THERAPEUTIC RESONANCE[1]

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The practice of psychotherapy as a healing art involves the development of two capacities in the therapist. One is the capacity to resonate in response to the patient. The second is the development of technical therapy skill to the point of intuitive mastery. When these capacities work in concert, there is the highest probability that therapy will lead to healing the patient.

Healing, in this paper, refers to more than achieving insight or behavior change, although these things often follow. The word is used to mean restoring someone to a state of well-being, and refers to the process of exchanging suffering for ease, illness for health, and conflict for a sense of basic wholeness and strength.

Therapeutic resonance is the vehicle to healing. Resonance is a way of "being with" another person and expressing fundamental receptivity and openness to that person. To resonate with someone is to serve as a mirror for him[2], and to be so closely identified that you feel his experience. Resonance is rooted in a stance of quiet attention, with minimal resistance or value judgment about its nature. Therapeutic resonance allows for more smoothly flowing progress, and this is indicated when a patient does not appear disturbed or unduly jarred by resonant interventions. Resonance between therapist and patient is confirmed when the therapist responds to the patient and the patient accepts this and responds back as though at one with the therapist.

Resistance to resonance on the part of the therapist tends to be an obstacle. Therefore the therapist must create an "inner silence" (Izutsu, 1975, p.3) for each patient that allows the resonance with that patient to come into awareness. Izutsu observed that a highly developed artist who is painting a picture

of bamboo "throws his own self wholly into the living spirit of the bamboo until he feels a mysterious resonance of the pulse-beat of the bamboo in himself as identified with his own pulse beat....he has 'become the bamboo'" (p.3). A therapist who is open to resonating with a patient, and is aware of the possibilities of such resonance, is in an improved position to create a healing therapeutic atmosphere. For instance, if a patient is talking in an unemotional manner and the therapist begins to feel depressed and hopeless — a feeling that abates slightly as the patient pauses between sentences and then continues — a resonance may be occurring. The patient may be reflected in the mirror of the therapist.

In Western psychological theory, parallels can be found to the experience of resonance. Sullivan (Mullahy, 1970) theorized that certain phenomena took place by means of a "mode of communication or emotional contagion [that] may not occur through ordinary sensory channels" (p. 344). Heimann (Racker, 1968) noticed a "rapport on a deep level [that] comes to the surface in the form of feelings" (p. 128). Spotnitz (1976) referred to the transmission of emotional states from patient to therapist as "emotional induction" (p. 25), a process that is "...constantly ongoing between human beings on an unconscious level" (p. 25).

A therapist who is unaware of resonance may be inadvertently controlled by it. For example, a therapist who begins to resonate with a patient's depression, and is unaware of doing so, may fall silent and passive in response. This is a reaction to resonance, and is not resonance itself. A therapist who is particularly vulnerable to ill effects from certain states may unintentionally fend off certain resonances. For instance, if a therapist cannot tolerate feeling hopelessnesss at the moment that resonance with the patient would require it, he may resist this experience. A process that is not available to the therapist's conscious mind may push him away from a state of being with the patient. The therapist's departure from resonance may

take the form of talking too much to reduce his own tension or trying to intervene to change the experience of the patient into a more tolerable one with which to resonate.

Izutsu (1975) cites the following koan:

> A monk once asked Master Chao Chou: "Who is Chao Chou?" Chao Chou replied: "East Gate, West Gate, South Gate, North Gate!"

As with Chao Chou, all gates to the therapist's mind must remain open and all travelers must be allowed to enter without exception. The therapist must be open to all that may arise in the session. All feelings and thoughts of the therapist may be a reflection of the patient, and the therapist must accept them. Love, depression, happiness, confusion, despair, frustration, sympathy, hopelessness, thirst, headache, disappointment, negativity, a desire to help, and even a desire to reject one's experience; all must be allowed in, but not all are to be acted upon. Speaking must be limited to the appropriate time and words. The timing, tone, and format is determined by a combination of therapeutic resonance and technical skills.

A therapist must be trained in such a way that the natural process of halting certain experiences at the "gate," which often occurs beneath the level of awareness, is curtailed during the time with patients. This is not easy. Just as a city has walls and gates for protection, so does the mind. Does this mean that the therapist must be able to tolerate psychotic feelings if working with a psychotic, and suicidal feelings if working with a suicidal patient? Yes it does, if these are the experiences of the patient. No ordinary person wants to experience such things voluntarily. Therefore, the therapist's reflexive reaction for self-defense must be disciplined for the sake of the patient. Racker (1968) described the danger of one such reflexive reaction in his discussion of "talionic" (p. 139) responses by the therapist.

When we accidentally place our hand on something hot, we immediately pull it away. But in the therapy session, if we feel compelled to say something, we must *not* do so; this reaction must be evaluated quickly, then either spoken or withheld and tolerated. With training and practice, the time interval of this evaluatory process can be a fraction of a second and may eventually become almost intuitive.

THE THERAPIST IN TRAINING

A therapist and his supervisor must also respect the limits of the therapist for such tolerance. The opening toward "gatelessness" takes time. As with meditation, continued practice and training allow a broadening of one's levels of awareness. The use of psychotherapy for healing is most likely to occur when the therapist has attained these prerequisites:

1. The capacity to resonate with the patient.
2. The capacity to welcome being a reflection of the patient, no matter how uncomfortable or disquieting.
3. The awareness that this process is occurring.

Once these three criteria have been met, the rest is a matter of technique and experience.

Deepening one's practice of therapy requires discipline, and certain technical procedures can provide a structure for learning and practicing it. It is important to learn patience, restraint, and self awareness in the early stages of training. As with meditation, the basic discipline of sitting still, being aware, and being quiet — no matter what the mental or somatic experience — needs to be practiced until it comes naturally. Once this is learned, the therapist can relax into the work.

Supervision and technical interventions should provide a temporary bridge between the patient's experience and the therapist's experience. The supervisor needs to resonate with the therapist-in-training as well as with the therapist's patient. Experiencing such resonance by a supervisor enhances the therapist's practice of resonance. It allows him to get in touch with, learn to tolerate, and eventually welcome his own experiences.

In resonating with the therapist-in-training, the supervisor will probably resonate with the therapist's difficulties with the case, as well as his overall experience. Generally, it is countertherapeutic to transmit resonance to the therapist's difficulties, and the prudent supervisor restrains himself. Eventually another resonance may arise, one which would be helpful to express to the therapist. (Usually resonance is transmitted verbally, although there are times when it is enough simply to have the resonance.) An example of resonance between supervisor and therapist is described below.

Recently, a therapist-in-training came to me for supervision about a case that worried her greatly. Her patient felt increasingly that his life was crumbling around him, and he was panicky about having a psychotic break. She responded to him with similar panic and tried desperately to soothe, comfort, repair, and investigate his problem. Her efforts were in vain; he was unable to speak easily with her and continued to be overwhelmed by his feelings.

In resonance with my supervisee, I experienced panic about this patient's potential for a psychotic deterioration and about the effect that this would have on my supervisee. This resonance was probably also reflective of the patient's panic about his increasing loss of control. I felt a second resonance, a desire to reassure and soothe the therapist, which I assumed reflected both her desire to soothe her patient and his desire to be helped. Clearly, both were struggling against their experiences and sinking more deeply into trouble. In addition, this

therapist had a long-standing tendency to doubt herself. She would become very upset if she appeared to fail in any way. Her confidence required bolstering for her to proceed down her own path of development as well as to help her patient.

I decided to keep the early resonance of panic to myself so as not to upset both therapist and patient further, and chose to respond with the soothing resonance once it had reached sufficient intensity. I spoke gently to the therapist, asking her a question to transmit my resonance and to indicate my faith in her, thus making for a less pressurized therapy process. "The patient has been in treatment with you for some time now. What makes you think that the work you have done in the past will not turn the tide as soon as he is ready?" I reassured her about the difficulty of the case and commiserated with her about the burden. She seemed less anxious after these interventions and reported "feeling less like racing to put out the fire."

The following week, the therapist reported that a change in her patient was apparent within minutes of starting his session. The patient calmed down, talked more freely than ever before, and reported a substantial quieting of his fears. Yet the therapist reported having done hardly anything beyond approaching the session with less panic.

In essence, this supervision consisted of containing the panic of both therapist and patient, modeling mindful restraint for the therapist, allowing a transition in resonance to occur, transmitting resonance through a soothing tone of voice and discussion, and thus providing a bridge to help the therapist soothe the patient. The supervision changed the therapist, and the patient responded to this almost immediately — confirming that the experience was therapeutic resonance.

The use of resonance cannot be learned in an intellectual manner. It must be learned experientially through supervised practice. Trungpa (1984) emphasizes the importance of training. He gives the example of a race car driver who can

> "drive at two hundred miles an hour on the race track because of his training. He knows the limits of the engine and the steering and the tires; he knows the weight of the car, the road conditions, and the weather conditions. So he can drive fast without it becoming suicidal. Instead it becomes a dance. But if you play with letting go before you have established a proper connection with discipline, then it is quite dangerous." (p. 55-56)

Trungpa (1984) points out, in discussing the process of relaxing in one's discipline, "It is a relaxation based on being in tune with the environment" (p. 56). In the case of therapy, interventions flow from training, discipline, a knowledge of one's own mind, and an ability to resonate with the patient's mind.

TECHNIQUE

Resonance alone is not sufficient to heal a patient. In addition, the skillful therapist participates in strategic activities which arise from the "ground" of resonance. Such activities can be seen as falling into one of three categories. These are contemplative silence, "being-with" interventions, and homeopathic interventions. It may at first seem contradictory to use the openness and goal-lessness of resonance in a strategic fashion, however a skilled therapist can act spontaneously as well as strategically in the same moment.

Contemplative Silence

The role of silence in the healing process is often overlooked. As it is currently practiced, therapy often becomes an educational process for the patient instead of a healing process. Many patients enter therapy with the misconception that if they can discover what they do that causes their pain and why

they do it, they will be magically released from suffering. In my opinion, this is not the case.

It is important for the therapist to acquire insight into the patient so that the experience of resonating with him can be understood in the context of greater knowledge and understanding about the patient. But it is equally important that the majority of this work occur inside the therapist in periods of *contemplative silence* during the session.

Contemplative silence is the process of listening silently, having an awareness of resonance with the patient, being with his moment-to-moment experience, maintaining awareness of the patient's history and current life, and being ready for intervention (i.e., ready to speak to the patient). Intervention occurs at a moment when the patient requests it or when all the elements of the session create an opening for the next intervention. Otherwise, it is important to limit one's activity. In the practice of zazen[3], limiting "activity to the smallest extent" (Suzuki, 1970, p. 75) is a way of being in the present moment and expressing that moment internally. In the practice of contemplative silence, limiting one's activity leads to a resonance from which flows the capacity for healing action.

Contemplative silence also serves as an exercise in discipline for the therapist if an intensely disquieting experience occurs. It is at this very moment that it is most important to tolerate and study in silence. As Lief (1985) stated, "if we allow ourselves to feel discomfort, a natural receptivity and insight will develop" (p. 11). With repeated practice, the therapist develops the capacity to act in a healing manner no matter what the emotional atmosphere of the session. In this way he becomes more "able to cross the river without falling into its turbulence" (Trungpa, 1973, p. 173).

By way of illustration, in a therapy session with a patient I had been seeing for some time, I was suddenly overcome by a strong impulse to be more giving to him. I thought that this experience was a resonance, and probably reflected some

neediness in my patient. I then remembered that a friend of mine made me a small gift of a picture-postcard of a Japanese woodcut, which I was carrying with me in my appointment book. I had a strong desire to give my patient this postcard. Using contemplative silence, I withheld expressing or acting upon this feeling, studied it, and let it intensify in my experience. In his next session my feelings of warmth and wanting to give the postcard were even more intense. In my silent study, I noticed that there was no indication from the patient or any element in the session that created an opening for such a gift. Again I held back. As the patient entered my office for his next session, he handed me a rolled-up piece of rice paper and informed me that this was a gift he had meant to give me for some time to express his gratitude. I unrolled the paper and found a woodcut print.

In retrospect it was instantly clear to me that my feeling of wanting to give the woodcut postcard was in resonance with the patient who had a desire to give. By using contemplative silence and simply tolerating my experience until its meaning was clear, I allowed the patient to go down the path he wanted to take and unfold the therapy in the manner he needed. The outcome of silent resonance may be to withhold, or instead to provide an intervention. In the case discussed, intervention might well have interfered.

There are, however, times when silence can be destructive to the therapy. In these instances, silence would not be in tune with the patient and is not contemplative silence. Certain patients require extensive talking from the therapist. Similarly, therapists early in training sometimes need to talk to discharge uncomfortable feelings that remove them from a resonance with the patient. After this discharge they can return to being with that patient again.

The state of mind realized through a seasoned meditation practice comes as a result of just sitting, following one's breath and attention, in good posture, again and again. As this state

becomes more natural to the individual, meditative awareness and openness may be generated throughout the individual's day-to-day life. Similarly, the repeated practice of psychotherapeutic resonance may be seen as a path that deepens one's ability to resonate and furthers one toward being able to act in a healing manner with a variety of individuals, in differing treatment atmospheres.

Being-with Interventions

Providing interventions that establish within the patient a sense of being understood completely — of temporary oneness with the therapist — may well be the most important activity of the therapist. Such intervention gives the patient a sense that he is not suffering alone and unnoticed, and an opportunity for relief from defensiveness. For the patient who is hesitant, beaten-down, weakened, and isolated, this intervention can have the effect over time of a transfusion. It serves as a reinforcement for the patient's "selfhood," which translates into a strengthening of his will. Interventions may rely on a tone of voice or an attitude that flows from the therapist's resonance, and may take the form of siding with the patient or even verbally attacking others by whom the patient feels he has been harmed. They may take the form of soothing, validating, reflecting, or supporting the patient's view.

An example of being-with intervention involves a session I had with a patient who had just lost a much-wanted baby in her eighth month of pregnancy. She came into her session in searing grief and intolerable pain. Upon hearing her discuss the details of the miscarriage intermingled with the details of the preparations she and her husband had made for the baby, I resonated with her deep loss, sense of isolation, pain, and grief. She was crying in a very stiff, pained manner, tears running down her face, but with little relief. I did not restrain

my eyes from tearing and made an occasional remark with grief and sympathy in my voice which flowed from my strong resonance. In response, the patient let herself relax and sobbed openly and deeply for some time.

Another example of a being-with intervention can be seen in a session I had with a man who spent his life as the family scapegoat and who finally felt completely and utterly defeated and rejected by his family. He seemed exhausted and drained, he hung his head, and could hardly speak loud enough to be heard. His children, who lived with his ex-wife, recently refused to visit him or call; his mother had recently died and complained about him even on her deathbed; family members complained about having to ride to the funeral in a limousine with him; and his father cut off communication with him completely after his mother's death. Although the patient had a depleted presentation, I experienced outrage and anger at the insensitivity of his family and thought this to be a resonance with a hidden part of the patient. I began interjecting negative comments about his family and allowed some of the resonant anger to flow into my words: "They spoke to you that way at the funeral?!;" "They treated you like dirt!;" "What a bastard!;" and so on. The patient began to seem slowly resuscitated from his lethargy and began showing his anger. He banged his fist on his chair as he talked and ended the session by resolving, "I am not going to let them beat me down!" This invigorating effect on a patient indicates that resonance has come full circle and the patient now resonates with what the therapist has transmitted.

The resonance of a therapist with his patient's state does not automatically mean that patient comprehends his own state or the therapist's resonance. The patient may be conscious or unconscious of these phenomena. For healing to take place, it is not necessary for the patient to be conscious of these states, but the therapist must be.

Poison as the Antidote for Poison: Homeopathic Interventions

Izutsu (1975) refers to the action of a Zen master bringing up an unanswerable question as a "pseudo-problem" to his students. Reflecting on such a problem can create a slightly unpleasant effect, just as reflecting upon the master's answer to pseudo-questions from students may also be unpleasant. Izutsu cites that Zen masters typically respond to such questions with a seemingly nonsensical and confusing response (e.g., a "sharp blow with a stick, a kick, a slap in the face, a shout, etc.," p. 12). Izutsu considers this as "giving poison as an antidote for poison" (p.10). Such responses tend to mobilize the student to strive harder to understand and to work with increased vigor.

In psychotherapy, such responses to a patient are completely inappropriate. However, a very mild verbal equivalent of these actions can be applied similarly to mobilize resources in the patient. According to Lucas (1986), "although healing is possible without using this slightly unpleasant stimulation, it is not usually as rapid."

A homeopathic physician administers small doses of toxins to individuals as a remedy for the symptoms that ail them. To stimulate healing, the highly diluted toxins selected for administration are those that produce similar symptoms to the ones that are already troubling the patient (Moskowitz, 1980). Such a procedure can also be applied to the therapy patient who has self-destructive reactions to contact with specific interpersonal and emotional "toxins."

When an individual's personality or spirit is damaged and hurt, certain weaknesses are apparent. Due to the harm done, certain types of stimulation can attack these weaknesses and create havoc within that person since he is defenseless against them. For instance, the patient who has been injured so that he cannot defend against emotional abuse by others, may re-

spond to such mistreatment with increased self-abuse, depression, anxiety, or suicidal ideation.

The therapist uses his own experience to create the remedy that is applied through a *homeopathic intervention*. When the therapist resonates to negativity in the patient, a homeopathic intervention may prove therapeutic. The negativity may be felt in many possible forms, including self-hatred (inadequacy, failure), anger at those who have harmed the patient, or frustration with the patient's behavior or self-destructiveness. The resonant negativity can also be felt against a stressor or disease process that the patient is undergoing. When the therapist is disciplined in containing negativity, he may apply a homeopathic intervention. (In the early stages of therapy this is ill-advised, but after the patient has been strengthened, this step can be considered.)

As in homeopathic medicine, the intensity of the resonance is diluted into a very mild dosage and enclosed in an indirect intervention. By "indirect," I am referring to such a subtle and low-intensity intervention that the patient is not consciously aware of having been slightly toxified. Homeopathic intervention might take the form of a slightly acerbic tone of voice, a subtle questioning or challenging of the patient's position, taking the point of view (to a very small degree) of those antagonizing the patient, or partially agreeing with a patient's self-criticism. A parallel in Western psychotherapy is Spotnitz's concept of "emotional immunization" (1976, p. 50) wherein the patient is given "verbal injections of the emotions he has induced in the analyst." Homeopathic interventions can stimulate a patient to rally and fight for his health, and eventually be less at the mercy of negativism.

For example, consider the case of a very passive and depressed patient who continually allowed others to take advantage of her without protest, while taking pride in her ability to be "understanding" and considerate of others no matter how they treated her. In sessions with this patient, I experienced a

complex resonance that simultaneously contained a sort of admiration of the patient's self-restraint and principles as well as an overriding anger and rebelliousness at the mistreatment from others. I decided to refrain from transmitting the anger to this fragile patient, and allowed the resonance of admiration for her restraint to flow into my intervention. I gave her a small dose of an experience that contributes to her constraint and complimented the patient on her consideration toward others. She responded, with a tone of protest, "But I'm so tired of being such a saint in my life!" Further intervention along this line would continue to foster protest and rebellion as the treatment progressed. (This is also an example of how transmitting one part of a complex resonance back to a patient tends to allow the patient to experience and ventilate the other part more fully.) As the patient became stronger and more expressive, my interventions slowly began to include very mild doses of my resonance with the anger I experienced, and I began using a slightly acerbic tone. The patient, growing increasingly more immune, resonated back with angrier protests and "corrections" of my point of view.

As the patient learns to defend himself, he begins to express hostility that was once directed against himself. Here the therapist must be disciplined, and must tolerate the hostility (and his reactions to the hostility), without fighting or otherwise defending himself. He must let himself be used for this purpose, much in the way that Trungpa (1973) describes the practice of a Bodhisattva[4]. Such a person has learned to "trust in the fact that you do not need to secure your ground" (Trungpa, 1973, p. 100). Defending against an initial expression of this type from the patient will turn the aggression back to the patient and will not encourage further strengthening and expressiveness. Such expressiveness from the patient is especially important where there is the potential for suicide or where there are indications of extreme somatic negativity, such as cancer.

The therapist's acceptance of negativity is an important aspect in helping a patient move towards health. In discussing the role of the Tibetan physician, Donden (1983) expressed a similar view, stating that the healer "contemplates that all of the darkness, all the shadows, all the sickness of the patient are being absorbed by oneself and all of the light rays [of health or sanity] are being emanated to the patient" (p.26). In order to promote healing, we need to be willing to practice this form of "exchanging oneself for others" (Kongtrul, 1987, p. 6).

HEALTH, COMPASSION, SKILL

The use of resonance as a vehicle for healing is based on the repeated experience that the patient will naturally follow an intrinsic path to health if provided with an atmosphere that allows for such movement. The patient senses this healthy path but may be unable to pursue it. In one manifestation or another, all who enter our offices present this dilemma, or the symptoms thereof, as their problem.

Through the healing process, the patient becomes reacquainted with qualities that may have been hidden or subordinated long ago. Restoring these qualities allows the patient to pursue his path and goals. If we are restoring qualities, then they have been there already. As Ryokan (1977) stated, "If we gain something, it was there from the beginning. If we lose anything, it is hidden nearby" (p. 48). Some qualities have been buried by various types of damage for years or even decades, and some may never have had the chance to develop fully before they were hampered or damaged. The reemergence and strengthening of these capacities helps the patient feel whole again.

The major task of the patients or supervisees is to arrive for the session, be themselves, and talk sincerely and openly about what is on their minds — to the best of their ability at that

moment. As the therapist practices resonance with himself, week after week, the patient becomes increasingly able to be himself and talk openly in a coherent fashion. According to Lucas (1986), providing the patient with "an environment that is attuned and familiar allows healthy and steady growth to take place."

The skillful therapist needs to focus his attention on his experience of resonance, noticing distractions and returning to resonance with the patient. This is not to say that the patient's history, patterns, dynamics, personal path, external-life current events, and culture are unimportant. These factors are, of course, extraordinarily important. They enter into the patient's presentation of himself just as the same factors enter into the therapist's resonance with the patient. Trungpa (1987) stresses the importance of placing the experiential focus of therapy above theoretical or historical factors that may be considered relevant to the patient:

> "The past is gone, and the future has not yet happened, so we work with what is here: the present situation. This actually helps us not to categorize and theorize. A fresh, living situation is actually taking place all the time, on the spot. This noncategorizing approach comes from being fully here, rather than trying to follow up some past event. We do not have to look back to the past in order to see what we ourselves or other people are made of. Things speak for themselves, right here and now" (p. 13).

The practice of resonance is a way of healing that can be developed if we are willing to experience another's suffering in the service of making that person well; it is an expression of compassion. As Donden (1983) indicated, healing occurs when the practitioner has this "fundamental proper motivation, which is love and compassion" (p. 22). The practice of resonance develops patience and tolerance in the therapist, and supervision offers a solid ground from which to conduct this practice.

Therapists are drawn to their profession by an ability to feel for others and therefore, usually have some innate experience of resonance. Therapeutic practice based on intellectual training alone is unlikely to nurture this capacity or teach the possibilities for its use. The practice of resonance is a way of being in which skill and compassion become intertwined, and cultivation of this skilled compassion is the path to becoming a healer.

NOTES

1. I am indebted to Dr. Edward Podvoll, Mr. Robert Walker, Mr. Reed Bye, and Dr. Gerald Lucas for their thoughtful dialogues that helped me to clarify the concepts in this article.

2. The convention of using he, him, his, and himself to represent all individuals is used throughout this article.

3. Zazen refers to the sitting practice of Zen Buddhism.

4. In the context of Buddhism, a bodhisattva is an individual who has dedicated his or her life to helping others.

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