A Primer for Psychotherapists

THE MIDDLE COURSE OF THERAPY

Kenneth Mark Colby M.D.

A Primer for Psychotherapists

Kenneth Mark Colby, M.D.

e-Book 2016 International Psychotherapy Institute

From *A Primer for Psychotherapists* by Kenneth Mark Colby, M.D.

Table of Contents

THE MIDDLE COURSE OF THERAPY

For discussion purposes we can designate the middle period of therapy as ranging from the first interpretations on to the very end of therapy. With the first interpretations the bulk of the therapeutic work begins. In theory this work will consist of freeing the ego of a symptom-producing neurotic conflict. In practice, the chief technical tools for the task are the therapist's remarks, which fall into two groups, (a) interpositions and (b) interpretations. The preceding chapter has already considered the rationale and use of interpositions. They continue through the course of therapy. Interpretations, more characteristic of the middle period, will now be examined and discussed.

Interpretations

An *interpretation* is a statement, phrased in one of various ways, which the therapist makes in reference to something the patient has said or done. The therapeutic intent of the statement is to confront the patient with something in himself which he has warded off and of which he is partially or totally unaware. Thus the unconscious is made conscious.

First, I propose to discuss the *what* of interpretation, later the how and *where.*

The most common interpretations a psychotherapist uses can be pided into three categories: (a) clarification interpretations, (b) comparison interpretations, and (c) wish- defense interpretations.

Clarification Interpretations.—These are statements by the therapist made to crystallize the patient's thoughts and feelings around a particular subject, to focus his attention on something requiring further investigation and interpretation, to sort out a theme from apparently persified material, or to summarize the understanding thus far achieved. They may take the form of questions, mild imperatives, or simplified restatements. Here are clinical examples.

1. During the middle of therapy for a marital problem, a young woman describes a brief period of new symptoms resembling a physical illness—malaise, fatigue, loss of appetite. In preceding interviews various aspects of her relationship to her husband had been discussed. They were both students in the same field, competing for academic success. She was the more successful and dominant of the two. Only

recently has she become more aware that the husband is also in one sense her child whom she protects, regulates, and manages.

The symptoms she now describes developed during a trip which she decided to take without her husband in spite of his pleas to go along. On the trip her determination to be alone wilted and she began to "feel like a heel" for leaving her husband behind. She begins to elaborate on her activities during the short vacation, but the therapist at this point wishes to restate the connection between symptoms and life experience in a clarifying and focusing way.

Ther.: So you feel guilty about frustrating your husband's wishes?

Pt.: That's right. After all, he wouldn't have been too much trouble. And he looked so hurt.

Ther.: Perhaps your tiredness was connected with this.

2. In each of the first few interviews, a young man has spent most of the time describing the events of several love-affairs. None of them worked out very satisfactorily. Sooner or later there would be an argument or falling-out.

The therapist has been struck by a characteristic of these affairs as yet unmentioned by the patient, namely that, in all but one instance, he was at ease within himself when the affair was platonic, while, when intercourse took place, an inner turmoil developed with insomnia, restlessness, etc. Thus far the therapist's remarks have been confined to interpositions. Now he wishes to point out this theme and send the patient's further thoughts along these lines.

Ther.: It seems in these affairs you've described, that when intercourse began is when you began to get upset.

Pt.: Yes, I've thought of that, too. Don't know what it is exactly.

Ther.: And when you began to get upset, then the arguments would start?

3. Several interviews ago the discussion touched on this soldier's fear of tough or aggressive men. At that time the therapist had been able to show the patient one aspect of this fear, i.e., that he might do something which would provoke an attack on himself. The patient agreed there was something to this. However, in subsequent interviews he did not continue with this topic, preferring to give attention to other matters.

Now in this interview the patient again brings up his fear of belligerent men, citing an example which recently happened. He again expresses puzzlement over why such a thing should bother him.

Pt.: I can't understand it. There's no reason for it. I've never been in a fight. I get along pretty well with everybody. It's all very confusing.

Ther.: Last time when we talked about this, it looked as if you were afraid you might provoke some attack or fight.

The therapist restates a previous interpretation, clarifying a starting point for the patient to think about.

Comparison Interpretations.—In these statements the therapist places two (or more) sets of events, thoughts or feelings side by side for comparison. They may parallel one another or show contrast. They may be concurrent or separated in time. Common typical subjects compared are past with present behavior, fantasy with reality, the patient's self with others, childhood with adulthood and attitude toward parent with attitude toward friend, spouse, or therapist. Comparisons may be used to emphasize patterns of repetitive similarities or to indicate recurring contradictions. They may be phrased in any form, the most frequent being the everyday ways of matching things.

1. Outstanding in this man's life has been his rebellion against his father as a person and as a representative of certain social values. In previous interviews he has given the therapist an extensive roster of traits that he finds repellent in his father.

Today, having not referred to the father for a few interviews, he reports how he enjoys entering a bar where he is well known. The bartenders, the waitresses, and the regular patrons give him the glad hello, and when he moves from table to table chatting and joking he gets the pleasant feeling of being a "big shot." The therapist recalls that one of the patient's complaints is that his father often acts the part of a "big shot" among his friends. The therapist then compares the patient's behavior with that of his father.

Ther.: In a way, isn't that like what your father does?

Pt.: How so?

Ther.: You mentioned once that it griped you how your father acted like a big shot. Now you say that you sometimes enjoy being like a big shot.

2. Near the beginning of the hour a woman of Lutheran background recounted a painful childhood memory in which at age four she was severely shamed by her mother for showing her underwear to assembled house guests. From this she went on to other aspects of her early training. Soon her mind traveled to present-day happenings, including references to an extramarital affair. Before, when she has tried to talk about this affair, she implied that there was something about her sexually which her husband cannot satisfy but which her lover can. It has never been clear what this is, because the patient becomes embarrassed and immediately shies away from the topic.

She again approaches the subject but blushingly hesitates and looks vexed. The therapist makes a comparison.

> **Pt.**: I don't know why it is. I never can seem to bring myself to say it, though I know I should talk about it. Maybe because it's such a private thing.
>
> **Ther.**: Or it's like showing your underwear to strangers.
>
> 3. Once a patient arrived late for her interview. She explained that she didn't own a watch. She kept track of the time at home by the radio and outside the home by public clocks or by asking people she happened to be with.

Many interviews later, the patient is describing some of her personality characteristics. She says she is a very efficient, businesslike person who takes problems as they arise and solves them as soon as possible. In particular it bothers her to be late for anything, and she makes strenuous efforts to be on time. The therapist compares these two sets of facts to point out their contrast.

> **Ther.**: But you said you don't have a watch.
>
> **Pt.**: That's right. I haven't had one for several years.
>
> **Ther.**: That's somewhat contradictory, isn't it? On the one hand you say you like to be punctual. On the other hand you don't have a watch, so you're never quite sure what time it is.

Wish-Defense Interpretations.—Into this category fall those statements of the therapist which directly point to the wish-defense components of a neurotic conflict. Though we speak theoretically of wish and defense as separate elements in a conflict, it is difficult in practice to observe or deal with one or the other in a pure form. What we see empirically and manipulate are ego mechanisms, alloys of both wishes and defenses. One isolated component cannot be handled without implicitly or explicitly involving the other.

However, it must be strongly emphasized to the beginning therapist that we try, as far as possible, to interpret *first* the defense element of the wish-defense system, as is illustrated in the following examples.

1. Therapy with an overtly homosexual man in his early twenties, suffering from acute anxiety, had progressed to the point where it became clear that his greatest fear was of being approached by a certain type of man. The latter was a tall, muscular, and strong brute, easily enraged by any opposition to his wishes.

While in therapy the patient was picked up by such a man, who became drank and powerless. As long as he could control his helpless companion and determine their sexual practices, the patient felt no fear. But as the man sobered up and suddenly insisted that the patient lie down, he became panicky and fled.

In approaching the conflict around the patient's unconscious and warded-off wish to be treated like a woman by another man, the therapist avoids confronting him with this impulse. The interpretation first refers to the patient's anxiety and flight in terms of his defense of projection.

Ther.: You get afraid of the strong man when it seems he can do something to you. What do you fear he wants to do?

2. The husband of this patient complains that she is a constant nag and this trait is responsible for his drinking. However, she feels that what he calls nagging is really her motherly concern for his welfare. From evidence gathered in previous interviews, the therapist knows that behind her kind protectiveness lie sadistic impulses toward the husband. But interpretations around this subject are first made in reference to her defense, not her wish-impulse.

Ther.: Do you feel you are overly protective toward him?

Pt.: Maybe at times. Like if a rainstorm comes up during the day, I worry he might be caught in it. That's silly because there's no reason to think he couldn't be in a dry place.

Ther.: And he gets annoyed when you fuss over him?

Pt.: He says it's too much. I mother him, but I don't think it's that bad.

Ther.: But why do you think your concern is so exaggerated? It's as if you were afraid he's always in danger of something.

How to Present Interpretations.—Clarification, comparison and wish-defense interpretations comprise the what of the usual confrontations made by the therapist. Next to be considered is *how* such statements are presented to the patient.

In brief, the interpretations of the therapist take all the grammatical forms common to everyday nontechnical language. Technical psychiatric words and phrases (masochism, Oedipus, etc.) are purely shorthand terms of convenience for scientific discussions and have no place in statements to the patient. Similar content in interpretations can be expressed in several ways, and in this sense the therapist's horn should have more than one note. For instance, the ideational content of an interpretation might refer to a patient's unrecognized fear of physical violence. This idea could be stated by the therapist as:

A question: "Do you think you could be afraid of violence?"

A suggestion: "Perhaps you really fear violence" [or] "That sounds like you fear violence."

A tentative assertion: "My feeling is that you are afraid of violence."

A pronouncement: "Violence frightens you!"

Of course, besides the verbal form, the therapist's accompanying tone of voice, gestures and facial expression (if vis-a-vis) carry an impact. This is an area uncharted by rules. One principle of help to the beginner is that he should interpret by and large in the form of questions or suggestions, avoiding the brandishment of his ideas with an air of finality. If the therapist offers, in words and tone, his comments as provisional statements, his method will circumvent unnecessarily induced resistances which arise from trying to force the patient to accept a gospel. H. Sullivan felt that really useful interpretations were "alternative hypotheses."

A second aspect of the manner in which interpretations are presented concerns the degrees of exactness and directness used in confrontation. Since the therapist does not immediately and incisively point to the fended-off area but prefers to lead the patient to it step by step, his interpretations vary in specificity from the first approach to the eventual disclosure. Thus the early statements on some topic are more generalized and open-ended, allowing them to be taken up by the patient in ways of his choice. N. Reider feels that the best initial interpretations are simply restatements of the problem in somewhat more dynamic terms. An illustrative example follows:

Unfortunately the major personality characteristic of a young clerk was to alienate those who wanted to be friends with him. In fact, he provokes rejection only from people who are in a position to help him.

As therapy progressed, he naturally began to involve the therapist in his standard interpersonal plot. From the transference sample and from other illustrations, the therapist could see that the patient fears liking someone since, due to certain childhood experiences, it is tantamount to causing their death. Thus in approaching this conflict the initial interpretations are presented, necessarily at different times, as:

> Do you feel that he rejected you for no good reason?
>
> Perhaps you had something to do with the break-up.
>
> That looks like you might have provoked him a little.
>
> We should have to wonder why you partly engineer these rejections.

As these interpretations are gradually accepted and assimilated by the patient, the therapist later becomes more direct and finally specific. It is to be understood that all these interpretations ranged over the course of many interviews and were woven into other remarks on other topics:

> Do you think maybe you are afraid of something the more you get to know someone?
>
> Are you afraid of getting too close to him?
>
> Perhaps what bothers you is liking the person.
>
> If you like him, something will happen to him.
>
> What you fear is that what happened to your brother might happen to him.

A final point to be considered in the how of interpretation concerns the frequency and extent of the therapist's remarks. It is best to interpret sparsely and succinctly rather than to respond capriciously and copiously to everything interpretable. A therapist should talk less than his patient. Just as with too many interpositions, if the patient is sprayed with interpretations, he soon feels befuddled and swamped by things to think about. This can induce a chaotic therapeutic situation. Effective interpretations are concise, simply phrased, and few in number, begin as approximations on the periphery, and end as

convergences on the center.

Timing.—Next comes the difficult subject of when an interpretation is given. Again, to state rules is as impossible as to speak generally about what players should do on the seventeenth move of chess games. At best we can only sketch a few elements characteristic of good interpretive timing.

As we saw in the use of interpositions (cf. page 42), the therapist takes note of the fluctuating tension-levels shown by the patient during an interview. An optimum level of anxiety is one sufficient to stir the patient to make the effort required in a psychotherapeutic interview, but not one of such a degree as to put his participating ego out of commission. Thus when anxiety (or some other affect) mounts to the extent of threatening the patient's ability to observe and report himself, the therapist steps in with an interposition or an interpretation to circumvent the interference. An apt metaphor of S. Bernfeld's compares the activity of a psychotherapist to the activity of a life-guard who for the most part sits and watches but who intervenes quickly when things go amiss.

Of greater importance in timing than the tension-state, which can be controlled solely with interpositions or "coasting" interpretations, is the learning state of the patient. That is, can he, with what he knows of himself at this point, grasp the interpretation and see its pertinent validity? This, of course, depends on the nature and function of his resistances (cf. page 99). Like pushing a playground swing at the height of its arc for optimum momentum, the best-timed interpretations are given when the patient, already close to it himself, requires only a nudge to help him see the hitherto unseen.

Dosage.—Closely associated with the problem of timing is that of dosage of interpretation. On page 89 it was mentioned that the patient's conflicts are approached only gradually over an extended period of time. How much the patient is shown each time is termed "dosage." Small doses (again the factor of resistances comes into play) are the most advantageous. A second principle involves the patient's self-esteem. An interpretation should be only of a dosage which spares the patient a severe loss of self-esteem or any other painful affect to which he is susceptible. Patients vary in their ability to tolerate affect tensions, and the therapist soon learns how slowly he must approach with confrontations and of what doses they can consist.

At times the patient may not agree with an interpretation. This does not necessarily mean that it is

incorrect, dynamically or economically. One tries to interpret at the point of least resistance at the appropriate moment, but of course such theoretical precision is often technically impossible. If the patient does not accept an interpretation, the therapist should beware of arguing with him to force conviction. Strong opposition on the part of the patient is a signal for a temporary and graceful retreat, as in the following example:

A symptom of an obsessive-compulsive woman in her twenties is the uncomfortably frequent thought that something disastrous might happen to her mother. Because of this she is intensely concerned with her mother's well-being, regularly phoning home several times a day to see if all is well.

Already several weeks of therapy have gone by in which her relationship to her mother has frequently been touched upon. In this interview she describes an argument with her mother over money in which she suddenly became very upset and anxious to the point where she had to leave the room.

Ther.: And how did you feel?

Pt.: Sick of the whole thing. It was only about fifteen cents, and why should there by such a fuss about so little?

Now the therapist attempts an interpretation in the form of a question which, though probably accurate in content, comes too close to the underlying conflict too fast and hence is resisted.

Ther.: Did you feel some hostility toward your mother?

Pt. (*indignantly recoiling*): Oh, of course not! I love my mother very much. How could you suggest such a thing?

Ther. (*affably*): It occurred to me, but don't take everything I say as necessarily true. I'm often wrong. My comments are meant only as trial balloons to see what thoughts they bring to your mind. In this case you feel that hostility was out of the question, that you have only friendly feelings toward your mother.

Pt.: That's right. We do have little squabbles at times, but they never amount to very much.

Ther. (*moving on*): What other things do you squabble about?

Thus interpretations made tentatively or as questions have the added value of skirting the possible full arousal of important resistances. The therapist can look at all interpretations as having an evocative as well as confronting purpose. Though the patient may not agree, the nature and intensity of the kindled response provide further psychological data to be examined.

Assessing the Effect.—Psychotherapists, veterans as well as beginners, often wonder how to tell whether an interpretation is effective. Actually we never know exactly which remarks have produced a dynamic change in the patient's conflict. Similarly, at the moment when an inpidual interpretation is given, we may be unsure of its effect. Simple agreement or disagreement on the part of the patient is insufficient evidence. He may agree verbally to please you or avoid a feared argument, or he may disagree for a host of reasons, while his subsequent remarks show that part of him fully accepts the interpretation.

Correct interpretations often produce a feeling of surprise or startled illumination which the patient expresses in the form of a short laugh and eye-opening. Probably the most useful index of the effectiveness of an interpretation consists of the patient's subsequent productions in the interview. If he gives the interpretation room in his mind, freely thinks out loud about it, and brings corroborative evidence from the present or past, then both confronting and evocative purposes are being served. Even if the patient is skeptical of the interpretation's validity but continues to produce thoughts, whether in the indicated direction or not, an evocative purpose is at least served, though the actual confrontations may have misfired. This event is reminiscent of A. N. Whitehead's "the basic quality of any proposition is not that it be true but that it be interesting and exciting." The following example illustrates how an interpretation may be followed up:

A bewildered college student comes to therapy for help in deciding whether to leave school or remain. The latter course is the wish of his parents, to whom he feels deeply indebted. However, he is not genuinely interested in college work and would prefer to study a craft. His indecisive vacillations have precipitated symptoms of anxiety and depression.

The day before this interview while he was at a party given by friends, one of his professors entered the room. The patient immediately became uneasy and developed his anxiety symptoms of flushing and sweating. The professor was a friend of his parents and also knew of his poor school performance.

Ther.: What thoughts were going through your mind there?

Pt.: Well, he knew all about me. Everybody else there thinks I'm doing fine. It was sort of a guilty feeling, too—embarrassed. I remember I used to feel that way as a child whenever my mother would come around when I

was playing with my friends. I didn't want them to see her. That was when everybody called her crazy.

Ther.: You were afraid the professor would expose you?

The therapist wishes to focus on the dynamics of the patient's reaction at the party. However, the patient dismisses this line of thought and continues his interest in the childhood situation with his mother.

Pt.: No, I don't think so. You know I never got over that feeling that I didn't want others to meet my mother. We never knew when she would make a scene, and when she'd start yelling I'd just want to get out of there fast. And I felt guilty as if I had done something bad rather than she.

Since the attempt to show the patient what he feared from the professor is unsuccessful for the moment, the therapist follows the axis of thought being evoked.

Ther.: Did you feel guilty about something else in connection with your mother?

Pt.: Quite possibly. I don't remember feeling guilty, but either I must have or should have because I was told many times that my mother wasn't always like this. It was after she gave birth to me that she had the nervous breakdown.

Ther.: So in a way it was implied that you were responsible for her crazy scenes.

Pt.: Yes, it would be. And that would be one reason why I'd feel embarrassed and want to run.

Comparing the confronting and evocative aspects of interpretation to serial tugs on a folding telescope, we see that each effort uncovers a larger and hitherto unseen segment of the anticipated whole.

Resistances

What serves as defense for the patient in his neurosis is directly observed by the therapist in the therapeutic interview as resistance. A defense operating against the efforts of therapy is termed a resistance. The characteristic defenses that the patient repetitively uses in warding off wish-impulses will be mobilized to ward off therapy as a threatened interference with neurotic equilibria. For instance, a patient whose sexual conflict originated in masturbation might speak freely in the interviews of intercourse but omit references to auto-erotic activities. Here the defense of repression blots out from the therapeutic situation what it correspondingly blots out in the patient's mind. An ideational

representative of an instinctual drive is barred from the patient's consciousness and from being verbalized to the therapist.

Interpositions and interpretations which lessen and remove resistances thus nullify defenses and in so doing change the balance of wish-defense conflicts. The first requirement of the therapist in dealing with resistances is the ability to detect them. Some degree of resistance is naturally always present with fluctuating levels of intensity. Levels which seriously block therapy must be recognized and lessened.

Each patient from the beginning shows what may be called his base line of resistances. These are defenses determined by the patient's psychological past. The long-range aim of therapy is to gradually overcome some of these initial obstacles, while the short-range aim is to modify whatever increases take place from the base line as therapy progresses, i.e., intercurrent resistances. The latter are defenses arising out of the transference situation.

The common forms of resistances observed in everyday practice are listed below.

Quantity of Speech.—Each patient has his own pace in speaking, and once the therapist becomes familiar with it, variations are easily noticed. The patient may begin to pause more often and for longer intervals. He often says that his mind is blank or that he cannot think of subjects to discuss. He may become silent, restless and uneasy.

At the other extreme is constant over-talkativeness. Or a patient, previously of modest output, may suddenly become very loquacious. He states that he has so many thoughts he doesn't know which to select, and he hops from topic to topic in a rambling and verbose manner.

Quality of Speech.—Although the patient may talk freely enough at his usual pace, the subjects of his interest often announce the presence of resistances. He may circle endlessly around his symptoms, reviewing in detail the same material over and over. Or he may stick to one area of his life without broadening out into other related areas.

Instead of discussing the problems which brought him to therapy, he may spend his time speaking only of the therapist, seemingly having lost interest in anything else. Much of the interview may consist of

the patient's intellectualizing in general or in a common form, psychologizing by testing out now one psychological theory and now another on himself. He may launch his detached views on the sterling or doubtful value of a psychological school and attempt to involve the therapist in these evaluations. Knowing that the therapist is a physician, the patient may speak only of medical matters and repeatedly request medical advice. Knowing also that psychotherapists are interested in hearing of sexual attitudes and activities, the patient may promptly and un- hesitantly give a detailed and chronological account of his sexual life. Or he may offer a series of long and complex dreams for interpretations.

Frank omissions and censorships appear. The patient will mention that he saw someone who said something, but he cannot give the name or the content because that would be passing on gossip. He may omit mention of a feeling or a detail of an event which the therapist knows from the logic of emotions and everyday experience must have occurred.

L. Kubie summarizes the form-content aspects of the patient's speech eloquently: "From moment to moment the patient struggles with impulses to hold back or not to talk at all, or to rearrange his words into pleasanter and more acceptable forms; that is, into forms which are more flattering to his self-esteem and to the impression which he wants to make on the therapist."

External Interferences.—All sorts of hindrances to the occurrence, duration, and consistent repetition of the therapeutic interview may arise. The patient may repeatedly come late, forget the hour entirely, or cancel the appointment at the last minute for realistically insufficient reasons. He may arrange so many other activities in his life in such a way that few interviews take place and these are separated by long periods of time. Or frequent changes of the appointment hour are requested perhaps along with abbreviations in the length. Minor illnesses become excuses to avoid interviews.

Often slight improvement of the patient's neurosis may offer him reasons to interrupt or discontinue therapy.

Modifying Resistances.—With the recognition of the patient's base line and intercurrent resistances, the therapist's attempts to modify defenses begin. The next step in the therapist's mind consists of speculation about what is being resisted or defended against and why. The intercurrent resistances, stemming from transference and temporarily blocking the uncovering process, are the source

of greatest immediate concern. If the therapist can understand their content and motivation, he can, of course, plan attempts to circumvent them, as in the following example:

For the past five or six years, a young man has suffered symptoms of depression and indecision. In the very first interview he mentioned also that he had been sexually impotent. However, in subsequent interviews there was absolutely nothing said about sexual matters for many weeks.

In the beginning stages of therapy the therapist learned of a typical pattern shown by the patient. Interviews took place on Friday and on the following Monday. Each interview began with the details of his everyday activities during the time between interviews. After about half the interview time was spent on these daily accounts, he would move on to discuss relationships and feelings. His interview base line is to speak rather easily and continuously with few pauses though some restlessness.

This hour is a Monday. Immediately a change in the patient's verbal and nonverbal behavior is noticeable. The interview begins with a prolonged silence. The patient frequently sighs, puts out a half-smoked cigarette to light another one, and shifts his position many times. Finally he begins by talking about an event of last week which he had discussed in the previous Friday hour. Long pauses develop with expressions such as "Let's see now" and "I should think of something."

Noting the omission of the usual week-end account and the other obvious signs of resistance, the therapist wonders what is being held back and why. Possibly the *what* occurred during the week-end and the why is anxiety over its specific nature. Recalling the long-range suppression of sexual data though a sexual problem is known to exist, the therapist's guess is that something sexual took place during the week-end which the patient is afraid to bring up because of his fear of the therapist's reaction.

> **Ther.**: What did you do over the week-end?
>
> **Pt.**: I knew I'd have to get to it sooner or later, so I might as well now. Saturday night I got drunk, dead drunk. I went with some of my friends to a whore-house. . . .

In this case a simple question spoken in a matter-of-fact way was sufficient to overcome, without any interpretation, an interfering intercurrent resistance.

To understand the motive for a particular resistance, we have only to apply our understanding of

the motive for defenses in general. Ego defenses originate and develop to discharge and bind tension. Tension is experienced as an unpleasant affect, largely anxiety (or its derivatives, guilt, shame, disgust) or rage. Since defense = resistance, the motive for a resistance is also an unpleasant affect which threatens to be evoked in the therapeutic process. The task of the therapist is then to formulate the answer to: "What is the patient afraid (or ashamed, etc.) of verbalizing?"

The content being fended off is deduced or guessed from one's over-all knowledge of the patient and the configuration of therapy at the moment of resistance. Many times, though he understands that the patient fears something and is avoiding it, the therapist is unable to grasp what the subject is. However, as will be shown (page 101), this does not necessarily prevent the removal of a resistance.

When timing and dosage of interpretations were mentioned (cf. page 90 f.), it was stated that the factor of resistances came into play. Now an additional principle governing interpretation can be presented, namely interpretations should be made at the point of least resistance. This implies that first interpretations are not made in reference to the chief symptoms, since we know that major defenses (resistances) operate in this area. A frontal attack on a strong defensive point is useless. Thus dealing with inter- current resistances to begin with is more effective than tackling base-line resistances. By removing lesser obstacles at first, larger fragments of defense can be approached and meeting the full force of resistances at any one time can be avoided.

Long-term (base-line) and short-term (intercurrent) resistances are attenuated in part by (a) the general permissive atmosphere of therapy with the therapist's calm, non-scolding attitude, but mainly by (b) the therapist's interpositions and interpretations. Just as not every observable pattern or conflict is interpreted to the patient, so not every recognized resistance is directly discussed. In fact, in psychotherapy the majority of resistances are by-passed with no attempt to focus the patient's attention on them. Those of sufficient dimension to seriously hinder the uncovering process must be interpreted. In a covering or supportive psychotherapy almost all resistances are left in the patient's keeping.

Interpositions alone are often sufficient to overcome an intercurrent resistance. Here is an example in which a reassuring explanation is used:

Sincerely attempting to say what comes to his mind, a man of religious background finds himself in

an uncomfortable position because he is having repeated homosexual fantasies in which he wonders what other men's naked genitals look like. Besides being ashamed of such thoughts, he is frightened by them because they might mean he must become overtly homosexual to be happy. In therapy he has great difficulty in elaborating on these fantasies, merely saying from time to time that he has them. The therapist attempts to modify the patient's anxiety in order to learn more about the nature of the fantasies.

Pt.: I know I don't like to talk about it. I writhe inside. Mainly I'm scared about what they mean. Maybe I'm homosexual. As soon as I think that, I stop them and try to think about something else.

Ther.: Fantasies like that don't necessarily mean you're homosexual. They're just thoughts like any other thoughts. And, as you know, most thoughts are never acted upon.

Pt.: That's comforting to know.

Ther.: And what do you think your fantasies really wonder about these genitals?

The patient was better able to go into more valuable details once the anxiety motivating his resistance had been somewhat relieved by the therapist's interposition.

In the following example the therapist confronts the patient with one of his interview traits. This interpretation, in the form of a question, attempts to show the patient a defense he uses in the hope that through understanding it he can begin to abandon it. Noteworthy is the therapist's ignorance of the content or the motive for the base-line resistance.

Before or after most of his remarks, a young scholar would make interpretations of them based on his reading knowledge of psychology. From the first interview this has been an outstanding characteristic. As yet he has not been able to approach any of his life problems, preferring to intellectualize at length. The therapist is not at all certain why this resistance operates or what it is directed against, but he wishes to lessen its interference with the uncovering therapy. Hence he begins by pointing the resistance out to the patient in order to initiate its resolution.

Ther.: Have you noticed that you tend to interpret everything you say?

Pt.: Yes, I know. It's as if I wanted to get my interpretations in first before you do.

Now it appears that his defense of theorizing is connected with his thoughts about the therapist. In

a sense he feels he too is an interpreter, a rival therapist.

Ther.: Why do you think it is that you have to beat me to it, so to speak?

Pt.: It's because I don't like the idea of your knowing more about me than I do myself. And I don't want you to surprise me with something I haven't already considered.

To prevent surprise is to prevent anxiety. If he has already thought of something, he has detoxified it and made himself immune.

Ther.: And what sort of surprises do you fear?

Pt.: One thing I wouldn't like to hear would be that I had feminine tendencies.

Ther.: Why? What would that mean to you?

What lies behind the resistance—anxiety about his masculinity- femininity—becomes a little clearer. An interpretation followed by matter-of-fact questions serves to modify the defense and permit an entry into a significant anxiety-laden area. The transference aspect of the patient's behavior is ignored, since the technique selected is sufficient for the time being to attenuate the resistance.

Interpositions and interpretations manage in the next example to remove an intercurrent resistance blocking the course of therapy.

For two or three interviews the therapist sensed a resistance increasing because of the patient's quality of speech. She spoke less and less of her conflict with her husband, spending most of the time talking about plans for a new house. In this hour nearly half the time has elapsed in which the patient has spoken only of rugs, drape colors, room measurements, etc. The therapist cannot fathom precisely what is being resisted, suspecting, of course, some new topic related to the husband and withheld because of the nature of the transference.

Ther. (*interrupting*): I have the feeling you are telling me all these things about the house in order to avoid talking about some other thought on your mind.

The patient falls silent and fidgets.

Ther.: What do you think?

Pt.: You're right. I've been wanting to tell you for a week but dodged it. One thing about the marriage that I haven't mentioned yet is that I think I'm sexually frigid.

Ther.: How so?

The therapist does not stop to inquire why the patient resisted talking of her frigidity. Finding the topic now open with the patient's resistance lowered, he is content to continue investigation of the newly disclosed subject.

One particular form of resistance merits special consideration because it is so frequent and at times trying. That is, the resistance of silence. On page 55 the three common methods of handling the patient's silences were mentioned: (a) inquiring about the patient's immediate thoughts, (b) asking a direct question, and (c) waiting for him to continue. We can now add a fourth device—interpretation of the silence. In the beginning of therapy, with the patient becoming accustomed to the new situation, a few silences are to be expected. The first attempts to overcome them consist of active questioning and encouraging on the part of the therapist, with a gradual shifting of the responsibility to end the silence to the patient.

However, when silences become so frequent or prolonged that a question or other interposition is not sufficient to reinstitute the patient's flow of speech, interpretation of the silence is called for. As with other resistances, the therapist attempts to formulate what could be the content and motive of the resistance. If this can be done, a more specific plan of approach can be attempted. If not, more gentle tactics are utilized. The first example deals with a silence in the beginning of therapy, and the second with one in the middle stages.

1. In contrast to the first two interviews when he talked volubly, this hour finds the patient almost dry of things to say. He appears edgy, looks here and there about the room, and at times acts a little grumpy.

lie is a government clerk in the late twenties. He feels stifled and penned in by his job. Wanting to quit and try some other work, he fears the independent move. Yet the idea of staying in his present lowly job fills him with guilt, since he does possess above-average talents, particularly in music composition. The conflict is directly represented in his family set-up, in which his father stipulates that he should

have a regular job while his mother encourages musical study.

The therapist tries a few questions which produce brief replies on the part of the patient. Waiting is also to no avail, since the patient tolerates the suspense in silence. Hence the therapist directly confronts the patient with his resistance.

Ther.: Something seems to be blocking you today.

Pt.: Guess so. I can't think of anything to say.

Ther.: What do you think that means? You come to talk, but you don't have anything to say.

Pt.: I don't know.

Ther.: Maybe it's the expression of the part of you that has doubts about coming here.

Pt.: That could be. I've wondered what can you do for me? Am I expecting some magic? I know you can't make up my mind for me. It's such a simple thing, too. Maybe I don't deserve to take up your time. I know you must have other cases more serious. Someone about to kill himself or fall apart. I don't have anything like that. When I talk about it, it sounds trivial.

Ther.: You feel a little guilty about taking up my time?

Pt.: I do. Maybe I shouldn't be here.

Ther.: No. I'm interested in helping you. If this problem bothers you enough to come, then it isn't trivial.

Already the transference fear of the therapist's unfavorable opinion develops. Clarification of the patient's feelings about therapy and a direct statement of professional dedication suffice to circumvent the resistance.

2. Several months of therapy have passed in the case of a hysterical woman suffering from arm and abdominal pains. She begins the hour with a few remarks about her job and then lapses into silence. Her manner and facial expression indicate her feelings of resentment.

Ther.: What are you thinking about?

Pt. (*sullenly*): Oh, nothing much.

Ther.: You sound angry.

Pt.: I am.

Ther.: What are you mad about?

Pt.: I didn't like your comment last time on my exaggerating things.

In the previous interview she had told of manipulating her boyfriend by threatening to kill herself unless he took her to the beach. One of her typical maneuvers is to heavily dramatize situations in order to get her way. The therapist had pointed out her mechanism of exaggerating the importance of her desires as an interpersonal weapon. At the time she agreed to the truth of the interpretation.

Ther.: But you agreed with me last time.

Pt.: I know it. But thinking about it later I didn't like it.

Ther.: You felt I was reprimanding you?

Pt.: No, not that. You were accusing me of being a phony. That's something I can't stand. Jerry says the same thing. He accuses me of always acting. Once we went to a party and . . . .

The silence is broken and the patient continues to produce.

In the last two clinical examples, transference factors are evident in the functioning of the patient's presenting resistance. This is such a common phenomenon that the therapist should always give it thought when considering possible motives for all resistances. That the patient resists the verbalization of certain topics because of his anxiety over the therapist's possible reaction or opinion is understandable when we reflect on the origin of defense mechanisms in childhood. The child learns to outlaw as dangerous (incurring loss of love or physical punishment) certain impulses, behavior, and emotional expressions because of reactions they produce in his parents. Since the therapist grows in part of the patient's mind as a parent-figure, it is to be expected that censorships and avoidances will take place in relationships to the new parent-substitute as a representative of the original parent.

Hence, once a resistance is recognized, the therapist should look for its possible connection with himself. This rule serves to introduce the all-important subject of transferences into our consideration.

Transferences

First, let us discuss the definition and usages of the word "transference." The more specific and

precise definition designates transference as the phenomenon in which a patient feels and behaves toward his therapist as he did toward important figures in his childhood (usually parents, siblings, or other relatives). Yet at times the term "transference" is loosely used to denote all the reactions of the patient toward the therapist. Actually this is a misuse of the word.

The patient's feelings toward the therapist are guided and determined in accordance with (a) his reality perception of the therapist's professional role, and (b) his past interpersonal experiences with significant family figures. At any given moment in therapy, the patient's orientation to the therapist represents a compounding of these two determinants with one or the other assuming reigning proportions. Reactions arising from (a) we consider appropriate to the present reality situation. For example, if the therapist openly insults the patient until he becomes angry, then the anger is not a transference but a normal emotional response appropriate to the situation. But if the patient is enraged because the therapist wears bow ties, then the disproportionate and inappropriate response signifies the presence of a transference.

Further uses of the word "transference" liken it to other terms. A "positive transference" means that in general the patient feels friendly towards the therapist and cooperates with him. "Negative transference" refers to the patient's resentment or unfriendly feelings which incline him to hinder or block the therapist's efforts. Again, these terms inadequately conceptualize the data observed in therapy. It would be more convenient to designate the relationship of specified intervals as friendly or unfriendly.

"Transference neurosis" has three usages of currency, referring to (a) a neurosis possessed by a patient capable of making transferences, (b) the transference phenomenon in its specific sense as defined above, and (c) an intensified form of the latter in which all of the patient's infantile conflicts are centered about the person of the therapist, a sort of galloping form of transference. I prefer to limit "transference neurosis" to the third category, designating the second simply as "transference."

A "transference improvement" consists of rapid amelioration of the patient's neurosis due to the particular nature and intensity of his transference onto the therapist. For example, a patient who equates neurosis with punishment for sins may give it up to win the approval awarded by a loving protector in the person of the re-edited parent, the therapist. A "transference aggravation" refers to an increase in the

neurosis brought on by the type of transference made by the patient. For instance, if the patient anticipates physical contact with the therapist, the frustration of this desire may heighten her presenting symptoms.

In the following pages the word "transference" will be used to indicate the patient's acting toward the therapist as he did toward someone of significance in his past. Emphasis is placed on the patient's actions and behavior, verbal and nonverbal, because it is through the observation of these that the therapist recognizes the presence of a transference. Seldom does the patient flatly state spontaneously that he feels toward you as he felt about one of his parents, since, though he is conscious of his feelings, what they are a repetition of is outside his awareness. Rather as you listen to the patient's communications, observing connections between present and childhood experiences, a third set of experiences strikingly parallels the first two. That is, the patient in his relationship to the therapist, repeats and relives feelings that he had and has in other life areas. To aid the beginner in detecting the nature of a transference, common transference facts of observation are listed below.

The patient may think, feel, or act toward the therapist as if the latter were filling one of the following roles.

The Therapist as Giver of Affection.—Besides the therapist's realistic role of showing interest and understanding for the patient as a suffering person, further and less highly differentiated forms of affection may be sought by the patient. He may wish love in terms of praise, sympathy, pity, or direct expressions of being liked. To receive from the therapist smiles, encouragement, or simply words alone, regardless of content, may give him a lifting feeling of wellbeing equivalent to being loved. Conversely he may interpret the therapist's neutral facial expression or silence as an actual rejection.

Indications of this attitude are the patient's attempts to make the therapist laugh, frequent asking for suggestions or information, or appeals for sympathy by exaggerating the severity of unpleasant situations. He may bring gifts or do favors, hoping for a return of the thus-given affection. When desires for affection are frustrated, the therapist notes the patient's overreaction to a realistically slight rejection. For example, if a patient requests to be seen at a certain time and the therapist explains that he cannot because someone else has that hour, the patient may act and look severely hurt. Or he may feel intensely

jealous of other patients and show his resentment by criticizing them or fuming at any interruption of his interview time by them. An extreme form of the expectation of affection from the therapist consists of desiring actual physical loving contact with him. Signals of such a desire are frank seductiveness by look and act, touching the therapist, or expressions of jealousy toward his wife who enjoys this intimacy.

The Therapist as Powerful Authority.—As the re-edition of a parent, the therapist takes over in the eyes of the patient attributes of strength and magic commonly ascribed by children to adults. Surrounded as he is in reality by the emblems (educational degrees and a title) of one type of authority in our culture, the therapist is predisposed to exaggerations of his power by the patient. To the patient a powerful authority who can reward, punish, and protect must be handled gingerly. Only things that can be pleasant must reach his ears. This authority must be cautiously sounded out for a long time in an effort to learn what areas can be demarcated as "safe" and "dangerous." If one succeeds in pleasing the potentate, he is rewarded by an invulnerable protection against anything bad happening. Of course a powerful figure, feared and respected, is also hated for the restrictions his assumed authoritarianism commands.

Such a view of the therapist by the patient can be deduced from several signs. The patient may be extremely agreeable and polite, always making his desires secondary to those of the therapist. For example, he will put himself to all kinds of trouble to choose an appointment time only slightly more convenient for the therapist. Or he will routinely call the therapist "sir" and submissively act as if he were dealing with an old man of world-famous importance. He may seek counsel on matters requiring wisdom and experience in fields unfamiliar to the therapist. He avoids expressing opinions—political, religious, social, etc.—which might disagree with those of the therapist and apologizes if one of his views might appear dissenting. All interpretations of the therapist (some of which must be wrong) are accepted as correct and final. If the therapist offers a view differing from one of the patient's, it is immediately adopted as of course true and how could he have been so stupid as to think otherwise. Later in therapy, he may make the accusation that he does not feel completely free in talking because of the therapist's censoring attitude.

The Therapist as Ideal Model.—The previously outlined role ascribed by the patient to the therapist may include or merge into the role of an admired, ideal model. The patient sees the therapist as

a supertype—supremely intelligent, learned, all-knowing, properly balanced, etc. If he patterns himself after this model, he will thereby gain some of its qualities, i.e., strengths. By copying a supertype, one becomes a supertype himself and thus becomes safe and powerful against any threat.

Identifications with the therapist are easily observed. The patient may dress like him, adopt his manner of speech, walking, and posture, or take over one of his characteristic gestures. The therapist's tastes in books, pictures, furniture, etc., may be embraced. Interests and hobbies previously ignored by the patient may suddenly gain importance for him when he learns they are pastimes enjoyed by the therapist.

The Therapist as Rival.—In this type of transference the patient acts as if the therapist were someone with whom he is locked in a competitive struggle. He feels the therapist must in some part be fenced with, outmaneuvered, and defeated. Men, especially when close in age to the therapist, may see him as a rival intellectually, financially, or socially. Women may see him as a competitor in the male-female struggle who attempts to assert a masculine superiority.

Clues to such an attitude are found in the following behavior. The patient may try to test out by direct questions what and how much the therapist knows and has read. He may first interpret all his communications and, when the therapist manages to get in an interpretation, consistently say that he has already thought of that. At times he might feel out the therapist's memory of past interviews, hoping to catch him in an error. Or he may try to get the therapist to speak once he has learned that the therapist prefers silence most of the time. He may tell the therapist of one of his attitudes toward life and add challengingly that no one could ever influence it. Men ask about the therapist's economic success or the stage of his professional career. Women seek to establish the therapist's position on the roles women should have in the world or gauge his vulnerability to womanly wiles of charm and flirtation.

The Therapist as Favorite Child.—Strangely enough it often happens that the patient acts and feels as if the therapist were his child. At first this seems to contradict our idea that a transference is the repetition of a childhood attitude toward parents. But if we remember that many people seek their unattained ego ideals through the medium of a child and that these ego ideals were derived from their own parents to begin with, then it becomes understandable that the child really represents, once

removed, a potential parent. The favorite child, if all goes well, will grow to become the idealized parent never achieved by the patient himself.

This phenomenon is particularly frequent when the patient is in fact older than the therapist. It does not necessarily lessen the therapist's powers to help, since the bright son is respected for his professional abilities. But in other aspects he becomes the object of protective mothering or fathering. For example, the patient may become solicitous about the therapist's health, instructing him to take better care of himself if he has a cold or warning him that he is working too hard. Women knit sweaters or bring food. Men offer advice about men's problems such as cars, investments, and business matters.

Throughout the course of psychotherapy, transferences contain one or the other of the five role-contents listed above. A transference seldom consists of one attitude in a pure form but is made up of a medley of these roles with one predominating at one time and some other at another. Also within a single hour the patient may react to the therapist as the embodiment of different figures. Hence it is more accurate to speak of a transference rather than *the* transference, since the content transferred undergoes shifts and changes.

Making Use of Transferences.—Once a transference is recognized, the therapist makes use of it in two ways. First by evaluating what transference role the patient is forming, the therapist gains understanding of what is being relived and re-experienced rather than being remembered. Secondly, the therapist may confront the patient with a transference to show him something he is unaware of or to overcome a resistance.

The manner in which a patient acts and feels about his therapist is a bonanza of psychological information. In subtracting the inappropriate from appropriate responses the therapist has a first-hand, immediately observable illustration of the patient's psychodynamics in an interpersonal relationship. For example:

1. A woman from an old Southern family broke away in late adolescence from family ties and values. She became a nomadic Bohemian vigorously opposed to all authority. She expressed her feelings by zealous work in Anarchist societies and other radical movements. In therapy she often told of fearlessly challenging policemen and openly sneering at successful businessmen.

Yet her behavior toward the therapist was in marked contrast to this. She was very respectful, nonaggressive and acquiescent- all attitudes she faintly remembers having as a child toward her parents until adolescence. The therapist's concept was that the patient unconsciously saw him as a feared and loved parent who must not be antagonized. She really feared authority as a source of punishment. Later in therapy this was confirmed by the fact that though she proudly told everyone else, she was unable for months to tell the therapist that her lover was a Negro.

2. Jailed for stealing, a tough adolescent boy snarled and wisecracked at all adults. A major event in his past life was the war death of an older brother noted for his kindness toward the patient. On meeting the therapist, the boy showed his usual bored nonchalance. For a few minutes he gave clipped answers to questions about his age, school grade, etc. Then spontaneously he added:

> **Pt.**: You know, it was my birthday yesterday.
>
> **Ther.**: And did anyone remember you?

Suddenly the patient burst into tears and sobbed heavily. From this moving transference reaction the therapist can see beneath the insouciant facade elements which do not appear in a routine psychiatric history.

The second use made by the therapist of a transference is in regulating the future course of therapy. In a mainly supportive therapy the patient is shown few if any aspects of his transferences. Transferences may be allowed to continue to increase defensive processes (cf. page 153). In an uncovering therapy the patient is shown those aspects of his transferences essential for his understanding of important neurotic conflicts. Of all the interpretations made in psychotherapy none carries greater weight in modifying defenses than a correct transference interpretation confronting the patient with the motivations of his thoughts and feelings for the therapist.

When is the patient shown his transference? The question of timing is answered by a rule of considerable value. That is, a transference is not discussed until a strong resistance is met. As long as the patient continues to talk freely about important problems with a minimum of resistance, the transference or transferences are left untouched. But when the patient becomes blocked or side-tracked in his efforts, discussion of his feelings about the therapist is in order.

The clinical examples on pages 98 and 105 illustrated how the patient may erect defenses around certain topics because of his emotions toward the therapist. Since it proved sufficient to overcome the presenting resistance, the factor of the therapist in those examples was hardly touched upon. In the following example the nature of his transference is more extensively unfolded to the patient.

An intelligent adolescent boy is undergoing psychotherapy in an effort to relieve his confusion over sexual and religious matters which bear on a rift with his parents. He is of a friendly, outgoing nature but sensitive to the slightest criticism.

It came to light in therapy that he is particularly intrigued, and excited by men's hair. This began at the age of four when he first saw his father's pubic hair and genitals. Nowadays head or pubic hair fascinates him. A few months before therapy he had fantasies of stealing hair shampoo from drug stores. He was conscious that it had some relationship to his father's use of shampoo, a habit denied him by parental edict.

In therapy one of the patient's characteristics is to say teasingly, "I'm thinking of something but I can't bear to say it." Until now this trait has been ignored by the therapist, since the patient usually went right on to another topic. However, at this point in therapy the trait has swelled to the size of a major resistance. The patient is silent, occasionally looks at the therapist expectantly, and repeats, "I just can't say it, I just can't say it." The therapist has the feeling that the patient is fencing tauntingly, that he is not really experiencing a painful affect in connection with his thought content. Finally the patient continues:

Pt.: You know I thought of stealing again the other day. This time it involved you. When I was downtown I thought of stealing the Saturday Review from the newsstands.

Ther.: Why the Saturday Review?

Pt.: That is where you come in. I had never seen it before until I saw it in your waiting room. It's sort of an intellectual magazine. Maybe I thought I'd be an intellect, too.

Ther.: It's interesting that of the two things you've wanted to steal, the first involves your father and the second me.

Pt.: You mean I think you're a father to me?

Ther.: Maybe. At least we see that you want something I have just as you wanted something your father had. You compete with me as you do with your father. Even in the interview here you struggle with me, like in holding back to see what I'll do about it.

A transference is actually a resistance in the sense that something is re-enacted or relived with the therapist rather than being recalled and verbalized to him. Two common forms of resistance repeatedly requiring transference interpretations arise when (a) the patient avoids a topic easily seen by the therapist as related to him and (b) the patient becomes interested in talking only of his feelings concerning the therapist.

In the case of (a), the therapist can initiate a discussion of the patient's feelings about him. As these feelings are revealed as motives for the avoidance, the therapist can begin to demonstrate to the patient their unrealistic basis in terms of ascribing one's own qualities to someone else or as literally transferring attributes from a historically important person to the therapist. When the patient with a sufficient reality sense understands this mechanism, the resistance diminishes and the topic being defended becomes available for investigation, as in what follows:

One day an outwardly majestic actress alternately paused and rambled during the interview in contrast to her previous smooth and relevant flow. In the past few interviews her usually seductive behavior toward the therapist has become in little ways increasingly more enticing. After a long silence, the therapist approaches the transference.

Ther.: It seems you are having some difficulty talking today.

Pt.: It does, doesn't it? I know I must try to be honest and tell you everything, but sometimes it's so hard. I don't know quite how to go about it. (*Silence*.)

Ther.: Is it something to do with me?

Pt. (*laughs*): It is. I think the main thing that bothers me is how you will take it. Not that you will do anything about it. I know by now that you won't laugh at me. But you will think this is so childish.

Ther.: Why would I?

Pt.: It's something anyone would think a grown woman should have gotten over by now. Once a few years ago I told my mother about it and she scorned me, saying I sounded like a bobbysoxer.

Ther.: And you're afraid I will react like your mother?

Pt.: It's silly to feel that way, I know. Well, what it is is a daydream I've had for years. In it I think of myself as a queen like Cleopatra who is surrounded by a sort of harem of big, handsome men. All these men are my slaves. Some are in chains. They do anything I want them to. For the first time a couple of weeks ago you were one of the men.

The therapist's interpretations, bringing out in the open the basis for her difficulty in speaking and indicating that she fears him as she learned to fear her mother, enables the patient to reveal an important fantasy which includes further transference material.

When the patient's resistance takes the form of his talking only about the therapist as in (b), whether in friendly or unfriendly terms, again the therapist must initiate an exploration of the phenomenon and its defensive purpose. The next example illustrates how this may be done.

For almost half of an interview the patient exhaustively expresses her admiration and near-love for the therapist. During this time in therapy she is considering separating from her husband, who she feels is intolerant and lacking in human understanding. So much of her attention is devoted to her praise of the therapist that she says nothing about the outcome of a marital argument unfinished at the time of the last interview.

At this moment she is describing further glorious things she has heard from friends about the therapist.

Ther.: And no one had anything bad to say?

Pt.: No. Or maybe I wouldn't let them. To me you are perfect.

Ther.: But nobody could be so perfect as the person you describe.

Pt.: I admit you must have faults, but I haven't found any. Even if you do, your understanding makes up for them. You're the only one who really understands me.

Ther.: And it's this not being understood that angers you about your husband?

Pt.: Yes. He's terrible. What I want is a man who understands that people have feelings and are not just machines. In fact I've thought it would be nice to be married to you. You are the only one who has ever been interested in me.

Ther.: But I'm paid to be interested in people, it's my job.

Pt.: I know. Still I think you would make me a fine husband.

Ther.: If I were your husband, who would be your psychiatrist?

Pt.: I wouldn't need one.

Ther.: Why not?

Pt.: Then I'd be all right. I wouldn't have to go through all this talking and questioning.

Ther.: Maybe in one sense that's what making me your husband means. I couldn't be objective about you, it would take away my power as a therapist.

Pt.: That comes close to something I once thought—if we were together you'd be on my level, not over me, and you couldn't pry into my life as you do now. Maybe I'd be telling you instead of you telling me.

Ther.: Like your husband now?

Pt.: You mean that I want to snare you like I snared him. You may be right.

The therapist succeeds in partially showing the patient that she repeats in her transference what she does with her husband and that hidden beneath her admiration of the therapist lie other less friendly motives.

Throughout psychotherapy each patient makes several transferences, the therapist representing now one figure, now another. The multiplicity and extent of these reactions depend greatly upon whether the therapist allows them to develop. Indeed it must be kept in mind that in some reality respects the therapist is like a parent especially when he may guide, suggest, and reassure. For example, suggesting to the patient that he postpone an important decision in a matter that could bring him unpleasant consequences is actually a parent-like function. Hence not all of the patient's reactions are transferences. Some are appropriate and proportionate to the therapist's realistic role.

Allowing transferences to develop means behaving as much as possible as a professional helper in an accepting, noncritical, non-moralizing manner. If the therapist is knowingly or unknowingly critical, then the patient is justified in behaving toward him as if he were a punishing parent and the opportunity for the patient to make this kind of a transference as a projection out of his own mind is unfortunately lost. "Manipulating" the transference in the sense of playing like a "pally" father or a loving mother is to be avoided in an uncovering therapy. To become convinced that his transference feelings are spontaneous creations of his own mind, the patient must have minimum reality justification for their nature.

Working Through

The process of repeated verbalization by the patient and interpretation by the therapist of central neurotic conflicts is called "working through." Over and over, now here in one area and there in another, important defenses and their motivations are brought into the patient's consciousness. A major resistance or defense is seldom undone by one interpretation or even by the activities of one interview. Dynamic, structural, and economic changes in neurotic processes are the result of weeks and months of working through.

Several mechanisms operate in working through, both in and outside the therapeutic interviews. First, in the interview recollection, reconstruction, re-experiencing and repetition take place. Recollection means the production of memories by the patient. These memories arise in accordance with what is being experienced in the present by the patient in an interpersonal relationship with the therapist or someone else. It is the task of the therapist when listening to the patient's recollections to try to correlate them with the present, with the transference situation and with other memories. This is usually done in the therapist's mind by listening for themes and patterns, which are easier to formulate, remember, and match than inpidual memory details, as in the following example:

> The patient is complaining that her boyfriend is very stingy. They are often treated to dinner by other couples, but he does not offer to return the gesture. Now she is embarrassed whenever she meets these friends, feeling that they must look down on her for having such a man. She recalls a couple of other men in her life who were the same way. In fact in the case of one of them his miserliness resulted in her leaving him.
>
> The therapist remembers that the theme of the previous interview was the generosity of a man who had befriended the patient. The theme of the two interviews then is "what men give and what men take." In his own thinking the therapist next relates this theme to the transference situation at the moment to see how the patient might view him in terms of giving and taking.

Reconstruction is the deduction of what the patient must have thought or felt at a time which he cannot recall clearly but about which he can give some data. The therapist and often the patient himself can make reconstructions based on knowledge of general human behavior. For example, a patient cannot recall what she thought when, at age eight, she first saw her father's erect penis but states, "It must have been a surprise and a shock, because the only male genital I had seen before was my baby brother's and I know such a sight would be shocking to a little girl."

Re-experiencing involves reliving feelings and behavior once experienced toward an important figure of the past. A transference is a re-experiencing. Of course, the phenomenon takes place to some extent in all interpersonal relationships, not only the therapeutic one.

Repetition means the frequent recurrence of all these mechanisms, including their interpretation by the therapist. Knowing that effective work requires the application of force over a period of time, the therapist patiently and repeatedly employs his techniques with versatility. By versatility I mean that the therapist shows some resourcefulness and suppleness in pointing out the same thing in many different ways. He avoids belaboring the patient with the same statement (e.g., "you are dependent") over and over until it becomes a chant. While the therapist slowly chips away at fragments of neuroses, the patient undergoes literally hundreds of modifying learning experiences.

Outside the therapeutic hours a working through goes on in that the patient repeatedly thinks of things he has learned and tests them out on himself in his life experiences. Processes for which we have no better terms than absorption, assimilation, and consolidation lead to the cumulative effects produced by dynamic uncovering psychotherapy.

Typical Use of Techniques

A sector from a clinical case is now presented to illustrate some typical techniques utilized in the middle of therapy.

Our patient is a mannerly woman in her mid-twenties. She comes for help because of generalized feelings of depression and dissatisfaction both with her job and her marriage. Working full time for low pay as a secretary, she gloomily sees no chance for a better financial future. This impinges on her relationship to her husband, who also earns little and who cannot keep a steady job. Even more upsetting is his heavy drinking. Two or three nights a week and every week end he drinks himself into a helpless stupor. All efforts on the part of the patient to help him stop drinking have failed. In fact he claims that it is her attitude toward him that makes him drink all the more. He refuses to consult a psychiatrist about his alcoholism, saying that it is entirely a matter of his own free choice whether he drinks or not. The patient suffers from conflicting thoughts whether to break up the marriage or try to

keep it going.

Her background was that of a small town girl growing up in a farming area in the West. Her parents were hard-working, religious people of the soil concerned with the immediacies of survival. She feels that she and her brother, five years younger, were raised in a fair and kindly spirit, her only criticism being that her father kept himself aloof from the jolly, rough-and- tumble play she saw carried on by other fathers with their children. On graduating from high school, she left home for a job in the city. First a clerk, she studied nights and advanced to a position as secretary in the company she works for at present. Three years ago she met her husband, at that time also employed by this company, and, after six months' courtship, they married. The husband drank only socially when she first knew him, but in the past two years he has become increasingly alcoholic.

Therapy thus far has consisted mainly of an expression of her feelings about the job and her husband, with some clarification of the second problem as being primary. The clinical diagnosis is a reactive depression complicating a character neurosis. The working dynamic diagnosis concerns the patient's orientation toward men, her husband in particular, and her participant role in a symbiosis with an alcoholic. Up to this point in therapy the therapist's remarks have consisted mainly of interpositions with an occasional comment to the effect that she feels protective as well as resentful toward her husband. The next five interviews are given in some detail.

Interview 15.

Today the patient is talking about many of the little habits and mannerisms her husband (John) has which irritate her. He never can sit still, he is always making some kind of noise with his mouth or nose, and he is inattentive about his clothes.

Pt.: His clothes are a sore spot with us. He never cleans or brushes them. If I'd let him, he would wear the same suit for days. I have to get after him constantly to change his underwear. And he never likes to buy a new suit. We are going down tomorrow to get him a new suit. He hasn't had one in years.

Ther.: You go with him when he buys his clothes?

Pt.: Yes. I don't trust him. He'd pick out something horrible. That's why I always buy his socks and ties. He has no taste in clothes. He likes bright colors, like yellow ties and green socks. He tries to look flashy, but he's not the flashy type at all.

Ther.: Does he object to your picking out his clothes?

Pt.: No. He seems to like it. Once in a while he used to squawk, but now he accepts it. Other things that I do annoy him, though. Like meals. He doesn't eat much, and he likes things that are bad for him—hot dogs and pie. I try to see that he has a balanced diet, fruit and vegetables. Yesterday we planned to have dinner at six. About four-thirty we went past a hot-dog stand and he wanted one. I told him it would spoil his appetite for dinner. He blew up, said I never let him have his own way. He's right as far as eating goes. But I do it for his own good.

Her concern over the husband's clothes and food and the way she dominates him "for his own good" point to her concept of him as a child requiring her motherly care. The therapist makes a clarification interpretation in the form of a question.

Ther.: It seems you are very worried about his diet. Are you afraid he will get sick?

Pt.: Yes, I am. John is quite thin and gets colds easily. And his drinking. I've read that if you drink a lot and don't eat the right things you're liable to get liver cirrhosis or a vitamin deficiency. God, we had a terrible time the other night. He came home drunk and kept on drinking. I didn't say anything to him about it because I'm beginning to see that it's hopeless. I can't do anything about it. He kept on drinking bourbon and stumbling around. I went to bed. About three o'clock I woke up and he still hadn't come to bed. So I went into the kitchen and he was lying there out cold. I tried to drag him but he's too heavy. He came to a little and pushed me away. He wanted to walk by himself. Now I know what they mean by "blind drunk." He just couldn't see things. He'd crash right into a table, fall down, get up again and smack into the door. Finally he let me put him to bed. When he gets that bad he's just like a helpless baby.

Ther.: Maybe that gets close to your feeling about him when he's sober, too. Buying clothes for him, looking after what he eats, protecting him from sickness—those are all things that mothers do for their children.

Pt. (*hesitantly*): Yes. I suppose so. Although I don't want to be a mother to him. Another thing that happens is, he gets so drunk that he's still drunk in the morning and can't go to work. That's why he can't hold a job. He doesn't show up regularly and they fire him.

The initial confrontation apparently does not sink in. She is hesitant to accept it and moves away from it in another direction. However, such understandings develop slowly and in small steps. The opportunity will arise again to show her this aspect of her marital relationship. The therapist's next question keeps her close to the general mother-child area.

Ther.: Do you get breakfast for him when he's drunk in the morning?

Pt.: Sometimes I leave orange juice for him to drink. Usually I'm so furious when he doesn't get up for work that I just leave. What bums me up is that I have to get up to go to work so that we'll have enough money to get by on.

She then continues to speak of their financial problems and his irresponsibility in money matters. She doesn't trust him to run a checking account and pays all the bills herself. More and more a picture of

this marriage develops in which, while he appears as the weak and submissive child bitterly taking refuge in the infantile oblivion of alcohol, she is the strong, managing, and domineering mother-figure. The interaction of the personality configurations of this couple illustrates how neurotic processes are shared. The problem for therapy is showing her her contribution to the symbiotic drama without accusingly attacking her self-esteem. Of greatest value will be her involvement of the therapist in a transference similar to the relationship with her husband.

Interview 16.

> **Pt.**: What you said last time about being a mother to John struck me. I was thinking about it afterwards . ..

Testimony that the seemingly dismissed interpretation of the last interview had an impact and echo.

> **Pt.**: . . . how that works. I do treat him like a child. Then I was thinking about other men I knew before I was married. Something of the same happened there. For instance, I went with a fellow for about two years. My girlfriend said he was a mouse and that I led him around by the nose. At the time I couldn't see it, but I can now. He used to like to go fishing, but I hated it, so we always did what I wanted to do on weekends. I had to teach him how to dance and how to act in a restaurant.

She continues to describe this relationship, which in many ways parallels the present one to her husband. The man was passive, submissive, and eager to please her. She finally sent him away because he seemed too weak and clinging for her to marry. She then takes up the topic of her ideal man.

> **Pt.**: All my life I had a clear picture of the kind of man I would like to marry. He is a tall, strong, clean-cut type, very successful and very intelligent. In my day-dreams I would meet him at a party, he would pay more attention to me than to any of the others, and eventually he would become completely devoted. I always liked the idea of a man doing all sorts of the little conventional things you see in the movies—bringing flowers, presents, surprise trips.
>
> **Ther.**: Did you ever meet anyone who filled this ideal?
>
> **Pt.**: Only once. About a year ago we met a couple at a bridge club we belong to. He seemed like a god to me, but he mostly ignored me. Somehow I always knew I'd never really get such a dream man.
>
> **Ther.**: You wanted a strong man, but you always wound up with weak ones.

A comparison interpretation contrasting her wish-fantasy with her reality behavior.

> **Pt.**: Yes, that's right. I know it can't be coincidental. I must attract weak ones. I know that I feel sure of myself with

men like my husband when I first meet them. Maybe I can tell that they are drawn to me. Or maybe that I can run them around. That's a horrible way to be. I used to laugh at women who nagged their men, but I guess I'm just as bad. (*Weeps.*)

The therapist waits for her to regain control of her feelings. When she is able to speak again, he asks a question designed to elucidate the marital relationship.

Ther.: When you first met your husband, was he immediately drawn to you?

Pt.: In a way. He worked in the same office I did. We started having lunch together . . . .

It develops that at first the patient did not feel her future husband to be the child he seems now. He was a witty, lively sort of person who amused her greatly. Once sexual intercourse began, she found it more pleasurable than she had ever experienced before. This to her was proof that it would be a happy marriage.

Pt.: In the past year all that has disappeared. We haven't had any sexual relations for six months and before that only about once a month.

Ther.: Does your husband object to this?

Looking to see if she controls him in this respect also.

Pt.: No. It seems to suit him. He doesn't say anything about it.

Ther.: And does such a period of abstinence bother you at all?

Pt.: No. I seem to have lost my sexual interest. Even during my periods which used to be the time I was most excited, I don't feel it any more. Once in a while I do feel affectionate toward John. Then I hug him or hold him in bed. But that's usually when I feel sorry for him, when I know he's sick emotionally and can't help himself. It's pity I feel, and you can't feel sexually toward someone you have only pity for.

Ther.: Nor toward a sick child. We must stop there for today, our time is up.

The therapist ends the hour with a repetition of the mother- child interpretation, proposing the absence of intercourse as further evidence for this concept.

Interview 17.

The patient begins this hour by speaking of one of her friends at work. Together they criticize

various aspects of the way the company office is operated. Also they confide in one another about their personal problems. The friend is unmarried and gets an allowance from her parents. Thus she is able to spend quite a bit of money on her clothes and personal belongings. She often gives the patient gifts of perfume or jewelry. Not only does this embarrass the patient, who cannot reciprocate, but it angers her in that the friend's largesse emphasizes her own limited funds, most of which are spent on rent, food, and household needs.

All this the therapist listens to without interposition or interpretation, waiting for an opportunity to take up the thread of the previous interview. It comes in connection with a dream.

> **Pt.**: I had a dream last night that I can remember clearly. Usually I can't remember them the next day. It was about dogs. I was standing in a large field. Across the field I could see a dog—an Irish setter—coming through the grass. When he got closer I could see that he, or I guess it must be she, was carrying a little puppy in her mouth. It was a mother dog and her puppy. The puppy was sick I imagined, because his nose was running and he was being carried. Otherwise he could have walked.

Dreams are used in psychotherapy but not fully interpreted in the manner characteristic of psychoanalysis. For example, in psychoanalysis the analyst would attempt to get associations to as many elements in this dream as possible, i.e., track down the detailed thought connection of why it is an *Irish* setter, what a field means, etc. But in psychotherapy the therapist uses the dream as if it were any other type of material presented by the patient. He tries to sort out a theme or pattern in it which relates to the past, present, or transference and then, if the patient's learning state (resistance) is suitable, points out the theme for further discussion. The technique used here at this moment is a typical one.

> **Ther.**: So the dream is about a mother dog and her sick child.
>
> **Pt.**: Of course it must refer to me and John. We've talked about my being a mother and he a child.
>
> **Ther.**: And he gets a lot of colds with a running nose?
>
> **Pt.**: Yes. I wonder why I dreamed about dogs. We don't have a dog. I was thinking of getting one, but then there's no one home in the daytime to take care of him. A dog is like a child. Maybe the dream is about that, too. I always wanted to have children, but now I'm not so sure. I'd never try to raise a child with John the way he is now.
>
> **Ther.**: How is it that you haven't become pregnant?
>
> **Pt.**: I was pregnant once before I was married and had an abortion. But you mean with John. At first we didn't even talk about having children. I don't know why. When I got to know him better, I got the feeling that he didn't want to have children. When I brought the subject up, he'd say we couldn't afford it or we didn't have enough room in

the apartment. But I could tell that he really didn't like children. Sometimes we visit a neighbor who has children, and John ignores them. He won't play with them or talk to them. Says they're noisy brats who don't know their place.

Ther.: So you haven't tried to get pregnant?

Pt.: No. Now, of course, I'm not even sure I want to stay with John. This would be no time to have a baby. Maybe I've always sensed that. I think I know what it is. He would be jealous of a baby. A baby would take away some of the attention I give him.

Ther.: A baby would be a rival for your motherly care.

Here a working-through is taking place. Repeated consideration and interpretation of a central mechanism help to fix it in the patient's consciousness. The dream has served its purpose in reopening the mother-child topic. Its relationship to the patient's pregnancy wishes and concepts is left unexamined.

Pt.: I'm sure that's what he feels underneath. And he's right. I couldn't spend as much time with him.

Ther.: You say you always thought of yourself as having children?

Exploring the strength of her need to have a child or a child substitute.

Pt.: I began to think of having children when I was about fourteen. All my girlfriends would spend hours talking about how many children we would have and what kind. I wanted three, two boys and a girl. I imagined just what they'd look like, where they would go to school, what they would become, and so forth.

Ther.: And your imagined husband was the ideal man?

Pt.: That's odd. I never even thought what their father would be like. My picture of an ideal man came later when I was about sixteen or seventeen.

How the adolescent idea of children without a father might relate to the pregnancy and abortion mentioned in passing is not explored. Such interesting by-paths must often remain untrod.

Interview 18.

After only a few minutes have gone by, the therapist is aware of the presence of an intercurrent resistance. Instead of speaking freely and evenly on a specific topic, the patient appears uncertain and backward. She meanders from subject to subject, and her Comments are punctuated with silences of

atypical length. She overelaborates minutiae and makes no mention of her presenting problems or the material of the preceding interviews.

> **Pt.**: I don't know what to talk about today. (*Pause*.) The other day I learned something interesting. I always like to learn new things. A friend and I were talking about baking. I brought up the fact that I've never learned how to make a pie. She offered to show me, so we went to her place. It's really very simple. First you make the dough. . . .

She gives in detail each step of pie-making. The therapist attempts to circumvent the resistance with a leading question but he is unsuccessful.

> **Pt.**: . . . it came out pretty well. I'm going to try it at home my next day off.
>
> **Ther.**: Does your husband like pies?
>
> **Pt.**: Not especially. He doesn't pay much attention to what he eats. (*Pause*.) Then I saw my other girlfriend, the one at work. She and I plan to go to a lecture together on psychology. She was the one who first became interested in psychology and psychiatry. She went to a lecture series and then began doing some reading. One day I saw a book on psychiatry on her desk. From then on it was our favorite topic of conversation. (*Long silence*.)
>
> **Ther.**: What are you thinking about?
>
> **Pt.** (*uneasy*): Something I read in one of the books. I can't remember which one. I liked the one by S. the best. It made a lot of sense to me. (*Silence*.)
>
> **Ther.**: You seem to have some trouble talking today.
>
> **Pt.**: I know. I was sure you'd notice it. I don't hide it very well when there's something I find hard to talk about.
>
> **Ther.**: Why is it hard?
>
> **Pt.**: I don't know. It just is.

Meeting a resistance, the therapist wonders first about its motive and content in terms of the transference. A further clue is that it has some association with her reading in psychiatry, an activity bound to have bearing on the therapeutic relationship. Hence the therapist gently shakes the transference tree to see what falls.

> **Ther.**: Maybe it's hard because it has something to do with me.
>
> **Pt.**: You're right. I read that in psychotherapy the patient has to tell all her feelings, even those toward the therapist. At the time I didn't think much about it. But when I began coming here I soon found out how hard that is. Lately, maybe because we've been talking about my treating a man as if he were a child, I've noticed that I have that

tendency toward you. Actually I have two separate feelings about you. One is that you are some sort of superman, perfect, always right. But the other is opposite to it. Not that you are really a child, but I feel motherly toward you. Days when you look tired I wonder if you are getting enough rest. Or when you cough I think maybe you are getting a cold and shouldn't sit in this cold room.

Illustrating a mixture of transferences. Her image of the therapist contains elements of powerful-authority, ideal-model, and favorite-child transference. Noteworthy is the fact that her view of the therapist represents a composite of the two men in her life, the fantasied ideal and the reality weakling. That the patient is talking at her normal pace again and is developing a topic, indicates the diminution of the particular resistance. Since the patient, by herself, is coming closer to an understanding of the parallel between therapist and husband, the therapist does not interrupt.

Pt.: Of course my feeling that you should take better care of yourself is maternal. And, as you pointed out once, this is how I react toward John. I'm always worrying about his health. There's no reason I should worry about you. A doctor certainly knows how to take care of himself.

Ther.: Especially if he is a superman.

Pt. (*laughs*): I almost forgot that. It's a funny mixture. How can a superman be a child who needs a mother? Maybe I think that underneath all men are children.

To himself the therapist thinks of the possibility that she wishes to make men children, reduce a superman to the status of a child. Obviously it is no time to interpret such an impulse. The evidence is still scanty, and it must gradually be approached from the standpoint of defense rather than wish. In the next interview a chance for a wish-defense interpretation presents itself.

Interview 19.

Pt.: After last time I gave a lot of thought to that point about how men are children to me. . . .

The extra-interview working through of reflection.

Pt.: . . . I had a good example happen to me yesterday. One of the men where I work was trying to look up something in the files. He looked as if he didn't know what he was doing. To me, anyway, he looked puzzled. As I went over to help him I said laughingly to one of the other girls, "It's all too complicated for the poor boy." When I got there I found out he knew as much about the files as I did. He had found a mistake in them and that's why he was having trouble. But I thought of him as a confused little boy whom I would have to help. That was my first reaction, so it must be a strong desire in me to think of men as children who need me.

The patient goes on to another example involving a young man she was briefly engaged to. Again

she is able now to see many of the mother-child aspects of this relationship. Then she begins to talk about her husband in terms of this theme.

Pt.: Two more things came to me about treating John as a child, a little boy. The first is not just treating him as one but in a way keeping him one. A few months ago he wanted to enlist in the Army. He thinks a war is coming and he would be drafted anyway. If he enlists he'd have a better job. But I thought of all sorts of reasons to talk him out of it. All the time I knew he wanted to be a soldier to see if he could be more of a man, a man among men and not a weakling doing women's work like clerking. (*Pause*.)

Ther.: You said there were two things in this regard. What was the other?

An interposition to keep the patient going.

Pt.: The other was when he wanted to grow a moustache. I had heard other women protesting about their husbands' growing a moustache and I laughed at them because I knew that they didn't like their husbands to assert their masculinity. But when John started it I was the same way. I poked fun at him for trying to be something he wasn't. I shamed him out of it. I kept him a boy, wouldn't let him do what men like to do.

Ther.: Why are you afraid of letting him be a man, more assertive?

A wish-defense interpretation made from the defense side. The therapist does not begin by pointing to her wish to weaken, fetter, and hamstring her husband but to her anxiety over his becoming strong and indomitable. Later the wish will be approached.

Pt.: I'm not sure. Maybe I want to be the boss. Or maybe I'm afraid he would give me a bad time.

Ther.: In what way?

Pt.: Leave me? I don't know.

As yet the childhood derivation of her relationship to men is unknown. The roles of the younger brother, father, and mother in determining her outlook during her formative years await discussion. Eventually the most effective interpretation of her behavior will show her the repetition of a childhood motif in her orientation to both husband and therapist.

We come now to the end stages of therapy. The next chapter concerns the several techniques available to the therapist for bringing therapy to a close. We must admit that it is exceedingly difficult to set up general criteria which decide when therapy should terminate. Absence of symptoms, freedom from work, social, or sexual inhibitions, and the giving and receiving of love with a loved partner are all theoretical goals whose achievement indicates that therapy can end. Few, if any, patients reach this ideal.

In practice, the therapist attempts only to accomplish a limited aim which differs from patient to patient. It may be the relief of a compulsion, or it may be a better marital adjustment with the compulsion remaining. For each inpidual patient the therapist has a particular goal in mind commensurate with the intensity of the patient's presenting problem and his psychological resources in allying with the therapeutic effort to overcome it.