Psychotherapeutic Strategies in the Treatment of Performing Artists

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Psychotherapy is a subject about which so much has been said and written that one approaches with trepidation the effort to summarize it. A full review is inappropriate for an article such as this. Instead, I will focus primarily on the problems of performers and the behavioral strategies of therapists.

Definitions

In the broadest sense, psychotherapy is a method of treatment that relies on *psychological* rather than physical interventions. Most physicians, whether or not they are aware of it, do some psychotherapy much of the time when they are with their patients. Effective history-taking, for example, requires an *empathic attitude*, a willingness to *identify* emotionally with the patient while maintaining clinical objectivity, and the ability to focus on appropriate issues, to ask relevant questions, and to listen attentively as well as reflectively.

In a more limited sense, psychotherapy has come to be regarded as a specific treatment procedure, to be practiced by *specialists*—in other words, by those clinicians who possess a talent for psychological work, who have undergone extensive training in the field, and who have acquired the skills and knowledge to qualify for membership in an association, school, or institute devoted to psychotherapeutic endeavors. Along with the professionalization of psychotherapy has come the necessity for licensing, and this may include non-M.D.'s, for example, clinical psychologists and clinical social workers.

The sense of psychotherapy as a *specialized treatment modality* has of course been of great value in the field of *psychiatry* and also to some extent in medical specialties in which large numbers of so-called *functional* or *psychosomatic* problems are seen, as well as in *pediatrics* with its emphasis on understanding the dynamics of family life and interpersonal relationships.

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Psychiatric Problems of Performing Artists

Despite the great number of books and articles on psychotherapy, very little has been published specifically about musicians and dancers (with the possible exception of a growing body of literature on the management of performance anxiety). It is not that psychotherapists have not been treating performers. Indeed, musicians and artists have always been part of the psychotherapist's case-load, beginning with the early days of psychoanalysis at the turn of the century. Gustav Mahler and Bruno Walter, for example, were personally treated by Sigmund Freud, and Freud's early associate Alfred Adler had a large clientele of actors and musicians. The pianist and composer Sergei Rachmaninov was treated with psychotherapy, suggestion and hypnosis—his third piano concerto is said to be proof of the successful outcome of the treatment. Robert Schumann had psychological help on numerous occasions, which I documented in my biography of this composer. (In those days psychotherapy was called moral treatment.) The organist and composer Anton Bruckner was hospitalized for three months, during which he received primarily psychotherapy. Finally, the dancer and choreographer Vaslav Nijinsky received expert care from the psychoanalyst Ludwig Binswanger in Switzerland.

Nevertheless, for a variety of reasons there is limited information on the incidence and treatment of psychiatric disturbances in musicians and dancers. Part of the problem is related to *confidentiality*. It may be deleterious to a career when a physical problem is revealed—a hand injury, a vocal nodule, or a dislocated elbow. Disclosure of a mental disorder is doubly stigmatizing. Although many performers are willing to joke that "you have to be crazy to be an artist," few are willing to discuss openly their own psychotherapy (with a few notable exceptions, such as clarinettist, actor, and film-maker Woody Allen).

Frankly, we had no clear idea of what to expect when we opened a Health Program for Performing Artists in San Francisco. Upon reviewing the records of our patients from the last year, we found that:

1. Performing artists do appear to be at risk for the development of psychiatric disorders that are amenable to psychotherapy.

2. However, that risk seems to be somewhat lower than for the general population. Surveys of our patients show that from 30 to 50% have so-called functional, emotional, or psychosocial problems without evidence of structural or organic pathology.

Our statistics reveal that 189 patients were admitted within the last 12 months to the University of California Health Program for Performing Artists in San Francisco. Forty-eight (25%) of these admissions were primarily for psychiatric conditions, including severe anxiety and/or depression, personality disorders, somatoform disorders, psychoses, and suicidal behavior. By comparison, 60 patients (32%) were referred to the Hand Service, 22 (12%) to ENT, 22 (12%) to Orthopedics, 15 (8%) to Internal Medicine, 11 (6%) to Neurology, 5 (3%) to Dentistry, 4 (2%) to Dermatology, and 1 to the Eye Service.

In a study by Cohen and Kupersmith[4] on the magnitude of the need for mental health care among performers, 87 performing artists seeking psychotherapy from the Department of Psychiatry at New York University were reported to have scored significantly higher on a rating scale of psychiatric symptoms than did a control group of non-patients. However, the performing artist patient group scored lower than a group of non-performing artist patients admitted for evaluation to the same clinic.

It may well be that performing artist patients have developed personality patterns and coping styles that are significantly different from those of non-performing artist patients. These differences may account for some of the special vulnerabilities as well as the special resistance to psychiatric disorders that has been observed among performers. I would suggest that psychotherapy and other psychiatric treatment procedures may have to be modified or tailored to meet the special needs of this patient population.

Goals and Indications

Psychotherapy aims at the fullest mobilization of the patient's inner resources for understanding his or her disability, and for making those changes or adjustments in personality and lifestyle that are most likely to reduce the problems resulting from disease. Psychotherapy is not considered a cure, nor does it promise greater personal happiness or career success. It is a form of experiential learning that always involves a human relationship. Usually this psychotherapeutic relationship is with one person ("individual psychotherapy"). However, several people ("group psychotherapy") may be able to learn together if they share a common interest in talking about private and often intimate aspects of life. Musicians and dancers, in my experience, are often too self-centered and independent for effective group therapy. Also, it seems easier for them to arrange their work schedules to conform to individual than to group therapy. Depending on the patient's problems, psychotherapy may also improve social awareness and lead to better interpersonal relationships. In artistic individuals, psychotherapy can promote tolerance for unexpected or unacceptable products of the imagination and sometimes enhance creativity. With persons who are achivement oriented, psychotherapy may serve to reduce inhibitions and ameliorate work-blocks. There are certain problems for which psychotherapy seems to be indicated and desirable.

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1. Critical moments in the course of an artist's career, especially a young and ambitious musician or dancer who finds himself or herself flooded with disturbing emotions.

Example: A 21-year-old clarinettist has just won, to her great surprise, an audition to play in a major symphony orchestra. She had been hoping to "take it easy" for a few years, continue her studies, make new friends, and get away from the hot-house environment of a music conservatory. Suddenly she finds it necessary to buy a car, move to a new environment, leave a newly-found boyfriend, and adjust to a rigorous schedule of rehearsals and performances. She is flooded with doubts, fears, excitement, and apprehension. There is severe performance anxiety. Questions about parental expectations, about her identity as a woman and an artist, about the demands of her teachers, and about her economic independence come into focus rapidly and simultaneously. She needs time to decompress and wants professional help.

2. Times when a professional career seems to be failing or has to be abandoned.

Example: A 32-year-old dancer enters the hospital because of suicidal impulses that were evoked when he was discharged from a job. Despite a physical injury 10 years earlier, he still dreams of success in the world of classical ballet. His depressive mood and self-destructive fantasies are combined with a delusional sense of self-importance and a paranoid feeling that all of his problems are caused by people who dislike him and are out to get him.

3. The approach of developmental stages in life for which an artist has not been prepared or which he or she would rather not have to face.

Example: A 65-year-old singer fears that he may have cancer of the larynx despite visits to numerous otolaryngologists who assure him that nothing is wrong. In fact, he has not been able to accept retirement and has been struggling to sing with an aging voice. There is a growing sense of guilt because of an extramarital affair. In the background is a rivalry problem with his sister, also a singer, who is much younger and more successful than he.

4. Problems of loneliness, particularly when accompanied by sexual frustration.

Example: A 55-year-old entertainer yearns constantly to re-establish the sort of love relationship she had with a well-known radio personality who died 10 years previously. She lives alone, with a cat her only companion. Although she is attractive and occasionally goes on dates, she cannot accept a friendship that is less perfect than the one she lost years ago, which resembled an idealized relationship she had had as a child with her overly indulgent father. Sexual frustration is intense because many of the men she meets in her profession are gay.

5. Complications arising from alcohol and/or drug abuse.

Example: A 32-year-old timpanist has been falling asleep during rehearsals and once "blacked out" because of heavy drinking. He has been abusing drugs off-and-on since age 19, partly to control a congenital benign tremor and performance anxieties that became much worse while he was a student at Juilliard. Following a breakdown during a summer music festival, he was hospitalized for six months. The diagnosis was psychosis related to drug abuse. He functions well when seen on a regular basis and maintained on anti-anxiety medication.

Strategies for Psychotherapeutic Intervention

The kinds of behavior I will address in terms of psychotherapeutic strategy are arranged hierarchically. First, the most general and essential strategies (for a clinician) are discussed, followed by strategies that are likely to be most effectively undertaken by those who have had extensive training and experience in psychotherapy.

1. *Giving undivided attention to the patient*

While this is a *sine qua non* of psychotherapy, it is also the most difficult to accomplish. It is very important to select a suitable place and sufficient time. The environment should be reasonably quiet without being absolutely silent. An office that is unduly noisy distracts from the emotional rapport that is necessary for effective listening. However, excessive sound-proofing produces an artificial deadness in the room, which is more suitable for a broadcasting studio than a doctor's office. Telephones and beepers should be muted. Musician-patients in particular are sensitive to sound, so the tone of voice used by the therapist should convey interest, alertness, and compassion. Verbal and nonverbal behavior must communicate the therapist's absolute conviction that, at that moment, the patient is the most important person to the therapist. This not only reinforces self-esteem but also helps to focus attention on what the patient is saying and feeling. At the same time, the therapist will be observing his or her own thoughts and feelings in reaction to the patient, and using what is called "counter-transference" to learn why the patient is affecting him or her in a particularly positive or negative way. There are several ways of attending to the patient.

- *Silent listening*, in which the therapist keeps absolutely quiet. While this may be the most effective way to maintain clinical neutrality, it can also be disturbing, especially for patients who crave recognition and are accustomed to applause.
- *Responsive listening* may be more desirable at times. Here the therapist utters sounds such as "uh huh," "yes," "I see," or "go on" whenever he or she feels that the patient is overly anxious about proceeding, or seems to have gotten stuck, or is resisting the basic tenets of psychotherapy—to think aloud, to be truthful, and to try to report the ideas, images, feelings, and memories that come to consciousness.

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- *Visual contact* between the patient and the therapist must be carefully adjusted to the needs of each particuar therapy. Patients who are starved for attention do better when they are looked at and observed directly. Others, who are self-conscious or embarrass easily, should not be forced to tolerate intense scrutiny. The furniture arrangement in the office ought to allow for various degrees of visual contact and distance. Chairs that swivel, so one can easily shift positions, chairs that recline, so that one can find the most comfortable posture, and a couch or sofa for the patient to lie on provide maximum flexibility in this regard. I emphasize *flexibility*. Rigid adherence to a single technique seems unhelpful except when patients lack discipline, which I find rare among performing artists.
- *Living up to the contractual obligations of the therapy* is another way to enforce attention. There has to be agreement on the purpose or goal of the treatment and the amount of time, energy, and money to be invested in the process. Setting an appropriate fee is important, because too much money spent on psychotherapy may stimulate unrealistic expectations and breed resentment, whereas fees that are too low may serve to devaluate the treatment. It also helps to have an agreement about what is to be done about sessions that the patient misses by accident or by design, and whether or not lengthy discussions over the telephone have to be paid for. In my experience, performers are unusually conscientious about adhering to contractual obligations. Accustomed to appearing punctually for lessons, rehearsals, and performances, they appreciate the value of time and money.
- *Sensitivity to the effects of separation*. Psychotherapy can evoke strong feelings of dependency evocative of the patient's dependence on parents and caretakers who gave him (or should have given him) unconditional attention when he was an infant. Therefore it becomes important to discuss any impending separations caused by the therapist's absences, such as holidays, work conflicts, or illnesses. Similarly, to avoid undue separation anxiety and depression, the therapist should prepare patients carefully for the end of treatment, and leave the door open for later contact should additional help be needed.

2. *Clarifying the meaning of what is said and implied.*

The essence of psychotherapy is a human relationship bonded by symbolic verbal and nonverbal interchanges, as opposed to direct intimacies that characterize other important relationships, such as in marriage, in close friendships, and between parents and children. Thus, many of the techniques employed by therapists involve linguistic elements. Language is considered to be a valuable component of cortical activity in the human brain, and, together with cognition and symbolization, probably aids in the control and organization of subcortical processes. A few of the linguistic strategies that psychotherapists employ are:

- *Asking questions*: The type and timing of questions are important considerations. There are generally two types of questions: (1) those that *open up* topics for further exploration, and (2) those that *narrow* the focus of interest. Open questions usually include phrases such as "How do you feel about. . .?" "Why do you. . .?" "Can you go on?" "What's next?" They allow the patient to associate more freely his or her feelings, thoughts, memories and observations. Nar-

row or so-called "closed" questions make more specific demands for information: "Who was that?" "Were you angry?" "Have you thought of. . .?"

The timing of questions and the proper mix between closed and open questions depends on the problem at hand and the state of the patient. While taking a medical history or during conditions of crisis or emergency, questions that elicit specific information—the *yes or no* approach— are more useful. Open and exploratory questions are usually preferable when one is working in a more leisurely mode, or when trying to understand dreams, memories, fantasies, and behavior patterns that have been influenced substantially by unconscious mental processes. Artistic patients who are highly intelligent and have much curiosity about themselves can often be relied upon to ask their own questions.

- *Clarification.* It should always be assumed that patients know more about themselves than a therapist ever will or can know. However, because much of that knowledge is inaccessible to consciousness at any one moment, the therapist's job is to make sure that he or she truly understands what the patient is talking about. There are several ways to seek clarification. Open questions may be asked, such as "I don't understand. . ." "Would you repeat that?" "What do you mean?" Narrower focus is provided by statements such as "Do I understand you to meant that. . .?" "Can you tell me precisely about. . .?" or "Wasn't it. . .?" Note that the tendency is to find out what degree of clarification is possible through further dialogue. Another but somewhat riskier approach to clarification is by making statements such as: "It seems to me that what you are saying is. . ." "You mean. . ." "Another way of putting it would be. . ."

Clearly the authority and wisdom of the therapist vis à vis the patient must be a guide to the nature of clarification. The patient is more of an expert when it comes to his or her own upbringing, work history, and sexual preferences. The therapist has more authority when it comes to questions about general health and disease, ability and disability, diagnosis and prognosis. By finding the proper balance between clarifying *questions* and *statements*, the therapist not only encourages a meeting of the minds but also regulates the pattern of give-and-take, of activity versus passivity in his or her relationship with the patient.

3. *Interpretations.*

This is the process whereby a therapist encourages the patient to accept a new or different level of understanding about some aspect of his present and past behavior. It works best with patients who are struggling to find meanings in their symptoms or problems. Indeed, a useful rule of thumb is to allow the interpretation to flow from the patient's own queries, rather than to impose a new meaning from the outside as a teacher might. Of course, much depends on the therapist's personal philosophy and what theories of the mind he or she believes in. There are many competing theoretical systems, such as ego-psychology, object relations theory, and self-psychology; adaptational theory, interpersonal relationships, and communications theory; cognitive therapy, body awareness, and Gestalt psychology. No research so far has convinced me that one system is superior to another. In fact several studies have shown that when it comes down to what therapists *actually do* with their patients, there are more similarities than differences between the various schools or theoretical systems.

It is important for a therapist to be familiar with a variety of approaches. Again the emphasis should be on *flexibility*. The therapist should try to adapt his or her belief systems and theoretical assumptions to the specific needs of the patient, including the patient's age, gender, sexual orientation, social background, religion, education, status, and life experience. I believe it is a mistake to impose some particular doctrine about human behavior, whether it derives from science, religion, or common sense.

4. *Integrating psychotherapy with other treatment procedures.*

An important consideration in psychotherapy today is how best to combine psychotherapy with psychoactive medication. It is a relatively new problem for two reasons. First, it was long considered contrary to good psychotherapeutic technique for the therapist to treat the patient medically. The more orthodox, psychoanalytically oriented therapists insisted that performing a physical examination and prescribing medication were absolutely contraindicated. The interventions were thought to interfere with appropriate therapeutic distance, to disturb the therapist's neutrality, and to make the therapist too powerful and intrusive, like a parent. The second reason for the therapist to avoid providing medical therapy was that there really was not much in the way of medication available that could actually relieve the symptoms for which patients were seeking treatment. That has changed dramatically. First the neuroleptic drugs have enabled control of disturbing hallucinations, confusional states, and psychotic behavior. Tricyclic anti-depressants made it possible to reduce and limit some of the more common forms of depressiveness. The benzodiazepines have afforded effective relief from states of anxiety and panic. Lithium carbonate, MAO inhibitors, and beta blockers have increased the range of control over other disabling symptoms.

Thus today it would seem anti-therapeutic for a psychotherapist *not* to use psychoactive medication. The primary question usually is, Should the therapist write the prescription and monitor its effects or should another person do this? Obviously the second alternative is necessary when the therapist has not been medically trained. On the other hand, psychiatrists usually prefer to combine psychotherapy with psychoactive drug treatment, since it then becomes possible to observe closely the changes the prescribed medications produce in the patient, and to adjust the depth and intensity of psychotherapy accordingly. Clearly a number of requirements must be met.

- The therapist has to understand what the psychoactive medications can be expected to do—the desirable or targeted effects versus the undesirable or side effects. The therapist must inform the patient about changes that will take place, when these changes are most likely to occur, and how long they will last. It is essential to have the patient's active collaboration in drug therapy, which reinforces his collaboration in the psychotherapy itself.

Patients know more about themselves than a therapist ever will or can know.

Example: A 31-year-old French-horn player requests help during a state of agitated depression—his third such episode since age 16. He has many self-destructive ideas but does not wish to be hospitalized. He is especially concerned about an upcoming performance of *Till Eulenspiegel* in which he must play a difficult solo, as well as about a tour of the orchestra later in the year. It was decided that in addition to working on a number of basic dilemmas in his personal life, he should be taking a high potency tricyclic antidepressant for control of the major symptoms. These drugs can have autonomic side effects, including dryness of the mouth. It was explained that the dryness could be relieved somewhat by taking frequent sips of water or by chewing gum or candy. The patient was prepared to experience some discomfort while playing his horn, especially at the beginning of treatment. The results were excellent. Not only did the patient play beautifully and elicit praise during the concert, but as the depression subsided he also was able to participate in constructive discussions about his conflicts in regard to the tour, his status in the orchestra, and other personal problems.

- It is necessary for the therapist to develop an understanding of changes in the patient's behavior that can be attributed to the effects of medication and those that are the result of insight and self-awareness attributable to personal growth. This is especially important when treating patients who cannot tolerate medication for long periods of time, so as to avoid the danger of regression to undesirable patterns of behavior that the medication has helped to control.

Example: A 30-year-old composer who suffered from bipolar mood disturbances ("manic depressive disorder") since childhood decided to stop taking lithium, which had enabled him to endure a recent manic episode. During that episode he was able to complete a symphony that was performed and won an award for the most original composition submitted during the year. In reviewing the progress he had made as well as the risks he was taking by stopping the medication, two things became clear. First, it was owing to the lithium that he had been able to master the disruptive impulses and distractions that had kept him from completing his symphony and orchestrating it. Second, the originality of this work, its fascinating themes, and its appealing instrumentation had nothing to do with the lithium salts he was taking (although he did quip one or twice that the harmony was becoming a little "salty"). Rather, his success was a tribute to his musical genius (something his parents were never able to acknowledge) as well as to the growing capacity for accepting himself as an artist, which to some extent was a byproduct of his involvement in psychotherapy.

5. *Addressing the specific issues of being a performer.*

This is an area that has not been well described in the professional literature on psychotherapy; much of this discussion is based on experience gained by myself and with colleagues by working with performing artists in Northern California. How generalizable the information is, remains to be seen. Surely this is a golden opportunity for well-designed clinical research.

It is essential that a psychotherapist try to obtain a detailed understanding of the patient's choice of modality for self-expression (acting, music, painting, writing, etc.) as well as the specifics of instrumental training, the nature of previous experiences with teachers and mentors, the realities of past and current successes or failures in performances, and career expectations including hopes for fame, status, wealth, and immortality.

At some point, it might be desirable for the therapist to witness a patient's performance.

Some of this information can be obtained in the context of an initial thorough evaluation, including a detailed medical and personal history. However, some of the critical developmental problems will emerge only during treatment, when the patient begins to remember and face up to significant incidents from the past that carry emotional weight.

Example: Only after several months of psychotherapy could a 45-year-old harpist disclose that when she was 17 she had been enticed into a sexual relationship by her music teacher. This had been a source of intense guilt and anxiety; guilt because she was fond of the teacher's wife, whom she felt she was allowing her teacher to betray; anxiety because she feared that the teacher would ultimately reject her in favor of another attractive young student. When the latter actually happened several years later, the feeling of rejection, added to the patient's already chronic guilt and fear, precipitated an acute depressive episode.

Because of the long and complicated educational histories of our patients, many of whom have been affiliated with the performing arts since childhood, we have found it desirable to select therapists who themselves have had training in the arts and in some instances continue to perform. Thus our clinical social worker is a trained dancer; one of our psychiatrists is a pianist with two grown-up sons in the arts; I am a violinist active in chamber music. Our impression is that these aspects of personal life experience make it easier to establish emotional rapport with our performer patients, to help in selecting appropriate topics for discussion and further analysis, and to steer the psychotherapeutic dialogue in and out of troubled waters.

6. *Sharing the performing experience.*

Several psychotherapeutic strategies tend to be considered controversial in the context of classical psychotherapy, although they are recommended in the literature on group therapy, especially so-called "activity groups," as well as in play therapy with children. Specifically, they relate to the question of a therapist's active involvement in the patient's performances, practice sessions, rehearsals, or concerts.

Some degree of vicarious participation in a patient's performances often seems to occur spontaneously and naturally in the therapist's imagination while he or she reflects on what the patient has been describing. But words can go only so far in describing actions, and there may come a time when a patient, no matter how willing, and a therapist, no matter how knowledgeable, cannot quite put their finger on what the problem is. At that point it might be desirable for the therapist actually to witness a performance.

Example: A pianist of Japanese ancestry, complaining of her lack of success, her personal unhappiness, and her inability to get along with American musicians, was invited to play something for the therapist. She selected the first movement of Beethoven's Emperor Concerto. Her bombastic performance, accompanied by exaggerated movements that resembled a duel with sabers, led the therapist to surmise that she was seeking to identify with aspects of her father's Samurai traditions and was unconsciously enacting a death struggle with the piano.

Attending the concerts of a musician, observing the audience reactions at a ballet performance, and reading the review of newspaper critics may be cited as additional examples of participation. Depending on the circumstances, and never without exercising clinical judgment, the therapist may bring his or her observations and judgments to the patient's attention.

It may become necessary and desirable for patient and therapist to make music or dance together. I recall a difficult case that was referred to me by another therapist who found the patient impossible to treat. He was unemployed, depressed, spoke only about his physical symptoms, kept threatening to kill himself, and refused to accept medication. After the second visit to my office, the patient, a 33-year-old composer and pianist, asked whether I would play some sonatas with him. I gave the clinically appropriate answer: "Let's see what that would mean, and try to talk some more about it first, along with anything else that might be on your mind." For several weeks the patient accepted this advice and tried his best to talk. But usually after 10–15 minutes he would stop and want to leave. Several times he walked out of the office before the end of his session. Then one morning I received a letter. The patient had decided never to come back. Therapy was of no use. He felt terrible and was going to jump off of the Golden Gate Bridge. I answered his letter by saying I could understand how he felt and would agree to stop psychotherapy. However, I wanted him to come back for just one more visit, so that we could talk about his question about playing sonatas together, which I felt had never been answered. The patient agreed to be seen one more time, and I told him, "Yes, I do want to play sonatas with you." After that I made regular house calls carrying my violin instead of my little black bag. We seldom exchanged words, except to talk about what we would play and occasionally to comment on the music. Within six months the patient had begun to compose a trio (an unconscious message, perhaps, that he was ready for a third person in his life). He then found an excellent job teaching music in a university. His symptoms gradually subsided. After two years the patient told me that the problem with his previous verbal psychotherapy had been that usually after 10 minutes he had said everything there was to say, that all he could think of was music, and that whatever I told him made no sense whatsoever, so why not end it all.

In doing psychotherapy with performers who are deeply disturbed, it may be desirable to use a co-therapist, an experienced clinician who works more as a coach than as a doctor or a teacher. Let me illustrate this approach by citing the "Plan" of a therapist-coach (Dr. Frank Johnson) in treating a young pianist.

"I introduced myself to her before she began talking as a *consultant*, and defined my role as attempting to assist her in mental and physical preparation for playing, practicing, and performing. I told her I would be interested in discussing the variability in pianistic performance, both as experienced by her and by others, as a way of placing her own playing in more realistic terms. I also said that it would be important for me to try to help her develop a more reasonable *mental set* concerned with actual piano playing. Possibly the most important area, however, would be to assist her in assuming more ego control over the planning for what she does. It is conspicuous in many of her stories about her preparation for music that she exercises very little planning and furthermore subordinates herself to other people, some of whom are not necessarily prepared to guide her in the ways that she apparently needs.

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"I suggested that the next time we meet that she bring a spiral notebook that she and I would use to try to project more clearly her intentions concerning the learning of certain pieces over periods of months and the ways in which that might be approached. I would also witness her playing and talk to her about methods of practice that are less compulsive and involve a mental set of 'listening to oneself play' rather than obsessing about the 17 things that 'might go wrong.' "

Conclusion

What counts most of all are the intellectual commitment and emotional honesty of the psychotherapeutic relationship. Rather than *doing* psychotherapy, one has to *be* psychotherapeutic. As a famous psychiatrist once said, "A therapist is a kind of service man. There are so many things a patient can want to use you for—and if you can swallow your own ideas of how things *should* be, you can perform a real service."

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