Confrontation in Psychotherapy

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The Place of Confrontation in Modern Psychotherapy

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In this chapter I will describe the place I see for confrontation in modern psychotherapy and psychoanalysis. Because this is a “difficult” subject, both to exposit and in the extent of controversy it provokes, I want first to reach for perspective, in particular on the various psychiatries occupying the contemporary scene.

Today psychiatry is badly fragmented, new people coming into the field find themselves bewildered, and by nothing more than the issue psychotherapy, active or passive? I remember Ives Hendrick’s saying that when he began to teach psychiatry, the great need was to stop the doctors from talking and start them listening. So completely was this achieved that by the time my generation arrived, the great need was to start them talking again. Today they are talking again. Indeed we are in a time of active therapies that stand in the sharpest possible contrast to psychoanalysis, both in their techniques and in their therapeutic claims.

Psychoanalysis has proved itself remarkably adept at understanding patients, down to the smallest details, through formulations of great clarity

and completeness: the whole compromises a wonder of present intellectual life. At the same time psychoanalysts point to extraordinary difficulty *changing* the patients, despite prolonged and frequent contact. Indeed some of the patients appear to get worse, the well-known regression in treatment; and this conclusion is supported by the few good statistical studies there are.

All the while the active therapies, existential analysis, social psychiatry, behavior therapy, biological treatments, marital and sexual treatments, such as those of Masters and Johnson, claim to be greatly changing the patients, a claim they support with often impressive statistics. What is more remarkable, these schools present little evidence of understanding the patients; often they disdain the painfully arrived at understanding of more traditional psychiatry. The younger generation of psychiatrists, for example, turns away even from familiar history taking and psychological examining procedures in its eagerness to get to therapeutic activity.

In short, we have the contemporary spectacle of doctors who understand much and make modest claims of effectiveness standing against doctors who appear to understand little and claim to effect a great deal. Admittedly these remarks caricature a situation more complicated and overlapping, but they do reflect significant parts of present reality. It is as if knowledge were impotent and action blind.

How are we to understand this paradox? Sometimes, it is claimed, the statistics refer to different sets or levels of data. For example, analysts may be changing character, defenses, or patterns of behavior admittedly chronic, while behavior therapists affect only symptoms, social psychiatrists act on the external environment, and existentialists restrict themselves to the patients' values or expectations. The difference in results is said then to be due to these differences in goals.

It is also argued that the active therapists do effect change, but that the change is temporary or purchased at such a price that wiser heads would avoid it. Indeed, the present era of active therapies can be compared to psychotherapeutic trends seventy to eighty years ago. At that time education (which can be compared to behavior therapy), manipulation (which overlaps with social psychiatry), and value reorientation (which suggests existential therapy) were widely advocated and practiced, only giving way, and then not everywhere, to the psychoanalytic effort to reach behind symptoms and syndromes to the historical events and psycho-pathological processes behind, with the goal of modifying these.

The two solutions are at root one: that psychoanalysis appears to be less effective because it attempts to be more profound; or, from the standpoint of the other schools, these claim to be more effective because they are less "profound"; that is, less patient of historical reconstruction and less gingerly

about therapeutic intervention. I doubt that any meaningful reconciliation is likely among many of the viewpoints, certainly not among some of their leaders, because the schools have become polarized, at least in their writings and teachings, though probably not so much in their practices. Psychoanalysis has separated itself very sharply from syndromic, descriptive psychiatry, despite the great need for accurate diagnosis in the determination of analyzability; it has separated itself from the interpersonalists or Sullivanians, despite their contributions to the management of psychotic defenses. (We see in Harold Boris' Chapter Nine the discussion of techniques similar to those of Sullivan, 1940, and Frieda Fromm-Reichmann, 1950.) And psychoanalysis has kept apart from existentialism, despite the work of Avery Weisman (1965) and a very few others; I can find in psychoanalytic writings almost no understanding of existential analysis. These are matters of particular importance in psychoanalytic training, for there is no assurance today that candidates have had adequate training in descriptive psychiatry, for example. Often they have read only in psychoanalysis itself. The result is that today many ambulatory cases of mania, psychopathy, and schizophrenia are taken into intensive psychotherapy or analysis out of diagnostic ignorance. The clinician's surprise is often registered by use of the term so popular today, "borderline."

Partly as a result of the isolation of psychoanalysis, perhaps even more as a result of its growing sophistication and self-consciousness, there has

been a tendency to replace the psychoanalytic therapist by the analytic technician, a path so much followed in the whole of medicine. While the analytic technician may have great deftness, while he may even justly pride himself on not doing obvious harm, one suspects something critical is missing.

It was not missing early in the development of psychoanalysis, when Freud brought himself body and soul to the work. I suspect it began to disappear when the criticism of bias or suggestion was leveled at Freud's scientific claims and when transference and countertransference phenomena began to come clearly into view. Then psychoanalysis entered a second phase, one more like a smooth, slowly moving lake than the wild rapids of its beginning. Analyses lengthened; the doctors fell more silent and gradually quiet; unobtrusive men took the place of conquistadors and conquerors. It was like the consolidation of a new province: after the generals come the administrators, bureaucrats, lawyers. One result was that the old charge of suggestion had largely to be dropped (it was transferred to the patient's having *read* psychoanalysis), for these analysts waited and listened for the transference neurosis to unfold; they were like scientists in their laboratories, painfully checking and rechecking, not discovering but confirming. A neutral, passive, almost aseptic technique developed appropriate to the scientific task in hand. Who could doubt that the transference neurosis occurred spontaneously or that every attempt had been made to avoid the great

artifacts of countertransference? Some well-trained and experienced analysts broke out of this mold, Franz Alexander, John Murray, others; but an attitude of caution or even delicacy prevailed. We can compare it to the Halstead era in surgery, when the emphasis fell on technique and respect for the tissues.

The reaction against the era of consolidation has been strong. Social psychiatry has attacked the analytic concentration on individual patients: must not the social context change, too, if gains are to be kept; or what happens to marriage and family when one person changes and the others don't? Existential psychiatry, for its part, attacked the intellectualism, the attempted separation from value judgments characteristic of psychoanalysis: how real is the scientific neutrality proposed? Behaviorism sought to bring reality gradually but *forcibly* to the patient's attention; otherwise will not his extraordinary capacity for avoidance triumph over every verbal effort? And, in many instances, is not the neurosis in the transference either a pale imitation of the natural neurosis or so overwhelming as to be unmanageable? The behaviorists have asserted that, like the psychoanalysts, they want to attack the neurosis as the patient experiences it in treatment; but that we need more precise control over the exposure of the neurosis and its confrontation by reality.

Analysis has not stood by helpless while these active therapies have more and more caught professional, as well as public, attention. Analytic

literature has increasingly discussed parameters of treatment, alliance formation, and perhaps most important, working through. If I catch the music of recent technical developments, I hear therapists becoming stronger, more personal, more active, even insistent; for does not the neurosis, even clarified, clarified, and clarified again, seemingly bored to death, *remain*, like that legendary guest, the Bore? It is the therapist who more often than the neurosis grows bored and leaves.

Now I do not want to suggest any turning back of the clock. There is no return to the childhood of analytic technique recapitulated in these well-known words (Freud, 1914):

> In its first phase—that of Breuer's catharsis—it consisted in bringing directly into focus the moment at which the symptom was formed, and in persistently endeavouring to reproduce the mental processes involved in that situation, in order to direct their discharge along the path of conscious activity. Remembering and abreacting, with the help of the hypnotic state, were what was at that time aimed at. Next, when hypnosis had been given up, the task became one of discovering from the patient's free associations what he failed to remember. The resistance was to be circumvented by the work of interpretation and by making its results known to the patient. The situations which had given rise to the formation of the symptom and the other situations which lay behind the moment at which the illness broke out retained their place as the focus of interest; but the element of abreaction receded into the background and seemed to be replaced by the expenditure of work which the patient had to make in being obliged to overcome his criticism of his free associations, in accordance with the fundamental rule of psycho-analysis. Finally, there was evolved the consistent technique used today, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the

> patient's mind, and he employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient. From this there results a new sort of division of labour: the doctor uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty, (p. 147)

No, the issues we need to discuss are not suggestions and the radical shaping of analytic content practiced at the turn of the century. The issues concern the "forgotten situation," the relationship of doctor and patient, and, of course, the resistances. To what extent are we able to *enter*, not merely have the patients "relate," the past, those "forgotten situations"? Should we not speak of a need for the doctor and patient to confront one another? And to what extent must we also confront the *resistances*? Harold Boris has already discussed this last brilliantly (Boris, Chapter Nine); I will only add some remarks about resistances that lie in the character.

In summary, I will argue that the vigorous pursuit of all three confrontations, with the past, between the persons, and of the resistances, underlies successful application of the *traditional* therapeutic techniques, such as clarification, abreaction, and transference interpretation; these last *depend upon* confrontation with the past, person, and neurosis. Finally, I will emphasize that this confrontation process cannot be depended upon to occur spontaneously, however elegant and pure the technique or the neurosis; in fact the whole neurotic process is against it. The neurotic process wants to

hide or disguise the past, separate the persons of doctor and patient, and protect the neurosis.

The order in which I discuss these three types of confrontations is not random. I believe that confrontation with the past is the first to be undertaken; this is necessary in order for the therapist to place himself within the patient's world and to overcome the resistances to historical reconstructions. If this is not done initially, the resistances will too much delay and often prevent the work. (Successful confrontation of the past also reduces the need for some of the very subtle and difficult techniques that Harold Boris, Chapter Nine, describes.) On the other hand, confrontation of the persons involved and of the neurosis occurs simultaneously.

Confrontation of the past may seem at first glance the most obvious aspect of all therapy and any emphasis on the word confrontation little more than gilding the traditional lily. God knows, therapy is an historical investigation; it means to uncover the past; the whole procedure aims at a reconstruction of the past into the fullest possible conscious thought and feeling. One aim is to put the past truly behind but not in the sense of a repressed or dissociated forgetting. The past is to be with us but as a companion, not a hidden, secret master. We argue that those who forget or ignore the past are doomed to repeat it.

For what reason, then, do I emphasize *confrontation* with the past? I remember hearing many times in my residency that it did not matter whether a past experience was real or fantasied, that what counted was the experience's psychic reality, the conviction or investment a memory commanded. Much was said about Freud's discovery that reports he had taken to be realities were at least in part fantasies, but less about Ferenczi's (1949) hint that with many of the cases Freud had been right in the first place, that indeed real experiences probably strengthened if they did not initiate the fantasies.

I myself came to a conclusion very similar to Ferenczi's on the basis of comparing psychotic and neurotic perceptions, with a generous assist from Adelaide Johnson (1956). I will not review the whole train of, to me, impressive evidence that I presented elsewhere (1964), but give the conclusion: the old teaching, psychic reality, rather than reality or fantasies, conceals the empirical findings that, where psychic reality becomes so strong that it overrides even contemporary reality (as in hallucinating), such psychotic reality seems more often than not to have behind it a past real experience. I would go so far as to suggest that, in the absence of brain lesions or toxic states, people cannot distort reality to the extent we call psychotic, unless they have actually experienced a similar distortion (presented to them as outward reality) in the past. In essence, the claim is that the psychotic person does not have a distorted reality sense in the way that particular

expression is usually used, does not have a weak ego, so to speak, so much as a strong past. Along this same line Dr. Vicki Levi and I have been drawing together case material from a paranoid man that carries the Schreber argument one step further: not only does the paranoid person suffer from massive amounts of repressed and projected libido, but past experiences of an aggressive nature against the patient have also provided a real basis for the concept of an external persecutor, who at the same time must be loved. (This is surely the conclusion to be drawn from Niederland's (1963) discoveries about the Schreber case itself.) And the patient's appearing unrealistic or psychotic is a function of intrusive past perceptions that must be partly disguised, because the patient still cannot face the reality of the incredible past history.

It is not necessary here to review in any detail the impact of family studies on contemporary psychiatry. Suffice it to say that much more pathology has been observable in even apparently well families than was suspected up to now. For example, much more family violence occurs than was believed possible, more children annually in this country dying at the hands of their own parents than of many physical diseases. We are essentially being asked to make as radical a shift in our views of the normal, as we did when Freud clarified the nature of primary process mental life. Not only do our minds teem with perverse thoughts, and violent ones as well; but the *Ladies Home Journal* picture of ideal family life is as far from reality as is the

Norman Rockwell picture of young Americans full of clean thoughts. Obviously many family relationships are as dangerous as many viruses and cancers, so that external reality as well as internal reality calls for a radical reshaping of our expectations.

We should not, therefore, be surprised to find that our patients' fantasies are matched by their past realities, in many cases. Most of us are not so squeamish, as our profession was a hundred years ago, as to reject the patients' "bad" thoughts; but many of us are still very reluctant to acknowledge the extent of their "bad" homes. This reluctance added to any denial by the patients of the reality of their parents may prevent the historical reconstruction.

The revision of our expectations is important. Too often we may attempt to reach the patient's unconscious conflicts before the parental realities are enough explored and accepted. Such a mistake was implicit in Freud's view of Schreber's experience with his father, radically at variance with what Niederland (1963) discovered. An earlier generation of psychiatrists was, perhaps out of habit or defensiveness, too ready to make the assumption of parental normality. It is not a mistake we should continue.

I appreciate that parents characteristically "change" during psychotherapy and analysis, that some of the initial condemnation of parents

during treatment springs from the disappointments of the child, and that patients must gain perspective on parents, often to the point of reconciliation. This should not obscure, however, any partial justice of the child's complaints, only because it is easier to make a solid peace with parents if their real features are acknowledged, and not just by the patients. Parents may appear to change during treatment precisely because their negative features have been acknowledged. In short, I believe therapists should beware of putting themselves too much in the position of parents by automatically lofty or neutral attitudes toward patients' complaints, lest realistic aspects of the patients' complaints harden the transference neurosis immutably. From such attitudes too, in part, flows the condemnation of analysis as the guardian of society and the "adjuster" of patients.

I make this point at such length because it brings us directly to the issue of confrontation. As long as Vicki Levi's patient remained in doubt about the reality of his past persecution, his reality sense was clouded. A doctor's inability to accept the past reality or, at least, the doctor's insistence on remaining neutral as to whether it was reality or fantasy, assisted in that clouding. When, however, the doctor grew increasingly sure it was real and insisted on the patient's confronting that reality, the contemporary clouding of the reality sense cleared (cf. Rosen, 1955). How is the patient to get help with his "defective reality sense" if the doctor won't believe the truth?

Now, I want to argue that this lesson is not applicable to psychoses alone. Neuroses, too, present us with a clouding of the reality sense, although much more limited and less profound than in psychoses. More often than not, this loss of full reality sense in neuroses is shown by an over-investment in certain objects or by assigning special feelings to them; for example, the phobic patient is not "realistic" about the phobic object, although he may have *intellectual* insight. Similarly, the fetishistic patient *experiences* the shoe as if it were a penis, even though intellectually, even perceptually, it remains a shoe. In every neurosis one comes upon bits of psychosis, what I call neurotic delusions; *i.e.*, misconceptions very heavily defended; the resistance is of psychotic proportion. In these instances I have always found heavy reality contributions. As long as the neurotic person, as well as the psychotic person, remains in doubt about the reality status of these early perceptions, as long as the therapist remains neutral on the issue—early experience, fantasies, or reality?—the patient cannot complete the *historical* reconstruction and take that first step toward freeing up the fixations. He is unable to gain perspective on the past; for in any historical construction, the issue, fact or fancy, is central. The historian has a vital interest in the *truth value* of assertions.

Even more important, the therapist is repeatedly called upon to push through, against the patient's denial or other resistances, an accurate account of early experience. Some part of the patient's feelings is isolated or repressed by means of denial or distortion of some part of an early experience. There

cannot be an abreaction of those feelings until the reality distortion is corrected. We encounter the vigorous correction of such distortion in all Freud's case reports. I am not speaking now of interpretations; instead I mean such statements as, this must have meant so-and-so happened. How can we deal with, even recognize, *fantasies* until we have a clear grasp of *reality*?

This is the essence of my point. Past reality must have its day in court. The delineation of ideas, complexes, conflictual fantasies, and the ego measures brought to bear against them have been the traditional materials of psychoanalysis. I am saying that a third material must stand equally beside them, the patient's historical past; and that this historical reconstruction will not occur spontaneously, even in neuroses. We can truly speak of three analytic tasks; fantasy work, ego work, and historical work.

Now it can be argued that the word confrontation does not belong here, that I am merely describing "clarifications." Certainly it could be cogently argued that to get a bit of reality past many of the resistances we meet a quiet clarification will do better than bombastic insistences; the latter are likely, with many patients, to excite more resistances—than they overcome. That is plain enough. And throughout I never mean to equate confrontation with bombast, screaming, or emotional outpourings of any particular sort. Someone said that Lincoln could make a fool stop and think with a joke or a glance. Many of the most effective confrontations are that quiet or that

homely. The goal is to get the message across, not to be ourselves defeated by the resistances, whatever the method. We want the patients to confront their inner and outer realities, and in the long run it is the therapist alone against the resistances.

Much analytic remembering fails to reconstruct the past; perhaps it is too intellectual or too purely perceptual a recollection, and this failure fully to enter the past opens the way to acting it out. For these reasons, *confronting*, *meeting*, *encountering*, such words as these, seem to me to represent better the work to be done in relationship to the past than such a word as *clarification*. I believe, further, that with some patients, whose pasts have been extraordinarily difficult, it will be impossible to indicate an understanding of their pasts without participating in the correction of their presents, whether by general social or local family interventions. To stand idly by discussing the difficulties of the past while these continue in the present is to convince the patient you have no real grasp of the past.

Of course, as the transference neurosis develops, we will be blamed for the past. That is precisely what we want to have happen. My point is that transference interpretations cannot be convincing if the interpreter does not really understand, first, what he is being blamed for and, second, whether his neutrality and passivity indeed make him resemble in actuality any unfeeling figures of the past.

So much for confrontation with the past. Of course a great many questions remain. We have to ask ourselves, for example, to what extent we *ever* reconstruct the past, to what extent we can speak at all of reality in the past. To me these are philosophical questions, and I can only hope the metaphysicians will not upset irretrievably our rough clinical categories. One clinician I have found useful on this subject is the analyst Samuel Novey. His little book, *The Second Look* (1968), deals entirely with the issue of reconstructing personal histories; further, he has a special interest in those confrontations with the past that occur when a patient returns to the actual scenes of his childhood. He indicates, too, that not only does the transference present us with the past, as do such accidental events as encounters with childhood scenes, but also with *present reality*, which so often matches the past closely enough to trigger off inner confrontations.

The place of confrontation with the person of *doctor and patient* is, of these types of confrontation, the most difficult to discuss and certainly the most controversial. Psychoanalysis prides itself on a technique relatively free of suggestion, personal influence, charlatanry of any kind, despite the abuse it takes on all these counts. Am I suggesting that we return to the time of Mesmer, deepen our voices, and darken our rooms? No, but I do want to suggest that not every personal encounter is quackery or charisma.

We are all well aware that the hidden element in much

psychotherapeutic success is the personality, the character of the therapist. We take pride in this, as well as some scientific embarrassment. I am going to argue that the personality or perhaps better the person of the therapist—where it has not been inhibited out of existence—is a necessary element for applying the traditional psychotherapeutic techniques, that these techniques cannot *take hold* in a completely neutral or passive solution.

We have in our Boston community several very able therapists who do not appear to confront their patients with their persons, who would in fact vehemently deny such aggressive behavior, but whose very presence is itself a great confrontation. One I know seems just to sit there, in his benign quiet way, hardly breathing, but all the while bringing to bear a vast silent request for relevance, feeling, sharing. Many others of us have to raise our voices, kick, or scream to come across one half as much, to encounter so extensively the patient and his neurosis or psychosis.

There is another therapist among us, a Toscanini of psychoanalysts, who is so self-effacing, neutral, objective, so *spare* that the word *personality* hardly applies to him at all. Yet stay a little longer, feel a little more, as the patient must. How many of you could be less than honest with him; would it be possible to find anything in him on which to hang distrust; would not his most casual interpretation sound to you more deeply than the rest of us in chorus? Or, one last example, I know a distinguished woman therapist whose

patience and strength are literally like mountains. Oh, call this literary or hysterical hyperbole all you want, but then be with her a while. Do you mean to tell me that when she makes a "clarification" it is not as different from your mealy-mouthed passive therapist's clarification as Beethoven's *Ninth* is from my whistling "Dixie"? No, there is almost that much difference between them.

I am saying that the medium must carry the message, and if the medium is wrong, or if the medium is missing, there will be no message. The anesthetic is perfect, the diagnosis correct, the nurses skilled, the patient ready, but too often the psychiatric surgeon has no knife.

I think the lesson is clear. We must be careful how we teach objectivity and neutrality, for with many students we will too readily suppress what personalities they have. Of course some need to put away parts of their personalities; but on the whole most psychotherapists are hardly an aggressive lot, not particularly loaded with what the world calls personality; and what capacity they have for confrontation is too readily snuffed out.

I predict that, if we do allow both our knowledge and our capacities for sharing what we know to flourish, both our objectivity and our capacity for intimacy, the tiresome and seemingly endless debate about the value of psychotherapy, will soon expire. Psychotherapy is effective; it can be remarkably so; it often remains only to do it.

Only with the development of the transference neurosis do the precise nature and full extent of the patient's illness become apparent; the doctor then confronts the illness, in both its fantasy and ego components. Those active therapies that do not allow such a development keep themselves from anything like a full knowledge of psychological illness.

The therapist's passivity and neutrality are the essential elements for this full unfolding of the neurotic process. It is true that in psychoses and in borderline and some character states transference (indeed transference psychosis) may develop so rapidly, if the doctor is too neutral and passive, that the treatment situation is irretrievably overrun. It is to such situations that Harold Boris (Chapter Nine) is addressing himself. But with less severe conditions, there is general agreement that some degree of passivity and a considerable neutrality make possible understanding of any particular illness. These are the lenses by which we focus on, we could almost say enlarge, the patient's neurosis. They are truly diagnostic instruments.

Essentially we *lure out*, you might say, unconscious material into the treatment relationship; the result is transference; we replace a repression with a projection. Hysterical types do this most rapidly, with their penchant for dramatic projections; but paranoid people provide the same treatment opportunity, if the doctor can keep ahead of the loss of reality sense. More literal minded obsessional types take longer to develop the projections but

may then have a sharper reality sense to dissect them. A blank screen provides the most faithful and visible reproduction, the blankness demanding neutrality and the screen passivity. All this seems clear and well established among us. It is essentially an experimental method in the best scientific tradition. The doctor arranges for the production of the experimental or transference neurosis so that he can take its measure and determine its treatment.

What am I contributing by using a forcible, affective-seeming word like *confrontation* for the quiet intellectuality of the usual words, *analysis of the resistances*? Of course there are *intellectual* confrontations, but I think we mean by interpretation or analysis something different. It suggests giving the patient a translation or understanding of this piece of his behavior; the implication is that he can take it or leave it. As Paul Myerson (Chapter One) indicates, the word *confrontation*, on the other hand suggests force or blockade, the *imposing* of a counterforce to the neurosis. Alexander's example (Myerson, Chapter One) illustrates this: the patient is irritating; the doctor gets irritated; the two, as it were, cancel each other out, neutralize each other perhaps, so that the progress of the treatment can continue.

Presumably Alexander did not *analyze* his patient's resistance but, instead, attacked it because the patient did not accept that it needed analysis, indeed that it was anything but perfectly justified and sensible. Alexander's

attack made this piece of the patient's behavior ego-alien; it set up an internal conflict, as Boris (Chapter Nine) puts it. Now we are moving toward the heart of the matter.

Attitudes of neutrality and passivity allow the neurosis to emerge in front of the doctor, *provided* the patient's defenses allow such an emergence. If not, only that part of the neurosis consisting of the ego defenses emerges. The doctor is then confronted by the outer structure of the neurosis; his efforts to get *inside* are frustrated, or he is given only bits and pieces. Or, still another variant, the patient allows the doctor detailed, genetic insight, but without affective accompaniments; the patient agrees the doctor may be right, but so what? The patient's main investment remains in himself as a superior being, above anything the doctor can say.

I think many students of psychoanalysis would agree that some of the most important contributions to resolving these difficult situations came from Wilhelm Reich (1933). He highlighted the presence of the neurosis in the character. If I understand the way Reich found he had to make these interpretations, they seem more like confrontations than clarifications. And the reason is obvious. By definition *symptoms* are brought to the doctor for remedy; *character*, on the other hand, is equally much by definition, silent to the patient. The characterological aspects of ourselves are like French glass; others can see in, but we can't see out. What is the passive neutral doctor to

do about these silent aspects of the patients?

One answer is to say, as I have often heard it said, that the psychoanalyst cannot deal with any problem that the patient does not bring him; that is, he must wait for a problem to become *symptomatic*. In this way of thinking, any effort to approach the non-symptomatic is looked on as specifically nonanalytic and thrown into the limbo of parameters. Patients are "analyzable" only if their character problems are very slight or self-resolving. Personally, I believe the declining impact of psychoanalysis in psychiatry, general medical practice, and elsewhere, springs from this self-imposed restriction.

But how is the doctor to remain passive, neutral, and at the same time to take arms against a sea of characterological troubles? In asking this we arrive at the heart of the difficulty. If the doctor leaves his neutral, passive position, does he not prevent the development of the very transference neurosis that successful treatment requires? Or, from the other side, if he remains passive and neutral, do not the patient's characterological problems block either the doctor's view of the transference neurosis or his ability to interpret it meaningfully? I believe this is the central issue of the analyzability problem.

Or the doctor springs on the neurosis, wrestles it down, feels triumphant, only to discover that the neurosis comes back for more and more.

The neurosis has seemingly gained fresh strength from its exercise with the doctor. Again, we can all think of many examples of this too, where the patient's rationalizations match point for point the therapist's interpretations, like a battle spreading along ever-widening fronts. Here there is confrontation all right, but no resolution. We do not want every skirmish to turn into a war.

The neurosis is an active force—it is not simply as Charcot and Janet believed—a weakness of the personality. We know that treatment is a struggle. We would *like* to keep it intellectual; we may be smarter than some patients, even smarter than their neuroses, and have sharper ideas. But we know the voice of reason is weak; it rides a great archaic mount, so we expect to struggle. But grabbing something from a person's grasp seldom prompts them to give it up; the whole force of the reaction is opposite.

Like children lost in the forest we would all wish here for a magic wand to guide us out of this forest. The magic wand would say, "Therapist, yes, you must be passive and neutral and passionate all at once, or all in succession, without any one posture muddling the others." That would be a magic wand! And perhaps the wand would add, "Considering all your training and teachers, and the amount of money you are paid, you should be able to do it."

Well, we *are* in the forest; but we are not children, and there is no magic wand. Perhaps we encounter here one of those basic natural antinomies Kent

wrote about, inherent conflicts that admit of no resolution. Or perhaps we have some psychological equivalent of the Heisenberg principle; we can no more be both passionate and objective than we can know both the velocity and position of certain particles. I am tempted to leave the whole matter there, confident that most of you will insist upon being both active *and* passive, neutral *and* passionate, letting the devil take antinomies and Heisenberg principles. It did not require this discussion to teach us that psychotherapy calls for both objectivity and intimacy, freedom and goals, passivity and activity. I believe, myself, that only the long period of psychoanalytic confirmation I referred to earlier, with its necessary emphasis on neutrality and objectivity, is a period we are leaving behind. And only our having stayed so long there and drunk so deep of those waters can explain our ever having needed to question the necessity of confrontation in the first place. Of course, psychotherapy and psychoanalysis require both clarification and confrontation; of course each is helpless without the other; and of course there must be inherent conflict between them—hence, the art and perhaps never the science of psychotherapy.

But how, in fact, are we to move the characterological to the symptomatic without destroying the treatment? Often we wait for life to do it —by forcing insight on the patients, through the pressure of circumstances or the criticisms of a friend. Of we may act as Alexander did, by a flash of anger that overrides the patient's resistances and establishes the characterological

trait now as a symptom.

The commonest method is neither of these. It is the method Elvin Semrad (1971) succinctly calls “the right hand and the left hand.” We give with one hand, or we spend the credit we have in hand, while at the same time something unpleasant is pointed out. At the moment of special closeness we chance the separation of the patient from a bit of his character. The closeness makes seeing it the doctor’s way possible, a transient identification; and the greater that closeness, the more likely the insight will be kept long enough to be useful. Then the work of understanding can begin. This is not intimacy for its own sake, but to make possible a confrontation and, in turn, analysis.

What this method and Alexander’s have in common is *feeling*, one positive, the other negative. Perhaps that is what is meant by the existential saying (Jaspers, 1900) “Nothing happens until the doctor is touched by the patient” (p. 676). Or perhaps it was said even earlier and in Boston by the old words (Peabody, 1927) “The secret of taking care of the patient is caring for him.” We see here a reconciliation of those polar positions of psychotherapy, objectivity and intimacy, reason and feeling, each so vital, each so helpless without the other: intimacy makes objectivity usable, while objectivity justifies and spends the gained intimacy.

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