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# The cultural work of office charisma: maintaining professional power in psychotherapy

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**Abstract** This article examines the cultural practices through which a group of professionals infuse their work and community with charisma. Although previous research has theorized the "charisma of office" (Weber 1978), we know little about how the occupants of such offices sustain it. I focus on a group of psychoanalytically-inclined psychotherapists, whose field, despite its early charismatic beginnings, has been especially embattled in recent decades. Drawing on ethnographic and interview data, I reveal how they share stories emphasizing their "idealization" by others, draw boundaries between their professional and private lives to manage their work identities, and perform interpersonal affective work that shores up their claims to extraordinary abilities. Together, these cultural practices constitute charisma within the professional group. This article thus makes a case that, as expertise becomes increasingly contested, we must look beyond social organization and the evidentiary bases of knowledge to understand professional authority.

**Keywords** Boundary work · Charisma of office · Emotion work · Professional power · Psychoanalytic psychotherapy · Storytelling

Authority is a classical Weberian theme, one that has been taken up and developed in a diverse range of literatures including those on the state, the professions, and organizations, to name a few (e.g., Benzecry 2006; Esquith 1987; Ewick and Silbey 2003; Freidson 1970; Linde 2009; Parsons 1951; Starr 1982; Timmermans 2006). This article focuses on professions, but departs from previous emphases on their "rational-legal" (Weber 1978) power drawn from credentialing, efficacy, and market conditions (Abbott 1988; Freidson 1970; Starr 1982). In fact, just as we have been seeing an increased "expertification" of society (Brint 1994; Stehr 1994), science and technology scholars have demonstrated that contests around expertise abound (Arksey 1994; Emke 1992;

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Epstein 1995, 1996; Hardey 1999; Prior 2003). Charismatic elements of authority, I contend, cannot be overlooked if we want to better understand the staying power of professions.

The field of mental health is especially open to contestation because knowledge about the roots of illness, its development, and proper treatment is still limited (for critiques, see Goffman 1961; Healy 1997; Horwitz 2003; Scull 1989; Whooley and Horwitz 2013). This article focuses on a particularly embattled group, namely psychoanalytic therapists. Psychoanalysis has been previously characterized as a charismatic cult organized around Freud (Zaretsky 2000, 2004). Its success depended on the conditions of its emergence: the industrial revolution wrought changes that touched virtually every aspect of people's lives (e.g., Hale 1995; Zaretsky 2000, 2004). Within such uncertain times—deemed essential to the triumph of charismatic leaders (Reed 2013a, 2013b; Weber 1978)—Freud voiced the inchoate feelings of unsettledness that seemed to plague many of his generation (Hale 1995; Zaretsky 2000). He was able to articulate a "new experience," i.e., "personal life," that resonated with those swept up by the social upheaval of the early twentieth century (Zaretsky 2000, p. 330). Psychoanalytic theory created new possibilities for self-understanding by elaborating concepts such as the "unconscious" and psychic reality, and tying both to sexuality. Despite beginning to lose some of its power in the years following the Second World War, psychoanalysis emerged in the 1960s as a cultural force, particularly in academic circles (Zaretsky 2000, 2004). But its dominance in clinical practice has been curbed by the rise of psychopharmacology and other competing talk therapeutic interventions (Hale 1995; Healy 1997; Luhrmann 2000; Schechter 2014; Zaretsky 2004). Most notably, cognitive and behavioral approaches, described as "evidence-based" or "empirically supported," have challenged psychodynamic therapists' efficacy claims. Consequently, practitioners of psychoanalytic interventions today, often called upon to justify their approach, are motivated to establish and uphold their expertise.

Between 2009 and 2011, in interviews with novice and experienced psychotherapists, as well as during ethnographic observations at an outpatient psychiatric clinic, I examined how professionals within the field of psychoanalytic psychotherapy sought to shore up its boundaries and authority. Adam, a psychodynamic[1] psychotherapist and psychoanalyst who has been in private practice for more than twenty years, described popular perceptions of his profession:

> [O]ccasionally at cocktail parties people get anxious when they find out I'm an analyst. … I think people have all sorts of fantasies … that analysts have certain … special capacities to … see through [them]. You know? I'm actually a very acute diagnostician, like I *am* very good at that. But I am not interested in doing it when I'm not in my office.

[1] This is another term for "psychoanalytic psychotherapist" and I use the two interchangeably. Practitioners distinguish both psychodynamic and psychoanalytic therapists from psychoanalysts who are credentialed to practice the more intensive form of this treatment.

I heard similar accounts in other interviews. Often, narrators chuckled, amused at the outlandish notion that they might possess, as Adam put it, "special capacities" to "see through people." At times, they expressed frustration at the (admittedly rare) interpersonal difficulties linked to their occupation. Yet such stories also signaled an undercurrent of pride: Adam believed himself to be a "very acute diagnostician." It matters less here whether their "anxious" interlocutors really hold such "fantasies" about psychotherapists' skills. Instead, I take such storytelling, along with boundary drawing, and emotion work, to be cultural strategies by which this professional group maintains a form of power akin to charisma. Among psychoanalytic therapists, the pride and recognition that these narratives evoke, bolstered by the therapeutic "frame" (Gutheil and Gabbard 1993) and the affective connections they attempt to forge with their patients, strengthen their claims to authority and give meaning to their work.

Characterizing a professional group as charismatic may seem like a contradiction in terms. By Weber's (1978) definition, "genuine" charisma is non-routine, discontinuous, and revolutionary. In contrast, even the narrowest understandings of expertise encompass the mundane and repetitive activities necessary for gaining experience and becoming proficient in a particular set of knowledge and skills. Nonetheless, scholars have noted the ways in which charisma does become routinized and linked to professional authority (Eisenstadt 1968; Shils 1965, 1982; Weber 1978). But despite efforts to theorize institutionalized charisma, we still know little about how it is maintained. In this article, I argue that the "charisma of office" (Weber 1978) is constituted in part through the everyday cultural practices of those occupying such roles. In psychotherapy, as in other professions that require access to people's intimate lives, charismatic practices are a primary means through which experts seek both to perform and to guard their authority.

The charisma of the psychoanalytic movement became routinized shortly after its migration to the United States from Europe, where membership in the profession was quickly limited to credentialed psychiatrists (Hale 1995; Zaretsky 2004). Zaretsky (2000)) proposed several explanations for the continued charismatic pull of psychoanalysis: first, training in institutes enforced links to founding figures, Freud in particular, through practices of reading, writing, and the training analysis; second, psychoanalysis built closer ties to the arts; and third, it successfully promoted ideas about sexuality and sexual love.[2] This article departs from historical and institutional approaches to professional charisma (e.g., Shils 1982; Zaretsky 2000, 2004) and focuses on contemporary practices. It illuminates the everyday cultural work by which psychoanalytic therapists maintain their charisma of office. My ethnographic and interview data suggest that clinicians share stories emphasizing their "idealization" by others, draw boundaries between their professional and private lives to manage their work identities, and perform interpersonal affective work that shores up their claims to extraordinary abilities. Such practices are aimed at distinct audiences, namely practitioners and patients. However, insofar as colleagues discuss these aspects of their work with each other in public talks, at conferences, and in private supervision and support

[2] Zaretsky (2000) argues that the charisma of psychoanalysis has ebbed and flowed since its emergence, an argument in keeping with Reed's (2013b) contention that charisma is not a permanent state attached to an individual or group. Rather, it is a performative act or sets of acts that depends on a "spiral of success" (Reed 2013b).

groups, they contribute to maintaining charisma *within* the professional group. As such, the goal of this article is not to demonstrate that patients themselves attribute charismatic power to psychoanalytic therapists. Instead, I take these practices to be illustrative of the cultural work of professionals who attempt to imbue meaning into their increasingly embattled work routines.

In the following pages, I review previous research on professional authority, focusing on its cultural dimensions. In addition, I examine affinities between "emotion work" (Hochschild 1979, 1983) and the charisma of office. Next, I discuss the methods and data that inform my analysis, along with their limitations. The empirical section is organized around three themes: first, I show that storytelling is central to how psychotherapists uphold the charismatic quality of their roles; second, I illustrate the role of boundary drawing in maintaining charisma; third, I illuminate the affective practices by which clinicians embody this authority. I conclude with a further elaboration of the relationship between emotions and expert authority, and suggest directions for future work investigating manifestations of charisma in professions.

## Professional authority and its charismatic manifestations

Paul Starr (1982), one of the most astute observers of professional authority, distinguished between its social and cultural dimensions. In keeping with early scholars of professions, Starr focused on medicine as the typical example of professional success (Anspach and Halpern 1993; Freidson 1970). Echoing Weber, he proposed that physicians' *social* authority amounts to the legitimate ability to give commands to affiliate occupations and patients (1982, pp. 13–14). Yet neither nurses, technicians, nor patients would follow "doctor's orders" if they did not (at least partially) agree with medical definitions of illness and health, and the paths that link the two. Doctors thus also possess the *cultural* authority to shape "patients' understanding of their own experience" and have their "definitions of reality and judgments of meaning and value … prevail as valid and true" (ibid.).

Physicians are not the only group with such power. For example, Timmermans (2005, 2006) noted that death investigators' most challenging task is to determine whether a death is a suicide. Their pronouncements have implications not only for epidemiologists, health officials, police, and the families of the deceased, but also for our broader understandings of what suicide is (ibid.). Yet recent observers have pointed to a decline in medical professionals' social authority both at the organizational level, prompted in part by "managed care" (Hafferty and Light 1995; Leicht and Fennell 1997; Ritzer and Walczak 1988; Starr 1982), and at the practical level, with the rise of "lay expertise" and patient activism (e.g., Brown and Zavestoski 2004; Emke 1992; Epstein 1996; Hardey 1999; Prior 2003). This article thus asks how experts whose influence is contested continue to claim legitimate social and cultural authority.

Previous research has provided partial answers. For Parsons (1951), professional dominance rested on values such as universalism, functional specificity, affective neutrality, and altruism (or collectivity-orientation). "Affective neutrality" was especially important, as it not only ensured doctors' objectivity, but also facilitated their ability to extract essential information from patients

(Parsons 1951, pp. 447–461). Freidson (1970) posited the trust of the state and of a particularly influential social group as pre-conditions of professional success. In contrast, Abbott (1988) argued that the balance between a profession's abstract knowledge and the effectiveness of its interventions must be taken into account. Other scholars have shown that authority is made concrete through practices of speaking, dressing, and feeling—in other words, through orchestrated performances (e.g., Goffman 1959; Haas and Shaffir 1982; Ibarra 1999; Smith and Kleinman 1989). Medical students don the white coat and other trappings of the doctor role to inspire trust in their patients even as they are anxiously aware of their professional shortcomings (Haas and Shaffir 1982). This scholarship has emphasized physicians' affective *detachment* even as they attempt to navigate the difficult feelings stirred by illness and death (e.g., Hafferty 1991; Lief and Fox 1963; Parsons 1951; Smith and Kleinman 1989).

I build on early scholars' attention to the cultural work of performing professional authority. But I contend that previous research has overstated professionals' efforts to separate the public sphere of expertise from the intimate realm of emotion. Hochschild's (1979, 1983) landmark elaboration of "emotional labor" and "emotion work" has provided us with a rich vocabulary to describe the affective components of modern workplaces. Those who have written in this tradition have tended to emphasize the inequalities and alienation that can afflict service workers required to provide a particular affective landscape for consumers (Hochschild 1983; Leidner 1993; Wharton 2009). Few scholars have examined the empowering dimensions of emotional labor (but see Orzechowicz 2008; Paules 1991). Most often, emotions are thought to interfere with the establishment of professional credibility (e.g., George 2008; Parsons 1951; Wharton 2009). But what happens when experts, such as psychotherapists, but also coaches (Chambliss 1988), teachers (Edwards 2010), business managers (Goleman 1995), or priests (Weber 1991), exercise a form of authority that "speaks to the hearts" (Weber 1978, p. 221) of their respective "clients"? Collins (2004) has argued that some individuals command "emotional energy" that grants them higher social standing in "interaction ritual chains." Taking a parallel track, this article posits emotional labor, along with practices of storytelling and boundary drawing, as central to the maintenance of a professional authority akin to charisma.

Genuine "charisma" in its ideal-type is "a certain quality of an individual's personality by virtue of which he is considered extraordinary and treated as endowed with supernatural, superhuman, or at least specifically exceptional powers or qualities" (Weber 1978, p. 241). Such "pure" charisma manifests itself in the *duty* of followers to recognize it and its bearer; in other words, "genuine" charisma is an act of "recognition," an imputation that a group of people make onto another person by virtue of his or her recurrently demonstrated special qualities.[3] Such charismatic leaders reject "all rational economic conduct" (ibid., p. 1113); their power is highly unstable and volatile. Propelled by the deep affective loyalty they inspire in their followers, they

[3] By a Durkheimian logic, this would be an act of "misrecognition" in which a group's feelings of "collective effervescence" would lead it to attribute special powers to a leader (or totem) that in fact belong to itself (Durkheim [1912]1995; see also Bourdieu 1987). Camic (1980) has argued that such imputations can take on a different tone depending on whether followers' practices flow from id, ego, or super-ego needs.

can overthrow "custom, law, and tradition" (ibid., p. 1117), instigating revolutionary change (Greenfeld 1985; Reed 2013b; Smith 2000; see also, Eisenstadt 1968).[4]

By its very opposition to tradition and existing institutional norms, genuine charisma is "foreign to everyday routine" (Weber 1978, p. 246) and thus faces challenges of succession (see, e.g., Benzecry 2006). But Weber recognized that charisma *can* become routinized, stating, "when the tide that lifted the charismatically-led group out of everyday life flows back into the channels of workaday routines, at least the 'pure' form of charismatic domination will wane and turn into an 'institution'" (1978, p. 1121). Thus, whereas genuine charisma seems to emerge in "uncertain times" (Reed 2013b; Thorpe and Shapin 2000; Weber 1978) routinized charisma has been theorized as a component of mundane, presumably more settled times (Eisenstadt 1968; Shils 1982).[5] Yet the opposition between settled and unsettled times may be overstated. While revolutions, wars, or economic downturns—to take three commonly invoked examples—are periods experienced by large swaths of populations as uncertain, times of relative calm do not necessarily translate as such for individuals or small groups. "Stability" and "uncertainty" are both objective and subjective states and can co-exist at different scales. In fact, needs[6] dispose some people to impute charismatic qualities onto others, as well as onto ideas or institutions (Bourdieu 1987), irrespective of larger social conditions (Camic 1980). We thus must avoid using the apparent "settledness" of the social environment as a criterion for deciding whether "charismatic domination" may be at work.

Although arguably a more pervasive social phenomenon than its 'genuine' counterpart (e.g., Chen 2012; Eisenstadt 1968; Shils 1982), institutionalized charisma has received little attention in recent scholarship. Attempting to erase the difference between the two, Shils (1982, p. 110) argued that charisma is "the quality which is imputed to persons, actions, roles, institutions, symbols, and material objects because of their presumed connection with 'ultimate,' 'fundamental,' 'vital,' order-determining powers" (see also, Chen 2012 for a similar argument). Building on the Weberian argument and drawing on Durkheim's writings about social order, Shils (1982) contended that charisma can exist in society in more or less concentrated form, contributing as such not only to revolutionizing and destabilizing collectivities, but also to maintaining them. The "*charisma of office,*" Weber argued, depends on the "acquired qualities" of those occupying said office and the "effectiveness of the ritual acts" (1978, p. 248). "Charisma of office" is thus not a "unique gift of grace" (Weber 1978, p. 1135), but a "quality" that resides to varying degrees in different social loci (Shils 1982) and that

[4] Such change is especially likely in conditions of high ambiguity or uncertainty (Friedland 1964; James and Field 1992; Reed 2013b; Thorpe and Shapin 2000; Turner 2003). For example, in mid-seventeenth-century Virginia, Nathaniel Bacon took advantage of Governor William Berkeley's hesitance in a war with Native American tribes and led the rebellion that plunged the state into civil war (Reed 2013b). In the mid-twentieth century, J. Robert Oppenheimer helped keep together the unstable alliance between scientists and the military in the Manhattan project (Thorpe and Shapin 2000). Bacon, Oppenheimer, and other such charismatic leaders drew their force from the affective devotion they inspired in their followers during uncertain times (Camic 1980; Lindholm 1990; Reed 2013b; Shils 1982; Thorpe and Shapin 2000). This is akin to the role that Freud played in the early twentieth century, as he articulated various sources of personal discontent and uncertainty into a coherent theory of self and a set of practices around its mending and discovery (Zaretsky 2000, 2004).

[5] While charismatic and everyday rhythms seem to merge in periods of routinization, genuine charisma is, Eisenstadt contended, "revived again only in situations of extreme and intensive social disorganization and change" (1968, p. xxi).

[6] Such needs can have various sources and have been explained both psychoanalytically (Camic 1980) and field theoretically (Bourdieu 1987).

depends on the performances of those claiming it. Thus, unlike the prophet whose personal gifts inspired followers' devotion, the priest draws authority from his "office" and the rituals performed in service of a sacred tradition (Weber 1991, p. 46). "Pastoral care," aimed at "the religious cultivation of the individual," amounts to a "charismatic distribution of grace" (ibid., p. 75). Routinization does not result in a loss of charismatic qualities. Instead, such qualities depend on priests' access to intimate knowledge about people and their troubles, and the sacred rituals of confession.

We might then argue that professions positioned at the nexus of "guilty knowledge" (Hughes 1958) and the confessional mode (Foucault 1978) could be deemed closer to what Shils (1982) described as society's "vital powers." Priests, therapists and other counselors, but also physicians, teachers, coaches, lawyers, managers, and politicians,[7] are part of a group of professions that work with the embarrassing, the dirty, the perilous, and other uncomfortable aspects of human existence (Hughes 1958; see also, Brint 1994, p. 27). Their authority is facilitated by credentials granting them the "license" to gain and act upon "guilty[8] knowledge," while their expertise can function as a "mandate" to define others' "proper conduct" (Hughes 1958). Moreover, the "confessional act" renders this expertise sacred. To Foucault (1978), the act in which a "speaking subject" seeks to attain some ultimate truth by narrating her deepest fears and desires has become one of the defining elements of modern Western societies (see also, Rose 1996). The confession cannot but "unfold within a power relationship," as the listener "intervenes in order to judge, punish, forgive, console, and reconcile" (Foucault 1978, pp. 61–62). Such judgments transform confessors' sense of themselves (Foucault 1978) but, I suggest, depend on participants' convincing affective displays within carefully curated environments.[9]

Emotional labor, I proposed earlier, is a key component of institutionalized charisma, particularly in professions. Additionally, scholars have contended that storytelling can be similarly productive: it imbues meaning into rationalized practices and organizations (Clark 2005; Ewick and Silbey 1995; Polletta et al. 2011) and can "charismatize the routine," as Chen (2012) found in the Burning Man organization. Boundary work (Lamont and Molnar 2002) often works in tandem with such "charismatizing" practices setting the profane apart from the sacred (cf. Douglas 1966). Professionals construct boundaries to define and claim legitimate jurisdiction over an area of knowledge (Abbott 1988; Gieryn 1983), as well as maintain hierarchies in the work place (Bechky 2003; Vallas 2001). Boundaries can be wielded to set apart lay people's "ordinary" understandings from professionals' "extraordinary" knowledge. Yet as "experts of the ordinary" (Arnason 2001), psychotherapists are especially motivated to engage in boundary drawing and storytelling practices. On more than one occasion I heard residents and other trainees wonder what precisely it was that they did to help

[7] Ng and Kidder (2010) elaborate a theory of emotive performance by taking politicians as a case.

[8] A priest "cannot mete out penance without becoming an expert in sin" Hughes (1958, p. 79) contended, "else how may he know the moral from the venial"?

[9] As some of the most authoritative interlocutors in the confessional mode, therapists are veritable "technologists of the self," furthering the project that scholars have attributed to the psychological sciences: the making of modern selfhood (Foucault 1978; Hacking 1995, 1998; Lunbeck 1994; Rose 1990). Though Foucault (1978) emphasized the discursive elements of therapeutic technologies (see also, Rose 1990, 1996), I highlight here their embodied affective dimensions and the cultural practices that set the therapeutic space apart from everyday life.

patients as they sat and listened to their "confessions" hour after therapeutic hour. These doubts were voiced by a psychiatry resident who recalled a patient accusingly tell him, "I could just go home and talk to a wall, and it would be cheaper!"

Yet these exchanges were counteracted by the stories that Adam (cited earlier) and his colleagues shared to highlight imputations of remarkable skills. Moreover, therapists' carefully guarded professional persona is shielded from direct external observation by the rituals of working within the therapeutic frame (Gutheil and Gabbard 1993). Even supervision ultimately relies on therapists' accounts of their work (see also, Luhrmann 2000). These accounts, as I show in the empirical section, revolved around the "emotion work" (Hochschild 1983) that therapists undertook in clinical sessions. There was thus little room for challenging such stories of extraordinary skills: the therapy office shields clinical work from direct observation[10] while clinical accounts of working with difficult patients "demonstrated" just what those "extraordinary" skills might be.

For many in the psychoanalytic community, the label of "psychoanalyst" remains a prominent symbol of power and knowledge. But the number of novices willing to undertake training to become psychoanalysts has vastly diminished in recent decades (Schechter 2014). Zaretsky (2000, 2004) has emphasized the role of such training within psychoanalytic institutes in cultivating the profession's "charismatic quality." Pointing to the heyday of American psychoanalysis in the 1950s and 1960s, he found that:

> Even as they were caught up in the process of routinization, connection to a charismatic source of meaning shaped the inner life of American analysts and distinguished them from their fellow doctors. No mere economic rewards could explain the discipleship, the self-denial, the years of training, the night classes, the monastic demeanor, the secrecy, and the dedication that produced the analyst. (2004, p. 293)

Training remains a consuming process. Those who venture into this field[11] study psychoanalytic theories and ideas, undergo analysis, and treat patients with psychoanalytic methods over multiple years. Yet there is a large contingent of clinicians who practice psychoanalytic interventions but who are not formally accredited as psychoanalysts. They are known as psychodynamic psychotherapists. The findings of this article apply both to psychoanalysts and to those clinicians who work under the aegis of psychoanalytic thought. Differences between their approaches have diminished over time but can include the content of conversations with patients, the techniques they employ (e.g., free association and dream work are more typical of psychoanalysis), and session frequency. The psychoanalytic couch, a mainstay in offices since Freud, can no longer be counted on to

[10] Video and audio taping remain sources of deep skepticism among psychoanalytic clinicians who are sensitive to anything that may have an impact on the "dynamics" of the therapeutic relationship.

[11] While a majority of psychiatric residents pursued this track in the 1950s, only one to two residents per year joined the local analytic institute in the site where I conducted my fieldwork (see also, Luhrmann 2000). The American Psychoanalytic Association has also registered an absolute decline in the number of trainees (Schechter 2014, p. 24).

distinguish analysts from their psychodynamic colleagues.[12] Although most of the participants in this study used it for analytic work, some did not. For the purposes of this argument, it suffices to note that even those clinicians practicing the less intensive approach evinced similar orientations towards charismatic meaning-making.

## Methods and data

This article is based on select data from eighteen months of ethnographic fieldwork and sixty in-depth interviews. I observed the talk therapeutic training of psychiatry residents, psychologists, and social workers in the outpatient psychiatric clinic of a medical system affiliated with a large public university. Trainees learned how to do psychotherapy through a combination of lectures, working with patients, and supervision.[13] The ethnographic data for this article comes from my observations of the psychodynamic "core class," a one-and-a-half hour weekly meeting in which residents (mainly those in their third and fourth years), along with two or more experienced psychotherapists (all of whom were affiliated with a psychoanalytic institute and practiced psychoanalysis and psychodynamic therapy), discussed theory and cases. Each resident was expected to treat one to three psychodynamic patients beginning in their second year. Two experienced psychoanalysts served as their instructors: Terry, trained as a psychiatrist, and Patricia, a psychologist. Other psychoanalysts occasionally visited the seminar, either to present their own cases or to discuss a resident's case material in group supervision sessions. Advanced residents presented their own work with patients, usually focusing on one or two sessions of an ongoing treatment.

I also conducted sixty semi-structured in-depth interviews, twenty-five with psychodynamic practitioners and psychoanalysts. Seventeen in this latter group worked in private offices, whereas the rest were either affiliated with group practices or hospital clinics. Participants varied in level of education (including social workers, psychologists, and psychiatrists), and years of experience (from six months to more than thirty years). Interviews lasted between one and three hours and covered four topics: professional history, what a typical therapy session looks like, what therapists think about and how they feel when they interact with patients, and whether and how their professional knowledge has been relevant to their lives outside of work. Some of the stories I draw on in the following pages emerged in response to the last set of questions (e.g., "How does your work influence your social and family life?").

It is important to note my exclusive focus on psychotherapists. As such, I am unable to speak empirically to how psychoanalytic clinicians' attempts at maintaining a

[12] There is a great deal of tension in the psychoanalytic community over different definitions of psychoanalysis: Freudians and ego-psychologists reject relational approaches as non-analytic because they rely on the therapeutic relationship as a treatment tool (in contrast to the former who adopt a "neutral" persona that provides interpretations) (for a detailed and insightful discussion of the professional stakes of these differences see Schechter 2014). I eschew a deeper discussion of these differences, as I found them to be inconsequential to this analysis.

[13] Unlike residents training at earlier times (e.g., Bucher 1965; Light 1980; Strauss et al. 1964), participants in this study were not obligated or even strongly advised (in the public fora I observed) to undertake their own therapy. This is partly a function of the decreased emphasis on psychoanalytic practice in their post-training careers.

"charisma of office" are received by their patients. However, mental health workers form a significant portion of psychotherapy clients and my own findings indicate that many non-psychodynamic therapists along with those who practice this orientation choose it for themselves when they face difficulties. This seems to indicate that the charisma of psychoanalysis depends, at least in part, on clinicians and their actions. Other scholars have traced the broader "cultural authority" (Starr 1982) of psychoanalysis, especially its impact on how we think about what it means to be a "normal" or well-functioning human being (e.g., Bellah et al. 1985; Hale 1995; Illouz 2008; Luhrmann 2000; Zaretsky 2000, 2004). I add to these accounts an examination of the affective and spatio-temporal dimensions of therapists' cultural authority, as well as the narratives by which practitioners affirm their charismatic powers to each other, thus giving meaning to their work.

## Sharing stories of charismatic recognition

Residents seldom discussed publicly the social burdens that accompanied their choice of profession. Yet during one meeting of the psychodynamic core class, Terry, the instructor, asked them:

> Terry: …what's the most often [sic] remark that you hear when you tell people that you are a psychiatrist?
>
> Rob: Never say that! It's too dangerous! All of a sudden I'm hearing about this woman's sexual problems and her three kids and five partners, and I'm like, "please I just want to fill up my gas tank!"
>
> Russ: Or they stop talking to you!
>
> Terry: I often hear, "Oh, will you tell me what this dream means?" or "You must have some great ideas about me!"... or "I'd better stop talking to you because I don't want you to figure me out!"....
>
> Corey: Always prefaced with "I'm not crazy"....
>
> Rob: Yeah, but then you can say "let's make an appointment and we can figure that out"...

To Terry and the residents, the "dangers" of disclosing their occupation are twofold: one is either placed in the uncomfortable position of learning intimate details about people's lives or is simply rejected ("they stop talking to you!"). Dreams seem to remain fertile ground for the popular imagination, a manifestation of the continued cultural authority of psychoanalysis. However, as I argued above, I take such exchanges not as indicators of how the public at large views psychiatry or the psychoanalytic profession specifically but as cultural practices particular to an epistemic community. These practices aim to create common meaning around the value and continued relevance of psychoanalytic skills. The stories help build a sense of identity

among psychotherapists and affirm their capabilities, as the invitation "let's make an appointment" to "figure out" whether you "are crazy" implies. Psychiatrists work in conditions of overwhelming uncertainty. Without the ability to "control" the outcome of a treatment, belief in their own skills remains paramount to the functioning of the profession (Light 1980).

Residents were not the only ones to share stories that hinted at the attribution of extraordinary abilities. Morris, a middle-aged man who had been practicing psychodynamic psychotherapy and psychoanalysis for over two decades, told me that his professional role usually does not affect his social life. "It runs you into things," he added, "when you talk to [strangers] on the airplane." He continued:

> Then you see interesting reactions people have, you know.... "I can't say anything now" or … they want to talk about a lot of difficulties or, you know, some particular issue or something like that…. That used to happen more than it does now. Maybe because … being a therapist is a more frequent occupation than it used to be, you know, somewhat. And people think they know what it is. There're more maybe socially available prototypes that make it look safer? Less witch-doctory than it—than it used to be thought of, you know, head-shrinkers were the scary people.

Morris's story closely resembled those shared by Terry and the residents. His experiences were similarly plagued by either a closing off or intimate opening up of social interactions. Both scenarios hint at an imputation of extraordinary abilities: the therapist is imagined as a person whose skills make possible a clairvoyant understanding of a stranger's personal problems. He is also depicted as having an uncanny talent for fixing such problems in the temporal frame of a flight. This, Morris noted, is akin to being considered a "witch-doctor," a healer whose abilities are both supernatural and "scary." Morris rightly pointed out that the proliferation of the counseling professions has led to the creation of "more socially available prototypes." As such, psychotherapists' *dangerous* charisma has become routinized, their discourse demystified, incorporated into the larger culture of self-help (Illouz 2008). I call psychotherapists' charisma "dangerous" to emphasize the "guilty knowledge" (Hughes 1958) they possess. Psychoanalysis built its cultural authority on the fertile ground of "neurosis," a state that could afflict anyone no matter how healthy they seemed (Hale 1995; Metzl 2003; Zaretsky 2004). It was this notion that allowed clinicians into the heart of family troubles and sexual desire, becoming the keepers of their patients' secrets.

It is worth noting that stories of extraordinary skill were more often shared by practitioners of psychoanalytic interventions compared to those adhering to therapies, such as cognitive behavioral, that have greater purchase in the world of "evidence-based" medicine today. I take these narratives as attempts to assert the continued relevance and influence of psychoanalytic practices in an environment that has proven largely hostile to them. Harry, another experienced psychodynamic therapist, told me that in social situations where he is likely to meet strangers, disclosing his occupation sometimes "makes people anxious in a way in which they wanna prove to you that therapy isn't helpful or doesn't matter." He thought this was a challenge unique to his profession, one that he attributed to people's worry "that there's something about being a therapist that means I would see something, or see deeper, or know something….

That I use my x-ray vision and see deep into their soul. (Laughter) And—and, you know, after they have spoken a mere three words, right? I have—I have such extraordinary expertise….” Harry did not read people’s desire to “prove … that therapy isn’t helpful” as a possible indication of the power and cultural caché of psychopharmacological interventions. Rather, he viewed it as an indirect imputation of unparalleled “expertise,” a kind of “x-ray vision” that can only be blocked through a direct counter-attack and dismissal. His sarcastic tone when discussing such imputations belies the import of his account to maintaining a sense of community and professional pride.

Yet such storytelling can imbue routinized practices that have lost their original charismatic quality with a sense of the exceptional (Chen 2012). While the narrative about “interacting with strangers” was fairly commonplace, an even more frequently invoked trope in psychoanalytic understandings of patients’ problems was that of “idealization.” Therapists used this term to denote the possibility or, more likely, the probability, that patients develop particularly positive ideas about clinicians and their personal lives. Adele, an experienced practitioner of psychodynamic therapy and psychoanalysis, dwelt on the ways in which her personal and professional lives intertwined. She explained that therapists “become idealized[14] from the minute … somebody makes the phone call. And so yes, many, many, many people believe you live this charmed life.”

During our interview, she recalled patients’ varying reactions to her divorce, years earlier. Disappointment in a therapist’s personal difficulties, Adele pointed out, can be “a wonderful jumping off point for what they expect … their marriages are supposed to be like, what—how they’re supposed to handle things, their shame, their sense of inadequacy, comparisons, and competition that … they live with all the time whether with siblings or coworkers….” Yet, even as patients may grasp intellectually that their therapists’ lives are far from perfect, Adele believed that some still assume that “somehow you have the skills and the capacity to manage all of this without it affecting you at all. Because your knowledge as a therapist supposedly can help you handle anything and everything.” It is “*so* common,” Adele emphatically stated, “an exception rather than the rule that somebody comes in and doesn’t expect that you know everything, that you have…all the answers.” When her divorce made clear that Adele did not “have all the answers,” one patient left. The reality of her fallibility was too harsh and the spell of her charisma broken. In turn, patients’ expectations can become fodder for the psychoanalytic mill.

When clinicians share stories of “x-ray” vision or skills that “can help you handle anything and everything” they engage in the kind of “recognition practices” that Junker (2012) considered constitutive of charismatic authority. While he specifically used this term to signal the recognition that flows from followers to a charismatic leader, here it is those who claim the charisma of office, those who, in Shils’s (1982, p. 111) telling, “possess an intense subjective feeling of their own charismatic quality,” that work to amplify it by narrative means. This can further the group’s belief in its own healing powers and, especially, in its methods—a “technique of control” (Light 1980) that is

[14] In fact, the end of “idealization” is considered an essential sign of the patient’s emotional growth and her readiness to exit treatment, as evidenced by the advice that an experienced psychoanalyst gave residents: “The other criteria [for termination] is that the therapeutic relationship is not distorted any longer, the therapist is not denigrated nor idealized, and that ability to see the therapist as a real person, for the patient to say ‘I know you have that quirk but you’re human,’ that ability is to connect to someone else as a whole human being.”

essential in a field plagued by uncertainty (cf. Schechter 2014). Yet there is more to this cultural work than storytelling, and Adele's example brings this element into relief: boundary work. Adele broke the "wall" shielding her private from her public life when she stopped wearing her wedding band. This created opportunities for contestation just as it illuminated her "idealization" by some patients.

## Drawing boundaries to delimit a therapeutic persona

Psychotherapists actively worked to construct a therapeutic persona, an image that delimited the personal from the professional. While many of my psychoanalytic interviewees argued that patients are entitled to know their professional qualifications, they made clear that they are to know as little as possible about their personal lives.[15] Spatio-temporal boundary work facilitates such control. The dreaded coffee invitation that some participants in this study received was met with a resounding "no." Only three of the twenty-five psychoanalytic practitioners I interviewed mentioned conducting some therapy sessions outside the office, and two described unusual situations: one's dying patient needed assistance in the hospital, while another's was facing a crisis when the office was made unavailable by ongoing construction. Adele discussed her one-time decision to take a walk outdoors with a patient for whom she believed this would be beneficial.

The office is a liminal space, "apart from the rest of the world," in which patients can, as an experienced analyst put it, "feel safe and free to say what's going on internally with impunity." Another interviewee told me that by limiting interactions to the office and the forty-five minutes of the therapy session, patients "won't have to worry about … what I think about them otherwise. So if they're very angry at something that I say, they can express the anger fully without fearing that I would retaliate in some way." By setting boundaries between inside and outside of therapy, the material environment provides patients with a sense of safety. But time and space are also important markers of professional power (Freidson 1970).

Patients enter therapists' offices and inhabit them within parameters over which they have little control. The chairs in which therapists sit session after session are theirs and theirs alone. In her discussion of psychoanalytic psychotherapy, Luhrmann (2000, p. 187) pointed out that therapists' and patients' "chairs are identical so that the patient will not feel belittled by his own chair's inadequacy." While my observations confirmed the aesthetic identity of the chairs, I found that they had distinct meanings. This became apparent in some of my interviewees' discussions of undergoing therapy themselves. Elena, a psychologist who had been practicing what she described as integrative psychotherapy for close to five years, thought that all clinicians ought to undergo therapy, if only to be "able to sit in the client's seat and to feel that

[15] There is some variation along theoretical lines about this stance: Freudian analysts are more likely to espouse the virtues of the "analytic mask" whereas relational analysts favor a more flexible approach around disclosure of affective states and personal information. However, despite these espoused differences, all psychoanalytic therapists talked about sharing emotions through facial expressions (and, in one example given by a relational practitioner, by touching the patient on the arm). Moreover, they all placed personally significant items in their offices (such as works of art, pictures of places they visited, or, rarely, pictures of a child in her early years).

vulnerability." To Elena, being "on the other side" and "humbled in that way" are lessons that therapists should learn as they venture further into the profession. Her point illustrates the power inscribed in the spatial organization of the office: the therapist's chair is the locus of authority and expertise; conversely, the spaces that patients occupy are imbued with "vulnerability."

An essential function of the therapy office and hour is to allow clinicians to maintain a professional persona (Goffman 1959) in interactions with patients. Harry chose his private office with a very particular goal in mind. When we first met, he recalled his early training, completing an internship as part of his doctoral work in clinical psychology. He evoked with humor his first office, which, like that of the other interns, was in a basement and reached via a creaky elevator and a long, dimly lit hallway. Harry recalled feeling as though he was at a police station, taking suspects to an interrogation room. When searching years later for an office, he wanted a space that could communicate to his patients, as one of his supervisors told him, "what a wonderful therapist you are." The office has to be a "decent space," Harry explained, so as to give patients the impression that "they're dealing with a professional … who is at least successful enough" to pay for a good room, one with tasteful decorations, nice furniture, and, in his case, a great view. In this way, the office serves as a stage upon which therapists construct successful professional identities.

My conversations with Sue, a recent graduate of the psychiatry program where I conducted my fieldwork, convinced me of the import of boundary-work for maintaining a professional identity. Sue spoke at length and with little prodding about her self-presentation, voicing the kinds of concerns that fueled her conversations with colleagues during their training years. She avoided going to particular places around the city where she may run into her patients, did not engage in any public behaviors that may give them reasons for negative evaluations should they actually meet (such as public smoking or excessive drinking), and spent time curating her appearance. With experience, figuring out what she felt "comfortable letting the patient know about [herself]" and "[w]hat happens when [she runs] into patients outside of the office" became easier. She had recently faced the latter scenario:

> I have been taking yoga classes … for a year and a half and I have always wondered, "What would happen [if I ran into a patient]?" This time it happened. This is the first time. Okay. And it … made me anxious especially the first day. I was like, "Well, [my patient and her husband are] in the back and I'm in the front. I guess I should really try and make my yoga pose pretty good because they're staring at me" (Laughter)…. And you want to look competent and good in front of your patients…. I think that it has a little bit more meaning for a psychiatrist because you spend so much of your time encouraging your patients to be competent in their lives, right? And so in some ways it's great to run into a patient and think, oh, after class, I could be like: "Remember all of those times that I told you, you need to exercise? Hey, I'm doing it, too."

Sue's experience was unique in terms of the length of time she had to spend in the presence of her patient outside the therapy office (another practitioner told me she refused to join a tennis team when she learned that a patient's mother was a member). Yet it illustrates the care with which therapists think about how they appear to their

patients and the role of the therapy office in maintaining this appearance. Sue's professional image and authority were affirmed when she "practiced what she preached." For this clinician, exercising was more than the default recommendation repeatedly heard in physicians' offices; it helped solidify her professional identity and credibility. The therapeutic frame thus protects practitioners' authority by allowing them to craft an identity that can be replicated, when necessary, outside the office.

Therapists also attempt to balance personal and professional identities by following the interdiction against accepting their friends or acquaintances as patients. My interviewees attributed the importance of this rule to the difficulties of doing therapy when personal feelings are involved. They believed that patients' personal knowledge of the clinician would muddle their ability to engage in the psychodynamic process. Conversely, the therapist's own feelings would get in the way of understanding patients' wishes, desires, and disappointments. For therapy to work, patients must have only incomplete knowledge of their therapists. As Luhrmann (2000, p. 189) pointed out, "the asymmetry of the therapeutic relationship makes the confessor—the patient—feel extremely vulnerable … [and] develop powerful feelings about their analysts or their analyses." These powerful feelings are essential to psychodynamic work and can foster the kind of "idealization" Adele and her colleagues mined for insights into their patients' unconscious lives. This, in turn, can be linked to charismatic power. Boundary work allows psychotherapists to shield themselves, however imperfectly, against the kind of exposure that would call into question their "extraordinary" knowledge and skills. I turn next to these skills to highlight the emotional undercurrents by which psychoanalytic therapists constitute their charisma of office.

## Emotions and the "charisma of office"

"Emotion work" such as calling up or repressing a feeling (Hochschild 1979, 1983) is common in psychotherapeutic interactions. Novices learn to follow the "feeling rules" (Hochschild 1979) of their profession early on by managing and tolerating intense affect and learning how to display empathy. One experienced analyst told residents that the ability to bear patients' pain and sit with their fears is essential to forming trusting therapeutic relationships:

> I think that one of the most helpful techniques to be aware of is staying in your chair, meaning that the patient comes and tells you that they're afraid to talk to you because they're worried that this and the other might happen, and then they do talk to you and nothing bad happens. [It] furthers the treatment. Helps to detoxify their worries and fears so that she shares some of her pain with me and I'm comfortable with it, and interested, and she feels I'm understanding her….

The clinician's body language, along with what she says or does not say, is part of her affective communication with patients. "Staying in your chair" symbolized, for this analyst, a therapist's ability to tolerate patients' intense emotions, as well as her own reactions to the confessions she hears in clinical sessions. Her imperturbability and seeming moral neutrality are among the "acquired qualities" (Weber 1978) necessary to maintain the charisma of office. Such affective projection of power is partly an

embodied skill and partly, as I point out above, a virtue of the therapeutic setting. An experienced psychoanalytic practitioner told residents that therapy can be patients' "private oasis, their retreat … it's a luxury, in the sense of total contemplation, in the space of our busy lives." This "luxury" of "contemplation" is complemented by the "freedom" to speak frankly. Both are fostered by therapists' measured emotions in the therapy space. As one of my interviewees put it, it's "the same four walls and the same person" that patients come to interact with session after session. As such, the constancy of the therapy space and time and the reliability of the therapist are "co-produced" (Jasanoff 2004), strengthening the latter's claims to charismatic authority.

But therapists were not simply concerned with displaying the right mixture of empathy and control: they were also interested in fostering particular affective dispositions in their patients. Clinicians tended to express particular feelings when they interpreted their patients' emotional reactions as somehow deficient or "repressed." The most common example was that of patients who were thought of as "intellectualized," in other words, detached from their emotions. Joan, an experienced therapist who professed an eclectic orientation but had extensive training in psychodynamic therapy, told me:

> Sometimes clients will share things with me, for example, if they're talking about sexual abuse, and then that happened, and that happened. .. and they'll share something that's just *unbelievably* awful, and I start to feel angry. I will say things like, "I'm aware that I'm feeling really angry about what happened to you, but I notice for you, that... it doesn't seem like there's anything there. Why do you think that might be?" So … sort of taking ownership for the emotions….

Giving clients a voice for their emotions and a vocabulary to talk about them is, Joan believed, an important aspect of her work. As the expert, she "knew" the "appropriate"' emotional response to abuse, but demonstrated her knowledge indirectly: she did not tell her patient what they *should* be feeling. Rather, she related how *she herself* felt while listening to the patient's history of abuse. Although Joan's own emotions exceeded her patient's in intensity, she managed and framed them in such a way that she maintained control over the affective landscape in session.

On a different occasion, Joy, an experienced practitioner of psychoanalysis and psychodynamic therapy, told me she regularly felt intense emotions with her patients. I asked her to explain how she thought of such experiences. She said:

> … sometimes those strong feelings are elicited without the patient feeling them themselves…. For example, I have a very troubled man that I see, who is very often deeply suicidal, who was very badly treated … as a kid, and has a lot of very disturbed social relations, and … often... doesn't have any idea what he's feeling except a kind of morbid sense of helplessness... and hopelessness. But there are times with him when I just experience heartbreak, you know, and... I'm certain that some of what I'm experiencing is his dissociated pain. You know, and in a sense tuning into that through what's going on in my own heart gives me some sense of what's missing for him, or where we might go next, or what's right under the surface and being avoided.

Joy turned to what was "going on in [her] own heart" to understand how her patient might be feeling, even when such feeling is "under the surface" or "avoided." Like her psychoanalytic colleagues, she used her emotions to understand her patients' unspoken experiences. This is not simply an exercise in description (a constative act, to use Austin's [1962] language; see also, Reed 2013a), but rather one of ascription, a "performative" act that makes real the very thing that is being described (Austin 1962; Reed 2013a). Put simply, when therapists "feel" and "name" patients' feelings, they bring such feelings into being. Joy again:

> I think that that can be very healing sometimes, you know, to feel the experience of another person with whom they are safe... naming and registering … that kind of deep emotion together. Now, with the … man who also often doesn't feel his feelings, one reason for doing that might be to say …"I can sense something that I think... you can't yet put into words." … And if I'm not too far off, often people do have a sense that it's right, even if it's remote. But the reason for doing that, often too, is to help a person... acquire some more confidence and certain more feelings of safety with their own feelings. Because … a lot of times people are terrified by their own emotions, the intensity of them... the kind of unnarratable quality of them, because they have not been adequately mirrored and named early on in their life. So I want… to say, "These feelings are tolerable, they're human, I have them too. We can name them."… And that's an educational process really that we're involved in…. But I have to be believable. I have to be able to say I feel it too … or I have felt it.

This quote illustrates psychotherapeutic work aimed at bringing particular affective and relational states into being. The therapist gets a feeling and names it, and, if she is "believable," the patient has "a sense that it's right," and the feeling is made real. The issue of "believability" is paramount: charismatic authority (or any authority for that matter) is not established randomly. Rather, it is based on credible displays of extraordinary skill, on the "effectiveness of the ritual acts," as Weber (1978, p. 248) put it. The spatio-temporal environment in which Joy practices her craft along with her displays of affective strength *and* sensitivity constitute her as a believable witness to and authority on her patient's pain. In naming the feeling, Joy makes her patient's emotion not only "tolerable" but also "narratable." Within the "educational process" of psychoanalytic therapy, patients thus learn how to identify and discuss their feelings.

This should not be taken to mean that patients always receive therapists' "interpretations" with approval or agreement. Rather, clinicians told me, patients can and do disagree, and such disagreement is welcomed and, in fact, expected. Thus, Harry pointed out, if "I'm slipping into this role... of this authority figure … the priest who reads entrails … I make pronouncements… 'old wise one has now said it' … that's very destructive to the therapy process and to the relationship." Instead, the process "ought to feel alive in a way in which, if [I] say [something] and it … moves things along, it ought to be jarring, or get people to see things differently." More importantly, patients ought to feel comfortable voicing what "seems off the mark."

Variations on these comments recurred in most of my interviews and point to another facet of the emotion work therapists perform in the clinical session: they must be able to withstand rejection, criticism, and disagreement. In many cases, therapists

attribute such disagreement to patients' lack of readiness to withstand a difficult psychological truth. This explanatory schema places responsibility for failure with patients, not therapists, allowing the latter to maintain their sense of expertise and control (see also, Light 1980). Therapists are thus more likely to exercise "cultural" rather than "social" authority (cf. Starr 1982): they do not command patients to accept their worldview, but rather, through a process of exchange, aim to convince them of its correctness. This work of convincing depends on therapists' own "believability," as Joy put it, their authoritative and charismatic embodiment of particular affective states.

Emotion work grants therapists control in interactions with patients. In turn, mastering this particular "technology of self" (Foucault et al. 1988) legitimates their expertise and places them in a position of power. Clinicians thus appear less susceptible to the uncertainties that beset all who venture into the affective realm. Emotion management further allows therapists to enact particular ways of being for their clients. By sharing her own feelings of anger while listening to her patient's stories of abuse, Joan exemplified "normal" and expected emotional reactions. Joy "educated" her patient by naming his "heartbreak"—as she put it—and making it possible to feel and talk about that difficult emotion. Joy is not only "believable" to her patient, but also, more importantly, to herself. She reaffirms her own professional identity by serving as the medium through which the patient comes to know himself. This is charisma's productive dimension (cf. Reed 2013a), fostering particular subjectivities that, in this case, fit with psychoanalytic expectations of how a well-functioning human being should experience emotions.

## Discussion and directions for further research

This article has shown that the charismatic dimension of professional authority is grounded in the cultural work of storytelling, boundary drawing, and emotion work. Psychoanalytic clinicians share narratives with each other that highlight their "extraordinary" skills and knowledge. These narratives, I contend, help dispel practitioners' uncertainties and give meaning to their work. Moreover, the boundaries that they enforce and maintain around the clinical setting help safeguard therapists' professional credibility. Should patients learn about clinicians' personal lives they would have access to potential grounds for doubt and distrust. Instead, the imbalance created by the clinical relationship is intended to curtail confessors' ability to question the legitimacy of the ritual or therapists' authority. Not that such contestations do not occur; when they do, therapists utilize them as opportunities for re-asserting control. They do so by turning to the psychoanalytic concept of "resistance" and employing their affective skills. Thus, charismatic performances of embodied emotion work become essential to psychoanalytic clinicians' power in the face of challenges to their credibility.

Previous works have equated professionals' emotional distance with authority. Whether it is "affective neutrality" (Parsons 1951) or "detached concern" (Lief and Fox 1963), professionals' remoteness "reinforces [their] power and keeps clients from challenging them," "[b]ecause we associate authority in this society with an unemotional persona" (Smith and Kleinman 1989, p. 56). In this view, neutral affect serves a

dual role. First, it ensures that experts fulfill the demands of their jobs to the best of their technical and cognitive abilities (cf. Parsons 1951). Second, it (re)affirms their authority in interactions with experts and non-experts alike. In contrast, I contend that psychotherapists' affective practices help them embody a form of authority that is akin to the "charisma of office." As I have shown, "detachment" only partially captures therapists' projections of strength and calm when faced with patients' difficult emotions. Instead, clinicians' self-examination and emotion work hint at greater interpersonal affective involvement (see also, Shapin 2004).

While this article emphasizes emotion work as a key component of charismatic performances, further studies are needed to investigate whether patients perceive these practices to be as compelling as therapists contend. Clinicians face emotions that seem unbearable to patients with strength and control; they "believably" "feel" their "anger" and "hopelessness." In these accounts, therapists embody the "exemplary" charisma that Weber (1991, p. 55) distinguished from "ethical" prophetic action. Unlike the latter, which emphasizes following God's will, the former promotes salvation through a "do as I do" ethic (ibid.). Similarly, clinicians aim to "speak to the hearts" of patients and change their sense of themselves partly through embodied emotion work. Within the bounded spatio-temporal context of therapy, clinicians enact a professional persona partially crafted to "educate" patients about the skills required to become self-reflexive and emotionally calibrated persons. I take therapists' accounts of such practices, especially when shared with trainees and colleagues, as constitutive of a community of knowledge. Storytelling, whether about emotion work or "x-ray" vision, enforces a belief in "extraordinary" abilities among professionals themselves. It is part of the "recognition practices" (Junker 2012) that sustain their charisma of office.

Psychoanalytic therapists may be uniquely situated to exert such charisma. However, financial advisers, lawyers, physicians, and other professionals possess the kinds of expertise that thrive at the nexus of "guilty knowledge" and the "confession." Their charismatic practices are open to further investigation. Moreover, while other scholars have also argued that emotions are more important to professional work than earlier thought (e.g., Edwards 2010; Goleman 1995; Halpern 2001), future studies can elaborate the relationship between emotion work and charismatic authority. One potentially fruitful avenue would be to connect particular kinds of emotion work and its attending cultural practices with the varieties of charisma outlined by Camic (1980). Bringing together Weber's formulation with Freudian writings, Camic (1980) differentiated "attributed specialness" into omnipotence, excellence, sacredness, and the uncanny. Each of these types of charisma meets a particular kind of needs, i.e., extraordinary dependency, ego-ideal, superego, and id (ibid.). However, each is also, by necessity, "performed" and "performative" and, to echo Reed's (2013a) recent call, more sociological analyses can investigate the manifestations of such charismatic forms in society.

This article provides some possible avenues for furthering our theoretical and empirical understandings of the charisma of office. It illustrates the value of studying the cultural dimensions of professional authority by showing that psychoanalytic psychotherapists rely on storytelling, boundary-drawing, and emotion work to infuse a charismatic quality into their routines. As expertise becomes increasingly contested, we must look beyond social organization and the evidentiary bases of knowledge to understand professional authority in both its social and cultural forms.

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