experienced guilt over these feelings and was plagued by the idea that in our relationship her rightful place was to remain behind me and in my shadow.

From the first, then, emotionally laden memories and predetermined patterns of responses triggered by the ending of Ms. S's treatment, the consultation with Dr. Y, and her referral to me dominated her thinking and behavior. But she was not the only one who was influenced by such forces. I, too, was under the sway of certain memories, expectations, and pre-set ideas.

To begin with, my reaction to Dr. Y, the referring analyst, was a complicated one. As I mentioned, I had always admired him for his charisma, his wide-ranging knowledge, and his remarkable energy. In that respect, he was quite unlike my own father, who, often depressed, lacked this vibrant quality. For me, Dr. Y became the father I had always wanted but did not have. I wished, therefore, to please him, to do well with the patient he had sent me, and to prove that I was worthy of his respect. On the other hand, I found myself angry with Dr. Y for what I regarded as a misrepresentation of Ms. S. He had, I thought, sold this patient to me and was not entirely honest in doing so. As it happened, my father was also in sales and, when the spirit moved him, he could be an effective salesman. On more than one occasion, he made promises to take me places that he did not keep and, after a while, I became suspect of such talk.

Dr. Y's behavior in promising, but not delivering, the wonderful case that he described must have played into memories of this aspect of my father's behavior and caused me to react, as I had done in childhood, with resentment and a wish to strike back at the man who had deceived me. In this situation, that meant an unconscious wish on my part not to please Dr. Y, and not to do what he wanted. Since, clearly, his wish was for me to do a sterling job in treating Ms. S, the mix of reactions that I had towards Dr. Y complicated the response that I had to the patient he had sent me. How often does it happen that our initial reactions to patients, and perhaps even our more enduring ones, are colored by our relationship with the referring source? This is a factor, I believe, that can exert an important influence on the beginning phase of treatment.

It happens, too, that just as Ms. S was an older sister to a younger brother, I am a younger brother who has an older sister. As was true in Ms. S's family, the boys in our family were given certain advantage. Like D, I went to a private school and an Ivy League college, while my sister attended local schools. And, as was true in Ms. S's situation, more was expected of me and my brother than of my sister. Thus Ms. S's history reverberated in important ways with my own and stirred reactions in me that I had kept at bay for some time.

As a result of old feelings of guilt newly aroused from the outset of treatment, I found myself in quite total sympathy with my patient's view of her own life. She had gotten a raw deal, she believed, and her resentment and rage were fully justified. She was the victim of discrimination, her life was decisively affected by this fact, and her present unhappiness was directly traceable to this state of affairs. She sought, and was entitled to, reparations.

While, of course, there was much truth in this view, it did not represent the whole story. A great many other factors, including the way Ms. S reacted to her own wishes and fantasies, clearly played important roles in her difficulties. Under the sway of unconscious guilt feelings aroused by Ms. S's story and a rapidly developing transference to her as my older sister, I initially found myself identifying so closely (and defensively, I suspect) with her position that it was difficult for me to assume a sufficiently objective stance in my work with her.

At the same time, I found myself responding to my patient's competitive remarks, and especially to her put-downs, with a wish to join the fray and to defeat her. Whenever my sister competed with me, my tendency was to respond with a need to assert myself, win in the competition, and to maintain the natural order of things—that is, with me, the first-born son, as the King of the Walk. It took making some errors in Ms. S's case, including my falling into a couple of unproductive skirmishes with her, for me to get a handle on the problem and to recognize how easily I could slip into enactments related to an old scenario.

One might say that this was an extraordinary situation, that parallels existed in the life circumstances of patient and analyst that do not often occur, and that this coincidence put a particular spin on this treatment, stimulating transferences in both participants that were unusually rapid and intense. No doubt this is true.

It is also true, however, that this case is not quite as unique as it may seem. Parallels in the lives of patient and analyst, especially in the sharing of certain psychological experiences, are not so rare. In my work, at least, I find much in the inner worlds of my patients that resonates meaningfully with what I have known and experienced. Sometimes it is in our ways of thinking and responding rather than in actual experiences that significant sharing occurs. Unless our self-scanning efforts can pick up these less obvious similarities between ourselves and our patients, they may lead to bits and pieces of acting

out based on unconscious identifications. Not infrequently, such behavior occurs early in treatment before we can develop a fuller understanding of our patients' psychology and the way in which it resonates with our own. While sometimes the analyst's actions, being in tune with particular wishes or needs of the patients, have the effect of strengthening the alliance, at other times they unwittingly cause disruptions in it. In the case of Ms. S, if earlier on I had been aware of the long-forgotten piece of my own history that was being enacted with her, perhaps I would have been able to avoid the problems caused both by my initial disappointment in Ms. S and, later, by my putting too much weight on the realities of her early life and, especially, on the inequities that she suffered in childhood. While, assuredly, these were important in her development, equally important were the rivalrous and hostile fantasies, as well as the guilt feelings, that she harbored for so long a time.

It sometimes happens that we encounter patients with whom we seem to have little in common; whose attitudes, values, and life experiences seem, in fact, quite alien to us. While on a fundamental level there is enough alike in all of us, I believe, so that there is an ample basis for empathy even in such cases, the initial feelings of strangeness and alienation may create a barrier to the development of rapport.

In such situations, something more than a lack of familiarity is at work. Our earliest fears of strangers, the unknown, the mystical, and the alien, are aroused. Stimulated by these ancient fears, we often respond with anxiety and a wish to return to the known and the familiar; in short, to patients with whom we can more readily identify.

Whatever situations we encounter, however, whether they are ones in which similarities between patient and analyst lead to rapid identifications or ones in which feelings of unfamiliarity and distance initially predominate, the development of a positive alliance or a good working relationship between patient and analyst often depends on our capacity for self-examination. I am not talking here about comprehensive and sustained self-analysis, if indeed such an entity exists, but of a kind of self-awareness based on the ability to scan one's reactions as one begins work with a new patient. For it is this valuable tool, along with the *mensch* factor, a way of looking at the world that respects the needs, rights, and realities of another person, that ultimately gives rise to the *gesundheit* factor. And this phenomenon, we know, is the unmistakable sign, long awaited by analysts and therapists of every persuasion, that treatment has gotten off on the right foot and that a good and solid alliance is in place.