IN TREATMENT: DOCTOR PAUL WESTON—PSYCHOTHERAPIST OR CINETERAPIST?

*Be-Tipul*, the basis for HBO’s *In Treatment* series, debuted on Israeli television in 2005. Conceived by producer/director Hagai Lei and writer Ori Sivan, its format was novel: On four successive days, Tel Aviv psychologist Dr. Reuven Dagan met with four private patients; same patient, same weekday; and on the fifth with Gita, his mentor, supervisor, and sometime therapist. Dr Dagan’s wife, adolescent children, and various client-related characters made cameo appearances. But at the heart of each episode was always the session itself.

Prior to *Be-Tipul*, an entire hour of psychotherapy had never been shown on big or small screens. It seemed a received truth of the film industry that no viewer would want to endure actual sessions, for most devolve around what Virginia Woolf called the “cotton-wool of everyday life”—with little drama or penetrating insight. Besides, who would tolerate such work a day banality being lensed predominantly in head shots?

Before *Be-Tipul*, screen psychotherapy consisted of Tinseltown’s notions of treatment’s juicy bits—shocking revelations about the traumatic past; earthshaking insights; seismic intrapsychic changes; pyrotechnic confrontations between patient and healer, and so forth. Potential viewer ennui was also regularly staved off by making the therapist race out of his office to rescue a client from some desperate circumstance. In John Huston’s *Freud*, the founding father himself shouted profound insights at an Anna O character from the bottom of a railway bridge, to prevent her fatal swan dive.

When I lectured at the Jerusalem Cinematique in the late seventies, private psychotherapy was not as available in metropolitan Israel as it was in the United States. A typical urbane New Yorker or Angelino would gab about couch time at the drop of a martini. But psychoanalytic treatment, even when available, was viewed by many Israelis as whinging self-indulgence, unworthy of the Sabra’s true grit.

The author thanks Professor Krin Gabbard for his invaluable assistance.
Although the number of psychoanalysts and other therapists increased over the next thirty years, even sophisticated Israelis tended to keep mum about their treatment. Nevertheless—or precisely because Be-Tipul outed therapy, the series was a huge success. It garnered rave reviews, plentiful awards, and put Israeli television drama squarely on the artistic map (before Be-Tipul, mediocre soap-opera fare was the norm). Although no statistics exist, the impression prevails in Israel that more patients are in treatment than three decades ago, and that Be-Tipul got them there. Certainly people now speak more openly about therapy.

Israeli cultural critics have vigorously investigated Be-Tipul’s stunning impact upon the national mentalité. The series’ appeal has been attributed to its adroitly personalizing the country’s perennial sense of crisis by means of the psychological crises of Dr. Dagan’s clients, and of the therapist himself.

Commentators have further conjectured that Be-Tipul captures the yearning for self-realization and intimacy in Israel which began in the nineties after decades of private and state approbation of collective experience. Israeli feminist critics speculated that Be-Tipul implicitly endorsed a “feminine” perspective vis-à-vis the exploration of the intrapsychic world and interpersonal relationships, as opposed to the rugged “masculine” call to action which has played such a large part in shaping the nation’s character, as well as its politics.

Israeli psychoanalysts have chiefly addressed Be-Tipul’s sociocultural reverberations. Rather little has been written about Dr. Dagan’s clinical performance.

**BE-TIPUL AMERICANA**

In Treatment, HBO’s translation of Be-Tipul, likewise consists of weekly sessions with Dr. Paul Weston—Dr. Dagan’s avatar—and four of his patients. The week ends with a session between Weston and Gina, his supervisor/quondam therapist, with whom he has had a stormy relationship dating back to his student days.

The show has received favorable, if not uniformly glowing critical notices during two seasons. But it has never been as popular as other HBO productions such as The Sopranos, Six Feet Under, and the recent Big Love. The discrepancy between Israeli and American response probably stems from our longer and greater exposure both to real-time and real-time psychotherapy (particularly the case with urban Americans), and to radio and TV programs starring pop psychologists like Drs. Ruth, Laura, and Phil dishing out banal advice.
In Treatment has had little if any influence upon our culture at large, nor has it provoked the abundant lit-critical inquiry spurred by Be-Tipul in Israel. However, American psychotherapists have been saying a great deal about Dr. Paul Weston. His therapeutic assets are lauded in some quarters. But his technical errors and ethical lapses have been critiqued far more extensively.

WESTON: WHEN HE IS BAD

From a peer-review perspective, Weston has substantial professional flaws. He intensively needs to be needed, presumptuously injecting himself into his patients’ lives from the launch of therapy. Although he sees patients once weekly and face-to-face, his working model is classically psychoanalytic (children and adolescent excepted, of which more presently). He is unpracticed in the nuanced approach required by weekly therapy, in which “soft” interpretations—especially during the early stages of therapy—are often commingled with a variety of supportive measures.

For instance, in weekly therapy, one ordinarily does not want patients to exit the office more troubled than when they entered. Nevertheless, Weston habitually makes distressing interpretations at the end of a session, totally unaware that he may be leaving a client dangling in shock or despair for another week. The first session with Weston, and virtually every one thereafter, is chockablock with transference-heavy interpretations. They often are simplistic, premature, ill-timed—Groddeck-wild. As a result, he often provokes irate negative therapeutic reactions, which in real life would send patients out his door forever. (In the series they always return for more, else how could the show go on?)

Weston’s default stance is passive/classic psychoanalytic/Rogerian. Sometimes he mainly spends a session answering questions with questions. However, he can turn activist on a dime, frenetically advising and admonishing a patient, when more prudence is indicated. For example, in his initial consultation with April, a tough-minded architectural student, she reveals that she just consulted with another psychologist. She abhorred the woman, and ended treatment before it began. The therapist then bombarded her with phone calls which she never answered.

Several minutes later she hands Weston a paper on which she has set down her problem: a recent diagnosis of lymphoma. An oncologist has advised her to undergo a course of chemotherapy, but she wants to consider holistic options. Weston harshly confronts her with the gravity of her diagnosis and insists she begin chemotherapy immediately. In-
stantly defensive, she retorts that he is acting like her previous “moronic” therapist, and abruptly ends the session. Visibly agitated, Weston keeps pressing her to return as soon as possible. She blows him off and slips away...

Although Weston does grasp April’s terror, his overweening compulsion to rescue her prevents him from gauging the depth of her resistance to psychotherapy and chemotherapy. (It’s not unlikely she views both as gross encroachments of a hard-won autonomy.) Forcing another session upon her in fact duplicates the first therapist’s exasperating intrusiveness.

A more seasoned therapist would acknowledge how difficult it must have been for April to tender her diagnosis, and express appreciation for the trust implicit in her “gift.” He or she would empathize with her ambivalence about having to chose chemotherapy or holistic treatment immediately, then spend the remaining session gently exploring her overall life circumstances. The therapist would conclude by asking her to come back as soon as she wished—sooner might be better—to finish the initial assessment and explore how he or she might be of help to her.

In the series’ first season, Weston meets Alex, an ace jet-fighter pilot grounded with post-traumatic stress after destroying an Afghani village school. Alex is bright, articulate, ruthlessly competitive, utterly unknowing about the intrapsychic mise-en-scène. Although erroneous military intelligence probably caused the terrible mishap, he is painfully unable to rationalize away his guilt.

As Alex’s third session opens, he lugs a boxed espresso machine into Weston’s office. He explains that he bought it because Weston’s coffee is so vile. While Weston feebly protests that he cannot accept the machine, Alex proceeds to assemble it, brews a cup, and sips away. Weston makes general observations about hidden motivations behind gifts, but does not tell Alex to remove the machine. It remains in plain sight during the rest of season one, outliving its donor into the second season.

An experienced therapist would have quickly headed Alex off at the pass. Since Alex is a psychological naif, one would thank him, explain the general reasons for refusing presents, and begin to explore his possible motives for flagrantly invading Weston’s space (e.g., establishing male dominance; maintaining a presence in Weston’s life outside his sessions, etc.). Should Alex remain obdurate, one might have to state that therapy cannot proceed under these circumstances, and respectfully tell him he has to chose between French roast or treatment.

Weston’s abortive romance with Laura, an alluring anesthesiologist in her early thirties, comprises his most disturbing dereliction. His erotic
obsession spurs a cascading of glaring lapses in judgment, countertransfertential acting-out, and culpably unethical behavior. High-functioning borderlines are some of our most difficult patients. Laura is an exemplar: Her capable façade conceals a host of alarming psychopathologies, including a disastrous capacity for manipulative betrayal and masochistic self-deception in her relationships with men.

She entered therapy a year before to resolve her ambivalence about marriage. In the very first session of season one, she discloses that she has been in love with Weston from the moment they met. She scornfully dismisses transferential interpretations, insisting her passion is the thing itself, not a bloodless intellectual fantasy. With the uncanny perspicacity of the bright borderline, she has sussed out the withering of his spirit and the ruin of his marriage.

Weston replies he can only be her therapist, not a soul mate. She provokes him with a graphic account of a sleazy sexual escapade in the washroom of a bar. Although he is now thoroughly smitten, he continues to reject her overdetermined adoration. She accidentally meets Alex coming out of Weston’s office and promptly seduces him. Both then spare Weston no lurid detail of their one-night stand. Goaded beyond endurance when Alex calls her a crazy, worthless bitch, Weston impulsively throws coffee in his face, and pushes him against the wall. Alex later accepts Weston’s apology, and resumes therapy. Weston then admits to Laura that he deeply cares for her.

Several sessions later, Alex claims he is “cured” and entreats Weston to certify his return to flying—“up there, everything is simpler.” Knowing Alex is still wrestling with grief, Weston nevertheless complies. Alex dies shortly afterward in a training accident, which may well have been a concealed suicide. By mutual consent Weston and Laura break off their unconsummated relationship.

Weston’s failure to register the magnitude of Laura’s infatuation during a year of therapy is striking. One speculates that his blind spot does not stem from deficient empathy, but from a desperate denial of his growing infatuation. In any case, once aware that her ardor has come to completely dominate Laura’s treatment and her outside life, he faces several hard alternatives.

He can labor to winkle out the neurotic roots of her fatal attraction. Resolving a crippling erotic transference would certainly help her love more wisely and well. But if her transferential distortions are so potent that they definitively undermine her capacity for ego-distance, Weston should terminate her therapy, however painful that may be on both sides of the couch, and urge her to seek help elsewhere.

But what if Laura’s affection for Weston is genuine?—unlikely, but
not unknown. As Gina reflects, isn’t love always based on some degree of transference? If her love is indeed authentic, the outcome could be even more bitter. Authenticity, after all, offers scant solace if the patient’s sentiments are not reciprocated.

On the other hand, what if Weston is also genuinely in love? Conceivably he could continue Laura’s therapy, while undertaking treatment himself to ascertain whether his affection is real or neurotic. However, maintaining therapeutic objectivity while noodling around with one’s countertransference under these circumstances seems virtually impossible.

Some investigators of client–therapist romance advise a cooling-off period of variable duration before the parties begin “dating” again (how tepid a word!). It’s recommended that both also enter, or continue, therapy to ensure that their love is not based on unconscious distortions.

Other analysts prescribe permanent amputation for the problem. Under the rule of abstinence paramount to our work, the therapist renounces further involvement with his or her ex-patient. Again, no easy matter, for wisdom may languish when libidos are inflamed on both sides of the couch. Human nature being what it is, absence from felicity often plays better in novels or onscreen than in practice. All too commonly, the romance continues. And, as the old proverb goes, that which does not begin well, rarely ends well. In the Big Apple, we all know where the bodies are buried.

In his typically muddled fashion, Weston manages to have the worst of all possible worlds. Ethical constraints, as well as innate timidity, lead him to shilly-shally about committing himself to a relationship with Laura. Her affair with Alex, clearly undertaken with malice aforethought, finally forces him to recognize that he indeed loves her, even as that insight inalterably subverts her treatment, replicating her propensity for impossible, often sordid, relationships. Laura’s fling with Alex drives Weston into an oedipal delirium, which fatally infects his work with both Laura and Alex.

An affair between patients is almost always rooted in complex neurotic transferences, and poses an enormous threat to the treatment of both parties. It is urged that these spurious matches should be strongly discouraged. Weston should have immediately interpreted the destructiveness of Laura and Alex’s affair, indicating he cannot continue treatment with either of them should it continue.

Jealously attacking Alex constitutes sufficient grounds for termination in the real world, whether initiated by patient or therapist. Instead, Weston asks for pardon, receives it, then continues traumatizing Alex,
wearing down his fragile defenses with interpretations about the traumatic origins of his driven perfectionism and competitiveness, too soon and too deep.

Weston then allows Alex to return to duty, while some part of him knows Alex is still too depressed to fly. (One recalls how King David, lusting after Bathsheba, sends her husband to be slaughtered in the front line of battle.) The malpractice suit brought by Alex’s father against Weston is thus completely justified. Laura shares Weston’s guilt. Awareness of their mutual culpability in Alex’s death plays a major role in killing their love before it get off the ground.

WESTON: WHEN HE IS VERY, VERY GOOD

Countering Weston’s glaring technical deficiencies and countertransferential quagmires are the times he can also be puzzlingly competent, dedicated, and compassionate. He may shed his Groddeckian propensities, and make apt and well-timed interpretations. He is an attentive listener, with a finely honed sense of humor, which he uses to promote a patient’s healing ego-distance.

Many people enter treatment so acutely or chronically distressed as to feel dropped out of the sky into a jumbled morass, sans cause or effect. Weston can be extremely proficient at reassembling a fragmented narrative into a plausible timeline, fostering insightful connections between past and present. On this score, his therapy with Walter, a depressed CEO caught up in a convoluted tangle of business and family difficulties, is particularly fine.

Besides his other virtues, Weston is also a therapeutic multitasker, moving easily between treating adults of all ages, couples, children, and teenagers. Actually, Weston is at his best with kids and adolescents. His understanding of developmental tasks is excellent. He dexterously shapes his interventions to the age and stage of each young patient.

His therapeutic stance is not marred by passivity or condescension. He never sides with parents, or makes clumsy attempts to win trust by acting like a kid. He is inveterately respectful of a youngster’s space. Unlike his treatment of adults, he doesn’t push transferential issues, focusing his efforts on the “here and now.”

In season one, Weston evaluates Sophie, a fifteen-year-old promising gymnast, for suicidal ideation, following a suspicious accident. Despite resistance to therapy from every side, he wins her confidence, and encourages her to explore her conflicts about continuing an athletic career. Her ambivalence is compounded by pressure from her separated
parents, and the blandishments of a coach who has seduced her. Through a strong working alliance with Weston, she frees herself from crippling guilt about the affair, resolves to renounce gymnastics for college, and makes peace with her parents.

April, the student with lymphoma, returns to treatment, and begins chemotherapy. She forms a strong working alliance with West. Her therapy reveals that she had been struggling with late-adolescent identity issues long before her diagnosis. The stresses of coping with cancer—the depletion of energy and compromised body image attendant upon chemotherapy, the menace of death itself—now threaten to jeopardize an already fragile self-esteem and compromise her development. With Weston’s support, she is able to cope with her illness, while defining herself in work and love. Here, too, his professionalism is exemplary.

In season two, Weston treats Oliver, an eleven-year-old struggling with obesity and his parents’ impending divorce. Late-latency children and early adolescents can be a child therapist’s most challenging clients. Weston’s shift between play and “talking” therapy is particularly artful. He integrates Oliver’s treatment ably with counseling his parents about their son’s weight problem as well as their anguish about divorce. Weston is careful to protect Oliver’s confidentiality. His work with the couple is always in service of his work with the younger. (One notes that Oliver’s parents divorce far more equably than Jake and Amy in the previous season. The difference is largely due to Weston’s freedom from the negative countertransference, based on his own marital troubles, which he brought to his work with the first couple.)

WESTON AS CINOTHERAPIST

Setting Weston’s summary therapeutic deficiencies against his impressive gifts, it is difficult to determine whether he suffers from mid-life depression, tinged with narcissism and sociopathy, or a severe case of multiple personality disorder. The diagnostic riddle Weston poses to the clinician is tidily resolved by the film scholar.

For there is no single Dr. Paul Weston. There is a character called Dr. Paul Weston, who practices that dubious subspeciality I have elsewhere named “cinotherapy.” It originated nearly a century ago, coterminous with the invention of cinema itself. Psychoanalytic film research has identified three cinotherapist types:

1. *Dr. Dippy* (after his debut appearance in the 1906 comic short *Dr. Dippy’s Sanitarium*). Wackier than his clientele, he is ridiculed, humiliated, and tutored by his patients in the plain horse sense he so notoriously lacks. Dr. Leo Marvin of *What about Bob?* is a Dr. Dippy nonpareil.
2. Dr. Evil is the psychiatric version of the mad, bad scientist. A cunning psychopath or psychotic, Dr. Evil delights in betraying the trust of vulnerable patients. He often dons the mask of sanity during working hours, then indulges his murderous inclinations off duty. Horrific examples include Dr. Robert Elliot of Dressed to Kill, and Dr. Hannibal Lecter of Silence of the Lambs, whose exceptional expertise is compromised by an unfortunate penchant for eating the clientele.

3. Dr. Wonderful is the therapist as eternally bounteous Good Parent. Although usually male, he is maternal at core. Selflessly dedicated, a cornucopia of empathy, insight, and patience, Dr. Wonderful is available anytime, anywhere, behind the couch, over the telephone, by the bedside. If you can’t come to him, he will gladly come to you, fees rarely mentioned.

His office is devoid of other patients. He seems to exist only to treat the protagonist. His marriage is loveless, or devastated by years of caring for others to the neglect of wife and children. In either case, his fatal attraction to a female patient is a staple of cinetherapy narratives. Weston’s aborted romance with Laura also instantiates Dr. Wonderful’s familiar role as wounded healer.

Most Dr. Wonderfuls are Jewish (e.g., Dr. Berger of Ordinary People); Dr. Susan Lowenstein of The Prince of Tides is one of the type’s few females. Many a gentle patient brings his frozen heart for warming at Dr. Wonderful’s Heimlich hearth. Weston has almost every attribute of the Jewish cinetheapist, but one does not easily imagine Gabriel Byrne, with his fetching brogue and twinkly Irish eyes, sporting phylacteries, yarmulka, and prayer shawl. Otherwise, Weston arguably is the most wonderful Dr. Wonderful to date.

Alarm about Weston’s clinical ability, or the accuracy of In Treatment’s portrayal of psychiatric illness and treatment, ignores the film industry’s sovereign purpose. With rare exceptions, mainstream movie and TV dramas are not made to educate audiences about anything, neither psychotherapy, nor veterinary medicine, nor stuffing a goose. At increasingly greater cost, movies are chiefly produced to generate ever more enormous profits by satisfying our ancient appetite for compelling stories. This is not necessarily a bad thing. Stories may be both compelling and educational, even fueled by the worthiest motives. Seven Spielberg’s desire to inform his audience about momentous historical events before the fading of collective memory is laudable, whether documenting Holocaust horror in Schindler’s List, or the carnage and heroism on the beaches of Normandy in Saving Private Ryan. But the makers and backers of these films surely hoped they would not be lucrative for lucre’s sake alone, or solely provide backing for future projects (for Spielberg and Tom Hanks, HBO’s Band of Brothers and The Pacific series).
Schindler’s List and Saving Private Ryan adhered considerably to historical fact. But both—especially Schindler’s List—also contain significant inaccuracies and historical distortions. Usually, these are not due to poor research, but are based on the implicit mandate to keep viewers riveted to the screen. By the same token, In Treatment is at times faithful to clinical reality. But if character or narrative development demand the sacrifice of clinical accuracy, depend upon it, that price will be paid.

The cinetherapist’s exercise of his native skills facilitates effective unfolding of a film’s narrative. In their authoritative Psychiatry and the Cinema, Glen and Krin Gabbard observe that a cinetherapist constitutes a *ficelle* for the screenwriter (from Henry James’s aperçu: the *ficelle* is the system of strings used to control a puppet). Cinetherapists can engender exposition through flashback, incite stunning revelations and spectacular confessions, and illuminate traumas in the troubled mind from the unquiet past.

Weston acts as the *ficelle* both of his patients’ and his own stories. His numerous therapeutic liabilities become narrative assets in the service of heightening audience satisfaction. Each season In Treatment covers only nine weeks of therapy. The session in each episode lasts approximately a half hour. In this setting, it becomes even more vital to engage audience attention, quickly establishing the foundation for an arresting plot so viewers will crave more.

Hence Weston’s diving headlong into his patients’ lives, inciting transferences, uncovering trauma prematurely and painfully, or spectacularly blowing the lid off the patient’s id. In aid of sustaining dramatic impact, his immoderate desire to be wanted, and his compulsion to rescue, are threaded through nearly every subsequent session with his adult patients. (As noted, he maintains appropriate ego-distance with youngsters, whose dilemmas he addresses without gross transferential intrusions.)

One has observed that liberating the cinetherapist from the office is a staple in cinetherapeutic care. It is far more dramatically rewarding to watch Weston’s visit to Walter’s hospital bedtime after the latter’s suicide attempt, or to see Weston at Alex’s funeral with Laura, than suffer through the usual therapeutic bromides intoned from the office chair—“Tell me more about your father (mother, brother, lover) . . . what happened then . . . uh huh . . . that must have been really tough for you . . . I see . . . uh huh.”

Weston’s office itself plays a significant narrative role—particularly in the first season, where it is situated within his home in such a fashion that the boundary between his work and living space can become as po-
rous as the interface between Weston and his clientele. The office has no waiting room, enabling patients to literally collide with each other or intrude unknowingly upon another patient’s session, toward potent dramatic ends (e.g. Laura and Alex’s first encounter).

The patient bathroom is in Weston’s office, and figures prominently in several episodes. Amy resolves her ambivalence about motherhood by interrupting a couple’s session to miscarry in the loo. On another occasion, when the office toilet is stuffed, Laura convinces Weston to let her use a bathroom in the house, which allows her to invade his physical, as well as his mental territory. In season two, Paul has divorced and moved to Brooklyn. He lives and practices in a small apartment, again without waiting room space, again setting the stage for provocative collisions.

Egregious sexual boundary violations offer the supreme dramatic premium in the practice of cinetherapy. It thus comes as no surprise that Weston’s miscarried love affair with Laura, articulated with his insensate jealousy toward Alex, comprised the most interesting episodes in the series for many viewers.

OTHER FACTORS IN WESTON’S CONSTRUCTION

_In Treatment’s_ executive producers are Mark Wahlberg and writer/director Roberto Garcia (whose talents figured prominently in HBO’s _Carnivale_ and _Big Love_ series). Working closely with Hagai Levy, Garcia drew heavily—sometimes word for word—from _Be-Tipul’s_ universe. Other talents involved most closely involved in the creation of _In Treatment_ include several other well-known directors, writers, and a cast of fine actors (Gabriel Byrne as Weston, and Diane Wiest as Gina are particularly impressive).

One submits that with varying mixes and writers in each episode, Weston’s character is essentially “subcontracted,” reconstructed and reconstrued, however small the extent, from one episode to the next. Weston’s house indeed has many mansions. The same is true for each patient. (According to Roberto Garcia’s overarching intentions, a central core of Weston and his patients’ characters is always maintained throughout the series. Garcia himself directed and wrote a number of episodes.)

One further speculates that Weston’s “reconstructions” may also have been influenced by other significant production team members—for example, a line producer, assistant director, cinemaphotographer, editor, etc.
It is even possible that a minor player, key grip, or best boy could have made a serendipitous contribution, however small. Several therapists have also been informal or formal consultants to the show. According to sources in the industry I cannot reveal, their suggestions about Weston often go partly or totally unheeded.

All of these people, high upon or lower down the production ladder have brought to the series—and to the formation of Weston’s persona—their unique knowledge and subjective biases about every imaginable aspect of the mental health field. Key influences include formal education, beneficial or disastrous experiences in therapy, and information derived from other sources of variable reliability, notably the media.

Contributions to Weston’s construction by people outside the production team are impossible to know or gauge, but play some part—from the wings as it were—in the creation of any play, film, or television drama. Participants in that obscure feedback loop through which movie and TV dramas are received and created comprise a giddy congeries of husbands, wives, children, other relatives, friends and lovers, their therapists, financial backers, reviewers, and fans.

**IN TREATMENT: CUI BONO?**

The “applied analysis” of cinema has steadily escalated over the last thirty years. So have arguments among mental health professionals about the beneficial or deleterious effects of portraying therapy in film or television. Because of its wide exposure, *In Treatment* arguably has provoked the most argument.

Naysayers insist that most of the cinematic depictions of psychotherapy are harmful to the public and to the profession. For who would want to place his or her mental health in the hands of a lunatic Dr. Dippy, or the malevolent Dr. Evil? How could a real therapist ever hope to compete with Dr. Wonderful? Couldn’t Dr. Wonderful’s instant accessibility and boundless empathy lead to unrealistic expectations? Would Dr. Weston’s uncritical acceptance constitute a cure worse than the disease in narcissistic patients?

Enthusiasts about cinotherapy—in my experience, they were often cinephiles themselves long before they became practitioners—have now waxed so sanguine as to recommend using feature films in teaching psychological disorders. Movies and TV programming are also being employed in individual and group therapy settings to implement free association and stimulate discussion of shared problems. One of my patients, a therapist in training, was recently told by a supervisor that Weston could serve as a superb role model for her.
I have discovered no reliable studies about the tutelary benefits of cinema for practitioners, nor is there evidence of harmful effects upon laypeople from exposure to cinetherapy. The literature on either side of the debate is completely anecdotal. One can only offer personal conjectures.

My sense is that the series has had far less impact on the public’s mental health than therapists of whatever conviction would like to think. A few potential patients may avoid therapy because they fear becoming the object of a therapist’s madcap maladroitness or maddened lust. A few may seek help believing that their therapist will be as wonderful as Weston. And I do not doubt that some may use In Treatment as a springboard for learning more about psychotherapy, and even entering therapy. But I continue to believe that the majority of viewers chiefly regard the series as reasonably well-executed entertainment.

In Screen Memories: Hollywood Cinema on the Psychoanalytic Couch (1993), I wrote that:

In the main, Hollywood has given little back to the profession compared to what it has taken [at the movies] ... therapeutic practice is distorted or trivialized.... Cinetherapeutics continues to privilege the quick fix over the boredom and sweat of therapy. [Cinotherapists] continue to push catharsis without insight, common sense direction one could get over the fence, and the perennial blaming of parents.

In Treatment at least has captured something of the sweat and—yes—occasional boredom of psychoanalytically oriented psychotherapy, as opposed to the decerebrate quick fixes still being served up at the Simplex. After one of Weston’s many scathing denunciations of insight-oriented therapy, Gina’s response comes as a sensible description of our work and its modest goals.

She admonishes Weston that we must keep listening compassionately as participant–observers of the treatment process. But we should go no further than participant observation, no further than illuminating the occulted causes of suffering. We strive to remove the blocks that nurture and nature, character and constitution, have put in the way of our patients becoming whatever they were meant to be.

Inappropriate personal involvement and a plethora of advice, however well intentioned, only interfere with the work. As Freud famously stated, we aim to help patients live less neurotically in a neurotic world. We cannot stop them from choosing yet another painful path if they are so inclined.

Of course, the same Gina who proffers this wise counsel, the same Gina foregrounded as Ideal Therapist by In Treatment, inappropriately
takes on Paul and his wife Kate in couple therapy during season one, thoroughly bungles the job, and finally tells Weston in Kate’s presence to go to Laura. It is bad business clinically—but it is also show business, in the grandest tradition of cinetherapy.

RECOMMENDED READINGS


HARVEY ROY GREENBERG