THE TECHNIQUE OF PSYCHOTHERAPY

THE "WORKING-THROUGH" PROCESS

LEWIS R. WOLBERG M.D.

The "Working-through" Process

Lewis R. Wolberg, M.D.

e-Book 2016 International Psychotherapy Institute

From *The Technique of Psychotherapy* Lewis R. Wolberg

The "Working-through" Process

Mental health is won only after a long and painful fight. Even in supportive therapy, where goals are minimal, the person clings to symptoms with a surprising tenacity. In reeducative therapy the patient returns repetitively to old modes of living while making tentative thrusts in a new and more adaptive direction. In reconstructive therapy the struggle is even more intense, the patient shuttling back and forth, for what seems to be an interminable period, between sick and healthy strivings.

The initial chink in the patient's neurotic armor is made by penetrations of insight. The patient tries stubbornly to resist these onslaughts. The implementation of any acquired insight in the direction of change is resisted even more vigorously. Only gradually, as anxieties are mastered, does the patient begin to divest neurotic encumbrances.

Change is never in a consistently forward direction. Progress takes hold, and the patient improves. This improvement is momentary, and the patient goes backward with an intensified resistance, retrenching with all previous defenses as the problem is investigated more deeply. Anxiety forces a reverse swing toward familiar modes of coping with fear and danger. This is not a setback in the true sense because the individual integrates what has happened into the framework of rational understanding. With the gain achieved from this experience another step forward takes place. Again, anxiety forces a return to old methods of dealing with stress or resorting to disguised adaptations of one's defenses. In association with this there may be discouragement and a feeling of helplessness. But this time, the reintrenchment is more easily overcome. With the development of greater mastery there is further progress; and there may again be a regression to old defenses. The curve of improvement is jerky, but with each relapse the patient learns an important lesson. The neurotic way of adaptation is used less and less, and as patients gain strength through what is happening to them, they are rewarded with greater and greater progress.

It is discouraging to some therapists to encounter such curious reluctances in their patients toward moving ahead in treatment. The therapist is bound to respond with discouragement or resentment when, after having made an estimable gain, the patient experiences a recrudescence of the symptoms.

Should the therapist communicate dismay to the patient, the latter is apt to regard this as a sign of hopelessness or of having failed the therapist. Actually, there is no need for despondency or pessimism should the patient fumble along, repeat the same mistakes, or backslide when logic dictates that one forge ahead.

One way the therapist may maintain control of personal feelings is to anticipate setbacks in all patients. No patient will be able to acquire new patterns overnight. Each patient has a personal rate of learning, which may not be accelerated by any technical tricks.

Before structural psychic change can take place, it is necessary for patients to amalgamate changes that they have achieved in one area with other areas of their personalities. Analogically, it is as if in a business institution that is failing specific enlightenment comes to one department of the organization. After a new policy is accepted and incorporated by this department, it is presented to the other organizational divisions for consideration. Resistance against changing the status quo will inevitably be encountered, with eventual painful yielding by department heads, executives, and other administrative personnel. Many months may go by before the recommended reforms are generally accepted and put into practice. Not until then will the influence on the business be felt. In emotional illness, too, enlightenment produced by understanding of one facet of the individual's behavior will have little effect on the total behavior until it is reconciled with the various aspects of the patient's personality.

This process of *working through* is usually extremely slow, particularly where basic character patterns are being challenged. One may painstakingly work at a problem with little surface change. Then, after a number of months something seems to "give," and the patients begin responding in a different way to their environment. Gaining satisfaction from the new response, they integrate it within their personalities. The old patterns continue to appear from time to time, but these become increasingly susceptible to influence and replacement with new more adaptive reactions. Having achieved a partial goal, one is motivated to tackle more ambitious aims. The investigative operation is extended toward these new objectives, and the working-through exercise then goes on with retreats and advances until constructive and established action eventuates.

Thus, a patient with a disturbing personality problem came to therapy because of the symptom of

impotence. Understanding of his sexual misconception, with a working through of his fear of performance, opened up the possibility of more advanced objectives. A portion of an important session with this patient follows:

Pt. I saw Jane after I spoke to you. Sexually we got along better than we ever had. She had a good orgasm, and it was really the first time. We've been seeing each other for about 5 months, so it was sort of a milestone as far as I was concerned. And yet, I wasn't, I didn't feel as though I'd done a great thing, as though I'd "arrived" or anything like that.

Th. Previously you had felt—I can even recapture your own words—that if an occasion ever occurred with a person like Jane where you could really function to your own satisfaction and to hers, it would really mean you had achieved your goal. Now that it's come about, it hasn't proved to be anything like you anticipated.

Pt. I said to myself that something seems to be stopping me almost from thinking about it. I said, "Now, let's think about this thing because this is supposedly very important." And I just didn't grasp it, as though there's something you want so much, and you get it, and it doesn't mean anything. I said this ought to give you a wonderful feeling; this should be good for you, that this happened. It was good, but it didn't solve all my problems like I imagined it would. And I don't know whether it's because it's become less important to me. It continually demonstrates this business of I could do such-and-such, if only this were the case. How foolish that is because I thought to myself, "Well, really it's just once. Maybe it should be another time. Maybe I should prove myself again. Once really isn't enough." But I feel I could do it three or four times, or a hundred, and it still wouldn't be enough. *[The patient is apparently aware of the fact that sexual success will not solve all of his problems.]*

Th. As a matter of fact, it is possible that the reason you weren't functioning well sexually with her is that you weren't permitting yourself to enjoy sex for the pleasure value but rather for its value in building you up. *[interpreting his neurotic use of*

Pt. I would guess that I have certainly changed in that respect. It bothered me though that it didn't mean more to me than it did. I thought, "Well maybe that's why it happened," because it didn't mean so much to me. So that we're still really on the same basis, as far as this business is concerned.

Th. Mm hmm.

Pt. I say to myself, "Well, there's three women, Barbara, Martha, and Jane, that I'm sleeping with. I have now reached a point where I, they've all been able to have orgasms. It made me feel comfortable, but not. . . maybe I could be better off if I could think, 'Jesus, I'm terrific, or what a great man I am now'." But I don't feel that way.

Th. It would be a very neurotic thing to build up your self-esteem solely and completely, or largely, on the basis of how you function sexually. That's a facade that will cross you up.

Pt. It would be like evaluating a man on the basis of his appetite. If I would be with a woman and I could only have one orgasm, I would think to myself, "Well, you're not as much of a man as if you had two or three orgasms." And yet, it would be like saying, "If a man eats a plate of oysters, if he eats only one plate, he's not as much a man as if he'd eaten two or three plates." I realize my attitude is ridiculous.

Th. But still you seem to think one way and feel the other way.

Pt. It really is a tough situation. This sort of thing seems to be pretty much the kernel of my difficulty. It radiates in all actions and all spheres. I mean the sexual element now seems to, right now, this week anyhow, seems to be receding somewhat into the background and other aspects becoming important. I see where it's necessary to do more, to alter your personality and your attitudes. A whole new set of values have to be evolved, what's good and what's bad, what's right and what's wrong, the sort of life you want to live and what you want to do about it, which, I presume most people never really figure out. I have toyed with the idea before, but now I want to get into myself more.

Another patient with sexual fears and problems in his marital life was, with continued working through, able to make good progress. His relationship with his wife improved. Sexuality became less compulsive a function; he began to achieve greater assertiveness and a feeling of increased self-esteem. These changes are illustrated in the following fragment of the session that follows:

Pt. Tuesday night I decided to bring some flowers home. It was like a miracle, a tremendous response. In fact my wife's face was so overjoyed that I really felt a little sorry that—well, she'd been so miserable—it just required little things like that, not much to make her happy. I talked to her last night about my work, and she interpreted my actions as rejection. But it wasn't so, I told her. I said the things you really want are the important ones. She said that it's true. I explained to her about my work and eventually I thought I'd be able to spend more time with the children, and I was working toward that end. I feel much more comfortable in the situation. I was afraid that I'd have a compulsion to want to do as many things as possible along these lines, so that she'd know I was thinking of her. And the result would be that I'd have a conflict between wanting to do those things and other things like my work. But I find it's not so. I feel very comfortable, much more comfortable in the situation. I feel that I can do those things if I want to. If I think of something to make her know that I'm thinking of her, it's not an effort really on my part. I don't feel a compulsion to want to do them. In fact, when I got the flowers, I really enjoyed getting them. I would say right now that my situation, therefore, on the whole is a little better. These other things aren't important to me. My wife is enjoyable. I'm more in control of the situation.

Th. You'll be able to make even further progress if you can think objectively about your situation and not act impulsively as you once did.

Pt. Yes, I guess so. I guess being tied up in a situation makes you lose your perspective, but I was so interested in the things that she was actually finding fault with me for, I felt that I concentrated on those, taking them as a personal affront, instead of realizing what they were. I suppose that the situation will change again in some way, but right now I guess things are fairly peaceful, considering everything. I have a great deal of work to do, but I think I'm less neurotic about it; for the first time, I would say, since I've been in business, I am willing and eager to strip myself of as much detail work as possible. Before I was just holding on to it. I made up my mind that this work has to be done and that until I do it, I won't be able to take it easy. The work has to be done before I can take it easy. So I said to myself, "Well, it's really awful because if I had three days like Saturday, where no one bothered me, in a row, I could do it all." So I told my wife that I'm going to have to work a few nights and she said O.K. In fact, last night, I did one of the things that she complained about, I came home late again. But it was wonderful; she didn't complain about it. She greeted me with a smile and said nothing about it. So I could see that that wasn't the important thing. I would say that I feel on the whole that I sort of climbed a little and reached a little plateau, if such a thing is possible.

Th. Well, let us examine that plateau, and see what incentives there are to move ahead. Because virtually, in terms of your goals that you came to see me for originally, you've pretty much achieved those, haven't you?

Pt. I suppose so. The physical symptoms that I had, I don't have them any more. I assume they'll just fade away, because I never think of them. Sexually, I'm functioning much better than I ever did before. So I guess on those two counts I've come a long way. That's true.

Th. In your assertiveness, in your capacity to stand up for your own rights, what about that?

Pt. Well, I'd say there is probably less progress made on that score. We haven't been working on it as much as the other thing.

Th. Well, do you feel that it's been a problem? Do you feel that that constitutes a problem for you?

Pt. Yes, definitely, but now I feel more like a person with rights and things like that, more of an individual than I felt before. But I think I still have a long way to go to feel really an assertive person, I would say. And this may be just a temporary peace that I've achieved. All the elements that caused me anxiety for the past few months have reached the point of equilibrium.

Therapeutic progress is gauged by the ability of the patient to apply what has been learned toward a more constructive life adaptation. The recognition of disturbing drives and the realization that they are operating compulsively do not guarantee that any modification will occur. Nor do they mean that the patient has the capacity for change. The ability to progress depends upon many factors. Foremost is the desire for change. Among the motivating influences here are a sense of frustration induced by an inability to fulfill normal needs and growing awareness that neurotic strivings are associated with suffering far in excess of compensatory gratifications.

The detection of contradictions in the personality structure also acts as a powerful incentive to change. It is, however merely the first step in the reintegrative process. Thus, if a patient exhibits a pattern of compulsive dependency, the mere recognition of dependency and its consequences will not alter the need to cling tenaciously to others. While it may point the way to the more basic problem of inner helplessness and devaluated self-esteem, there is still a need to examine the meaning of the patient's impaired self-esteem as well as to determine its source. Furthermore, there is required an appreciation of the motivating factors in the individual's present life that perpetuate feelings of helplessness. Understanding the origins of one's dependency trend and tracing it to determining experiences with early authorities are important steps, but these too are usually insufficient for cure. As long as basic helplessness continues, dependency has subjective values the individual cannot and will not relinquish. While the irrationality of one's drives may be recognized as well as the unfortunate consequences, one will desperately cling to them, at the same time rationalizing prevailing motives.

Partial insight regarding deep dependency promptings will not eradicate them nor dim their acceptance the remainder of one's life.

Working through, as has been previously indicated, is especially difficult in reconstructive therapy and a description of the process may at this point be helpful. The releasing of the self from the restraint and tyranny of an archaic conscience, freeing it from paralyzing threats of inner fears and conflicts, is an extremely slow process. Ego growth gradually emerges, with the development of self-respect, assertiveness, self-esteem, and self-confidence. It is associated with liberation of the individual from a sense of helplessness and from fears of imminent rejection and hurt from a hostile world.

The process of ego growth is complex and merits a more elaborate description. Fundamentally to encourage such growth it is necessary to cajole the ego into yielding some of its defenses. Within the self the individual feels to weak to do this and too terrified to face inner conflicts. Unconscious material is invested with such anxiety that its very acknowledgment is more than the patient can bear. Rooted in past conditionings, this anxiety possesses a fantastic quality, since it is usually unmodified by later experiences. It is as if the anxiety had been split off and were functioning outside the domain of the ego. In therapy it is essential to reunite the conscious ego with the repressed material and its attendant anxiety, but resistance constantly hampers this process. Promoting resistance is the hypertrophied set of standards and prohibitions that developed out of the individual's relationships with early authorities. These standards oppose not only the uncovering of unconscious material, but also the expression of the most legitimate personal needs.

Working through in reconstructive therapy must be accompanied by a strengthening of the ego to a point where it can recognize the disparity between what is felt and what is actually true, where it can divest the present of unconscious fears and injuries related to the past, where it can dissociate present relationships with people from attitudes rooted in early interpersonal experiences and conditionings. Ego growth is nurtured chiefly through a gratifying relationship with the therapist. The exact mechanism that produces change is not entirely clear. However, the therapist-patient relationship acts to upset the balance of power between the patient's ego, conscience, and repressed inner drives. The ultimate result is a liberation of the self and a replacement of the tyrannical conscience by a more tolerant conscience patterned around an identification with the therapist.

The relationship with the therapist may, however, light up the individual's fears of injury, as well as inordinate expectations, drives, and forbidden erotic and hostile desires. Despite the lenity of the therapist, the patient will keep subjecting the therapist to tests in order to justify a returning to the old way of life. If the therapist is too expressive in tolerance of the patient's deepest impulses, the patient will look upon treatment as a seduction for which one will pay grievous penalties later on. On the other hand, a repressive attitude expressed by the therapist will play in with the patient's residual concept of authority as restrictive and, therefore, deserving of customary evasions and chicaneries. At all times the patient will exploit usual characterologic defenses to prevent relating the self too intimately to the therapist. The patient has been hurt so frequently in previous interpersonal relationships that there is the conviction that danger lurks in the present one. Under the latter circumstance the working-through experiences may take place within the transference relationship itself particularly when the patient is in long-term therapy and the therapist encourages the development of a transference neurosis. Obviously the therapist must have had psychoanalytic training to lead the patient through the rigors of the neurotic transference experience.

Many months may be spent in dealing with resistances that ward off the threat of a close relationship with, and the acknowledgment of certain irrational feelings toward, the therapist. The therapist acts to dissolve these facades by direct attack. Perhaps for the first time patients permit themselves to feel, to talk, and to act without restraint. This freedom is encouraged by the therapist's attitude, which neither condones nor condemns destructive impulses. The patients sense that the therapist is benevolently neutral toward their impulses and will not retaliate with counterhostility in response to aggression. Gradually the patients develop reactions to the therapist that are of a unique quality, drawing upon emotions and strivings that have hitherto been repressed. The release of these submerged drives may be extremely distressing to the patients. Because they conflict so outrageous with standards, bound to reject them as wholly fantastic or to justify them with rationalizations. There is an almost psychotic quality in projected inner feelings and attitudes, and the patients may fight desperately to vindicate themselves by presenting imagined or actual happenings that put the therapist in a bad light.

As the patients experience hostility toward the therapist and as they find that the dreaded counterhostility does not arise, they feel more and more capable of tolerating the anxiety inevitable to the

release of their unconscious drives. They find that they can bear frustration and discomfort and that such tolerance is rewarded by many positive gains. Finally, they become sufficiently strong to unleash their deepest unconscious drives and feelings, which previously they had never dared to express. Projecting these onto the person of the therapist, the patients may live through infantile traumatic emotional events with the therapist that duplicate the experiences initially responsible for their disorders. The latter phase occurs when the patients have developed sufficient trust and confidence in the therapist to feel that they are protected against the consequences of their inner destructive impulses.

Sexual wishes, hostile strivings, and other drives may also suddenly overwhelm the patients and cause them to react compulsively, against their better judgment. The patients almost always will exhibit behavior patterns, both inside and outside the therapeutic situation, that serve either to drain off their aroused emotions or to inhibit them. They may, for instance, in response to feelings of rage, have a desire to frustrate and hurt the therapist. Accordingly, they will probably have but tend to suppress imprecations and derisive feelings about the therapist, minimizing the latter's intelligence, or emphasizing any shortcomings. They may become sullen, or mute, or negativistic.

These reactions do not always appear openly and may be manifested only in dreams and fantasies. Sometimes hostility is expressed more surreptitiously in the form of a sexual impulse toward the therapist, which may have its basis in the desire to undermine or to depreciate. At the same time the patients realize that they need the love and help of the therapist, and they may feel that expression of hostility will eventuate in rejection. They may then try to solve their conflict by maintaining a detached attitude toward the therapist, by refusing to verbalize freely, by forgetting appointments, or by terminating treatment.

A danger during this working-through process is that the patients may act out inner impulses and feelings and fail to verbalize them. This is particularly the case where the patients are given no chance to express everything that comes to mind. Such acting-out has a temporary cathartic effect, but it is not conducive to change. If the patients do not know what they are reliving, they will think that their reactions are completely justified by reality. If acting-out goes on unchecked, it may halt the therapeutic process. The most important task of the therapist here is to demonstrate to the patients what in the therapeutic relationship is being avoided by acting-out.

As the patients realize that their emotions and impulses are directly a product of their relationship with the therapist, they will attempt to justify themselves by searching for factors in the therapist's manner or approach that may explain the reactions. Inwardly they are in terror lest the therapist call a halt to therapy and thus bring to an end the possibility of ever establishing an unambivalent relationship with another human being. Yet they continue to respond with contradictory attitudes. On the one hand, they seek praise and love from the therapist, and, on the other, they try to repudiate and minimize the therapist. They resent the tender emotions that keep cropping up within themselves. The battle with the therapist rages back and forth, to the dismay of both participants.

One of the effects of this phase of the therapy is to mobilize ideas and fantasies related to past experiences and conditionings. The transference relationship is the most potent catalyst the therapist can employ to liberate repressed memories and experiences. As the patients express irrational impulses toward the therapist, they become tremendously productive, verbalizing fantasies and ideas of which they were only partially aware.

Sooner or later the patients discover that their attitudes and feelings toward the therapist are rooted in experiences and conditionings that date to the past; they realize that these have little to do with the therapist as a real person. This has a twofold effect: first, it shows them why exaggerated expectations and resentments develop automatically in their relationships with others; second, it permits them to see that they are able to approach people from a different point of view.

The transference is a dynamic, living experience that can be intensely meaningful to the patient. Recovery of repressed material is in itself insufficient. The material has to be understood, integrated, and accepted. During reconstructive therapy much material of an unconscious nature may come to the surface, but the patients will, at first, be unable to assimilate this material because it lies outside the scope of their understanding. In the transference relationship the patients are able to feel their unconscious impulses in actual operation. They realize them not as cold intellectual facts but as real experiences. The learning process is accelerated under such circumstances.

The transference not only mobilizes the deepest trends and impulses, but also it teaches the patients that they can express these without incurring hurt. This is unlike the ordinary authority-subject

relationship, in which the person feels obligated to hold back irrational feelings. Because of the therapist's tolerance, the patients become capable of countenancing certain attitudes consciously for the first time. They appreciate that when they express destructive attitudes toward the therapist, these do not call forth retaliatory rejection, condemnation, or punishment. They gradually develop a more tolerant attitude toward their inner drives, and they learn to reevaluate them in the light of existing reality rather than in terms of unconscious fantasies and traumatic events in the past. As they undergo the unique experience of expressing their deepest strivings without retaliation, they also begin to permit healthy attitudes to filter through their defenses. The therapist becomes an individual who fits into a special category, as less authority and more the friend.

The tolerant and understanding attitude of the therapist provides a peculiar attribute of protectiveness; for the patients alone are unable to accept inner conflicts and impulses and use the therapist as a refuge from danger. The conviction that they have a protector enables them to divulge their most repulsive dreams, impulses, emotions, memories, and fantasies, with an associated release of affect. Along with growing awareness of their unconscious drives with placement in the time frame of earliest childhood, the patients sooner or later discover that there is a difference between what they feel and what it actually going on in reality; they find that their guilt feeling and anxiety actually have no basis in fact.

The patients may bring up more and more painful material. Encouraged to express themselves, they begin to regard the therapist as one who bears only good will toward their repressed drives. They will continue to exhibit all of their customary interpersonal attitudes and defenses in their relationship with the therapist, but they can clarify these to themselves under a unique set of conditions—conditions in which they feel accepted and in which there is no condemnation or retaliatory resentment.

The reorientation in their feelings toward the therapist makes it possible for them to regard the therapist as a person toward whom they need nurture no ambivalent attitudes. Their acceptance of the therapist as a real friend has an important effect on their resistances. These are genetically related to the hurt that they experienced in their relationships with early authorities. The lowering of resistances is dynamically associated with an alteration in their internalized system of restraints, for, if they are to yield their defenses, they must be assured that the old punishments and retributions will not overtake

them. It is here that their experiences with the therapist play so vital a role because in it they have gained an entirely new attitude toward authority. Their own conscience is modified by adoption of a more lenient set of credos.

One of the chief aims of reconstructive therapy is to render the conscience less tyrannical and to modify it so as to permit the expression of impulses essential for mental health. Perhaps the most important means toward this alteration is through acceptance of the therapist as a new authority whose standards subdue and ultimately replace the old and intolerable ones. In the course of the therapeutic relationship the patients tend to identify themselves with the therapist and to incorporate the therapist's more temperate values. The ultimate result is a rearrangement of the dynamic forces of the personality and a reduction in the harshness of the superego.

Identification with the therapist also has a remarkable effect on a patient's ego. Progress in reconstructive therapy is registered by the increasing capacity of the reasonable ego to discern the irrationality of its actions, feelings, and defenses. The rebuilding of ego strength promotes a review of old repressions, some of which are lifted, while others are accepted but reconstructed with more solid material, so that they will not give way so easily to unconscious fears. Growth in the rational power and judgment of the ego makes it possible to identify these destructive strivings, which, rooted in past experiences, are automatically operative in the present.

Ego strength, consequently, results both from liberation of the self from the repressive and intolerant standards of the tyrannical conscience, and also identification with the accepting, non-hostile figure of the therapist. Ultimately, ego growth involves an identification with a healthy group. This is, of course, the final aim in therapy, and a good relation with the group eventually must supplement and partly replace the personal identification.

The undermining of the superego and the strengthening of the ego give the patients courage to face their fearsome impulses, such as hate. They become increasingly more capable of expressing rage openly. The possibility of their being physically or verbally attacked by the therapist becomes less and less real to them. As they resolve their hate and fear, they are likely to experience an onrush of loving emotions. Particularly where a transference neurosis has been allowed to develop, these may burst forth in a

violent form, as in a compulsive desire for sexual contact. In this guise feelings may be loathsome and terrifying and may become promptly repressed. Sexuality, to the mind of the patients, may mean unconditional love or surrender or a desire to attack or to merge with another person. Inextricably bound up with such destructive feelings are healthful ones, but because the patients have been hurt so frequently in expressing tender impulses, they have customarily been forced to keep feelings under control. In their relationships with the therapist they learn that normal demands for understanding and affection will not be frustrated and that these have nothing to do with hateful and sexual attitudes.

As the therapist comes to be accepted as an understanding person, the unconscious impulses come out in greater force, and the patients discover that they are better able to tolerate the anxiety that is created by such expression. In contrast to what occurs in real life, resistance to one's divulgence is not reinforced by actual or implied threats of retaliation or loss of love. The patients then become conscious of the fact that their terror has its source within themselves rather than in an implied threat of hurt from the therapist. This insight does not help much at first, but gradually it permits the patients to experiment in tolerating increased doses of anxiety.

The development of the capacity to withstand pain makes it possible for the patients to work out more mature solutions for their problems, instead of taking refuge in repression, a defense hitherto necessitated by an inability to tolerate anxiety. The discovery that they have not been destroyed by their impulses and the realization that they have not destroyed the therapist, whom they both love and hate, are tremendous revelations, lessening the inclination to feel guilty and to need punishment, and contributing to their security and self-respect.

At this stage in therapy the patients become more critical of the therapist and more capable of injecting reality into the relationship. They attempt to test out their new insights in real life. They do this with considerable trepidation, always anticipating the same kind of hurt that initially fostered their repression. As they discover that they can express themselves and take a stand with the therapist, a new era of trust in the therapist is ushered in with a definite growth of self-confidence. Over and over they work through with the therapist their own characterologic strivings, reexperiencing their unconscious impulses and the accompanying reactions of defense against them. Gradually they become aware of the meaning of their emotional turmoil, as well as of the futility of their various defenses. The continuous

analysis of the transference enables them to understand how their neurotic drives have isolated them from people and have prevented expression of their healthy needs.

A new phase in their relationships with the therapist ensues. Realizing that the therapist means more to them than does anyone else, they seek to claim this new ally for themselves. They may wish to continue the relationship indefinitely, and they may look upon the completion of therapy as a threat. Clinging to their illness may then have positive values. However, they soon begin to understand that there are reality limitations in their present relationship, and they begin to realize that they do not get out of it the things that they are beginning to demand of life, that the outside world is the only milieu in which they can gratify their needs. They find the relationship with the therapist gratifying, but not gratifying enough; their reality sense becomes stronger, and their ability to cope with frustration is enhanced. Finally, they set out in the world to gain those satisfactions that they have never before felt were available to them.

The working-through process is not always accompanied by the intensive transference manifestations such as have been described. Indeed, the relationship with the therapist may be maintained on a more or less equable level, the working through of attitudes, feelings, and conflicts being accomplished exclusively in relation to persons and situations outside of therapy. This is particularly the case in supportive, reeducative, and psychoanalytically oriented psychotherapies in which a transference neurosis is more or less discouraged. But even in the latter therapies it may not be possible to keep direct transference from erupting; if this occurs, some of the working through will have to be focused on the patient-therapist relationship.

Again it must be emphasized that circumvention and avoidance of a transference neurosis do not necessarily limit the extent of reconstructive change that may be achieved by skilled therapists with less intensive therapies than classical analysis. Nevertheless there are some patients in whom repression is so extreme that only a transference neurosis will serve in its resolution. (See also Chapter 42)

EXPEDITING WORKING THROUGH

It is salutary to avoid reinforcing the patient's concept that one is a laboratory of pathological traits.

Our focus on symptoms, conflicts, defenses, and personality distortions may divert us from accenting the sound, constructive, and healthy elements that coexist. Patients are sufficiently alarmed by their difficulties not to need constant reminders of the various ways that these obtrude themselves in their lives. In a subtle way they perceive that the therapist is more interested in their pathological traits than in other aspects, and they may respond to this reinforcement by concentrating on them at the same time that they build a shell of hopelessness around themselves. As they repetitively indulge their neuroses, and the therapist keeps pointing this out to them, they may begin to feel out of control. Ultimately, they may give up and assume the attitude that if they are unavoidably neurotic, they might as well act like heroes in a Greek legend, marching with head up to their inevitable doom.

Neurotic trends are tenacious things and do not yield by constant exposure of their existence or source. They must gradually be neutralized through replacement with more effective and adaptive substitutes. This process will require that the therapist mobilize all positive resources at the disposal of the patients. While one should not avoid acquainting the patients with what they are doing to sabotage their adjustment, and perhaps the reason why, one should at the same time point out what constructive elements are present simultaneously. For example, a saleswoman in therapy who is burdened by a need to fail, destroys again the opportunity of advancement by insulting the vice president of the company, who is in charge of her operations and who is considering her and a colleague for a post that is more interesting, better paying, and more prestigious. The patient eager to have this new job, to her own consternation finds herself engaging angrily in complaints and recriminations about the company's policies and operations charging that the vice president must in some way be involved. The patient reports to her therapist.

Pt. I did it again. I was so furious with myself. I even realized what I was doing while I was letting off steam. I'm just a mess.

Improper Response

Th. You aren't, but what you're doing to your life is. You shouldn't have allowed yourself to criticize your superior directly.

Proper Response

Th. It's obvious to me that you care enough about yourself to be disturbed by what happened. When a similar situation

presents itself that invites you to fail, you will most likely be able to anticipate your response in advance and alert yourself to any sabotage talk.

The patient should be apprised of her active need for cooperation. She must be told that one cannot change without experimenting with certain new actions. Like any experiments she must take some risks, and she must be prepared to face some failure and disappointments, even a few hurts. Successes cannot occur without some failures. The therapist should extend as much help and encouragement as is necessary— but no more. It is important that the patient assume as much responsibility as possible. Role playing here can be helpful.

To summarize, the following principles may be found helpful:

1. Patients must proceed at a pace unique for themselves and contingent on their readiness for change and on their learning abilities.

2. Reinforcement for progress is needed in the form of therapist verbal approval whenever the patient takes a reasonable step forward.

3. If resistances to movement develop, the focus on therapy must be concentrated on understanding and interpreting the patient's resistances.

4. Adjuncts, like assigning homework practice sessions, for the gradual mastery of certain problems may help deal with obdurate resistances.

5. Encouraging the patient to generalize from the immediate situation one aspect of experience, or the control of a symptom, to other experiences may be important. This eventually enables a view of the immediate disturbance in the light of the total personality structure.

6. Adjuncts like role playing may be indispensable.

ILLUSTRATIVE CASE MATERIAL

Illustrative of the working through of transference is the case of a young divorcee with a personality problem of detachment, whose marriage had broken up largely because of her general apathy. Sexually frigid and with little affectionate feeling for people, she had never been able to establish a relationship in which she could feel deep emotion. After a prolonged period of working on her resistances, she began to

evince positive transference feelings toward me, as manifested in the following fragment of a session:

Pt. I had a dream yesterday. We were dancing together, and then you make love to me. Then the scene changes, and there is a fellow sitting on a bench, and you kiss me and in jest ask him to leave. And then you sit down, and I lie down with my head against you. You put your arms around me. And then the scene shifts again, and you and I are in the kitchen. And my daughter, Georgia, is climbing over the sink toward the window, and I pull her in. Then I'm standing there with my son, John, in the hallway and you very professionally ask if there is anyone else I am waiting for. You came to find out about John. You forget the fact that you asked me for dinner, and I'm very let down and wake up with that let-down feeling.

Th. What are your associations to this dream?

Pt. I awoke with the feeling that I'm very much in love with you. I want you to love me very much. It's a desperate feeling that I can't control.

Th. How long has this feeling been with you?

Pt. It's been accumulating over a time, but it suddenly hit me last night, and when I awoke this morning, I knew, *(pause)* This is a funny thing to ask you, but I feel sexually attracted to you. Is it ever permissible to . . .to. . . I mean *(blushes)*

Th. You mean to have an affair?

Pt. Yes.

Th. Well, I appreciate your feeling very much. It often happens that in therapy the patient falls in love with the therapist. This is understandable because the patient takes the therapist into her confidence and tells him things she wouldn't dare tell herself. But in therapy for the therapist to respond to the patient by making love would destroy therapy completely.

Pt. I can understand perfectly. But I felt that you responded to me, (*laughs)* that *you* were in love with me. I think you are the most wonderful man in the world.

Th. You may possibly feel I reject you. It is important though to explore your feelings for me, no matter what these may be.

Pt. I agree, agree with you, of course. I can't see how this happened to me though. It never happened before. It's a hell of a note, but as you say, it must inevitably happen.

There ensued a prolonged period of strife in which the patient veered from sexual to hostile and destructive feelings toward me. The following session, for example, reflects negative impulses.

Pt. I'm furious at you. I don't, didn't want to come today.

Th. Can you tell me why?

Pt. Because you've gotten, gotten me to feel like a human being again instead of a piece of wood, and there's nothing to

do about it. You know very well there's nothing to do about it.

Th. You mean, now you're able to feel about people and there's nothing you can do about expressing yourself?

Pt. (angrily) Oh, please be quiet will you. *(pause)* Here you went and got me all stirred up for absolutely nothing. It's like you want to torture and hurt me.

Th. What makes you think that I want to torture you and hurt you?

Pt. I didn't say you wanted to. I don't believe I've reproached you at all. I never reproach anybody for anything, I never have.

Th. But . . .

Pt. Have I ever implied or said one word of reproach to you? I don't believe I have.

Th. No.

Pt. No. I don't think so. I don't reproach anybody for anything. I don't want you to do anything at all, except just let me walk out of that door.

Th. Do you really want to walk out of that door?

Pt. I'm going to walk out of that door. You see, what you don't know about me yet is that I've a very, very strong will, *(pause)* You sit there in that chair, and I sit here opposite you, and you've got that lovely warm darn way of speaking, and before I reach that door, you'll freeze like an icicle. And I can do exactly the same thing, exactly the same thing.

Th. You mean just to get even with me?

Pt. Have you ever seen me try to get even with anybody? I don't think you have. I'm not a very vindictive person.

Th. Do you think I really act icy to you?

Pt. But you do.

Th. When?

Pt. I went out of here the last time ashamed of myself. I went down that street crying. I was crying. I felt you rejected me, cold to me.

Th. You felt that I rejected you? You felt that I acted cold toward you? When did I act cold toward you?

Pt. Let's drop that rejection business, shall we? It isn't a question of being rejected. It has nothing to do with it at all. And if we get right down to it, what difference does it make whether you do or you don't?

Th. It makes this difference, that I am very much interested in helping you.

Pt. If I walked out of this room, you'd never think of me again.

Th. You feel that if you walk out of this room, I'll never even think of you again.

Pt. That's exactly how I feel! Exactly what I feel. Yes. Suppose you had to do the same thing for every patient. You couldn't last, any more than any other doctor could last, any more than any trained nurse could last. They can't. *(pause)* Well, I'm feeling a lot better getting that off my chest.

Th. I'm glad you're feeling better.

Pt. Yes. I'm sure. I think you owe me quite a little time. I don't believe I've ever stayed here 45 minutes, have I? I don't think so. I've always looked at that clock and I've gone. I've gone to the second at 40 minutes after I got here. *[This is not exactly correct, but I decide not to challenge it.]*

Th. Why?

Pt. Because I don't want anything from anybody. Because I don't want one minute of anybody's time.

Th. You just want to be completely independent?

Pt. Yes, I do.

Th. I wonder if you trust me?

Pt. I've always trusted you. What do you think I'm coming here for? There isn't anybody that is forcing me to come. Who is it that drags me any place on a chain? If I didn't want to come, there isn't anybody that could make me come.

Th. Indeed. You know, too, that it's good that there's nobody that forces you to be here. It has to be completely a free-thing with you, a voluntary thing with you, a thing that you really believe in.

Pt. I don't know what I'm going to do when I have to leave you, when I'm through with this.

Th. Why?

Pt. I can't depend on anybody, see?

Th. You're afraid to get dependent on me?

Pt. I'm afraid to get dependent on any human being, because there isn't a living human being that I can trust. Not even you. I can't trust anybody on earth. And that's the truth.

Th. I can't force you to trust me, but I hope you will. I'll do everything in my power to be worthy of that trust. But I can appreciate the suffering and torment that you must go through as you begin to feel feelings for me.

Pt. But you do torment me.

Th. How do I torment you?

Pt. I think you resent me, even despise me.

Th. Did I ever do anything to give you that impression?

Pt. No, but ... I guess I must *think* you reject me. But you really don't.

The brief samples of the interviews contained here do not permit the detailed and painful elucidations of the genetic origins of the patient's problem. This was rooted in relationship to her early parenting figures. Her mother was a vain, rejecting, narcissistic woman and her father a cold, detached individual to whom she could never get close. She was made to feel that human beings should at all times control their emotions. Her dreams in therapy left no doubt in my mind that she was transferring her repressed feelings related to her father toward me. The working through of her feelings toward a more constructive solution is shown in this portion of an interview that occurred several months after the initial onset of transference:

Pt. When I came to you, you were exactly what I needed at that moment, and you comforted me when I came, and for the first few weeks—it was no more than that—then I began to like you. I liked you more and more, and it was interesting to me that I could feel that way about a person because I had not up to that point. You were the first person that I felt anything for since many, many years ago. So I reasoned it out, and I felt that you were probably ... I didn't know what you were like as a man. I knew you only from a professional standpoint, what you were like. Maybe I would not feel that way if I did know you, I don't know. I was trying to tell myself I didn't know enough about you to feel that way. It wasn't anything sound. And another thing I felt was that you were probably a symbol of what I would like to have or feel for someone, that you just were a symbol. Actually, I didn't know enough about you to feel that way, and I kept telling myself that, and, during your vacation when I left I thought I didn't know how I was going to get along without seeing you. It was really the high point of my week when I came to see you. I looked forward to it, and I really enjoyed that more than anything else that I did. So, during the summer, I thought, "Well, I am going to miss him. How will I get along?" I sort of leaned on you, and I had gotten so much comfort. Then, something began to happen to me, and I felt that even if I felt that way, maybe you did like me very much, maybe you didn't. I don't know whether what you say is all professional. I felt that as far as you were concerned, even if you did like me, and I liked you as you said, which was what I had figured out for myself, that any sort of very close friendship was not possible and isn't practical. I felt that I needed you much more as a doctor than a man at that point and that I should forget about it. So it was something that I was putting on. I probably needed something, maybe it wasn't necessarily you. So I sort of started to look around at men. I was aware more of the attention they paid me. I responded more, which I had never done. I found that I was giving them a little more encouragement because I never radiated any encouragement. I felt that if I were to find someone, I was very happy that I could feel that way about someone. I really was because I didn't think I could any more, I just didn't. I missed seeing you, which was very unusual for me, because I hadn't felt that way about anyone in many years. So I started to look around; as I say I have responded, but I haven't found anyone that I do feel that way about. Of course, I haven't had the opportunity.

Th. At least you are not running away and are not guilt-ridden. You may feel that if the right sort of person came along, there may be a possibility for a relationship. But what about me right now?

Pt. Well, I'll tell you how I feel about that. When I first came here, not the first few weeks, but a little later, I felt that you did like me personally. I don't know how justified I was, but I did feel that.

Th. You mean that I was in love with you?

Pt. Not that you were in love with me, but that you were attracted to me, that you did like me. But, of course, again I said that maybe I was so keyed up; I thought maybe I had sort of colored it, which was unusual for me, because I have never in all my life responded to any man or made the first steps without his feeling a great interest in me. I have never, so that if it was so, it was different than it had ever been because that was never so before. I have never made the first move or picked someone and said I liked him and want to know him, and I'd like to be in love with him. I never felt that way.

Th. It was always as a result of somebody else's actions first.

Pt. Of somebody radiating more than the usual amount of interest. So that I felt that it was different and I was rarely wrong, I mean, I was always right, but, of course, as I say, I was in a different state of mind than I am today. I am much calmer, probably see things a little clearer. So that I felt that you didn't love me, and I hoped that you didn't. In a way I wanted it, and yet I realized that I hoped you didn't because I might respond. I just felt it was wrong because you were the wrong person, because you are my doctor. "So, find somebody else," I said to myself. (*laughs*) As a matter of fact a very funny thing happened. I ran into my uncle who referred me to you shortly after first starting with you. I was beginning to feel that way about you, and I was curious about you. I met him in a restaurant. We talked for a few minutes. He asked me how I was getting along. I said I was making progress. He asked me how I liked you, and I said very much indeed, you were grand. He said he thought so too. You were practical, and he recommended you because he thought you would be what I needed. So I said, "Is he married?" And I was blushing. So he said, "He has an awfully nice wife and some lovely children." I realized then that probably I had radiated something that I hadn't intended to. I must have radiated some interest.

Th. Your reaction to me was one that occurs commonly in psychotherapy.

Pt. I realize this.

Th. Sometimes it's necessary to have such a reaction to get well.

Pt. That's the thing, that's the reason I bring it up.

Th. You might never get well if you didn't have a positive attitude toward me. That attitude we can use as a bridge to better relationships with men. There is a possibility that you may not find a man right away. There is a possibility of that, but at least you will know that it's not because of any block in you; it's not because you have no capacity to love.

Pt. Well, it's been, and I'll tell you it's been an amazing thing. I used to wonder at it myself because I certainly am not cold. I used to wonder at myself because it didn't seem to concern me. I mean sex. That's the truth of it. But I'm getting myself interested now.