Avery D. Weisman, M.D.

Confrontation, Countertransference and Context

CONFRONTATION IN PSYCHOTHERAPY

Confrontation, Countertransference and Context

AVERY D. WEISMAN, M.D.

e-Book 2015 International Psychotherapy Institute

From *Confrontation in Psychotherapy* edited by Gerald Adler and Paul G. Myerson

Confrontation, Countertransference and Context

AVERY D. WEISMAN, M.D.

The turning point of psychoanalysis came at that moment when Freud told his hypnotized patients to open their eyes. He stopped squeezing the skull for traumatic memories, as if the head were a pus pocket of noxious events. Instead, he invited the patient to participate in a mutual quest that would end when both understood how the past influenced the here-and-now.

Psychoanalysis was at first an exercise in resurrection of what had happened (catharsis), then, what must have happened (reconstruction) and, after that, what might have happened (fantasy and psychic reality). Patients were urged to recall the unrecallable, to relinquish burdensome memories they had not known about. Above all, they were asked to gaze into the darkness of the mind and find clarity. To do so, they were encouraged to abnegate surrounding reality, including their own critical faculties.

True, it was something like a conjurer and his assistant, working with the properties of mental functions and with the ceremonials of medicine. Nevertheless, in many studies, Freud laid down principles of psychopathology that we use today to understand the value of confrontation.

These principles declared that mental life has a common basis in a dynamic psychology, that we withdraw from painful stimuli but seek satisfaction. In any case, we move toward an equilibrium of impulse and quiescence. Words, thoughts, and actions are parts of a single process; each stands in the place of the other at times, so that unimpeded utterances must sooner or later restore what has been forgotten by retracing old pathways. Self-illumination has a healing effect, Freud thought; and by regaining awareness of faulty experiences, by finding the time and place of the original trouble, the mind's aberrations could be cured.

From the perspective of so many decades and generations these principles seem naive, indeed. The psychoanalyst was not like a surgeon who extirpates a source of infection, and yet must remain aseptic himself. When Freud's patients opened their eyes, what did they see? He, too, had to join them in a moment of confrontation. They could see that historical facts are not the same as psychic reality and that psychic reality has a way of rewriting the past. Mere uncovering of past events was doomed to fail; moreover, patients were apt to oppose efforts on their behalf. They could look without seeing and could also refuse to acknowledge what was too revealing. Denial and repression thus formed the basis for later theories of defenses.

Psychoanalysis depends upon a concept called the "dynamic unconscious." But constant preoccupation with what is unconscious and

forgotten may blunt our appreciation of an active and dynamic consciousness, which can perceive and select, act upon and assess its own experience.

In early days, psychoanalysts tended to slight consciousness as if it were merely a smudge on the pages recording unconscious events. Consciousness was an obstacle or, at best, a pathway from the land down to the sea. The analyst's job was to submerge himself as quickly as possible into the depths.

No one can analyze or be analyzed entirely from the position of what is unconscious. Critical faculties cannot be arbitrarily suspended; people cannot say, "I am not aware of what I am aware of." We are conscious and often conscious of having a purpose. Consciousness is not limited to whatever we passively perceive; it is an active response to demands that reality makes upon us. Perception itself is activity incarnate. We respond and are responsive as well. We reach out with our minds and are grasped in return by entire worlds of objects, people, things, symbols, and so forth. Similarly, we may be threatened and shrink back, preferring to deny, to mitigate, displace, and qualify our fears into extinction.

For similar reasons of active consciousness and reciprocal responsiveness to confrontations, analysts cannot be so disengaged from what they are doing that their responses can be separated entirely from the thrust of what patients report. The analyst is not an educated scavenger

searching his patient with a mental Geiger counter, nor are patients paragons of passivity who lie obediently and uncritically, awaiting moments of illumination or an epiphany. Indeed, if this were so, it would be a sign of stagnation, not one of expectancy.

Consciousness is dynamic enough, if we insist upon drawing too sharp a distinction between what is self-evident and what is latent and emergent. Memories may be the building blocks of therapy, but remembering is not a therapeutic act in itself. It is only in the here-and-now that we find a place to stand. And it is from where we stand that we can open our eyes, confront, and be confronted with how we contribute to each other's reality.

Everything else seems to be fragments dissected away from the tissue of contemporary experience. The mystique is gone; contemporary doctors, by which I mean doctors who deal with the contemporaneous, instead of with the remote past or the immediate moment of behavior, strive to uncover the problematic, to define the ambiguous, and to assess potentiality for change.

We do not know if anyone is ever cured by psychotherapy or what the factors are that facilitate benefit. We do know, however, that communication makes a difference to people and that confrontation is a significant, even decisive, element in that professional format of communication called psychotherapy.

The aims of this chapter are four-fold: (1) to define *confrontation* as it is used in psychotherapy, (2) to show how *countertransference* slants the nature of confrontation, (3) to emphasize anew the significance of the emotional *context* in which the encounter between doctor and patient takes place, and (4) to underscore the significance of the doctor as an *instrument of assessment*.

In what follows, I use common terms like *therapy*, *doctor*, and *patient* simply because I am accustomed to the medical model and synonyms are too cumbersome. Nevertheless, I am persuaded that medical models and their idioms do not adequately encompass that process called psychotherapy. People consult psychiatrists because of personal vulnerability, not because of mental illness. Insofar as people can be influenced by psychological means, undertaken with an informed consent, we can scarcely confine ourselves to the special world of couch and chair. The analytic viewpoint, however, is typical of one such strategic pursuit of the way people think and feel about key life events.

Confrontation

The language of confrontation is active or passive; the object may be the patient or the doctor; confrontation can be directed toward something else, or the doctor can be confronted.

The term, confrontation, has become a cliché in our times. In modern parlance, it has come to mean the very opposite of true communication; it signifies a moment of high antagonism when we face our adversary. This is, of course, not what I mean here. In psychotherapy, the purpose of confrontation is very simple: to separate what a man is from what he seems to be, states himself to be, or would have us believe he is.

We are not concerned with how this man got the way he is nor with theories about how he might have become something else. We do not really know how people get to be the way they are. The doctrinal determinism that analysts sometimes espouse covers our soft data and manifest indeterminism. Fortunately, etiology is not the purpose of therapy. Were psychological topics wholly deterministic, we would not be so concerned about confrontation. Instead, we would merely rationalize our hopelessness and forget about the creative potential residing in the future, sometimes in the form of surprises, good or bad, that reality holds in store.

Although there may be much communication between two people, there is not true confrontation without a strategic effort to unmask denial. This does not imply that confrontation crudely and relentlessly attacks a point of protection. But it does mean that verbally or non-verbally, directly or indirectly the target of confrontation is a point of protected vulnerability. There is a difference among the content, or "what," of confrontation, the

implementation, or "how," and the timing, or "when." It is equally important to know who confronts whom, as well as his purpose in doing so.

If my definition of confrontation as the "tactics of undenial" seems too simple, it is because confrontation can be implemented in various ways and can have subsidiary purposes as well. We can elicit or impart information that seems quite impersonal and objective; yet, in doing so, the patient is confronted with something he might have taken great pains to deny. For example, to ask certain women how old they are may be tactless; but, in a suitable context, the correct answer may undercut a source of denial and self-deception. Confrontation can evoke emotion or can direct behavior—subsidiary purposes that in themselves may not be recognized as part of undenial. Doctors are not opposed to offering comfort and support, nor does good medicine necessarily taste bitter. But the opposite of true confrontation is a strategy for comforting, assuaging, and reassuring. Perforce, confrontation is an effort to penetrate a screen of denial, aversion, or deception.

In general, communication in psychotherapy is a report of things not directly observed or presented in evidence. These may be events that happened to the patient or ideas pertinent to the patient that the therapist communicates. Confrontation, however, has a *direction* that most forms of communication do not have. In most cases, the direction is toward significant

vulnerability and heightened defensiveness.

General problems of when to confront and the reasons for confronting cannot be dealt with categorically. The clinical condition known as narcissism may be used here as an expedient example.

Narcissism is necessary for a healthy self-regard, but the "clinical condition" may create more problems than it solves for certain patients. In these instances, someone may be sheltered by his narcissism, but at the cost of constant vigilance against assaults on self-regard. He may be protected in his everyday transactions, but in psychotherapy be extremely sensitive to confrontations. He may fluctuate between overweening arrogance, braggadocio, or self-righteousness and unnecessary self-abasement, self-pity, and sense of shame. During psychotherapy, he protects himself against anticipated punishment and criticism by cultivating the therapist's good will and approval. When this seems unrealistic, he may seize the initiative and blame himself before the therapist does. Or he may accompany his statements with benign disparagement, as if to neutralize criticism in advance and to extract some reassuring word from the doctor.

It is futile to reassure such patients about the doctor's forbearance and understanding. Life-long obeisance to (and resentment of) higher authority, combined with chronic conviction of being unworthy (and unjustly treated),

is not relieved by being told how wise, unprejudiced, and compassionate the judge happens to be. Refusal to pass judgment is not a method for assuaging guilt. Although the therapeutic task is very difficult, unwarranted guilt can be relieved only by switching standards of judgment and by reversing the nature of the unspoken guilt. Punishment has at best only a temporary effect and provides no additional understanding and protection.

Superfluous guilt and arbitrary abasement usually correspond to some "psychic crime" or "surplus reality." But, reasonable as this theory is, the precise offense, real or fantasied, seldom can be identified and, by suitable tactics, dispensed with once and for all. Such "crimes" as can be identified are not very horrendous; and because the therapist has not been injured, he cannot forgive, even if it were in his power and interest to do so.

Many male patients believe that it is unmanly to admit fear or to acknowledge dependency or to yearn for unconditional love, especially when dealing with a male therapist. It is part of the narcissistic image and system of defenses to call upon certain stereotyped relationships and styles of communication. That illness is a part of being alive, not a moral judgment, and that a sense of unnatural pride may conceal a precarious trust are utterly unacceptable to people with the "clinical condition" of narcissism. As a result, such patients accumulate an endless list of accusations and reasons for counteraccusations: "You are angry at me for being late, for being early, for

smiling, for being glum, for being lazy, for being ambitious, for being inhibited, for acting out…." For the purposes of discussion, these antithetical *mea culpa* are paradoxical efforts to maintain a high level of self-respect and to deny an unnaturally high demand upon the therapist.

No one denies in a vacuum. Denial is part of a social process that relieves a potential threat by replacing it with a more acceptable version of reality. In psychotherapy, the denial is intended to bring about an acceptable relationship with the doctor, on whom the patient depends. In highly narcissistic patients, dependency is at once a demand and a threat, not very far removed from a fear of submission and of being victimized.

Narcissistic patients are difficult primarily because their demands constitute a *confrontation* for the doctor. He is confronted with a persistent, intractable challenge to his competence, compassion, objectivity, moral impeccability, and professional calm.

If there is any valid general statement about when to confront, it is probably when the doctor feels confronted and, simultaneously, calls upon his patient to relinquish his denial, thereby reestablishing or solidifying their relationship. In the example of a narcissistic patient, the doctor confronts the patient with his attitudes toward the therapy. He does not challenge the validity of self-rebuke; instead, he points out the patient's seeming anger

because the doctor is invulnerable in the patient's eyes, in addition to the patient's wish for an unconditional, responsive expression of love. Anything that falls short of this unconditional vote of confidence is construed as punishment or deception. When anger has been excluded or denied, the result is an inappropriate and ambivalent idealization; the therapist has become the arbiter of guilt and the responsible source of unconditional love.

With this brief and somewhat inconclusive example, I emphasize that the target of confrontation in psychotherapy is not the predominant symptom, but is whatever seems to be a *sign* of protected vulnerability. Guilt and shame, and self-rebuke alternating with arrogance are symptoms; the sign is conviction of being treated harshly. Signs are usually interpreted as "defenses," which, in this case, are projection and rationalization.

In contrast to the courtroom where a crime is in evidence but the sentence has not been pronounced, the patient who suffers from the "clinical condition of narcissism" comes in with the sentence but not the explicit crime. He probes for approval and disapproval with differential protests and confessions. In this way, he hopes to discover what the doctor considers deplorable or praiseworthy. It is only when the patient acquires a modicum of trust that confrontation begins to take effect. Without trust, confrontations are as futile as a telephone that rings when there is no one to answer.

It is quite easy for a doctor to ask patients for trust. Most therapists assume that they are always trustworthy. Hence, because guilt and shame are opposites of trust and confidence, the doctor who is not spontaneously trusted is confronted with an attack upon his own self-regard; and many feel guilt and shame. When this occurs, it is time for the doctor to examine and assess his own "clinical condition" so that he can at least trust the patient who does not immediately trust him.

The essential ingredient in trusting is that the therapist cares. He can be wrong, but he cannot be indifferent or disrespectful. When Alexander (1950) spoke sharply and correctively to the disagreeable young man, he might have antagonized the patient without producing the constructive changes he reported. But nothing succeeds like success, and the case would not have been reported if the confrontation had failed. Even so, I cannot believe that this was a one-shot confrontation and that it came from the blue, like one of Jove's thunderbolts. Testimonials always smack of the miraculous; *i.e.*, a wonder of nature that follows a bold intervention and yet by its very spontaneity seemingly contradicts laws of nature. Testimonials may come from grateful patients and proud therapists, and both may be equally dubious. In Alexander's reported case, we do not know about the underlying stratum of trust that provided a fertile matrix for the confrontation. We are told only of the mistrust.

Confrontations should be studied apart from their therapeutic effect. Too much emphasis upon cure or transformation of character leads to a disparagement of how and when we confront as we do. Our discussion would be shortsighted, indeed, were we to overlook the therapist's investment in being right or in reporting successes. While there are comparatively few doctors who claim medicine-show cures, many psychotherapists tend to explain away their refractory cases by translating their patients' characters into confrontations that blame the patients for being as they are.

Part of the overemphasis upon "treatment" comes from a skewed version of the transaction between doctor and patient. Confrontation, as has already been pointed out, is but one aspect of communication; it is not necessarily tied to a medical model of disease, cure, and causality. Indeed, it makes more sense to regard "treatment" as a special form of confrontation, within the broad scheme of communication tactics (Watzlawick, Beavin, and Jackson, 1967). Unidirectional treatment is based upon an image of a doctor imparting something to a patient. Confrontation, however, is a reciprocal process in which the doctor is called upon to correct his own interventions.

Even though some people willingly surrender their autonomy, trust does not flourish when one person is overpowered by another. We cannot agree to trust wholeheartedly; we can agree only to a common field of acceptance, with each person accepting the significant participation of the

other. It is around this axis that confrontations operate, and the process of revelation and undenial begins.

Confrontations deal primarily with reality, not with what is true. As a result, we can effectively confront with an incorrect assessment! What is more important is the immediate context of experience that is shared. It is this that enables the doctor to recognize that denial, reaction formation, and negation are effective vehicles of self-revelation. After all, scientific reliability is based upon a common agreement, and validity consists of a search for justification of our beliefs.

Countertransference

When we try to expose an area of denial, to challenge a belief, or to influence the direction of behavior, we confront. But what determines how we influence the direction, selection, and assessment of what we do? Even though we examine ourselves for bias, preconception, value judgments, and our own existential position within a common field of reality, it is inevitable that correction is not always possible and that our private reality shapes, colors, and gives substance to our perceptions, performance, and pronouncements within psychotherapy.

Transference is recognized to be a regular part of any therapeutic encounter. Therapists are much more reluctant to talk about

countertransference. However, as with patients, doctors often reveal themselves through their efforts to deny and to preserve detachment. The graven image of an impersonal therapist is often a mask covering a fear of causing harm or of disclosing the effect of the patient's confrontations.

Transference may be defined as a claim that a patient makes upon the reality of his doctor. Although transference is, theoretically, not identical with what is called "transference neurosis," the transference that we usually pay attention to is the one in which the claim is thought to be unjustified but the patient insists that the doctor cooperate by making his own reality available. Consequently, doctors view this aspect of transference as pathological. When their own counterresponses are revealed, however, it is seldom thought to be constructive, but only to be pathological. The image of the unresponsive therapist is so closely treasured that a legitimate response is almost unthinkable. Countertransference, therefore, is often thought to be a kind of secular sin.

I do not deny that some forms of transference and countertransference are "pathological," but only because the claims and counterclaims obstruct the other person's sense of separateness and right to freedom. Unless the psycho-biological medium that we call therapy is merely intended to consolidate illusions, countertransference should be recognized for what it is —*the directional determinant of confrontation*.

Confrontation is a strategy in which the aim is to separate the reality of one person from his neurotic expectations of himself and others. Transference and countertransference tend to become mirrored images of each other. If neither is assessed accurately, one is confused with the other. Both may take over therapy, so that mutual expectations and reality claims become too enormous. These expectations and claims, we must add, may produce excessive frustration or undue gratification. But so much has been written about transference that I can confidently leave it aside and offer a more systematic, albeit brief, account of countertransference.

The attitudes that convey countertransference arise from the same internal sources that contribute to other kinds of attitude, feeling, disposition, and behavior. These sources are conveniently called *primary*, *secondary*, and *tertiary processes*. Primary processes refer to that collection of undifferentiated appetites and aversions, wishes and fears, attractions and repulsions that preempt our attention, draw us onward, or push us away from various kinds of relationships. Primary processes lend *direction* to what we do, or think, or say. Secondary processes designate the habitual, preferential pathways that enable us to carry out or to refrain from unqualified participation in various relationships. These pathways lend style and shape to our idiosyncrasies; they standardize our responses and limit our options. Secondary processes provide the means of *selection* for perceptions and performances.

The third source of countertransference attitudes is seldom made explicit. Tertiary processes are the values, standards, directives, prohibitions, and imperatives that determine how and when we pass judgment upon what is good or bad, right or wrong, true or false, successful or unsuccessful. Collectively, tertiary processes provide the *assessment* of whether or not what we do is worth doing.

I have not resorted to more conventional terminology, such as id, ego, and superego, nor made use of reifications, such as ego functions, coping mechanisms, and defensive formations. I have omitted them not only because these terms suggest that we know more than we do but also because I am primarily concerned with the field of communication and the forces of countertransference. Countertransference, like transference, is a truncated form of action, transmogrified into speech. Its thrust is determined by memories, expectations, perceptions, fantasies, experiences, and whatever other elements of satisfactory, unfulfilled, and surplus realities can flow into the crucible of what we do. In the case of countertransference, what we do, or say, is a claim upon that portion of another person's life that impinges upon our own.

The substance of countertransference shapes itself according to the field of interaction, real and potential. Conversely, countertransference may mold the field itself, enabling observers to infer kinds of countertransference

and transference that are different from the types of interaction that prevail. Let me illustrate with brief descriptions of *complementary*, *antagonistic*, *parallel*, and *tangential countertransference*.

Complementary countertransference may occur when the special strengths of the therapist seem designed to fit the problems of the patient. For example, certain tempestuous, impulsive patients are helped by a somewhat steadfast, organized doctor who understands and identifies the critical situations that trouble them, although he is not influenced by these forces. Such a doctor may be a rock of dependability for moody, erratic patients. Analogously, certain rigid, conscience-ridden patients may derive much benefit from being treated by a colorful, open, and emotional doctor who does not hesitate to express his face judgments without endlessly debating and weighing alternatives.

Complementary countertransference may, therefore, fulfill the doctor's personality requirements and simultaneously enhance the background of mutual trust that therapy requires. It does not always work out well, however. For example, it is not unusual to find a patient who reports that he has been in psychotherapy or analysis for well over ten years. Typically, the interaction starts in college after the patient undergoes a depression, disappointment, failure, or loss of some key relationship. With the doctor's help, he is able to continue in school, graduate, and, sometimes, even marry,

when the doctor indicates that this step is warranted. Then, for some reason, therapy is interrupted, often when circumstances require a move to another city. The patient wants to resume therapy even before he is settled in the new community, and the first doctor often selects his successor. Nature abhors a vacuum, and some professional patients abhor life without a therapeutic relationship. While we can call this "unresolved transference," what about "unresolved countertransference"? The next therapist finds that the patient has certain "unresolved" expectations that only his first doctor can fulfill. Because no two relationships are quite identical and no two countertransferences are the same, the patient may begin to treat himself, according to his latent identifications with the former therapist. The second doctor is tacitly excluded; the patient becomes his first doctor's double, or stand-in.

Antagonistic countertransference is easy to recognize when a therapist is openly critical, as a result of antagonism or exasperation. But there are less conspicuous forms of antagonism that even the therapist fails to detect. The therapist may be disrespectful, self-righteous, belittling, or indifferent to the patient or to the patient's reigning standards, way of life, or scale of success. Every confrontation transmits a reproach or devaluation. In response, the patient is apt to become overly submissive and so quietly resentful that one day he walks out. There are many moral dilemmas in psychiatry, and therapists are far from paragons. Antagonisms are to be expected, because,

after all, we care only about things we care about, and some people are simply incompatible. Moreover, false forbearance, gritting one's teeth, and intractable boredom usually produce a hopeless standoff, seldom a significant confrontation.

As a rule, antagonistic countertransference can be better understood, even if resolution is not always possible. In the first place, anger, jealousy, and so forth need not doom therapy, but instead can be an entering wedge for a more complete clarification of the interaction as a whole. We do not send angry patients away, why are there not similar options for therapists? In the second place, the insidious quality of antagonistic countertransference shows up in the direction and selection of confrontations. Should an observant therapist start to question himself, he could well begin with the state of trust between himself and his patient and then begin to identify the ways in which his patient has implicitly confronted him. If antagonism can be honestly confronted, the countertransference may be converted into a more productive, adversary approach, one that challenges shibboleths but does not require argumentation. To challenge without rancor may be a fresh approach, but the therapist should be prepared for fresh and explicit counterchallenges.

Parallel countertransference refers to a situation in which therapist and patient share the same problem, almost to the same degree. Could I look at the world through your eyes, and were you to see things as I must do, we

might exchange viewpoints; and then never again would I see the world in the same way, nor would you be the same person you were before.

What if doctor and patient, by having the same problem, can look at each other only through mutually blinded eyes? It is wholly possible, even common, that two human beings share a mutual failing, point of vulnerability, or conflict. Few therapists could work effectively, or ineffectively, for that matter, without a strong sense of empathy. However, parallel countertransference is most difficult when the two participants seem to share common defenses and denials. Then there is scarcely any true confrontation, other than gentle conversation that excuses and supports their mutual well-being.

We can sometimes find therapists who identify with a repudiated aspect of their patient and, as a result, become antagonistic toward the defensive operations that the patient uses. This is probably not an instance of parallel countertransference, because it is feasible that identification with someone else's ambivalent or repudiated attitudes might create rather interesting confrontations!

Parallels between doctor and patient are, understandably, very difficult to detect. Mutual denials never cancel each other out. Consequently, characteristic examples of parallel countertransference are very elusive. Let

me cite only one example. When doctor and patient are both people who are accustomed to doing things for themselves and by themselves, an impasse of extremes may ensue. Either the doctor restrains himself unnaturally from offering confrontations, lest he unduly influence the patient, or he resents efforts of the patient to confront him with his inactivity. Needless to say, both alternatives may coexist. In response, the patient who prefers to do things his own way finds that his doctor objects when he makes mistakes, as if he should know better, and that the doctor's confrontations tend to deflate and devaluate.

Tangential countertransference may be suspected when everything that the doctor says or understands seems grossly inept, irrelevant, peripheral, or out of focus. There is no "meeting of minds." Mutual expectations and available attitudes offer too few points of contact for a genuine exchange and confrontation, even though therapy may continue. Tangential countertransference often occurs when doctor and patient come from dissimilar subcultures and backgrounds. Is it possible, for example, for a white, middle-class therapist to understand the demands, disappointments, and demoralization that a black youth encounters while growing up in a ghetto? Conversely, does the therapist's awareness of his alien attitude and limited experience lead him to overemphasize sociological deprivations and to overlook highly personal issues that he could recognize, trust, and offer confrontations about?

It is sometimes easier to put oneself in the place of a psychotic than to understand a person from another culture or country. Psychiatric training has, at least, equipped us to find our way around and to ask directions in the realm of psychosis. In another culture, we may know similar words, but with dissimilar contexts and meanings. As a result, the verbal instruments of confrontation are not available; countertransference can make few claims upon the other one, unless it is that we bid him to make use of trust, without confrontations.

These comments may suggest that countertransferences always mean trouble and that confrontations based upon countertransference are bound to be egregious distortions. Not so. Because there are so many possible varieties of countertransference, confrontations may be productive or nonproductive in degrees, depending upon how readily and intelligently the therapist can correct his own responses. Moreover, countertransference is simply one indication of how the therapist looks at the here-and-now. His confrontations bear witness to a process of mutual recognition. Stereotyped countertransference means a stereotyped pattern of confrontation, and we all know what this means. Flexible and responsive therapists are not strangers to discordance, diffuseness, and uncertainty and, we hope, are not unfamiliar with concordance and a sense of closure in the course of confrontation.

Context

The therapeutic encounter is primarily contemporaneous, but it stretches beyond the moment, beyond hypothesis and technique, and beyond mere facts. Its open-endedness should not be confused with haphazardness. The contemporaneous is not necessarily extemporaneous. A skilled interviewer is a practiced professional, and a skillful professional has a variety of options when dealing with emerging situations.

Unfortunately, whenever we talk about context, communication, relationships, meanings, defenses, and so forth, our efforts sterilize the immediacy of the here-and-now, contemporaneous event. The flow, quality, and intensity of how one person defines himself with respect to another can seldom be characterized. Even the simplest transaction requires so much explanation, that, like a joke, its impact is destroyed. Nevertheless, it is the context that provides the meaning and the motivation for whatever happens. How we happen to say what we do when we do cannot be understood apart from the context in which it occurs.

Any scene acquires its meaning by relating it to the drama as a whole. Situations cannot be isolated from an implicit totality, however vaguely that whole is defined. And it is not altogether paradoxical to recognize that the totality cannot be grasped until we know something about individual moments.

It would not do for me to discuss the philosophy of contextualism at this point. Whitehead (1933), Mead (1956), Pepper (1948), Polanyi (1964), Moreno (1953), and Korzybski (1950) are only a few illustrious people who have enlightened us about this viewpoint. As if to illustrate the thesis, each man approached the subject in his own way, according to a still larger context and sphere of operations. Definitions are scarcely ever relevant or revealing, but let me characterize what I mean by context: it is a concatenation of whatever is contemporaneous to a specific instant. It is not strictly circumscribed by time, because other times and places can be brought to a confluence of the moment. Thus, a casual conversation may exemplify a context; a conference or a hospital record may be considered a context, and so can a fleeting memory or image that thrusts itself upon consciousness. Contexts are *ideographic instances*.

No therapist can be a complete outsider in his contacts with patients, just as there is no contact between people without some version of communication. The context defines his participation in psychotherapy as both an *encounter* and an *evaluation*. He brings himself into the situation and is an instrument of assessment. In the previous section, I described different ways in which countertransference influences the encounter. The therapist, I urged, should be able to correct his private distortions. When he evaluates and assesses the therapeutic context and its content, he must also be able to select significant dimensions in the transaction. In brief, given an encounter,

he looks for an available and significant interface with which he can make contact.

No therapist can or should be wholly objective unless he is sure that his capacity for denial and self-deception is limitless. There is always some self-correction and selfvalidation at work, so we can be objective only insofar as we recognize our habitual viewpoints and perseverations.

It is customary for psychiatrists to assume a position of solemn, antiseptic scientism when talking to their colleagues or writing for publication. In actuality, however, we do not painstakingly collect data and patiently wait for validating evidence for our hypotheses. For the most part, our work runs far ahead of our theories; the image of a careful laboratory experiment is most inappropriate. In the immediacy of the encounter, we deal with what seems real and relevant at the time, and we confront according to the same criteria. Naturally, we look for thematic realities that persist. But primarily we sense the intentionality and involvement (*i.e.*, direction) that characterize the context (*i.e.*, selection), and bind it together according to an inner validity (*i.e.*, assessment). I encounter, I evaluate, and so, too, does the other person.

The simultaneous assessment and evaluation inherent in the psychotherapeutic occasion discourage free-wheeling improvisation.

Moreover, our purpose in confrontation is always to recognize and respect mutual fields of reality. Whatever we do, it is to undeny, to dissipate deception, and ultimately to increase the range of options that any person has for contending with what imposes unnecessary control over him. We do not merely think or talk. Descartes's familiar formula, "I think, therefore I am," is a very specialized viewpoint. We could not take psychodynamics very seriously if we did not believe that human interaction is directional, interrelated, and purposeful. The formula ought to be, "I am, therefore I think, act, feel, falter, encounter, assess, and do a great many other things, many of which I don't understand at all."

How can we draw a line around our encounters and understand the special context more effectively? Not too long ago, the psychotherapist wrote notes during sessions. This was ostensibly because he wanted a jog for his memory, but often enough it was because he wanted a barrier. Fortunately, this situation and the psychotherapist who exemplified it are almost extinct. He wanted to emulate a tape recorder and, of course, he failed. And if, today, a psychotherapist expects to emulate a computer, he will also fail. What he eliminates (and what is more critical than his fallible memory?) is a sense of personal involvement and intentionality that grasps the totality while struggling to assess details. None of us is exempt from our shortcomings, distortions, narcissistic disavowals, and denials. I have urged you to heed the directional component of countertransference, because our confrontations

depend upon self-correction as well as upon our alertness in assessing the context as a whole and the individuality of the other person (Wolstein, 1959). With these precautions, I present the following guidelines as a summary:

1. Confrontation draws upon empathy, but empathy does not mean that we share an identity or an ideology.

2. Countertransference distortions are likely when we find ourselves angry, disappointed, exasperated, gratified, especially frustrated, jealous, or in some other way imposing our individual imperatives upon the confrontations.

3. Confrontations can be contaminated by fantasies of being the magic healer, rescuer, shaman, sage, or parent, because this may not be the level of need and communication on which the other person is operating.

4. Confrontation consists of mutually self-corrective activities. It is not intended to be a directive or a prohibition. We seek forbearance, not compliance, firmness, not coercion. We cannot offer options, we can only help someone to use the options he has.

5. Efforts to understand too much are suspicious indications of countertransference ambition. We cannot respond to every demand and confront along a vast panorama. Denial cannot be eliminated completely, because strategic denial may be a requirement of living itself.

6. A tendency to overemphasize technique or, conversely, to

discourage thoughtful reflection as "cerebral" are signs of countertransference distortions of the field.

7. Trust means only that we have a common field of acceptance. Although it is feasible to have a mutual alliance at the outset, trust is always conditional. The term trust is often a shibboleth in psychotherapy, but it can become a euphemism that conceals an impasse.

8. Words are not magic, nor must confrontations be followed by signs of conspicuous change. Confrontations are only special vehicles of communication that seek an opening at a point of contact with protected vulnerability.

9. On the whole, confrontations are only statements about the other person's existence, not hypotheses about his status as a scientific object. We respond to his separate reality and cannot, therefore, be too punctilious about the longitudinal truth of what we say.

10. We can generalize; we can be precise. But it is essential that we also be contemporaneous.

Bibliography

Alexander, F. (1950) Analysis of the therapeutic factors in psychoanalytic treatment. In *The Scope of Psychoanalysis.* New York: Basic Books, Inc., 1961, pp. 261-275.

Korzybski, A. (1950), *Manhood of Humanity, Second Edition*. Lakeville, Connecticut: International Non-Aristotelian Library Publishing Co., Institute of General Semantics.

Mead, G. H. (1956), *The Social Psychology of George Herbert Mead*, ed. A. Strauss. Chicago: University of Chicago Press.

Moreno, J. (1953), *Who Shall Survive? Foundation of Sociometry, Group Psychotherapy and Sociodrama*. Beacon, New York: Beacon House, Inc.

Pepper, S. (1948), *World Hypothesis: A Study in Evidence*. Berkeley and Los Angeles: University of California Press.

Polanyi, M. (1964), *Personal Knowledge: Towards a Post-Critical Philosophy*. Harper Torchbooks. New York and Evanston: Harper & Row.

Watzlawick, P., Beavin, J., and Jackson, D. (1967), *Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies, and Paradoxes*. New York: W. W. Norton & Co., Inc.

Whitehead, A. (1933), *Adventures of Ideas.* New York: The Macmillan Co.

Wolstein, B. (1959), *Counter-Transference*. New York, London: Grune & Stratton.