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From the Executive Director

The Philadelphia System

Systems of psychotherapy evolve from the theories of the mind ambient during their construction, from experience and happenstance often specific to the practice of their developer, from the success or failure of the models for therapy made available by texts, teachers, and peers, and from the peculiar personality and needs of whoever has decided to move into such new territory. So many colleagues have shared in the development of the approach that is now becoming known as The Philadelphia System, and so many of our patients expressed pleasure at what they experience as the difference between our ideas and the approaches to which they had earlier been subjected, that I have agreed to summarize in this communication what will be described in a book at some later date. Here I will only sketch an outline of a system of thought, hoping that others will be able to use it as an armature around which they can sculpt the body of their own work.

Us and Them

I do not believe that psychotherapy is special or that psychotherapists are special, and I insist that our role in society is to help others by assisting their normal growth rather than to deal with the afflicted as if they were less than us. The evolution of one's personal scripts is a life task, and there is no intrinsic difference between patients and therapists. Therapists who stop growing are as stuck as any of their patients. To those who ask our help, we are only guides for one or another part of their journey. Therapy should never be stigmatizing; it should be engaged in such a manner that those who come to us feel welcomed as peers rather than supplicants to the priest of a church full of mysteries known only to its initiates. It is important that name conventions be brought to the fore as soon as a contract for therapy has been established—the needs of both patient and therapist will determine whether they will address each other by their titles, their first names, or any other mutually acceptable label.

Trained initially as a physician, I see those who come to me as patients rather than clients. Psychotherapy is one of the healing arts and all its practitioners doctors of varying degree of involvement with the whole person. Where there is life-threatening crisis the therapist must operate in the manner of an emergency room physician, taking action swiftly to protect the lives of all involved in that crisis. We must be willing to take responsibility where needed and also insist that our patients take responsibility when possible. I believe firmly that the patients who step over the threshold of our consultation room and with whom we have negotiated a therapeutic contract have the right to our attention any time they are overwhelmed by the conditions that brought them to our attention. The discomfort that has brought someone to see us knows little about time and certainly cannot restrict its activity to the tiny fraction of a week represented by the session with us. When a patient calls too often we must assign blame for this inconvenience on some failure of our own technique.

Neither do I believe that there is a hierarchy of therapists. Although physicians are allowed to enter the body with scalpels, probes, and pills, these privileges and responsibilities represent only one realm of healing. Although some psychologists have been trained in the arcana of the Rorschach test and the specifics of operant conditioning, these privileges and responsibilities represent only another realm of our collective art. Skill with the lighted wand of EMDR, therapeutic massage, the use of hypnosis in severe dissociative disorder, the interpretation of PET scans and EEGs, or the spiritual exercises of St. Ignatius cannot be generalized over our entire therapist population. This is an era in which no individual understands and is expert in all methods of treatment. If a colleague is gifted in a form of therapy in which I have not been trained or for which I show no talent, I refer patients to this individual rather than force them to live with my addled fantasy that I am superior in all matters. It is the patient's need that must rule and the therapist's responsibility to remain always aware of the broad range of techniques and approaches capable of helping. Increasingly in our era, and to a greater extent in the future, psychotherapy is a team effort rather than an individual enterprise.

Psychotherapy is also the way we earn our living, and we must respect the right of our colleagues to work and earn. When patients come to us unhappy or unfulfilled in their current therapeutic investment we remain respectful of the current or previous therapist, remembering always that even in an incomplete or failed therapy there had been long periods of warmth and success. (Each of us has made the mistake of informing a friend in an apparent romantic breakup that we never liked the now-discarded other; when the romance heals we become anathema to both partners.) When a colleague sends us a patient for assistance in the realm of our expertise we must maintain respect for that therapeutic relationship and act as a consultant rather than a thief. No matter how dearly you love the technique at which you have become expert, always avoid the trap of derogating those who do not practice exactly like you. Recognize always that the referring colleague is as much your patient as the individual who comes to your office; the fact of your expertise confers some degree of responsibility for the emotional health and well-being of your peer as well as that of the designated

patient you are now working to assist. Recognize also that many of those who send you their case failures are experiencing shame simply because what they offer (which is a big part of who they are) has not worked; kindness should be a central part of your personality and kindness to colleagues a central part of your position within the therapeutic community. If you find it difficult to live in this manner, ask a colleague to help you work it through—we can't help people in a sector we haven't healed in ourselves.

Theoretical Underpinnings

The Philadelphia System is based on the affect and script theories of Silvan S. Tomkins. We take for granted that the therapist understand the nine innate affects as the basic motivating factors in human life, and that as one grows from infancy through adulthood experience is registered as Stimulus- Affect-Response Sequences that are stored in memory as scripts. The evolved function of a script is to simplify the process through which any mental content may be analyzed for its resemblance to prior experience and to provide rapid deployment of strategies for its management. Although script formation confers great operational efficiency, it tends to distort the percepts and cognitions of the moment so they may be handled as part of our already established knowledge and set of skills. Scripts allow us to act swiftly and surely whether or not our actions are truly appropriate to what has actually happened.

The skilled therapist is a teacher who can impart information of all kinds in ways that fit the needs of the patient. Slowly, carefully, but as early as possible in the course of therapy and to the extent that they are able to concentrate on such information, we teach our patients about the affect system, sketch Tomkins's model for the relation between stimulus density or gradient and the specific affect triggered, and ask patients to study their own emotional experiences in order to label the innate affects involved. We explain that the affects operate like a bank of spotlights, each of which with great rapidity turns on and off in accordance with its innate physiological trigger, shifting whatever has triggered that affect from ground to figure. It is only when an affect focuses us on its trigger that we can use the highest level of conscious attention to do whatever is needed; when the problem thus illuminated has been addressed, we are free to attend to whatever next triggers any affect. We want patients to understand that this normal plasticity of the affect system allows us optimal freedom to assess and handle any and all stimuli. Most of us start therapy embarrassed that we have emotions at all, and it is the job of the therapist to legitimize affect by making it obvious that without this amplifier system that governs all attention and consciousness we would be pallid, unmotivated, and poorly able to live in the world.

Two of the innate affects (interest-excitement and enjoyment-joy) feel wonderful; one (surprise-startle) is so brief that it doesn't have a flavor of its own; and the other six (fear-terror, distress-anguish, anger-rage, dissmell, disgust, and shame-humiliation) feel awful. Simply because we have no choice but to accommodate to this palette that provides the affective coloration of life, our existence is managed according to the four principles or rules of what Tomkins (1962) called a "blueprint." People live best when they can 1) maximize positive affect; 2) minimize negative affect; 3) minimize any impediments to the expression of affect; and also 4) maximize the power to accomplish these three goals. By teaching this group of concepts, we make sure that the patient understands normal life as a kaleidoscope of stimulus-affect-response sequences; as a result, emotion at any intensity may be studied, understood, and handled optimally. Any time we ignore data brightened by the affect system we lose information vital to survival. Patients often respond with pleasure to the idea that their emotions are useful and valuable rather than an inconvenient interruption in whatever else might have been going on when they appeared. Affective experience should not be considered an unpleasant event to be dismissed by drugs or other detours that preclude analysis of its triggering stimulus and the historical events within which its significance must be interpreted. Older systems of therapy instructed us to search for the "conflict" that had produced emotion, whereas we are aware that affect is the normal response to the way information is handled by the central nervous system and therefore largely unrelated to conflict.

Yet it is possible for us to experience an affect for a number of reasons, all of which are related to the biology of emotion. I have pointed out (Nathanson, 1988, 1992) that human emotion involves realms of hardware, firmware, and software that are loosely analogous to the components of the ubiquitous desktop computer. The hardware for affect includes the central nervous system with all its tissues and chemical messengers, the skin and muscles of the face (the display board for the affect system), and the various endocrine and exocrine systems that control distant structures. The complex, genetically programmed mechanisms we call drives and affects are present from birth; through learning, they may be modulated or controlled but not altered in any permanent fashion. As a group, they may be thought of as firmware much like the chips that carry commands for the computer, instructions that were once written by programmers but are now inalterable. What to the computer user is known as software (sets of instructions written in such a way that they can be altered easily) and the data it handles are much like the variable called human experience. Our upbringing in a family, a nation, and an era makes us both similar to and different from other people. Even though all of us possess roughly the same hardware and firmware, what we encounter in our path through life ensures that we will know, understand, and define our emotions in quite individual ways. The emotion experienced by any adult is both biography and biology.

Tomkins (1962) pointed out that pain is not tissue damage as such but a report about that damage made by specialized pain receptors that are unrelated to the actual tissue that has been injured. This evolved separation between the bodily systems that handle injury and those that make reports about it allows such disorders as referred pain and chronic pain syndromes in which little or no tissue damage can be found in the area that hurts (Nathanson, 1995). Similarly, affect is neither the stimulus itself nor our appraisal of it, but a report about that stimulus based on the way it is received by the neural apparatus. Our connection to the external and internal world is, therefore, partly the report of our sense organs and partly our affective response to those and other reports. Said another way, the structures and mechanisms responsible for the acquisition of data are different from the affect system that assesses the way this information enters the system. It is for this reason that we can have clinical syndromes that involve disorders of affect (distortions of the reporting mechanism) that are not caused by the information being reported (data of the sort that is the normal trigger for

affect) but from malfunction of the physiological systems that make up the affect system. For example, although psychological events alone may indeed lead someone to become excited enough to behave in a manner that might be characterized as hypomanic, the forms of mania seen in Bipolar Affective Illness are caused by a quite separate mechanism. Panic Disorder and the varied forms of persistent dysphoria lumped diagnostically as the spectrum of Depressive Disorders may be caused by disorders of the neurochemistry for affect as well as scripts that maintain one's experience of the noxious affect.

Essential to the life of an optimally healthy adult is the ability to react to any stimulus with whatever affect it may trigger. Each subunit in the bank of spotlights mentioned above must be free and able to turn on and off at whatever speed is dictated by the stimulus of the moment. In a very real sense, psychotherapy is the art through which an expert provides techniques that improve toward normal the plasticity of the affect system. Whenever in our work we encounter an individual who seems stuck or trapped in one or another affect, we try to figure out whether the persistence of this particular spotlight involves a disturbance of hardware, firmware, or software. Persistent anger, fear, distress, excitement, shame, dissmell, disgust, startle, or even contentment may be caused by many factors including scripts that keep that affect locked on, by abnormalities of brain structure, by neurochemical dysfunction, or by (as yet poorly studied) malformations of the cellular structure involved in the actual circuitry for any innate affect. The competent therapist will consider all of these in an effort to understand the cause of such disorders of affect plasticity, and work within a team to provide treatment for the underlying cause.

Treatment

It should be clear, then, that referral of a patient for psychopharmacologic intervention represents neither a failure of the patient to work optimally in therapy nor the failure of the therapeutic system preferred by the non-medical therapist but recognition of the plurality of causes for any dysphoria. Medication offered by a psychiatrist who understands the relation between the affect system and its biology may be considered adjunctive to the primary therapist's work toward helping the patient achieve optimal plasticity of the affect system and alter the preexisting management scripts. In a very real sense, the most important benefit attained as the result of pharmacologic relief of unremitting affect is not the cessation of the unrelenting emotion but the acquisition of normal plasticity and with it the ability to experience all nine innate affects with far greater freedom. Nevertheless, at no time should any member of the therapeutic team convey to the patient that any and all intense and unremitting emotions are caused by errors in neurochemistry that require medical treatment.

The competent therapist must understand the range of affective responses experienced by those who are asked to take medication (Nathanson and Pfrommer, 1996). Prime among these are fear (that one has lost control of one's own body; that one may now be subject to unknown and perhaps dangerous toxic effects of medication; that one is becoming a drug addict) and shame (I am a failure, a defective person whose very body is inadequate; I will be derided by those who see me as flawed; every time I take my medication I am reminded of my shame; are my thoughts, actions, and feelings real or the product of some substance that is alien to my body?; has this medication changed me so much that I am not myself?) The Philadelphia System recognizes that these responses are both normal and capable of discussion within the therapeutic encounter.

No matter how fervently we might wish otherwise, we must take for granted that a large fraction of our patients will stop their medication without telling us. When, after stopping their medication, they continue to feel well or explain that they are now free from a dysphoria they had earlier been unable to describe adequately, we compliment them on the success of their experiment and work to establish a relationship within which they may in the future be able to discuss with us their discomfort about medication. Just as often, the dysphoria for which they had taken the medicine returns with a vengeance, and the patient is frightened, guilty, and filled with whatever noxious affects the medication was targeted to remediate. In such situations we define the act of stopping the medicine as the sort of healthy experimentation undertaken by most patients, assist the patient toward resumption of that or another medication in order to facilitate and maintain the normal plasticity of the affect system.

Just as at all times we encourage the patient (rule 4 of the Tomkins blueprint) to express affect (rule 3) so that positive affect may be maximized and negative affect minimized (rules 1 and 2), it is of the utmost importance that the therapist be able to express affect openly, clearly, and honestly. Therapists who do not respond to the affect of the patient with appropriate affect of their own prolong therapy, for it must be recognized at all times that the therapist is an exemplar, the most important specimen of the group of people who adhere to a particular system. To the extent that our own affective expression is blanched or in any way artificial, we train the patient to imitate our failure to operate in accordance with the blueprint. In no sense do I recommend that the therapist use the patient as a sounding board for unmodulated intense feelings that may have been triggered by some action of the patient; it is not the job of the patient to provide solace for us as an external modulator of our affective experience. Yet if the patient discontinues a medication in such a way that serious harm may result (for example, when an anticonvulsant is used for the control of Bipolar Affective Illness, rapid withdrawal may precipitate grand mal seizures) it is only normal for us to inform the patient that this action frightens us. We therapists must be both disciplined and real. Although there is a slight chance that self-disclosure on the part of the therapist may cause some interference with the development of the transference, of far more importance is the benefit to be achieved when we model the mature expression of affect and drive home the point that all normal people experience affect. To whatever extent self-disclosure by the therapist is a critical part of therapy it must always model affect management rather than shameless self-exposure.

Within the Philadelphia System, all human action is understood in terms of its relation to one or another identifiable script, and all therapy conceived as the alteration and transformation of the pre-existing dysfunctional scripts. Since scripts are built not on "facts" but on stimulus-affect-response sequences for which analogues are assembled throughout life to strengthen and affirm the script, it is both unnecessary and counterproductive for the therapist to ask the patient to return time and again to the historical scenes or interactions assigned

as the root "cause" of the "problem." One of the complaints voiced most frequently by people who come to us after the failure of backward-looking systems of therapy is that session after session had been spent in an attempt to assign the discomfort of the moment to a specific scene from the past.

Wherever possible, the patient will be refocused on analogues of the stimulus-affect-response sequences in question, rather than on early history as such. Scripts owe their power not to the specific originating scenes for which they may have evolved, but to the way they accrete analogues and metaphors; thus, the ability of the therapist to construct analogues is essential to therapeutic success. Stimulus-affect-response sequences offered as jokes, personal anecdotes, recollection of scenes from a novel, film, or television program, or reference to the well-known exploits of a public individual are all examples of analogues that may be used to great effect within therapy. Every anecdote is a microcosm of a script, and every time we demonstrate a healthy script or show an example of the dysfunctional script under examination we help the patient build new, more functional scripts. Although most people are well defended against an interpretation (which may initially be taken as shaming), no one is defended against an anecdote that can carry the same information with no immediate, obvious personal reference to the patient. Great therapists are usually great storytellers.

We are born with the ability to respond to certain stimuli with any of the nine innate affects, and the resultant scenes are experienced, assembled into scripts, and thereby modulated in response to the historical flow of our life experience. It is for this reason that Tomkins (1962, 1981) explained human personality as the result of the differential magnification of the innate affects. The pattern of affective modulation (the way we have learned or "decided" to handle the affects) that has developed for each of us may be thought of as an attitude, an approach to a potentially new situation actually based on past scenes and therefore not truly applicable to the present. It is such attitudes (incorporated in scripts) that account for the phenomenology of the well-studied distortions called transference and countertransference.

We understand transference as a normal phenomenon, a group of interactions governed by powerful preexisting scripts that therefore prevent intimacy or any authentic relationship. Patients may view therapists through a script that makes the therapist relatively invisible, and therapists may view their patients through a transference script that produces similar distortion. Countertransference is the special situation in which the therapist experiences an affective reaction to the patient within which the only role possible for that therapist is as a figure in the transference script from which the patient is currently acting. Neither transference nor countertransference is special or the particular province of specialists but rather the ordinary and natural result of script formation. It is for this reason that we identify and celebrate any increase in skill demonstrated by the patient rather than label it as defensive maintenance of core psychopathology within the transference. The acquisition of any new skill is not a "flight into health" but confirmation of the patient's ability to move away from old scripts and therefore an aim of therapy. It is important to remember that feelings travel easily between people who are not walled against affective resonance (Nathanson, 1986, 1992, in press), and that the mere experience of another person's emotions does not imply psychopathology on the part of anyone.

The Special Case of Shame

Earlier systems of therapy tended to blend most of the negative affects into group nouns such as "anxiety," "stress," and "tension." We teach that there are six negative affects, all programmed into the subcortical brain and all quite different in triggering source, facial expression, and inner experience. Using such terms as "optimal frustration" and "minimal activity," some therapists have developed techniques that force the patient to experience controlled doses of "anxiety" that force "material" from the unconscious into the therapeutic interaction. Sober study of these therapeutic modalities suggests that the affect responsible for this flow of information from the patient is not the affect fear-terror (here labeled anxiety) but shame-humiliation. One of the specific techniques used to produce this affective leverage is silence on the part of the therapist, which owes its power to the common observation that few of us are trained to remain silent more than a few seconds after the utterance of another person. In the Philadelphia System we ask the therapist to recognize that patients may remain silent for long periods of time not because of a conscious or unconscious wish to undermine the therapeutic process but because they are paralyzed by shame that requires immediate and empathic interpretation and support.

Indeed, it has been our experience that shame, rather than fear (anxiety) is by far the most important affect responsible for the discomfort of those who seek our counsel. We tend to focus on shame wherever we notice it, helping the patient realize that it is the result of a normal, physiological mechanism that we call an affect auxiliary, that everybody has such feelings, and that there are easily learned ways of emerging from the sting or parlaysis of shame. We teach patients the Compass of Shame (Nathanson, 1992) in order that they understand the role of shame in scripts ranging from mild to pathological withdrawal, from deference to masochism, from mild avoidance of shame to outright narcissism, and from the benign put down to vicious interpersonal abuse. It has been our experience, validated time and again by everybody who practices in this model, that acquisition of such information frees both therapist and patient to work together in harmony. It was Wurmser (1981) who pointed out that we are all ashamed to be seen naked unless the viewing other is held by the spell of fascination or under the umbrella of love. Pfrommer (personal communi-cation) remarked that revelation in the context of love is merely an exposure experience rather than a moment of shame.

Emotional Intimacy

An important advance in our therapeutic system was provided by Kelly (1996), who worked with Tomkins to develop a theory for intimacy that conformed with the latter's blueprint for individual wellness. Kelly (1996) determined that intimacy requires a private interpersonal relationship within which the two partners agree to 1) mutualize and maximize positive affect, 2) mutualize and minimize all negative affect, 3) express all affect to each other so these first two goals may be achieved, and agree to 4) maximize their power to achieve all of these goals. Happy couples 1) learn lots of ways to have fun together; 2) commiserate with and soothe each other when something makes one or the other feel badly; 3) favor the expression of their affect to each other even when to do so might at the moment seem embarrassing; and 4) work hard to identify and undo anything that prevents them from achieving these goals. Couples therapy, as recast by Kelly (1996), deals with impedements to the capacity for intimacy produced by such barriers as biological disorders of

affect, a family history of disavowal, dissmell, and/or disgust for any particular affect, and lack of skill at the modulation of another person's overwhelming affective experience. When one member of a partnership is unable to provide solace for the emotional pain of the other, the couples therapist who salves and soothes the one who hurts becomes a model from which the previously helpless partner may draw inspiration and develop skills. Those of us who work with couples to improve their ability to experience and express affect, to express affect to each other, to return to the business of having fun together as when love was new, and to salve each other's wounded feelings have noted rapid and significant improvement in the degree of intimacy thereby attained.

Over and over, Kelly (1996) reminds us that the first rule for intimacy requires mutualization and magnification of positive affect. Since we understand shame as the programmed physiological response to any impediment to positive affect (who among us has not felt its sting when a lover or spouse seems unconnected to us even for a moment?), it is essential for the couples therapist to understand that shame is the most important and the most frequently seen impediment to intimacy. The success of couples therapy is largely dependent on the ability of the therapist to identify and reduce the personal or interpersonal shame of those involved. This, of course, is only a restatement of the second rule for intimacy, that requires the couple to share and diminish all negative affect, for only to the extent that they learn to identify and give solace for each other's shame can they develop and maintain intimacy.

Yet if these rules for the enhancement of intimacy are examined carefully, they have much to teach us about the therapeutic encounter. When both patient and therapist are encouraged to speak their feelings, when the therapist discloses his or her own personal experiences and the affects associated with them, when the therapist is an actual or potential peer rather than a remote and emotionally unavailable expert, when even the best of therapy experiences turns sour but is reclaimed by open discussion of the feelings involved, then it is obvious that successful therapy breeds its own form of interpersonal intimacy. The therapist familiar with these concepts will never mistake the development of this healthy adult relationship for a transference script based on relationships that have little or nothing to do with the milestones for the development of healthy emotional intimacy described here. Therapists who do not experience such intimacy with patients who have shown great improvement are most likely blocking the expression and awareness of their own feelings for fear that they may be involved in countertransference.

Nevertheless, the (slow, eventual) development of healthy intimacy between patient and therapist must be viewed as a by-product of but not the purpose of the therapy, which at all times is aimed at increasing the freedom of the patient to live in his or her own world. Skills attained within the therapeutic encounter must always be viewed within new scripts that allow the patient increasing freedom from the constraints of the scripts that earlier ran his or her emotional life. Good therapy allows new experiences to be processed as truly novel (rather than as part of some developmentally earlier and highly scripted system of response) and new people to be appraised in terms of their true nature (rather than assessed for their resemblance to the individuals for whom the earlier scripts had evolved.) The emotional intimacy that develops during the course of psychotherapy may be understood as a rehearsal for emotional intimacy with new friends outside the therapeutic interchange. The competent therapist supports the patient's efforts toward establishing and maintaining relationships in whatever way best fits the growing self of the patient. Successful individual therapy always increases the patient's capacity for intimacy.

To the extent that psychotherapy is effective, all of the patient's ongoing relationships will be changed, simply because one who has learned how to deal with his or her own affective life both contributes more to and demands more from every relationship. In the Philadelphia System, the therapist is constantly aware that the patient who appears alone for sessions is actually a participant in a highly variable number of relationships outside the therapeutic environment. It is essential that the therapist take into consideration these invisible partners by visualizing them as if they were right there in the consultation room. The therapist must think carefully about the effect on these important people of both the old and the new scripts that characterize the patient, and be willing and available to turn invisible partners into visible presences within the session.

We welcome occasional visits by spouses, lovers, close friends, parents, children, and anyone else the patient deems important and with whom the patient wants to share the ambience of the therapeutic encounter. Certainly the therapist will evaluate these requests to determine whether a parent, partner, or spouse is for personal reasons attempting to squelch or control some moiety of the patient's growth, and we must always remain alert to situations in which the designated patient would be served better by our suggestion to delay this complex encounter until some later date. Nevertheless, whenever such intimates of the patient appear in our world, we shift casually from our concentration on the blueprint for individuals to the Kelly (1996) blueprint for couples. On occasion, one of these significant others may ask for personal therapy. We are willing to accept as new patients these spouses, lovers, children, and close friends only as long as the original, designated patient feels this is appropriate and desirable, is aware that strong feelings may be triggered by this change in the therapeutic gestalt, and is also willing to bring up for discussion any feelings brought about by this change in the therapeutic experience. Exempt those cases in which the significant other appeared for a session or requested therapy when the designated patient was clearly unready for such intrusion, in the three decades I have worked as a psychiatrist, most of the marriages in which the target patient rejected the spouse's wish to work with a therapist who operated in the mode I have described herein have ended in divorce. It is rare that partners in a successful marriage find much to keep secret from each other, and unusual in the situation where the therapist works with both spouses in individual therapy for significant difficulty to contaminate treatment.

Furthermore, although we never specifically encourage such action, we consider it normal for patients to introduce the therapist to their intended spouses; the therapy room is an important annex of the place and relationships within which the patient grew up. Although this may be confused with incomplete resolution of a parental transference, properly handled it is part of normal growth. We consider psychotherapy as one way people are enabled to become who they might have been had they the good fortune to grow up within an optimal family, and it is only reasonable that the patient retain a positive lifetime bond with the therapist, whether or not the two ever see each

other again. Healthy selfobject relatedness, the adult form of the affect modulating relationship seen first in infancy and continued through adult life in the form of healthy love, is a normal phenomenon that appears quite naturally as a result of the therapeutic encounter.

When therapy works, the therapist is no longer seen as an expert outside the world of the patient but as part of an internal reference system that has been incorporated into many life scripts. Successful therapy ends when the patient can say with pleasure or amusement "Every time in the past few weeks I have thought of something I wanted to discuss with you, within a couple of minutes I could hear your voice telling me exactly what I wanted to know." Good therapy does not "terminate" when formal sessions are discontinued, for the processes of learning and internal change go on forever. The competent therapist must relinquish his or her relationship with the patient who has become a peer despite the personal loss this entails. Similarly, no matter how thoroughly patients feel "done" with therapy, a large fraction of those who have prospered with us return time and again seeking advice on how to handle entirely new sorts of problems. Many patients visit to say "I'm not in any trouble or anything, but so much has changed in my life that I figured it would be best for me to deposit the stories here for safekeeping." Children and grandchildren of patients seen long ago feel free to visit me at will, for the therapist who has helped a patient achieve freedom will often be the focus of family stories and legends.

The Goals of Psychotherapy

Successful psychotherapy should change people in highly specific ways. Notwithstanding the internal and external conditions that brought this person or cluster of persons to us, our work should have been useful toward the attainment of normal plasticity of the affect system. There should be no impediment to the ability to commune with the affect of another person, and the data about others accessible through empathy available to be used in a disciplined and educated fashion. One should have access to any and all memories in order to inform current action despite the affect associated with these scenes when they first occurred. Whatever affects are triggered in response to any trigger should allow the former patient to react in whatever way fosters the greatest benefit for self and others. Therapy should assist its purchaser to be comfortable in solitude and work, skilled at intimacy, involved in and responsive to the community. Although these life goals are attainable to varying degrees for each of us, therapy confers steadily increasing ability to approach them all. It should be recognized that none of these goals is fixed or limited, that our standards for each of them will rise over time as we learn more, and that both patient and therapist will grow constantly in their skills, needs, and wishes.

The Central Incompleteness of Therapeutic Systems

Successful systems of psychotherapy are flexible, capable of constant improvement, and able to change as new theory allows the therapist to approach old problems as if they were novel. The Philadelphia System is now and will always be "under construction," and looks to both its practitioners and its patients for advice and counsel. I look forward to the readers' response so our system may improve further.

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