Faith, Hope, and Love in Psychotherapy

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Abstract

This article is the last known authored by Dr. Harold Mosak, Adler University co-founder and Distinguished Service Professor, Adlerian scholar, and a fellow of the American Psychological Association. It was recorded as a conversation during the last several months of his life. The article reveals Mosak's thoughts on what theories and practices work in psychotherapy, illustrated by examples of what worked for him and his clients in the decades of his own clinical practice. Although the term *common factors* is not specifically used, this article may be considered a contribution to a contemporary discussion about common factors in psychotherapy. Yet *factors* may sound too technical, too mechanistic for what this article offers—the idea of faith, hope, and love not as common factors, but as a powerful and necessary common feeling in psychotherapy. This article discusses Adlerian therapy as uniquely positioned to successfully bring faith, hope, and love into therapeutic encounters and to carry these feelings beyond therapy and into our everyday lives.

Keywords: Adlerian, hope, faith, love, psychotherapy

This article was recorded over several different occasions from late 2017 to early 2018. The days on which it was recorded matched the recording topics in ways I could not understand until later. The "faith" day was one of those bad-weather, bad-news days in late fall. As Dr. Mosak and I were sitting at the table in a common area of his care facility, it was nearly impossible to not be distracted by loud local TV station newscasters making sure that we had good audio and even better visual for all the murders, robberies, and falls on train tracks in the Chicago area that day. In addition, near us was a group of people playing bingo, as if trying to fix all the TV-reported misfortunes with a quick and light draw of random bingo luck. Victorious exclamations of "Bingo!" were constantly mixing with sounds of nursing calls and bits of social conversations among people going into and exiting elevators. Dr. Mosak seemed to be the only one unaffected by all of this, as he carried on with his talk, briefly glancing at his notes and occasionally checking with me or testing my students or me on how well we were learning from him. The second recording took place a couple of months later. It was snowy and cold outside: a very long winter, as he and I both agreed. Dr. Mosak was recovering from a bout with pneumonia and was wearing an oxygen mask. He said that he was happy the illness was over, mostly because the ban on

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visitors had been lifted. He planned to have more people come to see him. On that day, we recorded his talk about hope. The final talk—on love—was recorded right before Valentine's Day. On that day, someone brought Dr. Mosak a box with a huge Hershey's chocolate kiss inside it. Harold asked me to find a plate and cut the chocolate, so he and I could share as we were recording. He wanted only a few crumbs, and he joked that this was all the sweetness he could have until his next Valentine's Day.

I am sharing these details, as Harold wanted me to, so you can experience this article on more than one level. Dr. Mosak loved to teach. In those last couple of years of his life, he would ask me to bring more students. He would have them sit around him or on his bed, and he would always start his conversations with one question: "What do you want me to tell you today?" In the same way, as he dictated this article to me, he was looking at me and teaching me. So, if you are reading this article, he is now teaching you, too. The three main lessons I have learned from Harold are to carry the faith, to breathe hope, and to share love. You will now learn your lessons from Dr. Mosak, the Adlerian, the teacher.

Faith, Hope, and Love in Psychotherapy

I call this article "Faith, Hope, and Love in Psychotherapy." I am not a prophet. I am not a theologian either. I do not propose to do what other people have done when they have discussed similar topics, attempting to reconcile Adlerian psychology and psychotherapy with various religious principles. I am not going to do that. Saint Paul in I Corinthians writes, "And now abide faith, hope, love, these three; but the greatest of these is love." Saint Paul was an observant Jew before his sudden conversion on the road to Damascus, but he must have known, being an Orthodox Jew, the Hebrew equivalents: *emunah*, *tikvah*, and *ahavah*. In 1974, I wrote on this topic—about two sentences' worth. It appears in Corsini's *Current Psychotherapies* (Mosak & Maniacci, 2010), and I indicated that the necessary but not sufficient conditions in psychotherapy are faith, hope, and love. But editorial space limitations prevented my expanding on the subject. The following is my return to the topic.

Faith

References to faith often abound with terms like *transcends*, *invisible*, *supernatural*, and similar terms congenial to religion and philosophy. They shall not be used here. Operationally, to have faith in somebody or something centers on the ability to count on someone or something. If people

have faith in God, they are expressing the notion that they can count on God for whatever they subjectively count on him for. It's similar when they have faith in others or character traits such as honesty and loyalty to one's country (for example, Steven Decatur's quote, "Our country . . . but right or wrong, our country"). And in Adlerian psychology, and whatever else Adlerians have faith in, they all subscribe to the basic assumption of holism, teleology, phenomenology, field theory, the uniqueness of the individual, and the unity of the personality. By subscribing to these assumptions, they are expressing faith.

Therapists of various orientations follow many explanations of why their therapy works or works better than other therapies. There are literally hundreds of therapies. Some therapists allege that the superiority of their theory is what gives their therapy the edge. They describe their theories as deep, intensive, and intrapsychic, whereas others are scorned as superficial, supportive, repressive, regressive, inspirational, and commonsense. Freudian psychology of the previous century has had almost a monopoly in their therapeutic activity and teaching in the United States with this claim. One French analyst, Jacques Lacan, who came up with an exciting theory, once wrote that sometimes his theory was so complex that even he had trouble in understanding it. Other therapists attribute success to the personality of the therapist—for example, the therapist had to maintain anonymity, or the therapist had to be authentic, or the therapist had to be warm and accepting and demonstrate unconditional positive regard. And still others felt that the change agent resided in the therapist–patient relationship, so they began to study what was going on between patient and therapist. The Freudians were first at this, and they discussed the transference. Of course, they did not know about transference any more than I know about social interest. Still others found that the technique facilitates change. Whatever else may be said of the advocates of these theories and practices, all of them have had successes and failures. It would seem that there are some underlying common factors that make therapy work—when it indeed works. These ingredients are faith, love, and hope.

One factor is faith. Some have faith in the type of therapy ("My doctor told me CBT is the best"). Others express faith in the therapist ("You treated my neighbor who says you perform miracles"). There could be faith in the therapist's education and experience ("I see you went to Harvard—great school") or faith in the therapist's fame and reputation ("I came to you after reading your chapter in a book"). Sometimes, it is faith in the therapist's astrological sign, and here I have trouble. I've lost several patients because I am a Scorpio. There could also be faith in the therapy methods ("Everyone is talking about eye-movement desensitization and reprocessing") or faith in some other attributes. Faith does not have to have any evidence. It may or may not move mountains, but it does move therapy.

So therapy moves when a therapist is having faith in what she or he is selling and when the patient has faith enough to buy it. A therapist may be "selling" relationships or techniques or theory, but no matter what the therapist is selling, it is important for therapy to be a faith-enhancing experience. We hang out a zillion diplomas to impress the patient. We may put our names on TV. We set a practice in a prestigious location, like "Couch Canyon." Do you know where Couch Canyon is? It is in Los Angeles, and this is where many Freudians are practicing. And this is impressive for the patients who want to be impressed by this.

Now, I have a couch which I sometimes use for me. But I do not have a couch for therapy purposes. I do not invite the patient to lie down on a couch, and so on. I let them know; if they ask, I tell them the couch is a piece of furniture; that's all it is. And do you know where I learned that from? Freud! Freud explained why he used a couch and sat behind the patient. He said it had no meaning therapeutically; he just did not like people staring at him eight hours a day (Kunst, 2014). So, every therapist has things that are faith enhancing. If I do this, it's going to have the person up and around very quickly. And if I do not use these things, then the patient is not going to be cured. There is a big debate among analysts as to whether you use a couch or do not use a couch. In my day, everybody used a couch. These days, not every therapist uses a couch. So, we hang our diplomas on our wall, establish practices in prestigious locations. We keep shelves full of professional books, speak in words the patient does not understand to demonstrate our intellect, or speak in commonsense terms to inspire the patient to have faith in us. One of my patients thought I was a good therapist but couldn't place complete faith in me because she had always thought that a therapist "should wear a beard, have hard-rimmed glasses, and speak with a German accent." Well, if you have those qualities, how can you be a bad therapist? But all these things constitute faith in externals.

Existing concurrently with this faith in externals, at least in Adlerian therapy, patients have a lifelong faith in their lifestyles. It is something they honestly believe in. Lifestyles make sense of their world, their subjective fields. The lifestyle explains who they are and where they stand in the world. It explains what people are like and their own interpersonal expectations. Objectively, these things may not be true and may not be working, but patients believe they are true. And they worked until they did not work this time. Indeed, the convictions within the lifestyle are apperceptively biased and consequently contain basic mistakes. In spite of these errors, the patients view lifestyle as if it were all true, every word of it; and because of this intense faith in their lifestyles, the patients have a hard time dropping or modifying the things that they have had faith in all their lives. We have faith in it; we can count on our lifestyle. It helps us to understand experience, to predict experience, and to control experience. The lifestyle thus

provides a certain degree of security because if a patient acts on the basis of a lifestyle, everything will be OK, and therefore the patient will make every effort to hang on to it. Modifying or eliminating convictions of a lifestyle is generally not an easy task unless a patient has an immediate conversion experience, like, for example, Saint Paul had. No wonder patients display resistance when therapeutic interventions aim to have them do so. Such attempts threaten their security.

Every psychotherapy is an ideological conversion experience. You try to change the person's way of looking at and experiencing life. Even after trying a new way, a client relapses because he has a feeling that his old faith was at least as good as the new faith is, and he is still deciding whether he should hang out with one or hang out with the other faith experience. This is not an easy decision for patients to make unless there is a sudden conversion experience, as I talked about. Immediate conversion experiences happen in and out of therapy. The shortest therapy I ever did was about ten minutes long. The woman came to me and immediately started sobbing. She told me that she was a Depression-era child and that she did not have many things as a child. And then, without my asking her for an early recollection, she gave me one. In the recollection (of the Depression era, something like the 1920s or 1930s), the girls were hanging out and somebody got a bright idea: "Let's go home and ask our mothers for two cents so we can go to a candy store and get candy." So, all the girls go home and they ask their mothers for two cents, and my patient is greeted with "No! It's frivolous! Your teeth will rot." And her most vivid part of the memory was her standing on the corner, watching all the other girls, *all* the other girls going into that candy store to get candy. And now she really begins screaming, "Two goddamn cents! Two goddamn cents!" And I reached into my pocket and put two pennies in her hand, and closed her fist around it, and I said, "Now, as you have gone up with the rest of us, what are you going to do with the rest of your life?" And she got out of her chair, came over to me, stopped sobbing, and said, "You know, I do not think I am going to need you!" Most therapies do not go that easily, of course.

Strategically, we must help the patient to at least consider that what the therapist is selling is superior to what the patient currently has faith in and will buy them more security in life. I sometimes tell patients who hang on tightly to their convictions, who are not going to listen to anything, that therapy, unlike other games, is not a zero-sum game. In a zero-sum game, and this is what I tell a patient, if you win, I lose. If I win, you lose. The sum is zero. I tell them, "In therapy, if I win, you win, but if you win, you lose. So why don't you throw the game to me?" And some decide to at least consider the things that I am trying to sell. In selling them anything, you must sell them on one notion: that what they are getting is better than what they will have if they do not change. But even if a patient buys an entirely

new lifestyle from us, this will be another apperceptive bias. It will still be a subjective way of looking at the world. So why change at all? Adler had an answer. He said that in therapy, we do not try to change a patient from the inside out. The goal of therapy is not to reconstruct the entire lifestyle but instead to replace large errors with smaller ones (Adler, 1988).

Understood among people is that therapy may be seen as an ideological conversion experience, with the therapist serving as, to use Freud's term, a "secular priest" (Gelfand, 2000; Wehner, 2012). Its aims are to help patients switch from their faith, what they count on, to another—to count on life and themselves, to pursue self-actualization, as Rogers puts it, or self-realization, as Maslow puts it, or social interest, as Adlerians say. Next, there is faith in self, which the patient may not have to a very large degree when he enters therapy. We constructed a therapy along those lines because not having faith in self is the inferiority feeling.

To help the patient have faith in self, there are a good number of techniques. Let's assume that your head, at least symbolically, is divided into two parts. Now in one part, you have memories and thoughts about all the good things that you are, all the positive things, all your successes in life. With that part, you manage to solve all problems that come up. The other part of your head contains memories of all your failures, things that you did wrong. With that other part, you do not solve problems that come up. Now, if you set up the situation that way, and you are smart, which side of your head are you going to work with? Let's think of a neurological example. This part of your brain knows that 2 plus 2 equals 4. The other part of your brain feels that 2 plus 2 is who knows what. Maybe 5. Now I present you with a problem in your arithmetic class: 2 plus 2. The idea is to use your head in a way that works. In fact, if you do not use your head in a way that works, with as simple a problem as that, you are going to wind up very unhappy. And that will be your choice—to work with the wrong side of your brain. Well, even with complex problems, there's no point in going for the wrong answers, but some people do. It is your choice, and it has nothing to with evidence.

Next is acting *as if*. Do you know what acting as if is? There is a nice story that goes along with acting as if. Dreikurs told that story, and the story was by Max Beerbohm, a British novelist (Beerbohm, 2015). There was a small village in Europe with very few people in it. And among the people living in this village was a young man. And he had all good qualities except one: he was ugly. And while all the young men in the village got themselves girlfriends, he just had no luck because he had no faith in himself. "How can I go out and present myself to girls looking like this?"

So, he only had one friend in town. One day he was talking about his problem with his friend, and his friend said, "Go on out and find a girl."

"Looking like this?" responded the man. "I can't go out and find a girl looking like this."

And finally, the friend said this: "I will tell you what. In the village across the river, there is a mask maker who can make a mask for you that is so realistic that you can't tell it from real skin."

He was not going to do it. He kept repeating what our patients often tell us: "It would not work! I will know what is under a mask! No use!"

Finally, his friend prevailed, and the young man went across the river and got the mask that felt like real skin and looked like real skin. And he came back to his own village, and people did not know who he was. He looked that different. And suddenly, his life turned around. He had friends, and he had a girlfriend, and he had no problems with anyone. But he was always afraid that somebody would look under his mask and see his real face.

Well, he finally met a girl, and he fell in love with her, and she loved him. But now he was in real trouble because she wanted to talk marriage, and how could he talk marriage knowing the one thing he knew that she did not know? So she pressed him and she pressed him, and finally, he said, "OK, I guess I better tell you," and he ripped off his mask and told her that he was an ugly man and that he had a mask to cover his ugliness.

She said, "You are crazy."

He said, "What do you mean I am crazy? Have you really taken a good look at me?"

She said, "Have you taken a good look at yourself?"

And so they looked in the mirror. And guess what? He looked like his new face. So basically, if you change your view of yourself, you can have more faith. They got married, of course.

Another topic in this discussion of faith is the therapist's faith in him- or herself. And this a therapist does not always have. Why doesn't the therapist have it? Come on, you know! You have experienced it, certainly. I have been told over and over and over again that I am wrong. I took classes; my teachers told me I was wrong. I saw patients; my supervisor told me I was wrong. It gets ingrained in you that you are not as smart as your teachers and supervisors. And maybe you shouldn't be doing psychotherapy at all. Ever had that feeling? So, the therapist doesn't have faith in himself. In addition to that, the patient comes up with something that the therapist had not expected. And the therapist doesn't know what to do about this unexpected turn. So, he worries, "Maybe I shouldn't be here because a therapist ought to know everything," which is not true. And if you badger him, the therapist may even admit it's not true. Other than that, if he gets into some of these sticky situations, the therapist feels it is true.

Freud made his theories get reanalyzed every few years to make sure that "you are wrong" didn't stick with him all the time. Now, here, Adlerian teachers have an advantage if they act as real, good Adlerian teachers. What advantages do we have? We have something called encouragement. And if you use encouragement, you do not tell your students, "You are wrong. You

are wrong. You are wrong." Instead, you will say, "Let's see how you can do this better." So encouragement is, in a certain sense, a faith-enhancement technique. I do not always know what to do, but I always know that something can be done. Go ahead! It's not terrible. Many times, people ask me about prognosis. I have a very simple prognosis. It applies to every patient and every therapist. Everybody in the world can be better than he is right now, right this minute. From my experience, and from your experience, we know that no discouraged therapist will ever encourage a patient.

This is what I want to say about faith. You asked me, "Why do you think patients speak about it so often and therapists either miss or do not hear enough? What might explain it?" Well, that's not hard to answer because when patients come in, they are generally in trouble. Not always, but generally in trouble. They come in with a lack of faith. And you know what? The patient thinks, "We keep talking and you do not help me at all." But the therapist doesn't want to talk about that. Why doesn't the therapist want to talk about that? Well, like you said, the therapist does not have faith in the client, but he doesn't have faith in himself either. So when the patient says, "This therapy is not helping me," do you know what the therapist often thinks? "You are right; I am no good. I am screwed." And if both are agreeing that therapy is not helping, you've got a big therapeutic problem. So that was not hard to answer, right?

What else do you want to know about faith? You asked me if Adler had faith that what he was doing was right. Well, that's a tough one for me to answer because I was 16 when Adler died, so I did not know anything about Adler. I did not know anything about psychology. Adler traveled the United States at a time when people were looking for a cure. And he responded to it with, "I've got the cure." In my reading of Adler, I do not find any point where he said, "I blew it." You almost get the feeling that if you walked into Adler's office, you got cured. Well, it's not true. But he had faith in himself, and his patients then had faith in him and gained more faith in themselves. That was probably contagious.

Did you hear, on your way here, a lady saying about flowers in my room, "Those flowers, he deserves them"? You did? Good. You heard and saw something that you did not understand. I do not know that lady; I do not know her name, and so on. She's never stopped before today to say, "You've earned flowers." But yesterday, at lunchtime, I was sitting in the lounge and she was sitting in the lounge, and she couldn't get out of her chair. So I got my walker and walked over to the other side of the lounge, and I took her arm and said, "OK, let's do this together."

And she smiled at me. She said, "Yeah!"

So I helped her up, and she went to her table and I went to my table. And having encouraged her that there was somebody in her life that was willing to help her, I've earned the flowers. And you see, that's the kind of

thing that you do, something that the patient regards as important, and the patient says, "He made a major life change in me."

Now, about 5 years ago, I was in one of these places. I'd had surgery. And every day, they stood me up to the balance bar and had me walk to the end, or as close to the end as I could get, and I got up on my end of the balance bar and held on and was thinking, "Which foot should I try to move: my right or my left?" Because I wasn't sure I could move either. And suddenly I looked up and they had a woman there who they were going to discharge. And she was at the other end, and she hadn't walked in 2 years.

And they said, "OK, we are going to start teaching you to walk."

"I can't! I can't! I gotta be in my wheelchair!"

So they stopped helping me so that they could help her, get her moving, and she wasn't going to move. So I called across to this lady, and I did not know her name, and I said, "Hey, I will tell you what. Let's meet in the middle and dance," and I started to walk. And she saw me walking, and she decided to imitate me. So she walked from her end, and I walked from my end, and we got to the middle, and holding on to the bar, we each danced with each other. Then she walked back to her end, and I walked back to my end, and I said, "You think they can start getting you ready to go home tomorrow?"

"Yeah!"

Well, that's a faith-enhancing experience. For one moment she wasn't sure if she could take one step, and the next one she felt, "I will get there." So you do not have to always have the fancy explanations and interpretations that the books or your teachers tell you. Sometimes, something that you did not even know you were doing can be, well, faithful. Yes, you are right, especially if at the end, you can dance with somebody. Yeah. So this is what I am going to send you home with. Next time you come, we are going to talk about hope.

Hope

Let's now talk about hope. You can't talk about psychotherapy unless you include hope. There are certain psychotherapies, like the behaviorism, where hope is not an explicit virtue. Just do this and the patient will do that. But nevertheless, there is the implicit feeling that if you do something specific, there's hope for the patient, and if you do not, there's no hope for the patient. So hope is necessary in doing psychotherapy.

Now, this runs contrary to some of the teachings of certain schools because among the Freudians, for example, hope was not very important. You go 20 years and maybe you will learn something, and if you go 40 years you will learn some, but the point was you would never be cured if you were looking for a cure in psychotherapy. You would learn, but you would not be

cured. So people spent their time and their money, three times, five times a week learning this, learning that, going over a dream that they had this week and another dream that they had last week. And you can go on forever, and many people did go on forever with psychoanalysis.

But Adlerian psychology was an optimistic psychology. And Adler indicated that hope, even though he did not explicitly talk about it, was terribly important (Main & Boughner, 2011), because how can you instill hope in a patient who does not have hope if you do not have hope yourself? So first, as therapists, you had to be a person who had hope, so Adlerian psychology, almost right from the beginning, was an optimistic psychology. And this drove Adlerian psychology in ways that other psychologies could not accomplish because if you have hope, there will be some people who could be really cured in a very, very short time. It did not take 20 years. And it did not take five times a week. So right from the beginning, Adlerian psychology was a time-limited psychotherapy. Adler decided that if you had hope for the patient, you could look to the patient to even drive some of the therapy. The patient could choose what to talk about, how, and how long he wanted to talk about it, instead of the therapist deciding all of this. It became more of a patient-driven therapy. And in a sense, it was a forerunner of Rogerian psychology in that the patient was going to decide what to talk about rather than the therapist deciding what to talk about. For example, other psychotherapies would take as long as required, from their point of view, to treat depression.

Adler said to patients who were depressed, "I can cure you in something like three weeks, if you will do what I ask you to do." Well, patients who did not have very much hope up until that moment felt, "Well, 3 weeks to 4 weeks is not that much when you match it against 20 years of what the Freudians are doing." So Adler would say, "What I would like you to do is, every day, do one thing which will put a smile on somebody's face, because if you put a smile on somebody's face, first of all, you will learn that you are an agent of change, and if you can change the other person, you can change yourself, too."

Second, change is contagious. You see this not in psychotherapy alone; if I tell you something that is funny, let's say, and you laugh, I am going to smile at least, or at least consider smiling, because what's so funny about it for you if it is not funny for me? So on that basis, there is the element of change. In addition to that, you notice how easy it is to put a smile on somebody else's face. If I tell you a joke and you laugh, it's easy. Well, if it's easy for you, why can't it be easy for me?

See another example, not from Adler, but from Dreikurs: Dreikurs was the first person to introduce group therapy in private practice. What does that say? It says it can be done more briefly with group therapy. It sells hope. In addition to that, Adler spoke, although not explicitly again and not at

length, about modeling. If the therapist is in good spirits and can laugh and smile and sell hope, there is a good chance that the patient may model him- or herself after it and decide, "Well, I can do that, too." If you look through Adlerian literature, you will find Adler coming up with little techniques like that. So Adler writes somewhere about a patient saying to him, "You are my last hope," and he responded, "No, not the last hope. Perhaps the last but one. There may be others who can help you too" (Adler, 1956, p. 339).

So we sell hope. One of my patients was very hopeless—nothing ever looked good to him, and he was prepared for every hopeless contingency. So I asked him, "Do you have an emergency plan in case something goes right?" We sell hope in other ways, and one of these ways we sell hope is in terms of philosophy and religion. So you do not necessarily change the patient's religion. But on the other hand, religion in various ways sells hope. So you use the person's religion to imbue a sense of hope. Let me see if I can give you an example.

There was this minister I treated who came to see me after being depressed for a while and not doing anything about it except, perhaps, for praying a little bit about it. And finally, he collapsed at the altar, and he knew that it was time to do something, so somebody suggested he come see me, and I saw him. And I asked him, "Do you believe in God?"

And he said, "Of course I believe in God."

And I asked, "Do you believe that God forgives sins?"

And he said, "Yes."

"Now," I said, "that includes you, of course."

And he said, "Naturally."

And I said, "How come God can forgive your sins, but you can't forgive your sins? Is your view superior to God's?"

And he laughed, and he said, "No."

I said, "Well, you can say no all you want. But if you look at it, what you are doing is saying, 'I have a higher standard of what I should be than what God has for me.'" And that was the beginning of the end of that feeling for him in therapy. He could easily maintain superiority over God and have no hope. Or he could choose hope by deciding to remain human.

Some say that there are people who have no hope, like people who tell us that they want to commit suicide. Then, the question is, why have they come to see a therapist? What keeps them talking to a therapist? They have hope, even if it's a residual hope. And we must drag that hope out and really water it good.

Hope contrasts with faith in several ways. Faith is generally present oriented. Hope is future oriented. Faith implies certainty—if I have faith in something, I know with certainty it is so and is something we can count on. Hope, in contrast, focuses on possibilities and probabilities. Sometimes it includes "if only" statements. If only I can get a job, I will stop being depressed.

Love

The third thing that Adlerians sell is love, and not love in a romantic sense, certainly. Now, you find that there are a few psychotherapies that center on love, but they do not center on love the way Adlerian psychology does. We do not teach students how to love in therapy. We teach them how to interview, how to interpret, but not how to care with love. You see, if you cannot touch a patient, then there are certain kinds of love you cannot express. After all, there are certain people who are down in the dumps, and you pat them on the shoulder, and they are not alone; they are not in the dumps. They have an ally in therapy—a sense of commonality. So we have the feeling that every person is worthwhile, but there is a difference between being worthwhile and acting worthwhile. And can you get a person to act worthwhile? Well, some people say no, but some people say, "Yeah, if you know the right ways of approaching it." Again, you can find, in the books that I have mentioned, ways of getting people to act worthwhile. And sometimes, it does not require any major interpretation or any of that.

I was driving home years ago from the Adlerian Child Guidance Center with a lady who was cotherapist, and we got to my house and my wife was standing on the sidewalk with our newborn baby. The woman got out, made the usual noises about the new baby, and my wife said, "Would you like to hold it?" And that woman was flabbergasted. She took the baby and held it. She said it was a turning point in her life. Somebody had trusted her with the most important and valuable thing in her life, and not a word had been exchanged. But it was a turning point in her life.

Many times, we find turning points in our lives that do not involve any therapeutic interventions in a pure sense. Sometimes just doing something a different way may do whatever we'd like to see done for the patient. When I have cried with the patient, when I laughed with the patient, it has done more in many instances than when I would, say, do interpretations of the patient. So a man comes to see me, I've seen him for a while, and he's getting more depressed because his brother has just committed suicide, and I talk with the patient and stir him up and suddenly, instead of saying nice things about his brother, he smashes his hands down on his chair and he says, "Goddammit, he wasn't very nice in committing suicide, no matter what he was facing. Look what he did to the rest of us." And then we begin to talk about the meaning of the suicide for him.

I have given a paper, and you can see it in my résumé, called "Interpretation: Is That All There Is?" (1984). I think I gave it to the New York Psychoanalytic Society, and I said that interpretation is nice, and I still interpret for people, but there are other things I do, too, that help the patient grow. This probably comes from Rogers, but I help people grow. I do not quite cure them; I do not operate in therapy that way. In therapy, I help the patient to

grow, to see things differently, to do things differently. And for him to grow, he has to feel that I have some investment in him—that I want him to grow. I want him to go forward. So in helping my patients to grow, I have learned that I grow, too; I see things differently. But just as I educate my patients, if you want to look at it that way, my patients, possibly inadvertently, help me to grow, too, as a human being, as a therapist. OK, that's all I've got to say for right now.

Some months ago, you asked me why hope, faith, and love? Why these three as factors of psychotherapy? Why not something else? Why not more than three? Why not fewer than these three? What about these things? First, these are chosen from the Christian bible. And you can look at it in different ways, if you see not only faith, hope, and love, because other therapists will list many more things in addition to faith, hope, and love. So you must decide as a therapist what you are aiming for. I have no investment in these biblical three; I am not a Christian, but as I look at faith, hope, and love, it's a good way of looking at what I try to do.

And if you say, "Gee, there's another element," then I'd be willing to consider another element. So, for example, I am willing to include truth as a fourth element, but that doesn't mean that everything that happens in psychotherapy is true. It is only true from the patient's point of view or a therapist's point of view. Still, I have an objection to putting forth a truth and examining how true you must be in talking to a patient. In other words, can you ever lie to your patient? Well, there are answers to that, but for me, if you lie too often to your patients, you will have no faith. So on that basis, I do not need truth as an absolute element, but if you want to talk about it, that's OK with me, too. And like you just said, if you lie to your patients, there is also no love. And those who lie to their patients probably do not have as much faith in themselves.

But I think we ought to make the point. It is sometimes difficult to have faith for a therapist or a patient. If I have a patient, as I have had many times, who is going to die, what I say may not always be true, but this is not what this patient is needing from me. He may need hope. And when there is not much hope, he may need faith. And when faith cannot handle all that comes, he will need my love.

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