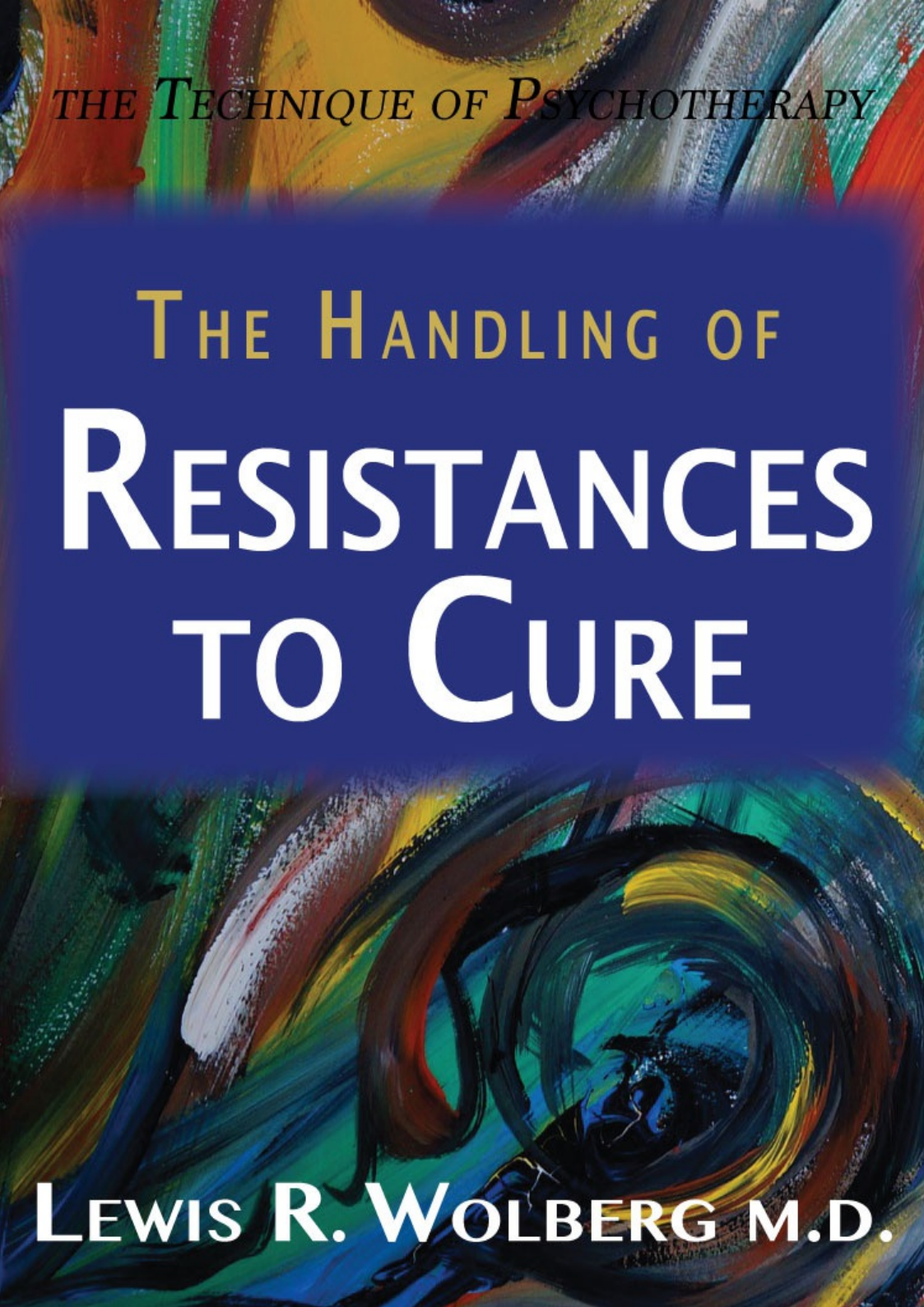
THE TECHNIQUE OF PSYCHOTHERAPY
THE HANDLING OF
RESISTANCES
TO CURE
LEWIS R. WOLBERG M.D.

The Handling of Resistances to Cure

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From *The Technique of Psychotherapy* Lewis R. Wolberg

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The Handling of Resistances to Cure

Despite our best intentions and the most heroic efforts, even where patients express hope and determination to conquer their problems, they may sometimes be unwilling to relinquish them. Personality change is painful as progress takes hold. Anachronistic patterns regressively pull the individual back to the dreams and demands of the past. Temporary secondary gains and the desire to avoid anxiety at all costs hold patients in a grip from which they may be unable to release themselves.

Interpretations of these defensive operations help patients gradually to an understanding of their unhealthy patterns and to a discovery of what, if any, vicarious satisfactions they gain from them. In this way the patients learn to master some of the anxiety that made the defenses necessary. However, because certain drives serve a protective function and yield intense gratifications, the individual is apt to fight treatment desperately. Under these circumstances, therapy is interpreted as an assault on secret wishes and expectations.

FORMS OF RESISTANCE

In his book, *Inhibitions, Symptoms and Anxiety,* Freud (1966) emphasizes five types of resistance: (1) "repression resistance," which is motivated to protect the ego from anxiety; (2) "transference resistance," inspired by a refusal to give up hopes for regressive gratifications from the analyst, along with a desire to frustrate him or her; (3) "episonic gain resistance," which follows upon a need to indulge secondary gains and the advantages of symptoms; (4) "repetition compulsion resistance," motivated by a drive to repeat neurotic impulses under the lash of a self-destructive principle; and (5) the need for punishment to appease guilt. Psychoanalysis is a "never ending duel between the analyst and the patient's resistance" (Menninger, KA, 1961).

Resistance operates not only in psychoanalysis but in all forms of psychotherapy. This is not remarkable because therapy threatens to upset the delicate balance between various elements of the personality. To give up defenses, however, maladaptive as they may be, expose patients to dangers or deprivations that they consider more upsetting than the inconveniences already suffered as a result of

the symptoms.

Resistance may take myriad forms, limited only by the repertory of the individual's defenses. Patients may spend time on evasive and aggressive tactics: fighting the therapist; or proving the therapist is wrong; or winning the therapist over with gestures of helplessness, praise, or devotion; or seeking vicarious means of escaping; or evading treatment. Fatigue, listlessness, inhibitions in thinking, lapses in memory, prolonged silences, intensification of complaints, pervasive self-devaluation, resentment, suspiciousness, aggression, forced flight into health, spurious insight, indulgence in superficial talk, engagement in irrational acts and behavior (acting-out), and expressed contempt for normality may occupy patients to the detriment of their progress.

Resistances may consume the total energy of the patient, leaving little zeal for positive therapeutic work. Sometimes a skilled therapist may bypass resistance by prodding reality into the face of the patient. Sometimes it may be handled by interpretations. Often it operates in spite of attempts to dissipate it, bringing the best efforts of the therapist to a halt. Because resistance is so often concealed and rationalized, it may be difficult to expose. Even an experienced therapist may be deceived by its subtleties.

In supportive therapy resistance may be manifested in a refusal to acknowledge environmental disturbance or in a defensiveness about one's life situation. There may be a greater desire to cope with present known vexations than to chance unknown and perhaps grievous perils. There may be a reluctance to yield inimical conditions that gratify needs for self-punishment and justify one's recriminations against the world. In reeducative therapy, resistance to the changing of modes of relating to people cannot be avoided. New interpersonal relations are, in the mind of patients, fraught with danger. They can be approached only tentatively and with great hesitation. The patients may accordingly remain oblivious to their interpersonal distortions, no matter how frequently they are brought to their attention and how thoroughly they are interpreted. They will repeat the same patterns, with continuous bouts of suffering, and seemingly little insight into what is going on. In cognitive therapy, attempts to alter values or modify belief systems are often met with a confounding reluctance to yield anachronistic and debilitating self-statements. In reconstructive therapy impediments are even more manifest. A most complex array of resistances may materialize. This is especially the case where a

weak ego creates an inability to face and to master anxiety related to unconscious conflicts.

Suppression and Repression

Any material that is emotionally disturbing will be suppressed or repressed by the patient until enough strength is gained to handle the anxieties evoked by its verbalization. This material may seem, and actually may be, insignificant or innocuous. It is essential to remember, however, that it is not so much the events or ideas that are disturbing, but rather the meanings given to them and the feelings they inspire.

> Thus, a female patient suffering from feelings of hopelessness and depression, relieved through excessive alcoholic indulgence, could talk freely about her bouts of antisocial behavior that bordered on the criminal, with little disturbance; yet she required one year of therapy before she could relate an experience of removing the clothing of her younger brother and observing and handling his penis. The excitement of this experience and the guilt engendered by it were so intense that she had isolated the memory in her mind.

Only when I had proved myself to be a non-condemning person, who would not punish or reject her for the desires that produced this incident, was she able to bring it up and to reevaluate it in the light of her present-day understanding.

Intensification of Symptoms

One of the earliest symptoms of resistance to cure is a reinforcement of those neurotic devices that had previously kept the individual free from anxiety. Something to anticipate, consequently, during therapy is an acute exacerbation of neurotic symptoms. An explanation that the patient may possibly get worse before getting better is often a safeguard against interruption of therapy.

Self-devaluation

An insidious type of resistance is that of self-devaluation. Here patients refuse to concede that there is anything about them of an estimable nature or that they have any chance whatsoever of achieving worthwhile status. To every interpretation, they respond with the allegation that they are lost, that there is no need for them to continue, that they are hopeless, that it is too late in life to expect a change for the better. The inner image of themselves is often that of a hideous, contemptible person, and any attempt to

explain to them that this is a distorted picture usually falls on deaf ears; their self-contempt is used as a bulwark to progress in therapy. There may be, in addition, a deep wish to be cared for like a child by rendering themselves helpless (parental invocation). The desire to depreciate themselves may be in the nature of escaping criticism by anticipatory self-punishment. A masochistic indulgence is also a cover for a fear that if one acknowledges oneself to be an able person, active and independent efforts will be expected of one. Patients with this misconception will hang on to their self-contempt with a determination that is astonishing, and only painstaking analysis of this resistance can lead them out of their morass. Sometimes self-devaluation is masked by surface narcissism and grandiosity.

Forced Flight into Health

Another form of resistance is "forced flight into health." Here individuals try to convince themselves and the therapist that they are well and that they no longer need treatment. Any implication that they are not making a good adjustment is resisted with vigor. Actually, patients may conduct their affairs with a semblance of normality in that they appear to be confident, self-reliant, and normally assertive. Yet the trained observer may detect a false note and often can perceive the tremendous effort that is needed to maintain the illusion of health. This form of resistance is usually associated with the need to maintain a rigid watch over everything one says for fear one will lose control. From a pragmatic point of view, it makes little difference if a patient flies, swims, walks, or crawls to health, as long as one gets there. However, assumed health, fashioned by resistance, is generally short-lived.

Intellectual Inhibitions

The urge to ward off the therapist may result in a reluctance to think, to talk, or to feel. The patient, yielding to this urge, will insist that there is nothing pressing to talk about. Thus a singular sterility in the associations develops with an inability to think constructively about pressing problems.

The patient may break appointments, come late, forget to mention significant aspects of the day, block off memory of the dreams and fantasies, manifest inattention, show an inability to concentrate or to remember what has gone on before, relapse into silence during the interview, or display a mental fogging that persists both inside and outside of therapy.

The following excerpt from a session illustrates this phenomenon.

The patient, a divorcee of 32 years of age, with an hysterical, infantile personality, involved sexually with 2 men who were supporting her, came to therapy after making a suicidal attempt. After one year of treatment, her recognition of her dependency caused her to decide to get rid of her lovers and to get a productive job. The patient came a half hour late for the session that follows:

Pt. (*apologetically*) I've been forgetting things lately. Absent-mindedness for about 6 months. Last week I forgot to go to an important meeting. I will make appointments and completely forget them. I forget things to do.

Th. Let's explore that and see if we can learn something about it.

Pt. I keep forgetting names and telephone numbers. I don't know why. Maybe I'm so preoccupied with what's to become of me.

Th. Are you preoccupied?

Pt. I am. I can't remember anything.

Th. What *is* on your mind?

Pt. I have the constant worry that I better hurry and do what I have to do. I am concerned with dying. I keep thinking I may not be here long. I noticed yesterday that my shoes on the floor were empty. I then said, "What will people do with my shoes when I die? I wonder who'll go over my papers."

Th. What's this all about? Do you feel the life you are now living is not worth living?

Pt. I feel threatened by giving up these people who are supporting me. I wonder if I can live and get along. What will become of me?

Th. Maybe you resent giving up these dependent patterns?

Pt. I must resent it; yet even though I do, I can't tolerate them any longer. I've gotten to the point where I can be casual with my supporters and tell them exactly what I feel. I told Max that I can't go to bed with him; he's too old for me. This is terribly threatening for me because the instant I do that my income is cut off.

Th. Mm hmm.

Pt. And Max told me he would give me money without strings tied to it.

Th. This must be a great temptation.

Pt. It is, and I see myself not wanting to give it up. I've accepted it in my mind to try it out.

Th. You may be in a great conflict between being dependent and being active and independent.

Pt. Yes, I don't know which to do.

Th. That's something that you yourself will have to work through.

Pt. I suppose my mind is in a fog because I don't know what to do, but somehow I feel I'm getting stronger. *[The mental fog and her coming late for the session are apparently signs of resistance.]*

Very frequently, negativistic resistant states develop several weeks or several months after the patient appears to have entered into the spirit of treatment, spontaneously analyzing difficulties and making what appears to be good progress. Suddenly, without warning, a blocked, inhibited pattern develops.

Acting-out

Along with unwillingness to verbalize ideas and impulses, the patient may indulge in irrational acts and behavior in everyday life. This "acting out" appears to be a way of supporting the inability to talk during treatment. The acts serve to drain off anxiety and leave little energy available for work during the treatment hour.

Superficial Talk

Another form of resistance is a veering around one's problems in superficial talk. Here verbal comments are used as a defense to ward off basic issues. The patient may spend the entire time of treatment in talk that embraces topics of the day, current events, or past experiences portraying personal tragedy and martyrdom. There is little of deep significance in the conversation, and, if allowed to do, the patient may continue for years to discuss material that is interesting enough but that actually has little to do with significant problems. Often the patient will want to monopolize the interview and will resent the therapist getting a comment or an interpretation in edgewise. Rarely will the patient talk about attitudes toward the therapist, who may begin to feel merely like a sounding board for the patient's boasts and diatribes. It is almost as if in superfluous conversation the patient defies the world to make him or her talk about innermost problems. Associated with this, there may be an attempt to intellectualize, to figure out convoluted connections, and to present a rigid and logical system of what must have happened to one.

Insight as Resistance

A device that is apt to be confusing to the therapist is the use of insight as a form of resistance. Here patients routinely will go through a detailed accounting of how well they understand themselves, using the best accepted terminology, presenting the dynamics and mechanisms of their disorders in approved textbook style. To all appearances they have gained complete insight into the origin of their problems, into their compulsive trends and distorted relationships, and into the consequences and destructive influences of their neuroses. Yet in their daily experiences they go right on with their usual neurotic modes of adjustment, manifesting the same symptoms that originally brought them to treatment. It is probable in such cases that the patient's insight is a highly intellectualized affair that is employed to confuse himself or herself and the therapist.

There are many reasons why a person utilizes insight as a smoke screen behind which to indulge customary neurotic trends. One of the most common reasons is the desire to escape criticism and detection. Here, a dissociation exists between how the patient thinks and feels. It is often easy for the therapist to minimize the seriousness of the patient's disorder when confronted during treatment with a beautiful recitation of psychopathology. Behind the camouflage of insight it is apparent that the patient uses knowledge of mechanisms as an instrument to allay guilt and to forestall criticism in regard to daily actions.

This mechanism is often found in extremely dependent patients who have magical expectations of what therapy will do for them. The chief motivation for entering treatment is the feeling that the therapist will bring about those neurotic objectives that they, themselves, have failed to obtain through their own efforts. Compliance here is the keynote, and the patients, by reciting their spurious insights, will feel that the therapist must reward their aptitudes in learning with anticipated bounties. The facade is at least partially unconscious, and the patients may really believe that they understand themselves thoroughly. The clue to what is going on is usually furnished by the outbursts of hostility and criticism that eventually are pointed toward the therapist when, after months of precise and punctilious performance, the patients do not magically get from therapy what they originally set out to achieve.

Dissociating the Treatment Hour from Life

Sometimes resistance takes the form of the patient's utilizing the treatment hour as a special event dissociated from life. Regarding it as such, the patient will go into the mechanisms of interpersonal relationships with complete freedom, displaying insight that seems to end after he or she exits from the therapist's office. It is obvious that with the therapist, the patient is operating under a set of standards entirely different from those used with other people in general. There seems to be something recondite about the treatment hour, for it is set apart from all other experiences. The special resistance here is that of not seeing how the material that is uncovered in the treatment hour relates to everyday situations. This isolation of treatment from life is often rationalized by the patient on the basis that the therapist is a scientist, who does not condemn one for acts for which one would be punished by others. In this way the patient will lead a dual existence and seemingly be unable to fill the chasm between what happens in treatment and experiences outside of treatment.

Contempt for Normality

An insidious kind of resistance expresses itself in a fear of, or a contempt for, normality. Associated is a refusal to assume responsibility or to make an effort on one's own. By substituting new patterns for old, patients believe that they are yielding up something valuable, something they may never be able to replace, that they will become a prosaic bore, or that they may be exposing themselves to dangers with which they will be unable to cope. This type of resistance appears most intensely in reconstructive therapy after the patients have gained insight and are ready to execute it into action.

A patient with a phobic reaction extended to subway travel made a trip to my office by subway for the first time since treatment had started. She entered the room sullenly and remarked fretfully that she was furious with me. Her anger had started when she discovered that she had no great anxiety riding on the train. A fragment of the session follows:

> *Pt.* I am so angry and resentful toward you. *(pause)*
>
> *Th.* I wonder why.
>
> *Pt.* I feel you are gloating over my taking a subway. I feel mother is gloating too. *[Originally accompanied to my office by her mother with whom she had been living since her divorce, the patient with therapy gradually overcame her*

agoraphobia except for riding on the subway.] I resent her too. I felt she was pushing me, trying to force me to break away from her. She gloats if I do something that makes me independent. I feel that when I go ahead you gloat too. *[The patient had become so pathologically dependent on her mother that she was scarcely able to let mother out of her sight. Mastering some dependency and walking alone was achieved previously in therapy, although the patient was very reluctant to give up this aspect of her dependent relationship.]*

Th. It sounds as if you are angry about being able to travel on the subway.

Pt. Mother seems to be anxious to give up her responsibility for me. I resent that. But I also don't like the idea of my being so close to mother too.

Th. I see, as if you want to continue being dependent and yet resenting it.

Pt. When I get sick at night, I ask her to make me some tea; and then I resent her patrician attitude when she does this.

Th. But what about your feeling about me?

Pt. It's like giving in to you. But yesterday I felt liberated by the idea that I'm in the middle of a conflict and that coming here offers me hope. I realize that my neurosis is threatened by my getting well. (*laughs)*

Th. What part of your neurosis do you want to hold onto?

Pt. (laughs) None. But I have a feeling that I don't want to be normal, that in giving in to you I'll be like anybody else. Also that you'll expect more things of me. And (*laughs*) that if I get too well you'll kick me out. *[Here the patient verbalizes a variety of resistances: namely, a desire for uniqueness, a contempt for normality, a fear she will be expected to face more anxiety-provoking situations, a reluctance to give up her dependence on me, a punishing of her mother and of me by refusing to acknowledge improvement, and an unwillingness to yield her masochism and the various secondary gain elements accruing to her neurosis.]*

Occasionally a psychosomatic complaint may be a manifestation of resistance, as illustrated in the following fragment from a session with a male patient:

Pt. Everything was going well until this morning when I got stomach cramps. They have been with me all day.

Th. Mm hmm.

Pt. I find it hard to concentrate because my stomach bothers me so much. Mondays I always have a hard time for some reason. It's happened the last few Mondays.

Th. Seems like an unlucky day for you. *(pause)*

Pt. I was thinking about how long it takes to get well, and I was wondering if others did any better than I do. Of course, things are a lot better now, and I was thinking of taking a course in journalism up at the New School. The only thing is that it comes on Mondays, and that's hard. I . . . uh . . . uh . . . *(Patient brings hand to his abdomen.)* I had something I wanted to say . . . but I can't think of anything but these cramps. *(He takes a cigarette from a pack, reaches into his pocket for matches but cannot find them.)* Do you have a match?

Th. I believe so. Here's one. *(pause)*

Pt. Well . . . *(coughs)*

Th. You were saying that Mondays are pretty tough on you? Perhaps something happens to you on Mondays that upsets you.

Pt. I . . . I . . . I don't know.

Th. You do come *here* on Mondays.

Pt. Why . . . yes . . . yes . . . I mean I do.

Th. Maybe something is upsetting you in coming here?

Pt. I don't know what it might be. *(pause)* Maybe I'm upset that you feel I'm not doing well. *[We discuss his feelings that he is not living up to expectations. This is what has been giving him anxiety. His cramps are manifestations of internalized resentment and act in the service of resistance. [The symptoms soon vanished completely when he could see their connection with his faulty assumptions.*]

Reluctance to Yield the Pleasure Values of the Treatment Hour

A form of resistance that is frequently overlooked is one that involves reluctance to yield the positive pleasures that the patient gets out of the treatment itself. The patient may derive such comfort from the therapeutic hour that other gratifications seem dubious, and may refuse to give up the neurosis because of a desire to continue therapy indefinitely. This is frequently the case in a very dependent patient, who looks forward to the hour to get a "fix," who perhaps pays lip homage to all the dynamic principles uncovered during treatment, but whose chief motive for therapy is to get suggestions and courage to carry on with daily routines. Unless one watches oneself carefully, the therapist will fall into a trap laid out by the patient and may, by the patient's helplessness and apparent inability to do things voluntarily, feel forced to feed the patient with doses of advice and admonishments, which the patient absorbs as if these were pronouncements from the Deity.

Transference Resistances

Perhaps the most common and disturbing of resistances are those that are produced in response to the relationship with the therapist or that take the form of transference. Contact with the therapist is understandably disturbing when it mobilizes attitudes, impulses, and feelings that threaten the

repressive forces. Patients will, in the attempt to escape from the associated anxiety, exhibit their usual characterologic defenses to detach themselves, make themselves helpless, control and overwhelm the therapist, or render themselves invincible by pseudo-aggressiveness. In supportive and some types of reeducative psychotherapy the patients will manage to restore their equilibrium through the medium of such defenses, and they will, more or less successfully, repress disturbing irrational, unconscious drives. In reconstructive therapy, on the other hand, the therapist constantly interprets the nature and purpose of the various defenses as they arise. This constitutes an assault on the integrity of the repressive system and will precipitate much tension. Eventually the patient cannot help coming to grips with the emotions and drives that hitherto have been successfully avoided. The patient will then mobilize further protective devices to reinforce the crumbling repressions.

One of the earliest manifestations of this struggle is an intensification of symptoms, which seems to serve the desperate function of restoring psychic equilibrium. Soon the struggle becomes more personalized as the patient realizes that relationship with the therapist is the womb of the distress. Resistance once exerted against awareness of the original unconscious material is now shown toward projected and animated representations in the transference.

The patient may exhibit a disarming dependent attitude toward the therapist, who is regarded as the embodiment of all that is good and strong and noble in the universe. This kind of resistance is often found in individuals who are characterologically submissive, subordinate, and ingratiating and who strive to adjust to life by clinging parasitically to a more powerful person. It is as if the individual had an amputated self that could be restored only by symbiosis with a stronger individual. There is even an associated tendency to overvalue the characteristics and qualities of the therapist. This type of relationship is extremely shaky because the patient regards therapy as a magical means to security and power. Consequently, the therapist must always live up to inordinate expectations that are sheerly in the realm of fantasy, beyond possibility of fulfillment. The patient will make unreasonable demands on the therapist, and, failing to get what he or she secretly wants, be filled with outrage.

Another form of relationship resistance is based on an intense fear of the therapist as one who is potentially capable of injuring or enslaving the patient. This attitude stems from a hostile image of the parent that usually is applied to selected authoritative individuals. Treatment in such cases proceeds

only when the patient realizes that the therapist does not desire to punish or condemn for the impulses or fantasies, but instead is benevolently neutral toward them. Little progress is possible until the patient accepts the therapist as a friend, not foe.

Sometimes patients display a disturbing need to be victimized and unfairly treated. They will maneuver themselves into a situation with the therapist in which they feel they are being taken advantage of. They may even exhibit various symptoms that they attribute to the harmful effects of therapy. In order to reinforce their waning repressive system, they thus seek to transform the therapist into a stem authority who commands and punishes them. Where this happens, they will experience severe anxiety if the therapist is tolerant and condones their inner impulses.

When resistance is displayed in the form of hostility, the resulting reaction patterns will depend on the extent to which the patients are able to express aggression. Where the character structure makes it mandatory to inhibit rage, the patients may respond with depression and discouragement. They may then want to terminate therapy on the grounds that they have no chance of getting well. They may mask their aggression with slavish conformity and perhaps evince an interest in the therapist's personal life, assuming an attitude of camaraderie and good fellowship. There is in such efforts a desire to ally themselves with the enemy in order to lessen the danger to themselves.

On the other hand, where the patients are able to express hostility, they may exhibit it in many ways especially where the transference becomes intense. They may become critical, then defiant, challenging the therapist to make them well. Irritability is often transmuted into contempt, and the patients may accuse the therapist of having exploitative or evil designs on them. Feeling misunderstood and humiliated, they will manufacture, out of insignificant happenings in their contact with the therapist, sufficient grounds to justify their notion of being mistreated. They will become suspicious about the therapist's training, experience, political convictions, and social and marital adjustment. They may enter actively into competition with the therapist by reading books on psychoanalysis to enable them to point out the therapist's shortcomings. They may become uncooperative and negativistic.

Sometimes hostility is handled by attempts at detachment. The need to keep the therapist from getting too close may burn up a great deal of the patients' energy. They may refuse to listen to what the

therapist says. They may ridicule in their minds proffered interpretations. They may forget their appointments or seek to discontinue therapy, inventing many rationalizations for this. They may strive to ward the therapist off by discussing irrelevant subjects or by presenting a detailed inventory of their symptoms. In their effort to keep aloof they may attempt to take over therapy, interpreting in advance their unconscious conflicts, the existence of which they suspect or fabricate. An insidious type of defense is a preoccupation with childhood experiences. Here the patients will overwhelm the therapist with the most minute details of what must have happened to them during childhood, presenting a fairly consistent and logical survey of how previous inimical experiences must have produced all of their present difficulties.

Occasionally the impulse toward detachment is bolstered by contempt for the therapist's values; the patients will feel that their own standards are what really count. Because of this they will be convinced that the therapist cannot like them and will "let them down." They will rationalize these feelings and say to themselves that the therapist is no good, or incompetent, or of no importance, or that psychotherapy is nothing but nonsense.

The desire to control the situation may reflect itself in many ways. Some patients may seek to shower the therapist with gifts and favors, or they may develop a sentimental attachment that assumes a sexual form. Therapy may be regarded as a seduction, the patient experiencing in it intense erotic feelings. One of the motives involved in falling in love with the therapist is to put the latter in a position where there will not be too close probing into the patient's deepest secrets. The incentive may be to devaluate, test, influence, get the whip hand, or fuse with the therapist; in this way taking a shortcut to cure.

Many patients come to treatment not because they desire to function more adequately in their interpersonal relationships, but rather because they seek to obtain from treatment the fulfillment of neurotic demands that they have been unable to gratify through their own efforts. In such cases resentment and resistance develop when the patient does not receive from the therapist the specific type of help that was expected.

Upon analyzing what the patient wants from the therapist, it turns out that what is sought is not a

cure for the neurosis, but an infallible method of making it work. Many patients desire to achieve neurotic expectations without having to pay the penalty of suffering. The individual with a power drive may thus insist on a formula whereby one can function invincibly in all activities. The perfectionist will want to find a way to do things flawlessly, with as little effort as possible. The dependent individual will expect to amalgamate with the therapist and to have all whims gratified without reciprocating. The detached soul will seek the fruits of social intercourse, while maintaining distance from people. When these drives are not gratified in therapy, when patients sense that these are instead being challenged, they will become tremendously resistive.

In sicker patients, resistance is sometimes exerted against accepting the idea that it is possible to function adequately without repairing a fantasied injury to the genital organs. In the female this may be expressed in the expressed refusal of continuing life without the possibility of ever procuring for herself a penis, which she regards as the bridge to activity and self-fulfillment. In males, the assumption of a passive role is often interpreted as equivalent to being castrated, and resistance may be directed against assuming any role that does not involve aggressive "masculine" fighting or "machoism." Even accepting help from the therapist may symbolize passivity.

Psychotherapy may produce other unfavorable resistance reactions in patients with immature ego structures. The transference can become so dramatic and disturbing to these patients that they respond to it in an essentially psychotic manner. They will accuse the therapist of being hostile, destructive, and rejecting, and they will refuse to acknowledge that their attitudes may be the product of their own feelings. The reasonable ego here is very diminutive and cannot tolerate the implications of some surfacing of unconscious drives and conflicts. The patient acts out inner problems and constantly avoids subjecting them to reason. The acting-out tendency permits the neurosis to remain intact. Where the therapist is seen as a cruel or lecherous or destructive being who threatens the patient with injury or abandonment, any action or interpretation is twisted in the light of this delusional system. Fear and anxiety issuing from the patient's irrational strivings lie like boulders in the path, barring the way to a more congenial therapeutic relationship. In such cases therapy will be prolonged, and the relationship must be worked on actively so as to constitute for the patient a gratifying rather than threatening human experience. (See also Chapter 42)

METHODS OF HANDLING RESISTANCE

Little has been written on how definitely to solve the paradox of the patients who seek help yet resist any external control or guidance toward change. What would seem to be indicated is a participant model for therapy in which the patients take responsibility in treatment, monitoring their own behavior and determining the nature of their interactions, environment, and their future plans.

In psychoanalysis, early in treatment the patients gather from the passivity of the analyst that they have to make their own decisions and work through their blocks toward utilizing insight in the direction of change. Interpretation of resistances is the prime modality used and the analyst hopes that the patients will in the resolution of these obstructions generalize their learnings in therapy toward making new constructive adaptations.

In psychoanalytically oriented therapy, the therapist is more active and employs techniques in addition to interpretation to help the patients effectuate change. These techniques often draw from many schools and are more or less eclectic in nature.

In behavior therapy, the therapist is highly active, utilizing when necessary a rich assortment of devises, including systematic desensitization, operant conditioning, modeling of preferred behaviors, role playing, work assignments, and cognitive therapy. These treatments are sometimes blended with counseling.

At the outset it often becomes apparent that what some patients want from therapy is to overcome suffering without giving up attitudes and behaviors that are responsible for their suffering. What is required before any progress can be made is to work toward motivating the patient to change and to formulate worthwhile objectives in treatment. In behavior therapy these are delineated and persistently pursued.

In his chapter on self-management methods, Kanfer (1980) describes a behavioral model drawn from Skinnerian methods and research findings in social and cognitive psychology as well as current clinical practices. Through various techniques, the patient acquires skills for use in problem-solving. The patient is also trained in altering noxious elements of the environment. Development of constructive

repertoires is conducted through negotiations with the patient. Past experiences are reviewed only to provide information during behavioral analysis on the circumstances surrounding the original conditions when the maladaptive behavior was developed, and to point out the present inappropriateness of this behavior.

In controlled environments like a hospital or in military organizations, reinforcement contingencies may be relatively easily applied. But in one's ordinary living environment these are not so readily arranged, and it is for this reason that manipulation of cognitive variables through cognitive behavior therapy can be valuable in order to help evolve constructive self-reinforcing attitudes. A good deal of support will be required from the therapist at the start of treatment, but this will diminish as the patient becomes more skilled in self-management. A contract is usually negotiated, details of which spell out the required behavior, the time goal, the reinforcements for fulfillment of obligations, some aversive consequences of nonfulfillment of the contract, and the way reviews and evaluations will be conducted. Where required behaviors occur outside the range of observation of the therapist, self-monitoring is mandatory and here the patient will benefit from keeping a careful record of his or her behaviors. Assignment of tasks expedites self-observation and hastens the development of new behavioral repertoires. Techniques are employed to set up environmental conditions unfavorable to the undesired behavior, and to establish contingencies for self-reinforcement. Discussions cover the patient's experiences in self-management with the object of helping to transfer learnings and skills to situations that may develop in the future. There are other models one may follow if one is pursuing a behavioral program, but the one I have outlined seems to cover the essential points.

As soon as the therapist realizes that resistance is interfering with therapy, it is necessary to concentrate on the resistance to the exclusion of all other tasks. This may be done in a number of ways. In supportive and reeducative approaches, this is done by reassurance, persuasion, and various manipulative and strategic maneuvers. In reconstructive approaches a cognitive attach or the resistance itself is instituted.

Identifying the Resistance and Exploring Its Manifestations

Calling the patient's attention to the resistance itself and exploring its manifestations are essential

procedures.

For example, a patient has for the past few sessions arrived 5 to 10 minutes late. The sessions are spent in a discursive account of family events, including the impending marriage of his son, the forthcoming graduation of his daughter, and the attacks of "gall-bladder trouble" suffered by his wife for which she may need an operation. The responsibilities imposed on him by his business and social position also occupy his attention. He mentions having suggested a 2-week vacation in Florida, but his wife promptly vetoed the idea. He pauses in his conversation and then remarks that there is nothing on his mind.

Sensing resistance, I direct the interview along the following lines:

Th. I wonder if there is something on your mind that bothers you that you are not talking about.

Pt. Why, no, not that I'm aware of.

Th. The reason I bring this up is that you have been coming late to your sessions, and during your sessions you have kind of rambled along, not talking about things that bothered you too much. At least I have that impression. *[pointing out possible resistances]*

Pt. Why no, I mean you want me to talk about anything on my mind. I'm supposed to do that, am I not?

Th. Yes.

Pt. Well, I haven't had anything else bothering me.

Th. Perhaps not, but have you had any symptoms that upset you?

Pt. No. I've noticed though that my jaws tighten up sometimes. And my wife tells me I'm grinding my teeth in my sleep.

Th. Mm hmm. That sounds like tension of some kind.

Pt. I know I feel a little tense.

Th. A little tense?

Pt. I've been upset that I have to do, do, do for other people, give, give, give, and get little in return.

Th. As if people expect things from you and do not want to give anything?

Pt. Yes, I'm getting fed up with my life, the way it's been going.

Th. I see. This could be upsetting.

Pt. I suppose you'd say I feel frustrated.

Th. Well, what do *you* say?

Pt. (laughs) It's hard to admit it, but I am. Sometimes I'd like to chuck up the whole thing, and be single again, without responsibilities, to do what I want to do.

Th. I should think you would feel frustrated that you can't. If this is what you really feel this is what you want.

Pt. Lately I've been getting this way. *[The patient discusses his secret ambition of wanting to be a writer and admits that he was embarrassed to talk about this. He also was, he remarks, afraid to admit that he resents being tied down to a routine family life and has fantasized divorce. His resistance to talk about these things along with his internalized rage at his life situation seem responsible for his muscular symptoms.*]

Pointing Out Possible Reasons for the Resistance

Where patients are cognizant of their resistance but do not recognize its purpose, the therapist should point out various possibilities for the resistance. The defensive object of the resistance may be interpreted along with the facades; the patients may be shown that their resistance protects them against the threat of change. Thus, a patient hesitates repeatedly during a session; the periods of silence are not broken by the usual interview techniques.

Th. I wonder what the long silences mean.

Pt. Nothing comes to my mind, that's all. I kind of wish the time was up.

Th. Perhaps you are afraid to bring up certain things today. [*suggesting that her silence is a resistance to prevent her from bringing up painful material.*

Pt. Like what?

Th. Well, is there any event that happened since I saw you that you have not mentioned to me?

Pt. (*silence*) Yes. there was. I met a man last Wednesday who sent me. I made a big play for him and am going to see him Sunday. *[The patient's infidelity to her husband is one of her symptoms, of which she is ashamed.]*

Th. I see.

Pt. I have wondered why I did this. I realized you wouldn't tell me not to, but I feel guilty about it.

Th. Was that the reason why you were silent?

Pt. (*laughing*) Honestly, I thought there wasn't much to talk about. I minimized the importance of this thing. But I realize now that I didn't want to tell you about it.

Th. What did you think my reaction would be?

Pt. (*laughs*) I guess I thought you'd think I was hopeless or that you'd scold me.

Reassuring Tactics

Reassuring the patient in a tangential way about that which is being resisted necessitates an understanding by the therapist of the warded-off aspects.

For instance, a woman with an obsessional neurosis comes into a session with symptoms of exacerbated anxiety. She has no desire to talk about anything but her suffering. This seems to me a sign of resistance. When I inquired about dreams that she may have had, the patient reveals one that, in a disguised way, indicates murderous attitudes toward her offspring. The idea occurs to me that she is attempting to suppress and repress thoughts about her children.

A significant portion of the session follows:

Th. I wonder if you haven't been overly concerned about thoughts of your children.

Pt. I'm frightened about them, the thoughts.

Th. You know, every mother kind of resents being forced into playing the role of housewife. This is a cramped life to many persons. Most women may resent their children and from time to time wish they weren't around. It's natural for them to feel that, *[reassuring the patient about possible hostility]*

Pt. (rapidly) That's how I feel.

Th. They may even get a feeling sometime that if the children pass away, that will liberate them. Not that they really want that, but they look at it as an escape, *[more reassurance]*

Pt. That's what I didn't want to say. I've felt that it was horrible to be like that.

Focusing on Material Being Resisted

Bringing the patient's attention to the material against which the resistance is being directed must be done in a very diplomatic way, preferably by helping the patients to make their own interpretation or

by a tentative interpretation.

A patient with a problem of dependency complained of an intense headache and a general feeling of disinterest in life.

The interview was rather barren, but enough material was available to bring the patient to an understanding of what he was trying to repudiate.

Pt. My wife has been telling me that I just am not like the other husbands. I come home and read the newspaper and don't go grubbing around in the garden.

Th. What does that make you feel like?

Pt. I guess she's right. But as hard as I try, I know I'm being a hypocrite. I just gave that up.

Th. But your wife keeps pounding away at you.

Pt. Well, what are you going to do. I don't help her around the place. She resents my being as I am.

Th. But what do you feel your reaction is to her pounding away at you?

Pt. (fists clench) It drives me nuts. I'd like to tell her to stop, but I know she's right.

Th. Is it possible that you resent her attitude, nevertheless, and would prefer her laying off you when you don't do the chores? [*a tentative interpretation of the material against which there is resistance]*

Pt. God damn it. I think she is being unreasonable when she sails into me. *[The patient takes courage from my interpretation and expresses resentment.]*

Th. Mm hmm.

Pt. After all, I come home tired and I find no interest in planting cucumbers. Besides, it's crazy. My neighbors plant dollar tomatoes. Each tomato costs them a dollar. It's no economy. The whole thing is silly. *[The patient continues in a diatribe, venting his resentment about his wife's attitude. At the end of the session his headache has disappeared.]*

Handling Acting-out

Acting-out is a common manifestation that has been given various interpretations (Abt, 1965). Fenichel (1945) defines acting-out as "an acting which unconsciously relieves inner tension and brings a partial discharge to warded-off impulses (no matter whether these impulses express directly instinctual demands, or are reactions to original instinctual demands, i.e., guilt feelings); (the present

situation, somehow associatively connected with the repressed content, is used as the occasion for the discharge of repressed energies, the cathexis is displaced from the repressed memories to the present, 'derivative,' and this displacement makes the discharge possible.") Aronson (1964a) considers the essential features of any acting-out sequence to be a reenactment of a childish ("pregenital") memory or fantasy, of which there is no conscious recollection, precipitated by transference or resistance during psychotherapy, displacing itself to some organized "ego-syntonic" action, thus permitting a partial discharge of inner tension. At the same time there is no awareness of any relationship of the old memory or fantasy with the current action.

Prior to coming to therapy the patient, having indulged in acting-out tendencies as a way of expressing unconscious impulses and feelings, may have gotten into certain scrapes. During psychotherapy acting-out may occur even in patients who have, before treatment, shown no evidence of it in their behavior.

There are some psychotherapists who take the view that acting-out can serve a useful purpose in some patients, that it may be growth inducing and, particularly where basic problems originated in the preverbal state, they constitute a means toward assertiveness and a preliminary step toward gaining insight. Consequently, they tend to encourage and even to stimulate acting-out. Other therapists, however, regard acting-out as always detrimental to therapeutic progress since it drains off the tension that should be employed for a requisite understanding and working through of conflicts. Between these two extremes an intermediate viewpoint may be taken, acting-out being managed in accordance with whether it serves as an obstruction to or as an intermediate stage toward learning.

Some patients who were overindulged and poorly disciplined as children will engage in untoward acting-out behavior to goad the therapist into a setting of limits such as they had never experienced with their own parents. On the other hand, where parents have been too authoritarian and have cowed the patient to a point where the slightest emergence of defiant or antisocial conduct inspires fear of a counterattack, acting-out may constitute a breaking out of restraints. The handling of acting-out in these two instances will be different.

Where acting-out occurs as a resistance to therapy, it is usually inspired by the transference

situation. Because patients refuse to verbalize prior to acting-out and because they may conceal and rationalize their behavior, it may be difficult to deal with it therapeutically. For instance, a prudish female patient, shortly after starting therapy, confessed having involved herself in extramarital love affairs with several men. It was only through a dream that I was able to get a glimpse of her guilt feelings at sexual actions that were totally foreign to her personality. Confronting her with the existence of sexual guilt brought forth divulgence of the information that she had, during the past month, become so sexually aroused that she felt forced to seek satisfaction in outside affairs. Focusing on her feelings about me, the patient was soon brought to an awareness of how closely she had identified me with her father, and of how her incestuous impulses were being displaced. The establishment of the connections of her current behavior with its infantile roots enabled her to control her acting-out and to work through her fantasies within the therapeutic situation.

The therapist should consequently be alert to extraordinary behavior patterns that occur in the patient. Thus, a man who is ordinarily restrained may engage in random, multiple sexual affairs to the point of satyriasis, or involve himself in dangerous but exciting aggression-releasing situations that are potentially disastrous to him. One patient, for instance, whenever provoked by hostility toward her therapist, would get into her car and drive speedily and recklessly. Only when she narrowly escaped an accident would she slow down.

When acting-out is recognized, it is necessary to bring this to the attention of the patient. The therapist may suggest that there are reasons why the patient feels forced to engage in certain behaviors. Talking about feelings *prior* to putting them into action will help the therapeutic process. Acting compulsively the way that the patient does tends to interfere with therapy. Should the patient accept these statements and verbalize, enough energy may be drained off in the interview to forestall acting-out. Interpretation may also help to dissipate the need for unrestrained behavior. Interpretive activities will require a repeated pointing out to the patient of manifestations of acting-out conduct. At the same time attempts are made to link actions to fantasies or impulses that are preconsciously perceived. Material from free associations and dreams may be valuable here. What helps in most instances is bringing the patient to an awareness of evidences of transference. Should any of the acting-out manifestations contain healthy elements, the therapist should attempt to reinforce these. The strategic timing of interpretations is important. Where acting-out occurs during a session as a manifestation of transference and resistance,

interpretations will be particularly effective; nevertheless, a prolonged period of working through may still be required.

Should acting-out persist and should this be potentially dangerous to the patient, the therapist may direct the patient to desist from the acts on the basis of their destructive nature, while encouraging talking about impulses. Of course, in some instances, it may be impossible for the patient voluntarily to stop acting-out. Exhibitionism, voyeurism, transvestism, and masochistic sexual activities are examples. However, with persistence it may be possible to get patients to talk freely about their temptations and to help them, to an extent at least, to gain some voluntary control. Increasing the frequency of sessions and giving patients the privilege of telephoning the therapist whenever the impulse to act-out occurs are often helpful. As a last resort, if patients continue dangerous acting-out, the therapist may threaten to withdraw from the therapeutic situation unless control over impulses is exercised. Behavioral aversive conditioning techniques are sometimes employed as a means toward checking acting-out that cannot be controlled in any other way. Cooperation of the patient will, of course, be necessary. The patient may also be told, "If you want to continue in this self-destructive behavior, you can do it by yourself; you don't need me. If you want to change, I can help you."

It goes without saying that acting-out within the therapeutic session, like physical attacks on the therapist and lovemaking gestures, are to be discouraged or prohibited. Patients may be told that they can talk about anything they please, but that unrestrained actions are not permitted by rules of therapy. Experience has shown that these interfere with the therapeutic process.

Handling Transference Resistances

Where transference has developed to the point where it constitutes resistance to treatment, it will have to be resolved. If it is not dissipated, it will seriously interfere with the working relationship. Treatment may become interminable, the patient utilizing the therapeutic relationship solely as a means of gratifying neurotic impulses at the expense of getting well. Frustrated by the absence of what the patient considers to be the proper response to reasonable demands, the patient may terminate treatment with feelings of contempt for or antagonism toward the therapist.

Superficial manifestations of transference may often be adequately handled by maintaining a steadfast attitude and manner, constantly bringing the patient back to reality. Sometimes a studied avoidance of the role that the patient wants the therapist to play, or acting in an opposite role, minimizes transference. For instance, if the patient expects the therapist to be directive and controlling, on the basis of a conviction that all authority is this way, the therapist deliberately acts permissive, tolerant, and encouraging of those activities toward assertiveness and freedom that the patient cherishes but which he or she believes the parents had prohibited. Such role playing rarely is successful because the patient will usually see it as a ruse. It is better to interpret to the patient what the therapist believes is behind the patient's reactions.

A female patient, conditioned to expect punishment for infractions by a punitive parent, appears for a session depressed and guilt-ridden. She seems to demand that the therapist scold and punish her for having drunk to excess the evening before and for having acted sexually promiscuous. Not being able to stimulate this reaction in the therapist, the patient launches into an attack, upbraiding the therapist for passivity. The therapist continues to react in a tolerant and nonjudgmental manner, but interprets the responses of the patient in terms of her desires for punishment and forgiveness to propitiate aroused guilt feelings.

Severe manifestations of transference being rooted in infantile conditionings will usually require prolonged "working through." Strategically timed interpretations of the sources of transference in childhood experiences and fantasies, and of its present functions, will be required.

Among the most disturbing of transference resistances is that of the sexual transference, which takes the form of insistence that one can be cured only in a sexual relationship. While therapy may set off a temporary sexual attraction toward the therapist, this fascination usually disappears as therapy progresses or upon the simple structuring of the therapeutic situation. However, in some patients the sexual preoccupation becomes intense and persistent. A male patient, for example, will pick out from the behavior of a female therapist minor evidences that he will enlarge to justify his belief that the therapist must be in love with him. The protestations of the patient may greatly flatter the therapist, and the urgency of the expressed demands may tempt her to respond partially by touching or holding the patient. These advances are most provoking to the patient and incite greater sexual feeling. Should the

therapist engage in any kind of sex play with the patient, this can have only the most destructive effect on both participants. Once the patient has even partially seduced the therapist, he may develop contempt for her weakness and for her abandonment of ethical principles. The therapeutic situation will obviously terminate with any expressed intimacy.

It is important in handling sexual transference not to make the patient feel guilty about sexual feeling. Rather, the feeling should be accepted and an attempt made to find out what it means in terms of the patient's past sexual attitudes and behavior. For instance, sex may indicate being accepted or preferred by someone. It may perhaps have the connotation of vanquishing or humiliating others. Sometimes reassuring comments are helpful in abating the patient's reactions. Thus the patient may be told, "It is usual for persons to develop such feelings for their therapist," or "It is good that you have these feelings because they will enable you to work out important attitudes and relationships," or "The *feeling* you have toward me is a step in your ability to feel and to relate to other people," or "This will serve as a means toward better relations with others." Where the patient brings in dreams and fantasies, it may be possible to interpret, with all the precautions already mentioned, the sources of the patient's transference reactions.

Another disturbing resistance is that of the hostile transference. Here the patient will react to the therapist as if convinced of the reality of the therapist's unfriendliness, destructiveness, ineptness, seductiveness, and maliciousness. The patient will be importunate, irrascible, and insistent that it is the therapist who misinterprets and not he or she. The patient may become retaliatory or destructive in response to the therapist's fancied hostility, or may experience panic, depression, or psychosomatic symptoms. A resolution of hostility by the introduction of reality and by interpretation is indicated, following some of the suggestions given for the management of the sexual transference.

Where transference cannot be handled in any other way, active steps will have to be taken to minimize it. Such measures include a focusing in the interview on the current life situation rather than on early childhood experiences, avoidance of dreams and fantasies, discouraging discussion of the patient's relationship to the therapist, abandonment of the couch position and free association if these have been employed, decreasing the frequency of the interviews, presenting interpretations in terms of the character structure and current life situation rather than in terms of genetic determinants, and

greater activity in the interview.

THE NEED FOR WORKING THROUGH RESISTANCE

Resistance may burn up the entire energy of the patient, who may self-defensively concentrate on fighting the therapist, or proving the therapist to be wrong, or winning the therapist over with gestures of helplessness, praise, or love, or seeking various means to escape or to evade treatment. The struggle is an intense one and usually goes on below the level of awareness.

When one appreciates the purpose of resistance, one realizes that patience is a great virtue. The therapist must bear with the neurotic individual as he or she progresses and takes refuge over and over again in customary defenses. Resistance is yielded only after a great struggle, for change is a painful affair.

Since resistance has a dynamic function, an effort is made to help the patient to relinquish it slowly. Too sudden removal may produce severe anxiety and may provoke a reinforcement of the neurotic defenses intended to protect the individual. Relinquishment of resistance will thus be blocked by a threat of repetition of the anxiety experience.

Resistance is best managed by demonstrating its presence, its purpose, its ramifications, its historical origin, and the manner of its operation in the patient's present relationships with the therapist and with people in general. As resistances are gradually analyzed and resolved, repressed material appears in consciousness in a less and less disguised form. Resistances require a constant working through. A single interpretation of a resistance is hardly effective.

The therapist should allow resistance to evolve fully before taking it back to its origins. If a second resistance develops, the therapist must handle it by returning to the first one and demonstrating to the patient the interrelationship of the two. Tackling the patient's defensive reactions inevitably causes the patient to feel threatened and to dispute interpretations of his or her resistance. This reaction is opposed by a contrary motive, that of retaining the good will of the therapist. Often the patient will attempt to satisfy both of these motivations at the same time by abandoning his or her defense in the forms recognized by the therapist and changing it to a less obvious type. The understanding of these

elaborations and their continued exposure forces the patient to take a real stand against them and, finally, to abandon them entirely.

It is always essential to remember that resistance has a strong protective value. Patients will usually reject any insight that is too traumatic, perhaps toying with it for a while, then forgetting it. However, through careful handling, insight into how and why the resistance is operating may be gained. First, the patient must be made aware of the resistance. Merely calling attention to it alerts attention to a specific task. It prevents burning up energy in pursuit of maintaining the resistance, constructively diverting it toward tracing down its meaning.

Once a resistance develops, it is essential to abandon other tasks until it is resolved, because the patient will not be productive while battling the therapist. It is best at first not to probe too deeply for unconscious material, but rather to work intensively upon the immediate interpersonal relationship. To aid in the process, the patient must be impressed with the fact that there is nothing morally bad about showing certain defensive attitudes in the form of resistance.

The dealing with transference resistances may be a prolonged affair in the personality disorders. Here the ego seems blocked in absorbing the full meaning of the oppositional behavior as it becomes apparent. The patient may acknowledge the presence of certain drives. The patient may even understand their irrational nature and historical origin, but this pseudo-insight provokes little change in the customary life adjustment. The entire therapeutic process is intellectualized, the patient perhaps using insight to fortify himself or herself against anxiety. The patient's relationship with the therapist never proceeds to a level of good feeling that is shorn of hostility and inordinate expectations.

In infantile, narcissistic character structures particularly, intellectuality serves as a defense against unconscious impulses. Habitually there is a repression of the feeling aspects of the patient's personality, and mastery is sought through intellectual control. Any experience of feeling is regarded as catastrophic. By a curious transformation the defense itself may become a vicarious means of gratifying non-permissible drives as represented in hostile and sexual impulses.

Patients, who have a tendency to isolate emotional components from emerging unconscious material, may make the latter acceptable to themselves by repressing the affective content. Frequently

they strive to neutralize their panic by means of attempted foresight and reason. During therapy they give the impression of being very active and at first seem to work extraordinarily well. Even though they make a brilliant feat of minutely analyzing their inner mental processes, little change occurs. Such patients may involve the therapist in long dialectic arguments that take on the nature of debates. Words replace action and constitute a defense against feelings.

Interpretation of this type of defense is bound to create great turmoil in the patient. The patient is prone to feel attacked and criticized by the therapist. "Negative therapeutic reactions" are common, the patient responding to important interpretations not with insight or relief, but with depression and discouragement. Hostility may be directed at the therapist in an effort to annihilate the therapeutic work.

It is essential to remind every patient not to get too distressed if cure is not immediate. Some patients are confounded and depressed when they find, in spite of therapy, that they go on reacting in their usual ways. It may be necessary to explain that reaction patterns that have become established over a long period cannot be removed in a few sessions. They are habits that call for extended working through and reeducation.

In the event the patients insist they cannot get well because they are hopeless, the therapist may say, "You can express your hopelessness, but I will not go along with it. You can spend your energies feeling hopeless, and you don't need me for this; or you can spend your energies doing something about getting well in which case I can help you."

ILLUSTRATIVE CASE MATERIAL

Example 1

In this session, a female homosexual patient with a problem of dysphoria introduces a number of different resistances that block her progress.

> *Pt.* I keep losing my keys constantly. My mind can't seem to concentrate lately. I notice that the only time I want to think about my problem is when I come here. The minute I get out I feel relieved. When I leave here I notice my hands as very cold. *[This sounds like resistance in the form of intellectual inhibition.]*
>
> *Th.* I see. Can you tell me more about this?

Pt. When I get out of the office, in waiting for the elevator, I push myself up against the wall pretending the wall to be Helen *(the patient's homosexual love object).* I actually kiss that wall and I say, "Who does he think *he* is, trying to pull me away from my darling Helen. I won't have it, I just won't have it." *[This device seems to be a magical way of neutralizing therapy, which she interprets as a threat to her homosexuality.]*

Th. What does it remind you of when you do that?

Pt. Like being united with my mother. Everything seems to be O.K. again, and I can go on living. *[Having lost her mother in childhood, the patient's homosexuality, in part, is a neurotic attempt to reunite herself with her mother.]*

Th. Mm hmm.

Pt. You see. I do that.

Th. But why do you think I want to take you away from your mother?

Pt. I see that. You see, the information I get here, I feel, is going to get rid of the old regime and bring on a new regime.

Th. And the old regime is what?

Pt. Homosexuality. That's strong. It's easier to live in than the new regime.

Th. And the new regime?

Pt. Is getting rid of the mother fantasy and working it out.

Th. So that you would consider any insights that you get here in a certain way.

Pt. As dangerous to my ability to function *(pause)* for the moment.

Th. So when you come here, I upset the balance and you may want to go to the opposite extreme.

Pt. I shift to the opposite extreme so I can function.

Th. You must perhaps think of me as a terrible person to do this to you. *[probing our relationship]*

Pt. You are a horror, *(said facetiously)* I adore you, you know.

Th. You do? Why?

Pt. You know I do. *[Our relationship, though ambivalent, seems good.]*

Th. In spite of what I do?

Pt. In spite of it. (*coughs*)

Th. Maybe I better stop doing this to you. *[challenging her desire for health]*

Pt. Hell, no. I don't go wild. There is a certain amount of control.

Th. The fact that you know all the reasons that exist for your problem . . .

Pt. (*interrupting defiantly*) Doesn't do me any good.

Th. You are still the arbiter of whether you'll do anything about the situation or not. But at least you have the right to know all the facts. There is no magic about this. The whole thing is your choice. Nobody is going to take anything away from you, you don't want to let go of.

Pt. But I don't have the ability to make a choice rationally, *(yawns)*

Th. Right now your choice would be irrational?

Pt. Yes, I'd choose homosexuality. But, not really. You know, my mind is wandering. I'm trying not to listen to you. You know what I'm doing now? I'm trying to figure out my school homework. *[Patient is aware of her resistance.]*

Th. Not paying attention to what I'm saying.

Pt. Isn't that awful. First I yawn and then my mind wanders. And I wasn't even aware of what I was doing. *[Again she recognizes her resistance.]*

Th. But now you've caught yourself.

Pt. I caught myself.

Th. There must be a reason why it's dangerous for you to integrate what we talk about. *[pointing out possible reasons for her resistance]*

Pt. I just won't listen to you. *(coughs)* I'll bet this throat business has something to do with it. Obviously.

Th. You sense your own resistance. Do you want me to leave you alone?

Pt. No, no. But I do want to get well.

Th. It may take time for you to overcome this problem. It started far back in your childhood. And you have been reacting automatically since.

Pt. You know, I didn't hear a word you said. My mind keeps wandering, *[more resistance]*

Th. Do you remember anything we talked about the last session?

Pt. Nothing. My mind's a complete blank. I can't pull myself together at all. (*coughs*) And you know why I can't do this?

Th. Why?

Pt. Because you are sitting back and judging me on my little speeches.

Th. I'm judging you?

Pt. It's not true, but that's how I feel. I sort of feel I'm on trial and that I'm likely to do things wrong. The same thing happens when I get up and speak in class. It's funny that I don't remember a damn word of what you said today.

Th. How about what I said to you last time?

Pt. Oh, I remember that, but I can't put it together.

Th. Suppose you try.

Pt. It's like the only thing that can give me pleasure is my homosexuality and my torture fantasies with masturbation. I feel that you will take these from me. I say to myself that if I let you take these things away, the time will come when I'll need them and I'll be without them. Take life's last spark away.

Th. No wonder you can't concentrate here, if you think this is what really is going to happen. As if there can't be a good substitute for your present pleasures.

Pt. But it's not entirely what I feel because I do want to get well. But I can't seem to do it today. When I leave here, I suppose I'll kiss that wall to get my equilibrium back. Or I will get a hopeless desire and sexual attraction for you. I don't want to listen to what you have to say. I just want to be close to you. *[transference resistance]*

Th. In a way that's the same thing as clinging to and kissing the wall? (I am not trying to discourage her transference, but merely to control its intensity.)

Pt. It is exactly the same thing. It's the same thing I have about Helen. Intellectually I'm not interested. I want to get into bed with her. So stop talking and let's have sex. That's how I feel about you. Same kind of feeling.

Th. Sex appeases your tension? Is that what you really want exclusively?

Pt. Obviously not, but I can see how this operates. And another crazy thing I do. When I leave here and get onto the street, I imagine you are watching me from the window. I get into my car and roar off.

Th. What does that mean to you?

Pt. It's like I get my masculinity back again.

Th. Which means you feel you lose it when you come here?

Pt. (laughs) Yes, I really do. I know that's silly. I say, "I'll show him. I'll roar off. I'll show him he can't make me into a woman." I try to get my feeling of power. (*laughs*) How silly can you get?

Example 2

A patient comes in with a hoarseness so severe that she can hardly talk. This symptom came on her several hours prior to her session and was not accompanied by any other signs of a head cold.

Exploration reveals the symptom to be a manifestation of various resistances.

Th. I wonder if you have been at all emotionally upset prior to this hoarseness, *[focusing on possible emotional sources of the symptom*]

Pt. I don't know what you mean.

Th. Are you aware of anything emotional that is happening right now? (*long pause*) What about your feeling about therapy?

Pt. The only thing I can say now, which is nuts, is that I'm scared to death of you. *(pause*)

Th. The way you look at me is suggestive that you are afraid of me. (*The patient has a frightened expression on her face.)*

Pt. I was always aware that I had a tenseness before, but it never was like this. (*The patient is so hoarse it is difficult to make out what she is saying.)*

Th. What do you think this is all about?

Pt. I don't know, *(pause)*

Th. Have you had any dreams?

Pt. Yes, I had one dream I can hardly remember. It's scrambled, *(pause)* I dreamed I was in some sort of clinic. It was your clinic. *(pause)* And there was a young chap there who was very attracted to me. He was there for treatment too. I liked him, and he liked me. But I was a patient at the clinic and I was working there, both. I talked to a group of people on the stairs. You were there as an onlooker in a benevolent way. And I was kidding. I said I want to go to Paris and live a couple of years. But this guy I liked and I decided we would have to take you with us. We have to take Dr. Wolberg with us because we have to finish this treatment. I looked at you and said, "That's involved for you, isn't it?" You laughed. It was all said in fun. Then this young chap and I decided to go home, and we walked and walked. And all of a sudden it occurred to me that I was walking without any trouble at all. *(Among the patient's problems are muscular pains and arthritis complaints in both legs which make it hard for her to walk.)*

Th. Mm hmm.

Pt. (pause) And then I was back in the clinic, and this young chap said he wanted me to do his analysis. I said that's impossible. And he sort of grinned at me and disappeared out of the door. That's all I can remember. *[The thoughts that come to my mind are that the patient may represent herself in the dream as her feminine component and the young man as her masculine component. She wants to return to narcissism (loving the man) and feels she can function this way (being able to walk). However, she is unwilling to give up her dependency on me (returns to the clinic) and she relinquishes her masculine component (the man disappears out of the door). Another possibility is that the young man is a disguised symbol for me toward whom the patient feels she can express an erotic feeling. In this way she can dissociate her sexual feeling for me from her therapy. Working further on the dream may disclose its meaning.]*

Th. When did this dream occur?

Pt. Last night.

Th. What are your associations to it?

Pt. (pause) I'm blocked off on associations, *(pause)* I'm blocked off on thinking. I'm in a complete state of suspension, *[intellectual resistance]*

Th. What in the dream might give you clues about your fear of me? What might you be planning or thinking of that would make you afraid of me?

Pt. Well, when I said I want to go to Paris, I might want to run away.

Th. What does Paris mean?

Pt. If I could do what I want to do, I'd go to Paris for a couple of years. I love it, just adore it. I love the French people, their relaxation and acceptance. It was wonderful.

Th. What does Paris symbolize to you?

Pt. Fun and sex. It's a sexy place.

Th. And here you wanted to go with this young man.

Pt. Yes, he was cute. (*laughs)*

Th. Was there a sexual feeling about that dream?

Pt. Oh, yes, sure. I was all for this guy. I'll tell you who he was. I never thought of it until now. He was a guy I met at Bob's party last Wednesday night. He turned out to be a young psychiatrist, and he knew you. Which is connected with you. So there you are.

Th. So you really felt attracted to him.

Pt. Yes, but had to take you along.

Th. Why do you think you had to?

Pt. Obviously you two are the same.

Th. So that you may have sexual feelings for me and project them onto another person, or you have a fear of sex and also fear disappointment. [*tentative interpretation]*

Pt. {sighs) Couldn't that be the same thing?

Th. It might. There may also be a desire to leave your therapy and run off and have fun, and wonder about my disapproval of that. There may be many things. What do you think? *[tentative interpretations]*

Pt. Consciously I'm not aware of wanting to run away from therapy. It's very painful to me as you can see. I wouldn't

be happy getting out of it; I'd only be happy getting through with it. But the sexual thing troubles me.

Th. What about any sexual feelings toward me?

Pt. I think I've always had that. I block off though and can't talk about it. It's almost impossible. [*She recognizes her resistance.]*

Th. What does talking about the feelings do?

Pt. Make me scared of you. I don't want to talk about it. I'm sure that's what's happening to me now, *(pause)* I'm just preventing talking, that's all. *(pause)* And I feel silly. *[This indicates an awareness that her hoarseness may be a form of resistance against verbalizing sexual feelings toward me.]*

Th. Silly about your feelings?

Pt. Mm hmm. *I* think it does. All my life I've covered up important things, so to let it out is an almost impossible thing. I talk about sex often in a pseudosophisticated way. I can make smart cracks faster than anybody I know, but it has nothing to do with me. To talk about my sexual feelings—no, no. The minute it touches me, I clam up.

Th. Yet you haven't been too inhibited in your sex life.

Pt. I think I was a great deal, even though I didn't act it. *(pause)* I just thought of a dream I had in which you kissed me. I told you about it two months ago. From that time on I haven't been able to talk about my sexual feelings for you.

Th. Mm hmm.

Pt. When I'm lonesome I say you are very attractive to me sexually, *(pause)* I feel sexual contact with you is forbidden, like it would be with a father. *(The patient's voice is much clearer now, as if her hoarseness is vanishing.)*

Th. If it's true that you feel extremely guilty about having sexual thoughts about me, that would cause you not to want to tell me your thoughts, *[interpreting her resistance]*

Pt. That comes close to it, I think. It's silly. *(laughs)* I'm beginning to see through you. *(The patient's voice is very clear at this point, her hoarseness having subsided considerably.)*

Th. What do you mean?

Pt. You're trying to make me talk about you. All right, *(laughs)* I have varying emotions about you. First, I say, "To hell with that bastard, I won't go back to see him." Then I say, "That's what he expects me to do, so I shall go back to see him." And then I say you are trying to be my friend, trying to do something decent. Then I get contrite about having had bad thoughts. All of which is a bunch of crap. I know it as well as you know it.

Th. So you must feel resentful toward me sometime.

Pt. I feel, *(long pause)* I feel now, and I have for the last few times I've seen you, that all of the threads that have bothered me have all come together in one knot, which knot has become *you.* If I can get that knot untied, then I'll be free. All the other things that bothered me are minor. I'm pulling out everything I have to resist you.

Th. Resist me in what reference?

Pt. Horribly enough I'm afraid it's a resistance to getting cured, *[recognition of resistance of normality]*

Th. You sound disgusted with yourself.

Pt. I am.

Th. What might cure do to you?

Pt. Well, it could put me back to work. It could eliminate all my excuses for not doing things. It could make me take an aggressive and active role. It could make me stop drinking and take that fun away from me. It could make me take a decisive action about George *(her husband).* I've come through the labyrinth and I'm up to the door, and I'm just resisting like hell. *[The patient elaborates her many resistances against normality.]*

Th. You must be frightened. Because that door is the door people want to reach.

Pt. That's what I've been coming here to reach.

Th. And now that you're approaching it, you are a little afraid of it.

Pt. I'm scared as hell, but I'm beginning a little to understand it.

The following is an excerpt of the very next session that brings out some interesting points:

Pt. I had a very peculiar reaction. Of course, it is almost impossible for me to say it. a very peculiar reaction last time. And I don't know what it was that was said, whether it was something I said or something you said, I don't know. But it was something in connection with our conversation, our relationship. Then all of a sudden I got a "cat-and-canary" deal, which you knew perfectly well, because you couldn't help but see it on my face. I don't see how you couldn't, and then just as I left, I said, "I feel like you're laughing at me." I knew that you weren't laughing at me in the sense of being nasty, but you knew damned well I wouldn't tell you what was on my mind. And, of course, that's the hell of the "cat-and-mouse" thing, because I'm perfectly aware that you know what's on my mind. Or at least you know very well whether I'm holding something back and won't say it or not. And I know that you know; so, therefore, I get into one of these, as I say, "cat-and-mouse" deals.

Th. What makes you feel that I can read your mind, that I know what you're holding back?

Pt. I'll bet 99 times out of 100 you do. It's very difficult, and I feel very silly. Whatever it was, whether that was a part of it or something else, I got a reaction of being very silly and ingenue, and very ridiculous, and I couldn't get over that feeling. Now what tossed me into that?

Th. When did you get this feeling?

Pt. Sometime during the last part of our conversation last time. I don't remember very much what we said, only that I think you asked me how I feel about you.

Th. How *do* you feel?

Pt. Giddy.

Th. Giddy?

Pt. Yeah. I think when I use the word "silly" I probably mean that, *{pause*)

Th. How did you feel *I* must have viewed you? Was it that you thought *I* thought you were silly?

Pt. Yeah. I imagine that's it.

Th. Well, why?

Pt. (pause) My reaction when I left was that I wanted to put my arms around you and kiss you. Now whether that is a little-girl reaction or not, I don't know. But that was the feeling I had.

Th. You felt affectionate?

Pt. Yeah. And then I think that's probably why I felt embarrassed. I felt I *(laughs)* wanted to go over and sit on your lap, like a little girl, and I'm probably older than you are.

Th. You think I think you're silly if you want to do that?

Pt. Probably because I had the idea that you've been trying to make me grow up. And goddamn it, I don't want to grow up.

Th. If this is what you feel, this is what you feel. Let's try to understand it. Suppose you do feel like putting your arms around me or sitting on my lap. Do you think there is something wrong with that?

Pt. Apparently I do. I don't think so, but I *feel* there is. I must or I wouldn't react that way. And when I get the "cat-and-canary," as they say, the "cat-that's-robbed-the-canary-look" on my face, I usually have something in my head, which I entertain, which I think is not in order. *(pause)*

Th. You know it is rather interesting that you find it so hard to mention to me what had happened, *[focusing on resistance]*

Pt. Sometimes I'll go for months and won't mention some things to you. And it isn't because I want to hide something. That's the goddamned mechanism of this thing. I blurted out and told you the last time, but, of course, by the time I get to talking about things, it's just when I'm putting on my coat. Like last time I kicked myself around the block when I got outside. I thought, why that's perfectly silly, why shouldn't I have said that; I've said every other goddamned thing. It's a wonder I came back today and said it. Because sometimes I might go for months and I might talk about every subject in the world. But some little thing like that which apparently has significance for me, I can't talk about.

Th. Perhaps it had such deep significance to you for a special reason?

Pt. Well, I find you attractive, *(laughs)* It's silly, but I have a thought it would be nice . . . last time what I failed to say was that I thought it would be nice to go to bed with you. But it kills me to tell you that. [*sexual transference]*

Th. Perhaps you wonder what my reaction would be.

Pt. I can remember one instance now. I don't suppose it was the type of person. It was probably the way I was feeling at the time. But usually men have approached me and I pretty much took what I wanted and left what I didn't want alone. That's always the case. A few times I thought someone was awfully cute, and I have deliberately gone after it, trying to look undeliberate. The exception was this once, and I can't remember who this man was. I think I'd read it in a novel, and I decided to try to ask a man to sleep with me, and did. And the result was disastrous. He ran like he was hit by a poisoned arrow.

Th. I see.

Pt. This guy ran. I don't think I ever did see him again. I remember now. Yeah. To show you that I'm embarrassed about it, I can't remember his name. Anyway, he was a guy that I went to Vriginia with. I was going on my business. He was going on his business. He was trying to make a business deal with me. He was very good looking, and he was my type. He was dark and not too damned tall and big, and I thought he was very attractive. I had lunch with him several times. And so I was going to Richmond. And I said at lunch one day that I was going to go to Richmond on such and such a day. And he said, "What are you taking?" And I told him the train number. And I got on the train, and he had the compartment right next to me. That I've never figured out. Maybe it was just luck. So anyway, he started making love to me. He came in to my compartment, and we were having a couple of drinks, and we were talking. And he started making love to me and all in a roundabout way, an inch at a time, an inch at a time. He put his arms around me first, and all the powwow they go through. So I thought this is going to be silly. I'd been thinking about it for weeks. That looks good. I'd like to have that when I can get a hold of it. So I just turned and looked at him. I said, "You don't have to go through all this, because I *want* to sleep with you." And it scared the hell out of him.

Th. Do you feel that maybe you're afraid of being outspoken with me too?

Pt. Goddamn it, yes. (*laughs*) I see it now. I must be afraid. You will run off and leave me if I'm too outspoken. My parents never let me speak my mind. Everything I learned I got out of being on the go with the other kids on the street. *[We continue to explore her sexual feelings toward me.)*