



WORKING WITH RESISTANCE

Martha Stark, M.D.

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For Gunnar

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Preface

This book is about the patient's resistance and his refusal to grieve. Drawing upon concepts from classical psychoanalysis, object relations theory, and self psychology, I present a model of the mind that takes into consideration the relationship between unmourned losses and how such losses are internally recorded—as both absence of good (structural deficit) and presence of bad (structural conflict). These internal records of traumatic disappointments sustained early on give rise to forces that interfere with the patient's movement toward health—forces that constitute, therefore, the resistance.

Within the patient is a tension between that which the patient should let himself do/feel and

that which he does/feels instead. Patient and therapist, as part of their work, will need to be able to understand and name, in a profoundly respectful fashion, both sets of forces—both those healthy ones, which impel the patient in the direction of progress, and those unhealthy resistive ones, which impede such progress. As part of the work to be done, the patient must eventually come to appreciate his investment in his defenses, how they serve him, and the price he pays for holding on to them.

My interest is in the interface between theory and practice—the ways in which theoretical constructs can be translated into the clinical situation; to that end, I suggest specific, prototypical interventions for each step of the working-through process.

My contention is that the resistant patient is,

ultimately, someone who has not yet grieved, has not yet confronted certain intolerably painful realities about his past and present objects. Instead, he protects himself from the pain of knowing the truth about his objects by clinging to misperceptions of them; holding on to his defensive need not to know enables him not to feel his grief.

To the extent that the patient is defended, to that extent will he be resistant to doing the work that needs ultimately to be done—grief work that will enable him to let go of the past, let go of his relentless pursuit of infantile gratification, and let go of his compulsive repetitions. Only as the patient grieves, doing now what he could not possibly do as a child, will he get better.

I believe that mental health has to do with the capacity to experience one's objects as they are,

uncontaminated by the need for them to be otherwise. A goal of treatment, therefore, is to transform the patient's need for his objects to be other than who they are into the capacity to accept them as they are.

The patient's need for his objects to be other than who they are fuels the transference. After all, transference has to do with misperceiving the therapist, as both the good parent one never had (illusion) and the bad parent one did have (distortion). There is, therefore, a tension within the patient between his healthy ability to experience his objects as they really are and his transferenceal need to experience them as they are not—in other words, a tension between reality and transference.

In order to facilitate the working through of both the (disrupted) positive transference and the

negative transference, specific interventions are proposed—conflict statements that highlight the conflict within the patient between his knowledge of reality (informed by the present) and his experience of reality (informed by the past). It is the internal tension created through the patient's awareness of that discrepancy that will provide, ultimately, the impetus for change.

As the patient becomes ever more aware of the discrepancy between objective reality and his experience of it, the synthetic function of the ego becomes ever more active in its efforts to reconcile the two elements in conflict—and the balance shifts in favor of reality. It is this synthetic function of the ego that makes necessary the letting go of the past, the renunciation of infantile attachments, and the giving up of the illusions and distortions to which the patient has clung since earliest childhood in order not to feel his pain.

By way of this working-through process, the need to experience reality in ways determined by the past is transformed into the healthy capacity to know and to accept reality as it is, no longer needing it to be different. Transformation of energy into structure, need into capacity, is what enables the patient to relinquish his defensive need not to know. As he finally confronts the reality of the parental limitations, he lets go of the defenses around which the resistance has organized itself. As he gradually gives up his defenses and overcomes his resistance, he becomes freer to experience reality as it is, uncontaminated by infantile wishes and fears. He is sadder perhaps, but wiser too.

In the chapters that follow, I present my ideas about how the patient's failure to grieve fuels the resistance and interferes with the process of healing. Within the context of the safety provided

by the relationship with his therapist, the patient is given an opportunity to achieve belated mastery, is enabled finally to feel the pain against which he has spent a lifetime defending himself. Transformation of infantile hope into mature hope results from the surviving of that pain; by having the experience of grief and discovering that one can triumph over it, the patient finds his way toward realistic hope and mental health.

Author's note: In the interest of simplicity and uniformity, I have decided to avoid the awkward and confusing reference to "he and she" and "him and her." Therefore, in this book everyone is referred to as "he."

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This book is in memory of my friend, Peter Gardner, a colleague and professional photographer, who, knowing that my dream was to write, years ago promised me a photograph for my first book. The photo on the book jacket was indeed taken by him, but he died suddenly and unexpectedly just before the book went to press.

This book is for you, Peter, and for all the colleagues and friends who have believed in me and held me up along the way—knowing, even

when I didn't always, that someday I would get my
book written.

Foreword

The pioneers of psychotherapy quickly learned that an unconscious psychological force worked against a patient's conscious desire for cure. This impediment to change was captured in the term *resistance*. Then, as now, each new understanding of resistance simultaneously opened a door to fresh clinical challenges.

For a long while, Freud found transference to be a troublesome form of resistance to his talking cure. To his surprise, his dedicated care of patients stimulated passions toward him that clouded their reason and worked against the cure of cathartic insight. To bypass these conscious resistances, he tried many techniques including the laying on of hands and hypnosis. He discovered important

unconscious data through these efforts, but his patients' disturbing passions continued unabated. One of Freud's nimblest clinical achievements was to alter his one-sided pursuit of unconscious memory as he realized that transference was not only a very special instance of resistance, but also a golden technical guide for treatment. Rather than hiding the pathological past, he found that transference gave it life with a palpable and very present emotional vividness. Furthermore, focusing on the present consequences of past history was practical and close to the concerns of the suffering patient. Perhaps most important, he discovered that treatment floundered without attention to the pooling of the patient's pain in the doctor-patient relationship. In admitting transference to the therapeutic arena, however, Freud also found the complex defenses of human adaptation. Resistance now had many faces.

Through more than a century of psychological research, a multitude of facets of resistance have been conceptualized and generally accepted, as, for example, the ego mechanisms of defense. Certain concepts have even passed into the public domain as everyday argot. It is not uncommon to hear a person being accused of *projecting*, or being too *intellectualized*. Further sophistication recognized the origin of defenses from basic personality structure, as in the obsessive-compulsive character. Embedded in defenses is a person's mysterious commingling of biology, past, present, and culture. We no longer think of defenses as resistances that are purely avoidant of unpleasure and totally illusory, but rather as activities that are also simultaneously engaged in constructive adaptation to reality. Pathology is the relative balance of illusory avoidance to realistic adaptation. For the therapist, however, this

illuminating knowledge provides clinical conundrums.

If as clinicians we are attuned to the merger of avoidance and mastery in defenses, how do we guard against the danger of throwing the baby out with the bathwater? How do we avoid offensively traumatizing a patient by questioning a cherished way of ordering his or her life? Defensive styles, rooted so firmly in biology and experience, have a tenacity and ruggedness that challenge the impact of rational discussion. How does one gauge the possibility for change? And what of etiologic influences? Which theoretical framework provides orientation in the moment of clinical confusion? Despite an enormity of tactful empathy and a great reservoir of compassionate patience, most therapists suffer irrational countertransferences during intensive work with resistances. How does one convert the insights of countertransference

into useful technique? It is no surprise that the simple term *resistance* has remained part of our clinical lexicon. Resistance is resistant.

Dr. Martha Stark has approached this dense forest of psychic bramble and beauty with mental clarity and persistent declarative statements that mirror the clinical technique recommended for working with the resistance. With great patience, each topic, whether clinical or theoretical, is stated seriously, simply, and repetitively from many angles. Certain key themes and clinical examples are revisited throughout the book, providing an integration that is a veritable literary working-through. Loss, unresolved grief, and other unbearable affects that influence the course of people's lives are emphasized as dynamos that power resistance and underlie the failure to heal. Success in working through resistance reawakens the dormant possibility of that frail but intensely

human quality—choice. In the clinical examples there is often a long list of possible approaches to the clinical issue at hand, accompanied by an equally long consideration of possible outcomes. This obsessive dilemma will be familiar to most clinicians. Paralleling the clinical truth that many roads lead to conflictual Rome, many healing paths are offered as exits. People vary, and so must techniques.

As Freud knew, a positive transference is necessary to sustain the patient's soul while tampering with the intricacies of his or her mind. So, too, this compellingly honest presentation of Dr. Stark's mind and heart, graced by lucid writing, gives the reader an uncommon empathic chance to try on the attractive shoes of another clinician and learn.

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Introduction

Autobiography in Five Short Chapters by Portia Nelson

Chapter 1

I walk down the street.

There is a deep hole in the sidewalk.

I fall in.

I am lost ... I am helpless.

It isn't my fault.

It takes forever to find a way out.

Chapter 2

I walk down the same street.

There is a deep hole in the sidewalk.

I pretend I don't see it.

I fall in again.

I can't believe I am in the same place.

But it isn't my fault.

It still takes a long time to get out.

Chapter 3

I walk down the same street.

There is a deep hole in the sidewalk.

I *see* it is there.

I still fall in ... it's a habit.

My eyes are open.

I know where I am.

It is *my* fault.

I get out immediately.

Chapter 4

I walk down the same street.

There is a deep hole in the sidewalk.

I walk around it.

Chapter 5

I walk down another street.

Why is it that people continue to walk down streets with deep holes, even when they know the holes are there? Why do people keep doing things the same way over and over again, even when they know that doing things that way makes them feel worse and worse? Why do they not do those things they know would make them feel better?

Recently I saw in consultation a very depressed young man who, every day after work, sits in the dark in his living room hour after hour, doing nothing, his mind blank. By his side is his stereo and a magnificent collection of his favorite classical music. The flick of a switch and he would feel better—and yet, night after night, overwhelmed with despair, he does not touch the switch.

There is a “Saturday Night Live” skit in which two guys are sitting around talking, and one says to the other: “You know how when you stick a poker in the fire and leave it in for a long time, it gets really, really hot? And then you stick it in your eye, and it really, really hurts? I hate it when that happens! I just hate it when that happens!”

In this book we will attempt to understand why people feel compelled to repeat, in Paul

Russell's words (1980), that which they would rather not, why they find themselves doing the very things they know they should not be doing, why they find themselves unable to do those things they know they should. For a host of reasons that we will be exploring in depth, people are invested in maintaining the status quo. By clinging to the old, they preserve things as they are. It has been said that we are constantly recreating our pasts in the present, because that's all we know—that we dream of symphonies but confine ourselves to the simple tunes we have sung all our lives. How do we help our patients understand that they have choices about how they live their lives, choices about which streets they walk down, which holes they fall into?

It is people's compulsive repetitions, their recreations of the past in the present, that constitute the resistance. In their lives, in their relationships,

in their work, and, not surprisingly, in the treatment situation itself, people resist change. The hallmark of psychoanalytic work is the attention paid to the resistance.

As we strive to understand how it is that patients resist getting better, we will indirectly also be addressing the issue of psychotherapeutic change—in other words, what it is about the psychotherapeutic process that enables patients to get better. What is it that interferes with healing, and what is it about psychotherapy that promotes healing?

In describing the psychoanalytic endeavor, Freud declared that, just as in chess, the opening moves and some typical concluding situations are teachable, but not what goes on in between—which is what constitutes the actual analytic work. In fact, Freud has only one volume of papers on

technique and never deals in any systematic fashion with the ways in which patients' resistances can be analyzed and worked through. It is this very difficult middle game, as Freud called it, that we will be exploring in this book.

The Concept of Conflict

THE CONFLICT BETWEEN ID IMPULSE AND EGO DEFENSE

It was Freud who introduced the concept of resistance. Not surprisingly, therefore, the concept of resistance is based on a conflict model of the mind. Freud conceived of conflict, which he variously described as neurotic, intrapsychic, or structural, as conflict between id impulse pressing yes and ego defense countering no (with the superego coming down, usually, on the side of the ego). Or, in Greenson's words (1967): "A neurotic conflict is an unconscious conflict between an id impulse seeking discharge and an ego defense warding off the impulse's direct discharge or

access to consciousness” (p. 17).

Although Freud eventually delineated five types of resistance, deriving from three sources (ego, id, and superego), he initially conceptualized the resistance as consisting of those ego forces opposing the rendering conscious of the unconscious id impulses (and their derivative affects). The resistant patient was a conflicted patient was a defended patient.

Although drives were considered part of the id, affects (drive derivatives) were thought to reside in the ego; in fact, it was believed that the ego was the seat of all affects. When Freud wrote of psychic conflict between id and ego, it was understood that sometimes he was referring to conflict between id impulse and ego defense and sometimes he was referring to conflict between anxiety-provoking affect (in the ego but deriving

from the id) and anxiety-assuaging defense.

The patient is sad but does not let himself cry.

The patient is angry but is determined to remain in control.

The patient is upset but tries not to let it show.

The patient is frightened but pretends she is not.

The patient is disappointed but protests that all is well.

The patient is upset, angry, dissatisfied, or hurt; the patient is experiencing some affect that makes him feel anxious, uncomfortable. But he does not like feeling that way and so defends himself against the feeling by denying its existence, by protesting that he does not feel that way, or by insisting that he feels something else entirely; in any of a number of ways, the patient defends himself against the painful or anxiety-provoking affect.

In each such situation, the patient is experiencing an affect that the ego finds intolerable. In order to defend itself against the anxiety aroused by the affect, the ego mobilizes a defense to oppose the affect.

TENSION BETWEEN YES AND NO

On a microcosmic level, the conflict, then, is between id impulse (or its derivative affect) pressing yes and ego defense countering no. I would like, however, to propose that, on a macrocosmic level, there is a tension within the patient between those forces that press yes and those counterforces that insist no, a tension between positive and negative, healthy and unhealthy.

It's important to the patient that she do well on her exam, and yet she just can't seem to make herself study.

The patient has vague memories of “some awful sexual thing” having happened when he was very young, and yet he is unable to recall details.

The patient knows that eventually he must come to terms with just how angry he is with his father, and yet he is not ready to do that.

On some level the patient knows that eventually he must deal with just how disappointed he is in his therapist, but he is hoping that he’ll be able to get better without having to do that.

The patient wants to succeed, but he is not entirely sure that he deserves to make it.

The patient knows that her therapist is not really going to laugh at her, and yet she finds herself fearing that the therapist might.

The patient knows that his therapist doesn’t really have all the answers, and yet he wishes the therapist did.

In his heart of hearts the patient knows that his

mother will never really love him as he wants to be loved, and yet he finds himself continuing to hope that maybe someday she will.

There is always a tension within the patient between his recognition that it is up to him to take responsibility for his life and his conviction that it should not have to be his responsibility, always a tension between his investment in changing and his reluctance to let go of his old ways of doing things, always a tension between his wish to get better and his need to remain ill.

Menninger (1958) writes: "The patient seems to suffer simultaneously from a yearning to 'get well' and a compulsion to defend against any change in his life adjustment" (p. 101). As Freud (1920) puts it, "Every step of the treatment is accompanied by resistance; every single thought, every mental act of the patient's, must pay toll to

the resistance, and represents a compromise between the forces urging towards the cure and those gathered to oppose it" (p. 38).

Ultimately, the force defended against is that healthy (but anxiety-provoking) force within each of us that wills us to change, that force that wills us to let go of the old and to get on with the new, that force that wills us to get better. The counterforce is that unhealthy (but anxiety-assuaging) force within each of us that resists change, that force that clings to the past, wanting to preserve the status quo—whatever the cost. The conflict, therefore, is a conflict between the patient's healthy wish to change and his unhealthy resistance to change.

In other words, the patient both does and does not want to get better. He both does and does not want to remain ill. He both does and does not want

to get on with his life. He both is and is not invested in his suffering. He both does and does not want to be in treatment. He both does and does not want to terminate. He is truly conflicted about all the choices that confront him.

AN OPERATIONAL DEFINITION OF RESISTANCE

The resistance is made up of all those resistive forces that oppose the work of the treatment. In other words, we can think of the resistance, as it gets played out in the treatment situation, as speaking to all those resistive forces within the patient that interfere with the analytic process, all those resistive forces that impede the patient's progress in the treatment.

But what exactly is the work of the treatment? This question must be asked because whatever constitutes the work of the treatment ultimately

gives rise to and fuels the resistance.

Although most of us therapists would probably want to avoid going public with what we feel constitutes the actual work of the treatment, in fact each of us has a pretty clear sense of what we think that work generally entails. For the most part, we believe that the patient should:

1. come to each session
2. be on time
3. pay his bills reliably
4. feel his feelings
5. talk about them
6. not forget from one session to the next
7. try to say whatever comes to mind
8. talk about his childhood
9. reexperience, with affect, traumatic early-on experiences
10. be willing to talk about sex and aggression
11. be open and honest
12. have the capacity for insight

13. be interested in understanding his internal process, his unconscious repetitions, and the part he plays in his life's dramas
14. get angry, not abusive
15. have a mix of feelings about our periodic vacations
16. recognize that we have his best interests in mind and therefore come to trust us over time
17. deliver himself and his pathology into the relationship with us
18. come to let us matter the world to him
19. develop both positive transference and negative transference
20. acknowledge just how angry he is with his parents and, ultimately, with us
21. confront the reality of just how disappointed he is
22. come to understand his investment in maintaining his attachment to his parents
23. come to recognize the price he pays for maintaining such ties

24. confront the reality of his parents' very real limitations and move on
25. recognize the importance of the termination phase
26. complete treatment feeling a lot better about himself and the people around him
27. complete treatment able to accept himself and the people around him for who they really are.

If the patient does not do/feel these things, if he defends against doing/feeling them, then we think of him as resistant. If we tell the patient we are going away for four weeks, we expect that the healthy response will be one that acknowledges his upset, anger, hurt. If he does not admit to such feelings, in our hearts we think of him as defensive, resistant. If the patient wants us to give him feedback all the time, we think of him as resisting the real work of treatment; we believe that he must come to the point where he can

recognize that he should not always be looking to the outside for reinforcement, that he must learn to rely upon his own internal resources.

Let us propose the following: Within the patient is a tension between that which the patient should let himself do/feel and that which he does/feels instead. This latter is, of course, the resistance. Anything that interferes with the patient's doing/feeling the right thing, the healthy thing, is therefore a piece of the resistance.

We would wish that the patient could let himself feel things instead of being so blocked. Ultimately, patient and therapist must work together to get to the point where they can truly understand and appreciate why it is that the patient does not let himself feel things, what his investment is in not feeling.

We would wish that the patient could allow

himself to relax into the relationship with us, and yet he does not appear to be able to do that. Patient and therapist work together to understand all of what interferes with the patient's ability to be in a relationship, perhaps the fear that were he to deliver himself into the relationship he would lose himself, as he once lost himself in his relationship with his engulfing mother.

We would wish that the patient were willing to come each week instead of every other week. Patient and therapist work together to understand why the patient has the need to come every other week, perhaps a need to defend himself against an underlying wish to come every day, perhaps an investment in being self-sufficient because his parents were not people he could rely on.

We would wish that the patient could acknowledge just how awful his parents really

were, and yet he persists in his belief that they were wonderful. Patient and therapist work together to understand why the patient has the need to hold on to the illusion that his parents were wonderful, perhaps because it would simply hurt too much were he to confront the intolerably painful reality of just how awful they really were.

Both patient and therapist, as part of their work, will need to be able to understand and to name, in a profoundly respectful way, both sets of forces, those healthy ones that impel the patient in the direction of progress and those unhealthy resistive ones that impede such progress. Such a naming will make possible ever deeper exploration of the genetic underpinnings of the resistance, how and why it has come to pass that the patient resists doing the very things he must do in order to get better.

ILLUSION AND DISTORTION

Throughout the book I will use the terms *illusion* and *distortion*, both of which speak to misperceptions of reality. I will use the word *illusion* to mean a positive misperception of reality and *distortion* to mean a negative misperception of reality.

There are, of course, many ways to conceptualize the transference. In what follows, I have chosen to emphasize that aspect of the transference that involves a misperceiving of reality. Transference is about the need for one's objects to be other than who they are.

I would like to suggest that when we speak of the patient's experiencing of the therapist as the good parent he never had, we are actually describing a situation of positive transference. Positive transference is about illusion, about the

need to have the therapist be the good parent one didn't have. And I would like to suggest that when we speak of the patient's experiencing of the therapist as the bad parent he did have, we are actually describing a situation of negative transference. Negative transference is about distortion, about the need to have the therapist be the bad parent one did have.

Classical psychoanalysts have used the term *positive transference* in several different ways. Sometimes it would seem to mean, simply, the experiencing of positive, affectionate, loving feelings for the therapist, as one would experience in relation to a good parent. At other times positive transference would seem to mean the experiencing of unrealistically positive feelings, inappropriately affectionate and loving feelings for the therapist.

In what follows, I will be using *positive transference* to describe those situations in which the patient finds himself looking to the therapist to be a good parent—more specifically, looking to the therapist to respond to those of his needs that were not responded to in a consistent and reliable way by his parent early on. A positive transference emerges, therefore, when the patient looks to the therapist to provide now what was not provided early on. When a positive transference is in place, the patient either experiences the therapist (in the here and now) as the good parent he didn't have or is hopeful that the therapist will (in the future) turn out to be the good parent he didn't have. In both situations illusion is involved because the patient is looking to the therapist to make up the difference to him, to be now the perfect parent he did not have early on.

I will be using *negative transference* to describe

those situations in which the patient finds himself experiencing the therapist as the bad parent he actually had. More accurately, the patient either experiences the therapist as the bad parent he had or is fearful that the therapist will turn out to be the bad parent he had. I will discuss this further at a later point, but for now let me say that the patient both fears that his therapist will be bad and, on some level, needs his therapist to be bad.

Although the patient may have an illusion about the therapist as the good parent he never had, the reality is that the therapist is not as good as the patient had hoped. Furthermore, although the patient may have a distorted sense of the therapist as the bad parent he did have, the reality is that the therapist is not as bad as the patient had imagined he would be.

There is always a tension within the patient,

therefore, between his recognition of the reality that his therapist is not as good as he had hoped and his need to see his therapist as the good parent he never had. By the same token, there is always a tension within the patient between his recognition of the reality that his therapist is not as bad as he had feared and his need to see his therapist as the bad parent he did have.

There is always a tension, then, between the patient's recognition of reality and his need for illusion; always a tension between the patient's recognition of reality and his need for distortion; always a tension between reality (which the patient does know, on some level, even though sometimes he chooses to forget) and illusion/distortion (to which the patient clings in order not to have to confront reality).

To put it more generally, there is always a

tension within the patient between his capacity to perceive reality as it is and his need to experience it either in unrealistically positive or in unrealistically negative ways, a tension within the patient between his capacity to perceive reality as it is and his need to experience it as it isn't.

MENTAL HEALTH AND ILLNESS

There are, of course, numerous ways to conceptualize mental health. I would like to propose a definition that emphasizes the patient's capacity to experience reality as it is, uncontaminated by his need for it to be otherwise. Mental health has to do, then, with the capacity to experience one's objects as they are, uncontaminated by the need for them to be other than who they are; it speaks to the ability to accept objects, not needing them to be neither better or worse than they are. Mental illness could thus be

seen as the inability (or perhaps unwillingness) to experience one's objects as they really are. The patient who, early on, was traumatically disappointed at the hands of his parents will, as an adult, have both the intense wish for his objects to be the good parents he didn't have and the desperate fear that they will be the bad parents he did have.

Even though on some level the patient knows better, he is nonetheless always misinterpreting the present, making assumptions about the present based on the past. These assumptions, these expectations, are what give rise to the transference, both the positive transference (in which the patient's wish for good is delivered into the treatment situation and the patient comes to hope that the therapist will be the good parent he never had—what I am here referring to as illusion) and the negative transference (in which

the patient's fear of bad is delivered into the treatment situation and the patient comes to fear that the therapist will be the bad parent he did have—what I am here referring to as distortion).

There is always a tension within the patient, therefore, between his capacity to perceive reality as it is and his need to defend against such perceptions, a tension between anxiety-provoking reality and anxiety-assuaging defense. The patient defends himself against reality by way of clinging to his illusions and his distortions about it. The patient's defenses—the illusions and the distortions—thus constitute the resistance.

There is, therefore, always a tension within the patient between his healthy ability to experience his objects as they really are and his transferenceal need to experience them as they are not—a tension, in other words, between reality and

transference.

When a positive transference is in place, the tension is between reality and illusion. For example, the therapist will not be able to make up the difference to him or right the wrongs done early on, but the patient nonetheless finds himself continuing to hope that the therapist will. When a negative transference is in place, the tension is between reality and distortion. For example, the therapist will not laugh at the patient, but the patient finds himself fearing that the therapist might.

More accurately, perhaps, there is conflict within the patient between what he comes to know as real about the therapist and what he finds himself feeling, tension between the patient's knowledge of the therapist and his experience of the therapist. Whereas the patient's knowledge of

the therapist is informed by the present, his experience of the therapist is informed by the past.

THE REPETITION COMPULSION

It is the repetition compulsion—the patient’s tendency to repeat the past in the present—that causes the patient to deliver into the relationship with his therapist both his wish for the therapist to be the good parent he did not have, which fuels a positive transference, and his fear that the therapist will be the bad parent he did have, which fuels a negative transference. In other words, the patient finds himself longing for the therapist to be good (what we will later be referring to as the patient’s relentless pursuit of infantile gratification in the transference), even as he is needing the therapist to be bad, needing the therapist to confirm his worst fears, his worst expectations (what we will later be referring to as

the patient's compulsive reenactments of his internal dramas in the transference).

That the patient compulsively repeats his past in the present is double-edged. On the one hand, the compulsive repetitions fuel the resistance, fuel the transference. On the other hand, they are the forces that make possible belated mastery of the early-on environmental failures, mastery achieved by way of working through the resistance, working through the transference.

Russell (1982) has suggested that in the repetition is a healthy wish for containment. Intrinsic to the patient's relentless pursuit of infantile gratification is a wish to be stopped. Intrinsic to the patient's compulsive reenactments of his internal dramas is also a wish to be contained. We say of the repetition compulsion, therefore, that it always has both an unhealthy

aspect and a healthy aspect. The repetition compulsion is powered by the unhealthy need to keep things exactly as they have always been, a neurotic compulsion to repeat that which is known, that which is familiar, even if it is pathological. At the same time, the repetition compulsion is fueled by the healthy need to recreate in the here and now the original traumatic failure situation in the hope that this time the outcome will be better.

There is, then, a constant re-creating of the past in the present. The neurotic part of the patient is invested in keeping things the same. The neurotic compulsion to preserve the old in the new is the patient's way of remaining loyal, even after all these years, to his infantile objects. The past is, after all, the only thing he has ever known; it's familiar, it's comfortable, and it's safe.

But the healthy part of the patient wants the resolution, this time, to be different, and so the compulsion to repeat is also powered by the healthy urge to turn passive to active, the healthy urge to transform an experience passively endured into a situation actively created. The wish is for belated mastery, the wish is to be able, at last, to create a different outcome.

The repetition compulsion has also been viewed as having both an id aspect and an ego aspect. There is both a destructive force in the id that presses for a reexperiencing of painful situations and a reparative force in the ego that attempts to master and to integrate those experiences.

ANXIETY-PROVOKING REALITIES AND ANXIETY-ASSUAGING DEFENSES

First I discussed the classical formulation of

psychic conflict as tension between id impulse (or its derivative affect) and ego defense. I then discussed, more generally, the tension within the patient between those healthy forces that insist yes and those unhealthy counterforces that protest no. Now I would like to suggest that another way to conceptualize the nature of the patient's conflict is to think in terms of a tension within the patient between what the patient knows (on some level) to be real and what he experiences as real, the tension between the patient's accurate perceptions of reality and his inaccurate perceptions of it. In other words, now I am speaking to the tension within the patient between reality and illusion/ distortion, reality and transference, or, more generally, reality and defense. Although each of these pairs speaks to a different way of conceptualizing conflict, what they all have in common is the tension within

them between something that creates anxiety and something that eases it.

Let us look, then, at both the thing that creates anxiety and the thing that assuages it.

The thing that creates anxiety is an anxiety-provoking reality of which the patient may be fully aware, only dimly aware, or completely unaware. The anxiety-provoking reality may be an intrapsychic, or inner, reality (a prime example of which would be an affect, like anger or disappointment) or an interpersonal, or outer, reality (something real about an object, perhaps something disillusioning, the knowledge of which makes the patient anxious).

Additional examples of the inner realities defended against include anxiety-provoking impulses, uncomfortable affects, distressing memories, unpleasant experiences, painful losses,

frustrating disappointments. Outer realities defended against include acknowledging the reality of just how bad the infantile object really was and recognizing that the transference object is neither as good as the patient had hoped (which upsets the patient) nor as bad as the patient had feared (which challenges the patient's characteristic ways of experiencing his objects).

The thing doing the defending may be simply one of the many ways the ego protects itself against anxiety (an ego defense), or it may be one of the many ways the ego/self protects itself against knowing the truth about its objects. In other words, the defense that the ego mobilizes may be one of the well-known mechanisms of defense, like isolation of affect, repression, reaction formation, intellectualization, rationalization, or, more generally, a defense like the need not to know, the need to stay in control,

the need to be self-sufficient, the need to avoid being angry, the need not to cry.

But I am now suggesting that in addition to the more familiar intrapsychic defenses, there are also defenses that the ego mobilizes in order to defend itself against acknowledging the reality of who its objects are. Because of his need not to know, the patient clings both to unrealistically positive misperceptions of his objects (illusions) and to unrealistically negative misperceptions of his objects (distortions).

I am proposing, therefore, that we think of defenses as serving to protect the ego/self against the experiencing of anxiety-provoking realities. Whether the protection is of the ego against an anxiety-provoking intrapsychic reality or of the self against an anxiety-provoking interpersonal reality, the defense serves to protect the individual

against the experience of anxiety and/or pain.

Ultimately, the tension within the patient, then, is between reality and defense. More accurately, perhaps, the tension is between an anxiety-provoking reality (whatever the degree of the patient's knowledge of it) and an anxiety-assuaging defense (which determines the patient's experience of that reality). Alternatively, the tension is between the patient's knowledge of reality and his experience of it, the latter a defense against acknowledging the truth about it.

Examples of conflicts include:

The patient knows that he is sad, and yet he does not let himself feel it.

On some level, the patient knows that his therapist would not really shame him, and yet he finds himself fearing that the therapist might.

The patient is upset that he feels no better after

many years of treatment, but he tells himself that he has no right to be angry.

The patient is disappointed that the therapist does not give him the answers, but he cannot tolerate the feeling of being disappointed and so defends himself against the pain of his disappointment by insisting that he is entitled to know.

The patient knows that he must eventually come to terms with just how angry he is with his therapist, and yet he cannot tolerate the thought of being disappointed in him.

On some level, the patient knows that because he had such an emotionally abusive mother, he has paid a steep price in terms of his self-esteem, and yet he remains loyal to his mother and insists that she did the best she could.

The patient knows that he should be coming once a week, not every other week, and yet his fear is that if he were to deliver himself into the relationship with his therapist, he would lose himself.

The patient knows that he should be coming every week, but his fear is that if he were to entrust himself to the therapy, he would be bitterly disappointed (as he was in his parents), and he is not yet willing to take that risk.

The patient is beginning to realize that the therapist is not going to be able to make his pain go away, although he had thought that the therapist could and it had seemed not so unreasonable to hope that the therapist would.

The patient knows he must eventually make his peace with just how disappointed he is in his mother, but for now he cannot imagine ever being able to do that.

The patient is beginning to realize that the therapist is not going to be able to make his pain go away, but nonetheless he finds himself continuing to hope that the therapist will.

Although on some level the patient knows that the therapist does care, it is not always

easy for him to remember that.

Even though the patient knows that the therapist does not answer personal questions, he wishes that the therapist did and feels entitled to know.

In each of the above situations, the patient (on some level) knows and yet (on another level) chooses not to know.

CONVERGENT AND DIVERGENT CONFLICT

In all the examples up to this point, we see conflict between two forces in opposition, one force arising as a defense against the other, in fact dependent upon the other for its very existence. There is, however, another category of conflict, one characterized by conflict between two forces that exist independently of each other, two forces that are mutually exclusive. Kris (1977) has written about this as the distinction between convergent conflict (conflicts of defense) and

divergent conflict (either-or conflicts or conflicts of ambivalence).

The conflict between id and ego is a convergent conflict. Convergent conflicts arise from conflict between two forces where one is a defense against the other, one a direct result of the other. They arise in the context of tension between one force that presses yes and another force that counters such pressure with a no. The counterforce provoked by the force that presses yes is the resistance. Conflict between force and counterforce is convergent conflict.

For example, consider aggressive impulses that are opposed by the forces of repression. The presence of the id aggression arouses anxiety in the ego, which prompts it to mobilize a defense. The repressive force is a direct result of the presence of the aggression. The conflict is

therefore a convergent one.

As another example, consider the wish to change and the fear of change. The presence of the wish to get better arouses anxiety, which prompts the ego to erect a defense. The fear of change is the defense; as such, it is in direct opposition to the wish to change. The fear is mobilized as a result of the wish. This conflict too is a convergent conflict.

The two forces exist in a state of dynamic equilibrium; sometimes that which provokes the anxiety is the more powerful, sometimes that which defends against it. But whatever the relative strengths of the forces, they are both always present, in direct opposition to each other. Furthermore, such a situation can persist indefinitely.

When the classicists speak of psychic conflict, they are usually referring to intersystemic conflict

between id impulse (or derivative affect) and ego defense. By comparison, there are intrasystemic conflicts between forces within a structure, be it the id, the ego, or the superego. There are conflicts between love and hate, active and passive, progression and regression, the reality principle and the pleasure principle, to name but a few. These are divergent conflicts.

Divergent conflicts arise from a struggle between two forces that are mutually exclusive. We are talking no longer about forces in a state of dynamic equilibrium but about forces vying for exclusivity. Either the one or the other will win out, and the winning out of the one is accomplished to the (temporary or permanent) exclusion of the other. Convergent conflicts can be seen as “yes, but ...” conflicts, divergent conflicts as “either-or” conflicts.

With divergent conflict there is of course conflict, but, again, it is between two forces that are independent of each other. With convergent conflict, on the other hand, one force is clearly a defense against the other (in essence, it is a counterforce), and therefore it is something that needs, ultimately, to be worked through. As it is gradually worked through and overcome, the original force can be accessed, utilized, freed up, released.

In the chapters that follow, I will be addressing myself primarily to convergent conflict—to the conflict that exists between forces in direct opposition to each other, the one a result of the other. More specifically, I will be concerned with the patient's experience of the tension within him between the forces in opposition. It is this internal tension, created by the conflict within the patient between his knowledge of reality and his

experience of it, that will eventually provide the impetus for overcoming the patient's resistance.

Clinical Interventions

SITUATIONS OF CONFLICT

In order to demonstrate the ways in which the concepts of conflict and resistance can be applied to the clinical situation, let us think about the following three situations:

1. The patient is obviously upset but is trying hard not to cry.
2. The patient knows that his therapist will not laugh at him but finds himself fearing that the therapist might.
3. The patient is upset with his therapist and knows, on some level, that he must eventually confront the reality of just how disappointed he really is, but he would like to think

that he could get better without having to do that.

In our interventions in these three situations of conflict, we have three options, and we must decide from moment to moment which to choose.

The first option is to come down on the side of the force that says yes—which supports the patient’s health but makes him more anxious and, therefore, more defensive or resistant—and so we would say:

1. “You know that you are sad.”
2. “You know that I would not laugh at you.”
3. “You know that eventually you will have to face the reality of just how disappointed you are in me.”

Here we are naming something that was not previously named, in an effort to make the patient more conscious of an anxiety-provoking reality that he both does and doesn’t know. Actually, we

are naming something that the patient really does know (on some level) but against which he defends himself.

The second option is to come down on the side of the force that says no—that is, go with the defense, go with the resistance, which eases the patient's anxiety by helping him feel understood—and so we would say:

1. "You are determined not to cry."
2. "You find yourself fearing that I might laugh at you."
3. "You would like to think that you could get better without having to deal with just how disappointed you are."

In each of these instances, we are choosing, for the moment, to go with the resistance by naming the defense, in an experience-near, nonjudgmental, nonshaming way. In order to name the defense, we must be able to enter into the patient's internal

experience and be willing to experience the world as he does, so that we can articulate, on behalf of the patient, his stance.

The third option is to do both—first speak to the healthy force within the patient and then, just as he is becoming anxious, come down on the side of his resistance (in order to relieve his anxiety)—and so we would say:

1. “You know that you are sad, but you are determined not to cry.”
2. “You know that I would not laugh at you, but you find yourself fearing that I might.”
3. “You know that eventually you will have to face the reality of just how disappointed you are in me, but you would like to think that you could get better without having to deal with that.”

Such statements I refer to as *conflict statements*. In each instance, the conflict is between the patient’s

knowledge of reality and his experience of it. The conflict statement says, in essence, “Even though your knowledge is that ... , nonetheless your experience is that ...” or “Even though you know that ... , nonetheless you feel that ...”

As the therapist, first you come down on the side of the force that says yes, in an attempt to make the patient conscious of something of which he is either unconscious or only dimly aware. You come down on the side of the conflict that creates anxiety for the patient; but this is a side that needs eventually to be accessed, acknowledged, owned, reinforced, strengthened, before the patient can move toward health. Then you come down on the side of the force that says no, in an attempt to ease the patient’s anxiety, to help him feel understood, to help him feel that you are with him. As the patient comes to understand both his investment in the no and the price he pays for holding on to it,

the defense (the resistance) is gradually worked through and overcome.

Eventually, both patient and therapist must recognize, and be respectful of, the operation of both sets of forces, both the healthy ones that press yes and the resistive ones that insist no. The patient is gradually made conscious of what was unconscious, namely, the conflict within him.

A conflict statement attempts to help the patient articulate both sides of his conflict and, ultimately, to deepen and broaden his understanding of how he has come to be conflicted in the way that he is. It will be as the yes force is strengthened and the no force weakened that the balance shifts toward mental health (yes) and away from pathology (no).

THE CONFLICT STATEMENT

In a conflict statement, therefore, first you name the force that says yes, the positive force that is being defended against because it creates anxiety. In the first situation, the anxiety-provoking yes force is a painful affect; in the second, the anxiety-provoking yes force is the recognition that the transference object is not as bad as the patient had expected him to be (which arouses the patient's anxiety because it challenges his characteristic ways of experiencing his objects); and in the third, the anxiety-provoking yes force is the knowledge that the work to be done involves confronting certain painful interpersonal realities.

Then you name the force that says no, the negative force, the defense, the resistance. In the first situation, the patient's defense is his determination not to cry, his determination not to feel the intensity of his sadness. In the second, the

patient's defense is the assumption that the transference object will turn out to be just as the patient expected him to be (expectations arising, presumably, from earlier experiences at the hands of the infantile object). In the third, the patient's defense is his hope that he can get better without having to face certain painful realities. The therapist names the patient's defense in a way that highlights the fact of it, without implying that there is something wrong with it.

In other words, in a conflict statement the therapist first confronts the defense by highlighting the presence of the thing being defended against, and then supports the defense by coming down on the side of the thing doing the defending. In the first half of the conflict statement, the thing that makes the patient anxious is named; in the second half, the thing doing the defending is named.

The therapist wants to make his interventions as experience-near as he possibly can. To that end, it is crucial that he be ever attuned to the level of awareness that the patient has about both the things that make him anxious and the defenses he uses in order not to have to feel that anxiety. Furthermore, the therapist needs to speak in the language of the patient, so that his words ring true.

WORKING WITH THE PATIENT'S DEFENSES

Let us think about the following scenario. The patient comes to the session five minutes late and insists, with some vehemence, that his lateness has nothing to do with ambivalent feelings about being there, that he wanted very much to come.

The therapist knows that the previous session was very hard for the patient and that, despite the patient's protests to the contrary, the patient must on some level have feelings about that. The

therapist could choose to explore some of those feelings. The patient, in response to the therapist's attempts to ferret out his underlying feelings, might perhaps be forthcoming about such feelings, but more probably the therapist's probing would make the patient dig in his heels, would make him even more defensive. After all, the patient has already insisted, with some vehemence, that his lateness has nothing to do with mixed feelings about being there.

Let us imagine that the therapist decides instead to take the patient at his word and not to insist that the patient admit to having negative feelings about the previous session. The therapist recognizes that the locus of the patient's affect in the moment is his distress, his concern that he will not be believed—thus his vehement insistence that it was important to him to be there. And so the therapist says, "It's important to you that I

understand just how much you wanted to be here today, and on time.” Here, the therapist is going with the resistance, by resonating, in a respectful way, with the patient’s need to have the therapist believe that he wanted very much to come. The patient will feel relieved, because the therapist has appreciated how important it was to him that he be taken at his word.

The therapist must learn to be patient; he must not need the patient to be constantly acknowledging how he is really feeling. There will be time enough to explore how the patient is really feeling when and as the patient becomes less anxious, less defensive. As it happens, later in the session just described the patient began to talk about how difficult it was for him to be in a subservient position in relation to his boss at work and how particularly humiliating it was for him to have to punch in and out on a time clock. The

patient went on to volunteer that it was sometimes difficult for him, in the therapy sessions, to be limited to the 50-minute hour, that in the previous session, for example, he had been struggling to recover some painful memories from his childhood and had experienced the arrival of the end of the hour as extremely disruptive. The patient talked about how painful it is for him in the sessions when he finally “gets going” and begins to get into deep material, only to discover that his time is up. The therapist was then able to direct the patient’s attention to his relationship with his father, a man who was very much wrapped up in his own concerns and unable to give his son much time. The patient wept as he remembered a time when he had been excited about a science project he was working on for school, had asked his father to come up to his room to admire it, and had been bitterly disappointed when his father would not

even make the time to look at it.

The therapist, by not insisting that the patient 'fess up to how angry he was from the previous session and by being willing to take the patient at his word, was able to create a space within which the patient was able, when he felt ready, to find his own way to what really mattered to him, namely, that it was very painful for him that there was never enough therapy time, just as it had been painful for him that there was never enough time with his father. Had the therapist interpreted the patient's lateness as an instance of acting out negative feelings, as speaking to the patient's need to avoid dealing with how he was really feeling, or as arising from a wish to limit his therapy time, then the therapist might never have given the patient an opportunity to acknowledge that in fact it was difficult for him to be limited to so little time. (Shortly afterward, patient and therapist

decided to shift from once a week to twice a week.)

In the above example, in response both to the patient's lateness and to his insistence that the lateness had nothing to do with anything, the therapist appreciated the patient's need to have the therapist take him, and his investment in their work together, seriously. When the therapist said to the patient, "It's important to you that ...," he was being profoundly respectful of the patient's need to be taken at his word. Even though the lateness may well have been a piece of acting out, the therapist was able, eventually, to get to what was really going on by bearing with the patient and giving him an opportunity to talk about what had actually upset him during the previous session.

In general, whenever we use the construction

“It’s important to you that ...,” we are subtly suggesting the defensive nature of the patient’s stance. Without actually telling the patient that we think his need is suspect, we are nonetheless highlighting something that we want the patient eventually to notice, even as we are appreciating that, in the moment, the patient needs us to be on his side.

Examples of other interventions that support the patient’s resistance by reinforcing his defense are the following:

“You are determined not to let me matter that much.”

“You are determined not to let anyone matter that much.”

“You do not want to have to depend on me or anybody.”

“You’re not sure you have all that much to say about the termination.”

“You are not someone who gets angry without good reason.”

“It’s important to you that you be able, always, to feel in control.”

“You do not want to have to think about how sad you are feeling.”

“It hurts too much to think about how disappointed you are.”

When we go with the patient’s resistance, we are careful not to challenge it. We are not interpreting the patient’s defensive posture; we are naming it, highlighting it, defining it. It is his way of constructing his world, and we are respectful of it. We frame our interventions in such a fashion that the patient will feel understood and may even gain further understanding as well. We do what we can to use verbs that emphasize the element of choice in what the patient is doing/feeling; we want the patient, over time, to

recognize and to own the power he has to decide how he wants to experience his world. When we suggest, for example, that the patient is determined not to be angry, or when we suggest that the patient does not want to be someone who is dependent, we are attempting to name the power he has and to make him aware of the choices he is making.

Think about the difference between “You do not have all that much to say about the termination” and “You are not sure that you have all that much to say about the termination.” The advantage to the second intervention is that it lends the patient a little more dignity, highlights the element of choice in the way the patient is dealing with the termination. More generally, whenever we name the patient’s defense, we want to make him ever more conscious of the volitional component to his experience of himself and his

objects; in essence, we want him to move ever closer to owning the ways in which he constructs himself and his world.

In each of the examples above, we are attempting to name, define, or highlight the patient's basic stance in life, his characteristic (defensive) posture in the world. With our help, the patient is being encouraged to define ever more clearly the realities that he has constructed on the basis of his past experiences. Even though they are defensive, these realities are the ways the patient tends to perceive himself and his objects; they speak to his ways of being in the world. When the therapist names the defense, the therapist is encouraging the patient to articulate some of the basic assumptions he has about himself and his objects—his underlying “mythological preconceptions” (Angyal 1965)—in an effort to get the patient to be ever more aware of how he

structures his world.

The patient must understand that he has constructed a view of the world that involves distortion, illusion, and entitlement; he must recognize that he perceives the world through the lens of his distortions, his illusions, and his entitlement. These misperceptions determine the ways in which the patient structures his experience of reality and makes meaning of his world.

As I have been suggesting, even though on some level the patient knows better, he is nonetheless always misinterpreting the present, making assumptions about the present based on the past. When such assumptions, such expectations, are delivered into the patient-therapist relationship, they give rise to the transference, both the illusions that constitute the

positive transference and the distortions that constitute the negative transference.

In essence, the transference is the way the patient misunderstands the present. In order to work it through, a wedge must ultimately be put between the patient's experience of reality (inaccurate perceptions based on the past) and his knowledge of reality (accurate perceptions based on the present). But first, the illusions and the distortions that inform the transference must be uncovered and exposed to the light of day; the patient's ways of perceiving both himself and the therapist must be teased out and named, in an experience-near, nonjudgmental fashion.

Here are more examples of statements that reinforce the patient's defenses:

"You are not yet convinced that it is safe to trust anybody."

“You are not entirely sure that it feels safe in here.”

“You are not yet convinced that I can be trusted.”

“Your fear is that you will be judged.”

“Your fear is that I will judge you.”

“You are hoping that you will find here what you have not been able to find elsewhere in the past.”

“You want so desperately to be understood.”

“You are feeling understood in a way that you never imagined possible.”

“You are determined to find here what you were not able to find in the past.”

“You feel that it is your right to be compensated now for what you suffered as a child.”

“You feel that you must have guarantees.”

“You want me to tell you what to do.”

“You feel that you have already done everything you can on your own.”

Think about the situation that arises when the patient is convinced that he is so damaged from way back that there is really nothing he can do now to get better and nothing he should have to do. He is waiting for the therapist to come through. Meanwhile the therapist is convinced that the impetus for change must come from the patient and so is waiting for the patient to come through.

A good example of such an impasse is something that often happens at the beginning of a session. The patient comes in, sits down. He is quiet, waiting for the therapist to begin. The therapist, also quiet, waits for the patient to begin. The patient thinks it should be the therapist's responsibility to begin the session; the therapist thinks it should be the patient's responsibility.

This is a perfect opportunity for the therapist to tease out some of the patient's underlying

fantasies, namely: (1) that he, the patient, is so damaged, so impaired, that he cannot help himself because he truly does not know how (distortion); (2) that the therapist, an expert in such matters, knows what to do and can make him better (illusion); and indeed, (3) that the patient is entitled to this (entitlement). It is the patient's conviction that "I can't, you can, you should." Sometimes neither patient nor therapist recognizes that the patient is experiencing things in this way but, as long as the patient does, the situation will be stalemated; there will be a therapeutic impasse. It is therefore important that the therapist tease out what the patient's underlying feelings are about who should take responsibility for the work of therapy, so that the feelings can be explored in greater depth and understood as forces opposing the work of the treatment.

In order to get named what may be unconscious assumptions that the patient has about the work, the therapist may say something like, "You're not sure that you know where to begin," or "You're not sure you should have to be the one to start," or "Perhaps you're hoping I will get us started." In this way the therapist encourages the patient to elaborate upon his experience of himself as not able and his wish to have the therapist do whatever needs to be done. Such distortions and illusions need to be uncovered because, as long as they go unacknowledged, the patient may well go through the motions of doing the work of therapy but, all the while, be waiting for the therapist to take the responsibility for making him better.

OWNING OF RESPONSIBILITY AND MOVING ON

Patients present to treatment complaining of

any of a variety of symptoms, like low self-esteem, chronic anxiety, depression, and so on. The first part of the treatment involves helping the patient gain insight into why he is as he is; he is helped to recognize that many of his current problems are the result of things he experienced early on in his relationship with his parents. In essence, the patient comes to understand that it's not his fault that he has turned out as he has.

The second part of the treatment is often much more difficult. It involves helping the patient recognize that although it was not his fault then, it is his responsibility now, in terms of what he does from here on out. Admittedly, he is now a certain way and struggles with certain issues because of things that did and did not happen back when he was a kid; but now, armed with his understanding, what exactly does he plan to do in order to get on with the business of his life? This second part of

the treatment, then, involves translating insight into actual change. It requires of the patient an appreciation of the fact that although it was not his fault then, it is his responsibility now.

The patient may make fairly rapid progress during the first part of the treatment. He comes to understand, at least intellectually, that, for example, he has low self-esteem because he had a parent who was constantly putting him down. He may be able to get in touch with how angry that makes him feel as he thinks about it now. Or, as another example, the patient may recognize that she is drawn to certain kinds of men who, like her father, are initially exciting but ultimately rejecting and that—of course!—her heart will get broken repeatedly because the men she chooses are the last men in the world who will come through for her.

The first phase of the treatment may last anywhere from several months to a number of years. But then there comes a time when the patient begins to complain that despite his newfound insights and intellectual understanding of his issues, he feels stuck and is unable to go forward. Or, alternatively, the therapist begins to get a sense that the patient is stuck and is not getting on with the treatment or his life. Yes, the patient now understands that he is relentlessly self-critical because his mother was relentlessly disapproving, but he can't seem to translate that insight into actual change.

Such a patient may say to us, with incredible anguish, "What do I do now? I understand why I am as I am. I understand how my past has dramatically influenced who I am in the here and now. I am now in touch with and can own a whole range of feelings about my parents. I have raged, I

have wept, I have lamented what was and what wasn't. I have even confronted my parents. But it doesn't get any better, the pain doesn't go away. I'm still hurting all the time and sabotaging myself. I continue to have bouts of depression, my attacks of anxiety, my self-doubts, my confusion, my profound loneliness, my bitterness, my anger, my self-righteousness, my raw sensitivity, my old pain. It is all still part of the way I live each day. What am I to do? How do I get better? How do I get through this?"

One of the things that may be fueling the patient's resistance to moving through this phase of the treatment is his conviction that he is so damaged from long ago that he truly cannot take responsibility for his life and must be helped by way of input from the outside. Such a situation is so common that I have developed several interventions designed specifically to highlight the

underlying distortions, illusions, and entitlement that interfere with the patient's ability to take responsibility for his life.

THE DAMAGED-FOR-LIFE STATEMENT

The first intervention is something I refer to as a *damaged-for-life statement*. In it the therapist articulates what he perceives to be the patient's conviction about his own deficiencies and limitations, a conviction that the patient, perhaps unconsciously, uses to justify his refusal to take responsibility for his life in the here and now. The therapist highlights the patient's distorted perception of himself as a helpless victim and as therefore unable to do anything to make his life better.

The patient may experience himself as having been victimized by bad parenting early on; he may experience himself, more generally, as always a

victim of injustice, a victim of fate, a victim of unfortunate external circumstances; or he may experience himself as having an inborn, constitutional deficiency. In any event, he has a distorted sense of himself as damaged, incapacitated, rendered impotent.

The therapist names the patient's fatalism, his pessimism; the therapist recognizes that on some level the patient feels that the die has been cast, that he is destined for life to suffer, and that there is really nothing that he can do now in order to make things better for himself.

A damaged-for-life statement, then, attempts to articulate some of the underlying distortions to which the patient clings as unconscious justification for his inability or unwillingness to take responsibility for his life. Because such distortions constitute part of the patient's

resistance to moving forward in his life, it is obviously important that they be uncovered and named.

Examples of damaged-for-life statements that uncover underlying distortions are:

“Deep down inside you feel so damaged, because of things that happened to you early on, that you cannot really imagine being able to do anything now to correct it.”

“You feel that you got a bum deal as a kid, and you can’t imagine that you’ll ever be able to compensate now for the damage that was done to you then.”

“Because you were treated so unfairly as a kid, you feel handicapped now in terms of your ability to get on with your life in a self-respecting fashion.”

“You feel so incapacitated, so impaired, so handicapped, that you have trouble imagining how things could ever be any different.”

“You are in such pain, want so desperately to be free of it, and feel that you would do anything in order to get better, and yet you can’t really get a handle on what it is that you could actually do in order to get yourself to feel better.”

In a damaged-for-life statement, the therapist highlights the patient’s experience of damage done early on and then highlights the patient’s experience of his disability now. In essence, the therapist is highlighting the patient’s distorted sense of himself as a victim and as therefore not responsible.

THE COMPENSATION STATEMENT

Many patients feel, on some level, that they become complete only by way of input from the outside. They feel that because of damage sustained early on at the hands of their parents, they are now limited in terms of their own

resources; there is nothing they can do to get themselves better and must therefore rely on input from the outside in order to make up the difference. In what I refer to as a *compensation statement*, the therapist calls attention to the patient's wish to be compensated now for damage sustained early on; the therapist highlights the patient's illusions about being able to find someone on the outside who can make up the difference to him. Whereas the damaged-for-life statement highlights the fact of the patient's distortion, his misperception of himself as a helpless victim, the compensation statement underlines the patient's illusion that the object is a potential provider of the magic, the answers, the love, the reassurance, the things that will heal him and rectify the damage done early on.

If the therapist shares the patient's illusion, if the therapist also believes that the patient will get

better only by way of input from the outside, then it will be much more difficult for the therapist to help the patient work through his inevitable disappointment, disappointment experienced once the patient discovers that the mere act of being gratified does little to ease his pain or satisfy his hunger.

Examples of compensation statements are:

“You wish that I could do something to make the pain go away.”

“You would like me to tell you what to do and where to go from here. You can’t imagine that, on your own, you could ever figure out any of your own answers.”

“You find yourself looking to me to give you the respect that you have such trouble giving yourself.”

“You wish that I could reassure you that all your hard work will eventually pay off. You are not sure that you, on your own, can give

yourself such reassurances.”

“You wish that I could tell you what to do.”

“You wish that I would tell you what to do.”

“You feel you can’t do much more on your own.

At this point you wish that I could do something to help you out.”

“You feel you can’t do much more on your own.

At this point you would like someone else to tell you what to do.”

“Because you feel so confused and so lacking, you find yourself looking to people on the outside for direction and guidance.”

“At times like this when you are feeling completely empty and despairing, you begin to feel that you’ll never get better unless someone can help you out.”

“When you are feeling desperate, as you are now, you find yourself wishing that someone would understand and would come through with something to ease the pain.”

Eventually the patient must come to understand that what he is holding on to is an illusion. By having his wish for sustenance from the outside highlighted, the patient eventually has to face the truth—namely, that his wish to be healed by way of external provision is illusion, not reality. Were the therapist instead to name the reality, then the patient would be made anxious and might well get more defensive. The most effective intervention, therefore, is the therapist's naming of the patient's underlying illusions about his objects.

THE ENTITLEMENT STATEMENT

The third intervention is what I call an *entitlement statement*. In it the therapist recognizes that the patient not only wishes for input from the outside but also feels entitled to such input, feels that it is his due, his right, his

privilege to have someone from the outside make up the difference to him. Because he feels so cheated from long ago, he believes that he is now entitled to compensation in order to make up for the environmental failures early on.

Examples of entitlement statements are:

“Because you feel that it was so unfair, what your father did to you, deep down inside you are convinced that the world now owes you.”

“Your mother never understood you, and left you very much on your own, and now you feel that unless someone is willing to go more than halfway, you’re not interested.”

“Your sisters treated you terribly, and now you’re not interested in maintaining a relationship with them unless they are willing to go more than halfway now.”

“Your father never supported you and was always critical; at this point, you won’t be satisfied until he can acknowledge that he

was wrong and that he owes you an apology.”

“You feel you have worked hard in the treatment and have done everything that you can; you are now feeling that I have to give you something or you won’t be able to proceed any further.”

It is important that the patient’s sense of entitlement be recognized. Many patients who have reached some kind of impasse in their treatment have reached that impasse because, deep down inside, they feel that they have gone not only as far as they can but as far as they should have to. It is now up to the therapist. On some deep level, they feel that since it was not their fault then, it should not have to be their responsibility now, that it is up to the therapist to do whatever he can in order to make them feel better.

In sum, the patient’s distorted sense of himself as so damaged from early on that he is not now

responsible, his illusory sense of his objects as able to compensate him now for that early damage, and his sense of being owed that compensation need to be uncovered and named, so that the patient will be able to overcome his resistance to moving forward in the treatment and in his life.

RESPECTING THE PATIENT'S INTERNAL EXPERIENCE

In order to be able to name, in an experience-near fashion, the defenses to which the patient clings, the therapist must enter into the patient's internal experience and be willing to experience the world as the patient does; at least on some level, the therapist must be able to let go of his own ways of experiencing the world.

It is relatively easy for the therapist to empathize with people like himself, much harder

to empathize with people unlike himself. When the patient experiences the world as the therapist experiences it and reacts as the therapist would react, it is not too difficult for the therapist to enter into the patient's experience and to be with him in that. But when the patient is different from the therapist, then it is a lot more difficult for the therapist to enter into the patient's experience and come to understand, deeply, why he feels as he does and does what he does.

For example, it is not too hard to be empathic with a patient who is in a great deal of distress because her boyfriend physically abuses her. It is much more difficult to be empathic when she tells us that she cannot leave him. This latter situation requires of us that we let go of our investment in thinking that things should be a certain way; it means being willing to put ourselves in her place so that we can deeply understand why she needs

this man in her life. Even though there are times when he makes her feel horrible, it may well be that at other times she feels loved by him in ways that she has never before felt loved. Perhaps when he is loving her he makes her feel special. Perhaps she feels that she is deeply unlovable and should be grateful for whatever love she can find. Perhaps she does not realize that it could be different.

Perhaps being in the relationship with this man enables her to hold on to her hope that maybe someday, if she is good enough, she may yet be able to get him (a stand-in for her father) to love her as she so desperately yearns to be loved. She does not like the abuse but is willing to put up with it if it means being able to hold on to her hope that someday she may be able to get what she has wanted for so long. When people have had the experience of abuse early on, it is usually not enough that they now find a good (loving) object

who will treat them well. The investment is in finding a bad (abusive) object who can be made into a good object. The truly empathic therapist will be able to appreciate that while the unhealthy part of the patient is invested in recreating the early-on traumatic failure situation, the healthy part of the patient needs first to re-create it and then to have the experience of a different resolution this time. In that is heading.

The truly empathic therapist, therefore, will be able to enter deeply into the patient's internal experience and to appreciate, in a profoundly respectful way, how it is that being in the abusive relationship serves the patient—in other words, what her investment is in staying.

As another example, if the patient is blocked in his affect and/or does not let things get to him, it may be difficult for the therapist to be empathic

with the patient's need to be this way, because it is so different from how the therapist is and what he believes in. Nonetheless, it is important that the therapist, over time, be able to appreciate why the patient needs to avoid feeling his anger, his hurt, his disappointment, or his pain and why the patient needs to remain untouched.

In order to understand how and why the patient has come to be as he is, the therapist must listen very carefully both to what the patient is saying and to what he is not saying. Perhaps the patient is afraid that if he were to let himself really feel, he would lose control entirely, would be rendered helpless and disabled, and would never come out of it. Perhaps the patient's fear is that if he were to access his true feelings, he would discover not just anger, hurt, disappointment, and pain, but murderous rage, anguished despair, and devastating heartbreak. The patient may or may

not know this about himself. Or perhaps the patient has derived a fair measure of his self-esteem from being able to remain in control, on top of things, relatively unaffected by what happens around him—and is therefore not about to give up his stance of proud self-sufficiency and iron-willed self-control.

More generally, the truly empathic therapist must be ever respectful of the patient's needs, albeit defensive ones, to be as he is. The more different the patient is from the therapist, the more difficult it may be for the therapist to empathize with the patient. But whether that task is easy or hard, the therapist must be able to come to the point where he can deeply understand why the patient needs the defenses that he has, why the patient protects himself in the ways that he does, why the patient will not let himself know the truth about himself and his objects, why the patient

remains stuck, why the patient keeps repeating that which he would rather not, and why the patient cannot let himself do that which he should. It is this respect for the patient and what motivates him that informs the interventions the therapist then makes.

SUPPORTING THE PATIENT'S DEFENSE

Let me present an example of how productive it can be for the therapist to work with the patient's defenses. Consider the following exchange:

Therapist: I wanted to let you know that I'll be away for four weeks in August.

Patient: Oh, I'm glad you'll have a chance to get away this summer.

If the therapist were to try to interpret the id material, namely, to try to make the patient aware of her underlying feelings, he might then say

something like “I think you may also be angry and upset that I’ll be away for so long,” to which the patient might respond with “You might be right, but I’m not aware of feeling that way.”

The therapist may well be right, but if the patient opposes, as she is likely to do when an id interpretation is offered, then we’ve gotten nowhere and have instead created the potential for a struggle. Patients tend to defend themselves against acknowledging the id material, both to themselves and to us, for the very same reason they needed to defend themselves in the first place—namely, that acknowledgment of the underlying id content arouses too much anxiety. And so it is that the patient says defensively, “You might be right, but I’m not aware of feeling that way.”

An id psychology wishes to bypass interference run by the ego in order to get to the id content.

This is what Freud was all about initially (with his interest in hypnosis and the cathartic method); and it is what we, in our impatience, may sometimes unwittingly and mistakenly do with our patients. An ego psychology (which is what Freud later got into, in large part because of the introduction of the structural theory of the mind) recognizes the importance of understanding (and analyzing) the ego defense before access can be gained to the underlying id content.

Let us imagine that in response to the patient's "Oh, I'm glad you'll have a chance to get away this summer," the therapist says instead, "And it's important to you that it not bother you—my being away this summer." Such a statement is attempting to highlight, in a gentle manner, the patient's ego defense, her need not to let certain kinds of things get to her. The session might then continue along these lines:

Patient: That's right. I have always managed well on my own.

Therapist: Much of your life you have had to fend for yourself, and you have always prided yourself on how well you've done at that, on how independent you've been.

Patient: (with affect) Yes, when I was a little girl, when my parents went out they always had me look after my little brother. Nobody helped me. It was all my responsibility.

Therapist: When you were asked to be the caretaker, you did it well and you did it without complaining. Even if it did get a little lonely sometimes, you knew you could do it if you had to. (softly) So you know you can count on yourself to be able to manage just fine when I'm away in August.

Patient: (very sad, with tears) Yes.

This example provides a powerful illustration of how effective it can be when the therapist simply goes with the resistance by coming down on the side of the defense. When the therapist says, "And it's important to you that it not bother

you—my being away this summer,” he is letting the patient know that he understands, that he knows how important it is to the patient that she not let herself feel bad about her therapist’s upcoming absence.

The patient is then able to go on, with some affect, to elaborate upon her need for the defense—it served her well, in her family, to be self-reliant. In time, she had even come to pride herself on her ability to handle things on her own.

When the therapist says, “Even if it did get a little lonely sometimes, you knew you could do it if you had to,” he is using a conflict statement, first gently suggesting he knows that the child must have felt lonely sometimes and then respectfully acknowledging the pride that the little girl must have felt at being able to do it all on her own. By juxtaposing the thing being defended against

because it provokes anxiety and the thing doing the defending, the therapist is able to bring more closely together the two sides of the conflict with which the patient is struggling.

THE DEFENSE-AGAINST-AFFECTS STATEMENT

As we observed above, the thing that creates anxiety is an anxiety-provoking reality of which the patient may be fully conscious, only dimly conscious, or completely unconscious. The anxiety-provoking reality may be an *intrapsychic reality*, like an affect, or an *interpersonal reality*, something real about an object that makes the patient anxious.

For now, let us think about the situation that arises when the patient is resistant to acknowledging the presence of an anxiety-provoking affect. In that situation we may want to

use a particular kind of conflict statement, something I refer to as a *defense-against-affects statement*. I shall discuss such an intervention in order to demonstrate more generally the ways in which conflict statements can be used, whether to highlight defenses against anxiety-provoking intrapsychic realities (as this defense-against-affects statement does) or to highlight defenses against anxiety-provoking interpersonal realities (as do most of the statements discussed later).

The defense-against-affects statement is an attempt by the therapist to articulate, in a way that will make sense to the patient, the conflict the therapist senses the patient is having around allowing himself to experience an intolerable affect. In making the statement, the therapist is trying to engage both the patient's experiencing ego and his observing ego; the therapist wants both to validate the patient's experience and to

enhance the patient's knowledge. To that end, the therapist both resonates with his senses of where the patient is (thus providing validation) and articulates, on the patient's behalf, his understanding of the conflict with which the patient is struggling (thus enhancing the patient's knowledge of himself and his internal process). The goal is to make the patient ever more aware of the conflict within him—that is, the internal tension between the affects against which he defends himself and the defenses that protect him from having to feel them.

Examples of defense-against-affects statements are:

“You are sad, but you are determined not to cry.”

“You know that you are sad, but you are determined not to cry.”

“It bothers you when your mother says things like that, but you feel it's important that

you not let her get to you.”

“You know, on some level, that you must be very angry and disappointed with me, but at the moment you are not aware of feeling that way.”

The therapist needs to be able to understand and to name, in a profoundly respectful way, both the reality defended against and the defense itself. He must be able to understand that the patient both does and does not feel his pain, both does and does not feel his disappointment, both does and does not feel his anger.

The patient who says that he does not know how he is feeling, does not know how he is feeling; and the therapist must be respectful of the patient’s need not to know. In their eagerness to get to the underlying affect, therapists often box the patient into a corner by encouraging him to admit his real feelings. Repeatedly the therapist

asks the patient how he is feeling, even though the patient is clearly conflicted about feeling anything. Insisting that the patient talk about how he is really feeling defeats the purpose of getting the patient more in touch with his affect, because it makes the patient more defensive, more resistant.

As an example, let us think about a situation in which the patient is having trouble acknowledging the existence of his anger toward his mother. If we encourage him to express his anger, he may well oppose us by protesting that he is not angry with her, that in fact he is grateful to her for the many good things she has done for him over the years. In other words, he gets defensive.

On the other hand, if we can appreciate that of course he has many feelings about his mother and if we can help him express both sides of his conflicted feelings, both his gratitude and his

anger, then we have freed him up to acknowledge and explore the whole range of feelings he has toward his mother. And so we might say something like “Although there must be times when you find yourself feeling impatient with your mother and annoyed by all her demands, for the most part you are deeply grateful to her for all that she has given you over the years.”

The first portion of the defense-against-affects statement addresses the side of the conflict with which the patient, for now, is less in touch and less comfortable. The first portion addresses the side of the conflict that is being defended against—the drive/force/affect that would arouse anxiety if the patient were made aware of its existence. This side of the conflict is there but, for now, is defended against, and the patient has difficulty acknowledging its presence. This is the side that is more conflictual, more anxiety-provoking.

The second portion of the defense-against-affects statement addresses the side of the conflict with which the patient, for now, is more in touch and more comfortable. The second portion addresses the side of the conflict that does the defending; it speaks to the defensive stance or posture that the patient has adopted as a result of the operation of his ego defenses. This side has to do, therefore, with the patient's investment in staying as he is, in preserving things as they are. This is the side that is less conflictual, less anxiety-provoking. The second portion of the statement, in essence, names the patient's resistance, in an experience-near, nonjudgmental fashion; it names the way the patient defends himself against having to experience his feelings.

More examples of defense-against-affects statements are the following:

"Right now you are hurting so bad inside, but

you're afraid that you would come apart at the seams if you were to let yourself feel just how sad you really are."

"You know that you are angry; but your fear is that if you were to let yourself get into it, you would 'lose it' and would find yourself raging on uncontrollably forever."

"You know that you are disappointed, but you tell yourself that you have no right to be."

"You are upset, but you are not convinced that talking about it will do any good whatsoever."

"Although you know that you are not pleased with what's happening, you find yourself feeling unable to do anything about it."

"Even though you recognize that you must be sad, it is hard for you to let yourself feel it fully."

Such statements relate to forces of which the patient may, at least initially, be largely unaware. In order for the patient to be receptive to the

therapist's intervention, the therapist needs to be able to address the patient's conscious or preconscious experience of his conflict. The statement attempts to formulate, in an experience-near fashion, what the therapist senses is the patient's internal experience of his conflict. Ultimately, the therapist wants to broaden and deepen the patient's understanding of his internal psychodynamics; in order to do that, the therapist starts at the surface (in terms of the patient's level of awareness) and works downward (toward material of which the patient is less aware).

Regarding the first portion of the defense-against-affects statement, there will be times when the therapist might choose to say something like "You are sad ..." and other times when the therapist feels more inclined to say "You know that you are sad. ..." Both convey about the same thing but have slightly different emphases. In the

second intervention, the emphasis is a little more on the patient's knowledge of what he is feeling than on his actual experience of it. The patient is being subtly encouraged to step back from his experience of the moment in order to observe how he is feeling; paradoxically, by giving him a little more distance, that wording may well free up the patient to acknowledge an affect that he might not otherwise have felt comfortable acknowledging.

Regarding the second portion of the defense-against-affects statement, there will be times when the therapist might choose to say something like "you are afraid that ..." and other times when the therapist might choose to say "you find yourself fearing that ..." Here, too, both say the same thing but have slightly different emphases. Again, in the second intervention the construction gives the patient permission to step back from his experience of the moment and may well free him

up to acknowledge the anxiety-provoking affect.

In other words, by using expressions like “you know that,” “you find yourself feeling that,” “you tell yourself that,” and “you cannot imagine that,” you are emphasizing the patient’s sense of agency and, ultimately, the choices the patient has made and is making about how he experiences himself.

The defense-against-affects statement attempts to address, then, both the experiencing ego and the observing ego in order to give the patient the opportunity both to acknowledge how he is really feeling and also to step back so he can observe himself and his internal process. In this way the therapist hopes both to validate the patient’s experience and to enhance his self-knowledge.

THE STRUCTURE OF THE CONFLICT STATEMENT

More generally, the conflict statement (of which the defense-against-affects statement is a

specific instance) is intended to empower the patient or, rather, to encourage the patient to own the power he already has; the therapist is gently encouraging the patient to take ownership of his conflict and of the tension within him between feeling and not feeling, between doing the right thing and not doing it, between acknowledging reality and needing to defend against it. Furthermore, the therapist is suggesting, indirectly, that the locus of responsibility is an internal one—something over which the patient has ultimate control. By so doing, the therapist is facilitating internalization of the conflict; the conflict should be not an external one between the patient and his objects but rather an internal one, within the patient. Also, by juxtaposing the two sides of the patient's conflict, the therapist is

attempting to pique the curiosity of the patient's observing ego. The therapist is encouraging the patient to observe himself and to recognize discrepancies between his knowledge of reality and his experience of it.

The structure of the conflict statement and some examples follow:

“Although ..., nonetheless ...”

“A part of you ..., while another part of you ...”

“On some level ..., but on another level ...”

“On the one hand ..., but on the other hand ...”

“Although you know that it upsets you when your wife says things like that to you, you are not at all convinced that saying anything to her about how upset you are would make any difference.”

“Even though you know that eventually you must leave him, at this point you are not yet prepared to do that.”

“A part of you yearns to be known and understood, but another part of you is terrified at the thought of being that vulnerable.”

“On some level, you recognize that he got to you; but on another level, it makes you feel foolish to have to admit it.”

“On the one hand, you long to be close; but on the other hand, you hold back for fear of being hurt.”

All such statements are nonjudgmental, implying instead a deep appreciation for how complicated the patient's motivations are. As I have suggested, in order to formulate an effective conflict statement, we need to have entered so completely into the patient's internal experience that we can understand deeply both what he's feeling and how he defends himself against feeling it. We must listen very carefully to what the patient is telling us about why he is as he is and

why he does what he does, so that we can understand why he is so conflicted.

If he cannot let himself cry, we must come to the point where we deeply appreciate that his need not to cry has to do with his fear that, were he to let himself cry, he would never stop, because the reservoir of tears within him is so deep:

“Your heart is breaking right now, but you are afraid that if you were to let yourself cry, you would not be able to stop.”

If he cannot get out of the abusive relationship with his girlfriend, we must come to the point where we deeply appreciate that his need to stay in the relationship has to do, perhaps, with his feeling that although his girlfriend hurts him terribly, when she is loving him she makes him feel more special than he has ever before felt:

“Even though it bothers you when she treats you the way she does, you love her so much

that you cannot imagine leaving her.”

“Even though you hate it when she hurts you, you also know that no woman has ever made you this happy before.”

“Although there must be times when you wonder why you don’t just leave her, you can’t bear the thought of not having her in your life because she makes you feel special and loved in a way that you have never before felt.”

More generally, in a conflict statement the therapist articulates, on behalf of the patient, his understanding of the conflict with which the patient is struggling. He attempts to convey to the patient his respect for, and his deep appreciation of, the difficult choices the patient confronts. The therapist is not forcing the patient to take a stand, either to defend his current stance or to protest his wish to change. The therapist is maintaining his neutrality, positioning himself “at a point

equidistant from the id, the ego, and the superego”
(Freud 1936, p. 28).

In the example above, we understand that the patient feels uneasy about the unhealthy relationship he has with his abusive girlfriend, but we also appreciate that he is so invested in the relationship that he is not about to give it up. We must not need him to end the relationship with her because that’s the right thing to do. We must appreciate that, for the moment, the patient cannot leave the relationship because it is still serving him in some way. The patient will not be able to leave his girlfriend until he has come to a point where he understands, deeply, what his investment is in staying. He must also come, over time, to recognize the price he pays for keeping things as they are.

By juxtaposing the force that says yes and the

counterforce that says no, we are offering the patient an opportunity to elaborate upon either his investment in doing/feeling the things that would constitute mental health or his investment in doing/feeling the things that constitute his pathology. Now we are speaking not just to the conflict within the patient between feeling and not feeling but, more generally, to the conflict within the patient between his knowledge of reality and his experience of it (in other words, the conflict within him between his ability to perceive reality as it is and his need for illusion and distortion). In response to the conflict statement, the patient either can go on to elaborate upon what he knows to be right (whether a feeling, an action, or a perception) or can explore his investment in maintaining things as they are.

An effective conflict statement enables the patient to feel deeply enough understood that he

will be stimulated to elaborate, in the form of associations, upon either his wish to get better or his wish to remain the same. Our hope is that, as the patient explores in ever greater depth both sides of his conflict about change, he will begin to produce genetic material—to unearth significant events from his past and to revive childhood memories. As such material is recovered, patient and therapist come to understand better why and how the patient has come to be as he is.

In the example above, as the young man talks about how special he sometimes feels when he is with his girlfriend, he goes on to associate to how he never felt special growing up, that his mother was too busy to spend much time with him, and that he grew up feeling very lonely and fearing that he would never find anyone to love him. He cries as he remembers just how unloved he felt as a young boy; all the old pain is reawakened, the

pain of his loneliness revived.

But he goes on to say that he is not sure how much longer he can stand being treated as shabbily as he is sometimes treated by his girlfriend. It does make him angry, and there are times when he thinks about leaving her. He starts to talk about how he would like to find someone who would be good to him all the time, someone whom he could really love and who would really love him. He acknowledges that he never imagined that he would be worthy of such love, because his experiences early on (in relation to his unavailable mother) led him to believe that he would never find real intimacy. He goes on to say that he is beginning to think that it may not have to be as it has always been, that he may yet be able to find love.

THE PATH-OF-LEAST-RESISTANCE STATEMENT

As we know, a conflict statement highlights two sets of forces within the patient, both the anxiety-provoking healthy force which impels the patient forward, and the anxiety-assuaging resistive force, which impedes such progress and constitutes the patient's pathology:

“Although you know that you must eventually come to terms with just how angry you are with me, for now it feels too overwhelming to think about ever being able to do that.”

“Even though you know that you have paid a steep price in terms of how you now feel about yourself because of how impatient and critical your father often was, you tell yourself that he did the best he could because he had so many other, more important things on his mind.”

Sometimes, however, the conflict highlighted relates more obviously to actual choices the patient now has about how he lives his life:

“Even though you know, on some level, that you must also be angry, nonetheless your experience is simply that you are sad.”

“Although on some level you know that there are some things you could choose to do, you tell yourself that none of those things would make a real difference.”

In the first of these statements, the patient’s conflict is between acknowledging how angry he is, which is difficult to do because it makes him so anxious, and simply feeling his sadness, which is a defense against the anger. In the second, his conflict is between acknowledging that he is master of his own destiny, acknowledgment of which makes him anxious, and feeling that he is powerless, which is a defense against owning his responsibility.

A conflict statement that highlights the patient’s choice between two alternatives lends itself nicely to being translated into a *path-of-least-*

resistance statement, in which the therapist highlights the fact that it is easier for the patient to do what is old and familiar, even if pathological, than for the patient to do something different, new, more healthy. Such statements are in the nature of a confrontation and can be used to highlight the fact of the patient's choice; the therapist wants the patient to take ownership of the decisions he makes.

The prototypical path-of-least-resistance statement first names the defense and then names the healthy force defended against: "It is easier to ... than to" In the examples that follow, the first statement in each pair is a conflict statement; the second is the path-of-least-resistance statement derived from it. Note that the conflict statement is often the more cumbersome of the two.

1. "Even though you know, on some level, that you must also be angry,

nonetheless your experience is simply that you are sad.”

2. “It is easier to be sad than to acknowledge how angry you must also be.”

1. “Although on some level you know that there are some things you could choose to do, you tell yourself that none of those things would make a real difference.”

2. “It is easier to tell yourself that there is nothing you can do to make a difference than to admit that there really might be something you could do.”

1. “Although you know you could have done things differently, you find yourself wanting to blame everyone else.”

2. “It is easier to blame everyone around you than to look at what it is you might have done differently.”

1. “Although you know that you could try to talk about just how upset you

are, it is hard not to retreat.”

2. “It is easier to retreat than to talk about just how upset you are.”

1. “Although you know that there are things you could do, you find yourself feeling overwhelmed by helplessness.”

2. “It is easier to feel overwhelmed by your helplessness than to confront the reality that there are things you could do.”

1. “Even though you know there are options, you find yourself feeling hopeless.”

2. “It is easier to feel hopeless than to think about options that you have.”

1. “Although you know on some level that you may never be able to find what you are so intent upon finding, you refuse to take no for an answer.”

2. “It is easier to insist that you will not take no for an answer than to confront the reality that you may never find what you are so

desperately seeking.”

1. “Even though you know that you should sit with just how devastated you feel, a part of you is tempted to act out your rage impulsively.”
2. “It is easier to act out your rage impulsively than to sit with just how devastated you are.”

In a path-of-least-resistance statement, the therapist is intentionally being somewhat provocative, somewhat confrontational, by suggesting that the patient is responsible for the choices he makes. The therapist is suggesting that the patient, as helpless and out of control as he may sometimes feel, is nonetheless always making choices. Furthermore, the therapist is implying that the patient often opts for the path that seems to offer the least resistance because it provokes less anxiety within him. The message to the patient is that the locus of responsibility is an

internal one, one over which the patient has ultimate control.

THE PRICE-PAID CONFLICT STATEMENT

At this point let me introduce another intervention, something I call a *price-paid, conflict statement*. Such an intervention is a particular kind of conflict statement in which the therapist, in the first part of the statement, names the price the patient pays for maintaining the status quo of things and refusing to confront certain realities and then, in the second part, names the defense the patient uses to deny the price paid. A price-paid conflict statement is most effective when the patient has himself already begun to acknowledge that he pays some price for clinging to his old ways of doing/feeling. Examples are:

“You know that you will be limiting the benefit you can get from therapy by coming every other week, but you’re feeling that you

cannot at this time commit to coming each week.”

“Even though you know that your mother’s constant criticism took its toll in terms of how you now feel about yourself, at this point you don’t want to have to think about that.”

“You recognize that as long as you refuse to deal with just how disappointed you are with your marriage, you will continue to feel depressed, but it is easier for you to feel depressed than to think about the terror of being alone again.”

“You know that you do have a drinking problem and that you do things while under the influence that you later regret, but you tell yourself that you don’t have to stop drinking entirely; what you do isn’t that bad, it’s fun, and anyway, you deserve to be able to be irresponsible sometimes.”

“You know that your difficulty speaking up has created problems for you in your relationships, but it makes you anxious to

think about really putting yourself out there.”

“Although you know that your reluctance to commit to the treatment makes our work more difficult, you find yourself wanting to hold back so that you don’t run the risk of being hurt again.”

If the therapist senses that the patient has begun to see that there may be something problematic about how he has been living his life, something problematic about the ways in which he has been limiting both himself and his possibilities, the therapist may formulate a price-paid conflict statement in which he attempts to create further tension within the patient by emphasizing the cost to the patient of defending himself in the ways that he does. He directs the patient’s attention, therefore, to the price he pays for refusing to confront certain painful realities (past and present) in his life. Whereas in the first

part of the intervention the therapist directs the patient's attention to something the patient would rather he did not, in the second part the therapist resonates with the patient's need to maintain the status quo of things. Whereas most of the other conflict statements that I have discussed strive to be more balanced in terms of first provoking and then easing the patient's anxiety, in a price-paid conflict statement the therapist (sensing that his alliance with the patient is strong enough to tolerate such an intervention) aims to create further tension within the patient in order to make the defense more ego-dystonic. The therapist is hoping to make it increasingly difficult for the patient to remain attached to his defense.

CONFRONTATION AND PARADOX

In essence, a conflict statement is made up of two parts, a part that confronts and a part that

expresses a paradox. The first portion of the conflict statement names something for the patient that arouses anxiety and against which he therefore defends himself. The second portion of the conflict statement names the thing that the patient does in order not to have to experience anxiety.

If the therapist chooses to emphasize the first portion of the statement, then in essence the therapist will be confronting the patient with something that the patient would really rather not have to feel and/or know. If the therapist were to choose instead to stress the second portion of the statement by supporting emphatically the patient's defense, then the therapist might end up exposing the paradox inherent in the patient's position.

The following are examples of confrontation:

“Even though you know that on some level you are furious at him, you would rather we not talk about it.”

“Although you know that, before you can get on with your life, you will need to work through your relationship with your mother, you find yourself hoping that perhaps you’ll be able to get better without having to do that.”

“Even though you know that someday you will need to deal with these issues before you can have the quality of life that you seek, for now you are feeling that you have done the work that you set out to do and are therefore looking ahead to termination in the near future.”

Here the therapist is coming down solidly on the side of the force that needs eventually to be acknowledged, confronted, dealt with, worked through. The therapist recognizes that, in so doing, he is increasing the patient’s anxiety, but there will be times when the therapist deems it appropriate

to name, rather forcefully, the thing the patient is so obviously not dealing with or the work the patient must ultimately do before he can get on with his life. The therapist decides where to put the emphasis based on his sense of what the patient, in the moment, most needs and/or can tolerate.

The following are examples of expressing the paradox:

“Even though you know that you have some resentment toward your mother for having failed you in the ways that she did, you tell yourself that you have no right to be angry and that you should be grateful for all the sacrifices she has made on your behalf.”

“Although you sometimes find yourself resenting the weekly visits to your mother in the nursing home, you tell yourself that, after all that she’s done for you in her time, the weekly visit is the least you can do to

show her your appreciation.”

Here the therapist is coming down so solidly on the side of the patient’s defense that, in effect, the therapist is exposing the paradox the patient has constructed. In the second example, the therapist is even insinuating that the patient’s weekly visit to the nursing home (which the therapist recognizes is a piece of the patient’s defensive need to protest his love and gratitude for his mother) may not be enough.

The patient may well counter the therapist’s move with a heartfelt insistence that he feels his weekly visit is enough—in fact, perhaps too much already! The therapist has thus made the patient acknowledge the side of his ambivalence with which he is much less comfortable, namely, his anger with his mother and his outrage at how demanding she is of him and his time. By speaking up on behalf of the patient’s pathology, the

therapist, in effect, forces the patient to speak up on behalf of his mental health.

TITRATION OF ANXIETY

When you address both sides of the patient's conflict—that is, when first you name the thing that is anxiety-provoking and then you name the thing that is anxiety-assuaging—you can modulate the level of the patient's anxiety. First you increase it and then, just when the patient is beginning to feel anxious, defensive, you come down on the side of the patient's defense, which eases the patient's anxiety, making him less defensive.

At any given point in time and for each patient, there is probably an optimal level of anxiety. Too little produces no impetus for movement of any kind, while too much produces immobilization and leads to an intensification of the patient's defensive efforts. By emphasizing either the ego-

dystonic aspects of the patient's conflict (in the first portion of the conflict statement) or the ego-syntonic aspects (in the second portion), the therapist can modulate the level of the patient's anxiety.

What the optimal level of anxiety is depends on many things—the patient's ego strength, the depth of understanding he has acquired about his conflict, how motivated he is to get better, how solid the therapeutic alliance is, and how interested the patient is in gaining insight, to name a few. From moment to moment, the therapist must assess just what that optimal level is.

Early on in the treatment, the patient may well be more invested in preserving the status quo of things than in changing. Consequently, the more anxiety-provoking side of the patient's conflict (his wish to change) is put in the first portion of the

conflict statement, while the less anxiety-provoking side (his resistance to change) is put in the second part. Later on, as the patient comes to understand both his investment in the defense and the price he pays for maintaining that investment, he may be at a point where it is more anxiety-provoking for him to be reminded of his resistance to change than to be reminded of his wish to change.

At this later time, an *inverted conflict statement*, in which the therapist intuitively inverts the order in which he names the two sides of the patient's conflict, may be more appropriate. Whereas a conflict statement speaks first to the patient's health (his wish to change) and then to his pathology (his resistance to change), an inverted conflict statement speaks first to his pathology and then to his health.

Note the difference in emphasis between the conflict statement (the first sentence in each of the pairs that follow) and the inverted conflict statement (the second sentence in each pair):

1. "Even though it makes you feel uncomfortable when she hurts you, you also know that no woman has ever made you this happy before."
 2. "You know that no woman has ever made you this happy before, but you are finding that you feel increasingly uncomfortable about how much she hurts you."
-
1. "Although there must be times when you wonder why you don't just leave her, you can't bear the thought of not having her in your life because she makes you feel special and loved in a way that you have never before felt."
 2. "You know that you can't bear the thought of not having her in your life because she makes you feel special and loved in a way that you have

never before felt, but you are beginning to think more and more about leaving her.”

The second statement in each pair, the inverted conflict statement, is addressed to a patient who is becoming increasingly uncomfortable with the abuse he has been tolerating for a long time. Meanwhile he is becoming increasingly comfortable acknowledging the outrage he feels about just how hurtful his girlfriend is. Such a patient will be receptive to an inverted conflict statement because he has made enough progress in the treatment that now his wish to get better (even if it means leaving his girlfriend) is stronger than his fear of change. Whereas before it was the thought of leaving his girlfriend that filled him with anxiety and dread, now it is the thought of not getting better, the thought of remaining stuck, that fills him with

anxiety and dread.

As the patient gets more and more in touch with the price he pays for behaving as he does, as he begins to recognize the self-imposed limitations on his functioning because of his investment in maintaining things as they have always been, and as he begins to experience more and more acutely the pain he feels because of some of the choices he has made, the therapist may find himself intuitively inverting the conflict statement, so that now the first portion of the statement addresses the patient's resistance to change and the second portion addresses the patient's wish to change.

RECONNECTING CONFLICTING ELEMENTS

Throughout this book we will be exploring the various uses for conflict statements. Whatever the particular situation, each statement emphasizes a different aspect of the conflict within the patient.

But each statement highlights tension between something anxiety-provoking and something anxiety-assuaging; each either makes the patient increasingly aware of the forces within him that press yes or makes the patient increasingly aware of how he clings to defenses that oppose forward movement—or does both.

Many of the conflict statements that the therapist uses are attempts to reconnect elements that have been defensively disconnected. Schlesinger (1982) writes about the patient's defensive "disjunction," the defensive breaking of connections between ideas as a particular ploy that the resistance uses to obscure and to confuse. From this it then follows that the work of interpretation, as he notes, is "to restore the sense of relatedness that has been removed by defense. The most common way for this task to be accomplished is for the therapist to summarize his

understanding of what the patient has been telling him. In doing so he condenses the patient's verbiage. In the therapist's boiled-down version, the patient's major ideas are much closer together. Their interrelationships thus become more obvious and their collective impact correspondingly greater" (p. 32).

Understanding and Being Understood

MOMENT BY MOMENT

Within the patient are opposing forces, those that seek empathic recognition and those that seek insight. I would like to suggest, therefore, that the therapist must decide, from moment to moment, whether the patient wants to be understood or, rather, wants to understand. The therapist must be ever attuned to, and respectful of, that tension, that balance.

Sometimes the patient wants simply to be understood. He may, for example, be totally immersed in a compulsive reenactment with his

therapist of an internal drama and have no interest whatsoever in understanding the part he plays in it. At such times it behooves the therapist not to badger the patient with premature interpretations but instead to resonate empathically with where the patient is so that he will know that he is being listened to and understood. Although the therapist may want the patient to understand, the patient is not at that moment interested in understanding. That is the therapist's agenda, not the patient's, and the therapist must exercise restraint.

Balint (1968) encouraged therapists to assume an “unobtrusive” stance, so that the patient would be able “to discover *his* way to the world of objects—and not be shown the ‘right’ way by some profound or correct interpretation” (p. 180). And Winnicott (1958) observed that, over time, he had learned to be more patient and to wait, resisting

his temptation to ply the patient with clever interpretations. He realized, he said, that those interpretations did more to show the patient the limits of what he knew than anything else.

Sometimes, however, the patient does become curious about his internal process and is then interested not only in being understood but also in understanding. He may find himself wanting to understand the part he plays in his life's dramas and, at such times, may be very receptive to the therapist's interpretations. The therapist uses his intuition to respond to those moments when there are such windows of opportunity, those moments when the patient has the capacity for insight.

There are times, then, when we simply tell the patient where we are going for vacation; but there are other times, those windows of opportunity, when we encourage the patient to become curious

about the internal workings of his mind—where does his question come from? what does he really want to know? and why now? There are times when we provide reassurance to the patient who clamors for it; but there are other times when we encourage the patient to look at his internal process—why the need to get reinforcement from the outside? why such insistence? and what does that say about his experience of his internal world and his external objects? In other words, there are times when we simply gratify the need; but there are other times when we wonder, with the patient, about why he feels the need.

It is important not to ask the patient directly, Why do you feel the need? Such a question may well make the patient anxious. If, instead, we name, in an experience-near, nonjudgmental fashion, the defense itself, then the patient may go on to elaborate upon his need for it.

To the patient who clamors to be told that you love him, you might say one of the following:

“You feel that you have to know that I love you.”

“You feel that you have to be able to hear me say that I love you before you can feel that I really do.”

“You feel that you can’t know for sure that someone loves you unless that someone tells you that she does.”

The patient might then elaborate: “I can’t know for sure unless someone tells me they love me. I never felt secure in my mother’s love for me. It’s like she always kept me guessing. If I had been good, then she would reward me by loving me. But when I had been bad, she would punish me by withdrawing her love. I just feel so confused now about whether I am or am not loved.”

To the patient who insists that you give him answers, you might say:

“You feel that only I have the answers, that on your own you won’t be able to find them.”

“You feel that you need to hear answers from me, need to have me tell you what to do.”

The patient might then respond: “I don’t feel that I can trust myself to find the right answer. Somehow I guess I have the feeling that there is a right answer, and I want to make sure I find it. I get panicked that I may end up doing the wrong thing, so I look to people outside me to tell me what to do.”

It is important that the therapist remain attuned, on a moment-by-moment basis, to whether the patient is interested simply in having his experience understood or is interested in observing his experience and understanding it. And so the therapist must decide from moment to moment whether to be with the patient where he is (in order to help the patient feel understood) or

to direct the patient's attention elsewhere (in order to help the patient understand). When the therapist is with the patient where he is, he eases the patient's anxiety. When the therapist directs the patient's attention elsewhere, he raises the patient's anxiety. The therapist can therefore titrate the level of the patient's anxiety by doing either one or the other, or first one and then the other. Sometimes the patient is simply feeling his experience and needs to have the therapist be with him in that. At other times, the patient can step back from his experience and become curious about his internal process. At such times, he brings to bear his observing ego and is then willing to have the therapist direct his attention elsewhere.

For the most effective work, we need the cooperation of both the patient's experiencing ego and his observing ego. If only his experiencing ego is engaged, then the patient has no capacity to step

back from his experience in order to observe himself. If only his observing ego is engaged, then the patient may be able to achieve intellectual insight but unable to translate it into emotional insight and actual change.

I think that the most effective game plan is one in which the therapist alternates between being with the patient where he is and directing the patient's attention elsewhere, between engaging the patient's experiencing ego and engaging the patient's observing ego, between encouraging the patient's elaboration of his subjective reality—his characteristic (defensive) posture in the world—and reminding the patient of objective reality.

Back and forth, back and forth, over and over again. Systematically, repeatedly, again and again. This is what is meant by working through the resistance. It is a process requiring that the

therapist demonstrate to the patient the same thing again and again, at different times, and in various connections. Here too. Here now. Here also.

FOCUSING THE PATIENT'S ATTENTION

The therapist must also decide, from moment to moment, whether to address his interventions to the patient's present, the transference, or the past. Menninger (1958) has suggested that if the patient is talking about what's going on in his life on the outside, the therapist should be with the patient in that, and then, when the moment is right, direct the patient's attention to the transference. By the same token, if the patient is talking about what's going on in the transference, the therapist should be with the patient in that and then, when the moment is right, direct his attention to the past, to his infantile objects. This is

known as Menninger's triangle of insight.

As we know, one of the goals of analytic work is to render conscious that which was unconscious, to extend the province of the ego, and more specifically, to make the patient ever more aware of the relationship between his experience of his past objects, the transference object, and his current objects. Useful are statements that encourage the patient to discover previously unrecognized connections:

“Is that feeling of entrapment reflected in your relationship with me too?”

“I wonder if you ever feel criticized here in the same way that you feel on the outside.”

“Is that relevant in here too?”

“You talk about how judged you feel by me in here. Is that a familiar feeling, one from way back?”

“Do you remember ever having felt that kind of

shame when you were growing up?”

Patients often talk specifics, details about this and that. They tell us stories about what’s been happening in their lives, the events of the previous week. They talk about facts and things, not always their feelings about those facts and things. They talk about the present, not always about their relationship with us or their childhood.

In Chapter 2 I talked about the importance of naming, defining, highlighting the patient’s basic stance in life, his characteristic (defensive) posture in the world; we want the patient to become ever more aware of how he tends to experience himself and his objects. As examples of such interventions, I cited:

“You are determined not to let me matter that much.”

“You are determined not to let anyone matter that much.”

I would like now to suggest, more generally, that as we listen to the patient, we may want to organize ourselves around the affect the patient is feeling or, perhaps more accurately, the affect the patient would be feeling were he to let himself feel it; in other words, we organize ourselves around the locus of the patient's affect. We then try to relate that affect to some theme, some pattern, some repetition in the patient's life. Examples include the following:

“You wish that somebody could tell you what to do.”

“You wish that I could tell you what to do.”

“You wish there were answers.”

“You wish that someone could give you an easy answer.”

“You wish that I could give you an easy answer.”

“You wish there were guarantees.”

“It makes you sad to think about all that could have been.”

“It upsets you when you think about all the missed opportunities.”

“You feel outraged when you think you have been treated unfairly.”

“Perhaps it is very confusing when I ask you if you feel that way in here too.”

“It is frightening to be feeling so vulnerable.”

“It makes you angry to be feeling so out of control in here.”

“You don’t like the feeling of being trapped.”

The emphasis is on the patterns, the repetitions, the recurring themes—and their associated affects.

We listen carefully, enter into the patient’s internal experience, and articulate on his behalf our understanding of what he’s feeling in the moment. If we are accurately attuned, then in

response to our intervention the patient goes on to elaborate upon his experience.

We also have the option of gently suggesting that what the patient is feeling in the present situation may well be part of the way the patient has come, over time, to experience himself in relation to the world. For example, instead of saying, "It saddens you to be feeling so misunderstood," we may want to broaden that idea by saying, "It always saddens you when you feel so misunderstood." The broader statement may enable the patient to go on to elaborate details about how deeply misunderstood and unappreciated he has always felt and how much that has hurt.

If the patient is talking about some problem he is having in his job, we listen closely and resonate with where he is, his anguish, his upset, his

frustration, his outrage. But then we try, as best we can, to abstract out some pattern, some recurring theme, and its associated affect:

“It is upsetting to be feeling so out of control.”

“It bothers you when you feel taken advantage of.”

“It enrages you when you feel taken advantage of.”

“It hurts to be so unappreciated.”

We want to encourage the patient to elaborate upon his upset at feeling so out of control, his outrage at being taken advantage of, his pain at being unappreciated. So first we resonate with where the patient is, in the hope that the patient will feel understood and will then go on to elaborate upon what he is feeling. But then, when we sense that the patient is ready, we direct his attention elsewhere, because we suspect that what he feels on the job is relevant in other areas of his

life as well. We point him in the direction of the transference by saying: “I wonder if there are times when you have felt out of control in here with me too.” Or we direct his attention to the past: “This feeling of being trapped and out of control, is that an old, familiar feeling?” In other words, when the moment is right, we draw the patient’s attention to his tendency to misunderstand the present in terms of the past. Sometimes it is not so much a misinterpreting of the present in terms of the past as a tendency to be particularly sensitized in the present to those issues unresolved from the past.

The technical task for the therapist is to find those moments when he can mobilize the patient’s observing ego, those moments—those windows of opportunity—when he can direct the patient’s attention somewhere else. When the patient is in the midst of his pain, he does not usually want to

understand; he wants understanding, empathic recognition of his pain. The patient's intense affect can be interpreted only when the patient has achieved a certain distance from it.

So, initially the therapist may need to be with the patient where he is, in his pain, in his anguish; and then the therapist may be able to direct the patient's attention elsewhere, so that the patient can come to understand what his pain is all about: "It hurts so much to be so 'not seen' by John. I wonder if being 'not seen' awakens some of the old pain about how you felt 'not seen' by your father."

The therapist is encouraging the patient to see for himself that there are things in his life that keep happening over and over again, unconscious repetitions the patient is repeating that he would rather not.

With our help, the patient is encouraged to

define more clearly the realities that he has constructed on the basis of his past experiences. The patient is encouraged to articulate some of the basic assumptions he has about himself and the world, some of the underlying convictions he has about himself and his objects. These are the patient's defenses to which he clings and around which he organizes himself; these are the ways the patient structures his being in the world.

The patient's attention must eventually be drawn to the fact that there are recurring themes, repetitions in his life, and that he, the patient, is the common denominator. The patient must come to see that there are patterns. As Menninger (1958) notes, such patterns, like the footprint of a bear that lost several of its toes in a trap long ago, stamp themselves with every step of the patient's life journey.

The patient's attention is also drawn to his own activity, to the fact that it is he himself who has been bringing about that which, up until then, he had thought he was experiencing passively: "The experience, then, is of being not seen by your boyfriend, and that hurts; though we are also beginning to see a pattern here, that you seem to choose narcissistic men who, like your father, don't really listen and don't ever really get to know you."

Ultimately it is the fact of the repetition, the fact that it happens over and over again, which the patient now sees, that goes a long way toward persuading the patient that in the future things no longer need to be the way they always were in the past.

CLINICAL EXAMPLE: A DEFENSE AGAINST PAINFUL AFFECTS

The clinical example presented in this section deals with a patient's resistance to acknowledging his pain, his disappointment, and his anger about the lack of connection he has always felt. The identifying details for this clinical example, as for all others, have been altered to protect privacy.

The patient is a depressed, anxious 47-year-old man who has been in treatment on and off for about a year with a colleague of mine. The patient periodically complains that he feels stuck and is not sure that he wants to continue therapy. Important facts: an unavailable father; a problematic marriage; and confusion about his sexual orientation (a history of homosexual activity, but always with extreme ambivalence).

I see the patient every month in order to monitor the antidepressant I have prescribed. What follows are *process recordings* of a portion of

our third meeting: I have reported what I said in its entirety but have condensed some of what the patient said, and I have included my comments on our interaction.

Although it is a consultation, I think that it nonetheless illustrates some of the points I have been trying to make about the ways in which the therapist enters into the patient's internal experience and listens intently with both his head and his heart. The therapist organizes himself around the locus of the patient's affect in the moment and tries to understand both what makes the patient anxious and how the patient defends himself against the anxiety. The therapist is then deciding, from moment to moment, whether to challenge the patient's defense, whether to support it, or whether first to challenge and then to support the defense; in other words, the therapist is deciding whether to encourage the

patient's forward movement, whether to whether to encourage the patient's forward movement, whether to encourage the patient to elaborate upon his resistance to moving forward, or whether to do first one and then the other.

Patient: I'm feeling better, but still tired and working hard ... I'm on the computer for the time being and changing the system so I can't do the psychological testing right now ...I'm just so busy ... I do not want to call Andy, but it's a struggle. My wife has been complaining about no sex, but I'm just so busy and tired all the time.

The patient is describing some of his symptoms, his hard work, his exhaustion, how busy he is, how pressured he feels.

Consultant: You're feeling very tired and busy and don't have much energy available for meeting other people's demands.

The consultant can feel the patient's exhaustion. She picks up on how tired the patient is feeling and goes on to frame the issue as one of people placing demands upon

him that he feels he cannot meet. She wants him to understand that she is with him.

Patient: My wife complains all the time that I'm not doing things right ... she was telling me the other day that she was angry with me because I had not yet made the arrangements for our vacation. She is upset that I don't talk to her enough.

The patient confirms that he is always in the position of disappointing and angering his wife because of the many ways in which he fails her.

Consultant: It seems as if she's always wanting things from you that you can't give her.

Here the consultant puts into words, on the patient's behalf, what she senses the patient is feeling.

Patient: I'm just so tired ...And we argue a lot still ... I watch TV ... I escape ... I get away ... I can't stand it.

The patient elaborates upon how difficult it is for him to be in the position of having things demanded of him.

Consultant: Sometimes it just gets to be too much.

The consultant picks up on the patient's feeling of being overwhelmed by all the demands. The consultant is here being what Havens (1986) has described as passively empathic: "Passive empathy is a waiting, sentient attitude, echoing some of the patient's statements and, above all, supporting and reflecting his emotions" (p. 17).

Patient: I feel I'm a bad husband, a bad father ... I can't give people what they want ...even at work, my boss wants me to start working on this other project before I finish the one I'm working on now.

The patient talks about his sense of himself as a failure, especially as a husband and father but also at work.

Consultant: You've spent a lifetime trying to give people what you thought they wanted and, at this point, you're exhausted.

The consultant chooses not to address the specifics of the patient's sense of himself as a failure but rather to step back from the here and now in order to frame the patient's hard work as a lifelong attempt to give people what he thought they wanted. The consultant is attempting to dignify the patient's struggle by

reframing his hard work as not so much an escape but rather an effort to please people.

Patient: ...and wondering why I can't give them what they want. What's wrong with me?

The patient elaborates upon his deep sense of himself as having always been a failure, as having never been able to give people what they wanted.

Consultant: You want so much to be able to do things just right, and it upsets you a lot when you feel that you are in the position of disappointing someone.

The consultant senses that the patient is also angry, but she stays right with the patient where he is—namely, his investment in doing things right and the upset he feels about disappointing people.

Patient: There was a time when my wife would make me so upset that I would just walk out ...she was always telling me that I should be home more often, should do more around the house, and should be more available to her and the kids ... I don't get quite as upset anymore, but it's still very hard.

The patient goes on to talk about how angrily disappointed his wife is in him and how difficult it is for him to be with her.

Consultant: ...and you're still in the position of feeling that you can never quite measure up to your wife's expectations.

The consultant resonates with the patient's experience of discomfort at never quite measuring up to his wife's expectations. The consultant is certainly aware that the patient is probably as angrily disappointed in his wife as she is in him, but the consultant appreciates that the patient is not yet able to acknowledge the intensity of his own outrage and dissatisfaction with her.

Patient: I tell myself that she's going through the change of life, but still, it is very difficult.

The patient elaborates upon one of the defenses he uses in order not to have to feel how angrily disappointed he really is in his wife.

Consultant: ...and she is very busy letting you know just how disappointed and angry she is.

This the consultant says matter-of-factly,

saying what the patient cannot quite let himself say.

Patient: All the time, and the children do too ...they are always complaining about how I'm not around enough ...I'm kind of on the outside.

The patient goes on to say that his children also complain about his lack of availability. The patient defines his stance as one of being an outsider.

Consultant: ...and that feeling of being on the outside, that's an all too familiar feeling, isn't it? Wasn't that the position you had in relation to your family as you were growing up?

The consultant senses that this is probably a familiar feeling for the patient, one he must have had in relation to his family. The consultant here chooses to direct the patient's attention backward.

Patient: Yes, I was always the black sheep in the family ... I could never do anything right ... I haven't had any contact with my brothers or sister since 1982, and my parents hardly talk to me at all anymore.

The patient readily responds by offering a

description of himself as having always been the black sheep in the family. He goes on to mention how little contact he has had in recent years with his family.

Consultant: ...and when they do, they are always reminding you that you have been a big disappointment to them.

Here the consultant chooses to highlight the parents' disappointment in him. The consultant wants the patient to recognize that there is a recurring theme here, that this may well be the story of his life, to be ever in the position of feeling that he is a big disappointment to people.

Patient: But I always tried so hard ... I could never satisfy them. My father was impossible to please.

The patient, clearly pained at the reminder of just how disappointing he was to his parents, protests that he always struggled to please them.

Consultant: Even as a young boy, you were trying so hard to please people and to do things the right way.

The consultant pursues this path, suggests that even as a young boy the patient was trying hard to please people and to do things the right way. The consultant is hoping that the patient will be able to develop some compassion for the little boy he once was, the little boy who was always working so hard to get his parents to love him.

Patient: When I was a kid, I loved the Church ... it was the only place I felt I belonged and could be accepted.

The patient remembers warmly his attachment to the Catholic church, the only place he felt he belonged and could be accepted—clearly in marked contrast to his experience at home with his parents.

Consultant: You found peace there. At last, you were away from all the pressures and expectations.

The consultant stays with the patient and names, for the patient, the peace he must have found and the freedom from pressure and expectation that he must have felt within the walls of the Church.

Patient: I guess that's right ... I felt I had a place there ... I felt secure, that I belonged. But then, when

I was in tenth grade, I had so much work to do in school that I couldn't keep being an altar boy and eventually I stopped going to church.

The patient, remembering, wistfully remarks that in the church he felt secure, that he belonged. But then he recalls leaving the church because he could not keep up his obligations as an altar boy when the pressures of his school work intensified.

Consultant: You've always been so afraid that you would let people down.

The consultant again picks up on this now recurring theme of the patient's concern about letting people down. The consultant continues to paint a sympathetic picture of the patient as someone who has always been afraid that he would turn out to be a disappointment to others.

Patient: Even in the Service ... Yes, I was afraid I would let down my buddies. And, in 1975, when I was hospitalized for five days for my nerves, that was because I was feeling that I couldn't do everything that was expected of me ...I just couldn't anymore.

The patient confirms that, indeed, he has always been fearful that he would be in the position of letting others down and of failing to do what was expected of him. The patient is feeling understood and is also coming to understand his own motivation a little better.

Consultant: You were just so tired by then. All your life you have tried so hard to do the right thing, and it makes you frustrated and angry that there has been so little recognition of that and so few rewards.

The consultant frames the patient's fatigue as an understandable response to the patient's lifelong effort to do the right thing. At this point the consultant senses that she has a window of opportunity to direct the patient's attention to something the patient has been busily defending himself against all his life—his anger. And so the consultant gently challenges his defensive need to deny his upset by suggesting that he must feel frustrated and angry that his hard work has been so unappreciated.

Patient: All that happened was that I wore myself out. Now that I'm on my medication, I can't even get angry. My wife was hiding the medication.

She's threatened by my being in therapy ...she doesn't understand anything about me or what's happening in my life. She wouldn't be able to deal with it.

The patient explains why he can't get angry; but then, interestingly, he goes on to complain about his wife and her lack of understanding of him.

Consultant: You would want to be able to tell her about how you're doing, but you get frightened that she might not be able to handle it.

The consultant is willing to pass, for now, on the patient's anger, and names instead the patient's fears about his wife's fragility. The consultant, remembering that the patient has said that his wife complains that he doesn't talk to her enough, is here offering the patient a conflict statement in which she names the patient's conflict about telling his wife what's going on with him.

Patient: She doesn't know how to deal with me at all.

The patient picks up on the second part of the statement, confirms that his wife has no idea about how to deal with him.

Consultant: And you end up feeling frustrated, disappointed.

The consultant picks up on the patient's disappointment.

Patient: But she's so busy telling me all the time about how disappointed she is with me ... I know I've been a bad husband and father. That's when I want to call my friend Andy.

The patient hears this but is a little uncomfortable with the thought that he might be disappointed in his wife. He protests, although somewhat halfheartedly, that it is she who is disappointed in him. He then goes on to talk about how he thinks about getting away from her disappointment by calling Andy. The patient turns to Andy whenever he feels uncomfortable, as he may now be feeling in relation to the consultant. She may have made the patient anxious by her line of questioning; in fact, the patient is probably not yet ready to access either his disappointment or his anger.

Consultant: You find with Andy a kind of acceptance and a feeling of belonging that you've never found with the other people in your life.

Here the consultant takes a bit of a leap; she

senses that part of what makes time with Andy so compelling are the feelings of acceptance and belonging that the patient has never been able to find with the other people in his life. Here the consultant is doing something that Havens (1986) refers to as active empathy. Drawing upon Martin Buber's evocative phrase "bold swinging ...into the life of the other" to describe it, Havens suggests that active empathy involves an intuiting of where the other is, a putting into words of what the other is feeling but has not quite yet said. In this way the consultant is able to find" the patient, "reach" him, and "stir" him (pp. 16-17). Here the consultant is hoping to frame the patient's behavior in a way that will enable him to be more understanding of himself.

Patient: Yes ... I guess I do, but I shouldn't call him. I don't want to be turning to him when I'm upset.

The patient acknowledges the truth in what the consultant has said and is pleased to have it understood but is also made a little anxious by the consultant's understanding. The patient then expresses some of the discomfort/guilt he feels about turning to Andy for comfort.

Consultant: It torments you. It feels so good being with Andy, and yet you tell yourself that you shouldn't be calling him.

The consultant picks up on how tormented the patient feels. The patient has now acknowledged both sides of his ambivalence about being with Andy. At this point the consultant decides to make a fairly balanced intervention; she offers the patient a conflict statement in which she speaks first to the positive side of the patient's ambivalence about Andy (how good it makes him feel) and then to the negative side (how guilty it makes him feel).

My contention all along has been that when we formulate a conflict statement, the first portion speaks to the patient's mental health while the second portion speaks to the patient's pathology. You might now ask if I am suggesting that the patient's desire to turn to someone outside his marriage for comfort is a healthy response to the pressure he experiences at home in relation to his wife. No. But I am suggesting that the patient needs ultimately to get in touch with and to own the intensity of his desire to do that, given that it is there. The consultant goes on to name the

patient's defensive reaction to having his desire—namely, his guilt—which is part of what interferes with the patient's owning his desire.

Patient: I try not to call him ... I try not to want to see him and be with him.

In a somewhat anguished way, the patient responds by elaborating upon how desperately he struggles to avoid giving in to his desire to be with Andy.

Consultant: It's so hard to know what to do ...it's such a difficult choice.

The consultant appreciates the difficult choice that confronts the patient and resonates with how painful that must be for him. The consultant avoids coming down on either side of the patient's ambivalence about being with Andy. She neither supports the patient's desire for Andy nor challenges it; she simply appreciates how tormented the patient is by the choice that confronts him.

Patient: It torments me ...because I can't decide what I should do about it.

The patient confirms that he is tormented,

because he remains so confused about what the right thing to do is.

Consultant: It's a real dilemma. You find solace, comfort with Andy and a kind of escape from the constant pressure you feel at home and you are so grateful for that, but then you are plagued with anguish and guilt about the sexual component in it.

The consultant responds with another conflict statement to the patient's anguish about what he should do. This time she elaborates in more detail upon the pleasure the patient derives from the relationship with Andy, on the one hand, and the tormented guilt that plagues him, on the other.

Patient: It makes me feel so guilty and ashamed when I turn to a man, but I'm glad that I'm finally talking about this ...it's been hard to talk about in the past.

The patient picks up on the guilt and the shame that he experiences and then goes on to express relief that he is finally talking about something that has been preying on his mind for a long time.

Consultant: There's some relief for you in being able

now to talk about something you couldn't talk about before.

The consultant reinforces the relief the patient feels at being able, finally, to talk about his relationship with Andy and the anguish it causes him. The consultant is also subtly suggesting that it is good that the patient is now able to talk about something that he could not let himself talk about before.

Patient: Yes, I feel a lot of relief.

The patient, clearly more relaxed now, confirms just how relieved he is.

Consultant: It feels good to have someone to talk to about how important Andy has been to you and how confused you are about it all.

The consultant, in responding to the patient, here acknowledges her appreciation for how important Andy has been to the patient. The consultant stays with the patient where he is, avoiding any temptation to direct the patient's attention elsewhere; the consultant wants to give the patient the opportunity to go where he will.

Patient: I just haven't known what to do about Andy.

The patient reiterates how confused he has been.

Consultant: It is so hard to know how to understand what place Andy should have in your life ...It's hard to know what you should do with some of the feelings that get stirred up for you about Andy.

The consultant, recognizing that for the moment the patient is not sure where he wants to go with all this, decides to offer the patient a slightly different perspective on his relationship with Andy. The consultant frames the patient's issue as one of not knowing how to understand the place Andy should have in his life. When the consultant makes reference to the feelings that get stirred up for the patient, she is offering him an opportunity to elaborate further upon the range of feelings he has in relation to Andy.

Patient: That's right. It is very confusing ...and frightening.

Here the patient introduces a new element—how frightening it all is for him.

Consultant: You find yourself wishing that you hadn't called him, but it's so difficult not to call

because some of those moments you've spent with him were the best moments in your life.

The consultant senses that the patient is frightened about how out of control he feels but is also now allowing himself to be a little more vulnerable. She decides, therefore, to offer the patient an inverted conflict statement in which she comes down first on the side of the force that is blocking the patient's movement and then on the side of the force that impels the patient forward. To this point the consultant, in naming the patient's conflict, has always been careful to acknowledge first the patient's desire for Andy and then his holding back; the patient's desire has been the more anxiety-provoking of the two forces and so the consultant has always first named the desire and then the patient's anxious/guilty response to that desire (his holding himself back). Now, however, the consultant senses that the patient is getting a little more comfortable with acknowledging the intensity of his yearning for Andy, and so she inverts the order in which she arranges the two sides of the patient's conflict about being with Andy. First she names his resistance and then she names his desire. She is guessing that he can now tolerate a naming of

the intensity of his desire for Andy without being made extremely anxious, without being made defensive.

Patient: I love being with him. It feels so good to spend time with him—I get such relief. But I know I shouldn't always turn to him when I feel bad.

The consultant has guessed right. The patient elaborates upon just how much he loves spending time with Andy, although he is then made anxious and so reiterates his concern/guilt about his tendency to turn to Andy when he is feeling bad.

Consultant: You know that spending time with Andy makes your life so much more tolerable, but you tell yourself that you shouldn't need him.

The consultant here offers the patient a conflict statement, in which she has reverted to naming first the desire and then the defense.

Patient: I'm haunted by the guilt I feel—I shouldn't be turning to a man when I'm frustrated and feeling awful inside.

Now the patient elaborates upon the defense, the guilt he feels and how haunted he is by his

sense of his own badness.

Consultant: The problem is ...what to do with all the tension that builds up inside of you.

Here the consultant makes a rather bold leap: she associates to the patient's earlier talk about how hard he works and how much pressure he always experiences; and she suddenly appreciates that part of what must make it especially difficult for the patient is the fact of all the tension that builds up inside him and how then to discharge it.

Patient: Yes, that's the problem for me, exactly. At work and at home with my wife, when I feel so much pressure, I withdraw.

The patient responds immediately in the affirmative; he confirms that the problem exists in all areas of his life. He goes on to suggest that his way of dealing with the pressure has been to withdraw.

Consultant: If you can't find relief by spending time with Andy, then you withdraw because nothing else seems to work. And it hurts too much to be in the position of spending time with someone who makes you feel that you are constantly disappointing her.

The consultant understands that the patient feels he has few alternatives, that if he cannot turn to Andy then he must withdraw. The consultant also frames the patient's withdrawal as an understandable response to how hurtful it must be for him to spend time with someone (his wife) who is always reminding him that he is a big disappointment to her. The consultant is appreciating that the patient has had to resort to time with Andy and withdrawal in order to deal with his frustration.

Patient: You know, I don't think my father liked spending time with my mother either—she was such a nag—so he was always retreating into his newspaper or taking a nap. He really wasn't there for me either ...but I just don't know what to do with how awful I feel now. It gets so bad sometimes.

The patient associates to his parents' relationship and to how his father avoided spending time with his mother. He remembers his father's withdrawal, from both her and him. Made anxious by the memory of how unavailable his father was to him, he brings his attention back to the present, protests that he just doesn't know what to do with how awful

he feels in the here and now.

Consultant: The problem is ...how to live with the despair that builds up inside.

The consultant picks up on this theme and goes on to introduce a new element, the patient's despair, which she senses has been there all along even though it has never been named by either of them.

Patient: Yes, deep in my soul, I feel despair. I've even been thinking about going back to the Church.

The patient feels profoundly understood and says that the despair is deep within him. Interestingly, he reports that he has been thinking about returning to the Church.

Consultant: When you were a boy, you got from the Church what you could never get from your father. You're hoping to be able to recover now, by going back to the Church, what you once had when you were an altar boy.

The consultant makes explicit the relationship between the patient's involvement, as a young boy, with the Church and the lack of security and connection he felt in relation to his father.

Patient: Maybe I'll be able to find a place where I feel

I belong.

Wistfully, the patient expresses his wish to be able to find a place where he can feel he belongs.

Consultant: ... a place where you no longer feel on the outside and like such a disappointment to everybody.

The consultant gently resonates with the patient's wistful yearning to belong, to be accepted, and to protect himself from the painful experience of feeling always that he is a disappointment to the people around him.

Patient: ...and it'll give me some relief.

The patient, pleased to be understood, acknowledges that finding a place where he could feel he finally belonged would be a tremendous relief for him.

Consultant: The problem has always been ...what to do with all the tension and pressure you feel inside, what to do with your pain.

The consultant recognizes that the patient does not turn to Andy simply out of weakness or withdraw because he is an unloving husband and father, but rather that he resorts

to these alternatives because of his need to do something with all the tension, pressure, and pain that build up inside him. The consultant dignifies the problem the patient has when she suggests, again, that the problem has always been one of figuring out what to do with all the accumulated tension, pressure, and pain.

Patient: Yes, except with my computers. When I turn to my computers, then it feels good—then it doesn't hurt so much.

The patient acknowledges the truth in this and goes on to say that in his work he finds relief.

Consultant: In your work, you find release and peace of mind.

The consultant joins the patient and then introduces a new element, the peace of mind that the patient finds in his work.

Patient: Yes, but I never feel that with my wife—I never find that with her.

Whereas earlier the consultant had directed the patient's attention to the situation with his wife, now the patient himself associates to the situation with his wife; he is clearly struck by the contrast between the gratifying

relationship with his work and the frustrating, unfulfilling relationship with his wife.

Consultant: With your parents, especially your father, you never had the kind of relationship that you would have wanted. You've lived your life yearning for connection and a sense of belonging. With Andy you're able to find it, but with your wife you don't ...and that's what hurts.

The consultant steps back to frame the patient's lifelong yearning for connection and a sense of belonging as a very understandable response to the lack of connection and acceptance that he experienced in relation to his unavailable and chronically disappointed father. The consultant then frames the relationship with Andy as affording the patient an opportunity to find the connection he has searched for all his life. She goes on, gently, to compare what the patient has been able to find with Andy to what the patient experiences in relation to his wife. Although he finds it with Andy, with his wife he clearly doesn't—and that's what hurts so much. Whereas earlier in the session the patient was talking about how painful it was for him to be in the position of disappointing his wife, now the consultant is

encouraging him to look at how painful it is for him to be in the position of feeling disappointed.

Patient: (very sad) I wonder if I'll ever be able to feel that with her. I get frightened that I may never find it with her and that she'll always be disappointed with me.

The patient, very sad, acknowledges his fear that he may never find that connection with his wife. Because he is more comfortable speaking to his experience of himself as disappointing than to his experience of himself as disappointed, he here suggests that he is afraid his wife will always be disappointed in him.

Consultant: (softly) ...and you with her.

The consultant reminds the patient that he may also be disappointed in her.

Patient: (very, very sad) I guess I knew that she was not there for me, but I couldn't admit it ...and I felt so guilty about turning to Andy for comfort. But I guess I really don't feel much connection with her.

The patient does not fight this. Instead, he acknowledges what, on some level, he has

always known—that his wife has never been there for him. This is the first time that he speaks directly to his disappointment in her, the knowledge of which he has been defending himself against for years. He too is now understanding his turning to Andy as an attempt to find with Andy the comfort and connection he has been unable to find with his wife.

Consultant: On some level, you've always known, but it has hurt too much to feel the pain and the disappointment of that.

The consultant recognizes that, on some level, the patient must always have known but that it hurt too much to feel the pain and disappointment of that knowledge.

Patient: Even when we got married, deep down inside, I knew that I didn't love her in the way that I would have wanted to, but I couldn't admit that, even to myself. I wanted so much to be able to feel that I had finally found what I had always been looking for, but I knew it wasn't right. I guess I really don't feel much connection with her ... it is pretty lonely.

The patient goes on to elaborate upon how he needed from the beginning to deny what he

really knew—that he did not love his wife in the way that he would have wanted to. He acknowledges that he wanted very much to believe that he had finally found what he had been seeking for so long, but that he has always known it was not right. He admits, finally, that he really does not feel much connection with his wife and that he is pretty lonely.

Consultant: ...and it breaks your heart.

The consultant, feeling his sadness, feeling his loneliness, tries to voice the depth of his pain for him.

Patient: (very, very sad; slowly) ...yes.

The patient, in a heartfelt fashion, acquiesces.

The patient has spent a lifetime defending himself against feeling the pain of his lack of connection with others. Because of an early-on lack of connection with an unavailable, unsupportive father who was never satisfied, the patient never felt connected, never felt that he belonged, that he was accepted. Instead, he always

felt like an outsider, was told that he was a black sheep, and was faulted for being a big disappointment.

Not surprisingly, he reenacted that drama in his marriage; he chose a wife with whom he has never felt a connection and by whom he has never felt accepted. But he has spent years denying that lack of connection, defending himself against confronting the intolerably painful reality of that lack of connection—and the reality of his subsequent loneliness.

The patient defended himself against acknowledging the pain, the disappointment, and the anger he has felt in relation to others (particularly his father and his wife) by focusing instead upon his sense of his own inadequacies. Unable to bear the pain of his disappointment with his objects, unable to own the outrage he has felt

in relation to them, he took the burden of their badness upon himself, decided that it was he who was bad, not they. Instead of confronting how he really felt about them, he defended himself against confronting the reality of that, in the process sacrificing whatever good feelings he might have had about himself. The patient has spent a lifetime refusing to know the truth about his objects, refusing to acknowledge how they have hurt and disappointed him.

In the session recounted above, the consultant is able to ease the patient gradually toward acknowledging both the intensity of his yearning to belong and to feel connected and the depths of his despair about never having found that connection with either his father or his wife. The consultant is respectful of the patient's need to protect himself in the ways that he does. She gives him room to elaborate upon his defenses and his

need for them; she does not challenge the patient's misperception of himself as bad (as the culprit) and his misperception of his wife as good (as reasonable in her demands and her dissatisfaction with him). In fact, the consultant is often the spokesperson for his defenses and articulates, on his behalf, his experience of himself and of his objects. In other words, the consultant not only offers the patient an opportunity to be as he is without having to get defensive about it but also supports him in his need to see the world as he does.

But against the backdrop of the support he receives from the consultant, the patient is gradually able to find his own way to his disappointment, his anger, and the truth about his objects; he is able to get in touch with what, on some level, he has always known but been too frightened to let himself acknowledge. By the end

of the session, the patient is himself admitting that there are realities he has always known that have been too painful for him to confront. The patient, at least for the moment, is in his pain, in his disappointment, in his heartbreak; he is, at least for the time being, no longer defending, no longer resisting knowing the truth.

Learning to Contain Internal Conflict

THE CAPACITY TO EXPERIENCE INTERNAL CONFLICT

As I have said in the preceding chapters, a conflict statement highlights both what the patient knows and what the patient experiences. In order for it to be effective, therefore, the patient must have the ability to hold in mind simultaneously both his knowledge of reality (informed by the present and fueled by capacity) and his experience of it (informed by the past and fueled by need). More specifically, the patient must be able to acknowledge (at least to himself) that he really does know what's right, what's healthy, what he

should be doing/feeling. The patient need not commit himself to doing that something, but he should at least have the capacity to recognize what constitutes health, reality, the right way.

In other words, in order for a conflict statement to be effective, the patient must have the capacity to experience internal conflict; the patient must be able to recognize that the locus of his conflict is an internal one, not an external one. He must have the capacity to own both sides of his conflict, to take responsibility for both those positive forces that impel him in the direction of health and those negative counterforces that impede such progress. In other words, he must not operate totally out of infantile need but must be able to take some adult responsibility for his actions.

By way of a series of conflict statements that

locate the conflict within the patient, the therapist is then able to create tension within the patient that makes it increasingly difficult for him to remain attached to his old ways. The patient is almost forced to let go of his defenses because they no longer serve him in the ways that they once did. As the patient gradually relinquishes his infantile attachments, he finds his way to yes and the conflict between yes and no is eventually resolved.

But not all patients have the capacity to tolerate internal conflict. Some will be able to experience it only at times; others will be unable to experience it at all. When the patient is unable to sit with, and to own, both sides of his conflict, then conflict statements serve neither to enhance the patient's knowledge nor to validate his experience. In such instances, conflict statements will be relatively ineffective in terms of moving the

patient toward resolution of conflict.

The classic example of a patient who cannot tolerate interned conflict is, of course, the borderline personality. Because such patients have a tenuously established libidinal object constancy at best, they are unable to hold in mind simultaneously two sides of anything, including a conflict. In fact, the hallmark of a borderline is that he lacks the capacity to sit with internal conflict and intense affect (particularly rageful disappointment) and, instead, tends to act out in impulsive, destructive ways; he truly cannot contain himself.

For a patient who cannot tolerate internal conflict, merely naming the conflict will do little to facilitate forward movement. What such a patient most needs is the provision of containment of his impulse to act out. What he most needs, then, is

not understanding but restraint.

The patient's inability to provide such containment for himself fuels the patient's need for the therapist to provide it for him. The patient's deficit involves his inability to contain himself; the need, therefore, is for the therapist to provide containment on the patient's behalf. In essence, the deficit creates the need; the need is for the therapist to serve as a deterrent, as a lid for the patient's id. In his capacity as a container, the therapist performs those functions that the patient would perform endopsychically if he had the capacity.

THE CONTAINING STATEMENT

I would like now to propose the use of something to which I refer as a *containing statement*, for those patients who have difficulty sitting with internal conflict and find themselves

feeling compelled to discharge that tension through some kind of action, often destructive. Containing statements will certainly be useful for the borderline. They will also be useful, more generally, for any patient who, in the moment, is having difficulty tolerating the presence of internal conflict and is feeling compelled instead to act it out.

Let us imagine a situation in which the end of the hour has arrived and the patient remains seated, clearly intent upon remaining. How does the therapist get the patient out of his office?

If we were to try to be empathic, then we might say something like “Perhaps you are wishing that you could stay all day.” This is certainly a *nice* thing to say, and the patient indeed feels understood, feels legitimized, and nods agreement. He remains seated.

If instead we were to try to set limits with the patient—that is, if we were to try to provide external structure in order to compensate for the patient’s lack of internal structure—then we might say, with a certain kind of no-nonsense affect, something like “I’m sorry but our time is up, and we do have to stop.” The patient, now enraged, just sits, rooted to the spot.

My proposal is that the therapist, in his capacity as a container, should offer a containing statement, an intervention in which he is empathic and sets limits; he both resonates with the affect and reminds the patient of a reality. And so the therapist says, “Perhaps you are wishing that you could stay all day but, as you know, our time is up and we do have to stop.”

We first resonate with the locus of the patient’s affect, with what the patient is experiencing in the

moment, namely, a desire to stay; then we remind the patient of the reality of the situation, namely, that his time is up. First we gratify by empathizing, and then we frustrate by reminding the patient of reality.

Actually, in suggesting that resonating with the patient's affect is being empathic, I am really misusing the word, because the truly empathic therapist will recognize that what the patient most needs in the moment is not just empathic recognition but also actual containment. The truly empathic therapist will recognize that what the patient most needs is both understanding and restraint. By resonating with the affect that the patient is experiencing in the moment, the therapist is offering the patient understanding; by reminding him of the reality of the situation, the therapist is attempting to provide restraint.

By way of a containing statement in which the therapist first resonates with the patient's desire to remain and then reminds him of the reality that the time is up, the therapist is attempting to avert a potentially disastrous situation. When the therapist says, "Perhaps you are wishing that you could stay all day, but, as you know, our time is up and we do have to stop," he is first appealing to the patient's experiencing ego and then attempting to engage the patient's observing, or reasonable, ego.

Notice that the therapist inserts the phrase "as you know" when he says, "...but, as you know, our time is up and we do have to stop." With that insertion, the therapist is trying to empower the patient. Indirectly, the therapist is encouraging the patient to take some responsibility for his actions and to recognize that the locus of control is an internal one. The therapist is emphasizing the element of choice for the patient.

Let us imagine another situation, one in which we are no longer talking about a potential crisis but an actual crisis. Perhaps the patient has already been traumatized by the therapist's failure of him; now it is crucial that the therapist be able to contain the patient's rageful disappointment so that the patient will not impulsively act out his rage in destructive ways, either to himself or to the relationship. The patient must be contained. And so the therapist says something like "I know that at times like this you think about never coming back because it hurts so much to be here; but we both know that if you are ever going to get better, then someday you are going to have to give somebody a second chance."

Other examples of containing statements are:

"You just can't get rid of this idea that when you feel hurt by me, you are allowed to retaliate, even though you know that such

behaviors are destructive to our relationship and to the bond we have worked so hard to develop.”

“You just can’t get rid of this conviction that if you feel hurt by me, then you get to do anything you want, including breaking the rules, which you and I both know we need to have in order for our relationship to continue.”

“I know you’re hating me right now, I know you can’t imagine ever being able to forgive me, and I know you want to walk out this minute; but you and I both know that someday you’re going to have to figure out why it’s so much easier for you to get rid of people in your life, even people who care about you, than to forgive them.”

“I know that you’re in deep, deep pain right now and wishing you were dead; but you and I both know that if you killed yourself, then your kids, whom you love deeply and would never want to hurt, would never get over it.”

“You think all the time about killing yourself to ease the pain; but you and I both know that if you did it, your kids would never get over it and would never forgive you.”

“You want me to understand that you do not want to be here today, but unless you come over here and sit down, we cannot begin.”

“When you get angry like this, you think about taking flight; but we both know that someday you’re going to have to stop running.”

“You’re hating me right now and thinking about killing yourself or breaking off treatment; but you and I both know that if you are ever going to understand why you have such trouble getting close to people, then someday you’re going to have to slow down and give yourself a chance to figure out what keeps going wrong for you in relationships.”

In all these containing statements the therapist first resonates with the patient’s affect and then

brings him up short by reminding him of something that really does matter to him, even if sometimes he chooses to forget that reality. In a conflict statement, the therapist first challenges and then supports. In a containing statement, the order is reversed; the therapist first supports the patient and then confronts him.

When the patient has the capacity to tolerate internal conflict and is not at risk for acting out, the therapist is able to use conflict statements to facilitate the patient's progress in the treatment. In such statements, the therapist attempts to enhance the patient's knowledge by confronting him with what he really does know to be real, even if sometimes he would rather forget. Although the therapist then goes on to ease the patient's anxiety by supporting the defense the patient mobilizes self-protectively, the therapist has had the opportunity to name a reality that the patient has

been busy defending himself against. The therapist is striving to put a wedge between the patient's knowledge of reality and his experience of it in order to create tension within the patient that will ultimately provide the impetus for forward movement. As we know, the patient relinquishes the defense as it becomes increasingly ego-dystonic.

When the patient has less capacity to tolerate internal conflict and is more at risk for acting out, the therapist cannot formulate effective conflict statements because the patient does not have the ability to acknowledge that the responsibility for his actions is his own. By way of example, let us return to the situation of the patient who remains seated, unwilling to leave at the end of the hour. Let us imagine that the therapist offers the patient a conflict statement in which first he reminds the patient of what the patient really does know about

the end of the session and then he resonates with the patient's desire to stay all day: "Even though you know that our time is up and we do have to stop, nonetheless you are wishing that you could stay all day." That statement will probably be relatively ineffective as a deterrent to the patient's determination to remain seated.

The patient, caught up in his need to stay, loses his capacity to acknowledge what he really does know to be the reality of the situation—namely, that his time is up and he must go. Thus, a more effective intervention than the conflict statement would be a containing statement that first engages the patient by resonating with his internal experience and then brings the patient up short by reminding him of what he really does know: "Perhaps you are wishing that you could stay all day, but, as you know, our time is up and we do have to stop."

Whereas a conflict statement first directs the patient's attention elsewhere and then resonates with where the patient is, a containing statement first resonates with where the patient is (in order to engage the patient) and then directs the patient's attention to something that the therapist hopes will serve as a deterrent to the patient's acting out. When the therapist provides containment, he gets the patient's attention by resonating with where the patient is; then he brings the patient up short by directing the patient's attention to something that the patient really does know to be real, even though, in the moment, the patient may want to forget it.

In order to formulate an effective containing statement, the therapist must so have entered into the patient's internal experience and come to understand him that the therapist will pretty much know what to say in order to bring the

patient up short. The most effective containing statements are those that hook the patient because they address something that really does matter to him. For example, by reminding the patient of the price he will pay if he acts out his rageful disappointment, the therapist may be able to contain the patient's impulsivity.

In short, the therapist must function as an external container because the patient lacks the capacity to provide this containment on his own. It is the therapist's external provision of this containment that enables the patient to survive the crisis and to recover his capacity to behave more responsibly.

CLINICAL EXAMPLE: PROVISION OF CONTAINMENT

In this section I will present the case of a patient who, in the midst of her pain and outrage,

loses the capacity to control her impulse to act out destructively. The patient is a 28-year-old woman who had been in therapy for about six months with a male colleague of mine at the point when he referred her to me for an evaluation because of his concern about her potential for acting out her rage at her husband.

Her mother, described by the patient as a “disgusting bag lady,” was a schizophrenic; her father, a violent alcoholic and prone to “rage attacks,” died when the patient was 16. An aunt and uncle were surrogate parents and brought up the patient and her sister.

As an adult, the patient had a series of destructive relationships but managed, finally, to find a decent man, Bob, whom she married at age 23. During the first years of their marriage, although the patient would sometimes fly into a

rage and lash out at everything and everybody around her, sometimes throwing and breaking things around the house and several times even striking Bob, for the most part she was able to restrain herself and never seriously jeopardized either her own health or Bob's.

More recently, however, Bob, now himself in treatment and no longer as willing to tolerate her abuse, began to talk about a trial separation. The patient, in her desperation, became increasingly provocative, rageful, vicious, and threatening to Bob; she was clearly terrified that he would leave her and, in her desperation, was having ever greater difficulty controlling her destructive behaviors in relation to him. At such times the patient would lose the capacity to tolerate internal conflict, lose the capacity to acknowledge that the locus of control was an internal one over which she ultimately had control.

With such a patient, conflict statements will tend to be less effective because the patient, in the moments of her outrage and impulse to lash out, loses sight of how much she loves her husband and loses the capacity to control herself. Containing statements may then be necessary in order both to provide some reality testing and to facilitate the patient's recovery of her capacity to contain herself by taking responsibility for her actions.

There follow excerpts from my consultation with the patient and a brief discussion.

1. Patient: I really need your help. I just don't know what to do. I'm feeling really desperate ... I am just so angry, I feel that I could kill Bob. I'm attacking him viciously and I'm wearing him out. I don't know if he'll leave or not, but I don't even care—I am just so angry.
2. Consultant: You are feeling out of control....
3. Patient: I'm just so mad, I don't care what happens.
4. Consultant: When you're feeling this angry and this desperate, you stop caring about

anything.

5. Patient: Yes, all I can think about is how angry I am.
6. Consultant: ...and how much you want to hurt Bob.
7. Patient: Yes, I know he says he loves me, and I know he says he is doing the best he can, but it feels as if he's doing absolutely nothing. He tells me that he's hanging in, but I hate him when he says that because I don't think he should get any extra credit for "hanging in." He says he thinks that "it's too much," but he has no idea what he's talking about ...This is nothing! ... In my time, I've taken so much more abuse than he has ...How dare he say that what he has to tolerate from me is "too much!"
8. Consultant: He has no idea what it is to be really abused.
9. Patient: No, none at all ...He thinks he has it hard, but he hasn't experienced one tenth of the shit I have had to put up with ...I just feel so angry and so overwhelmed.
10. Consultant: ...and you're wishing that somebody could do something to help.
11. Patient: Nobody has ever done anything to help me.
12. Consultant: Everybody has let you down when you needed them.
13. Patient: I really hate Bob and that's awful, because he's the only one who has ever tried to help, but nobody can do anything to help ...nobody ever has.
14. Consultant: It feels as if the damage done to you early on was so great that there is now nothing anyone can do to make it right.

15. Patient: (less angrily) I think I am really damaged.
16. Consultant: (softly) ... for life.
17. Patient: I don't think that I'm ever going to be normal.
18. Consultant: ... or that you'll be able to have the kind of life that others have.
19. Patient: I try so hard....
20. Consultant: It's not for lack of trying.
21. Patient: (sadly) I have been so good, and this weekend I went to my sister-in-law's graduation and was so sad ... I have put up with so much more than Jane and I don't get a fraction of the attention she gets ... Nobody notices.
22. Consultant: Nobody begins to see just how much pain you're in.
23. Patient: I was always told that I had no business complaining ... My aunt and my uncle told me: "This is what you have to do." Nobody ever said they were proud of me ... I have been taking care of people my whole life.
24. Consultant: And now you're wondering: When do I get mine?
25. Patient: I never get taken care of ... No one has ever taken care of me ... That's why I'm so angry at Bob ... I feel so poorly taken care of by him ... I really feel that I want to kill him! ... I don't know what to do.
26. Consultant: You're in such a bind: you are so enraged at him that you want to hurt him; and yet you're terrified that if you go too far, you may end up losing him.
27. Patient: I feel so torn apart inside ... I am in a bind

... I can't see that anybody has given me anything ...Bob says he's there for me, but he isn't.

28. Consultant: It's tormenting ...you so don't want to be doing this; and yet you feel, in a way, that you just can't help it.
29. Patient: (feels a little relief; both angry and sad)
It's hard to be feeling so out of control.
30. Consultant: You feel that you can no longer do everything on your own.... You would wish that someone else could do something to make you stop.
31. Patient: Yes, I really don't feel that I can do it by myself.
32. Consultant: ...and you want to make absolutely sure that I really get it, just how desperate you are ...and afraid....
33. Patient: Yes, yes, I'm terrified that I'll lose control.
34. Consultant: Right now you are feeling absolutely desperate and out of control of your anger, your resentment, and your hatred toward Bob ...And it's even harder still because you feel entitled to it ...But you and I both know that when you do get ugly with Bob and really lash out at him, you end up scaring yourself to death because you really don't want to drive away this man who does love you and does care.
35. Patient: (soberly) No, I really don't want to lose him ... I know that I get too angry ... it feels like this is more than just about Bob.
36. Consultant: But when you get this angry, it's hard to tell people apart....maybe Bob catches some of the anger that was intended for

other people.

37. Patient: Maybe I never felt safe enough to express it before ... I didn't feel safe at all in my family ...But, you know, I really don't want Bob to leave.
38. Consultant: Then you'd really be all alone again.
39. Patient: (very sadly) I've always been alone ... I'd like to apologize to Bob for what I'm doing, but if I tell him how sorry I am, I will hate him even more because I'm the one who is supposed to get support, not give it ...Sometimes all I can think about is how enraged I am.
40. Consultant: You don't really want to be hurting him, but sometimes you just don't know what to do with how angry you feel all the time.
41. Patient: In fact, I was told by my aunt and uncle that I shouldn't be angry, that I was supposed to be nice to people.
42. Consultant: ...that you were a bad person for being so angry.
43. Patient: I worked so hard to be good to people, including my aunt and uncle, but when did they ever take care of me or give me the support I needed?
44. Consultant: So you've always been in the position of giving others the kind of support you so desperately wanted for yourself.
45. Patient: Yes, I've always done that ...it's always been that way, and what good has it done me?
46. Consultant: You're sick and tired of being there for everyone else and having no one there for you.

47. Patient: It's just not fair, it's just not fair.
48. Consultant: It really isn't fair, is it?
49. Patient: (angry tears) No, it really sucks ...
Sometimes it feels like such a black hole ...
I get so angry that I don't know what to do.
50. Consultant: You're still so angry with your mother ...
She couldn't begin to take care of herself,
let alone take care of you ...And your
father's periodic outbursts were
absolutely terrifying. ...You could never
feel safe or taken care of by either.
51. Patient: I get so angry and I can't let anyone near
because my guard might break and then
I'd feel the pain ...they were horrible
parents, but if I keep myself surrounded
by anger, then I don't have to feel the pain
so much ... if I keep myself angry, I'm
reasonably safe.
52. Consultant: Ah, so you're not just angry about what
happened with your mother and father,
you're hurt too.
53. Patient: How do you describe never being
anything but let down?
54. Consultant: Not clear that there are words to describe
just how awful it feels to be in the
position of having your heart broken
again and again.
55. Patient: (now crying) It hurt me so much that they
were never there for me ... it just hurt so
much ...I've never known what to do with
how much it hurt.
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The patient is a woman who, in moments when

she is feeling not cared for, not understood, alone, deprived, damaged, overwhelmed, victimized, helpless, becomes so enraged that she is unable to control herself and her impulse to act out destructively. At such times, she loses the capacity to take responsibility for her actions and instead finds herself behaving in ways that she later regrets. Because she cannot provide her own containment, she must look to the outside for the provision of restraint.

The patient's complaint is that no one has ever really understood just how ragefully disappointed she can become, how alone she then feels in her anguish and her outrage, and how out of control she then gets. The consultant picks up right away on the patient's desperation and call for help; the consultant attempts to convey her appreciation for just how frantic the patient is.

The consultant later picks up on the dilemma with which the patient is struggling regarding her impulse control in relation to Bob. On line 26: “You’re in such a bind: you are so enraged at him that you want to hurt him; and yet you’re terrified that if you go too far, you may end up losing him.” Here the consultant first resonates with how enraged the patient is and how much she wants to hurt Bob; then the consultant, although still empathizing with the patient’s affective experience (in this instance, of terror), indirectly suggests that if the patient goes too far, then she may well end up losing her husband. In this second part of the intervention, the therapist is doing a bit of reality testing for the patient. Rather than saying, more directly, “If you go too far, you may end up losing him,” the consultant says, “You’re terrified that if you go too far, you may end up losing him.” The consultant is here attributing a

certain knowing of the truth (in terms of the consequences of her impulsive behaviors) to the patient, who, in the face of that knowing, is then “terrified.” In other words, the consultant is attempting to ease the patient in the direction of taking a little more responsibility for her actions.

The consultant goes on to frame the bind in which the patient finds herself as one that causes the patient much anguish, much torment. On line 28: “It’s tormenting. You so don’t want to be doing this; and yet you feel, in a way, that you just can’t help it.” Here again the consultant, in the interest of encouraging the patient to take some responsibility for her actions, first attributes to the patient the desire not to be doing this and then resonates with the patient’s experience of helplessness in the face of how ragefully unhappy she feels. The consultant appreciates that the patient does not perceive herself as having the

capacity to provide her own controls; the consultant, by naming, nonjudgmentally, the patient's experience of helplessness in the face of her outrage, is hoping here also to facilitate the patient's eventual owning of responsibility for her actions.

On line 34 the consultant offers the patient a containing statement: "Right now you are feeling absolutely desperate and out of control of your anger, your resentment, and your hatred toward Bob. And it's even harder still because you feel entitled to it. But you and I both know that when you do get ugly with Bob and really lash out at him, you end up scaring yourself to death because you really don't want to drive away this man who does love you and does care." First the consultant resonates with the patient's feelings of absolute desperation and hatred of Bob (feelings of outrage to which the patient feels deeply entitled), and

then the consultant reminds the patient of what she really does know—that when she behaves outrageously in relation to Bob, she runs the risk of driving him away.

In the second part of the containing statement, the consultant is suggesting that the patient, when she gets ugly with Bob and really lashes out at him, knows that she then ends up scaring herself to death because she really does not want to drive him away. It is important to recognize that the consultant is encouraging the patient to own more responsibility by suggesting, not that the patient knows she may lose

Bob, but that she knows she may actually drive Bob away. Furthermore, the consultant does not simply suggest that the patient knows, on some level, the realities of the situation; rather, the consultant suggests that the patient knows about

just how awful she feels (“scared to death”) when she behaves irresponsibly in relation to Bob because she does, on some level, understand the consequences of her behavior. The consultant is attempting to bring the patient up short by reminding her not just about what she knows to be real but about how terrible she feels in the face of that knowledge. By way of the containing statement, the consultant is encouraging the patient to recognize that the locus of control is an interned one and that she is responsible for her actions, even though she sometimes loses the capacity to remember.

The patient is sobered by the reminder that there is, of course, a relationship between how she behaves toward Bob and how he then reacts. The patient is being reminded of cause and effect, of the fact that there are consequences to one’s actions. In response to the consultant’s provision

of containment, the patient, now more reflective, observes that she really does not want to lose her husband. She goes on to note, insightfully, that her anger may well be more about her past than her present—“It feels like this is more than just about Bob” (line 35).

At this point the consultant senses that the patient is now much more open to acknowledging responsibility for her actions and is now capable of holding in mind simultaneously both her knowledge of reality and her experience of it. The consultant could choose, therefore, to offer the patient a conflict statement—“Even though you know, on some level, that Bob is not really your father, at times like this it is hard to remember that he is not your father and does not deserve to be treated in the way that you treat him.” As it happens, the consultant chooses instead to pick up more generally on the patient’s misunderstanding

of the present in terms of her unresolved past —“But when you get this angry, it’s hard to tell people apart. Maybe Bob catches some of the anger that was intended for other people” (line 36).

The patient responds by getting more in touch with her sadness, her aloneness, and her fear. She is now beginning to acknowledge, both to the consultant and to herself, just how frightened and out of control she feels at times.

On line 40 the consultant again frames the patient’s internal state as one of confusion; the patient has a dilemma: “You don’t really want to be hurting him, but sometimes you just don’t know what to do with how angry you feel all the time.” First the consultant encourages the patient to own that healthy part of her that knows the consequences of her behaviors, and then the

consultant resonates with the patient's experience of being out of control, being a helpless victim in the face of her outrage. On line 41 the patient responds by acknowledging the bind that her aunt and uncle used to put her in when they insisted that she not be angry, that nice people didn't get angry (when in fact the patient was often very angry). Even as a child, the patient was in a constant bind that caused her much anguish and torment and made her feel awful about herself; she was not given much help with containment but was expected instead to provide it for herself, to be a good little girl.

On line 44 the consultant picks up on the patient's experience of herself as having always been in the position of giving others the kind of support she so desperately wanted for herself. The consultant understands and appreciates the patient's bitter resentment and outrage at how

unfair it all was. In essence, the consultant is validating, not challenging, the patient's experience of outrage; the consultant's message to the patient is that it is certainly legitimate for the patient to experience the anger that she does, given what came before. But now it's clear that the anger and the outrage are really being felt in relation to what was back then (when she was a child) and not so much in relation to what is now (when she is an adult).

On line 51 the patient offers the insight that she knows she gets angry in order not to have to feel all the pain inside. The anger serves as a defense against the underlying sadness. On line 52 the consultant picks up on that idea—"Ah, so you're not just angry about what happened with your mother and father, you're hurt too"—and then reinforces it on line 54—"Not clear that there are words to describe just how awful it feels to be

in the position of having your heart broken again and again.”

On line 55, with heartfelt anguish, the patient finally acknowledges the deep pain and hurt that she has felt her whole life because her parents were not there for her. She admits that she has not known what to do with, or how to contain, how much it hurts. The patient is finally in touch with the heartache, pain, and sadness against which she has spent a lifetime defending herself—by being angry and acting it out. She is finally confronting the anguish that has been festering inside of her from way back; she is finally feeling the pain of her grief.

This vignette is a good illustration of a situation in which the patient is having difficulty taking control of her actions. The consultant offers assistance by way of providing, externally, the

containment that the patient, in her moments of upset, loses the capacity to provide for herself. The patient is then able to recover the ability to take responsibility for her actions and to recognize that the locus of control is an interned one. The patient recovers the capacity to experience internal conflict without feeling compelled to act it out in impulsive, destructive ways.

Freud on Resistance

Whatever interrupts the progress of analytic work is a resistance.

—Sigmund Freud, *The Interpretation of Dreams*

THE RESISTANCE AS A PATHWAY TO THE UNCONSCIOUS

I have been suggesting that the therapist must be respectful of the patient's resistance, the patient's need to defend himself against certain intolerably painful affects, memories, experiences, realities. The resistance, however, was not initially thought to be something of which the therapist should be respectful.

As we know, Freud introduced the concept of resistance; he did it in the context of the

topographic model of the mind, a model of the mind that posited consciousness, preconsciousness, and unconsciousness. He believed that the resistance was conscious and was an expression of the patient's negativism. Some theorists—Milman (1987) foremost among them—have suggested that the impetus for Freud's "discovery" of resistance was his impatience with patients who, despite his insistence that they say everything that came to mind, did not. The resistance is, after all, a much more frustrating phenomenon if we believe that the patient is willfully opposing us, if we believe that the patient could easily do something about his obstructionism, were he only a nicer person and less invested in making our lives miserable.

And so, initially, the resistance was seen as an obstacle to be eliminated. It was only with Freud's (1923) introduction of the structural model of id,

ego, and superego, and with his recognition that not only id impulses but also ego defenses were unconscious, outside the patient's awareness, that the resistance was seen in a more benevolent light. The resistance was now understood to be not an obstacle to treatment but an extremely important pathway to the patient's unconscious.

The following comes to mind for me as illustrative of the importance of resistance as a pathway to the unconscious. In this particular situation, the patient's resistance involved a symptom that had long been intractable and to which the patient clung until its unconscious meaning could be fully understood. Once it had been fully understood, the symptom was no longer necessary and the patient could let go of it.

The patient had long had an eating disorder, about which she had told no one except her

therapist (a supervisee of mine). She and her therapist had been working together for years and had done some excellent work over the course of that time; much had improved in her life, but the eating disorder persisted.

Then one day something happened. As she often did, the patient had been talking about her father, whom she detested. He was an alcoholic who, whenever his wife was away for the evening, would sneak under cover of the dark into his daughter's room, where he would do all kinds of sexual things to her. By day, it was never acknowledged between them. In this particular session, the patient was saying that she could not understand why she had never said anything about it to anybody.

Suddenly the therapist understood something. Suddenly she saw the connection between the

patient's eating disorder and the secret she and her father had shared. The patient's eating disorder, a secret that made her feel both deeply ashamed and privately gratified, was a neurotic reenactment of the secret she and her father had shared, a secret that made her feel both terribly dirty and, when she dared to let herself remember, secretly satisfied and special. Once the therapist made the connection between the patient's eating disorder and the secret she shared with her father, and once the patient was able to remember the pleasurable (as well as the painful) aspects of her relationship with her father, she became less invested in her eating-disordered behavior and was eventually able to give it up.

In this particular instance, the patient's resistance, in the form of a symptom, provided access to her unconscious, led to the uncovering of a previously unrecognized attachment to an

infantile object who was both hated and intensely loved. Were we to describe this situation in terms of conflict between forces, we would say that there was a tension within the patient between being symptom-free and having the eating disorder. Once the deeper meaning of the patient's symptom was uncovered and, therefore, her investment in having it was understood, then it was no longer necessary for the patient to hold on to the symptom, and she was able to move forward in her life, free of the eating disorder.

FREUD'S FIVE TYPES OF RESISTANCE

In 1926, in an addendum to his paper entitled "Inhibitions, Symptoms and Anxiety," Freud outlined five major types of resistance, deriving from three sources—ego, id, and superego. Three types of resistance derived from the ego, one from the id, and one from the superego.

Ego Resistances

The first type of resistance Freud described, one that derives from the ego, is called the repression resistance. The repression resistance has to do with the barrier erected by the ego to keep out of consciousness the forbidden, anxiety-provoking libidinal and aggressive drives, which are constantly threatening to break through.

The second type of resistance, which also derives from the ego, is called the transference resistance. Freud says that instead of remembering, the patient repeats, in the form of a transference reenactment. More accurately, perhaps, the transference is the patient's way of remembering. The transference, then, is a repetition of the past, a reexperiencing without memory, an unconscious reenactment without conscious recall.

Also deriving from the ego, the third type of resistance has to do with the ways in which being ill provides secondary (or epinosic) gain. Such secondary gains include the gratification of dependency needs, the need for attention, the need to be taken care of, and the need not to have to take responsibility for one's life. To the extent that being ill is in some ways an indictment of those around the patient, being ill serves to gratify his aggressive impulses as well. The secondary advantages that the patient derives from being ill need to be recognized before he will be willing to let go of his illness.

Id Resistance

The fourth type of resistance that Freud identified derives from the id; he spoke of the id resistance as involving adhesiveness of the libido and as fueling the repetition compulsion. Freud

recognized that the libido tends to remain compulsively attached to its objects; once it has cathected an object, it is reluctant to give it up. He said that the libido is intensely opposed to detachment from its infantile objects.

For Freud, *objects* were the external objects from whom the patient sought infantile gratification. For Freud, then, the libido remains tenaciously attached to external objects that are experienced either as gratifying or as potentially gratifying.

But let us also think about the patient's intense attachments—quite evident in our clinical work—to his internal bad objects. Are not such attachments also an aspect of the patient's resistance, and do they not also fuel the patient's repetitions? It was object relations theory that recognized the importance of the patient's intense

attachments to his internal bad objects. Those attachments are part of what makes it so difficult for the patient to move forward in the treatment and in his life.

What exactly is the nature of the attachment?

I would like to propose that both aggression (or hostility) and libido are involved. Aggression and hostility are directed toward the interned bad object because it is, after all, a bad object, which has frustrated or disappointed. But libido is also directed toward the object because a bad object is still much better than no object at all. If a bad object is all that the child has ever known, then it's best that he make do with that—because that's all there is. Furthermore, there is a libidinal investment in the object because, as bad as it is, there is still the hope that it may someday become a good object.

Clinically, it is extremely important to recognize that the patient's attachments to his internal bad objects have both negative and positive aspects, both aggressive and libidinal components. Think, for example, of the patient who has been involved in one relationship after another with abusive men. We find out that her father sexually abused her when she was 4. She is aware of hating him and of feeling contempt for him, but she is not in touch with any positive feelings about him. Before she can truly renounce him and, in the process, relinquish her pattern of involvement with abusive men, she must get back in touch with her long-repressed yearning to be close to him. She must eventually acknowledge that she once loved him, before he exploited that love and broke her heart. Otherwise, she will be destined always to contaminate her present with the past as she compulsively plays out her

unresolved childhood dramas in the here and now with the men she chooses to love. She will be destined always to choose good men and experience them as bad, or to choose good men and behave in such a fashion as to get them to become bad, or, simply, to choose bad men.

Or think of the patient who is scathingly self-critical and relentlessly self-denigrating. We find out that his father was a demanding, judgmental perfectionist who never found fulfillment and pleasure in his own life and so lived vicariously through his son. The patient is deeply attached to his father. Before the patient can give up his self-loathing, he must get back in touch with, and fully own, his rage at his father, his rage that his father never really loved him for who he was, set impossibly high goals for him, and unfairly demanded that he achieve the kind of perfection and happiness that the father was never able to

find for himself in his own life. Until the patient can acknowledge both the libidinal and the aggressive aspects of the tie to his father, he will be unable to let go of his self-hatred and his sense of himself as a failure.

I came to understand the importance of both the libidinal attachment and the aggressive attachment from reading Fairbairn (1943), who writes that the child takes the burden of the parent's badness upon himself in order to master his disappointment in the parent and to preserve the relationship. Once he has internalized the bad parent, he splits it into two parts, the exciting object, which offers the enticing promise of something good, and the rejecting object, which ultimately fails to come through and devastates. The so-called libidinal ego attaches itself to the exciting object, and the antilibidinal ego attaches itself to the rejecting object. These attachments

are then repressed. Meanwhile, the patient is forever in search of love objects that can be made into exciting/rejecting objects, promising but never fulfilling. And the drama is reenacted over and over again, in the hope that perhaps this time it will be different.

The process is one of internalization, splitting, and repression. The bad object is first internalized; it is then split into an exciting object and a rejecting object; and, finally, both objects, and the ego's attachments to them, are repressed.

The child's compulsive attachments to his internal bad objects (both the libidinal ego's attachment to the exciting object and the antilibidinal ego's attachment to the rejecting object) are therefore unconscious; but they powerfully affect subsequent relationships. Before the patient can separate from his infantile objects,

he will need to become aware of both the libidinal and the aggressive components of his tie to them; rendering conscious the unconscious attachment will go a long way toward diffusing the intensity of the attachment. The patient may also have to reexperience, in the here and now, in relation to the therapist (a stand-in, of course, for the parent), some version of the original experience of pleasure and then pain, excitement and then devastation, seduction and then betrayal. Belatedly, he grieves the reality of how initially enticing but ultimately rejecting his parent really was and of how deeply betrayed he now feels.

In sum, although Freud talks about the id resistance as an adhesiveness of the libido, I think it is important to remember that there is also an adhesiveness of the aggression that makes it difficult for the patient to separate from his infantile objects and to overcome his compulsion

to repeat that which he would rather not. Fairbairn is suggesting something else as well. Whereas Freud is talking about adhesiveness of the libido to good objects, Fairbairn is talking about adhesiveness of the libido to bad objects, in other words, the libidinal ego's libidinal (or positive) attachment to the bad object. The libidinal ego yearns for the exciting but ultimately rejecting object. Freud speaks to attachments that are libidinal in nature and are to external good objects; Fairbairn to intense attachments that are both libidinal and aggressive in nature and are to internal bad objects.

I will develop these ideas further when I discuss sadomasochism in Chapter 12; but for now let me suggest that Fairbairn's elaboration upon the child's ties to his internal bad objects is an important supplement to Freud's depiction of the child's ties to his external good objects. And

although Freud believes that the patient is ever in search of infantile gratification from his external objects, it must be remembered that the patient also has very intense aggressive and libidinal attachments to (and powerful identifications with) his internal bad objects and is ever busy re-creating in the here and now the early-on traumatic failure situations.

I am suggesting, therefore, that both adhesiveness of the libido to the external good object (about which Freud wrote) and attachment of the aggression and the libido to the internal bad object (about which Fairbairn wrote) are part of the resistance from the id and, as such, fuel the patient's repetition compulsion. Freud was, after all, more interested in the positive transference, whereas Fairbairn was more interested in the negative transference. Both, of course, are part of the patient's resistance—both the patient's

relentless pursuit of infantile gratification (which fuels the positive transference) and the patient's compulsive reenactments of his unresolved childhood dramas (which fuel the negative transference). In any event, it was out of respect for the power of the id resistance that the concept of working through was developed.

Superego Resistance

The fifth type of resistance that Freud identified derives from the superego. Freud conceived of guilt as the reaction of the ego to its awareness that, in the eyes of the superego, it is failing to perform as it should, by virtue of the presence of forbidden id (both libidinal and aggressive) impulses, which are threatening, constantly, to break through the repressive barrier. The superego resistance, as Freud called it, arises therefore from the patient's

(unconscious) sense of guilt and need for punishment—the punishment an attempt to ease the guilt. The harsher the superego, the greater the resistance from the superego, the more formidable the guilt.

THREE TYPES OF GUILT

Freud's Concept of Guilt

Freud's perspective on guilt is an intrapsychic perspective, in keeping with a so-called one-person psychology. As we know, Freud originally conceived of psychoanalysis as a two-person psychology. In the early days of psychoanalysis, he believed that neurosis, particularly hysteria, was the result of an actual seduction. His "seduction theory" was clearly a two-person psychology (Modell 1984).

But when Freud decided that his patients'

“memories” of childhood seduction were not fact but fantasy, he abandoned his seduction theory and at the same time his interest in an explicit two-person psychology; he adopted, instead, a one-person psychology. And so it is that Freud conceived of guilt as something the ego experienced in relation to the superego.

A two-person psychology, on the other hand, would explain guilt as something the subject experiences in relation to its objects. There are two kinds of guilt that derive from such an interpersonal perspective, depressive guilt and separation guilt. Both figure prominently in our work with patients and often interfere with their therapeutic progress.

Depressive Guilt

In the case of depressive guilt, the patient feels guilt or concern about harm his aggression is

doing or might do to someone he has come to love. Depressive guilt is part of what makes it difficult for the patient to own and to express how angry he sometimes feels at the therapist.

It is Klein to whom we give credit for naming this kind of guilt. She suggested (1933) that the capacity to experience depressive guilt is a developmental achievement. During the paranoid-schizoid position of earliest infancy the infant has no concern for his objects (they are loved if they gratify, hated if they frustrate); once the infant attains the depressive position, however, he develops the capacity to be concerned that he may hurt those he has become capable of loving.

In the depressive position, the infant begins to recognize his mother not as a collection of anatomical parts—breasts that feed him, hands that hold him, eyes that smile at or frighten him—

but as a whole person with a separate existence, a person in her own right, someone who provides the infant with both good and bad experiences. With achievement of the depressive position, the infant comes to experience concern for the survival of the object, guilt about previous aggression toward it, and a desire to make reparation to it. The infant now fears loss of the (good) object as a result of his (bad) aggression.

So too with the patient who, in the treatment, may have difficulty getting angry at his therapist, whom he has come to love very deeply. It is important that the therapist give the patient the opportunity to talk about how hard it is for him to get angry at someone he loves for fear of destroying that someone with his aggression.

So, whereas Freud conceives of (oedipal) guilt from an intrapsychic perspective, as what the ego

experiences in relation to the superego, clearly we are here conceiving of (depressive) guilt from an object relations perspective, as what the subject experiences in relation to the object; it is a two-person theory of the etiology of guilt.

Klein goes on to suggest that the infant, in the throes of his depressive guilt about having destroyed the object he loves with his hate, needs to have the experience of being able to restore that object, through his love; the infant has a longing to be able to recover the lost loved object. His fear that he might have destroyed the object he loves motivates him to mobilize all his love and all his creativity in order to repair the damage done, in order to restore the good object.

The mother's reappearance and her continuing love for her infant, despite the infant's hating of his mother and the infant's aggressive attacks

upon her, are tremendously reassuring and help the infant overcome his depressive guilt. (Winnicott [1958] has spoken of this same phenomenon as the mother's survival of her infant's attempts to destroy her.) Even though there may be times when the mother hates her infant, the mother's ongoing availability and love for her infant provide reassurance about the strength and resilience of the object. Over and above that, it lessens the infant's belief in the omnipotence of his badness and the power of his destructiveness. It increases the trust he has in his goodness, his love, his creativity, and his capacity to repair. With the repeated experience of loss and recovery, the infant acquires an increased confidence in the strength of his good object and in his own love and creativity. It is this reparative drive that is, in the Kleinian view, the most important impetus for growth.

I think it is crucial, therefore, that the therapist appreciate the importance of the patient's concern about hurting with his aggression, his anger, and his hate the person he has come to need and to love. Furthermore, the therapist himself needs to know that he will be able to survive the patient's assault on him and on his competence, his integrity, his caring, and the therapist needs to convey that confidence to his patient. If in any way the therapist instead conveys to the patient his concern about his (the therapist's) capacity to survive, then the patient's fears will be reinforced and the patient will be frantic with concern for the survival of his ambivalently held love object, the therapist. The patient will then have difficulty expressing his dissatisfaction with the therapy and the therapist for fear of doing irreparable damage. Clearly, such reluctance on the patient's part to give voice to his disappointment will seriously

interfere with the progress of the treatment, with the working through of the transference.

To a patient with depressive guilt, the therapist might say:

“You know that you are angry with me, but you are reluctant to express it for fear that it will hurt me in some way.”

“You are upset that you still feel so bad after all these years of treatment, but you cannot bring yourself to tell me about just how dissatisfied you are, for fear that it would be destructive to acknowledge how you really feel.”

Separation Guilt

The second kind of guilt that arises in the context of a two-person psychology is separation guilt. It is Modell to whom we owe our understanding of this very powerful resistive force.

Modell (1965) has suggested that the separation-individuation process—of the infant from his primary objects—is accompanied by guilt, guilt that is different from the more classical oedipal guilt associated with forbidden libidinal and aggressive strivings and different from Klein's depressive guilt about having harmed an ambivalently held love object with one's aggression.

In his article entitled "On Having the Right to a Life," Modell (1965) introduces his ideas about separation guilt, the person's guilt about separating from the parental objects, becoming his own person, and carving out an existence for himself, apart from his parents. Modell suggests that such guilt is present to some extent in everyone. It represents a fundamental human conflict. But some people appear to be burdened with an excessive amount of separation guilt and

the belief that they are not in fact entitled to a good life; they carry with them the conviction that they do not have the right to a life. The guilt of separating and individuating from the nuclear family carries with it a sense that those who have been left behind are now damaged; the guilt-ridden person believes that he has gained something at the expense of someone else.

In separation guilt the bottom-line conviction is that having something good for oneself means that the other has been deprived. The belief is in a zero-sum game. Modell suggests that there may even be the fantasy that in order to be born, someone else must die.

I worked intensively for years with a schizophrenic man who believed, deep within his soul, that if he were to separate from his family in order to go out into the world on his own, it would

kill his mother. But I have also worked over the years with patients who have had less obvious pathology but, on some level, the same kinds of concerns. They feel that they do not have the right to a rich and fulfilling life as long as other family members continue to suffer.

The patient who talks repeatedly about how undeserving he feels may need to be given the opportunity to see such feelings in the context of his guilt about separating from his family. The separation guilt may be so powerful that the patient needs to make a failure of himself. He then ends up with nothing, but in the process he has relieved his guilt.

Another way that people attempt to deal with the separation guilt they feel is to deny the fact of their separateness by clinging to the illusion that they are no different from their primary objects. I

think this phenomenon (the denial of separateness) may be the source of some of the very powerful negative identifications that patients have with their primary objects. For example, consider the patient who, as a result of good work done in the therapy, is carving out a life for herself but seems unable to rid herself of her depression (her mother's depression, as it turns out). The patient's depression may be her last-ditch effort to remain loyal to her family of origin. By clinging to a negative identification with her chronically depressed mother, she can deny her separateness from her mother, thereby relieving her guilt.

In our work with patients who have separation guilt, we need to appreciate how powerful their guilt really is and how great a part it plays in the resistance. Their loyalty to their infantile objects is such that they feel deeply undeserving; they truly

do not feel that they have the right to a life. Some appropriate interventions the therapist might make are the following:

“You want desperately to find a wonderful woman with whom you can have a close relationship, but you are not sure that you have the right to such happiness.”

“You want to be able to excel in your work, but you tell yourself that you are not entitled to find such success.”

In sum, the patient’s guilt is thought to derive from three sources:

1. the fear that he is bad because of the presence of forbidden libidinal and aggressive impulses;
2. the fear that he is bad because of the harm his aggression may do to people he has come to love; and
3. the fear that he is bad because of his wish to separate from his family of origin in order to carve out a life for himself.

DEFENDING AGAINST HELPLESSNESS

Before I go on to how we deal with the resistance, I would like to touch on a very common theme. What about the patient who always feels responsible for everything and who always feels guilty? The bad news is, yes, the guilt, and the burden of that. But the good news is—what? The good news is how gratifying it is for the patient to feel so omnipotent. The patient is burdened with his guilt but gratified by how powerful and how important he feels.

Ultimately, the patient needs to get in touch with and to acknowledge how gratifying it is and how good it feels to be so important. As with anything else that is dysfunctional, the patient, before he can let go of it, needs to understand how having it serves him—in other words, what his investment is in it. Though he complains about feeling burdened with guilt and responsibility, he

maintains his investment in the stance because it feels good to be so powerful and compensates for underlying feelings of impotence. In fact, we often discover that the patient's illusions of grandiose omnipotence are compensatory for underlying feelings of impotence and inadequacy, about which he feels deep shame. We find a connection, therefore, between omnipotence and guilt, impotence and shame.

These connections square with the experience of a patient of mine whose mother suicided on the eve of her daughter's leaving home to go to college. For years my patient and I talked about how guilty she felt about her mother's suicide. But the guilt persisted.

Eventually we came to recognize that her feeling of having been responsible for her mother's suicide was a compensation for how

utterly powerless she had always felt in relation to her mother, a depressed, chronically suicidal alcoholic who clung to her alcohol and her depression despite the daughter's enraged protests. Only when we recognized the compensatory nature of her feelings of responsibility for her mother's suicide did we get to the real issue—namely, that it was easier for her to feel omnipotent (even if that feeling was accompanied by terrible guilt) than to feel impotent (with its accompanying shame). My patient and I had had trouble getting to the feelings of powerlessness and shame because of her insistence that she was guilty, responsible, and, therefore, powerful. After all, people tend to confess their guilt, hide their shame.

Later still, we came to understand that the real guilt she felt had to do not so much with guilt about having been responsible for her mother's

death as with guilt about having felt so relieved
once her mother was finally dead.

Resistance as a Failure to Grieve

Genuine grief is the sobbing and wailing which express the acceptance of our helplessness to do anything about losses. If instead, we whine and complain, insist that this cannot be, or demand to be compensated for our pain, then we are forever stuck with trying to redeem the past.

—Sheldon Kopp, “The Refusal to Mourn”

PROTECTING AGAINST THE PAIN OF KNOWING

Whether we speak of the resistance as arising from the ego, the id, the superego, or, as I suggested earlier, from the patient’s need not to know the truth about himself and/or his objects, the resistance gives rise to the patient’s pathology.

It is because the patient resists, because he defends himself in the ways that he does, that the patient does not get better and instead remains stuck.

In earlier chapters I suggested that the patient defends in order not to have to know. On some level, the patient has a certain knowledge of reality (whether about himself or his objects) that he does not or cannot confront. In order not to have to confront what he really does know, he clings to a variety of defenses that enable him not to know the truth about himself and/or his objects. Such defenses, therefore, serve to protect him against the pain of knowing. The patient may employ one-person or two-person defenses. In other words, the defense may be simply one of the many ways the ego protects itself against knowing the truth about an internal reality, or it may be one of the many ways the ego/self protects itself against

knowing the truth about its objects.

Here are examples of one-person defenses: By isolating his affect, the patient is able to talk of painful things without having to feel the intensity of his pain. By using reaction formation, the patient is able to imagine that he loves his mother when in fact he hates her. By repressing his hurt, the patient is able to pretend that all is well. By intellectualizing, the patient is able to remove himself from the pain of his heartache. By insisting that he is self-reliant, the patient is able to deny his vulnerability and need for others.

These are examples of two-person defenses: By clinging to the illusion that his mother was devoted to him, the patient defends himself against the excruciatingly painful reality that his mother was extremely narcissistic and ultimately inaccessible to him. In other words, by clinging to

the illusion, he does not have to face the pain of his disillusionment. By clinging to a distorted sense of himself as unlovable, as bad, as unworthy of being loved, the patient defends himself against the horrible reality of just how unloving his parents really were. In other words, by clinging to the distortion that he was unlovable, he does not have to confront the reality that it was his parents who were unloving.

Whether one-person or two-person, the defenses protect the patient against acknowledging either an internal reality or an external reality. Their presence enables the patient not to have to confront certain intolerably painful realities—and not to have to grieve them.

CLINICAL EXAMPLE: FAILURE TO GRIEVE

The clinical example presented in this section deals with a patient's resistance to acknowledging

how much pain she feels in relation to her mother. Because she has never dealt with just how devastated she was by her mother's lack of availability, she has spent a lifetime trying to extract from others the attention, recognition, and praise that she never got from her mother.

The patient is a very hardworking 33-year-old woman who has been in treatment for about three years with a colleague of mine. The patient has made some rather dramatic changes in her life over the course of those years but is still "always in overdrive," works over 80 hours a week, is never able to ask for help, is always exhausted, and lives on the verge of burnout. Over time, both patient and therapist have become increasingly frustrated in their efforts to "contain" the patient's workaholism.

Important facts: the patient's mother, herself a

workaholic, died several years ago; the father was completely unavailable; the patient has been able to access her outrage about her father but has never really acknowledged just how disappointed and angry she feels about her mother.

Some months before the session presented here, I started the patient on an antianxiety drug. I see her every month in order to monitor her progress. What follows are excerpts from our fourth meeting, along with my comments.

Patient: I worked so many extra hours this month—all these projects are due at work. My boss said that I don't really have to kill myself in order to get them in on time, but I feel that I have to meet the deadlines. I know I should be asking for help, but I don't know how to do that.

The patient begins by talking about how busy she has been all month. She is clearly feeling overwhelmed by what she feels is expected of her. She then halfheartedly formulates her own conflict statement: she says that she knows she

should be asking for help but does not know how to do that. Both sides of her conflict about asking for help are articulated, but in the first part she is merely giving lip service to what she imagines others would think she “should” do, and she then protests that she does not really know how to do it anyway. By raising the issue in the way that she does, she rather effectively dismisses asking for help as a viable option.

Consultant: You’ve been working so hard, and you’re so tired. You’ve thought about asking for help, but it’s hard to imagine actually doing that.

First the consultant resonates with how hard the patient has been working and how tired she now is. The consultant wants the patient to know that she understands. But then the consultant goes on to offer her own conflict statement, in which she presents her own version of the patient’s conflict around asking for help. In the consultant’s rendering of the conflict, the consultant picks up not so much on what the patient should do as on what the patient must sometimes have thought about doing. Whereas the patient has dismissed her own idea of asking for help as untenable because she really does not know how to do that, the consultant’s tentative suggestion that

there must be times when the patient has thought about reaching out for help cannot be as easily dismissed. When the consultant goes on to express her appreciation of the fact that the patient probably finds it hard to imagine actually doing that, she is coming down on the side of the patient's defense; she understands that the patient is made very anxious at the thought of reaching out to others for help and so goes on to name, in an experience-near, nonjudgmental fashion, what she senses will be the patient's (defensive) reaction to what she, the consultant, has just said about asking for help. By expressing the patient's conflict in this way, the consultant is making it more difficult for the patient to dismiss the idea completely.

Patient: I can't ask for help, I just can't—I don't even know what I would ask for.

Because it is harder to dismiss, the patient must take what the consultant has just said seriously, which challenges the patient's investment in doing things on her own. The patient, made anxious, defensive, protests that she "can't" ask for help; she goes on to say that she's not even sure she would know what to ask for. The patient is here defining her resistance to altering her stance; she "can't" ask for help,

she needs to be doing it on her own, it makes her very anxious to think about reaching out to others for help. Although the patient has said that she knows she should ask for help, she is clearly resistant to the idea of actually doing things any differently from her on out.

Consultant: ... and anyway, you have not quite yet reached your limit.

Recognizing that she has made the patient anxious, the consultant now backs off. Not only does the consultant not counter the patient's (defensive) protest that she doesn't know what to ask for, she reinforces the patient's resistance by suggesting that the patient has not yet reached her limit anyway. The consultant, by emphasizing the patient's stoicism, is here presenting the paradox of the patient's position to the patient.

Patient: I know I've reached my limit—I know it, but I can't do anything about it—I can't stop. Somehow I feel I just can't give it up.

The paradox forces the patient to acknowledge the other side of her ambivalence—namely, that she has indeed reached her limit. The patient has now admitted how painful it is. But since she is not yet prepared to do anything

about her situation, she must now justify her inability (unwillingness) to do anything about it. She is therefore forced to articulate what she really feels—namely, that she is a helpless victim of her relentless drivenness. (“I can’t stop.”) She is making more explicit her internal experience of victimization.

Consultant: There is something about working so hard that feels addictive, something compelling about working this hard.

Here the consultant decides to pick up on the patient’s obvious investment in the workaholic behavior. Thinking that the patient’s need to work has a compulsive, driving quality about it, the consultant suggests that the patient must find it “compelling,” even “addictive,” to be working so hard. The consultant is giving the patient an opportunity to elaborate upon her investment in the defense.

Patient: Sometimes it feels like a drug—sometimes it makes me high.

The patient acknowledges that part of the appeal of working so hard has to do with how “high” it makes her feel.

Consultant: You know that you may end up just about

killing yourself, and yet there's a way in which that high feels so good that you don't feel you can give it up.

The consultant formulates another conflict statement, in which she first highlights what the patient does know on some level (namely, the price the patient may end up paying and then resonates with just how good it makes the patient feel to be working so hard—which makes it so hard to give up.

Patient: I want to, but I just don't know how.

The patient insists that she does want to give it up; but then, made anxious even at the thought of relinquishing the defense, the patient protests that, in essence, she is helpless to do anything different because she does not know how. She has reverted to her original stance of feeling like a victim, powerless in the face of her compulsion.

Consultant: You tell yourself that you want to, and yet there's something so compelling about working up to and even beyond your limit that you cannot imagine really giving that up.

The consultant offers another conflict statement, in which she is attempting to frame

a little more clearly the patient's ambivalence about giving up something that really does feel so good. When the consultant says that the patient tells herself that she wants to give up her workaholism, the consultant is doing something that I refer to as giving the patient the benefit of the doubt. In fact, the patient has probably not spent much time thinking about wanting to give up the workaholic behavior, but the consultant, in an effort to access that healthy part of the patient that wants to change, makes an intervention (in which she suggests that there must be times when the patient tells herself that she wants to change) that addresses itself to something with which the patient can resonate without being made too anxious. The consultant goes on to define ever more clearly the patient's investment in doing something that is so obviously compelling. The consultant is conveying her respect for the patient's investment in the defense.

Patient: Yes, yes....

The patient feels deeply understood.

Consultant: That must be what your mother felt too.

To this point, the consultant has mostly been

with the patient where she is. The consultant now decides to take this opportunity to direct the patient's attention elsewhere. Knowing that the patient's mother was herself a workaholic, the consultant encourages the patient to make the connection between her own conflict about working so hard and what must have been her mother's conflict as well.

Patient: Yes, and I would try to convince her to give it up.

The patient responds immediately in the affirmative and, interesting, goes on to associate to her own experience of having tried to get her mother to give it up; she is here acknowledging that, though she knew her mother must be getting some pleasure from her compulsive hard work, it was difficult to be in the position of watching her mother kill herself.

Consultant: ...knowing all the while that there was no way she would ever give it up, because it was such an incredible high to be feeling so productive, to be knowing that she was getting so much done.

The consultant does an interesting thing here: she elaborates upon what must have been the

mother's investment in her compulsive hard work so that the patient, from a distance, can observe in another the power of the "incredible high" that comes of knowing that one is working that hard.

Patient: Yes ...she worked all the time. She didn't take vacations—she didn't take any time off at all. I guess that's the way she needed to live her life.

The patient, easily able to understand by way of her identification with her mother, elaborates further upon her mother's investment in working all the time; she concludes that her mother must have "needed" to live her life that way.

Consultant: Maybe it was worth it because it felt so good. At least she knew that her life was important and that she mattered to people.

The consultant, also understanding, appreciates that it must have been worth it because it felt so good. The consultant goes on to suggest that the mother was at least guaranteeing herself an "important" life and the knowledge that she had "mattered" to people. The consultant is experiencing the paradox at the heart of the patient's stance.

Patient: But I look at my mother's life and it was pretty empty.

The patient, not surprisingly, protests—which puts her in the position of having to remark upon the emptiness of her mother's existence.

Consultant: Perhaps not rich or full, but something exhilarating and compelling about living that way...?

The consultant persists but is willing to suggest that perhaps it is not so much that a life filled with hard work is rich or full (clearly it was not for the mother and is not for the patient) as that it is exhilarating and compelling.

Patient: Compelling, yes, but so exhausting— I can't imagine why she did it or why I continue the way I do.

The patient is in a bit of a bind here. She finally grants that working so hard may be compelling, but has to add that it is exhausting. The patient is now highlighting the price paid for the defense. In general, the consultant does not want to be in the position of having to point out to the patient the price she pays for having a particular defense; it is better that the patient be the one to recognize and to

name the price paid. The patient goes on to question, very appropriately (given the price paid), why anyone would want to live that way. She is able to make explicit the connection between her mother's workaholism and her own.

Consultant: On the other hand, how could you possibly decide to stop when it feels so good?

The consultant, undaunted, continues to come down on the side of the patient's defense by appreciating just how difficult it would be to give up something that feels so good.

Patient: But it only feels good when someone notices how hard I've been working. Later I step back and it's already gone.

The patient admits that it is not the hard work per se that is rewarding but rather the recognition she gets from others that makes it worthwhile. But then, having said that, she has to admit that the defense does not even work all that effectively because, after a while, the good feeling begins to fade (because it depends upon external reinforcement to maintain itself).

Consultant: ...and yet the fear is that if you don't work

that hard then you won't get even those few precious moments when you finally get recognized and appreciated for your incredible hard work.

The consultant continues to go with the resistance by naming the patient's fear that if she doesn't get the recognition and appreciation this way, then she might not get anything at all. The consultant is elaborating upon the patient's investment in the defense—at least it secures for her a few of those precious moments (even if they are fleeting).

Patient: I don't know what I'd do without those moments. Every now and then, somebody notices—every now and then, somebody tells me that I've done a great job. When that happens, it feels so good.

The patient acknowledges that, indeed, the moments of recognition are precious to her. The patient is admitting that although those moments are rare, they do count for a lot. The patient is making explicit her investment in the defense.

Consultant: As a child, you never felt that your efforts were recognized and appreciated.

To this point, the consultant has been very much with the patient; now, sensing a window of opportunity, the consultant decides to direct the patient's attention elsewhere—in fact, to the patient's childhood. The consultant is reasonably sure that the intensity of the patient's need for recognition derives from traumatic thwarting of that need early on. The consultant's heart goes out to that little girl who, so eager for recognition from her parents, was in the position of having her heart broken time and again by parents who were oblivious to her.

Patient: My efforts were what kept the family together—but it was simply expected of me—my mother was so busy with my brother, Bob, who was adopted, and my father was just absorbed in himself.

The patient is then able to announce, with bittersweet pleasure, that it was by dint of her own hard work that the family remained intact. But then she goes on to lament the fact that her effort (and, by implication, her self-sacrifice) was not recognized or appreciated because it was expected of her. She clarifies that her mother's attention was focused on her brother, her father's on himself.

Consultant: ...and that left you feeling very empty, alone, and not seen.

The consultant has compassion for the little girl the patient once was. The consultant gently names the “empty,” “alone,” “not seen” feelings that the little girl must have felt, intolerably painful feelings against which the patient has been defending herself her whole life.

Patient: (sad, tears) I just didn’t count, I just didn’t matter. All my mother cared about was Bob—all my father cared about was himself.

The patient is visibly moved. With tears, she notes that she just did not matter. She is talking about how awful it was when she was a little girl and how sad she knows she must have been then and is now as she remembers. The patient is able to let herself remember just how bad it was; in the moment, she is no longer defending against the pain of it. Now she too has some compassion for the lonely little girl she used to be.

Consultant: (softly) There was no one to care about, and care for, you.

The consultant suggests that the situation

must have been such that there was no one to care either about or for the patient.

Patient: No one ever took care of me.

The patient, very sad, acknowledges the truth of this. She is very much in the moment, vulnerable, open, remembering, undefended, confronting the reality of just how bad it was.

Consultant: You were always so on your own.

The consultant, staying with the sad affect, recognizes and acknowledges that this state of affairs must have meant that the patient was very much on her own, having to fend, always, for herself. The consultant is painting a picture of the patient's current stance of incredible hard work and fierce independence as having arisen out of necessity—if she had not taken care of herself, no one else would have either.

Patient: If it weren't for my grandmother, I don't know what I would have done. She could see how hard I was working and always had something nice to say to me—that always made me feel special, appreciated—she would sometimes even pat me on my shoulder when I had done an especially good job.

The patient, feeling understood, remembers how grateful she has always been to her grandmother, without whose approval she would not have made it.

Consultant: Thank God for your grandmother and thank God that you were able, as you got older, to figure out a way to get at least a few more of those moments, a few more of those precious moments of special recognition, praise, and attention. By always working so hard, you have been able now to find what you so longed for as a child.

The consultant reinforces that she was indeed lucky to have had her grandmother and then goes on to suggest that she was also lucky (and smart) to have been able to figure out a way to compensate for how little recognition and attention she got otherwise. The consultant is highlighting how adaptive it was for the patient to develop the defense of hard work and proud self-reliance. She is also making explicit the connection between the patient's lifelong history of hard work and her yearning now to find the recognition, praise, and attention that were denied her then (by her parents).

Patient: Yes ...it's always meant a lot to me to get the tens and to get the rave reviews, but then I feel so empty.

The patient, appreciating the acknowledgment of that, remembers the praise with pleasure but then goes on to admit to how empty it all can feel.

Consultant: As a child, you so desperately wanted to get recognized and appreciated, but you almost never did. Your parents never even noticed how hard you were trying. At last, you have found a way to get the attention you have so desperately yearned for all your life.

The consultant chooses, for now, not to focus on the patient's acknowledgment of how empty it all feels but instead picks up on the patient's yearning as a child to get appreciation. The consultant goes on to reiterate the adaptive nature of the patient's defense, that at last she has been able to find what she has so desperately wanted all her life.

Patient: I love it when people notice how hard I work and are impressed.

Having just been given permission to feel good about the attention she has been able to get,

the patient responds by acknowledging unambivalently how much she loves the recognition. The patient is now explicitly owning her investment in the defense.

Consultant: Even if the wonderful feeling of having your hard work noticed and valued doesn't last for long, at least you will have gotten some moments of that wonderful feeling.

Now the consultant offers a conflict statement, in which she first returns to the patient's earlier statement that the precious moments of recognition are so transient and therefore empty but then, almost dismissing this, goes on to resonate with just how good it feels to be getting, finally, the long-awaited recognition.

Patient: Something is better than nothing ...even if it is at my expense (small laugh).

The patient, with some distance and some humor, acknowledges that she has settled for something for which she pays a high price but from which she derives at least some pleasure.

Consultant: Yes, even if it does mean that you have to work yourself to the bone, at least you're finally getting what you've longed to have all your life. At last you're getting the recognition

and appreciation you've waited your whole lifetime to find.

The consultant offers another conflict statement, juxtaposing the price the patient pays for having the defense with the patient's investment in the defense.

Patient: (sad, resigned, helpless) Yes ...my parents never paid attention to anything that was important to me. After all that I did for them, my parents were so unwilling to give me anything.

The patient, in despair, acknowledges just how deeply her parents let her down. She goes on to elaborate, with some bitterness, upon her resentment that after all she sacrificed on behalf of her family, she got so little in return. She is admitting to knowing that, even as a child, she was looking for a payoff for her unstinting efforts and self-sacrifice. Where before she was mostly in touch with her sadness, she is now getting more in touch with her deep resentment and outrage.

Consultant: It doesn't seem fair, does it?

The consultant picks up on this and observes that it wasn't fair. Note that she doesn't say,

“You must be feeling that it wasn’t fair, ” or “I wonder if you feel it wasn’t fair. ” The consultant is much more in the moment when she says, from her heart, “It doesn’t seem fair, does it?”

Patient: No, they never played fair.

The patient, able to hear this without getting too anxious, agrees that her parents “never played fair. ”

Consultant: It was clear that your father was not going to budge an inch on your behalf. But with your mother, it was more confusing. You didn’t feel that you could always count on her to be there for you, but you did know that she was trying to be a good mother and clearly wanted you to be happy.

The consultant, knowing that the patient has difficulty acknowledging her anger toward her mother, senses a window of opportunity here, a chance to direct the patient’s attention to the fact of her outrage. The consultant knows that the patient has no difficulty whatsoever acknowledging her angry resentment of her father; she decides to juxtapose the father’s unbudging stance with the more confusing situation of the mother. The consultant then

offers a conflict statement in which she first names the patient's knowledge of the mother's unreliability (which is bound to make the patient somewhat anxious) and then, somewhat paradoxically, suggests that the patient at least knew that her mother was trying hard to be a good mother.

Patient: I suppose so, but she just didn't know how to be a good mother.

The patient, feeling a little cornered, halfheartedly grants that her mother was probably trying to be a good mother, but then, unable to leave it at that since it represents, at best, only a piece of the truth, she goes on to note, for the record, that her mother really did not know how to be a good mother. On some level the patient is letting her mother off the hook by suggesting that the mother did not know how, but she is also, on another level, implicating her mother as not a good mother.

Consultant: It feels as if she did the best she could and that it would be unfair to have expected more.

The consultant continues to pose the paradoxes of these constructs to the patient; she now suggests that the mother was

probably doing the best she could and then gives voice to something the patient has herself probably protested in her time, namely, that it would be unfair to have expected more from her mother. The consultant is here naming what the patient might have felt compelled, defensively, to name if the consultant were not doing so already.

Patient: She put all her efforts into Bob, and she screwed me up by ignoring me.

The patient is now freed up to protest that her mother was busy ignoring her because she was so invested in the patient's brother.

Consultant: But she wanted so much to do the right thing by you and didn't mean to hurt you.

The consultant continues to go with the resistance, with the patient's need to protect her mother from the intensity of her rageful disappointment. In a last-ditch effort to defend the mother, the consultant protests that the mother wanted to do the right thing and did not want to hurt the patient. The consultant, by speaking up on the mother's behalf, is again presenting a paradox to the patient.

Patient: But sometimes I wonder if she was doing

what was right for me or what was right for her.

The patient simply cannot bring herself to say that her mother tried to do well by her because she knows, deep down, that that is not at all the truth; the patient must therefore get in touch with and acknowledge some of her bitter disappointment about her mother's obvious lack of availability and effort. And so the patient now hints at her suspicion that what she really thinks is that her mother was taking care of her own needs, not the patient's.

Consultant: You wonder sometimes about her motivation.

The consultant gives further voice to the patient's concern about her mother's motivation.

Patient: Yes ...because ultimately it didn't do my brother any good or me any good either. Bob doesn't want to take care of himself, and I've never known how to ask to be taken care of.

The patient is freed up to observe that her mother's behavior served neither Bob nor herself well. In making this observation the patient is noticing that her own difficulty in

asking for help may have its roots in this relationship with someone who was never able to offer much support.

Consultant: That's sad.

The consultant, aching for the little girl the patient once was, says neither "You're sad" (which might be experienced by the patient as somewhat intrusive) nor "I'm sad" (which unnecessarily introduces the feeling state of the consultant). The more impersonal "That's sad" encourages the patient to step back from what she is saying in order to observe and to feel the pathos in it.

Patient: If only she had seen how much she was hurting me.

The patient, herself now more compassionate toward the little girl she once was, laments, "If only she had seen how much she was hurting me." The patient is able to confront the reality of just how unavailable her mother was to her without being made too anxious.

Consultant: If only she had seen how much she was breaking your heart ...

The consultant elaborates a little further still,

sensing that the patient is very much with her and is now much more open to acknowledging the negativity she feels in relation to her mother, negativity that in the past she steadfastly denied.

Patient: (very sad, deep sigh) Everybody was telling my mother to back off with Bob, but no one was telling her to be more available to me.

The patient, very sad and no longer fighting it, observes that when she was young there was no one to tell her mother to be more available. The patient is not saying it directly but obviously knows that someone has finally gotten it, has understood just how alone and on her own she was as a child.

Consultant: If only someone had seen how alone you were and how much you needed someone to take care of you ...

The consultant elaborates upon the yearning and longing for someone to notice that the patient must have felt early on.

Patient: (very sad, now lots of tears) There were so many people around, and nobody saw.

The patient, deeply sad and in much pain,

through her tears remembers that there were so many people who could have done something to help her out but did not.

Consultant: No one was there to look out for you. No wonder it's so hard for you now to ask that people notice and be willing to help you out.

The consultant resonates with the pain of her deep hurt and sense of betrayal. The consultant then makes a connection between the patient's experience early on of not having been noticed and her current difficulty in asking for help.

Patient: My whole life, I've been so alone. My whole life, I've had to do it all on my own (now sobbing).

No longer resisting at all, the patient is at last really feeling her anguish and her grief about how bad it was and how alone she has always felt.

Consultant: (softly) ...how sad and lonely it must be, working and working and working.

The consultant gently resonates with how sad and lonely it must have been then and must be still.

The patient has spent a lifetime defending herself against feeling the pain and the outrage at how alone, unsupported, unrecognized, and unappreciated she was in her family. She has not been able to face the truth about just how unavailable her mother really was; instead, she has clung to her own workaholism in an attempt to find now a few of those precious moments of recognition and praise that were so rare for her as a child.

At the beginning of the session, the patient gives voice to just how difficult it is for her to reach out to others for help; she recognizes that she is overwhelmed and exhausted but is unable to imagine asking for help. As the session progresses, the consultant begins to appreciate and to name, on behalf of the patient, elements of the patient's investment in her workaholic behavior—namely, that working so hard is

“compelling,” it “feels good.” Then the consultant highlights the connection between the patient’s workaholism and her mother’s workaholism. Now patient and consultant observe the ways in which the mother’s hard work served her. But soon the patient, horrified, backs off, and wonders why in the world anybody would want to live that way.

Interestingly, it is now the consultant who legitimizes a person’s choice to work so hard; why would someone stop if working that hard feels so good? In essence, the consultant is elaborating upon the patient’s (and her mother’s) investment in the defense; the consultant is nonjudgmentally naming the patient’s investment in her pathology. The patient then has to acknowledge that it feels good only if someone notices and that, even then, the pleasure one gets from such recognition is fleeting.

But the consultant, undeterred, continues to speak up on behalf of the patient's defense; she persists in her support of it by highlighting the ways in which working so hard serves the patient. It falls to the patient to protest that there is a price to be paid for working so hard, for being so invested in the defense.

For the most part, therapists want to decrease the patient's anxiety, not increase it. In this particular situation, however, the patient has been in therapy for over three years but is still very firmly entrenched in her workaholic stance, still experiences herself as a helpless victim of her compulsive drivenness, still needs to protect her mother from the intensity of her outrage, and, more generally, is still very defended, resistant. Although she gives lip service to wanting her life to improve, she is clearly more invested in maintaining the status quo of things than she is in

changing it.

It may ultimately be more useful to this patient to create more, rather than less, tension within her. The consultant does this by speaking up on behalf of the patient's need to maintain things as they are. By being the spokesperson for the patient's resistance to change, the consultant forces the patient to be the spokesperson for her wish to change. In essence, by elaborating upon the ways in which the patient's defenses serve her, the consultant is creating more, not less, tension within the patient and forcing her to get in touch with and to name both how empty and unrewarding the workaholic behavior ultimately is and how angrily disappointed and alone she has always felt in relation to her neglectful and oblivious mother, whose attention she was never able to engage, no matter how hard she worked.

In other words, the consultant, by highlighting the patient's investment in her defenses, puts the patient in the position of having to name the price she pays for clinging to them. The consultant, by coming down on the side of the patient's defense, is forcing the patient to own what she knows to be the truth about her workaholic behavior and her mother's unavailability. The consultant is bringing into sharper relief the conflict within the patient between her unhealthy need to maintain things as they have always been, in order not to have to feel her pain, and her healthy wish to relinquish the struggle and to own how she really feels.

The consultant carefully avoids being in the position of naming for the patient the price she pays for clinging to her defenses and refusing to acknowledge the truth about things; instead, the consultant strives to get the patient to acknowledge both sides of her conflict, both her

investment in her defenses and the price she pays for being so invested, both her resistance to change and her wish to change. The consultant avoids a struggle with the patient; by coming down on the side of the patient's resistance in the way that she does, the consultant forces the patient to own both sides of her conflict.

By the end of the session, it is very clear that the patient's workaholism is a defense that has served her well; it has enabled her to find a few precious moments of recognition and praise, moments that were so rare for her as a child. It is also clear that she has clung to the workaholism as a way of holding on, masochistically, to her hope that someday, somehow, some way, she would be able to get her objects to be forthcoming; even now, all these years and years later, she is still yearning to find the recognition and praise she never got from her mother as a child.

But as she gets more and more in touch with how throwing herself into her work enabled her not to have to feel the pain of her disappointment in her mother, she is able to get more and more in touch with her sadness, her hurt, her sense of betrayed, and her sense of outrage. She cries for the little girl who had to tough it out on her own and for that little girl grown up, who is still working and working and working to find someone to notice and to care.

This clinical example demonstrates nicely the relationship between the patient's resistance and her inability to confront an intolerably painful reality about her mother's unavailability. In the sections that follow, we will be exploring, more generally, the relationship between the patient's resistance and his failure to grieve. I will suggest that it is as the patient grieves that the resistance is overcome and the patient gets better.

TOLERATING THE INTOLERABLE

First of all, what exactly do we mean by grieving? I think that grieving involves facing, head on, certain intolerably painful realities about one's objects, past and present; it means recognizing that one's objects have certain very real limitations; it means accepting that one is ultimately powerless to do anything to make those painful realities different. Grieving requires of the patient that he feel, to the very depths of his soul, his anguish and his outrage that the therapist is as he is, that the parent was as he was, that the people in his life are as they are, and even that he is himself as he is. Ultimately, the patient must feel all of what needs to be felt in order to make his peace with the reality of just how imperfect, just how flawed, just how disappointing his world really was and is.

Grieving does not mean being depressed,

feeling sorry for oneself, blaming oneself, blaming others, feeling victimized. The patient who faults, blames, and accuses is not accepting the reality of things as they are. Nor is the patient who protests that it isn't fair, that he is entitled to more. Nor is the patient who insists that his objects change, demands that his objects be other than who they are. Such patients are not accepting reality; they are refusing to accept it. They are not confronting reality and doing what they must do to come to terms with it; instead, they are refusing to confront reality, they are refusing to grieve. They are doing something that I refer to as pseudogrieving, which involves a display of emotion that mimics grief but is not the real thing.

A Hasidic saying (Buber 1966) speaks to this distinction: "There are two kinds of sorrow.... When a man broods over the misfortunes that have come upon him, when he cowers in a corner

and despairs of help—that is a bad kind of sorrow.... The other kind is the honest grief of a man whose house has burned down, who feels his need deep in his soul and begins to build anew” (p. 231). The bad kind of sorrow is what I am here describing as pseudogrief; the heartfelt grief of a man who feels his pain deeply is a healthy response to disappointment and to loss.

Genuine grief involves confronting the reality of just how bad it really was and is; and it means accepting that, knowing that there is nothing now that can be done to make it any different. It means coming to terms with the fact that neither the objects in one’s world nor one’s self will ever be exactly the way one would have wanted them to be. Nor will life ever be exactly the way one would have wanted it to be. It means knowing that one may well be psychically scarred in the here and now because of things that happened early on but

that one must live with that, knowing that there is no way to undo the original damage done. Perhaps there are ways to compensate for the early-on injuries, but there is no way to undo them, no way to extract from one's objects in the here and now recompense for the wounds sustained then.

Grieving means being able to sit with the horror of it all, the outrage, the pain, the despair, the hurt, the sense of betrayal, the woundedness; it means accepting one's ultimate powerlessness in the face of all this; and it means deciding to move on as best one can with what one has—sadder, perhaps, but wiser too. There is a kind of peace that comes with recognizing that things were as they were and are as they are. No longer does one need one's objects to be other than they are; no longer does one yearn for things to be different; no longer does one compulsively repeat the past in the present in the hope that perhaps

this time it will be different. It means appreciating that one has what one has. There may even come a time when one begins to recognize that if it had been different, one might not have become who one is.

The patient who is able to confront reality and able to grieve it is a patient who no longer needs his defenses and is therefore no longer resistant. On the other hand, the defended patient, the resistant patient, is someone who has not yet grieved, has not yet confronted the painful realities about his objects, both infantile and contemporary. Unable to bear the pain of his disappointment, he clings to his defenses. In order not to know, the patient holds on to unrealistically positive perceptions (illusions) about the goodness of his objects and unrealistically negative perceptions (distortions) about the badness of himself—and, by way of projection,

about the badness of his objects.

By clinging to the illusion, for instance, that his therapist will make up the difference to him and will make his pain go away, the patient defends himself against the excruciatingly painful reality that neither his therapist nor anyone else will ever be able, really, to right the wrong or entirely undo the damage sustained early on. By clinging to the illusion, the patient does not have to confront the reality of the therapist's limitations.

By clinging to a distorted sense of himself as damaged from way back and therefore incapable now of doing anything on his own to make things better, the patient defends himself against the frightening reality that, if he is to get better, ultimately it really is up to him. By clinging to the distortion, the patient does not have to confront the reality that it is his responsibility.

The patient's illusory sense of his objects as good, or at least potentially good, and his distorted sense of himself as bad speak to his refusal to confront reality, his refusal to mourn. The patient who keeps hoping that things will change has not yet confronted the reality that they will not. The patient who imagines that it is he who is undeserving and bad has not confronted the reality that it was his objects who were limited. The patient will remain stuck in his life and in the treatment until he comes to the point where he can confront, head on, the excruciatingly painful reality of all the good that was not and all the bad that was, and can somehow make his peace with it.

Put somewhat simply, the patient is ill because he has not yet grieved all the losses he has suffered; instead, he defends himself against experiencing such losses. To the extent that he is defended, to that extent will he be resistant to

doing the grief work that ultimately needs to be done, to that extent will he be unable to let go of the past, let go of his infantile attachments, let go of his relentless pursuit of infantile gratification and his compulsive reenactments, to that extent will he be unable to get on with his life. It will be only as the patient grieves that he gets better.

In the context of the patient-therapist relationship, grieving means facing, head on, the excruciatingly painful reality of the therapist's limitations (the therapist, of course, a stand-in for the parent). It means recognizing that he, the patient, is ultimately powerless to do anything to make that reality different—at the same time that he is responsible for doing whatever he must do in order to go forward in his life. And it means feeling all his pain, all his outrage, and all his anguish about just how limited his therapist, his parents, and the people in his world really are. It will be as

the patient confronts these hard realities head on
and grieves them that he will let go of his defenses,
let go of his resistance, and get better.

Grief and Internalization

THE ORIGINAL TRAUMA

I am suggesting that the patient, as a child, was made ill as a result of being unable to face, head on, the heartbreakingly painful reality of just how disappointing his parent really was. In order to render his parent less bad, the child took the burden of the parent's badness upon himself (creating a distorted sense of himself as bad). In this way he was able to preserve the relationship with his parent and his illusions about the parent as good and ultimately forthcoming. Feeling bad about himself seemed like a small price to pay if it enabled him to preserve his belief in the parent's goodness, his hope that perhaps someday,

somehow, some way, if he could but get it right, his parent's love would be forthcoming.

That process, that taking on of the parent's badness, happens in an obvious way with abused children. It is easier to experience oneself as having deserved the punishment than to accept the reality of just how abusive the parent really is, easier to fault oneself and feel guilty than to fault the parent and feel angry—ultimately, it is easier to experience oneself as bad than to accept the parent's badness.

By sacrificing himself, the child can deny the parental badness and can cling to the hope that if he tries really hard to be really good, then maybe someday, somehow, some way, he will be able to get his parent (or someone who is a stand-in for his parent) to love him as he should have been loved. After all, if the badness resides within

himself, then he has more control over it than if it resides within the parent.

And so the child clings to the illusion that his parent was good and to the distortion that he himself was bad—although the reality is that it was he who was good, the parent who was bad (including here the parent's sins of omission as well as the parent's sins of commission, the absence of good as well as the presence of bad). Had the child been able to accept just how limited the parent really was, then he would not have the need to cling to the illusion of the parent as good and ultimately forthcoming. Had the child been able to accept just how limited the parent really was, then he would not have had the need to take the burden of the parent's badness upon himself in order to preserve the relationship with his parent. In other words, had the child been able to confront the intolerably painful reality of just how bad the

parent really was, then he would not now have the need for illusion or distortion.

As a grown-up, such a person brings to his relationships both his illusions and his distortions, both his unrealistically positive perceptions about his objects and his unrealistically negative perceptions about himself and, by way of projection, his objects. Under the sway of the repetition compulsion, the patient delivers both his illusions and his distortions into the transference. Paradoxically, even as he hopes for the best, he expects the worst. Even as he looks to the therapist to be the good parent he never had, he fears that the therapist will turn out to be the bad parent he did have. Even as he longs for the therapist to be good and to make up the difference to him, he needs the therapist to be bad, in order to conform to his worst fears, his worst expectations—because that is all he has ever

known.

As I discussed earlier, we speak of a positive transference when the patient delivers his illusions into the relationship with his therapist and comes to hope that his therapist will be the good parent he never had. We speak of a negative transference when the patient delivers his distortions into the relationship with his therapist and comes to fear that his therapist will be the bad parent he did have. In other words, the patient delivers his pathology (both his wish for good and his fear of bad) into the transference—in the form of his illusions and his distortions.

In sum, the presence of illusion and distortion speaks to the patient's failure to grieve. The illusions and the distortions arose, originally, in the context of defending the patient against confronting the horrid reality of just how bad it

was. In the here and now, they serve to defend the patient against confronting the not-always-so-horrid reality of things as they are.

TOXIC AND NONTOXIC REALITIES

This brings us to an important distinction: the distinction between the parent's traumatic failure of the child and the therapist's nontraumatic failure of the patient. I would like to suggest that the reality against which the patient defended himself as a child was a *toxic* reality, whereas the reality against which the patient now defends himself may well be a *nontoxic* reality. But in both situations, the person defends himself against acknowledging the reality because it hurts too much to know the truth, whether about the infantile object or the transference object.

Let us first consider the toxic reality: the parent did not love the child as he should have

been loved. The child cannot possibly confront the pain of that. And so, as we know, he takes the burden of that badness upon himself in order to preserve the illusion of his parent as good, in order not to have to feel the pain. The resulting distortions and illusions serve to protect the child from acknowledging the horrid, toxic truth about his parent.

What about the nontoxic realities? Ultimately, of course, the therapist is neither as good as the patient had hoped nor as bad as the patient had feared; but the patient does not want to accept the truth of that. And so he clings to his unrealistically positive misperceptions of the therapist in order not to have to face the pain of his disillusionment. And he clings to his unrealistically negative misperceptions of the therapist in order not to have to confront the reality that it need not have been as bad as it was early on.

Until the patient's new experience in the present with the therapist, the patient may not actually have realized just how bad the parent was. Along these lines, Clara Thompson (1950) has written: "In order to become conscious that something is wrong, one must have a new experience which makes one aware of new possibilities" (p. 98).

There comes a time, then, when the patient begins to recognize that things could have been otherwise. As the patient comes to know the reality of who his therapist is, he begins to get in touch with what could have been, begins to recognize that things with his parent could have been different. A turning point in the therapy for one patient came when he suddenly recognized, about his childhood: "My God, it didn't have to be that way...."

But this recognition, this knowledge, this reality, makes the patient anxious. It makes him anxious to be confronted with the reality that the therapist is not as bad as he had assumed the therapist would be (based upon experiences he, the patient, had early on in relation to a toxic parent). Once the patient comes to know that it could have been otherwise with his parent, then it is that his heart breaks.

In any event, that the therapist is not as good as the patient had wanted him to be is what I am here referring to as a nontoxic reality. By the same token, that the therapist is not as bad as the patient had expected him to be is also a nontoxic reality.

And so there are toxic realities, against which the patient must defend himself because he cannot bear the pain of just how horrid his parent really

was, and there are nontoxic realities, against which the patient tries to protect himself as well, because they challenge his ways of experiencing his objects—they challenge his need to experience his objects as other than who they are.

It is important, therefore, that we as therapists recognize and appreciate not only the patient's need to defend himself against acknowledging the horrid truth about his parent but also his need to defend himself against acknowledging the not-always-so-horrid truth about who we are, namely, that we are neither as good as he had hoped nor as bad as he had feared. The truth about his parent is a toxic reality; the truth about us is a nontoxic reality—but the patient feels the need to defend himself against both.

WORK TO BE DONE

Ultimately, the work that needs to be done in

order to work through the resistance is grief work. Instead of denying the reality of the early-on parental failure, the patient needs to be able to face it head on. Instead of raging at himself, he needs to be able to rage at the disappointing parent. Instead of experiencing the badness as within himself, he needs to recognize that it was in the parent. It is not he who is unworthy, undeserving, but his parent who was limited. Instead of clinging to the illusion that he may someday be able to extract the goodies from the parent (or a stand-in for the parent), he needs to accept the fact of his powerlessness to do anything in the face of the object's very real shortcomings and inadequacies.

Only when the patient can bear to recognize and face the reality of just how bad the parent really was, only when the patient can accept his ultimate powerlessness to get the parent to

change, only when the patient has raged about his parent and sobbed his heart out, only then will the patient be able to let go of the illusions and distortions around which he has organized himself and his experience of the world.

The therapeutic work requires of the patient that he make his peace with the fact that the therapist is neither as good as he had hoped nor as bad as he had feared. The patient makes his peace with the discrepancy between what he comes to know as real and what he imagined was real by way of working through the transference, both the positive transference disrupted (when it turns out that the therapist is not as good as the patient had hoped he would be) and the negative transference. Working through the transference is the process by which the patient is able, gradually, to relinquish the illusions and distortions to which he has clung in order not to have to confront the

painful realities about his infantile (and now contemporary) objects.

The therapeutic work requires of the patient that he be able to experience reality as it is and come to terms with it. In other words, to repeat, the patient gets better as he grieves. It is by way of grieving that the patient is able to relinquish his defenses and get on with both the treatment and his life.

Mental health has to do with the capacity to experience reality as it is. Mental illness (pathology) has to do with the need to experience it as it is not, in ways contaminated by the past. To the extent that the patient holds fast to his illusions and his distortions and refuses to face reality, to that extent will the patient be described as resistant. To the extent that the patient is able both to experience reality as it is and to grieve

past and present heartbreakingly painful realities, to that extent does the patient overcome his resistance and get better.

And so the patient's distortions (his sense of badness within himself and, by way of projection, within others), his illusions (his hope that his therapist, his actual parent, his objects will be the good parent he never had), and his entitlement (his sense that this is his due) all speak to his failure to grieve and constitute, therefore, an important part of his resistance to letting go of the old and opening himself up to the new.

It is as if he is saying: I can't, you can, and you should. As long as he clings to his distortions (I can't), his illusions (you can), and his entitlement (you should), he will not get better. As long as he refuses to grieve, refuses to remember, refuses to relive, refuses to let himself really feel, in his gut,

the depths of his devastation and his outrage about just how bad it really was, he will be destined forever to misunderstand his present in terms of his unresolved past. As Kopp (1969) observes:

The adult in whom the unmet, unmourned child dwells, stubbornly insists that he has the power to make someone love him, or else to make them feel sorry for not doing so. Appeasing, wheedling, bribing, or bullying are carried out in stubborn hope that if only he is submissive enough, sneaky enough, bad enough, upset enough, something enough, ... then he will get his own way. [p. 31]

It is only as the patient grieves the reality of what the parent did not give him that he can begin to appreciate and to take in all those things that the parent did give him. And it is only as the patient grieves the reality of what the therapist does not give him that he can begin to appreciate and to take in all those things that the therapist

does give him. As Kopp (1969) writes:

[The patient] must learn to live well, in the present, beginning with things as they are, and open to the ambiguities of this mixed bag of a world, as it is. And all of this he must do in spite of the fact that he has been cheated, has had to stand by helplessly while he was ignored, betrayed, undone; while he watched his hopes shattered, his most precious possessions lost, and his dreams unrealized, [p. 30]

The patient needs to be able, eventually, to come to terms with the reality of who his parent was to him. In doing so, he will be able to overcome his resistance to getting better, let go of his infantile attachments, become more realistic in his appraisal of himself and of others, let go of his distortions and illusions, and get on with the business of living.

INTERNALIZATION AS A PART OF GRIEVING

The patient gets better as he grieves, in large part because of the internalizations that accompany the grieving process. It is to self psychology that we look in order to enhance our understanding of the relationship between grieving and internalizing the good. In its barest bones, self psychology is a theory about grieving, grieving the loss of illusion; the illusions are about the perfection (or the perfectibility) of the self and/or the object. As part of the grieving, the functions performed by the disillusioning object are internalized and laid down as psychic structure, structure that transforms the patient's narcissistic need for perfection into a capacity to tolerate imperfection, structure that transforms the patient's need for external regulation of his self-esteem into a capacity to provide such

regulation internally.

In what follows, we will explore in greater detail the self psychologists' model for the development of psychic structure so that we can more fully appreciate the relationship of grieving to internalization and structural growth. Although the province of self psychology is the patient's need for perfection, our emphasis will be a more general one—namely, the patient's need for his objects to be other than who they are. By the same token, our concern will be less with the transformation of the patient's need for perfection into a capacity to tolerate imperfection than with the transformation of the patient's need for his objects to be other than who they are into a capacity to tolerate them as they are. In other words, our goal will be to conceptualize the relationship between grieving and taking in from the outside, internalizations that facilitate the

transformation of the patient's defensive need for illusion and distortion into a healthy capacity to tolerate reality as it is.

OPTIMAL DISILLUSIONMENT AND TRANSMUTING INTERNALIZATION

The self psychologists have conceptualized a model for development of self structure in which empathic failure provides an opportunity for growth. More specifically, self theory informs us that it is the experience of properly grieved frustration, against a backdrop of gratification, that provides the impetus for internalization and the laying down of (self) structure that enables the person to regulate internally his self-esteem.

In essence, when the parent has been good and is then bad, the child masters his disappointment with the frustrating parent by taking in the good that was there prior to the introduction of the bad.

He defensively and adaptively internalizes the good parent as part of the grieving process, so that he can preserve internally a portion of the original experience of external goodness.

Where once there was deficit, now there is capacity. Where once there was the need for external regulation of the self-esteem, now there is the capacity for internal regulation of it. In other words, where once there was the need for the parent to perform certain functions for the child in order for the child to feel good about himself, now the child is able to provide such reinforcement internally. No longer does the child need to be cherished, admired, perfectly mirrored by his parent in order to feel good about himself. As the child comes to understand and to accept the fact that his parent will not always be all that he would have wanted him to be or be able to provide for him in all the ways that he would have wanted, the

child begins to separate from the infantile object, to relinquish his infantile attachments, and to develop a capacity to rely upon himself.

Note that, according to self theory, good gets inside not so much as a result of experiencing gratification but as a result of working through frustration against a backdrop of gratification. More specifically, self structure develops not so much as a result of the experience of an empathically responsive parent but as a result of working through disappointment in an otherwise empathically responsive parent, working through a positive transference disrupted.

In other words, the impetus for internalization is the failure itself. As long as the child is having his needs met, there is no impetus for internalization because there is nothing that needs to be mastered.

KOHUT AND WINNICOTT ON INTERNALIZATION

Before we move on, I would like to spend a little time highlighting an important point: the relationship between the recognition of separateness and the capacity to internalize. Kohut (e.g., 1971, 1977, 1978) believes that internalization precedes separation. Winnicott (1969), on the other hand, believes that separation precedes internalization.

Let us first consider Kohut's perspective. He defines the selfobject as an object experienced as part of the self. Optimal disillusionment with the selfobject leads to transmuting internalization that results in the accretion of internal structure. As the child develops internal capacity, he becomes less reliant upon the outside for external reinforcement and no longer has the same need to use the object as a selfobject, as a "narcissistic

extension” of himself. The object can now be related to in a different way, a way that recognizes the object as separate from the self. And so it is that, in Kohutian theory, internalization precedes the development of the capacity to tolerate separateness between self and object.

Winnicott, on the other hand, believes that there is no impetus for internalization until the object is experienced as separate from the self. The object comes to be experienced as separate from the self only gradually and over time. Winnicott (e.g., 1960, 1963a) proposed the following developmental progression: first, a stage of absolute dependence (characterized by object relating, in which the mother is experienced as a subjective object indistinguishable from the self); second, a stage of relative dependence (characterized by the mother’s graduated failure of adaptation, which establishes her externality);

and finally, a stage of autonomy (characterized by object usage, in which the mother can be objectively perceived, is experienced as separate from the self, and is therefore capable of being *used*, that is, internalized).

For years I had misread Winnicott. I had assumed that when he spoke about the holding environment provided early on by the mother, he was suggesting that the infant is nourished by an environment that provides all sorts of nutrients that are then absorbed, taken in, as by osmosis—a kind of internalization.

In fact, Winnicott is not talking about internalization. The maternal holding environment provides a protective envelope within which the “inherited potential” of the infant can be actualized. The mother does not provide nourishment; she provides protection from

impingement. The mother allows the infant the experience of an “uninterrupted continuity of being”; in essence, she facilitates the coming into being of his true self. At this stage of development, internalization is not involved.

It is only later, with the achievement of the third and final stage of development (in which self and object are recognized as separate), that the child can internalize the object. Only when objects have come to be recognized as outside his sphere of omnipotence, as separate from him, does the child develop the capacity to internalize objects. In the way of things, achievement of the capacity to recognize the separateness between self and object occurs rather late. And Winnicott is very clear that until such a developmental stage has been attained, there is no capacity for internalization.

Given Kohut's and Winnicott's different models, how are we to conceptualize the relationship between the capacity to internalize and the recognition of separateness between self and object? I would like to suggest a way of integrating the two theories. Kohut says that the selfobject is experienced as part of the self. Perhaps we can refine this concept to say that the selfobject that gratifies is experienced as part of the self. As long as it is experienced as part of the self, there is no impetus for internalization. It is only when the selfobject frustrates that it is experienced (at least momentarily) as separate from the self. In fact, the experience of disappointment with the selfobject may be an important part of what establishes the object as outside one's sphere of influence, as separate from the self. Then, once the object is experienced as separate from the self, it can be internalized—in

order to be preserved.

It is by way of a series of such internalizations that the child (or the patient) is able to fill in his structural deficits and whereby he no longer has the same need to use the object as a selfobject. At this point, the child (or the patient) can relate to the object as a separate object, because separateness between self and object can now be tolerated.

And so frustration is a reminder of the separateness between self and object; it provides the impetus for internalizations that then make possible acceptance of the actual separateness between self and object.

INTERNAL IMPOVERISHMENT

How does the self psychological perspective on structural growth translate into the clinical

situation? Imagine the following scenario. The child, now grown up and in treatment for years, has made significant improvements in the external circumstances of his life but still speaks of a profound loneliness and a relentless despair. He is deeply attached to his therapist and feels held by him in the sessions, but between sessions he cannot sustain any of the good feelings and instead feels desperately alone and empty.

My claim will be that the patient's internal impoverishment, the paucity of healthy psychic structure, is the price he pays for his inability or unwillingness to grieve his past. It is the price he pays for his refusal to face the reality of just how bad it really was. Because the patient has never made his peace with just how limited his parent really was, he has a distorted sense of himself (as limited, as incapable, as having been so damaged from way back that he is not now able to do

anything on his own to ease his pain), underlying illusions (that his objects and, in particular, his therapist will be able to ease his pain), and deep entitlement (a profound conviction that this is his due).

But he will never get better as long as he clings, usually unconsciously, to those distortions, those illusions, and that entitlement. “It was not my fault then, so it should not be my responsibility now” is the patient’s belief; it is because the patient is firmly convinced of this that he does not really engage himself in the therapeutic endeavor.

If the patient is to benefit from the treatment, over time he must come to understand that his therapist will not be able to make him all better, will not be able to fill him up inside, will not be able to make up the difference to him and to right the wrong done, much as both patient and

therapist might wish this to be possible. Eventually the patient must feel his disappointment, his heartache, and his outrage about all this; he needs to feel, to the depths of his soul, his devastation that he will not be able to get from the therapist (a stand-in, of course, for the parent) what he so desperately yearned to have. He must face, head on, the intolerably painful reality of the therapist's limitations—namely, the therapist's inability to make up entirely for the bad parenting the patient had as a child.

Grieving means confronting the reality of just how bad it was then and is now; and it means accepting that, knowing that there is nothing that can be done in the here and now to make it any different. It is only as the patient grieves the reality of just how limited his parent was that he can begin to internalize all that the parent did have to offer. And it is only as the patient grieves

the reality of just how limited his therapist is that he can begin to profit from all that the therapist has to offer. It is only as the patient grieves the reality of what is not good that he can have what is good.

But as long as the patient refuses to face reality as it is and clings instead to illusions about what might be, he will not be able to internalize whatever good there has been for him—and he will continue to feel empty. It is by means of grieving that healthy structure is laid down, internal capacity develops, deficits are filled in, and the self is consolidated. It is by means of grieving the painful realities of past and present that the patient, over time, comes to feel a little more full, a little less internally impoverished. In other words, it is by means of working through disillusionment, working through positive transferences disrupted, that structural growth is

effected.

Self psychology is all about this process of grieving the loss of illusion, loss of the illusion that the therapist will be able to make up the difference to him, loss of the illusion that the therapist will be the good parent the patient never had. As he develops internal structure, the patient becomes for himself the good parent he never had.

SEDUCTION AND BETRAYAL?

In a way, sleight of hand is involved. On the one hand, we encourage the patient with impaired capacity and structural deficit to deliver his infantile needs into the transference; we imply that it will be safe for him to have such expectations in relation to us. We do not interpret his need to have us be perfect. We allow it to be, implying that we are comfortable with being experienced that way and potentially capable of

gratifying his need for perfection. In essence, we “seduce” him into having all sorts of illusions about us.

On the other hand, once the patient has finally developed a full-blown narcissistic (or selfobject) transference, he finds that we periodically disappoint him, that we are not perfect, and that we cannot always deliver what he imagined we could. In other words, we betray him, and we do it repeatedly.

How can this be right? Is it fair to offer the promise of something and then fail to deliver? It is perhaps the ultimate seduction and betrayal to imply that we will be able to gratify the patient’s infantile expectations and then to disappoint him over and over again, when it turns out that we really are not perfect.

I would like to propose the following. When

the child's developmental needs are repeatedly and traumatically frustrated, he eventually represses them, so that he will not have to be in the position of having his heart broken again and again. As long as his needs are repressed, we have no access to them, because the system is a closed one. Only with the therapeutic reactivation of his thwarted needs and their delivery into the transference (that is, only with the mobilization of a selfobject transference) can we convert what was a closed system into an open system, to which we have access.

Yes, as the therapist of someone who needs us to be perfect, we will be in the position of disappointing the patient over and over again, because we are not perfect. That is a reality, not a distortion. But if each such disappointment is the occasion for grieving the therapist's nontraumatic failures and the parent's traumatic failures, then

we will be helping the patient do some really important work. Heartache and disappointment recapitulated in the transference will afford the patient an opportunity to rework the heartache and disappointment experienced at the hands of the parent. It enables the patient to reexperience the original devastation, to put it into words and into perspective, to learn to bear it, and eventually to move on.

As we know, part of mastering the pain of the disillusionment are the defensive and adaptive internalizations that occur during that grieving process. Transmuting internalization and accretion of internal psychic structure result from the experience of having had and then lost. Unless the patient has had the opportunity to have illusions about the therapist, to lose them, and to work those losses through, then there is no opportunity for structural growth, no opportunity

for the adding of new good. And the patient (with structural deficits) will be destined forever to yearn for something he can never have, destined forever to feel empty, impoverished, and alone, destined forever to pursue that which he cannot have.

So there is, admittedly, an initial seduction and then repeated betrayals, but it is the recovery from such betrayals that constitutes the working-through process and is the means by which the patient is enabled to do some belated grieving, some structure building, and some relinquishing of his illusions, illusions that are, of course, part of his resistance.

SELF PSYCHOLOGY ON STRUCTURAL GROWTH

It is to self psychology, with its emphasis on illusion, disillusionment, grieving, and

internalization, that we look in order to enhance our understanding of how it is that illusion is relinquished, structure is laid down, and capacity is developed. I believe that self psychology provides a more comprehensive model for understanding structural growth than does either classical psychoanalysis or object relations theory.

To summarize what I have been saying to this point about grieving, internalization, and structural growth: according to self theory, an empathic failure (against a backdrop of gratification) is what provides the impetus for the accretion of psychic structure. If such a failure can be worked through and mastered, that is, grieved, then it is the occasion for a transmuting internalization, that is, the building of self structure. In other words, optimal disillusionment provides the impetus for internalizing a good object and laying down new structure; a loss

properly grieved gives rise to healthy psychic structure. More specifically, the regulatory functions that the selfobject parent had been performing prior to his failure of the child are internalized. Taking in the good that was is part of the grieving process and is the way the child masters his experience of the parental failure.

When it is said that the child works through, or grieves, his disillusionment, it is not always easy to conceptualize what is actually involved in that process. Tolpin (1983) has suggested that the working-through process involves some kind of “developmental dialogue” (often nonverbal) between caretaker and infant that enables the child to master his disillusionment with the parent. If all goes well, the child is then able, as part of coming to terms with the reality of parental shortcomings, to rely not upon the parent but upon his own resources to regulate his self-esteem

and to feel good about himself.

How does this relate to the work of therapy? Where it is difficult to conceive of the child's working through his disappointment with the parent, it is much less difficult to conceive of the patient's working through his disappointment with the therapist. In fact, such a process is what we speak of as working through a disrupted selfobject (or narcissistic) transference and is the process whereby functions are internalized, structure is laid down, deficits are filled in, and capacity develops.

I will be proposing that as the patient works through the loss of his illusions about reality, he is able to take in whatever good there is and, in the process, transform his defensive need for illusion into a healthy capacity to tolerate disappointment. As the patient gives up the illusions to which he

has clung since earliest childhood in order not to have to confront the pain of his disappointment with his infantile objects, he develops the capacity to accept that which he cannot change and to direct himself toward changing that which he can. As the patient works through disrupted positive transferences, he overcomes his need for illusion.

And so it is that self theory spells out very clearly the relationship between internalization and the development of capacity; it also facilitates our understanding of what is involved in overcoming the patient's compulsive need to contaminate the present with his past.

FREUD ON INTERNALIZATION AND STRUCTURE BUILDING

Before we move on, let us take a brief look at what Freud himself actually said about the relationship between internalization and structure

building.

The closest Freud came to addressing the relationship between internalization and structuralization was in his paper “Mourning and Melancholia” (1917), in which he hypothesized that internalization was the person’s defensive and adaptive reaction to the perceived loss of an ambivalently held, narcissistically cathected love object. When he wrote, “The shadow of the object falls upon the ego,” he was referring to just such a process of internalization and structure building. But he never really developed the idea.

Furthermore, I think that Freud says different things at different times about the structure that gets laid down as a result of internalization. In “Mourning and Melancholia,” Freud proposes one mechanism for the development of the superego. Six years later, in “The Ego and the Id” (1923)

(wherein he introduces the structural model of the mind), he proposes a different mechanism for its development.

More specifically, in the first paper, Freud suggests that depression (melancholia) results from internalizing the lost love object. In the aftermath of the “loss” of the love object, the shadow of the lost object falls upon the ego (which means that part of the ego becomes identified with the lost object). Where once the person raged against the abandoning object, now a part of the ego (which later came to be called the conscience or the superego) sets itself apart from the rest of the ego (now identified with the abandoning object), sits in judgment upon it, and rages against it. Where once the subject railed against the object, now the superego rails against the ego. The result is depression.

In the second paper, Freud introduces the structural model of id, ego, and superego and writes at greater length about the development of the superego. But this time he suggests not that the lost (oedipal) object becomes part of the ego but that the lost object becomes part of the superego. In essence, the shadow of the lost object falls upon the superego. Where once the object railed against the subject, now the superego rails against the ego.

In both instances, an internal relationship has replaced an external relationship. In the first instance, the person rages against himself where once he raged against the object. In the second instance, the person rages against himself where once the object raged against him.

In the first instance, the shadow of the object falls upon the ego. In the second instance, the

shadow of the object falls upon the superego.

In the first instance, the ego identifies with the lost object; the superego attaches itself to the ego (the lost object) and rages against it as once the person attached himself to the external object and raged against it. In the second instance, the superego identifies with the aggressing lost object and now aggresses against the ego as once the object aggressed against him.

I think this is confusing; and I think that Freud's inconsistency in this regard accounts in part for some of the lack of clarity that persists to this day about how it is that internal structure develops. For example, when does the lost object become part of the ego? When does it become part of the superego? And when does it become part of the ego ideal? Furthermore, when we speak of internalization, when do we want to emphasize

the subject's identification with the internalized object and when do we want to emphasize the subject's attachment to the internalized object?

Additionally, to what extent does loss involve internalization of good objects? To what extent does it involve internalization of bad objects? In other words, what is the relationship between loss and the development of healthy structure (which is what self theory emphasizes), and what is the relationship between loss and the development of unhealthy structure? A related question has to do with what gets internalized when a loss has been properly grieved and what gets internalized when a loss has been improperly grieved.

Freud did not particularly distinguish between good and bad objects; nor did he emphasize the importance of grieving the loss of an object, whether good or bad. But what he did say (in both

1917 and 1923) is that the person's reaction to the loss of an object is a defensive and adaptive internalization of it.

The Development of Pathology

“We don’t see things as they are; we see them as we are.”

—Anonymous

NONTRAUMATIC AND TRAUMATIC FRUSTRATION

To this point my emphasis has been on the relationship between loss and the development of healthy structure. In fact, I have been suggesting that it is by way of working through the experience of loss that the child lays down healthy structure to begin with and that the internally impoverished, structurally deficient patient lays down healthy structure belatedly. In other words, whether it occurs as an aspect of normal

development (in the child's case) or, later, over the course of a treatment (in the patient's case), a properly grieved loss results in the addition of new, healthy structure.

But what is it, we might now ask, that creates pathology? In other words, what is it that creates structural deficit (which speaks to the absence of good) and structural conflict (which speaks to the presence of bad)?

Before tackling this question, I would like to offer working definitions for both *nontraumatic (or optimal) frustration*, the hero in this piece, and *traumatic frustration*, the villain. In keeping with the self psychologists, let us define a frustration as nontraumatic if and only if it can be processed and worked through, that is, grieved. By the same token, a frustration is traumatic if and only if it cannot, for whatever reasons, be mastered.

The distinction is an important one. I will be developing the idea that nontraumatic frustration (a loss properly grieved) provides the impetus for internalizing one kind of object, namely, the good object, whereas traumatic frustration (a loss improperly grieved) provides the impetus for internalizing another kind of object, namely, the bad object. In other words, nontraumatic frustration results in healthy development and traumatic frustration results in pathology.

TRANSFORMATION OF NEED INTO CAPACITY

Before we consider the relationship between traumatic frustration and the development of structural deficit and conflict, let us look at the relationship between nontraumatic frustration and the development of healthy structure. First, what exactly do we mean by the term *structure*? Psychic structures are internal configurations that

are relatively enduring over time, relatively resistant to change, and, most important, perform functions. Structure means capacity.

The drive structures of classical psychoanalytic theory (the drive-regulating introjects in the ego and superego) perform the function of drive regulation (regulation in the sense of modulation or control). In fact, classical psychoanalysis is about development of the ego and the superego (or conscience) from the id; it is about transformation of id energy into ego and superego structure.

The self structures of self theory—the ambitions and purposes of the ego, the goals and aspirations of the ego ideal—perform the function of self-esteem (or, as it is more often called, self) regulation. Not surprisingly, self psychology is about development of the self—more specifically,

the ego and the ego ideal. It is about transformation of narcissistic energy into ego and ego ideal structure.

Let me back up a bit. As we know, the province of the classical psychoanalysts is development of the ego and the superego; their focus is on the id drives and the regulation (or control) of those drives. Initially, in classical psychoanalysis, the child's libidinal and aggressive drives are regulated externally by the infantile drive object. In other words, some drives are gratified, some are frustrated. Over the course of development, the function of drive regulation is internalized, and regulatory structures develop in both the ego and the superego (or conscience). Such structures are drive regulators, drive-regulating introjects; these introjects have taken over the function of drive regulation once performed by the drive object.

Classical psychoanalysis, then, is really all about transformation of the drives into drive-regulating structures in the ego and the superego. As energy is transformed into structure, need is transformed into capacity: the need for external drive regulation is replaced by the capacity for internal drive regulation.

We can express such a process of transformation in a number of ways. We can speak about transformation of the need for immediate gratification into the capacity to tolerate delay or of the need for absolute gratification into the capacity to derive pleasure from relative gratification. More generally, we speak of transformation of the need for external regulation of the aggressive and libidinal needs into a capacity to regulate such needs internally.

As an example, let us think about a little girl's

oedipal strivings, her urge to triumph over her mother and to have sex with her father. If all goes well, such needs become tamed over time and transformed into capacity. In other words, if the little girl's oedipal strivings have been gently but firmly frustrated—that is, benevolently contained by an optimally frustrating parent—and if the little girl has had the opportunity to process and master such frustration, then her matricidal and incestuous impulses become transformed over time into the capacity to take initiative in the pursuit of her dreams without the burden of guilt.

Where once there was energy, now there is structure. Where once there was need, now there is capacity; where once need for external regulation of the drives, now the capacity for internal regulation of them. The acquisition of such structure makes external regulation less necessary.

TWO NARCISSISTIC LINES OF DEVELOPMENT

Let us shift now from drive theory to self theory, where the emphasis is upon development of the self and the focus is upon the self-esteem and its regulation. Initially, in self theory, the child's self-esteem is regulated by the infantile selfobject. Over the course of development, the function of self-esteem regulation is internalized, and regulatory structures develop in both the ego and the ego ideal.

Kohut (1966) speaks of such structures as the ambitions and purposes of the ego, the goals and aspirations of the ego ideal. He goes on to suggest that the goal is transformation of the grandiose self into the ambitions and purposes of the ego, and transformation of the idealized selfobject into the goals and aspirations of the ego ideal. In other words, the goal is transformation of the narcissistic need for perfection (whether of the

self or of the object) into the capacity to tolerate imperfection.

More specifically, Kohut posits two narcissistic lines of development. One involves transformation of the need for a perfect self; the other involves transformation of the need for a perfect object. In more familiar terms, the first line of development involves transformation of the grandiose self into the ambitions and purposes of the ego, and the second line involves transformation of the idealized selfobject into the goals and aspirations of the ego ideal.

With respect to the first line of development, consider the mother who looks on with delight and admiration as her little baby plays in his crib with his rattle, trying as best he can to achieve mastery of it. She thinks that he is the most beautiful and the smartest little baby in the world.

Clearly, she is performing as a mirroring selfobject and is deriving pleasure from her little baby and his attempts at mastery.

We can easily believe that this lucky little baby, as a grown-up, will have internalized his mother's admiring interest and will now be able to derive his own pleasure from his attempts at mastery. In essence, the child's need for perfection of the self and mirroring confirmation of that perfection by the object will have become transformed into a healthy capacity to direct his efforts toward mastery and to derive pleasure from his pursuits. We can think of it as transformation of "Look at me, mirror; I am perfect, am I not?" into "I may not be perfect, but I know I am good enough; I am able to apply myself to whatever task is at hand, and I derive pleasure from mastering challenges and overcoming obstacles."

With respect to the second line of development, think of the child's need to be able to experience his parent as the embodiment of idealized perfection and then, through a fantasized merger with the idealized object, to partake of its perfection, strength, and tranquility. The function performed by the idealized selfobject is provision of an opportunity for the child to invest his objects with perfection so that he can look up to them for guidance and inspiration.

We can easily believe that this lucky little child, as a grown-up, will have internalized, in the form of his own standards of excellence, the qualities that the parent exemplified. In essence, the child's need for perfection of the selfobject becomes transformed into a healthy capacity to rely, for direction, upon his own internalized standards of excellence. Where once the child invested his parent with perfection so that he could look up to

the parent for guidance and inspiration, now he has the capacity to provide such direction on his own. We can see it as transformation of “I look at you and imagine that you are perfect; I too become perfect through my union with you” into “I now have my own goals and aspirations; I have my own dreams to pursue, my own potential to realize.”

In sum, the need for perfection of the self will have become transformed into a capacity to derive pleasure from mastery, and the need for perfection of the object will have become transformed into a capacity to be self-directed. Alternatively, we might say that the need for perfection of the self becomes transformed into a capacity to be self-motivating, whereas the need for perfection of the object becomes transformed into a capacity to be self-directing. In any event, the ego’s ambition has to do with the means, whereas the ego ideal’s goals have to do with the

end.

STRUCTURAL GROWTH

Some self psychologists have suggested that the need, more generally, is for external regulation of the self-esteem and that, if all goes well, the need becomes tamed over time and transformed into the capacity to provide regulation internally. If the parent is able, for the most part, to gratify the need and fails the child in only minor ways, then the child, as part of mastering the disappointment he feels, internalizes that function which the parent was performing prior to his failure of the child. The self structures that result take over the function of validation once performed by the selfobject, such that the child now has the capacity to provide his own reinforcement. Where once the child needed to rely upon his parent for mirroring confirmation,

now he has the capacity to rely upon himself for validation. Self psychology, then, is really all about transformation of narcissistic energy into self structure, transformation of the need for external reinforcement into the capacity to provide reinforcement internally.

Whether it involves drive regulation or self regulation, the process of growth (either developmental, in relation to the child, or psychotherapeutic, in relation to the patient) is accompanied by the transformation of energy into structure, need into capacity. Alternatively, if we choose not to limit ourselves to considering the fate of untamed libidinal and aggressive drives or the fate of the child's need for perfection, we could discuss (as we have been all along) the process of growth from the point of view of transforming the infantile need to experience one's objects as other than who they are into a healthy capacity to

experience them as they are. Such a perspective, moving beyond the concerns of drive theorists and self theorists, addresses itself more generally to that difficult process by which the individual matures, gradually coming to terms with the painful reality that his objects may not always be exactly as he would have wanted them to be.

DEVELOPMENT OF DEFICIT AND CONFLICT

Consider now the relationship between traumatic frustration and the development of pathology. To begin with, what happens when the child's infantile needs are traumatically frustrated, that is, frustrated by the parent in ways that the child cannot, for whatever reason, possibly master? Three questions can be posed:

1. What happens to the infantile need?
2. What does not get internalized that should?
3. What does get internalized that

should not?

First of all, according to self theory, a traumatically frustrated developmental need gets dissociated and split off. It is as if the child gets it, on some level, that the parent is not going to be someone he can count on; and so, in order to protect himself against the possibility of further disappointment and heartache, he represses the need and buries his pain. Over time, thwarted infantile needs not only persist but become intensified, reinforced.

The child of 2, for example, has an age-appropriate anal need to oppose, to challenge. Through the provision of limits that thwart the unbridled expression of the child's anal needs, the parent functions as a drive regulator. If the limits provided are gentle but firm and if the child is able to master his frustration with, and anger at, the authoritarian parent, then the child has the

experience of nontraumatic frustration. Over time and bit by bit, he will be able to internalize the limit-setting functions performed by the benevolently containing parent and modulate the intensity of his anal strivings.

If, on the other hand, the mother is too demanding, too punitive, too restrictive, too arbitrary or inconsistent in her limit setting, too authoritarian, too invested in struggling with the child, then it may well be too difficult for the child to master his rage at his mother for thwarting his anal need to oppose. In other words, if the child's anal needs are traumatically frustrated, then those needs become intensified over time.

As another example, the child of 4 has an age-appropriate narcissistic need to show off to Mommy how good he is on his ice skates. If she is able, for the most part, to gratify his need to be

responded to in an admiring way, and fails him in only minor ways, then over time his exhibitionism will become tamed and modulated.

But if she is unable to gratify his need to be admired, then as an adult he will have an exaggerated need to be admired for how good he is, will perhaps be a show-off. His narcissism will have been reinforced.

What happens to an infantile need that has been traumatically frustrated, then, is that it gets reinforced.

Turning now to the second question—what does not get internalized that should?—we know that, according to self theory, if a child's developmental need is traumatically frustrated, then by definition the child does not master his disappointment with his parent. There is no transmuting internalization; there is no taking in

of the good object; and there is no accretion of internal structure. According to self theory, then, traumatic frustration results in deficit, so-called structural deficit, by default—because of what does not happen.

When we say, therefore, that structural deficit is a result of frustration improperly grieved, we mean that there is now impaired or absent regulatory capacity, whether of the drives (in drive theory) or of the self-esteem (in self theory).

In the previous example of the 2-year-old, if the child's anal need to oppose, to challenge, is traumatically frustrated by a punitively limit-setting parent, then, because of what does not happen, the child develops a structural deficit—namely, an impaired (or even absent) capacity to regulate his own aggressive drives internally. In other words, the child's destructive need to

discharge his aggressive energy does not become transformed into a capacity to be healthily self-assertive and to direct that energy into constructive channels. Such a child will have a structural deficit in terms of his capacity to regulate his aggressive strivings internally.

In the earlier example of the 4-year-old, if the child's narcissistic need to be admired is traumatically frustrated by an unempathically responsive parent, then, because of what does not happen, the child develops a structural deficit—namely, an impaired (or even absent) capacity to regulate his own self-esteem internally. In other words, the child's exhibitionistic need to have his perfection confirmed by a mirroring selfobject does not become transformed into a healthy capacity to direct his own efforts toward mastery and an ability to derive pleasure from his own pursuits. Such a child will have a structural deficit

in terms of his capacity to regulate his self-esteem internally.

When an infantile need is traumatically frustrated, then, what does not get internalized is the good object, and the patient develops structural deficit.

When we talk about nontraumatic frustration, the need for external regulation becomes transformed—as part of the working-through or grieving process—into a capacity to provide such regulation internally as the functions performed by the optimally frustrating object are internalized. When disappointments are properly grieved, need is transformed, functions are internalized, and healthy structure is laid down. More specifically, structure is laid down (and structural growth effected) by way of two processes that occur simultaneously: both

transformation of energy (need) and internalization of function.

On the other hand, when the situation is one of traumatic frustration, then need becomes reinforced (not transformed) and regulatory functions are not internalized; the result is that healthy structure is not laid down and we speak of structural deficit. In other words, reinforced infantile need and structural deficit go hand in hand and are both the result of a failure to grieve.

What does get internalized when an infantile need has been traumatically frustrated? Self theory does not help us answer this third question. Self theory tells us simply that when there is traumatic frustration of a need, there is (1) reinforcement of the need and (2) creation of a structural deficit. I would like to draw upon object relations theory—in particular, on Fairbairn, an

object relations theorist of the British School—to supplement our understanding of what happens when there has been a traumatic frustration.

FAIRBAIRN ON INTERNALIZATION AND STRUCTURALIZATION

Fairbairn (1952) did not distinguish between traumatic and nontraumatic frustration, but he did propose a model for psychic development in which he suggested that when the child is frustrated by the parent, the child deals with such frustration by internalizing the bad parent. Unable to face the reality of the parental badness, unable to confront the reality of just how disappointing his parent really is, the child takes the burden of the parent's badness upon himself. It is easier to sacrifice himself and his good feelings about himself than to sacrifice the relationship with his parent. By making himself bad, he is able to cling to the illusion of his parent as good.

I would like to propose that we use Fairbairn's theory to understand what is internalized when the child's needs are traumatically frustrated. The child does not internalize the good object; instead, he internalizes the bad object by taking the burden of the object's badness upon himself in the form of internal bad objects or pathogenic introjects.

I am suggesting, then, that we rely upon Kohut and the self psychologists for our understanding of how good gets internalized (namely, by way of nontraumatic frustration) and that we rely upon Fairbairn and object relations theorists for our understanding of how bad gets internalized (namely, by way of traumatic frustration). Whereas self psychology provides an excellent model for the addition of new good structure and the transforming of pathological narcissism into healthy narcissism, unfortunately it does little to enhance our understanding of internal bad

objects. We must look to object relations theory in order to help us understand how bad objects get internalized and, once inside, how they can be modified.

To return, then, to our discussion of what happens when there is traumatic frustration of an infantile need:

1. What happens to the infantile need?
It becomes reinforced.
2. What does not get internalized that should? A good object.
3. What does get internalized that should not? The bad object.

Kohut and Wolf (1978) suggest that when the child's need is traumatically thwarted, it is reinforced and, because the good object is not internalized, structured deficits, in the form of impaired capacity, develop. I am here suggesting that we supplement such a view with the idea,

drawn from Fairbairn, that what the child does internalize is the bad object, in the form of pathogenic introjects. It is their presence that gives rise to the structural conflicts of which object relations theorists write. Traumatic frustration, therefore, gives rise to both structural deficit and structural conflict.

What, then, will be the goals of treatment? In drive theory's terms, we might suggest, based on the above, that the goals of treatment are to tame the id, to strengthen the ego, and to mitigate the severity of the superego. But since we are drawing, more generally, upon concepts from drive theory, self theory, and object relations theory, then the goals of treatment can be said to be modulation of need, filling in of deficit, and detoxification of the pathogenicity of the internal bad objects.

PATHOGENIC INTROJECTS

Let us now look more closely at the internal bad objects (or pathogenic introjects) that give rise to the patient's structural conflicts.

As I have been saying, pathogenic introjects are internalized when infantile needs (whether id needs or developmental needs) are traumatically frustrated. In accord with many of the object relations theorists, I would like to propose that we conceive of pathogenic introjects as internal presences that derive developmentally from internalization of the child's negative interactions with his parent. In other words, when the child takes the burden of the parent's badness upon himself, he does not simply internalize the bad parent; rather, he internalizes the negative interactional dynamic that exists between himself and his parent. Negative interactions repeated again and again in the child's relationship with his

parent, but never mastered, are taken into the child's internal world and become part of his repertoire of internalized object relationships.

The child internalizes the relationship in the form of pairs of introjects, referred to by Meissner (1976, 1980) as "introjective configurations" or "introjective constellations." One pole represents the characteristic position of the powerful parent; the other pole is complementary and represents the characteristic position of the vulnerable child. As an example, the child who was constantly put down by a discounting parent internalizes that dynamic in the form of a superior introject and an inferior introject. I think it is useful to think in terms of the superior introject taking up residence in the ego ideal and the inferior introject taking up residence in the ego. Where once the child experienced himself as inadequate in the eyes of the demanding parent, now the ego experiences

shame in relation to the contemptuous ego ideal. An internal relationship has replaced the external relationship. Or the child who was repeatedly abused by his parent internalizes that dynamic in the form of a victimizer introject and a victim introject. I think it is useful here to think in terms of the victimizer introject taking up residence in the superego (the conscience) and the victim introject in the ego. Where once the child experienced himself as helpless in the face of the parent's victimization of him, now the ego experiences guilt in relation to a harshly punitive superego. Here too an internal relationship has replaced the external relationship.

The child's pathogenic introjects then become part of a road map by which new experience is interpreted and given meaning. The pathogenic introjects color and distort the person's perceptions of himself and, when projected, his

perceptions of others. When such introjects are delivered, under the sway of the repetition compulsion, into the relationship with the therapist, the negative interactional dynamic that had characterized the earlier relationship with the parent becomes recapitulated in the (negative) transference.

The tip-off, therefore, that pathogenic introjects are involved is the fact of the patient's distorted perceptions of either himself and/or the therapist. Unrealistically negative perceptions of either the self ("I am bad") or the object ("You are bad") speak to the presence of underlying pathogenic introjects that will need to be reworked or detoxified before the patient can perceive reality as it is.

When the child internalizes aspects of the bad relationship with his parent, he does it in order

not to have to separate from the parent. This is very different from the situation in which the child internalizes functions performed by the good parent; as the good is internalized, the child comes to need his parent less and less and is therefore gradually able to separate from him. In other words, the child is able to relinquish his attachment to the infantile object by way of internalizing the good; on the other hand, when the child takes the parent's badness upon himself, he is able to maintain the infantile attachment and to avoid separation from the parent.

The introjective pairs exist as charged, toxic, unassimilated foreign bodies, neither really separate from the sense of self nor fully integrated into it. Some have suggested that they are like food in the stomach—they are in the stomach but not actually part of it.

There is constant tension within each introjective pair; in fact, it is the tension between the two poles of the introjective configurations that creates conflict, structural conflict. With regard to the superior/inferior introjective constellation, the tension is characterized by contempt and shame; with regard to the victimizer/victim introjective configuration, the tension is characterized by aggression and guilt.

No longer are we talking about conflict between id drive and ego defense; now we are talking about conflict within the pairs of introjects. No longer are we talking about structural conflict from the perspective of a one-person theory (the drive-defense model of classical psychoanalytic theory); now we are talking about structural conflict from the perspective of a two-person theory (the relational-conflict model explicated by Mitchell [1988]). In object relations theory,

internal bad objects are the building blocks of pathology. It is not surprising, therefore, that object relations theorists would conceive of structural conflict as involving internal bad objects.

THE NEGATIVE TRANSFERENCE

Whether we are thinking in terms of superior/inferior pathogenic introjects or victimizer/victim pathogenic introjects or any other introjective configuration, the conflict within the pairs is a closed system to which we have no access until it becomes externalized. When the patient delivers his pathology into the transference by way of projection, we have a recapitulation in the here and now of the negative interactional dynamic characterizing the early-on traumatic failure situation between parent and child. We have, in other words, development of a

negative transference.

It is important that the patient be able to deliver his pathology, in the form of his internal demons, into the transference so that we can gain access to what would otherwise be a closed system. We cannot effect structural change and the giving up of distortion until we have gained such access.

In a negative transference, the patient activates and projects onto the therapist either of the poles of the introjective pair. The patient delivers his pathology into the treatment situation by externalizing his conflict.

I would like to suggest that we call it a *direct transference* when the patient re-creates with the therapist the same interactional dynamic that had characterized the earlier traumatic relationship with the parent. A *direct transference* unfolds

when the patient projects onto the therapist the introject corresponding to the position that the powerful parent had in relation to him as a child; he identifies with the complementary pole and experiences himself in relation to the now powerful therapist as the vulnerable child he once was.

On the other hand, an *inverted transference* develops when the patient re-creates with the therapist the inverse of the dynamic that had characterized the earlier traumatic relationship with the parent. An inverted transference emerges, therefore, when the patient projects onto the therapist the introject corresponding to the vulnerable position that the patient had as a child in relation to the powerful parent; he identifies with the complementary pole and now does unto his vulnerable therapist what was once done unto him by his powerful parent.

Alice Miller, in her book *Thou Shalt Not Be Aware* (1984), is describing an inverted transference when she writes of a patient's reenactment with his therapist of his early-on traumatic experiences at the hands of his parent. In the neurotic and compulsive reenactment, the patient does with and to the therapist what was once done with and to him by the parent. Miller suggests that the patient, not able to feel his feelings because they hurt too much, instead delegates them to the therapist. In essence, the patient becomes the traumatically frustrating parent he once had and puts the therapist in the position of the traumatically frustrated child he once was; he repeats in the transference the early-on traumatic failure situation (this time with the roles reversed) so that the therapist can come to know, deeply, what it was really like for the patient as a child.

NEGATIVE IDENTIFICATIONS AND ATTACHMENTS

The presence of internal bad objects is doubly problematic for the patient. In order to demonstrate the point, let us think about the introjective pair of victimizer/victim. The patient identifies with either of the poles (either the mean, cruel parent or the undeserving, guilt-ridden child); he then comes to experience himself as bad, independent of any relationships he might have. Alternatively, the patient may project either of the poles onto his objects; he then comes to experience his objects as bad, independent of any interactions he might have with them.

In addition to his attachment to the introjects themselves, the patient is also intensely attached to the interactional dynamic that exists between the poles of the introjective configuration. Such an attachment fuels the patient's compulsion to

reenact, in subsequent relationships, the interactional dynamic that had existed in the early-on abusive relationship with the parent and was internally recorded in the form of the introjective pair of victimizer/victim. The patient reenacts that dynamic by way of projecting either of the poles onto the object and then identifying with the complementary pole; in that way the patient is able to re-create with others the bad relationship he had early on and thereby is able to maintain the infantile attachment.

Thus the presence of internal bad objects is accompanied by (1) the experiencing of oneself and one's objects as bad and (2) the compulsive reenactment, within one's relationships, of the bad dynamic that had characterized the earlier relationship with the parent.

ABSENCE OF GOOD AND PRESENCE OF BAD

In what follows, I am going to be working with a model of the mind that conceives of pathology as involving both structural deficit and structural conflict—in other words, a model that takes into consideration both the absence of good (deficit) and the presence of bad (conflict). I have been suggesting that the failure to grieve (traumatic frustration) is the source of the patient's defendedness, ultimately the source of his resistance. I have demonstrated the structural consequences of such failure—namely, absence of regulatory capacity (deficit) and presence of tension between psychic structures (conflict).

I now hope to show both how structural deficit gives rise to illusion and positive transference and how structural conflict gives rise to distortion and negative transference, and I will then demonstrate how the patient's transference need to experience his objects as other than they are is

systematically worked through. By way of the internalizations that accompany this working-through process, the structural configuration of the patient's internal world is gradually altered. Structural growth involves the laying down of new healthy structure and is accomplished by way of working through disrupted positive transference. Structural change involves the modification of existent pathological structure and is accomplished by way of working through negative transference. In other words, if something good is missing inside, then the goal is to add it. Alternatively, if something bad is already there inside, then the goal is to change it.

But how exactly do we add new good? And how do we change old bad?

In order to understand how new good structure is added, we look to self psychology,

which spells out nicely the relationship between working through, or grieving, the loss of transference illusions and laying down healthy structure. From self theory, we know that optimal disillusionment is the process by which transmuting internalizations and structural growth occur.

Self psychology provides an excellent model for the addition of new good structure but does not deal at all with the modification of existent pathological structure. (Admittedly, self psychology deals with the transformation of pathological narcissism into healthy narcissism, but the pathological structures to which I am referring here are the internal bad objects or pathogenic introjects that configure the patient's internal world.) Self psychology is, after all, a theory about deficit not conflict, absence of good not presence of bad, the filling in of deficit not the

resolution of conflict. There are no internal bad objects or pathogenic introjects in self theory—only impaired or absent regulatory capacity.

To repeat, self psychology is a theory about the absence of good; it is not a theory about the presence of bad. It is therefore a theory about structural growth, not structural change. It is a theory about working through disrupted positive (narcissistic or selfobject) transferences, not negative transferences.

In order to understand how old bad structure is changed, we look to object relations theory, which suggests that working through transference distortions is the way to modify underlying pathological structures, in the form of internal bad objects or pathogenic introjects. Object relations theory (as we shall later discuss) conceives of the transference in a dynamic sense as involving

ongoing cycles of projection and introjection. From this perspective, one can envision a process whereby pathogenic introjects delivered into the relationship with the therapist (thus creating a negative transference) are gradually detoxified over time by way of ongoing and repetitive *serial dilutions*, when it turns out that the therapist is not in fact as bad as the patient had feared he would be. By way of working through the negative transference, the pathogenic introjects are gradually rendered less toxic and structural modification is effected.

POSITIVE AND NEGATIVE TRANSFERENCE

What is the relationship between absence of good (deficit) and positive transference, on the one hand, and the relationship between presence of bad (conflict) and negative transference, on the other hand?

Up to this point I have been suggesting that there are two internal records of traumatic frustrations sustained by the patient in his early-on relationship with his parent: reinforced infantile needs (accompanied by structural deficit) because of what does not get internalized, and internal bad objects because of what does get internalized. The presence of infantile needs gives rise to the hope that each object encountered subsequently will be the good parent the patient never had. The presence of the internal bad objects gives rise to the fear that each object encountered subsequently may be the bad parent the patient did have.

Under the sway of the repetition compulsion, the patient delivers both his wish for good and his fear of bad into the relationship with the therapist. Both situations involve a recapitulation of the past in the present; both are instances therefore of

transference, whether we are talking about displacement of need or projection of pathogenic introject. I am here suggesting that we think of a positive transference as unfolding when the patient displaces his reinforced infantile needs from his parent to his therapist and that we think of a negative transference as unfolding when the patient projects his internal bad objects or pathogenic introjects onto the therapist.

In the context of the transference relationship, therefore, the patient comes both to hope for the best (through displacement of his reinforced needs) and to expect the worst (through projection of his internal bad objects). In other words, he delivers his pathology—both his wish for good and his fear of bad—into the transference, in the form of his illusions and his distortions. He delivers his pathology in the form of his need for the therapist to be other than who

he is.

The illusions and the distortions go hand in hand because they operate on different levels. At the same time that the patient expects (through projection of his underlying pathogenic introjects) criticism, disapproval, abandonment, abuse, and so on, on another level he hopes (through displacement of his infantile needs) for gratification and clings to the illusion that the goodies will someday be forthcoming. The patient may expect the worst but meanwhile continue to hope for the best.

The delivery of the infantile needs into the relationship with the therapist, by way of displacement, creates the illusion that the therapist will be the good parent the patient never had. Such transferences are positive and are accompanied by the wish that maybe this time the

patient will be gratified in ways that he was not as a child. This positive transference is accompanied by hope.

If the displaced infantile needs are narcissistic, then the transference that unfolds is called a narcissistic or selfobject transference. If the displaced infantile needs are neurotic, then the transference that emerges is called a neurotic transference. But whether the transference is narcissistic or neurotic, it is accompanied by positive affect and by the hope that maybe this time the patient will be gratified in ways that he was not as a child.

Very different is the situation in which the patient projects his pathogenic introjects onto the therapist and fears that he will be frustrated now in the very same ways that he was frustrated as a child. (Although the patient, of course, does not

want to be failed once again, on another level he needs the therapist to fail him exactly as his parent failed him—because that is all he has ever known. Were the patient to encounter something different from that at this point, it would make him very anxious inasmuch as it would pose a threat to what has become his way of experiencing his objects; were he to be exposed to something better, it would challenge the patient's loyalty to the parent.) The delivery of the internal bad objects into the relationship with the therapist, by way of projection, creates the distortion that the therapist will be the bad parent the patient did have. This negative transference is accompanied by anger, fear, hopelessness, and/or despair.

The clinical implications of the distinction between a positive transference and a negative transference are profound. When the patient is hoping that the therapist will be the good parent

he never had, we do not, for the most part, interpret such a transference. We allow it to be. Inevitably, there will be empathic failures. It will be the disruptions of the positive transference, occasioned by the empathic failures, that will call for interpretation and working through.

On the other hand, when the patient is experiencing the therapist as the bad parent he had (or fearing that the therapist will turn out to be the bad parent he had), we do interpret such a transference. As long as it goes uninterpreted, the patient will be in the position of re-experiencing in the here and now the same trauma experienced early on at the hands of the toxic parent.

We analyze, therefore, both the negative transference and disruptions of the positive transference. In both situations the patient's affective experience may be one of upset,

disappointment, sadness, hurt, anger, outrage. But in the instance of the negative transference, the patient's negative affect has to do with experiencing the transference object as the bad object he had feared it would be. In the instance of the disrupted positive transference, his negative affect has to do with experiencing disappointment that the transference object turns out to be not as good as he had hoped it would be. In the first instance, the negativity has to do with the bad that is; in the second instance, the negativity has to do with the good that is not.

THE IDEALIZING TRANSFERENCE

In order to highlight the distinction between a positive transference and a negative transference and the implications for treatment, let us look at what is called an *idealizing transference*. Is such a transference the result of displacement or

projection, displacement of the need for perfection (in this case, the need for an idealized selfobject) or projection of the pathogenic introject superior?

Let us think first about the idealizing transference that develops as a result of displacement. When there is displacement of the need for an idealized selfobject, the therapist is experienced as the embodiment of idealized perfection and then fused with in fantasy; in that way the patient partakes of the therapist's grandness—"You are perfect and I too become perfect through my fusion with you." The accompanying affect is of pleasure; and the patient is narcissistically gratified, in the sense that his own perfection is reinforced.

Let us compare this to the transference that develops when there is projection. When we have the introjective pair of superior (which resides in

the ego ideal) and inferior (which resides in the ego), there is a tension between the two poles. As we discussed earlier, when such a pair is present, the ego tends to feel shame and to experience itself as inadequate and defective in relation to the superior, perfectionistic, and contemptuous ego ideal.

If the superior pole is projected onto the therapist and the conflict externalized, the patient feels shame and experiences himself as inferior to the therapist. Although idealized, the therapist is seen as someone who reinforces the patient's feelings of inadequacy and defectiveness. The accompanying affect is of anguish, and the patient is not at all narcissistically gratified.

I do not think that this second transference, which derives from projection, should be considered an idealizing transference. I think that

when one speaks of an idealizing transference, one tends to mean the first situation (of displacement), although this is not always spelled out.

In the first situation, the patient feels good. Such transferences are positive and should not be interpreted—that is, not until they are disrupted, which will happen inevitably. It is important that the patient be allowed to have the experience of gratification afforded by a positive transference. In the second situation, the patient feels bad. Such transferences are negative and are a recapitulation in the here and now of the early-on traumatic failure situation. They should be interpreted, because they retraumatize the patient and reinforce his bad feelings about himself.

It is important, therefore, to distinguish between these two kinds of transference. In the first situation, the narcissistic need for perfection

is displaced onto the therapist. The therapeutic work that needs to be done, ultimately, is transformation of the need for perfection into a capacity to tolerate imperfection. The transformation is the result of working through a disrupted positive transference and is what structural growth—the adding of new good—is all about.

In the second situation, the superior introject is projected onto the therapist, and the patient identifies himself with the inferior pole. The therapeutic work that needs to be done, ultimately, is detoxification of the pathogenic introjects (both poles). The detoxification is the result of working through the negative transference and is what structural modification—the changing of old bad—is all about.

NEW GOOD OBJECT OR OLD BAD OBJECT?

Before we move on to a discussion of how the patient's resistance to delivering himself and his needs into the transference can be overcome, let us look a little more closely at how the patient experiences the therapist. To what extent is the therapist (in his capacity as a transference object) experienced as a new good object and to what extent as an old bad object?

Many theorists suggest that an important part of the healing that takes place in therapy has to do with the fact that the therapeutic setting is a symbolic re-creation of the early-on relationship between mother and child. But what is really meant by that concept? Does it mean re-creation of the old, bad relationship that this particular patient had with his mother, or does it mean creation of a new, good relationship unlike anything this particular patient has ever before had? In fact, when we speak of the therapeutic

setting as re-creating symbolically the early-on relationship between mother and child, sometimes one thing is meant, sometimes something else.

One model of therapeutic action (the deficiency-compensation model espoused by such theorists as Balint, Guntrip, and Kohut) conceives of the therapeutic setting as creating symbolically an ideal mother-child relationship. The therapist provides a holding environment that fosters growth, a symbolic creation of an ideal mother-child relationship very different from the pathogenic mother-child relationship this particular patient had.

Another model of therapeutic action (the relational-conflict model to which I referred earlier and espoused by such theorists as Loewald, Meissner, and Mitchell) conceives of the therapeutic setting as recreating the actual bad

relationship that this particular patient had with his bad mother. Now the therapeutic setting offers the patient an opportunity to re-create in the here and now the early-on environmental failure situation.

When I speak of the therapeutic setting as providing a symbolic re-creation of the early-on mother-child relationship, I mean both the creation of a new good situation (similar to what I have been describing as positive transference) and the re-creation of the old bad situation (very much akin to what I have called negative transference).

With respect to the creation of a new good situation, what I have been describing as positive transference is very much along the same lines as the relationship between patient and therapist delineated in the deficiency-compensation model of therapeutic action. I have suggested that a

positive transference arises in the context of the patient's wish for the therapist to be the good parent he did not have. Balint (1968) as well, put forth his idea that the patient needs to have the experience of being responded to as an individual; the therapist actively provides for the patient those forms of empathic recognition that the patient should have experienced early on but did not. Guntrip (1973) also conceives of psychopathology as arising from failure in the early-on environmental provision, failure in the early-on relationship between mother and infant. He conceives of the cure, therefore, as involving a corrective experience in the here and now—that is, the provision now (by way of the actual relationship between patient and therapist) of that which was not provided by the mother early on. By way of the therapist's consistent provision of ideal parenting and love in loco parentis, the

patient's weak and helpless infantile ego is transformed, over time, into a strong, mature ego that no longer fears life.

Although Balint and Guntrip believe that the therapist's gratification of the patient's need for a loving, unconditionally accepting, perfect parent is in itself healing, there are others who, while still in the tradition of a deficiency-compensation model of therapeutic action, believe that it is the therapist's failure of the patient, worked through and mastered, that offers the greatest opportunity for structural growth and healing. Kohut, as we know, believes that it is the experience of optimal disillusionment that provides the impetus for such salutary internalizations and that, without such failures, there is no real impetus for mastery and growth.

My emphasis as well, with respect to the

positive transference, is that its presence, while necessary for growth, is not sufficient. I believe that it is important for the patient to have an opportunity to believe, at least for a while, that he will be able to find the good mother he never had (positive transference). But I think he must eventually confront the reality that what he had hoped to find is but illusion, that he cannot really have it. As he gradually comes to terms with his outrage and his devastation about that—in other words, as he works through the disrupted positive transference—he becomes able to develop mature capacity where once he had infantile need. He acquires the capacity to accept things as they are; no longer does he feel the need to have that which ultimately he cannot.

With respect to the re-creation of the old bad situation, what I have been referring to as negative transference is basically the same thing that those

who subscribe to the relational-conflict model describe as the relationship that unfolds between patient and therapist when the patient re-creates with the therapist the same interactional dynamic that had existed between himself and his bad parent. The therapeutic setting is thought to offer the patient a chance to relive, to reexperience, indeed, to repeat within the patient-therapist relationship the original traumatic situation. But this time, because the therapist is not, in fact, as bad as the parent had been, there can be a different outcome. There is repetition of the original failure situation but this time with a much healthier outcome, the repetition leading to structural modification and integration on a higher level.

My claim, then, is that the therapist, in a deficiency-compensation model, is experienced as a new good object (positive transference). The

therapist, in a relational-conflict model, is experienced as the old bad object (negative transference). Ultimately, it will be important that the patient have an opportunity to experience the therapist as both a new good object *and* an old bad object. As Greenberg (1986) has suggested, “If the analyst is not seen as a new object, the analysis never begins; if not as an old one, the analysis never end” (p. 98). In the next chapters, we will explore the ways in which the patient’s transferential need to experience his therapist as both a new good object and an old bad object facilitates the process of structural growth and structural change.

The Defense of Affective Nonrelatedness

RESISTANCE TO DEVELOPING A RELATIONSHIP WITH THE THERAPIST

Sometimes the patient seems resistant to developing any relationship whatsoever with the therapist. Particularly during the opening phase of the treatment, the conflict for some patients is around having a relationship with the therapist in the first place—whether the relationship is real (in which case the therapist is accurately perceived for who he is) or transferential (in which case the therapist is misperceived as someone he is not). Some patients continue in treatment for years but on some very deep level are never really able to

deliver themselves and their vulnerabilities into the therapy relationship. Somehow they cannot tolerate the thought of having the therapist come to matter the world to them.

In fact, part of what enables the therapist to be effective (whether in his capacity as a new good object or as an old bad one) is that he comes to assume the importance of the “primal parent” (Janov 1970). When the therapist has been vested with the power of the original parent, then the patient’s relationship with the therapist can be a corrective for the damage sustained early on at the hands of the parent; and, by way of internalizing aspects of that relationship, the patient is able to let the therapist have an impact upon the structural configuration of his (the patient’s) internal world.

Interestingly, because the parent in the here

and now is no longer imbued with the same power with which he was once imbued, it is not so much the contemporary parent who can make the difference as it is the therapist, who is allowed to become, in a sense, a surrogate parent. Some patients report that their parent is actually more available to them now, when they are themselves adults, than the parent was when they were children; and they wonder why that availability does so little to heal their woundedness. In point of fact, the parent often matters less to the patient now than he once did; consequently, the parent now has much less power to heal than he once had power to hurt.

I am suggesting, therefore, that in order for the therapist to be able to make a difference to the patient, he must have assumed the significance of the infantile object. But the patient may fight having such a relationship with his therapist. The

patient may be concerned about losing control, regressing, or becoming too dependent. The patient may be afraid that if he were to deliver himself and his needs into the relationship, he would expose himself to the possibility of disappointment and heartache. Some patients must therefore deny their need for objects; they would like to believe that they need no one, that they can do it all on their own, and that they can be the source of their own emotional sustenance. They are reluctant to relinquish their stance of proud self-reliance.

To describe such a state of affairs, Modell (1975) has suggested use of the term *cocoon transference*. Patients who feel the need to protect the integrity of the vulnerable self from injury at the hands of the object are said to employ a “defense against affects” and are thought to be in a state of affective nonrelatedness. For patients

whose sense of self is precariously established, it is too threatening to be in relationship; the patient is terrified of being shattered, or fractured, by an unempathic response from the therapist. Instead, the patient maintains himself in a cocoon, a gossamer filament his only connection to the world around him.

Such a stance of self-protective isolation is often supported by illusions of grandiose self-sufficiency and a denial of object need. The struggle, says Modell, is to maintain the tenuously established sense of autonomy; the fear is that expressions of intense affect (particularly in relation to the therapist) will lead to dissolution of the integrity and cohesiveness of the self.

CLINICAL EXAMPLE: A DEFENSE AGAINST BEING IN RELATIONSHIP

The following clinical example deals with a

patient's resistance to opening herself up to being in relationship with her therapist. The patient is a 50-year-old single physician who has been in treatment for almost five years with a colleague of mine. The patient went into treatment shortly after the death of her mother, with whom she had had a close (though conflicted) relationship. Over the course of the therapy the patient has gained some insight and has made some changes, but for the most part she has never really delivered herself and her vulnerabilities into the relationship with the therapist, and the therapist has found herself feeling increasingly inadequate and helpless. The patient keeps herself at a remove, closed, hidden, inaccessible. She spends most of the sessions angry, complaining about how unappreciated she is and how hard she has to work. On the rare occasions when she speaks of her mother, she does not acknowledge much

negativity toward her. The only relationship the patient seems to have at this point in her life is with her younger sister, Betty. She has never felt particularly close to her father.

I have seen the patient intermittently over the past several years in order to prescribe drugs for sleep, which she takes on occasion and which her mother took before she died. What follows are some process recordings from a portion of our sixth meeting; each line is followed by a discussion.

Patient: My sister is driving me crazy. She calls me up on the phone really late at night and talks my ear off. I don't want to listen to her. She's a mess, and she never calls when she says she will.

The patient begins the session by complaining about her sister.

Consultant: Your sister can be a royal pain sometimes.

The therapist listens and responds empathically to the patient's expressions of annoyance about her sister.

Patient: Yes, she's—it's just too much. I see patients all day—I work so hard. And then she calls me late at night, and I feel I need to listen.

The patient elaborates upon how upset she is with her sister for being so inconsiderate and demanding.

Consultant: She is so demanding.

The consultant again empathizes with how difficult it must be to have a sister who is like that.

Patient: She goes on and on and on, complaining about everything.

The patient elaborates further still upon how chronically dissatisfied her sister is and how much she complains.

Consultant: Sometimes it feels as if no matter what you do or say, it won't really make any difference to her.

The consultant notes, to herself, that the patient's complaints about her sister parallel

the therapist's complaints about her patient. The patient describes her sister as going on and on and on, complaining incessantly, in much the same fashion that the therapist had described (to the consultant) her experience of the patient. Just as the therapist had said that she felt the need to listen to her patient, so too the patient is saying that she feels the need to listen to her sister. The consultant decides to put into words the painful experience of reaching out to someone in order to help that person but feeling, ultimately, that it makes very little difference (again noting, to herself, that she has probably captured the essence of what the therapist feels in relation to the patient).

Patient: She just spends most of her time talking about how lonely she is and crying.

The patient continues with her expressions of annoyance, impatience, and frustrated helplessness.

Consultant: You try so hard to be there for her.

The consultant empathizes with how hard the patient tries to be there for her sister.

Patient: I worry about her a lot, but I do what I can.

The patient now expresses more of her concern for her sister, protests, somewhat defensively, that she does what she can.

Consultant: You take good care of her.

The consultant senses that reassuring the patient about the good care she takes of her sister may ease, at least for the moment, the patient's guilt about not doing enough.

Patient: I try to do what I can, but she just doesn't ...
(pause)

The patient appears to feel the consultant's support and then starts to complain about the sister.

Consultant: ...appreciate your efforts on her behalf.

The consultant, sensing that the patient wishes that her sister were as appreciative of her efforts as the consultant has been, completes the patient's sentence for her. This is an instance of what Havens (1986) has described as cognitive empathy—The ability to complete another's sentences, which speaks to how empathically attuned one is to the other's emotional state (p. 19). With this patient, who is so fearful of making contact, the consultant

would like to be able to demonstrate, in a way that will not make the patient too anxious, that she does understand and does appreciate the patient's efforts.

Patient: At 11:30 last night, she called me because she said she needed my advice about something. She wanted to know what I thought she should do about her job situation. I've already told her exactly what I think she should do, but she doesn't listen. Instead, she just keeps calling to ask me what she should do. I am so tired of hearing her complain all the time. She never pays any attention to what might be going on for me in my life ... I just get so annoyed.

The patient responds by describing in some detail just how fed up she is with her sister, who never listens to the good advice she offers and appears not to care all that much about what is going on for the patient in her life.

Consultant: Sometimes she is just so inconsiderate—it's hard not to be angry with her.

The consultant names the sister's inconsiderateness and resonates with how angry the patient is with her sister. In retrospect, it might have been more useful for

the patient if the consultant had responded more directly to the patient's complaint that her sister never thought about what might be going on for the patient in her own life. By saying something like "No one seems to care about what might be going on for you, in your life, " the consultant would have been inviting the patient to offer more details about her own life, not just details about her experience of her sister and her sister's life.

Patient: I work so hard—What do I have to do...?

In any event, in response to the consultant's naming of the patient's anger, the patient complains bitterly that her hard work never seems to be enough.

Consultant: (gently) You would so wish that somebody could help you out in the ways that you try to help Betty out.

The consultant steps back for a moment in order to articulate, gently, the to-this-point-unacknowledged yearning the patient must have—namely, that someone would be there for her in the ways that she has been there for her sister. The consultant recognizes that the patient, who has much difficulty letting people matter, may be made anxious by this

intervention, but the consultant senses that the moment is right to name something she believes the patient, in her heart of hearts, wishes she could find. In the consultant's opinion, the conflict the patient is struggling with has to do with the tension between the patient's yearning to be taken care of and her denial of that need. The patient defends herself against her longing to be dependent upon someone by keeping herself out of relationship; with the exception of her sister, she has no real attachment to anyone, not even her therapist of five years.

Patient: But there isn't anybody—I have to do it myself. Some days, it's so hard.

The patient, in fact made anxious by the consultant's naming of the patient's wish to have someone looking out for her, defends herself against acknowledging such a yearning by protesting that there is no one, that she must do it all on her own. She goes on to acknowledge that sometimes it is hard. Although she is not able to admit that she wishes someone could be there for her, she is nonetheless able to admit that she is tired of being so alone.

Consultant: You are so tired of having to do it all on your own.

The consultant resonates with how tired the patient is of having to do everything alone.

Patient: I do it all by myself. There's no one I can really depend upon. No one at work even said anything after Mom died. They were so cold and cruel. I had played such a major role in those last months of her life and was feeling so awful, but my colleagues at work didn't care at all. People are like that. You can't depend upon anybody.

The patient expounds upon her upset that her colleagues were so insensitive around the time her mother died. She goes on to generalize, bitterly, that people are like that, they don't care and can't be depended upon. The patient is here elaborating upon her investment in her defense—namely, why she has felt the need to keep others at a remove: people cannot be counted on to help you out when you need them, and so you must not let yourself need them.

Consultant: You've spent your whole lifetime giving and giving to people, and sometimes you wonder: when do I get mine?

The consultant comments on the patient's years of unstinting effort and self-sacrifice, and then resonates with how unfair it all seems, how outrageous the lack of reciprocity.

Patient: Oh yes, but I don't think it will happen.

The patient appreciates the consultant's acknowledgment of her years of hard work but then bitterly speaks of her sadness about never getting anything back. The patient, who tends to have difficulty acknowledging any yearnings whatsoever, is here admitting indirectly that she wishes, perhaps, that things could be different.

Consultant: Stiff upper lip and just keep going ...

The consultant puts into words ("stiff upper lip and just keep going") what she believes is the patient's (defensive) stance—defensive in the sense of defending against the acknowledgment of underlying yearnings. The consultant is attempting to highlight the patient's defensive need to carry on, denying how devastated she might feel in the face of her frustrated longings.

Patient: But I'm exhausted. Sometimes, at the end of the day, I can barely make it home. It seems

as if all I do is put out for people. I'm just so tired.

Because the consultant has so captured the essence of the patient's defensive posture, the patient does not have to elaborate further upon the need for it and is able instead to name the price she pays for doing things in the way that she does—namely, that she is always so tired. That is, because the consultant has named, on her behalf, the up side of her defense, the patient has an opportunity to get in touch with the down side.

Consultant: Part of what makes it so difficult is that you're filled with despair about ever being able to find someone who will want to be available to you.

The consultant senses that for the moment the patient may be more open to acknowledging just how hard her full steam ahead self-sufficient stance is. The consultant suggests that it must be difficult to be filled with despair about ever being able to find someone who will want to give to her. The patient has not yet acknowledged her despair; the consultant is taking a chance here but senses that the patient may be able to tolerate having the

despair named without being made too anxious and therefore defensive.

Patient: I've had different relationships, but the men were all kind of wimpy and I didn't really feel that they were people I would be able to count on. I don't think anybody will ever be there (pause) you know, I guess my mom was my best friend.

In fact, with the consultant's naming of the despair, the patient is now able to open up a bit about some of her efforts in the past to find a relationship with a man. But by acknowledging her efforts to find someone (and, by implication, her underlying wish to have a relationship), she makes herself anxious and so goes on to protest that she really does not think she will ever find anybody anyway. Then, after a pause, she admits (somewhat surprisingly) that her mother was really her best friend.

Consultant: (gently) ...and it feels as if things will never be the same, without her around.

The consultant gently, respectfully, suggests that things will never be quite the same again.

Patient: Well, different, anyway. They'll never be

exactly the same. I just have to get used to that ...I'll be O.K.

The patient, made anxious, attempts to shrug it off by protesting that things may be different but that you have to learn to live with that.

Consultant: In fact, you pride yourself on how strong and tough you can be if you need to be.

The consultant quickly shifts her own stance. The consultant does not need the patient to admit that life has never been the same since her mother died; rather, the consultant goes with the patient's defensive need to protest that all is well by highlighting the pride the patient has always taken in being strong. The consultant takes her cues from the patient. When the patient needs to protest that all is well, the consultant does not challenge that; instead, she picks up (somewhat paradoxically) on the pleasure the patient derives from being so "strong and tough." There will be time enough to get back to the anxiety-provoking feelings that have prompted the mobilization of the defense.

Patient: I know how to get through it and keep going. Mom was in such pain at the end. Betty and I had to figure out what to do. We took care of

her all by ourselves.

The patient elaborates upon her ability to keep going, but her upset about her mother breaks through the defense. She remembers how much pain her mother was in at the end and then boasts that she and her sister were able to take care of their mother all by themselves.

Consultant: On some level, all your life you've been on your own and so you've learned well how to take care of yourself and others.

The consultant expresses her appreciation of the patient's expertise in taking care both of herself and of others but is also suggesting indirectly that the patient may have developed her expertise out of necessity. The consultant suspects that there may have been ways in which the mother, even when she was alive, was not there for the patient.

Patient: Yes, I really do know what to do. When we were growing up, it was my job to take care of Betty. I took good care of her. I was the mother, Mom had to work. Sometimes I expect something back from Betty because of everything that I did for her during all those years.

The patient is pleased to have had her expertise validated. She goes on to boast about how well she took care of Betty when they were growing up. Not quite recognizing that she is indicting her mother, she goes on to explain that it fell to her to take care of her younger sister because their mother had to work. She sidesteps the issue of whether she has feelings about her mother's lack of availability to her and instead protests Betty's lack of availability; bitterly she complains that Betty has never really appreciated her efforts and has certainly never reciprocated.

Consultant: It would help if she could be more appreciative and if she could find it within her to give you something every now and then....

The consultant resonates with the patient's outrage and bitterness about Betty's lack of appreciation and reciprocation.

Patient: If she could just think about me sometimes....

The patient is able to hear the consultant's support of her and responds by expressing her yearning to have Betty be more available to her. When Betty's lack of appreciation for the patient's efforts on her behalf first came up (at

the beginning of the consultation), the patient was able to express her outrage about that but was not able to gain access to any of her yearnings in relation to Betty. Now, however, she is able to acknowledge that it would be nice if Betty could think of her sometimes.

Consultant: It's painful when people don't seem to think much about you and what your needs might be.

The consultant gently names the pain a person can feel when the people around her do not think much about her and her needs. The consultant does not say, "You must feel pain that ..." or even "It must be painful for you that . . . rather, she says, "It is painful when. ..." By naming the patient's pain in this more impersonal way, the consultant hopes to make it easier for the patient to acknowledge the very real pain she has because her own needs for caretaking have not been responded to over the years.

Patient: But that's the way life is. That's the way it's always been. People just get caught up in their own lives, their own careers, their own relationships. People have never cared about how I might be doing.

The patient responds somewhat bitterly and from a place of deep despair. She acknowledges that her needs have never been recognized and responded to. She notes, sadly, that people get so caught up in their own concerns that they have little left over for her.

Consultant: And it doesn't feel as if that will ever change.

The consultant suspects that the patient's somewhat distorted perception of people as being more involved in their own lives than in hers probably arises from unresolved feelings she has about her mother. The patient has clearly never confronted the reality of her mother's lack of availability to her, and she has brought to subsequent relationships her expectation that the other person will be unavailable to her. The consultant senses that it would make the patient too anxious if she were to direct the patient's attention to her mother's limitations, so the consultant resonates with the patient's despair about things ever changing.

Patient: It would be foolish to expect things to be any different.

The patient, in protesting that she thinks it

would be foolish to expect that things could be different, is indirectly acknowledging that, in her time, she has herself had such expectations.

Consultant: It's easier not to hope.

The consultant goes with the patient's defensive need to deny that she would ever hope for things to be different.

Patient: I just end up getting disappointed....

The patient says now that she knows all too well the problem with having hope—that one ends up being disappointed. Although the patient is still having trouble acknowledging her underlying yearning to be in a caring (and caretaking) relationship, she is able to acknowledge that she knows something about what it is to have hope.

Consultant: It hurts too much to be in the position of looking to someone to be there for you and then to have the experience of having that person break your heart.

The consultant observes quietly that it hurts too much to be in the position of having hope and then of having your heart broken. The consultant does not address the patient

directly; rather, she seems to be making an impersonal observation about the danger inherent in looking to someone to be there for you—namely, that you may end up getting your heart broken. The consultant is not asking that the patient admit to having had her heart broken; the consultant, in support of the patient's defensive stance, is just appreciating how vulnerable it can feel to be in the position of counting on someone else to be there for you.

Patient: (somewhat shaken) It's not ever going to be different. It would be so silly for me to think that things could ever be any different, (looks as if she feels like crying but is trying to fight it) Rather than getting my heart broken, I just need to cope.

The patient, shaken by the therapist's intervention, somewhat lamely protests that it will never be any different, that it would be silly to think otherwise. Clearly fighting to hold back the tears, the patient calls the consultant's bluff, in a sense, taking the consultant's "impersonal" observation personally: "Rather than getting my heart broken, I just need to cope. " The patient is talking about why she is so invested in not

letting herself look to others for attention and support; she is clarifying her investment in her defensive posture of needing no one and doing it all on her own.

Consultant: There's something so sad about all this....

The consultant, sensing that the patient does not want to be in her sadness, nonetheless wants to acknowledge the patient's heartache in a way that will not be too threatening to her. The consultant decides, therefore, to say, somewhat impersonally, "There is something so sad about all this...." The consultant is hoping that this statement will enable the patient to observe herself from a distance and to have some compassion for the person who feels that she cannot now afford to let herself hope for anything from other people.

Patient: (now in the sadness, crying and not able to talk; eventually, backing away from the pain)
But I enjoy giving to other people.

The patient cries for the hurt, wounded, vulnerable person who must deny her longings to be close. She then backs away from the pain and protests, again somewhat lamely, that she enjoys giving to other people.

Consultant: Though there may be ways in which it bothers you that you do not get much from the people in your life, it makes you feel good to know that you have something to give to them.

The consultant offers a conflict statement in which she first names that which the patient knows but wishes to forget (namely, that she may well be bothered by the fact that other people do not give her much) and then resonates with the patient's need to see herself as finding fulfillment through giving to others. That is, the consultant first challenges the patient's defensive need to see herself as satisfied with things as they are and then supports it.

Patient: People like me, and I'm grateful for that.

The patient, somewhat defensively, protests that at least people like her, for which she's grateful.

Consultant: That's a good feeling, their appreciation.

The consultant immediately shifts from a more neutral position in relation to the patient's conflict to a position more supportive of her investment in being a caretaker for others.

Patient: I'm not doing so much really.

The patient, pleased, modestly protests that she isn't really doing much.

Consultant: In a way, it's almost easy....

The consultant gives voice to the paradox underlying the posture of the patient by taking her protestation one step further and suggesting that the patient's efforts on behalf of others may almost be easy.

Patient: One patient, I had to refer him to a surgeon to have part of his lung removed because of the cancer. I went to see him. I won't ever forget the way he looked. I did what I could to help out his wife. She said she was very grateful that I took the time to visit. It was all so sad. Sometimes I still go to visit him, when I can.

The patient responds by telling a story about how available she was to a patient of hers and how supportive she was of that patient's wife. The patient is clearly pleased to be able to report that the wife expressed gratitude to her for her efforts on her husband's behalf.

Consultant: Your job demands a lot of you and you do

it well.

Here the consultant, sensing that the patient needs to be displaying her caretaking abilities, is herself appreciative of the patient's dedication as a physician.

Patient: It's nothing to me. He looks in my eyes and I can see his fear. I just need to make sure that he doesn't see the fear in my eyes.

The patient modestly passes off the consultant's praise of her efforts and goes on to talk of her patient's fear, adding that she needs to make sure he does not see the fear in her own eyes.

Consultant: He mustn't know that there are times when you too feel your own kind of terror.

The consultant, actually misinterpreting what the patient has said, responds by talking of the patient's terror about her life and its emptiness.

Patient: I don't know how much longer he can last. He's in such pain, and the cancer is so aggressive—I don't know what to do for him.

The patient, taking the consultant's empathic rupture in stride, clarifies that her fear relates

to her sense of her patient's mortality. She goes on to talk of how helpless his cancer makes her feel.

Consultant: You would so wish that you could ease his pain....

The consultant, aware of how invested the patient was in her mother's care, resonates with her investment in being a healer for others.

Patient: Oh, yes. When Mom got diagnosed with cancer and then had extensive metastases, the doctors were not going to give her chemotherapy, but I said, you have to. They were reluctant to do that but finally agreed to it. They weren't sure what would happen, but it gave my mother another several months.

The patient does associate to what happened when her mother was diagnosed with cancer. She talks of her efforts on her mother's behalf and of her wise choice to insist that the reluctant doctors give chemotherapy.

Consultant: Your decision saved her life....

The consultant appreciates the patient's efforts on her mother's behalf.

Patient: Sometimes it was so hard—they had to feed her intravenously, (angrily) Talk about quality of life! But you know, I think she did enjoy something of those last months. She asked that she be able to spend as much time as she could at her cabin in the mountains. When I would visit her, she would tell me that it was because of me that she was finally able to find peace. She so loved the mountains.

The patient responds by acknowledging just how difficult those last months were, for both her mother and herself. Poignantly she reflects upon the peace and happiness her mother finally found during those last months in her cabin in the mountains; she recalls her mother's expressions of appreciation to her for making it all possible.

Consultant: (softly) You gave her that....

The consultant, softly, appreciates that final gift that the patient was able to offer her mother.

Patient: (with the suggestion of tears) I'm glad we had those final months together.

The patient, struggling not to weep, talks of her own happiness that she had that time with

her mother.

Consultant: You will cherish forever the memories you have of those times.

The consultant resonates empathically with the pleasure the patient experienced during that time.

Patient: It was good to be with Mom. Sometimes she was very mean and controlling, but she tried hard.

The patient grants that it was good to be with her mother. Interestingly, she now feels the need to say that there were times when her mother was mean and controlling, although (as if to undo this) she goes on to say that she knows her mother tried hard. The patient has formulated her own conflict statement, in which she first acknowledges how awful her mother could be and then, made anxious by such an acknowledgment, defends against it by protesting that her mother at least tried hard.

Consultant: There were things about her that you didn't really like, but you always knew that she was doing the best she could.

The consultant offers a parallel conflict

statement, in which she first names an anxiety-provoking reality (the patient's dislike of certain things about her mother) and then names the patient's defense against confronting her dissatisfaction with mother.

Patient: Actually, there were times when she could be a royal pain in the ass.

The patient is able to admit that there were times when her mother was indeed very difficult, very stubborn. The patient is here acknowledging negative feelings about her mother that she is usually reluctant to acknowledge.

Consultant: She was a strong-willed woman.

The consultant reinforces what the patient has just said.

Patient: (chuckles, remembering) Oh, yes, she sure was. I had thought that I wanted to be a pediatrician, but she told me I should be an internist. I guess she got her way on that one!

This prompts the patient to remember, with amused fondness, how insistent her mother was about her daughter's choice of specialty.

Consultant: She was someone who usually got what

she wanted!

The consultant stays with the patient's lighter mood.

Patient: But there were times when I felt I just had to get away. She tried to control me too much, even up to the very end. She had such an iron will and was always so determined to have her own way.

The patient is now ready to acknowledge that there were times when she felt the need to escape from her mother's control.

Consultant: There were times when she was simply too controlling, but you knew that she was trying hard to be a good mother.

The consultant picks up on the patient's upset with her mother but, in order not to make the patient too defensive, reiterates the point they each made earlier that the patient's mother was, after all, trying hard. The consultant is here making a conflict statement, in which the patient's conflict about acknowledging just how angry she felt toward her mother is being articulated.

Patient: I think she loved us—and she meant well.

The patient, made somewhat anxious, reassures herself that her mother did love her daughters and did mean well.

Consultant: She gave you something that you fear you'll never have again.

The consultant, careful not to challenge the patient's need to see her mother as having meant well, remarks that her mother gave her something that she must be afraid of never having again. The consultant is willing to support the patient's need to see her mother as having been a good mother.

Patient: There will never be another Mom in my life.

The patient feels the consultant's support and sadly agrees that she will never have another mother.

Consultant: When she died, a part of you died.

The consultant rather boldly asserts that when the patient's mother died, a part of the patient died as well. The patient has never dealt with the grief she feels about the loss of her mother; she has confronted neither the range of feelings she had about her mother when her mother was living nor the range of feelings she

has now about her mother.

Patient: (shaken) Well, it's different. It will never be the same, and I have to get used to that. I can't expect that people will understand how special she was to me, and I certainly can't expect people to care about me the way she did.

The patient, somewhat shaken by the consultant's strong statement about the devastating impact her mother's death had on her life, mumbles that certainly things are different now. The patient reverts to her defensive posture of gritting her teeth and going full steam ahead. The patient observes, somewhat bitterly, that she should not expect people to understand how special her mother was to her or to care about her in the way that her mother did. Even as the patient is protesting that it is unreasonable to expect people to care in the way that a good mother would, it is clear that on some level she still very much cherishes the fantasy (the illusion) that she will someday be able to find a good mommy who will care for her as her mother should have but did not.

Consultant: You tell yourself that you shouldn't

expect people to understand or to care.

The consultant resonates with the patient's defensive protest that it is not appropriate to expect others to understand or to care. The consultant is here presenting a paradox to the patient, in that the consultant knows the patient still very much clings to her yearning to be taken care of.

Patient: When I get to thinking about how much I miss her, I start to feel terrible. The feeling of missing her suddenly wells up inside of me and it frightens me, so I try not to think about it. It doesn't make any sense to keep focusing on her, but sometimes when the people around me are so insensitive and demanding, it's hard not to be negative.

The patient cannot really take issue with what the consultant has just said because the consultant has so closely mirrored what the patient herself has just said. Interestingly, at this point, the patient appears to be in touch with her yearnings for her mother and painfully acknowledges just how much she misses her mother. She remarks that the pain of that missing makes her feel terrible and so she defends herself against it by trying not to

think about it. She admits, however, that when others are insensitively placing demands upon her, it is hard for her not to feel angry (negative).

Consultant: You try not to let it get to you, but you can't always pull that off.

The consultant observes that the patient is not always successful in her efforts to protect herself. The consultant is appreciating both the patient's investment in having her defense and the ways in which the defense sometimes fails her.

Patient: When I'm tired, after a long day at work, that's when it happens.

The patient confides that she is most vulnerable, least defended, at the end of a long day, when she is exhausted.

Consultant: That's when it all comes tumbling down around you, just how alone you now are, and how much you miss her....

The consultant can easily picture how alone the patient must feel and how much the patient must miss her mother at those defenseless times.

Patient: In the evenings and on the weekends, I'd rather work weekends ...They're so long.

The patient does not contest this, instead goes on to elaborate that the most difficult time for her is time that is unstructured.

Consultant: It's harder to get away from the pain when you've got free time on your hands.

The consultant appreciates that it is particularly difficult to defend against the pain during long stretches of free time.

Patient: The doctors have wives who do things for them, but I don't have someone to cook me my meals or to pick up things from the dry cleaner. I have to do it all on my own. Sometimes it's so hard and I just get so tired.

The patient shifts away from her pain and reverts to her stance of angry, bitter complaining—a stance that is much more familiar, comfortable, and self-protective. But now the patient is acknowledging that there is a price to be paid for being so self-reliant and for doing it all on her own—namely, that it is “so hard” and she just gets “so tired.”

Consultant: You're just wishing so much that you had

someone who would take care of you, help you out.

The consultant here names explicitly the patient's longing to have a good, mommy to take care of her, to help her out.

Patient: Well, I'd at least like them to think about me and what my life is like.

The patient, somewhat sarcastically, affirms that she would at least like some consideration from others.

Consultant: It seems as if no one really appreciates just how hard it is for you, and lonely....

The consultant observes gently that it seems as if no one really appreciates just how hard and how lonely it is for the patient. Although the consultant senses that the patient (on some level) has registered the fact that the consultant knows and understands, the consultant is willing at this point not to challenge the patient's (distorted) perception of herself as not understood and of others as not understanding. Clearly the patient is invested in experiencing her objects as inattentive, unavailable, insensitive to her needs; the patient assumes that her objects will

be as absent as her mother was. (Here the fact that this is a consultation and not a therapy session does make a difference in terms of the consultant's decision not to challenge the patient's transferential misperception of her as not understanding.)

Patient: They cancel plans at the last minute. Sometimes they even forget we had made plans to get together.

The patient expounds upon just how unreliable people can be—and insensitive to her needs.

Consultant: People let you down all the time. It seems as if no one will ever be able to be there for you in the way that your mom was.

The consultant contrasts the unreliability of the people in the patient's life now with the reliability of her mother when her mother was alive. The consultant understands that the patient, at this point, needs still to be defending against acknowledging the pain of her mother's lack of presence in her life. The patient clings to the illusion of her mother as having been there for her in order not to have to face the horrid truth about her mother's lack of availability.

Patient: (head down, quiet tears, softly) No.

The patient weeps for her lost mother.

Consultant: It's so sad to think about having lost something that was so precious.

The consultant appreciates how sad it is to have such a loss.

Patient: (suddenly angry, needing to get away from the intensity of her pain) It should never have happened to her, the cancer. She should never have had to suffer as she did. How can life have any meaning anyway, if you can suddenly be stripped of it just like that.

The patient, no longer able to tolerate the intensity of her sadness, reverts to her anger and protests the unfairness of it all. She then plunges into despair, wonders how life can have any meaning anyway if it can be lost at any point.

Consultant: It was just so not fair ...and it makes you wonder sometimes if anything makes any sense.

The consultant picks up on the unfairness of it all. She goes on to resonate with the patient's despair, appreciates that of course it makes the

patient wonder if anything makes sense anymore.

Patient: But I can't let myself have those thoughts. I have to carry on. So much is expected of me ... people count on me. I can't afford to cry. I have to keep going.

The patient clearly needs to defend against acknowledging the depths of her despair; she reminds herself that she must carry on, that much is expected of her, that she cannot afford to cry. She clings to her stance of fierce independence and tough-mindedness in order to deny her grief about the loss of her mother.

Consultant: You tell yourself that you must be strong and that strong people don't cry, even when they're hurting inside and missing someone.

The consultant articulates, on behalf of the patient, her (defensive) need to "be strong," her (defensive) need not to cry, even though she is hurting so much inside. The consultant understands the patient's need for the defense and also understands that the patient's stance is a defensive one.

Patient: (bitterly) What good would it do?

The patient, now bitter, asks what good it would do to let herself feel the pain.

Consultant: After all, there's nothing that can bring her back.

The consultant certainly does not want to be in the unenviable position of having to answer such a question, so she treats it as a rhetorical question. She resonates with the patient's bitterness and elaborates upon the futility of it all anyway.

Patient: (fighting the tears) That's the way it is. I can't let myself have those thoughts ... I have to get on with my life (pause) ...but I'll always be alone.

The patient is obviously very shaken, very upset, and very much in her grief about the loss of her mother. Struggling to maintain her self-control, she tells herself that she just cannot let herself feel her despair. She reiterates that she must get on with her life, although she poignantly acknowledges her conviction that she will always be alone.

Consultant: It gets confusing—you're not sure if your life will always be filled with this emptiness and lack of connection or whether there is

reason to hope that things could someday be different. You tell yourself that you need to look forward, not backward.

The consultant does not want to be in the untenable position of suggesting to the patient directly that the patient's life could be otherwise if she could but work through her grief about her mother and relinquish some of the idealizations with which she has imbued her mother. The consultant decides therefore to attribute to the patient awareness of that possibility for change and so frames the patient's current state as one of confusion: will life always be filled with such emptiness and lack of connection or is there reason to hope that things could someday be different? The consultant is introducing the idea that there is reason for hope. The consultant then goes on to name the patient's (defensive) need to look forward, not backward; the patient certainly does not want to look back, but the consultant, by suggesting that the patient would want to look forward, is presenting a paradox to the patient (in the hope that the patient will then protest the extent to which she is still very much caught up in looking back).

Patient: Well, I don't know ...but I can't let people see

how much I'm hurting and how much I miss her. You know, I think about her all the time. Not a day goes by that I don't have some thought about her. I just wish so much that she were alive today. I never really had a chance to appreciate her when she was around.

Indeed, the patient now goes on to talk movingly about just how much she hurts and how much she misses her mother still. With heartfelt anguish, she articulates her yearning to have her mother alive today so that they could have a second chance.

Consultant: When you think about what could have been, it fills you with pain and regret.

The consultant resonates with the patient's regret about all the lost opportunities.

Patient: If only I could do it over again, then I would do it differently this time. I wouldn't have been so cold, so distant. I wouldn't have gotten so angry at her all the time—I'm angry all the time now. I don't let anybody get close. I know my therapist wishes that I could let her in, but I don't want to. I just feel so cold inside. I don't want anybody to hurt me ever again. I wish I hadn't pushed my mother away

so much, (now sobbing) I wish I had just once been able to tell her that I loved her.

With painful yearning, the patient acknowledges how much she wishes she could do it over again. Now we hear that the patient feels she was always distant and aloof from her mother, that she was herself not all that available to her mother. She remarks upon just how angry she sometimes was with her mother; she admits that she knows she is angry all the time now. She knows that she does not let anybody get close, not even her therapist. She speaks of how cold she feels inside and how determined she is not to let anybody hurt her ever again. Here she is recognizing just how much her mother hurt her and how much she hurt her mother. No longer able to contain her grief, she begins to sob and finally acknowledges the most painful truth of all—namely, that she was never able to tell her mother, not even once, that she loved her.

The patient has spent a lifetime defending herself against feeling the pain of her lack of connection with her mother. In fact, her mother was really quite unavailable to her, controlling,

stubborn, insensitive, sometimes cold, even cruel. As a child, the patient, unable to confront the reality of her mother's very real limitations, took the burden of the mother's badness upon herself in order to preserve the illusion of her mother as good, available, understanding, caring. Because of the internalized badness, the patient now compulsively reenacts with others the interactional dynamic that had existed between herself and her mother—she experiences others (in a distorted fashion) as unavailable to her, unreliable, insensitive, and cruel and (except in her professional life) she is herself at a remove, distant, and even cold. Unable to experience her objects in new ways, she continues to relate to them in the old way.

Although as a doctor she is generously available to her patients, on a more personal level she cannot tolerate being vulnerable to others and

has eschewed real engagement. In order to avoid the possibility of further disappointment and devastation at the hands of hurtful others, she has adopted a defensive posture of proud self-reliance and tough-minded determination. She cannot commit to relationship; being in relationship is fraught with such anxiety that she has difficulty even acknowledging her longings to be in relationship; she defends against such longings. The patient has resisted delivering herself and her vulnerabilities into the therapy relationship as well. Angrily and bitterly, she protests her need for no one and her ability to do it all on her own.

The consultant does not challenge the patient's defensive need to be tough and strong, to do it all on her own; in fact, the consultant understands entirely the patient's reluctance to look to others for support and understanding. It is then for the patient to protest that in fact she pays a price for

being so self-reliant—she feels so unappreciated, she is so tired, she feels so alone. Once the connection is made between how alone she feels in her life now and how much she misses her mother still, she begins to understand her despair in the context of her conviction that she will never find someone to replace her mother.

Over the course of the consultation, as the patient becomes less defended, she gets more in touch with her grief about the death of her mother. Interestingly, near the end of the session, she is also able to confront the reality of just how unavailable her mother was even while she was alive. She is able even to acknowledge the regret she feels about all the lost opportunities in that relationship; she weeps for all that never happened between them. As she confronts the reality of just how disappointing that relationship really was, she gains access to her longing to be in

relationship, a longing she has defended herself against all her life because it hurt too much.

In essence, the patient's resistance to delivering herself and her longings into the treatment situation derives from a negative transference. The patient does not say that she experiences her therapist as unavailable, insensitive, unreliable, but she does suggest that she feels no one can be counted on, no one can be trusted to be available and to care. We can assume that despite her therapist's constancy and reliability over the years, the patient experiences her therapist (in a distorted fashion) as not really available, not really understanding, not really caring. As part of working through the patient's resistance to delivering herself into the therapy relationship, as part of working through the patient's defense of affective nonrelatedness, it will be important for patient and therapist to voice

between them the fact of the patient's mistrust of her therapist. Over time, they will also need to understand the patient's investment in such a defensive posture and the price the patient pays for maintaining it. As the patient's reluctance to be in relationship and the cost to her of that reluctance is more clearly understood, the patient may be able to access her longings to be in relationship and may then be able to enter into the relationship with her therapist in an affective way.

PENETRATING THE PATIENT'S DEFENSE

I'd like to return now to a more general consideration of those patients for whom the conflict is around having a relationship with the therapist to begin with. On the one hand, the patient wants desperately to be able to be close. On the other hand, being close may be experienced as being too vulnerable, too dependent, too out of

control—which is fraught with intolerable anxiety; the patient therefore denies his need for others and insists that he can do it all on his own. The healthy force within the patient yearns to be close; the unhealthy force fears such closeness and defends against such yearnings.

The patient may or may not recognize the presence of his desire and may or may not recognize the presence of his fear. For example, he may know that he is frightened but be unaware of his underlying longings, or he may know that he longs to be close but without understanding why he cannot let himself feel “held.” We will want to make the patient aware of the fact that he is conflicted; we will also want to give the patient an opportunity to explore the genetic underpinnings of both his healthy wish to be close and his defensive need not to be.

In the interest of highlighting those defenses that we sense are interfering with the patient's delivery of himself and his longings into the relationship, we may choose simply to name, in a nonjudgmental fashion, the fact of the patient's defense:

"You are not sure that you want to be dependent upon anyone."

"You are reluctant to be in the position of needing anybody that much."

"You are not convinced that it is safe to allow yourself to have those kinds of feelings in here with me."

"You are determined not to let me matter that much."

"It is frightening to think about needing me."

"It is frightening to think about needing anyone."

"You do not want to be missing me when I'm away this summer."

“It feels safer, somehow, not to let anyone get that close.”

“Perhaps it feels safer right now to be keeping parts of yourself hidden.”

“You do not want to have to depend upon me or anybody.”

“You do not want to be someone who needs people.”

Each of these statements is an instance of going with the resistance; the resistance is being named, in an experience-near, nonshaming way. The patient’s defensive need to avoid real contact is supported, reinforced, not challenged. By naming the defense, the therapist is highlighting the fact of it; but by doing it nonjudgmentally, the therapist is giving the patient permission to have such a need, without having to justify it.

The therapist recognizes not only that the patient is invested in maintaining his

independence, staying in control, and needing no one but also that the patient may well pride himself on just how independent, just how much in control, and just how self-reliant he can be. The therapist can do more, then, than simply name the defense; he can convey his appreciation of the pleasure the patient derives from being autonomous by framing his interventions in a laudatory fashion:

“You pride yourself on your ability to be self-reliant, to do it on your own.”

“You enjoy the feeling of being independent and are not about to give that up.”

“It is important to you that you be able to maintain your autonomy, that you not be in the position of needing someone.”

“You like the feeling of being always in control.”

If the legitimacy of the defense is not challenged, the patient may feel supported enough

that he is able to elaborate upon his need for the defense. He may associate to why he came to need the defense in the first place and how it now serves him. After all, the patient must understand all of why he cannot let himself do the things he wants to do before he can overcome his resistance to doing them. When his conflict is around being close to people, he must understand, first, that he is conflicted about being close; second, what his investment is in not being close; and third, the price he pays for maintaining his distance.

As the patient explores the underpinnings of his conflict around being close, he becomes increasingly conscious of the unhealthy, resistive forces that interfere with the delivery of himself and his vulnerabilities into the therapy relationship. He also gains insight into the reasons he protects himself in the ways that he does.

THE FACILITATION STATEMENT

The working-through process is facilitated by the use of something to which I refer as a *facilitation statement*, in which the therapist makes explicit both sides of the conflict with which the patient is struggling in the moment. In a facilitation statement the therapist articulates both the patient's desire and his fear, both the patient's healthy wish to do or to feel something and the unhealthy fears that interfere with his doing or feeling that something.

By way of facilitation statements, the therapist is attempting to facilitate ultimate resolution of the patient's underlying conflict by bringing together both the patient's healthy wish to move forward in the treatment and in his life and the patient's unhealthy fears about achieving such forward movement. The therapist names forces of which the patient may not be fully conscious. The

therapist wants, ultimately, to broaden and deepen the patient's understanding of his internal psychodynamics, both the healthy wishes that motivate him and the unhealthy fears that interfere with the realization of such wishes.

In order for the therapist's interventions to be facilitative, the therapist needs to have so entered into the patient's internal experience that he can speak the language of the patient and can articulate, in the patient's words, the patient's conscious or preconscious experience of his internal dilemmas. In the therapist's rendering of the patient's conflict, therefore, the therapist needs to be ever mindful of the level of awareness that the patient has achieved about both his underlying wishes and his underlying fears.

Thus, in a facilitation statement, the therapist juxtaposes, in an experience-near fashion, both the

patient's healthy wish to change and his unhealthy fears about changing. The therapist wants the patient to recognize that he is motivated by healthy forces but that he resists such forward movement because he is afraid. There are, of course, unhealthy, neurotic, infantile wishes that motivate patients (and about which they are conflicted); in a facilitation statement, however, the focus (in the first part) is upon the healthy, growth-promoting wishes that motivate the patient to realize his potential. By the same token, there are, of course, healthy fears that interfere with the patient's actualization of his potential; in a facilitation statement, however, the emphasis (in the second part) is upon the unhealthy, neurotic, infantile fears that need eventually to be explored and relinquished before the patient's resistance to moving in the direction of health can be overcome.

Part of what fuels the patient's unhealthy

fearfulness may be the distorted perceptions he has of himself and his own abilities. He may be unable to move forward in his life because he is held back by all kinds of negative misperceptions about himself, distortions that arise from having taken upon himself the burden of his parent's limitations, distortions that fuel his fearfulness and, therefore, his resistance. In a facilitation statement, the therapist is hoping to facilitate exploration of such defenses, so that they can ultimately be worked through and overcome and so that the patient's healthy wish to realize his potential can triumph. Examples are:

“You want desperately to feel better but are afraid you never will.”

“You wish that you could find an answer, but you are not convinced that you will be able to.”

“You would like to be able to move beyond how upset you are with me, but you are feeling

very angry and cannot imagine that you will ever be able to work through your disappointment.”

“You would like to be able to trust me, but you are afraid that you may never be able to forgive me for what I did.”

“You would like to understand why you are so sensitive to criticism, but you are not sure that such understanding will make any real difference in terms of your actual vulnerability to it.”

“You would like to be able to move beyond the depression, but you are afraid that you will have to suffer from depression all your life.”

“You would wish that you could find someone to love, but you are filled with despair about your ability ever to find such a person.”

“You want desperately to lose the weight, but you are afraid that you will not be able to motivate yourself to do that.”

“Although you would like to be able to separate

from your family, you are not sure that you could live with the guilt you would feel if you were to do that.”

By way of a facilitation statement, the therapist is giving the patient permission to expound upon either his healthy wish to change or his unhealthy resistance to change. In response to the last intervention above, for example, the patient may associate to how controlled he has always felt by his intrusive and domineering mother; perhaps he remembers the time she read his mail and how enraged he felt by her violation of him and his privacy. He reiterates his wish to be free of her, his wish to be able to live his life without having to account to his mother for his every move.

On the other hand, he may associate to how devastated his mother was when he told her that he was interested in applying to colleges out of state and how awful that made him feel. He may

say that since the death of his father when he was 10, he has felt responsible for his mother and has prided himself on his ability to take such good care of her. Nondefensively, he articulates both sides of his conflict about separating from his mother, extending his understanding of the underlying forces that motivate both his healthy wish to separate and the unhealthy separation guilt that fuels his resistance.

Is a facilitation statement an instance of a conflict statement? A facilitation statement resembles a conflict statement in that, first, it concerns itself with explicating both sides of the patient's conflict about moving forward in the treatment and in his life, and second, it names first the healthy, growth-promoting yes force (which constitutes the patient's mental health) and then the unhealthy, growth-inhibiting no force (which constitutes the patient's pathology, or resistance).

In important ways, then, a facilitation statement has the same format as a conflict statement. There are, however, a few interesting differences, differences that may be more in emphasis than in anything else. Whereas in a conflict statement the first portion usually names that which the patient would really rather the therapist not name, in a facilitation statement the first portion names a healthy wish the presence of which the patient may have much less trouble acknowledging. Whereas in a conflict statement the first portion articulates a force that provokes anxiety and therefore needs to be defended against, in a facilitation statement the first portion names a motivating force that provokes much less anxiety and, therefore, much less of a need for defense. Whereas a conflict statement first challenges a defense and then supports it, a facilitation statement is less involved with creating

such tension; a facilitation statement strives simply to get named both the yes force, which motivates movement toward health, and the no force, which resists such movement. The no may arise in response to the presence of the yes force (in which case we are dealing with convergent conflict) or it may exist independent of the yes force (in which case we are dealing with divergent conflict). Finally, a conflict statement highlights the tension between that which the patient knows (even if sometimes he would rather forget it) and that which the patient experiences, in order to make the patient's experience increasingly anxiety-provoking; a facilitation statement, however, is designed not so much to create further conflict as to explicate both sides of the conflict that already exists between healthy wish and unhealthy fear, between desire for change and resistance to it.

Perhaps, then, we could think of facilitation statements as making up a subclass of conflict statements. Both interventions name the two sides of the patient's conflict about overcoming his resistance and moving toward health; but the facilitation statement does so more with an eye to facilitating the patient's recognition of both his desire to get better and his fears about getting better, whereas the conflict statement attempts to create tension between the patient's knowledge of reality and his experience of it.

With respect to working through the patient's resistance to delivering himself and his vulnerabilities into the therapy relationship, a facilitation statement can be used to highlight both sides of the patient's conflict about being in relationship. The therapist, therefore, highlights, in an experience-near fashion, both the patient's longing to be close and his fears about being close:

“A part of you wants desperately to be known and understood, but another part of you is terrified at the prospect of making yourself that vulnerable.”

“A part of you wants to be known and understood, but another part of you wants to remain unknown, unfound, hidden.”

“A part of you wants so much to be able to trust me, but another part of you is scared and not at all sure that you want ever again to be in the position of depending upon anybody.”

“On the one hand, you want desperately to be understood, and on the other hand, you find yourself wanting to remain hidden, not exposed, not known—alone, but safe.”

“You wish that you could count on other people, but you have managed thus far on your own and you can’t imagine that you could ever really trust someone else to understand.”

“Perhaps you would want to be able to open yourself up to the possibility of a

relationship, but it feels safer somehow to remain cautious and to proceed at your own pace.”

“Maybe there are times when you wish that you could let me matter to you, but trusting me does not seem very safe right now.”

In general, as Modell (1975) observes, the therapist needs to use his intuition to assess whether, at any given moment in time, the patient wants to be found or wants to remain unfound. If the patient wants to be found, then the healthy side of his conflict is emphasized; if the patient needs to remain unfound, then the unhealthy side of his conflict—the resistance—is emphasized. Consider the following facilitation statements:

“You want so desperately to be close, to be known, to be understood, but you’re not sure it’s there to be had.”

“You want to be close to somebody, but you are absolutely terrified at the thought of

allowing yourself to be in the position of needing somebody.”

The first emphasizes the patient’s yearning to be in relationship; the second, his fears about being in relationship.

In any event, by way of a facilitation statement, permission is being given to the patient to elaborate upon either his longing to be close or his fears about being close. It is hoped that the patient, in response to the permission given, will associate to experiences he had early on that have affected his ability to commit to relationships. Perhaps he remembers a time when he, as a boy, did look to his father to be empathically responsive and was bitterly disappointed. The patient needs to be able to feel, now, some of the upset, anguish, and rage he felt as a child in relation to his father. In the here and now, the patient confronts the reality of just how

unavailable his father really was, how alone he always felt. He cries for the little boy who wanted so desperately to have his dad's interest and support; he cries for the little boy who was so eager to please and wanted so much for his dad to be proud of him. He is confronting the reality of just how hurt he was by his father, a man who was always so involved in his own activities that he did not have much time or energy left over for his son.

The patient remembers, in particular, the devastation he felt when his dad did not go to his school play because he had "inadvertently" made other plans for the evening. Even though the patient had a bit part, he had been so looking forward to having his dad go, so excited about showing off what he could do; he was crushed when his dad could not make it. He resolved, at that time, never again to put himself in the position of hoping for anything from anybody. As

the patient remembers, he relives the traumatic disappointment; he reexperiences in the here and now all the old feelings buried long ago. He gets back in touch with the heartbreakingly painful reality of just how disappointed and hurt he was by his dad; he confronts the reality of it and grieves it. He rages about it, screams out his pain, sobs bitterly. He cries for the little boy who was once so vulnerable, so hopeful, the little boy who ended up getting his heart broken by the person who meant the most to him. Such is the process by which the patient is coming to terms with just how disappointed he was in his father; he is making his peace with it so that he can recover some of the vulnerability and hope he once had.

As the patient comes to understand the reasons for his reluctance to commit to relationships, he gains insight into his need to defend himself in the ways that he does. As he

gains such understanding, his need to remain affectively nonrelated to the therapist diminishes, and his resistance to being in relationship is eventually overcome.

THE WORK-TO-BE-DONE CONFLICT STATEMENT

At this point let me introduce another intervention, something I call a *work-to-be-done conflict statement*. Such an intervention is a particular kind of conflict statement in which the therapist spells out, in the first part of the statement, the work the patient must do before he can get beyond whatever his stuck place may be and then, in the second part, names the defense that interferes with the patient's ability or willingness to do that work.

“Even though you know that you are disappointed in me and that you will not be able to get beyond that until you have

let yourself feel the full force of it, you would like to believe that you could get better without doing that.”

“Even though you know that you will need, eventually, to come to terms with just how angry you are with me, you would like to believe that this too shall pass.”

“Although you know that coming twice a week enables us to do more in-depth work, there’s a way in which (at this point in time) you are feeling that it takes too much out of you to be investing so much time and effort and money in our work together.”

“Although you know that you still have some unresolved issues and there is more work to be done at some point, in the moment you are feeling that you would rather not commit to any further therapy at this time.”

“Although you know that you could choose to ask your parents for money to finance your therapy sessions, it is important to

you that you not have to feel beholden to them for anything. Even if it means giving up the therapy that you have valued, at least you'll know that you owe your parents nothing."

"Even though you know that your father was mean to you and that someday you're going to have to let yourself get in touch with just how enraged you are about that, it's easier to think of yourself as having provoked his attacks than to face how insensitive he really was to you."

"Even though you know that you are someday going to have to recognize that your mother was never there for you in the ways that you would have wanted her to be, you find yourself thinking that if she could but admit that she was wrong, then it would make things so much easier."

In essence, the therapist is hoping to facilitate the working through of the patient's resistance by naming for the patient what the patient needs to do eventually in order to get better, in order to get

to a place where he can accept reality as it is, no longer needing it to be otherwise. The therapist does not simply confront the patient with what he must do in order to get unstuck; rather, the therapist names for the patient the work he must eventually do but then names, in a respectful manner, the (resistive) forces that are interfering with the doing of that work. The patient can then go on either to explore what is involved in doing the work or to explore further the forces that interfere with his doing that work.

As an example, how might the patient respond when the therapist says, “Even though you know that you are disappointed in me and that you will not be able to get beyond that until you have let yourself feel the full force of it, you would like to believe that you could get better without doing that”? Let us imagine that the patient articulates his belief that a person should not be controlled by

irrational feelings and should be able to move beyond them. The patient reports that his father was always delighted when he, the patient, could use his mind to triumph over matter. He recalls with pleasure an episode in which he fell off a swing and broke his arm; he behaved like a real trooper and his father was so proud of him, bragging for years to family friends about the toughness of his “little soldier.” The patient has learned well the lessons his dad taught him—that it is indulgent to let yourself get caught up in feeling hurt or disappointed or angry, that nothing is accomplished by surrendering to those feelings, that everything passes in time.

The patient is explaining his investment in his defensive posture, namely, that “being strong” is his way to earn his father’s approval; were he to let himself get bogged down in being disappointed or angry, he would run the risk of losing his

father's respect. But by way of the work-to-be-done conflict statement, he has also been reminded of what he will need eventually to do in order to get beyond the stuck place he has arrived at in the treatment—he will have to confront the reality of just how disappointed he is in the therapist. He may not like being reminded of what he suspected was true, but there is no real need for him to get defensive inasmuch as the therapist has clearly indicated that he understands the patient's reluctance to deal with just how disappointed he might be.

More specifically, a work-to-be-done conflict statement can be used to facilitate the patient's working through of his resistance to being in relationship with the therapist. As with all conflict statements, the therapist first directs the patient's attention to where the therapist wants the patient to be (namely, the work that must eventually be

done in order to overcome his fears about being in relationship) and then resonates with where the patient is (namely, the patient's fearfulness about being in relationship):

"You know that eventually, in order to overcome your fears of intimacy, you will have to let someone in; but right now you're feeling that you simply cannot afford to be that vulnerable."

"You know that someday, if you are ever to work all this through, you will need to let me be important to you, but for now you can't imagine ever being able to let me matter that much."

"You know that eventually you're going to have to let me in; but right now you're not yet ready to take that leap of faith. You don't ever want to be in the position of having to trust anybody ever again."

"You knew that you might someday need to let this relationship be important to you, but you were hoping that you could complete

your therapy without ever really having to do that.”

With a work-to-be-done statement the therapist wants to give the patient a sense of what he, the patient, must eventually do in order to overcome his resistance to being in treatment. At the same time, the therapist recognizes that the patient is not quite prepared yet to deliver himself and his vulnerabilities into the treatment situation. As the patient becomes more aware of his need to keep himself at a remove (affectively nonrelated)—his need to remain in control, his need not to become too dependent or too needy, his need not to regress—and as he comes to understand better the origins of such defensive needs, they become less and less necessary. Furthermore, as the patient comes to appreciate more fully the terrible price he pays for holding on to such defenses, their presence begins to create

further tension, further anxiety within him; and they become increasingly ego-dystonic. At this point we speak of the defense of affective nonrelatedness as having been overcome; no longer does the patient need to keep the therapist at bay. He has overcome what Khan (1969) has called his “dread of surrender to resourceless dependence” (p. 246). Now the patient is able to entrust himself and his vulnerabilities to the relationship with the therapist.

The Positive Transference

There was a recent *New Yorker* cartoon in which a gentleman, seated at a table in a restaurant by the name of The Disillusionment Cafe, is awaiting the arrival of his order. His waiter returns to his table and announces, "Your order is not ready, nor will it ever be."

TRANSFERENTIAL NEED

We know, then, that there are many patients who resist affective engagement with the therapist, resist delivering themselves and their infantile needs into the treatment situation. As we discussed in the last chapter, the patient's reluctance to enter into a full-blown transference

may involve the fear of being found, of being exposed; it may involve the fear of regressing, of becoming dependent, vulnerable, needy; it may involve the fear of losing control or of losing himself entirely. Or the fear may derive from negative assumptions the patient brings to the current situation because of bad experiences he had early on—a transference reaction. In any event, the presence of the patient's fearfulness interferes with the therapeutic reactivation of his infantile needs, interferes with the emergence of a transference, either positive or negative. The patient's fear constitutes the resistance and interferes with further work.

Once that fear has been overcome and the patient has delivered both himself and his vulnerabilities into the transference, the therapist gains access to what would otherwise remain a closed system. The therapist is able to access both

the patient's reinforced needs and his internal bad objects, the two internal records of traumatic frustrations sustained early on at the hands of the parent. In fact, the transference provides an important route to the patient's otherwise difficult-to-access past. Greenson (1967) has remarked: "Transference is a detour on the road to memory and to insight, but it is a pathway where hardly any other exists" (p. 182).

When the patient's traumatically thwarted infantile needs are therapeutically remobilized and delivered into the relationship with the therapist, a positive transference unfolds in which the patient comes to hope that the therapist will be the good parent he never had (illusion). When the patient's internal bad objects are therapeutically reactivated and delivered into the relationship with the therapist, a negative transference emerges in which the patient comes

to fear that the therapist will be the bad parent he did have (distortion).

Ultimately, the patient's transferential need to experience his objects as better than they really are must become transformed into a capacity to experience them as they are (a process of structural growth accomplished by way of working through disruptions of the positive transference); such a process involves taming the infantile need that underlies the illusion and transforming that need into healthy structure. By the same token, the patient's transferential need to experience his objects as worse than they really are must become transformed into a capacity to experience them as they are (a process of structural change accomplished by way of working through the negative transference); such a process involves detoxifying the pathogenic introjects that underlie the distortions and transforming those

pathogenic structures into healthy structures.

But now we find that there are patients who resist, not mobilization of the transference, but rather its resolution. In other words, whereas sometimes the stuckness involves the patient's inability to get into the transference, at other times the stuckness involves being so deeply entrenched in the transference that the patient cannot now get out. Both are situations in which resistive forces are interfering with the patient's forward movement; both are situations, therefore, of resistance. Paradoxically, resistance can involve, then, either the patient's reluctance to deliver himself into the transference in the first place or, following his delivery of himself into the transference, his reluctance to let go of it. In the second situation the transference itself has become the resistance.

No real structural work can be done unless the patient can tolerate first the mobilization of a transference and then its resolution. No real structural work can be done unless the patient can tolerate first the activation of need (both for good and for bad) and then the relinquishing of the need as it is transformed into capacity. It is in this way that structural growth (the addition of new good) and structural modification (the changing of old bad) are effected.

The hallmark of a patient in the throes of a positive transference is the intensity with which he clings to his infantile wishes and the relentlessness with which he pursues their gratification by the therapist. The hallmark of a patient in the throes of a negative transference is the intensity with which he clings to his infantile fears and the compulsive repetitiveness with which he reenacts, with the therapist, his

unresolved childhood dramas. Such patients have refused to confront certain painful realities about their objects, whether toxic realities about the traumatically frustrating parent or nontoxic realities about the nontraumatically frustrating therapist. In any event, they cannot face reality; they are unable to let go of their infantile needs; they cannot bear to know the truth about their objects past and present because it hurts too much.

In order to work through their transferential need to experience the therapist as other than who he is, the patient must face his pain. As the patient begins to confront his disappointment, he begins to let go of the illusions and the distortions to which he has clung in order not to have to grieve. In this chapter and the next, we shall look at the process of working through a disrupted positive transference and a negative transference,

the process by which the patient's need for his objects to be other than they are becomes transformed into the capacity to experience them as they are. As the patient lets go of his defensive need to experience his objects in ways determined by his unresolved past, the patient relinquishes his attachments to his infantile objects and separates from them. As the transference is worked through, as the patient's illusions and distortions are relinquished, as new good is added and old bad is changed, as the patient develops increased capacity, as the conflict within the patient between experiencing reality as it is and defending against it is resolved, the resistance is overcome and the patient can move forward in his life.

TRANSFORMING INFANTILE NEED INTO MATURE CAPACITY

Let us explore, first, the development of a positive transference and its ultimate resolution.

In other words, how is the patient's transferential need to have his objects be the good mother he never had transformed into a capacity to accept them as they are? If we are speaking in terms of internal self-esteem regulation, then we want to understand how the patient's narcissistic need for perfection becomes tamed, modified, and integrated into a capacity to tolerate imperfection. If we are speaking in terms of internal drive regulation, then we want to understand how the patient's need for external regulation of his impulses becomes tamed, modified, and integrated into a capacity to provide such regulation internally. Whether the need is for regulation of the self-esteem or regulation of the drives, the need more generally is for the object to provide something that the object will not always be able to provide; the need is for the object to be somebody he cannot always be. By the same

token, whether the capacity that develops involves regulation of the self-esteem or regulation of the drives, ultimately the capacity that develops enables the patient to relinquish his need for the object to provide external regulation and therefore to be other than he is. In any event, working through the patient's transference need for his object to be the good mother he never had (in other words, working through disruptions of the positive transference) enables the patient to accept the reality of who his object is.

It is to self psychology that we will look in order to understand this process of transformation—transformation of energy into structure, infantile need into mature capacity. In fact, Kohut's article "Forms and Transformations of Narcissism" (1966) addresses just such a process of transformation. Although self psychology relates more specifically to

transformation of narcissistic energy into narcissistic structure (transformation of the need for external regulation of the self-esteem into a capacity for its internal regulation), we will rely upon what self psychology has to say about the process by which disillusionment is gradually worked through to help us understand, more generally, the process by which the patient's unhealthy need for his objects to be better than they are becomes transformed into a healthy capacity to accept his objects as "good enough." The process is one in which infantile need is transformed into mature capacity.

THE EMERGENCE OF A SELF OBJECT TRANSFERENCE

When the narcissistic patient with structural deficit (impaired capacity to be internally self-regulating) presents to treatment, typically his chief complaint reflects his internal sense of

vulnerability, impoverishment, and worthlessness; he generally reports overwhelming feelings of futility, profound disturbances in his self-esteem, anxiety, and/or depression. Often he lacks vitality, a feeling of “aliveness”; he does not derive pleasure from the self and its activities; he lacks enthusiasm and initiative; and he lacks investment in long-term goals and ideals.

As we saw in the preceding chapter, the conflict for the patient, in the opening phase of the therapy (which may last for a year or two), is often around whether or not he dares to allow himself to be held by the therapist and, further, whether or not he dares to deliver himself and his narcissistic pathology into the relationship. The patient is profoundly fearful that giving up his stance of proud self-reliance, giving up his splendid isolation, will expose him to the possibility of further traumatic disappointment

and heartache. The patient's defensive posture is supported by illusions of grandiose self-sufficiency and the denial of object need. As Modell (1975) has suggested, the narcissistic patient seems to exist as if encased within a plastic bubble, a glass jar, a cocoon, relying upon himself for emotional sustenance and needing no one.

The patient wants desperately to be able to find an empathically responsive selfobject but may initially be quite reluctant to allow his narcissistic needs to become therapeutically reactivated, hesitant to entrust himself and his regressive yearnings to the relationship with the therapist because such longings (for perfection) provoke shame within him.

In Chapter 9 I spelled out the ways in which the patient's narcissistic defense of affective nonrelatedness could be worked through and

gradually relinquished. If the therapist can be gentle, compassionate, nonjudgmental, if he is willing to wait, if he is able to bear with the patient as the latter works to overcome his fear of committing himself affectively to the relationship, if the therapist can lend himself and his understanding to facilitate such a working-through process, then in time the patient's archaic narcissistic needs, his thwarted developmental needs, which were long split off and repressed, become remobilized in the therapeutic situation, and a selfobject transference emerges.

According to Kohut and Wolf (1978), a selfobject (or narcissistic) transference is a transference relationship that serves to enhance the patient's sense of perfection. If it is a mirror transference, then the mirroring selfobject provides mirroring confirmation, validation of the patient's grandiosity and omnipotence, the

patient's perfection. If it is an idealizing transference, then the idealized selfobject is experienced as the embodiment of idealized perfection and fused with in fantasy, which enables the patient to partake of the therapist's perfection, thereby reinforcing his (the patient's) own perfection. In either situation the result is a reinforcement or a bolstering of the patient's illusions of grandiosity and omnipotence, his illusions of perfection. Rothstein (1980) has aptly described self pathology as the narcissistic pursuit of perfection, the relentless pursuit of perfection within both self and others.

More generally, the narcissistic patient with structural deficits looks to others to perform those psychological functions that he cannot perform on his own. The patient looks to the object to be empathically responsive to whatever his need might be, whether for validation of how perfect he

is or simply for validation of who he is. By the same token, sometimes the patient will be satisfied with empathic recognition that is near-perfect, good enough; at other times he will need the empathic recognition done to perfection (and even minor deviations from perfection will be experienced as failures, which will have to be worked through). In other words, sometimes the patient needs his object to be only approximately empathic; at other times the patient needs his object to be absolutely empathic.

I am suggesting, therefore, that when we speak of the patient's narcissism, either we are referring, in the strictest sense of the word, to the patient's narcissistic need for perfection of both self and object, or we are referring, more loosely, to the patient's need for empathic recognition of whatever his developmental need might be. In the first instance, the need is for perfection; in the

second instance, the need is (more generally) for external reinforcement. In any event, whether we are speaking more strictly or more loosely, the narcissistic patient has a transferential need for his objects to be better (more perfect) than they are, and it is such a need that must become transformed over time into a healthy capacity to accept his objects as they are, imperfections and all. In what follows, I will be referring sometimes to the patient's need for perfection and sometimes to his need (more generally) for empathic recognition; usually the context will clarify which one I am referring to.

The deficit creates the need. The need is for an object to complete the self—for a selfobject. The presence of the selfobject enables the person with deficit to feel vital, alive, cohesive, psychologically complete.

What exactly is meant by *selfobject*? According to self theory, a selfobject is someone who is experienced as a part of the self (as a narcissistic extension of the self) and is used in the service of the self. It is used to provide narcissistic gratification—enhancement of one’s sense of perfection (strictly speaking) or enhancement of the self-esteem (loosely speaking). More specifically, a selfobject is used to provide self-regulation because such regulation cannot be provided endopsychically. Selfobjects fill in for missing psychic structure (missing capacity); as such, they function as precursors of psychic structure. In time, if all goes well, the functions performed by the selfobject are internalized, and self structure, in the form of regulatory capacity, is laid down. Now the functions once performed by the selfobject can be performed internally. In essence, internalized functions become psychic

structures, and the presence of structure goes hand in hand with the capacity to perform regulatory functions.

When we say that the patient uses the therapist as a selfobject, we mean that the therapist is experienced as the embodiment of a particular psychological function that the patient is missing. What is it like for the patient to experience such a transference? It feels good; it is a positive transference and, as such, is accompanied by hope. Do we interpret it? No, we interpret only its disruptions.

Through the relationship with the selfobject therapist, there is a second chance for the patient to continue the development that was thwarted early on by traumatic disappointment in the infantile selfobject. There is a developmental opportunity for a new beginning, a filling in,

firming, and consolidation of the self, a repair or restoration of the injured, damaged self—by way of the therapeutic relationship itself.

A selfobject transference is accompanied by illusion. Once it has emerged, the patient experiences the transference object either as actually gratifying or as potentially gratifying, either as good at the moment or as able to be made good at some point in the future. The patient's experience is either "You, the therapist, are the perfect parent I never had" or "My hope is that you will someday be the perfect parent I never had." In any event, the object is experienced, in an unrealistically positive way, as the good/perfect parent the patient never had.

Illusion is ultimately involved in such transferences. On the surface of things, what the patient is looking to the therapist to provide may

seem entirely reasonable, but underneath it the patient is really looking to the therapist to be the perfect parent he never had and to make up entirely for the early-on bad parenting. That is what is unrealistic; that is what is illusory. Of note is that the therapist may well be in collusion with the patient's illusion, in which case he too will be wishing that he could make up the difference to the patient and thinking, further, that he should be able to.

But much as both patient and therapist might wish it to be that way, it does not work like that. And it will be as the patient confronts the reality of his disillusionment that structural growth will occur and his need for illusion will become transformed into a capacity to experience reality as it is. It will be as the patient works through the loss of his illusions that he will overcome his resistance and get better.

THE ILLUSION STATEMENT

In order to facilitate the eventual grieving that the patient must do, the therapist names (in an experience-near, nonjudgmental way) the patient's illusions. The therapist wants to highlight the fact of the illusion without suggesting that there is anything wrong with having it. In an *illusion statement* the format is as follows:

"You are wishing that ..."

"You so want ..."

"You are hoping that ..."

Examples of illusion statements are:

"You are hoping that you will be able to find at last the understanding you have been searching for all your life."

"You feel that you have at last found the understanding you have been searching for all your life."

"You find in here the kind of validation that you

do not find on the outside, and that feels good.”

“You are pleased with the progress you’re making and feel that you will soon be able to stop treatment.”

“You are feeling that your mother is beginning to understand just how much she hurt you and you find yourself wanting to forgive her.”

“You feel that your mother is doing the best that she can, and for that you are grateful.”

“You never thought you would be able to feel this known and this understood.”

In the illusion statements that follow, the element of eventual disillusionment is already being introduced:

“You were so wishing that I would not let you down as the others before me have.”

“You were so wanting to find in here the kind of acceptance that you never before felt.”

“You so hoped that talking about all this would ease your pain.”

“You so hoped that by now you would be feeling better.”

In an illusion statement the therapist highlights the fact of the patient's hope—unrealistic hope, as it happens, but this aspect is not specifically emphasized. The therapist is trying to increase the patient's level of awareness about the illusions to which he clings, whether the illusions relate to the infantile object, the transference object, or a contemporary object. The therapist wants to encourage the patient to elaborate upon the illusions around which he has unconsciously organized his experience of the world and to make the patient more aware of the longings he brings to the therapy and the therapist. Acknowledgment of (illusive) hope is important foundation work for the patient's

working through of his eventual, and inevitable, disillusionment, when it turns out that the therapist is not as good (perfect) as the patient had hoped he would be. It is, of course, by way of working through such disillusionments that the patient will give up his illusions and overcome his resistance.

THE LEGITIMIZATION STATEMENT

What I call a *legitimization statement* can also be used to highlight the fact of the patient's illusions and to put those illusions into a historical context. The legitimization statement places into perspective both the unrealistically positive and the unrealistically negative misperceptions the patient has of the therapist. It is used when the therapist wants to help the patient understand that of course he is feeling as he is because of what has come before.

A prototypical legitimization statement takes the form “Given that ...then, of course ...now.” Such an intervention suggests that, given the nature of his past, of course now the patient has both certain wishes and certain fears. A legitimization statement validates the patient’s current wishes and fears, suggests that, in light of his past, it is entirely understandable that the patient has come to be as he is and to feel as he does. It emphasizes the genetic underpinnings of the patient’s current defensive stance, contextualizing it as a derivative of early-on bad experience.

In the following examples, the first legitimization statement in each pair highlights the patient’s wish, his hope that things will be different this time; the second statement highlights his fear that they won’t:

1. “Given that you never got love and approval back then, of course you

very much want it now.”

2. “Given that you never got love and approval back then, of course your fear is that you won’t get it now either.

1. “Given that you were so disappointed in the past, of course now you hope things will be different.”

2. “Given that you were so disappointed in the past, of course now your fear is that you’ll be disappointed yet again.”

1. “Given that your mother was so reluctant to give you emotional support, of course you find yourself hoping now that you’ll be able to get that from me.”

2. “Given that your mother was so reluctant to give you emotional support, of course you find yourself terrified now that you won’t be able to get that from me either.”

Remember that there are two internal records

of traumatic frustrations sustained by the patient early on: reinforced needs and pathogenic introjects. Under the sway of the repetition compulsion, the patient delivers into the relationship with the therapist his infantile need and/or a pathogenic introject.

Displacement, from the parent to the therapist, of the once-thwarted need creates an expectation of (potential) gratification. It gives rise to an illusion, which is accompanied by hope, the patient's hope that in the relationship with his therapist he will be able to find gratification of his need, that he will be able to get now, in the present, what he was never able to get consistently and reliably in the past. Legitimization statements attempt to highlight the presence of the wish and to contextualize it as a derivative of early-on bad experience. In essence, displacement of need has created an illusion of

potential gratification, which is what gives rise to the positive transference and what we are attempting to highlight by way of legitimization statements that name the wish.

As for projection of pathogenic introjects, it is accompanied by whatever distressing affect the patient experienced as a child when he was hurt, upset, disappointed over and over again by a traumatically frustrating parent. Projection of pathogenic introjects creates distortion, which is what gives rise to the negative transference and what we are attempting to highlight by way of legitimization statements that name the fear.

Although we are here (in our consideration of the positive transference) less concerned with the internal bad objects that are projected onto the therapist, thereby creating distorted perceptions of the therapist as bad in the ways that the parent

was once bad, it is worth noting that legitimization statements are used in both situations—they are useful for contextualizing both the illusions that accompany the positive transference and the distortions that accompany the negative transference. The therapist uses such statements to deepen the patient's understanding of why he has come to be as he is, to enhance his knowledge of himself and what motivates him in his relationships.

Here are additional examples of legitimization statements that highlight the patient's yearning (and name the positive transference):

“Given that you never really felt special as a child, of course you long for that now from me.”

“Given that you never really felt held as a child, of course you find yourself craving that now.”

Here are additional examples of legitimization statements that highlight the patient's fears (and name the negative transference):

"Given that you never really felt understood as a child, of course you are afraid that if you dare to reveal now what's most important to you, you'll be completely misunderstood."

"Given that your father always expected so much of you and was so rarely satisfied, of course now you hate it when you feel pressured to deliver, as you are now feeling in relation to me."

"Given that you've been hurt so many times in the past, of course now you find yourself reluctant to expose yourself once again to the possibility of heartache, and so you find yourself holding back in here, not wanting to trust me."

"Given that you always felt judged as a child, of course now you find yourself feeling particularly sensitive to being judged."

All such statements validate or legitimize the patient's current feelings of yearning, desire, vulnerability, susceptibility, anxiety, insecurity, fearfulness. In essence, the therapist is suggesting that, given the historical antecedents, it is entirely reasonable that the patient would now have the sensitivities that he has. We may even want to formulate a statement that legitimizes both wish and fear: "Because you had no one you could depend upon as you were growing up, of course now you find yourself wanting to be able to depend upon me but wondering whether or not it'll be safe to do so." By offering the patient a statement in which the therapist legitimizes the way the patient now feels, the therapist is attempting to decrease the shame he might feel at having his wish/fear exposed. The therapist hopes that the patient, in response to such an intervention, will feel supported enough that he

will be able either to elaborate upon the nature of his feelings in the here and now or to associate to further details about the genetic underpinnings of those feelings.

By way of summary, let me say again that illusion statements and legitimization statements are both efforts to get named, in an experience-near, nonjudgmental, nonshaming way, the illusions to which the patient clings in order not to have to face reality. The therapist wants to make the patient ever more aware of the ways in which he yearns for his objects to be other than who they are.

Whereas some, including Kernberg (1985), have suggested immediate confrontation and vigorous interpretation of the patient's unrealistically positive misperceptions of the therapist, the self psychologists believe that it is

for the therapist to comply as best he can with the patient's narcissistic needs. But the self psychologists, for the most part, do not claim that such compliance, on its own, effects actual structural growth. In fact, as we know, the self psychologists believe that gratification is necessary for such growth but not sufficient; it is frustration against a backdrop of gratification that prompts internalization, the building up of internal structure, the filling in of deficit, and the giving up of infantile need.

Incidentally, I think that a lot of the therapy done with narcissistic patients by therapists who are not well versed in self psychology is aimed at exhortation and shaming of the patient to temper his overt displays of exhibitionism and superiority. The patient is taught to keep to himself his grandiose claims and his infantile expectations. If the patient complies, then he no longer appears

narcissistic, but there has been no real structural growth; furthermore, we now no longer have access to his archaic narcissism. We have nipped in the bud any possibility for working with and transforming his narcissism from pathological to healthy.

ENTITLEMENT

Sometimes the patient with structural deficit may be relatively unaware of the infantile needs that inform the expectations he has about his objects. The patient may not recognize that he is now looking to the therapist to compensate for damage done early on. But sometimes the patient is very much aware of how he expects to be gratified by his therapist and may, in addition, feel quite entitled to that gratification.

In such situations the patient may even become insistent that the therapist give him

something or that the therapist do something for him. The internal experience of structural deficit is one of gaps, holes, lacks, an inner void; the patient may state quite explicitly that he feels something is missing inside and that he is therefore looking to the therapist to give him what he cannot give himself. Thus the patient pressures the therapist to do this, to do that. The patient may demand reassurance, answers, guarantees. He may insist that the therapist hold him, tell him he loves him, tell him he is special. The therapist may experience the patient as unreasonably demanding—but here it is especially important to remember that the patient's need for gratification is legitimate and that he should not be forced to relinquish his archaic claims. The patient is not trying to be difficult; the patient is simply looking to the therapist to provide for him in the ways that he cannot yet provide for himself. The therapist

needs to appreciate that under the circumstances the patient's sense of entitlement is entirely understandable and reasonable.

A patient in the throes of such a transference will be expectant, demanding, relentless, imperious, insistent, persistent. The patient's refrain goes something like this: "I want, I need, I must have, I insist ...that you give me this, that you tell me that, that you answer me, that you do this for me, that you do that for me." The patient wants it, and he wants it now!

It may be useful, at such junctures, for the therapist to make use of an entitlement statement (discussed in an earlier chapter), in which he frames the patient's feeling of entitlement in the here and now as a legitimate response to having felt so cheated and ripped off as a child. The therapist is acknowledging not only that the

patient wishes for the therapist to make up the difference to him but that the patient feels entitled to such compensation because he was so deprived as a child:

“Your mother never understood and left you very much on your own; and now you feel that unless I am willing to go out of my way on your behalf, you imply are not interested in having a relationship.”

“You feel you have worked hard in the treatment and have done everything that you can; you are now feeling that it is up to me because you can do nothing further.”

“You feel that you were so cheated as a kid that you should not have to do another thing at this point; you are feeling that if I can’t do it, then it won’t get done.”

“You feel that you are paying me to be the expert on these matters and that I should therefore tell you what to do.”

It is important that the patient’s sense of

entitlement be recognized and named, again in a nonshaming fashion. The rendering conscious of the genetic origins of such feeling of entitlement may diffuse some of the pressure and relieve both patient and therapist. If naming the entitlement and exploring its underpinnings does not ease things, then we run the risk of developing a stalemated situation characterized by something to which I refer as the patient's *relentless entitlement*. This is a particularly troublesome state of affairs, which requires a more aggressive approach than is ordinarily required to work through the patient's defensive need for illusion; it is usually much easier for the patient to give up his illusions than it is for him to give up his sense of entitlement. In Chapter 12, I will deal with the dynamics that underlie the defense of relentless entitlement and suggest ways to work through such a defense.

THE DISRUPTION OF A SELF OBJECT TRANSFERENCE

As we know, the self psychologists have conceptualized a model for psychic development in which they suggest that working through disappointment is the process by which internal structure develops. It is a prolonged grieving process and one that results in the preservation internally of that which was good externally. The working through of optimal disillusionment of developmental (or narcissistic) needs leads to transmuting internalizations and the accretion of internal regulatory structures. As the psychological functions once performed by the self object become internalized, internal structure is acquired, the self is consolidated, and the need for external reinforcement is replaced by the capacity to provide such reinforcement internally.

For the self psychologists, getting better has to

do with learning to master the disillusionment that comes with the recognition of imperfection; it has to do with mastering the loss of illusions about the perfection, or the perfectibility, of self and object.

Let's take a careful look at the working-through process for a selfobject transference because it is the prototype for the process by which need is transformed into capacity. The need to experience one's objects as better than they are becomes transformed into a capacity to experience them as they are. The process of transformation is a grieving process, a process of gradual disillusionment. The development of capacity is the result.

As I have said, when a positive transference is in place, it is unnecessary for the therapist to do any interpreting of it. The patient should be

allowed to feel narcissistically gratified, psychologically complete, cohesive, and alive, without being stripped of whatever illusions might be involved in such good feelings. As we will later see, this is a very different situation indeed from the situation that arises when there is a negative transference; when the patient recapitulates in the transference the early-on traumatic failure situation, then the therapist will want to interpret the patient's experience of the present as a misunderstanding of it based upon a traumatically disappointing past.

So, when a positive (or, in this case, a selfobject) transference has emerged, the therapist does not interpret it. The therapist only interprets disruptions of it; only in the context of the therapist's disappointment of the patient is there need for intervention.

And inevitably the therapist does fail the patient. The selfcohesiveness of the patient and the stability of the selfobject transference will be momentarily disrupted, temporarily threatened. The therapist's failure is experienced as a narcissistic injury, and the patient's reaction is one of outrage, devastation, and a regressive retreat.

The narcissistic patient experiences rage whenever he feels that his will has been thwarted; and in the aftermath of a narcissistic injury, the patient insists that he be recompensed, insists that it be made up to him somehow. There are patients who insist that they get their money back because they have not gotten better.

In fact, the narcissistic patient has an underlying conviction that it is his right to have the difference made up to him, that he is entitled to compensation for the damage sustained early

on. I had a patient who kept a secret ledger in which he charged his mother one penny for every time she was mean to him; he was never able to collect on it but, as an adult, still remembered the \$787.46 that was owed him.

When the therapist commits an empathic failure, the patient is upset at the selfobject for having failed to perform its assigned function and for having demonstrated its fallibility, its lack of perfection. The patient alternates between enraged protests at his own imperfection and angry reproaches against the selfobject therapist for having perpetrated the insult.

Narcissistic rage is a so-called breakdown product of selfobject failure, a disintegration product. There is, for example, a major difference between anger (or aggression) and rage. Whereas anger is considered the reaction of a healthy self to

frustration, rage is the reaction of a damaged self (Baker and Baker 1987).

Aggression is directed against objects, not selfobjects. Aggression is experienced against people who are recognized as being external to the self, not people who fill in for missing psychic structure. Aggression in the healthy self, then, is mobilized in reaction to a frustration; its purpose is to remove whatever obstacles may be interfering with the gratification of a particular need or the pursuit of a particular goal. Baker and Baker (1987) have suggested that “we may get angry at a recalcitrant nail that will not go into a wall when we try to hang a picture. However, when the nail finally yields and the picture is hung, the anger subsides” (p. 6). On the other hand, if the nail provokes a narcissistic injury, if it makes us feel defective or inadequate, we may become enraged and may attempt to retaliate against the

nail, by slamming it into the wall. Even then, the rage may persist. Narcissistic rage seeks revenge; it pushes us to get even, often without caring about the resultant damage (done either to the self or to others).

When the therapist, despite his best efforts, fails the patient, a disruption occurs. In the aftermath of an empathic rupture, and in the face of the patient's disillusionment, the therapist directs his efforts toward identifying the offending failure. The work involves a focus not upon the patient's upset or outrage but rather upon an understanding of the precipitating event, an understanding of the therapist's empathic failure that disrupted the positive transference. It is not the regressive position itself but the need for the retreat that should be the focus of the therapist's attention. A correct identification by the therapist of the exact nature of the offending failure, no

matter how minor, is necessary if the relationship is to survive, the disappointment is to be mastered, and a positive transference is to be restored.

In order to locate and understand the offending failure, the therapist may ask, "How have I let you down?" or "How have I failed you?" The emphasis is not on the patient's pathology. The question is not "How do you feel that I have disappointed you?" but rather "How have I disappointed you?" The reality is that the therapist, by being less than perfect, has indeed disappointed the patient. The patient had needed the therapist to be perfect, and the therapist was not. Given that the patient had imagined that the therapist was perfect, of course the patient is now devastated by the therapist's demonstration of fallibility and resultant failure of him.

THE DISILLUSIONMENT STATEMENT

The working-through process, a prolonged grieving process, can be facilitated by the use of an intervention to which I refer as a *disillusionment statement*. The disillusionment statement has two parts. In the first part, the therapist highlights the patient's illusions about the therapist's perfection; in the second part, the therapist empathically resonates with the patient's experience of disillusionment, disappointment at the discovery of the therapist's imperfection. The disillusionment statement, then, highlights the discrepancy between the illusion of the therapist as infallible and the reality of the therapist as fallible. It is used to facilitate the patient's accessing of his grief. Examples of disillusionment statements are:

“You wanted so much for me to be able to make it all better, and it upsets you terribly that I

don't seem to be able to make the pain go away."

"You had so hoped that I would be able to give you answers, and it angers you that I haven't done that."

"All you wanted was a little advice, and it bothers you that I haven't offered you that."

"Although you knew it would take time, you had hoped that you would be feeling much better after several weeks of therapy, and it bothers you that you still feel so bad."

"You were so hoping that I would not make the same kinds of mistakes that everyone else has made, and it makes you very sad that I too have now let you down."

"Sometimes you wish I knew what you were thinking without your having to say it, and so it's annoying when you find yourself having to explain it to me."

A disillusionment statement can be used both to help the patient understand himself better (by

highlighting the underlying illusions) and to help the patient feel better understood (by resonating with his disillusionment). In essence, it facilitates the working through of disrupted positive transferences; it facilitates the grieving the patient must do in order to let go of his illusions, the defensive misperceptions of reality that have been a part of his resistance.

A disillusionment statement is not a conflict statement, in that it does not first name a reality defended against and then the defense itself. It is, rather, a particular kind of legitimization statement, in that it attempts to contextualize the patient's current experience of disillusionment as an understandable response to having had illusions shattered. Given that the patient had believed that the therapist was (or would become) the perfect parent he never had, of course the patient is now devastated by the therapist's

demonstration of imperfection. Permission is being given to the patient to get in touch with the pain of his disillusionment and to feel his grief, both the depth of it and its intensity.

THE INTEGRATION STATEMENT

Another psychotherapeutic intervention, something I call an *integration statement*, can be used when the patient is feeling so devastated by the therapist's failure of him that he cannot remember ever having felt good about the therapist. The therapist enters into the patient's internal experience of upset, anger, and disillusionment and appreciates that, in the face of the current bad, the good of the past cannot be remembered and hope for the future cannot be sustained. In other words, the integration statement acknowledges the patient's difficulty holding on to good feelings when he is feeling

angrily disappointed. The integration statement resonates with the patient's current feeling of disappointment and, in highlighting the patient's difficulty remembering the good in the face of his current upset, gently reminds the patient of his previous experience of having felt good. Examples of integration statements are:

“When your heart is breaking, as it is now, you can’t imagine that you could ever dare to trust me again.”

“When you’re feeling this devastated, it’s hard to remember that you used to feel good in here and looked forward to coming.”

“When you are feeling this despairing, you can’t remember ever having had any hope whatsoever.”

The therapist does not simply remind the patient of what the patient, on some level, does know. In other words, the therapist does not simply tell the patient, “But you used to feel good

about me!" Such a blunt reminder of something the distraught patient no longer remembers makes the patient even more angry and, further, creates the potential for a struggle between patient and therapist. Rather, the therapist, appreciating that the patient does not, in the moment, remember the good that was, names the patient's difficulty remembering that good: "When you're feeling this disappointed, it is hard to remember that you ever felt good about me." Such a statement is hard to deny.

An integration statement is particularly useful for those patients who have especial difficulty holding in mind, simultaneously, both good and bad, both positive feelings and negative feelings. It is particularly useful, therefore, in working with borderlines, who, because they have at best a tenuously established libidinal object constancy, have much trouble remembering the good in the

face of the current bad.

We say, therefore, of the borderline that he has not yet achieved the capacity to experience optimal disillusionment. For him, every disappointment is a traumatic one because, in the moment of the disappointment, the object becomes all bad and there is no memory of the good that was. As a result, the disappointment cannot really be worked through, mastered, and rendered nontraumatic. There is no taking in of the good and no building up of internal structure (which helps also to explain the borderline's notoriously defective capacity for internalization). In essence, the borderline has neither the capacity to grieve nor the capacity to forgive. Thus, for the patient who lacks libidinal object constancy and truly cannot remember, there is no such thing as nontraumatic frustration or optimal disillusionment; every disappointment is

devastating, every frustration traumatic.

By way of an integration statement, the therapist wants to help the patient hold in mind, simultaneously, both the good (that is, the past experience of having been gratified) and the bad (that is, his present experience of disillusionment). To that end, the integration statement (1) acknowledges the patient's current feeling of upset; (2) remembers for him the good he has forgotten; and (3) articulates, on his behalf, the difficulty he has remembering it. In so doing, the therapist is hoping to remind the patient of what he really does know to be real, even though there are times when he forgets. Integration statements are designed, therefore, to facilitate the patient's working through of his bad feelings about someone once experienced as good.

THE WORKING-THROUGH PROCESS

As we know, the therapist's failure of the patient re-creates for the patient the early-on traumatic failure situation. In an earlier chapter I made the distinction between the parent's traumatic failure of the child and the therapist's nontraumatic failure of the patient. (At a later point I will discuss the situation that occurs when the therapist traumatically fails the patient, either because he simply does or because the patient gets him to.) In any event, whether we are talking about the parent's traumatic failure or the therapist's nontraumatic failure, the person defends himself against the pain of his disappointment; in neither situation can the person bear to face the reality of his disillusionment with the object, whether the infantile object or the transference object.

But the reality against which the patient, as a child, defended himself was a toxic reality,

whereas the reality against which the patient now defends himself is a nontoxic reality. The parent's failure of the child was a traumatic one, something that the child could not possibly master because it hurt too much to know that he was not loved as he should have been. The therapist's failure of the patient is a nontraumatic failure, an optimal disillusionment that also hurts but that can nonetheless eventually be mastered.

And so the therapist's present failure of the patient, even though nontoxic and therefore not so horrid, will re-create the parent's early-on traumatic failure of the child, those toxic failures that were intolerably horrid. The old hurts, the old pain, the old grievances get revived in the transference. Devastation reexperienced in the relationship with the therapist offers the patient an opportunity for a reworking of the original devastation. Belatedly, he grieves the early-on

privations, deprivations, and insults.

The patient rants, raves, sobs, wrings his hands, pounds his fists, screams out his anguish. Paradoxically, it is in the context of being “held” by the therapist that the patient can now let himself feel, in the present, in the context of his current disillusionment, all the old hurt, all the old pain, and all the old rage that belong more to the parent who traumatically failed the child than to the therapist who is now nontraumatically failing the patient.

On behalf of the child he once was, the patient grieves the reality of just how bad the parent was; on his own behalf now, the patient grieves the reality of the therapist’s very real limitations. The patient gets it, deep within him, that he is ultimately powerless to do anything to make those realities any different, much as he might wish to

be able to do so. Genuine grieving involves confronting the reality of just how bad it really was and is; and it means accepting that, knowing that there is nothing now that can be done to change it.

As we know, part of mastering the pain of the disillusionment are the internalizations that accompany the grieving. Taming of need, internalization of function, accretion of structure, and development of capacity result from the experience of working through disrupted positive transferences and the loss of illusion.

In order to facilitate the grieving the patient must do, the therapist must be able, himself, to tolerate his own lack of perfection; he must have transformed his need for perfection into a capacity to tolerate imperfection. He cannot expect his patient to accept imperfection if he (the therapist)

has not yet developed the capacity to tolerate it. It is indeed difficult, in the face of a patient's enraged protest that we have been unempathic, that we simply do not understand, or that we have been critical, to feel good about ourselves even as we are admitting that perhaps we were unempathic or did not understand or were in fact critical.

But if the therapist has not resolved his own narcissistic issues, then each time he fails the patient it will be hard for him to tolerate the patient's disillusionment with him and his imagined perfection. Furthermore, if the therapist, secretly, has shared the patient's fantasy that he, the therapist, can and should make up the difference to the patient, then he may have particular difficulty tolerating the patient's upset with him.

In demonstrating his fallibility, the therapist

has indeed let the patient down; and he needs to be able to hear the patient out, without suffering too terrible a blow to his own self-esteem. The patient is not distorting; the patient, in discovering the therapist's limitations, is accurately perceiving him as imperfect.

When the patient protests that the therapist should not be raising his fee, then it is important that the therapist be able to listen without getting too defensive. The therapist may well be doing what is right for him (the therapist), but it is wrong for the patient, and the patient wants the therapist to recognize that. The patient wishes that he could be special and not even have a fee; the therapist needs to appreciate just how devastating it is for the patient to feel that he is but another patient who must pay for the therapist's time and attention.

If the patient complains, for example, that the therapist has not responded in the right way, then the therapist has not responded in the right way, because it has not worked for the patient. The patient is the final judge. It is important that the therapist try to understand what the patient would have wanted him to say so that he (the therapist) can appreciate just how off he may have been. In such a situation, the therapist may admit that perhaps he was a bit off; the therapist is not, however, admitting that he is a bad therapist (although the patient, on some level, may be trying to get the therapist to feel that he is incompetent and to admit that).

But once the therapist has owned his own fallibility, patient and therapist can go on to look at what the therapist's lack of perfection means to the patient. The patient can begin to confront the reality that his objects may not always be exactly

as he would have wanted them to be; he grieves the lack of perfection in the therapist, in his parents, in his significant other, in the world, and even in himself. He would have wanted things to be otherwise, and it pains him terribly that they are as they are.

If the therapist can bear it that he is not perfect, then he can help the patient come to terms with it as well. Together, patient and therapist confront the reality of how limited the therapist really is. Would that the therapist could simply make the patient better by giving him now what he never had in a consistent, reliable way early on. Would that the therapist could head the patient's wounds by way of the therapist's understanding, his compassion, his caring, and his love. Patient and therapist must grieve together the reality of the therapist's limitations.

Paradoxically, as the patient confronts the reality that he will not be able to be made better by way of the therapist's provision of good parenting, as the patient works through his disillusionment with the therapist, he internalizes the good parenting that the therapist really has been able to offer and, in the process, develops the capacity to provide for himself that good parenting. As he masters his disappointment with the limitations in the therapist's parenting of him, he internalizes what good there has been in that relationship and becomes, for himself, the good parent he never had early on.

It is the work of grieving, the constant, repetitive raging, screaming, ranting, raving, and anguishing, that constitutes the process whereby the patient gradually lets go of his illusions. The patient gradually replaces his illusion that the therapist will be for him the good parent he never

had with a reality—namely, that he will have to become for himself the good parent he never had. His need for illusion gets replaced by a capacity to tolerate reality.

Grieving—grieving the loss of illusions about the perfection, or the perfectibility, of the object—is the way in which structural growth occurs. It involves working through disruptions of the positive transference, working through disillusionment. Transmuting internalization and accretion of internal structure result from the experience of having had and then lost: having the illusion; losing the illusion; and grieving that loss. Transmuting internalization enables the patient to make internal what was once external, enables the patient, ultimately, to do for himself what he once needed from his objects.

And so it is that the patient is gradually able to

give up the illusions to which he has clung in order not to have to feel his pain. As the illusions are relinquished, the resistance is overcome. The patient's need to experience his objects as the good/perfect parent he never had becomes transformed into a capacity to provide for himself such parenting and, therefore, to tolerate the reality that his objects will not always be as good/perfect as he would have wanted them to be. As the patient becomes for himself the good parent he never had, his need to have his objects be perfect becomes transformed into a capacity to accept them as they are—imperfect, to be sure, but nonetheless plenty good enough.

More generally, the need to experience reality as other (better) than it is becomes transformed into a capacity to experience it as it really is, uncontaminated by the past. Such a process of transformation is accompanied by the taming of

need, the accretion of structure, and the development of capacity. Where once there was need, now there is capacity. Self psychology helps us to understand this developmental process by which infantile need is transformed into mature capacity.

The Negative Transference

THE CHANGING OF OLD BAD

In this chapter we will look more closely at the process by which the patient's compulsive need to re-create the early-on traumatic failure situation in his current relationships is transformed into a capacity to experience his present objects as they really are, uncontaminated by the past. We are, of course, talking about the process by which the negative transference is worked through, the patient's internal bad objects are detoxified, and the resistance is overcome.

We have been postulating that structural growth, the addition of new good, is accomplished

by way of working through a disrupted positive transference, and we have looked to self psychology for help in conceptualizing the process. It is a process of transformation that involves grieving the loss of illusions about the perfection, or the perfectibility, of the self and/or the object. The defensive and adaptive internalizations accompanying that process enable the patient to preserve internally the external goodness. Where once the patient looked to his objects to provide good parenting, now he can be for himself the good parent he never had. Where once there was the need for illusion, now there is the capacity to experience reality as it is.

Let us now shift to a consideration of structural change, the changing of old bad—a process that involves the working through of the negative transference. We will look to object relations theory for help in conceptualizing the

process by which the patient's need for distortion becomes transformed into a capacity to experience his objects as they are. Such will be the process by which the pathogenic introjects (which give rise to the distortions) are gradually reworked and structurally modified.

A point should be clarified here. In order to treat for the internal absence of good, the patient must be given the opportunity to deliver his need for external good into the transference. Gradual internalization of the good encountered there is the process by which the internal absence of good is corrected. But in order to treat for the internal presence of bad, it is not enough that the patient have the experience of external good and an opportunity to internalize it; rather, the patient must be given the opportunity to modify the bad that is already inside. He does this by way of delivering it into the transference (creating,

thereby, a negative transference). When it encounters a response that is less toxic than that anticipated, the toxicity of the original projection is modulated; there is, in other words, a detoxification of the bad that already existed within the patient.

From an object relations perspective, the negative transference can be thought of as involving a series of cycles of projection and introjection. The patient, under the sway of the repetition compulsion, projects his pathogenic introjects onto the therapist, who is then experienced as the old bad parent. But the therapist is not, in actual fact, the old bad object. If the real relationship with the therapist is to serve as a corrective for the old one, ultimately the patient must both understand and experience the difference between what he had expected and what actually happens.

Although some object relations theorists, including Ferenczi (1926) and Alexander (1948), have proposed that the therapist should enhance the corrective emotional experience by deliberately assuming a stance that is diametrically opposed to the traumatogenic parental stance, I am not at all here suggesting that the therapist should introduce extra activity in order to compensate for the early-on parental abuse and neglect. I do not believe that it is necessary for the therapist to manipulate the interpersonal climate by intentionally behaving differently from the way the patient had expected him to behave. Nor do I believe that the therapist, in an effort to facilitate the therapeutic process, should manipulate the situation in order to compensate directly for the parent's failure of the patient. Rather, the therapist is different from the parent, and as the therapist highlights that

difference, the patient eventually begins to see it and to feel it.

There comes a time, then, when the patient is able both to recognize with his head and to experience with his heart the fact that the therapist is a new good object. The therapist, in essence, challenges the patient's projections by providing a response different from the response expected; that response leads to the modification of the projected introjects, in the direction of reality. The introjects that the patient reinternalizes are now slightly modified; they are an amalgam, part contributed by the patient himself (the original projection) and part contributed by the therapist.

As Meissner (1974) writes: "The quality of introjects is derived from and constituted by elements in both the inner and the outer worlds.

What is introjected is ...determined by the characteristics of the real object in conjunction with the elements attributed to it that derive from the inner world” (p. 176). Later he suggests: “What is internalized through introjection is a function of an interaction between the real qualities of the object and the qualities attributed to the object that are derived from the subject’s inner world” (p. 176).

What gets projected the next time is a little less toxic and a little more reality-based. What gets introjected on each successive round is ever less distorted. By way of a series of such microinternalizations, the patient’s pathogenic introjects are gradually reworked, rendered less toxic. In essence, it is by way of ongoing and repetitive serial dilutions that the patient’s underlying introjects become gradually modified in the direction of reality; as the introjects become

more reality-based, the distortions are gradually relinquished, structural modification is effected, the negative transference is resolved, and the resistance is overcome. Where once the patient's need was to distort his perceptions of reality in order to maintain his attachment to the infantile object, now he has the capacity to experience reality as it is.

ONE-PERSON VERSUS TWO-PERSON

What is actually involved in working through the resistance that arises from the patient's need to re-create the early-on traumatic failure situation in his current relationships? How does the therapist deal with the patient's projections, and what kinds of interventions does he offer the patient in order to facilitate the detoxification process?

By way of example, let us think about a

situation of negative transference in which the patient is mistakenly perceiving the therapist as critical. The negative transference is, of course, a case of mistaken identity. What is the process by which the patient is enabled, gradually, to relinquish such a transference distortion?

I will suggest that the working-through process is facilitated by both insight and experience, by both the gaining of insight into one's unconscious repetitions and the experiencing of something different from what was expected. In a one-person theory of therapeutic action, insight is thought to be the primary therapeutic agent. In a two-person theory of therapeutic action, a corrective experience is thought to be what ultimately heals.

In a one-person theory of therapeutic action, the therapist, in order to correct the patient's

distortion, offers interpretations that direct the patient's attention inward and backward, direct him to observe his internal process and the fact of his unconscious repetitions, his tendency to experience new good objects as old bad ones. The therapist's interventions encourage the patient to recognize that he tends to make (negative) assumptions about the present based on his past. The therapist does not specifically address the reality of the current situation; he does not specifically address whether the patient's perceptions of him as critical are accurate or not. Rather, the therapist simply calls the patient's attention to the fact that the patient seems to expect, unconsciously, that his current objects will fail him in the very same ways that his infantile object failed him. The message to the patient, whether explicit or implicit, is: "You tend to make the assumption that your objects, including me,

will be the same kind of critical that your mother was. Interesting, yes?" The patient is being encouraged to observe his internal process and to become aware of the negative filters through which he experiences his world. He is gaining an appreciation of the extent to which his perceptions of reality are contaminated by his compulsive need to experience the present in ways determined by the past.

The result is a rendering conscious of something that was unconscious, an increased self-awareness, and a strengthening of the ego. In other words, the patient gains a better understanding of the extent to which he organizes his experience of himself and his world around the negative experiences he had early on. It is believed that the acquisition of such insight motivates the patient ultimately to relinquish the distortion. In a one-person theory, therefore, insight is thought to

be the corrective for the transference distortion.

In a two-person theory, on the other hand, the relationship itself is thought to be the primary therapeutic agent. Accordingly, the therapist, in order to correct the transference distortion, encourages the patient to look outward in order to experience the reality of who the therapist actually is in the here and now—namely, that he is a new good object, not the old bad one. Either explicitly or implicitly, the therapist does address the reality of the current situation. The therapist challenges the patient's distortion by confronting the patient with the reality of who he, the therapist, actually is. In a two-person model, the message is: "I want you to see that I am not the same kind of critical that your mother was (and that you are therefore expecting me to be)." The patient must come to a point where he not only can recognize but also can feel that there is a

discrepancy between what he imagines to be real and what is in fact real, a discrepancy between distortion on the one hand and reality on the other.

The result is the creation of tension within the patient between that which he is coming to know (informed by positive experience with the therapist in the present) and that which the patient was assuming (informed by negative experience with the parent in the past). Ultimately, the patient lets go of the distortion because of his need to reconcile what he comes to experience as real with what, mistakenly, he thought was real; in other words, he relinquishes the distortion because of his need to integrate his new experience of the therapist as a good object with his old (distorted) experience of the therapist as a bad object. In a two-person theory, therefore, the real relationship itself is thought to be the

corrective for the transference distortion.

Where a one-person theory focuses upon insight as a corrective for the transference distortion, a two-person theory emphasizes the relationship itself as a corrective for the transference distortion. Where a one-person theory emphasizes the gaining of knowledge, a two-person theory emphasizes the provision of experience.

In what follows, I will be calling upon concepts drawn from both a one-person theory and a two-person theory in order to facilitate our understanding of the process by which the patient is enabled gradually to relinquish the distortions to which he has been clinging. The therapist strives both to enhance the patient's knowledge of himself and to provide a corrective experience. By way of interventions that encourage the patient to

look inward and backward, the therapist attempts to broaden and deepen the patient's awareness of his tendency to make assumptions about the present based on his past. By way of interventions that direct the patient's attention outward, the therapist attempts to highlight the discrepancy between what the patient is coming to experience as real and what the patient was assuming was real. The combination of increased insight and corrective experience enables the patient to let go of his distortions and to overcome his resistance.

RECOGNIZING A NEGATIVE TRANSFERENCE

As we know, a negative transference unfolds when the patient delivers, by way of projection, his internal bad objects (or pathogenic introjects) into the relationship with the therapist. The patient then comes to experience the therapist as the bad parent he had; alternatively, the patient

may not actually experience the therapist as the bad parent he had but may fear that at some point in the future the therapist will turn out to be the bad parent he had. Both are instances of negative transference, whether the badness is experienced in the present or anticipated for the future. Both involve a reenactment within the transference of the negative interactional dynamic that had existed between the patient and his parent.

The tip-off that projection and negative transference are involved is the fact of the patient's distorted perceptions about himself and/or the therapist. Whenever a patient experiences either himself or his objects in an unrealistically negative light ("I am bad" or "You are bad"), then we implicate the pathogenic introjects that populate the patient's internal world and that derive from internalizing the badness that had existed in the early-on

relationship between the patient and his parent.

At this point let me reiterate the distinction between a negative transference and a disrupted positive transference. A negative transference involves experiencing the therapist, in a distorted fashion, as just like the bad parent; a disrupted positive transference, however, involves experiencing the therapist, in a realistic fashion, as less perfect than the patient had hoped the therapist would be. Imagine, for example, a situation in which the patient is angry with the therapist. There are two possible explanations: either the patient is mistakenly experiencing the therapist as bad, or the patient is realistically experiencing the therapist as not quite as good as the patient had hoped he would be. In the first instance, we are talking about distortion, about negative transference, about negative assumptions made that are not founded in reality. In the second

instance, we are talking about disillusionment, about positive transference disrupted, about the reality of the therapist's failure of the patient. Both elicit the patient's anger.

In other words, if the patient is upset because the therapist has not given him the magic answer he had wanted, it may have to do with either a misinterpreting of the therapist's underlying motivations or an accurate assessment of the therapist's very real limitations. The patient may be wrongly assuming that the therapist has not offered him any magic answers because the therapist is withholding and does not care about him—clearly a situation of negative transference. On the other hand, the patient's upset may have to do with the pain of his disillusionment; he may be realistically perceiving the therapist as less omniscient than he, the patient, had thought his therapist would be. This latter is clearly a situation

of disillusionment and disrupted positive transference. More generally, the patient may be upset because things are as he had feared they might be and/or because things are not as he had hoped they would be.

Often both negative transference and disrupted positive transference are involved, simultaneously. It is important that the therapist recognize which piece is negative transference and which piece is disrupted positive transference, because the working-through process is different for each. Whereas working through a disrupted positive transference involves, ultimately, modulating the infantile needs and giving up the illusions arising from such needs, working through the negative transference involves, ultimately, modifying the internal bad objects and giving up the distortions created by such pathogenic structures.

Let me also clarify that as we explore the process of structural modification that accompanies the working through of the negative transference, my emphasis will be upon the patient's direct transference to the therapist. In an earlier chapter I noted the distinction between a direct transference and an inverted transference. A direct transference unfolds when the patient projects onto the therapist the role of the powerful parent and identifies himself with the vulnerable child he once was. Now the patient experiences the therapist, in a distorted fashion, as the bad parent he once had and experiences himself, similarly in a distorted fashion, as the vulnerable child he once was. The direct transference is a recapitulation of the early-on traumatic failure situation, with the therapist cast in the role of the victimizer and the patient identified as the victim. As part of working through such a negative

transference, the therapist will make interpretations that highlight the discrepancy between the patient's knowledge of reality and his experience of it. It is the internal tension so created within the patient that ultimately provides the impetus for letting go of the distortions that have given rise to the negative transference.

But in a situation of inverted transference, there is no discrepancy between what is real and what is imagined. With an inverted transference, there is no distortion, only reality. As we recall, an inverted transference unfolds when the patient puts the therapist in the position of the vulnerable child he (the patient) once was and, through his identification with the powerful parent, does to the therapist what was once done to him (the patient) by the bad parent. If, for example, the patient is relentlessly critical of the therapist as the patient's parent was once of him, then the

patient is truly behaving as a villain and the therapist is the patient's victim. As part of working through such a situation, the therapist will be unable to make interpretations that highlight the discrepancy between the patient's knowledge of reality and his experience of it because there will be no such discrepancy. What the patient actually needs in such situations is containment, but that is beyond the scope of this book.

WHEN THE THERAPIST BECOMES THE BAD PARENT

Also beyond the scope of this book is the situation (briefly described earlier) that arises when the patient exerts interpersonal pressure on the therapist to accept the projection of bad parent. Here we are dealing with a situation in which the patient's need to re-create his past in the present is so powerful that he is relentless in his unconscious efforts to get the therapist to fail

him in much the same way that his bad parent failed him. (But whereas the parental failure of the child could never be worked through, the therapist's failure of the patient can be worked through—which makes it the occasion for structural growth.) Once the therapist succumbs to the patient's efforts to get the therapist to fail him, we are no longer dealing with inaccurate perception but with accurate perception of the therapist as bad; we are talking no longer about distortion but about reality. In other words, we are talking about a situation of projective identification. Let me pose a question. We know that the transference involves a reexperiencing of the past in the present in a way that, as Greenson (1967) notes, "does not befit" (or "is inappropriate to") the present. The transference is thought to involve a misperceiving or a misunderstanding or a misinterpreting of the present in terms of the

past. When the therapist is put in the vulnerable position of the helpless child the patient once was (what we have been describing as an inverted transference), is that an actual instance of transference? In other words, is it an inappropriate reexperiencing of the past in the present?

I would suggest that it both is and is not. It is not an instance of transference inasmuch as it involves an actual, not a fantasized, experiencing in the present of the interactional dynamic that had characterized the early-on parent-child relationship. But it is an instance of transference inasmuch as it involves the inappropriate delivery into a current relationship of an early-on interactional dynamic that does not befit the present.

By the same token, when the therapist is

actually made into the bad parent by the patient (what we have described as a direct transference that involves the therapist's actual participation in the patient's childhood dramas), is that an instance of transference? In other words, is it an inappropriate reexperiencing of the past in the present? If the patient experiences his neutral therapist as critical, then we are clearly dealing with a negative transference, in that the patient's perceptions of his therapist are obviously distorted and therefore inappropriate to the present. But if the patient acts in such a fashion as to get his neutral therapist to become critical in fact and not just in fantasy, then are we still dealing with a transference situation?

In such a situation the patient protests that he is accurately perceiving his therapist as critical of him. The patient may go on to admit that he knows his parent was also critical and that the issue is a

charged one for him; the patient insists, however, that none of this negates the accuracy of his charges against his therapist. His claim is that his perception of his therapist as critical is real, not transferenceal or distorted. Meanwhile, the therapist protests that the patient's perception of him as critical is inaccurate and derives from the patient's past experiences with a critical parent; in other words, the therapist's claim is that the patient's perception of him as critical is distorted and speaks to the patient's negative transference.

Who is right? Both patient and therapist, I think. It is true that the therapist is being critical. That is a reality, so the patient is right. But it has become a reality because the patient, under the sway of his repetition compulsion, has been exerting pressure on the therapist to become his critical parent. The patient's transferenceal need to recreate his past in the present is so intense that

he gets his therapist to participate with him in a transference reenactment.

This “crunch” situation (Russell 1980) is a crucial crossroad. If the therapist cannot own his participation in the transference reenactment and remains steadfastly convinced that it is strictly transference (and therefore inappropriate to the current situation), then a therapeutic impasse, a stalemated situation, is the result. But if the therapist has the wisdom to recognize and the integrity to acknowledge his piece of countertransferential acting out, then patient and therapist can together go on to look at the patient’s transference need to make his objects over into his bad parent. Patient and therapist can together observe the power of the patient’s repetition compulsion—namely, that now here too the patient has succeeded in recapitulating his past in the present.

As we know, the unhealthy part of the patient wants the therapist to fail him. The healthy part of the patient wants the therapist to come through for him, by doing something different this time—repetition with a different outcome, repetition leading to modification. And unless the therapist can admit that he has been participating with the patient in a reenactment of the patient's unresolved childhood dramas and that he has indeed become, at least for the time being, the patient's critical parent, then there can be no such healthy resolution.

The therapist must be able to relent and must do it first. When both patient and therapist are involved, it is important that the therapist have the capacity to relent first. If the therapist refuses to own his piece of countertransference acting out and instead insists that the patient own his piece of transference acting out, then the

therapist may be forcing the patient into an old position, one that the patient had in relation to a parent who could not (would not) acknowledge his own limitations.

Alice Miller (1984) has written about the deleterious effects of what she calls the unspoken commandment within families of sparing the parents and blaming the child. She suggests that there is also an unspoken and equally destructive commandment within the patient-therapist relationship of sparing the therapist and blaming the patient. Just as the child was all too willing to take upon himself the burden of the parent's badness in order to preserve his illusions about the parent as good, so too the patient is often all too willing to take upon himself the burden of the therapist's badness in order to preserve his illusions about the therapist as good. Just as the child was more comfortable experiencing himself

as culpable than he was experiencing the parent as the culprit, so too the patient is often more comfortable experiencing himself as undeserving and unlovable than he is experiencing the therapist as imperfect and flawed.

If the therapist has a need to be good and cannot tolerate being bad, then the patient may not have permission from the therapist to call the therapist on being bad. Instead, in order to make sense of it all, the patient may take the badness upon himself, thereby reinforcing his sense of himself as bad, unlovable, unworthy, and undeserving. This happens sometimes, I think—particularly when the therapist has the narcissistic need to be perfect and has a limited capacity to tolerate being imperfect and being made wrong.

THE DYNAMIC BETWEEN PATIENT AND THERAPIST

Let us turn now to a closer look at the working

through of a negative transference—more specifically, a direct transference in which the patient is mistakenly experiencing the therapist as the bad parent the patient once had. As long as the patient experiences the therapist in this way, being in relationship with the therapist will be a very painful (unconscious) reminder of the early-on traumatic failure situation; in essence, it will retraumatize the patient. The patient will not be able to move beyond this stuck place until his transference distortions have been challenged and the underlying pathogenic introjects reworked. The patient will not be able to move forward until those resistive forces that impede such progress have been overcome. It will be as the negative transference is worked through and resolved that the patient recovers his forward momentum.

Let me backtrack a bit. Once the patient

overcomes his resistance to developing a relationship with his therapist, he delivers himself and his vulnerabilities into the relationship with his therapist. Under the sway of the repetition compulsion, the patient projects onto the therapist the pathogenic introject corresponding to the position the parent once had in relation to the patient as a child. A negative transference unfolds in which the patient re-creates with the therapist the same interactional dynamic that had existed in his relationship with his parent.

We know, certainly in theory, that if the patient is to get better, he must entrust himself to the therapeutic endeavor and be able to relax into a regressive transference in which he allows the therapist to assume the importance of the primal parent. By the same token, he must get to the point where he feels safe enough with the therapist that he is willing to risk exposing his vulnerabilities

and his infantile fears. We know that once the patient delivers his internal bad objects into the relationship and then re-creates with the therapist the traumatic failure situation that had characterized the patient's relationship with his parent, we have a unique opportunity to gain access to what would otherwise remain a closed system. Now we can make a difference; now we have a chance to have an impact on the structural configuration of the patient's internal world and to effect change.

In practice, however, it is often frustrating for both therapist and patient that the patient repeatedly distorts his perceptions of the therapist and of himself, even though on some level he seems to know better. Over and over again, the patient seems to ignore the reality of who the therapist actually is and instead gets caught up in making all sorts of negative assumptions about

him. Time and time again, the patient seems to deny the reality of his own achievements and capabilities and instead gets caught up in defaming, castigating, and berating himself.

By the same token, the patient comes to treatment protesting that he desperately wants his relationships to be different from here on out; but then he proceeds, with a vengeance, to re-create with the therapist the very same dynamic that had characterized his interaction with his parent. The intensity with which he tries to re-create the past in the present speaks to the intensity of his loyalty to his parent and his reluctance to give up such an infantile attachment. The more powerful the connection, the more entrenched the patient becomes in a negative transference.

THE PATIENT'S DISTORTIONS

Before we look at interventions the therapist

may make, let us look a little more closely at the distortions that fuel the negative transference. The patient presents to treatment with all kinds of false ideas about things, all kinds of unrealistically negative perceptions about himself and others. Angyal (1965) has suggested that the basic assumptions the patient makes about himself and his world be described as *mythological preconceptions*; such preconceptions derive from early-on traumatic experiences and come to inform the perceptions the patient has of his objects in the here and now.

The patient's distorted perceptions of both himself and others are part of what has made him ill. Their presence interferes with the patient's progress in the treatment and in his life; their presence interferes with the patient's ability to experience reality as it is, the hallmark of mental health. To the extent that the patient continues to

experience new good objects as old bad ones, to that extent will the patient be bound to his past, slave to his unconscious repetitions, and obstructed in his forward movement. To the extent that the patient continues also to experience himself as bad, to that extent will the patient be tied to his past and severely restricted in terms of the options available to him.

The patient's negative assumptions may include such ideas as:

"I am basically very much alone in this world."

"No one will ever really understand me."

"Everybody's out for himself."

"You can't count on anybody."

"I am unloving."

"I am damaged for life and there is nothing I can do about it now."

"You can't trust anybody."

“I am so stupid.”

“You get laughed at if you expose what really matters to you.”

“It’s better to keep yourself hidden.”

“People are so critical.”

Such distortions are experienced by the patient as realities, as absolute truths about himself and his world. They are filters through which the patient views both himself and others, ideas around which he organizes his experience of reality. In one way or another, both the self and the object are experienced as bad. The bottom-line assumption is that “I am bad” and/or “You are bad.”

As we know, the patient’s distortions derive ultimately from the presence of underlying pathogenic introjects configuring the patient’s internal world. They are internal presences that

derive developmentally from internalizing aspects of the bad relationship that the patient, as a child, had with his parent. The badness becomes internally recorded and is incorporated into the patient's reality sense; the introjects color and distort the patient's perceptions of himself and, when projected, his perceptions of others. They become, in essence, an important part of the patient's sense of self and sense of others.

The patient is not always aware that many of the negative feelings he now has about himself and others derive from negative experiences he had early on. Whenever the patient complains that he considers himself to be undeserving, worthless, bad, inadequate, a failure, he is talking about the price he has paid for having had an infantile relationship with a parent who felt that way about himself or felt that way about someone else or felt that way about his child. Such a message of

inadequacy was conveyed to the patient who, young and impressionable, took it very much to heart. The parent was his world, and the child believed him.

Furthermore, whenever the patient is experiencing himself as a powerless victim, he is feeling that way in relation to a powerful victimizer, whether the victimizer is an internal presence or an external object. By the same token, whenever the patient experiences shame, he is feeling that way in relation to an object experienced as contemptuous, whether such an object is internal or external. Often the patient is more aware of feeling bad about himself than he is of feeling bad about his objects. He may experience himself as unlovable, without recognizing that such a feeling means he is also experiencing his objects (whether internal or external) as unloving. The patient who protests

that he knows he will always be disappointed is also, indirectly, faulting his objects for being big disappointers. In other words, although the patient may not always realize it, whenever he is feeling bad about himself, an object is implicated; distorted perceptions always involve an interactional dynamic.

How does the therapist approach a negative transference in order to facilitate its resolution?

THE DISTORTION STATEMENT AND THE LEGITIMIZATION STATEMENT

Let us return to the situation in which a patient is experiencing his therapist as critical. If distortion is involved—in other words, if the therapist is not, in fact, being critical but is only being experienced as critical because the patient is misunderstanding his present in terms of his past—then we are talking about a negative

transference.

The therapist, in order to correct the patient's distortions, will offer interpretations that encourage the patient to observe the fact of his unconscious repetitions, genetic interpretations that encourage the patient to recognize that he tends to make assumptions about the present based on his past. The therapist wants the patient to gain insight; he wants the patient to see that he does certain things now because of what happened before. Examples of *distortion statements* the therapist might use, in a nonjudgmental, nonshaming way, are:

"You are feeling criticized by me, much as you must have felt criticized by your mother."

"You are assuming that I, like your mother, will be critical."

"Your fear is that I will turn out to be as critical as your mother was."

“It must be very painful when you find yourself experiencing me as the same kind of critical that your mother was.”

In a distortion statement, the therapist makes the connection between the patient's current experience of the therapist and his early-on experience of a critical mother, thus subtly implying the patient's distortion of current reality. But suppose instead that the therapist says something like “Because your mother was so critical all the time, of course it is very upsetting for you when you find yourself experiencing me too as critical” or “...of course it is very upsetting for you when I too seem to be critical” or “...of course your fear is that I too will be critical.” In placing the emphasis on what he senses the patient's current experience of distress must be, the therapist is being with the patient where he is. The therapist is helping the patient feel

understood and, we hope, less defensive.

Remember that I earlier suggested use of a legitimization statement to validate the patient's wishes and fears, brought to current relationships because of traumatic early-on experiences. I suggested that legitimization statements are useful for contextualizing both the illusions that accompany a positive transference and the distortions that accompany a negative transference.

In the example "Because your mother was so critical all the time, of course your fear is that I too will be critical," we are actually using a legitimization statement to frame the patient's sensitivity to being criticized in the context of his past and gently suggesting that some of how vulnerable the patient feels in the here and now may have to do with things that happened early

on. Again, as in a distortion statement, we are not specifically suggesting that the patient distorts reality now, but we are implying that the whole issue of being criticized is more charged than it would have been if the patient had not had the experience of a critical mother.

On the one hand, then, the therapist may say, “You are assuming that I will be the same kind of critical that your mother was”—a distortion statement in which the therapist is suggesting that the patient is making assumptions about the therapist based on experiences the patient had early on with a critical mother. On the other hand, the therapist may say, “Because your mother was so critical all the time, of course your fear is that I too will be critical”—a legitimization statement in which the therapist is resonating empathically with the patient’s sensitivity to being criticized because of experiences he had early on. The first

intervention aims to enhance the patient's knowledge, appeals more to his head than to his heart, and is addressed therefore to the observing ego. The second intervention aims to validate the patient's experience, appeals more to his affect than to his cognition, and is addressed therefore to the experiencing ego.

But in neither situation does the therapist specifically address the reality of the situation; he does not specifically address whether the patient's perceptions of him as critical are accurate or not. Rather, the therapist calls the patient's attention to the fact that there is some kind of connection between the past and the present. In any event, the goal is to help the patient recognize that because of experiences he had early on in relation to a critical mother, he now makes assumptions about how things will be in the here and now.

Legitimization statements can be used, then, to highlight not only the presence of whatever positive affect accompanies a positive transference but also the presence of whatever negative affect accompanies a negative transference. Examples of additional legitimization statements include:

“Because your mother made little time to be with you, of course you are afraid that I too will get too busy for you.”

“Given that your father was relentlessly demanding in terms of his expectations of you, of course it upsets you when it feels as if I too am asking the impossible of you.”

“Given that your mother could never acknowledge her part in what was happening, of course your fear is that I won’t be willing to own my piece either and will point an accusing finger at you.”

“Because your mother never really understood, of course you despair that I too will

disappoint you.”

In each of these examples, the patient’s current fear is understood against the backdrop of traumatically frustrating experiences early on. The patient’s upset, fear, distress, despair is framed as an understandable derivative of early-on bad experience never fully mastered and now delivered into the transference. By way of projection, the same situation that provoked the negative affect in the first place is re-created in the transference. Of course the patient now feels the same negativity that he once felt as a child, and the legitimization statement frames it as such.

In essence, a legitimization statement can be used to validate and to place into perspective both the wishes and the fears brought by the patient to current relationships because of traumatic early-on experiences. The therapist is hoping that he can, in a nonthreatening fashion, deepen the

patient's understanding of why he is as he is and enhance the patient's insight into what motivates him in his relationships.

Thus the therapist uses distortion statements and legitimization statements to highlight, in a gentle way, the presence of unrealistically negative misperceptions. The patient is not confronted with the reality of the situation; his distorted perceptions are not challenged. Rather, the therapist is simply attempting to highlight the fact of the patient's unconscious repetitions. He does this by way of transference interpretations that direct the patient's attention inward and backward in order to observe his internal process and the fact of his tendency to experience new good objects as old bad ones.

Over time, we want to help the patient recognize that his ideas about himself (and others)

are not well founded; they are distortions that derive from internalized pathogenic relationships. We want to help the patient recognize that his ideas do not represent reality but a distorted version of it, internalized many, many years ago, long since outdated, and no longer useful at all. We want to help the patient understand not only where his distortions come from but also what his investment is in holding on to them, how having them serves him, and how much he pays in the here and now for having them. As the patient becomes ever more conscious of the ill-founded assumptions that he makes, it becomes increasingly difficult for him to maintain his attachment to the distortions that have for so long informed his experience of himself and his objects. In the face of increasingly clear evidence that what the patient imagined to be real is at odds with what turns out to be real, it becomes harder and

harder for the patient to remain attached to the past, denying the reality of the present situation.

DIRECTING THE PATIENT'S ATTENTION OUTWARD

The patient is thought to relinquish his transference distortions as he gains more and more insight, but there is an equally powerful corrective provided by the relationship itself between patient and therapist. In addition to interventions that encourage the patient to look inward and backward—distortion and legitimization statements—in order to observe the fact of his unconscious repetitions, there are also interventions that encourage the patient to look outward in order to experience the reality of who the therapist is.

In the interventions described to this point, the therapist avoided addressing the reality of the

situation. There are other interventions, however, that focus more directly upon what is real in the patient's relationship with the therapist. In a way that is neither too threatening nor too anxiety-provoking, the therapist may want sometimes to challenge the patient's projections by confronting the patient with the reality of who he, the therapist, actually is.

The therapist wants to put a wedge between the patient's subjective experience of the therapist as critical (like the bad parent) and the objective reality of the situation, which is that the therapist is not in fact the bad parent. The patient must eventually come to a point where he can see that there is a discrepancy between what he imagines to be real and what is, in fact, real, a discrepancy between what is subjective and what is objective, a discrepancy between his distortions on the one hand and reality on the other.

Ultimately, the patient must come to recognize the split between his experience of the therapist as an old object (which is informed by his past) and his knowledge of the therapist as a new object (which is informed by the present). There is, however, a paradox involved here: although it is only as the patient becomes able to experience the therapist as he really is that the therapist can truly become available as a new object, it is because the therapist is a new object that the patient gradually becomes able to experience the therapist as he really is.

Just as a sculptor chips away at a block of granite, exposing underneath the true form of his sculpture, so too patient and therapist work together to chip away at the patient's misperceptions of the therapist in order to expose the underlying form of the therapist. It is then that the therapist truly becomes available to the

patient as a new object, as someone who can offer the patient an actual experience in the here and now that can be a corrective. It is then that we can speak of the real relationship as having the potential to correct for the transference distortions; as the distortions are gradually chipped away, the therapist becomes available as a corrective for the negative transference.

The therapist, therefore, wants to encourage the patient to look outward in order to observe the reality of who he, the therapist, is. The therapist wants to convey to the patient (but does not actually say):

“It was your mother who was so critical, not I.”

“You are assuming that I too will be critical—but I’m not.”

“I am not the negative, critical mother you sometimes imagine me to be.”

Each of these statements rather boldly challenges the patient's distorted perception of the therapist as the old bad object. Were the therapist naively to confront the patient with any of these statements, the patient would be made anxious and would become even more defensive. Little would be accomplished. The therapist must respect the patient's transference need to experience new objects as just like the old object; the therapist must appreciate that the patient remains loyal to the infantile object and experiences any suggestion that things could be otherwise as a serious threat to his characteristic way of experiencing reality. The therapist must understand that although the patient does know (on some level) that the therapist is a new good object, the patient is invested in experiencing the therapist as just like the old bad object.

THE MODIFICATION STATEMENT

In something that I call a *modification statement*, the therapist places side by side the patient's knowledge of reality with his experience of it. Like all other conflict statements, the modification statement first names an anxiety-provoking reality that the patient, on some level, does know and then names the anxiety-assuaging defense (the distortion) to which the patient clings in order not to have to know. The format of a prototypical modification statement is as follows:

“Even though you know that ..., nonetheless it
often feels as if ...”

“Although you know that ..., nonetheless it often
seems that ...”

Modification statements first direct the patient's attention to something the patient would rather not know (or be reminded of) and then resonate with where the patient is. They address first the observing ego and then the experiencing

ego. Examples are:

“Even though you know that I am not really going to laugh at you, sometimes you get frightened that I might.”

“Even though you know that you have a choice about how you use these sessions, you feel sometimes that it is I who have the control.”

“Although you know that I do care, when I don’t simply tell you what to do, you become frightened that maybe I don’t care.”

The therapist is highlighting the discrepancy between the patient’s knowledge of reality and his experience of reality. In order to put a wedge between reality and defense, the therapist calls the patient’s attention to the discrepancy between what he knows and what he feels—the discrepancy between objective reality and the patient’s subjective reality (in the form of his distortions).

As with all conflict statements, in the first part of the statement the therapist gently reminds the patient of what he really does know to be the reality of the situation, even if sometimes he chooses to forget. In the second portion the therapist articulates, on the patient's behalf, the latter's distorted experience of reality. The therapist wants first to enhance the patient's knowledge (which makes him more anxious) and then to validate the patient's experience (which eases his anxiety).

“Even though you know that you are the one who has chosen to come here three times a week for the past five years, nonetheless it often feels as if I am the one who makes you come.”

“Although you know that I would never violate your confidentiality, there are times when you become afraid that I might.”

The modification statement, then, addresses,

more or less directly, the conflict within the patient between his knowledge of reality and his experience of it. The patient is being encouraged to observe and to experience the discrepancy between what he really does know and what he finds himself experiencing. By juxtaposing the one with the other, the therapist is hoping to create a greater awareness of the conflict within the patient between what he is coming to see ever more clearly and all that he does in order not to see it. A carefully formulated modification statement is difficult for the patient to ignore; it speaks to things the patient knows, on some level, to be true.

In a modification statement there are times when the therapist may choose not only to highlight the patient's internal tension between what he is coming to know and what he was experiencing, but also to interpret more directly

the patient's distorted experience of the therapist as a case of mistaken identity, the more appropriate culprit being the parent:

“Even though you know that I am not critical of your decision, you find yourself fearing that I, like your mother, might be.”

“Even though you know that I do care, at this point in time you are not yet quite sure you can really believe that. Nor were you ever really sure you could trust that your father cared.”

Using the construction “you find yourself feeling” makes it a little easier for the patient to own that it is he who is feeling as he does (even though a part of him knows better). In accordance with Schafer's (1968) depiction of pathogenic introjects as “felt presences,” we are here suggesting to the patient that whatever he is feeling is something that is not yet fully a part of him; we are hoping that (paradoxically) this will

make it a little easier for him to admit that he is feeling that way. Temporal words—“sometimes,” “there are times,” “at this point”—are also useful; they suggest that we believe that what the patient is feeling is relevant in the moment and not necessarily a general statement about the way he will always feel. The intent is to frame the feeling as something that is finite in time and therefore as something over which the patient may have some control. The following modification statements make use of these techniques:

“Even though you know that I do care, there are times when you tell yourself that I don’t.”

“Even though you know that I do care, sometimes you find yourself feeling that I don’t.”

“Even though you know that I do care, at times like this you find yourself fearing that I might not.”

“Although you know that I do care, when I don’t

give you answers you find yourself feeling that I must not care.”

“Even though you know that I am with you, sometimes you find yourself imagining that I’m not.”

“Even though you really do know that I am with you, at times like this you find yourself fearing that neither I nor anyone else will ever really be there for you. No one ever has been.”

To this point we have been focusing upon the patient’s distorted perceptions of the transference object. As we know, however, the patient’s distorted perceptions of the therapist are matched by equally distorted, but complementary, perceptions of himself. The pathogenic introjects that give rise to distortion exist in pairs, with one pole representing the position of the powerful parent and the other representing the position of the vulnerable child.

In a modification statement the emphasis can fall on either the distorted experience of the object or the distorted experience of the self. Consider the following modification statements:

“Although you know that I am not critical of you, you find yourself fearing that I might be.”

“Although you know that what you’re doing feels right, at times like this you begin to feel unsure of yourself.”

“Even though a part of you recognizes that I do not ask you to be perfect, another part of you fears that I, like your father, will not be satisfied until you are.”

“Although you know that you do have some choices about how you use our time, you find yourself feeling that you don’t know what to do with it and wishing that I would tell you what to do.”

In the first of these, we are emphasizing the patient’s distorted experience of the therapist as powerfully critical; in the second, the patient’s

distorted experience of himself as insecure and vulnerable; in the third, the patient's distorted experience of the therapist as relentlessly demanding; and in the fourth, the patient's distorted experience of himself as inadequate and helpless.

When the therapist directs the patient's attention to what the patient really does know (even if sometimes he would rather not), it makes him anxious. When the therapist then resonates with where the patient is (by articulating, on the patient's behalf, his distorted experience of reality), it eases his anxiety. In other words, when the therapist challenges the patient's need not to know the truth about himself and his objects, the patient gets more anxious; when the therapist supports the patient's need not to know, the patient gets less anxious.

In an earlier chapter I observed that, at any given point in time and for each patient, there is an optimal level of anxiety. Too little produces no impetus for movement of any kind, while too much produces immobilization and leads to an intensification of the patient's defensive efforts (in this instance, his need for distortion).

In a modification statement, the therapist, of course, names both the reality defended against and the defense itself. The therapist should be ever attuned to the level of the patient's anxiety and to what the patient can therefore tolerate in the way of confrontation. By emphasizing either the reality or the defense, the therapist can rather effectively modulate the level of the patient's anxiety.

In the modification statement that follows, we are rather tentative, in the first half, in our naming

of the reality against which the patient defends himself; we are very respectful, in the second half, of the patient's need for the defense: "Although you are beginning to recognize that I may be somewhat more trustworthy than you initially thought, at this point you are not at all sure that I will turn out to be someone you can trust." Our sense here is that the patient is so frightened that he needs us to tread gently, needs us not to make him even more anxious.

In the next modification statement, we are more bold in our naming of what could be (even though we know it makes the patient anxious); we also emphasize, in naming the defense, the element of choice in the patient's holding back: "Although you know that I am trustworthy and that someday you may even find yourself looking to me for the support you feel is so lacking elsewhere in your life, you still find that there are

times when it feels safer, somehow, to hold back.” Our sense here is that this second patient is less reluctant than the first one to entrust himself to the relationship. Although respectful of his continued need for the defense, we also rather boldly highlight what the patient really does know to be true. We believe that the patient will be able to tolerate our confronting him with the reality of our trustworthiness. We are much less concerned about making him anxious than we were about making the first patient anxious.

With respect to regulating the level of the patient’s anxiety, observe that in the first half of a modification statement the therapist does not simply remind the patient of the reality of the situation. Rather, the therapist reminds the patient of what he, the patient, knows to be real. In other words, the therapist does not say, “Even though I don’t have the answers....” Rather, the therapist

names what the patient himself knows, even if sometimes the patient would rather forget. And so the therapist says, “Even though you know that I don’t have the answers. ...”

One of the several reasons for constructing the modification statement in this way is that the therapist wants to remind the patient that the conflict is an *internal* one. Some part of the patient does know the truth about his objects, even if another part of him would rather not. The therapist wants the patient, eventually, to be able to own both sets of forces, both those that are healthy and press yes and those that are unhealthy (resistive) and insist no.

The therapist wants to avoid being the voice of reality that challenges the patient’s defensive need to experience things as they are not. If the therapist puts himself in the position of being the

one who reminds the patient of reality, then he has created the potential for a struggle between the two of them. Were the therapist to take on the voice of reality, he would be pitting himself against the patient and indirectly encouraging the patient to protest ever more vehemently, and defensively, his own convictions about reality.

On the other hand, if the therapist gently reminds the patient of what the patient himself knows to be real, then the patient will have more trouble denying that reality. The therapist hopes that, over time, the patient will come to appreciate more fully that he is in conflict about his relationship to reality, a part of him knowing the truth about it and another part of him denying that truth. The conflict is within the patient, not between the patient and the therapist.

As the patient himself gains insight into his

internal process, as he begins to recognize within himself the tension between those forces that impel him forward and those counterforces that hold him back, the tension between that which he is coming to know and that which he feared, the patient may begin to formulate some of his own modification statements. Now it is the patient who says, “Even though I know that you’re not really critical, I can see that I am holding back for fear that you might be” or, “Although I recognize that you have my best interests at heart, there is another part of me that cannot believe that you would care that much.”

THE INVERTED MODIFICATION STATEMENT

Early on in the treatment the patient may well be more invested in his fears than in reality. As a result, the more anxiety-provoking side of the patient’s conflict (the reality against which the

patient defends himself) is placed in the first half of the statement, while the less anxiety-provoking side (the defense itself) is placed in the second half. Later on, as the patient comes to understand both his investment in his fear and the price he pays for maintaining such an investment, the patient may come to a point where it is more anxiety-provoking for him to be reminded of his fear than for him to be reminded of reality, more anxiety-provoking for him to be reminded of how he holds himself back than for him to be reminded of what is and, by implication, the good that could be.

At this later point the patient may be ready for an *inverted modification statement*, wherein the therapist inverts the order in which he names the two sides of the patient's conflict. Whereas a modification statement addresses first the patient's health and then his resistance, an

inverted modification statement first acknowledges the patient's fear and then names what the patient really does know (even though such knowledge threatens the patient's attachment to the infantile object). Whereas a modification statement speaks first to that force within the patient able to experience reality as it is and then to that force within the patient needing to deny that reality, an inverted modification statement speaks first to the patient's resistance to getting better (which has now become the more anxiety-provoking side of his conflict) and then to the patient's wish to get better (now the less anxiety-provoking side). Note the difference between:

1. "Even though you know that I would not laugh at you, sometimes you find yourself fearing that I might."
2. "Sometimes you find yourself fearing that I might laugh at you, although

you know that I would not really do that.”

1. “Although you know that I do care, you sometimes forget.”
2. “Even though you sometimes forget that I care, you do know, deep down, that I do.”

The first statement in each pair is a modification statement, the second statement an inverted modification statement. The inverted modification statements are addressed to a patient who is becoming more and more able to recognize reality for what it is, uncontaminated by his need for it to be otherwise. Now it is more anxiety-provoking for the patient to be reminded of his investment in his fear than it is for him to be reminded of reality.

The modification statement and the inverted modification statement are both important tools for the working through of the negative transference. By way of such interventions, which

direct the patient's attention outward, the patient's unconscious projections onto the therapist are challenged. The patient comes to see that he is making assumptions about the therapist that do not necessarily have any grounding in reality; he comes to see that his expectations in relation to the therapist have more to do with what happened early on than with what is happening now. The patient begins to see, more and more clearly, the truth against which he has long been defending himself.

In order for the patient to let go of his distortions, he must ultimately recognize the split between his knowledge of reality (which is informed by the present) and his experience of reality (which is informed by the past). The reality is that neither the therapist nor he himself is as bad as the patient imagined, experienced, expected, feared. It is then that the internal

tension created through the patient's awareness of those discrepancies will provide the impetus for change and will motivate the patient to give up his distortions.

EGO-DYSTONICITY

Before we move on to a consideration of how that internal tension provides the impetus for change, I would like to say a few more things about the patient's anxiety. When the therapist, by reminding the patient of reality, challenges the patient's defensive need to have reality be other than it is, the therapist makes the patient anxious. In fact, each time the therapist reminds the patient of what he really does know to be real (even though he often denies that he knows), the therapist makes the patient more and more uncomfortable. The patient is made anxious because the therapist is challenging the patient's

defenses.

As we discussed in an earlier chapter, the defenses serve ultimately to protect the patient against confronting the reality of just how bad his parent really was. Had the patient been able to confront that reality, accept it, feel all the hurt, pain, and outrage that he needed to feel in order to come to terms with it and move beyond it—in other words, to grieve it—then all would have been well. As part of mastering his disappointment, the patient would have internalized what good there was in the relationship with the parent. Healthy structure would have developed that would have enabled the patient to preserve internally the external goodness.

But if the patient, for whatever reasons, could not confront the reality of just how bad his parent

was, then, as we know, the patient took the burden of the parent's badness upon himself (in the form of internal bad objects); in order to preserve the relationship with his parent, uncontaminated by his rageful disappointment, the patient sacrificed his ability to experience reality as it was. The defenses he developed (both his distortions and his illusions) served to protect him against confronting the horrid reality of just how toxic his parent was.

As an adult, the patient brings to subsequent relationships his defensive need to experience himself and his objects as other than they are. Although such defenses once enabled the patient to survive what would otherwise have been an intolerable situation, now they constitute his pathology and interfere with his capacity to function effectively and to be in relationship. In the context of the treatment situation, a negative

transference unfolds as the patient comes to fear that his therapist will be as bad as the toxic parent was. (By the same token, a positive transference unfolds as the patient comes to hope that his therapist will be the good parent he never had, as I discussed in an earlier chapter.)

By way of statements that name the convergence within the patient of his knowledge of reality with his experience of it, the therapist challenges the patient's defense by reminding him of what he really does know, even if he often denies that reality. The truth against which the patient now defends himself is simply that his therapist is not as bad as the patient had expected him to be (nor is he himself as bad as he had feared he was).

In other words, where once the reality against which the patient felt the need to defend himself

was a toxic reality that was too painful to be tolerated, now the reality against which the patient feels the need to defend himself is a nontoxic reality. Where once the reality defended against was the traumatic reality of just how horrid the parent really was, now the reality defended against is the nontraumatic reality of who the therapist is—namely, that the therapist is not as bad as the patient had expected him to be. The reality now defended against is the not-so-horrid reality that the therapist is not, in fact, the bad parent. The therapist is a new good object, not the old bad one; as the patient begins to acknowledge the truth of this, he is filled with anxiety.

By way of modification and inverted modification statements, the therapist juxtaposes what the patient is coming to know (based on the present) with what the patient was assuming

(based on the past) in order to make it increasingly uncomfortable for the patient to cling to the defense. Such interventions pose a very serious threat to the patient's defense because they challenge the way the patient experiences the world; ultimately, such interventions threaten the patient's attachment to the infantile object, an attachment preserved by way of the defensive structures the patient has internalized. In other words, as the patient comes to appreciate the extent to which his knowledge of reality is at odds with his experience of it, it becomes increasingly difficult for him to remain invested in the defense, and there comes a time when the defense itself becomes anxiety-provoking. Now having the defense is conflictual, problematic, ego-dystonic.

Where once the defense—the pathology—was clung to in order to ease the anxiety the patient would have felt had he let in the horrid reality of

just how bad his toxic parent really was, now the defense becomes itself a source of anxiety. Where once the defense served the patient by alleviating the patient's anxiety, now the defense creates anxiety.

As the therapist continues to challenge the patient's defense, continues to challenge the patient's denial of reality, continues to challenge the patient's need to distort, anxiety is created within the patient. In other words, tension and conflict are generated that prompt the patient to move in some way in order to ease the anxiety and resolve the conflict. The internal pressure created by way of the therapist's interventions forces the patient to do something in order to relieve the tension. It is this tension, this anxiety, this conflict, that ultimately provides the impetus for further movement.

THE SYNTHETIC FUNCTION OF THE EGO

The synthetic function of the ego is constantly striving to reduce inconsistency. One of its goals is integration—integration of past with present, the imagined with the real, the old with the new. The synthetic function of the ego cannot tolerate the lack of harmony, the cognitive dissonance, between what it comes to know as real and what it was experiencing as real.

As the patient comes to recognize that the therapist is, in fact, a new good object and not the old bad object at all, the patient is in a real bind. To remain attached to the infantile object is to deny the reality of the present situation, but to accept the reality of the present situation is to let go of ties to the past. It is the synthetic function of the eventual renunciation of infantile attachments. In the face of increasingly clear evidence that what the patient imagined to be real is at variance with

what turns out to be real, it becomes more and more difficult for the patient to remain attached to the past, ignoring the reality of the present situation.

As the patient gains insight, therefore, into just how much his experience of himself and his objects is distorted by the negative assumptions he makes about them and as he gains additional understanding of the price he pays for holding on to such distortions, it becomes less and less tenable for him to remain invested in his old ways of experiencing things. As the tension within him between his knowledge of reality and his experience of reality becomes ever greater, the synthetic function of the ego becomes ever more active in its efforts to reconcile the two elements in conflict, and the balance shifts in favor of reality.

And so it is that the patient is gradually able to

give up the distortions to which he has clung in order not to have to separate from the infantile object. As the patient begins to let go of his attachment to the infantile object, he begins to let go of his compulsive need to re-create in subsequent relationships the interactional dynamic that characterized the relationship with his traumatogenic parent. He becomes freer to experience reality as it is, uncontaminated by the past.

As the distortions are relinquished, the resistance is overcome. The patient's need to experience reality in ways determined by his past becomes transformed into a capacity to know and to accept reality as it is, the hallmark of mental health.

DOVETAILING OF INSIGHT AND EXPERIENCE

What exactly is the relationship between

insight and experience? I have been suggesting that as the patient gains insight into the extent to which his perceptions are distorted, it becomes increasingly difficult for him to maintain his attachment to them; eventually he lets go of them because of his need to reconcile what he comes to see as real with what he feared was real. In other words, the patient relinquishes his distortions because of his need to integrate his knowledge of reality with his experience of it. On the other hand, I have also been suggesting that it is only as the patient relinquishes his distortions that the therapist can truly become available to the patient as a new object, as someone who can offer the patient an actual corrective experience in the here and now.

Which comes first? Is it the gaining of insight that enables the patient eventually to let go of his transference distortions? Or is it being exposed

(by way of the real relationship with the therapist) to a new experience that enables the patient eventually to relinquish his distortions? Expressed somewhat differently, the paradox can be conceptualized in the following manner: On the one hand, the patient cannot experience the relationship with the therapist as a new relationship until some of the transference distortions have been relinquished; on the other hand, the transference distortions cannot be relinquished until the patient can experience the therapist as a new object. It would certainly seem to be a chicken-or-egg problem.

Perhaps, then, we should think of the working-through process as one that involves a series of small steps:

1. As the patient begins to sense that the therapist may be a little different from who he had imagined the

therapist would be, the patient gradually gains a little insight (into the fact of his tendency to distort).

2. As the patient gains such insight, he begins to perceive the therapist more accurately.
3. As he perceives the therapist more accurately, he begins to recognize ever more clearly that there is a discrepancy between his knowledge of the therapist and his experience of the therapist.
4. As he experiences that discrepancy, the patient is made more and more anxious and it becomes increasingly difficult for him to maintain his attachment to the distortion.
5. As he begins to relinquish the distortion, the therapist becomes increasingly available to him as a new object—and so on.

I am suggesting that a dovetailing of insight and corrective experience enables the patient gradually to relinquish his attachment to the

defense and his loyalty to the infantile object.

From this it also follows that I conceptualize the process of change as effected by means of both understanding and experiencing. Both cognition and affect, intellect and emotion, head and heart, are involved. The transference distortions are corrected by way of both knowing (intellectually, cognitively) the difference between past and present, old and new, and experiencing (affectively) that difference in interaction with the therapist. The actual experience makes possible the acquisition of insight; by the same token, insight facilitates the consolidation of therapeutic experiences (Alexander and French 1946).

And so it is that, by way of a combination of insight and experience, the patient is enabled over time to feel that the therapist is a new good object, not the old bad one. There comes a time, then,

when the patient gets it that the therapist is truly different from the parent. That is, the patient comes to a point where he can feel (in his gut) the difference between real relationship and the transference.

In point of fact, the patient may not actually realize just how bad the parent was until he has a new experience in the present with the therapist. As Thompson (1950) has written, "In order to become conscious that something is wrong, one must have a new experience which makes one aware of new possibilities" (p. 105).

In other words, there comes a time when the patient begins to recognize that things could have been otherwise—that had his parents been different, he would not have had to suffer as he did. The real relationship with his therapist enables the patient to get in touch with what could

have been.

As the patient comes to recognize that things need not have been as bad as they were, he comes to a point where he must face the reality of just how bad his parent was and how scarred he now is as a result of that. Against the backdrop of his new relationship with the therapist, he begins to feel the horror of what was. As he thinks about what might have been, his heart breaks. He grieves for the wounded child he once was and the damaged adult he has now become.

But it is in the context of the new relationship that there is hope. The real relationship between patient and therapist offers an opportunity for a new beginning, an opportunity to correct for the early-on traumatic failure situation, an opportunity to resume the growth process interrupted years earlier. The underlying

pathogenic structures are gradually modified as the patient comes to understand his compulsive tendency to repeat his past in the present and as he begins to experience the therapist as a new good object, unlike the old bad one.

In sum, the patient's perception of the split between his experience of the therapist (informed by the past) and his knowledge of the therapist (informed by the present) is what eventually provides the impetus for change. The patient must recognize such discrepancies with his head and experience them with his heart. It is the internal tension created through the patient's awareness of that discrepancy that provides the motive force for change. In essence, the real relationship serves as a corrective for the transference relationship.

To the extent that the patient can come to recognize the discrepancy between objective

reality and his distorted perceptions of it, to that extent can he come, in time, to modify his pathogenic introjects in the direction of reality and health. One of the ways in which the therapist can help the patient recognize such a discrepancy is by means of a conflict statement that highlights the discrepancy between reality and distortion. It challenges the patient's unconscious projections onto the therapist by juxtaposing what is real with what the patient experiences as real.

Ultimately the patient gets better because of his need to reconcile what he comes to see as real with what he feared was real, his need to integrate his knowledge of reality with his experience of it. As he comes to understand ever more clearly the reality of the situation, he comes to recognize the fact of his distorted perceptions. As a part of the working-through process, he must get to the point where he both understands his investment in his

defenses and recognizes the price he pays for holding on to them. As this happens, it becomes increasingly ego-dystonic for him to maintain his attachment to them. As he gradually lets go of them, he grieves their loss, replacing them, over time, with healthier, more reality-based perceptions. His need to experience reality as it is not is replaced by a capacity to experience it as it is.

We speak of such a process of modifying existent pathological structure as the reworking of pathogenic introjects. It is accomplished by way of ongoing and repetitive serial dilutions that constitute the working through of the negative transference. And when we speak of structural modification or structural change, we are referring to just such a process of detoxifying pathogenic introjects. As the pathogenic structures are rendered less toxic, more reality-based, the

distortions to which they have given rise are slowly relinquished and the patient's infantile need to experience his objects as other than they are becomes transformed into a mature capacity to experience them as they are. As this transformation is effected, the negative transference is resolved and the resistance is overcome.

And so it is that, by way of increased insight and by way of a corrective experience that facilitates grieving and the mastery of disappointment, the patient is enabled gradually to give up the distortions to which he has clung since earliest childhood in order not to have to feel his pain, distortions that have colored his perceptions of both his objects and himself.

The Defense of Relentless Entitlement

Each child finds ways of pretending to himself that he is not as powerless as he feels. He must maintain the illusion that somehow he can get his parents to love him as he wishes to be loved.

—Sheldon Kopp, “The Refusal to Mourn”

RECOGNIZING RELENTLESS ENTITLEMENT

In order for the patient to get better, he must be able, eventually, to confront the toxic and nontoxic realities against which he has spent a lifetime defending himself. The patient’s defenses are relinquished as he confronts those realities and feels the pain of his grief. Grieving is therefore involved in working through both the negative

transference and disruptions of the positive transference. Facing his pain, confronting his disappointment, is at the heart of the healing process.

Not surprisingly, the patient defends himself against facing his pain; he defends himself against confronting his disappointment. It hurts too much. The patient, therefore, employs a variety of defenses to deny the reality of who his objects are and to protect himself against his pain and the experience of disappointment.

One such defense, something to which I refer as the *defense of relentless entitlement*, is used by many patients at some point or another to defend against the pain of disappointment. It is a particularly intractable defense; if its presence is not recognized and its dynamic understood, then it can powerfully interfere with the grieving process

and can bring the patient's progress in the treatment to a standstill.

The defense of relentless entitlement arises in the context of the patient's conviction that the therapist has "it" to give but withholds it. ("It" refers to whatever narcissistic supplies the patient yearns to have in order to feel psychologically complete—love, affection, contact, a hug, reassurance, guarantees, answers, what have you.) The patient is relentless in his pursuit of it; it is necessary, he feels, for his very survival. He deeply believes that the therapist could do it but refuses to, that the therapist has the capacity to give it but will not. The patient feels entitled to it; he is outraged in the face of its being denied.

Kopp (1969) has captured the essence of this stance: "The adult in whom the unmet, unmourned child dwells, stubbornly insists that he has the

power to make someone love him, or else to make them feel sorry for not doing so. Appeasing, wheedling, bribing, or bullying are carried out in stubborn hope that if only he is submissive enough, sneaky enough, bad enough, upset enough, something enough...then he will get his own way" (p. 31).

The defense of relentless entitlement is delivered into the treatment situation when the patient is confronted with the reality that the therapist is not the perfect parent the patient wanted him to be. The patient defends himself against the pain of his disillusionment by clinging to his relentless entitlement, his sense that the therapist could be, and should be, different.

Remember the claim that the patient's refrain is: I can't (distortion), you can (illusion), and you should (entitlement). In the face of the patient's

recognition that you can't (often experienced as you won't), or, in any event, that you don't, the patient is enraged. The patient uses the defense of relentless entitlement to defend himself against the pain of his disillusionment, as he gets it (at least on some level) that you can't/won't/don't.

Often the thing sought is, in fact, something that on the surface may not seem all that unreasonable. What the patient wants from the therapist may be simply the answer to a personal question, an empathic grunt, some advice, reassurance, a hug, some show of affection, some little exception made. But it is the relentlessness with which the patient pursues his quest and the intensity of his outrage in the face of its denial that demonstrates the defensive nature of his desire. It is the relentlessness with which the patient pursues the object that speaks to the patient's need to defend himself against the pain of his

disappointment.

It is also of note that the patient finds himself seeking the one thing that on some level he knows he cannot have. By way of example, in relation to a psychodynamically oriented psychotherapist who offers insight, understanding, compassion, concern, and caring, the patient may find himself wanting a hug; in the face of its denial, he becomes ever more insistent. On some level, of course it is not so unreasonable to want that contact; but in this context, and in light of what the patient knows to be the therapist's training and orientation, to want it, and with such intensity of desire, is the hallmark of a defensive need. That the patient wants something not that unreasonable on the surface of things is part of what makes this defense particularly difficult for the therapist to confront.

I refer to such a defense as the defense of relentless entitlement because that designation emphasizes the patient's refusal, perhaps inability, to bear the disappointment experienced in the face of the object's failure of him. The defense of relentless entitlement arises in the context of the patient's refusal to grieve.

The patient defends against his disillusionment by a relentless pursuit of his illusions. The yearning for that which is unattainable is a defense against object loss. The patient hopes against hope that the bad object will become good, that he will attain the love he so desperately wants, that the frustrating object will eventually gratify. In any event, he wants desperately for the object to be other than it is; his experience is that the object is lost to him, and he cannot tolerate that.

The patient defends himself against the acknowledgment of his disappointment by clinging to his relentless entitlement. He is relentless in his insistence that it is his due, that the wrong done be made right; he is also relentless in his outrage when this does not happen and relentless in his insistence that to be denied what he so desperately wants is unfair. Because the defense of relentless entitlement is a defense that protects the patient against the pain of his disillusionment, it is a part of the patient's resistance to working through both the positive transference disrupted (which involves coming to terms with the reality of the therapist's and, before him, the parent's very real limitations) and the negative transference (which involves coming to terms with the reality that it need not have been as bad as it was).

The patient just does not want it to have been

the way it was and claims that it should not have been that way and that he is therefore entitled now to have it be different. True, it should not have been the way it was, and would that it could now be different. But the patient will not always be able to get, in the here and now, exactly what he wants, much as he might feel that he must have it and that he is entitled to it.

To the extent that the patient's relentless entitlement is operant, to that extent is the necessary grieving derailed and the patient's progress in the treatment slowed down. The relentless entitlement must be recognized and worked through before the transference can be resolved.

NARCISSISTIC CATHEXIS AND AMBIVALENT ATTACHMENT

The object that the patient experiences as

being able to give “it” but as withholding it is, in Freud’s term, a narcissistically cathected, ambivalently held love object. The love object is narcissistically cathected in that the object is experienced as having something to give that will complete the self; it is therefore a selfobject. The object is experienced as necessary for the survival of the self. The love object is ambivalently held in that the attachment to it is an ambivalent one, both libidinal and aggressive in nature. The object is experienced as having “it” to give (and is therefore yearned for) but as withholding “it” (and is therefore aggressed against).

The patient, convinced that the object could offer the good if it were but willing, is relentless in his pursuit of gratification by the object. We would describe such an attachment as a positive one. But in those moments of clarity when the patient understands that gratification is not going to be

forthcoming, he turns on the object with rage for being so intractably bad and withholding. We would describe such an attachment as a negative one. The patient, in moments of hope, is libidinally attached to the object because the patient is hoping that the object will eventually come through; but in moments of despair, the patient is aggressively attached to the object, which is now experienced as failing to deliver what the patient had so desperately wanted.

We can look to Fairbairn (1952) to help us refine our understanding of ambivalent cathexis to an object. Fairbairn writes about the seductive object that holds out the enticing promise of something good and then fails to deliver; it is initially exciting, ultimately rejecting. He writes about the child's intense attachments to such an object—both the libidinal ego's attachment to the exciting object and the antilibidinal ego's

attachment to the once-exciting/now-rejecting object.

As we saw earlier, Fairbairn suggests that the child, in an effort to master his disappointment in the frustrating parent and to preserve the relationship, takes the burden of the parent's badness upon himself. The bad object is internalized. Once the child has internalized the bad parent, he splits it into two parts, the exciting object that offers the tantalizing promise of good things to come and the rejecting object that ultimately fails to come through and devastates. The so-called libidinal ego forms a positive (or libidinal) attachment to the exciting object, and the antilibidinal ego forms a negative (or aggressive) attachment to the rejecting object.

Because the seductive (exciting/rejecting) object ultimately breaks the child's heart,

Fairbairn describes such an object as a bad object (both that part of it which excites and that part of it which rejects). The child's attachments to the bad object, however, are ambivalent, both libidinal and aggressive. The child longs for it even as the child detests it for breaking his heart.

The libidinal ego is filled with longing for the exciting object. Even though on some level the libidinal ego knows that the goodies will not be forthcoming, nonetheless there is a way in which the libidinal ego keeps hoping that perhaps they will. The libidinal ego hopes against hope that the goodies will be forthcoming from the exciting (though ultimately rejecting) object, clings tenaciously to the illusion that they will be, and is insistent that they should be.

As we have observed, this hoping against hope is the way the patient defends himself against the

experience of disappointment. Instead of facing his disappointment head on and sitting with it, the patient clings for dear life to the illusion that, someday, somehow, some way, if he could but get it right, the goodies would be forthcoming.

The libidinal ego is the repository for hope. As Fairbairn notes, the libidinal ego is that part of the child's original ego that has not given up its longing for contact with the object. It continues to seek the enticing promise of relatedness.

When the object is experienced as rejecting, abandoning, withholding, denying satisfaction, the antilibidinal ego rages against it. The antilibidinal ego becomes the repository for all the animosity and destructiveness that accumulate as a result of the frustrated yearning for contact. It is relentless in its outrage and determined to do what it can in order to force the object to come through.

Ultimately, the libidinal and antilibidinal egos are invested in getting the object to change, in getting the bad object (the exciting/ rejecting object) to be good (that is, forthcoming with the goodies). The patient is insistent that the object change, that the bad object become good. The patient's defense of relentless entitlement speaks to the patient's efforts to force his objects to be the way he wants them to be because he cannot accept them as they are.

The patient who complains always of feeling victimized is a patient who may well be looking to his objects to change and is not able or willing to take responsibility for change himself. The patient who needs his objects to be other than they are is destined to feel, always, helpless and ragefully disappointed. In order not to feel that way, the patient must recognize that the locus of control is an internal one and that the responsibility for

change is his own.

A point of clarification is needed here. What is the relationship between the internal bad objects Fairbairn writes about (the bad mother split into an exciting object and a rejecting object) and, more generally, the introjective constellations, the pairs of pathogenic introjects or internal bad objects Meissner (1976) writes about?

As we recall, Meissner's introjective constellations arise from internalizing the negative relationship between parent and child and have two poles, one corresponding to the position of the powerful parent and the other to the position of the vulnerable child. The interactional dynamic between parent and child is re-created internally. For example, the victimizing parent is internalized as a victimizer introject and the victimized child is internally structuralized as

a victim introject; the victimization is played out, reenacted, internally, with the patient assuming both roles. The external relationship has been replaced by an internal one, and the external battle is now waged internally. By way of further example, the shaming parent takes up residence within the child's internal world in the form of a superior introject, whereas the shame-ridden child establishes its position as an inferior introject; the shaming of self is internally reenacted, with the patient both demanding perfection of himself and experiencing himself as a pathetic failure. As we know, either pole may be delivered into the relationship with the therapist, and a negative transference (either direct or inverted) then unfolds.

With Fairbairn's internal bad objects the emphasis is different. We are now talking about internal bad objects that exist side by side and that

derive from a splitting of the bad parent, once it is internalized. We are also talking about the nature of the child's attachment to such a parent, an attachment that is characterized by both anguished yearning and relentless outrage, both love and hate. We are no longer talking about the internal recording of the interactional dynamic between parent and child, with contributions from both sides. We are no longer talking about internal bad objects, in conflict with each other, that recreate internally the bad relationship between parent and child.

Interestingly, Fairbairn seems to be emphasizing the reality of the parent as seductive, as exciting/rejecting, as First offering the enticing promise of something good and then failing to deliver. When I speak of the patient's defense of relentless entitlement, however, I mean to be speaking to the patient's experience of the

therapist as seductive, whether that is the reality or not. The patient experiences the therapist as having “it” to give but as withholding it. Whether that is true or not is less important than that the patient clings to his insistence that “it” is there to be had but is being denied him. My emphasis, then, is more on the child’s or patient’s experience of the object than on the actual nature of the object itself, more on the child’s or patient’s experience of the object than on the reality of the object. The situation is of course made much more complicated when the therapist is in fact being seductive and thereby participating with the patient in a recapitulation of the early-on traumatic failure situation, thus fueling the patient’s relentlessness. The therapist’s participation in the drama may make it much more difficult for the patient to work through his defense of relentless entitlement.

PROTECTION AGAINST PAIN

Modell is one of those who has encouraged us to supplement a one-person model of the mind with a two-person model. He has suggested that there are both intrapsychic defenses, which protect the ego against the id, and interpersonal defenses, which protect the self against its objects.

As I mentioned earlier, he writes more specifically about so-called narcissistic defenses that serve to protect the integrity of the self against injury experienced at the hands of its objects, protect the self against painful interpersonal experiences. One such defense is something he refers to as a narcissistic defense against affects, or the defense of affective nonrelatedness, which protects the self from the experience of being shattered (or fractured) by an unempathic response from the other.

I would like now to suggest that the defense of relentless entitlement is another example of a narcissistic defense, inasmuch as it serves to protect the self from the pain of being denied something experienced as necessary for the very survival of the self. Both the narcissistic defense of affective nonrelatedness and the narcissistic defense of relentless entitlement serve to protect the self from the object. No longer are we talking about protection of the ego against intolerably painful intrapsychic realities; rather, we are now talking about protection of the self against intolerably painful interpersonal realities.

It will be as the defense of relentless entitlement is gradually worked through that the patient will begin to get more in touch with painful truths against which he has been defending himself his whole life. As a child, to have confronted and acknowledged the horrid truth

about his infantile objects would have been tantamount to psychic suicide. Now, in the context of being “held” by the therapist, the patient dares finally to face the horror of just how bad it was. As he confronts the truth, he feels the pain of his devastation, no longer needing to deny its existence. Belatedly, he grieves for the wounded child he once was and the damaged adult he has now become.

SADOMASOCHISTIC PSYCHOPATHOLOGY

The libidinal ego’s attachment to the exciting object and the antilibidinal ego’s attachment to the rejecting object is part of an internal situation that represents, according to Fairbairn, a basic schizoid position. (Fairbairn’s interest was in schizoid psychopathology.) I would like to propose, however, that Fairbairn’s depiction of an endopsychic situation characterized by intense

attachments to internal bad objects can enhance our understanding of sadomasochistic psychopathology. My contention will be that the intense attachments to the internal bad objects speak not so much to a schizoid retreat from such objects as to intense relatedness with such objects.

What is sadomasochistic psychopathology all about? I believe that sadomasochism develops in those who had the experience, early on, of being constantly criticized, put down, discounted, undermined, those who had the experience of humiliation, denigration, and abuse, whether emotional, physical, and/or sexual. But it also develops in those who had the experience, early on, of being initially excited by a parent who seemed to offer the promise of all sorts of good things and of then being heartbreakingly devastated by the parent's failure to make good on his promises. The child was repeatedly first

excited and then let down. Such disappointments were never grieved. Instead, the child was left with the sense that if he had just been good enough, then the parent would have come through for him. In this way the seeds are sown for the later development of sadomasochistic pathology.

Let us discuss first the masochism and then the sadism. The two are complementary and always go hand in hand.

Masochism

The masochistic stance is a defensive (adaptive) position adopted by the child who was constantly being traumatically disappointed by his parent. The parent was first seductive (offering the promise of something good) and then rejecting (failing to deliver, often in a dismissive, cruel, withholding manner). The parent, in essence, was an exciting/rejecting object. The child, unable to

deal with just how devastated he was and needing not to be angry about it, took the burden of the parental badness upon himself in order to preserve his illusions about the parent's potential goodness.

The masochistic stance is therefore a defensive posture characterized by the person's willingness to suffer, to sacrifice, to work very hard, to accommodate, to do anything that is asked, as long as he can hold on to the illusion, the dream, the hope that someday, somehow, some way, if he is good enough, works hard enough, persists long enough, and suffers deeply enough, then the long-awaited goodies will be forthcoming. He clings to the illusion that he will finally be able to get what he so desperately wants from the seductive (exciting but ultimately rejecting) object—either the parent himself or a stand-in for the parent; and he clings to his entitlement that this is his due.

Such is the masochistic stance.

The person delivers into subsequent relationships his thwarted infantile needs (often for a certain kind of special recognition or reward for his unstinting effort) and is then relentless in his pursuit of their gratification. He hopes against hope that perhaps this time he will be able to get what he never got back then.

Note that the investment is not so much in the suffering per se as in the hope, the illusion that gratification, recognition, reward will ultimately be forthcoming. The person is unwilling to relinquish his dreams, unwilling to accept the fact that they are unrealistic, unrealizable, unattainable; he is desperate in his pursuit of gratification and relentless in his insistence that such is his due.

Ultimately, he cannot bear to face the reality of

who his parent was. He needs to feel that his objects (either the actual parent or parent substitutes) will someday come through for him, and so he clings for dear life to his illusions and to his entitlement, demonstrating all the while an amazing capacity to endure. He finds it easier to take the burden of the parent's badness upon himself and to experience himself as undeserving and bad than to recognize the limitations of his parent; easier to feel guilty about his own presumed shortcomings and inadequacies than to own his disappointment in, and rage at, his parent for the latter's empty promises; easier to believe that it is through his own lack of trying, his own failure to be good enough, that his objects have not come through than that his objects are unloving and ungiving. He clings, therefore, to the illusion that if he works even harder still, he will be able to rectify that situation.

The masochistic stance is actually a stance that enables the person to hold on to his illusions, his dreams, his infantile longings. To subsequent relationships the patient brings his burning desire to have now the good parenting he never had early on, his desperate longing to have his objects come through for him.

One useful framework in which to view the masochist's illusions comes from Menninger (1958), who suggested that the patient expects the wrong things from the right people and the right things from the wrong people. The patient expects the wrong things from the right people because he imagines that good people in the here and now will be like the bad people he knew early on—clearly, instances of the negative transference. When we say that the patient expects the right things from the wrong people, we mean that what he wants may well be reasonable but that the

people he chooses to gratify his needs are not appropriate object choices. In fact, I would like to suggest that the relentless pursuit of the right things from the wrong people is the hallmark of the masochist.

The masochistic patient protests: Is it so wrong to want a little love, a little affection, some support, some kindness? Is it so wrong to want a sign that I matter, some indication that I am cared about? It is probably not wrong to want those things, but to demand those things from the people one has chosen to demand them from is probably a setup for disappointment. In that sense it is masochistic.

The story that comes to mind for me is about a patient for whom I did a consultation several years ago. He is a psychiatrist, had been in analysis for some eight years with a well-known and highly

respected local training analyst, and was feeling very stuck in the treatment. He explained to me that he was becoming increasingly dissatisfied with his analyst because he was not getting the kind of support he wanted and felt he deserved.

By way of illustration, he cited a time when he came to his analyst's office, lay down on the couch, and told his analyst in some detail about the very difficult day he was having—he had had three admissions to write up, he was reprimanded by the attending, his car was blocked in by other cars so that he had to take a cab to his analysis in order to be on time, in the confusion he had lost his wallet and had to write the cab driver a check, and so on and so forth. He told me with some anger and bitterness that all he had wanted from his analyst was an empathic grunt, some acknowledgment by the analyst of how frustrated and angry he, the patient, felt. He said to me: "Was

that too much to ask? All I wanted was a little kindness, a little compassion.”

He went on to talk about how his colleagues had confirmed his belief that if his analyst could not even give him that, then he, the patient, had no business remaining in such a disappointing relationship. It was masochistic for him to stay.

But as the patient’s story unfolded, I came to see things in a somewhat different light. Admittedly, it does not seem unreasonable to be asking for a bit of support, understanding, and comfort at a time when you are feeling overwhelmed and agitated. But for the patient to be looking for such support from someone who he knows does not give that kind of support (although he does offer many other things), for the patient to be looking still, even after these eight years, for support from someone who he knows

has never given that kind of support—that is what caught my attention. That is what seemed to me to be masochistic.

So, whereas the patient was feeling that it was masochistic for him to stay in a relationship with someone who was not giving him what he so desperately wanted, I was beginning to think that it was masochistic for him to want still that which he was clearly never going to get—and that the solution lay not in severing the relationship but in facing the reality that he would never get exactly what he wanted and grieving that. He would get other good things from his analyst, but never exactly what he wanted. In other words, whereas the patient was feeling that the analyst was being sadistic, I was beginning to think that more relevant was the patient's masochism—that is, his relentless pursuit of the unattainable.

I said I thought that, at this point, the work of the analysis involved his confronting, head on, the intolerably painful reality that his analyst would never be able to give him exactly what he wanted. I also said I suspected that the analyst was a stand-in for one or both of his parents and that his experience of frustrated yearning and longing in relation to his analyst was a recapitulation of an early-on (and never grieved) heartbreakingly painful relationship with a parent.

He confirmed that he had always wanted recognition from his father, a narcissistic man who was chronically depressed and totally unavailable for support or comfort. As he talked about his father, it became clear that he had never even begun to grieve the reality of just how limited his father was. As we explored other areas of his life, we found that it was a recurring theme for the patient to be ever wanting from his objects the one

thing they would never give.

I suggested to the patient that before he made a decision about whether or not to continue the analysis, he should make his peace with how disappointed he was in his analyst; in the process, he would be doing some important, even if belated, grief work around the inaccessibility of his father. And I suggested that instead of rushing off to pursue his search for gratification of his needs elsewhere, he should stay in the relationship long enough to understand why he was always in the position of trying to extract the right thing from the wrong object.

Sadism

Now where does the sadism fit in? My claim is that sadism is always a reaction, a response to some kind of trigger or precipitant. Sadism is the response of the masochist to the loss of hope. It is

the way the masochist reacts to disappointment and the loss of illusion.

The sadomasochist manages with unerring accuracy to choose either the object that will be least likely to deliver the goodies or an object that offers all kinds of good things but never exactly the thing the patient wants. In other words, the sadomasochist either uncannily keeps choosing bad (that is, initially exciting but ultimately rejecting) objects that become the source of constant frustration or chooses good objects that offer all manner of good things but not the one thing the person feels he must have.

And so, inevitably, the object (whether a bad one or a good one) fails the person, and the person's sadism is unleashed in the aftermath of that disappointment. In those moments of clarity, when the person sees that the rewards for his

unstinting efforts are not going to be forthcoming, he responds with a crushing sense of devastation and outrage. He experiences himself as having been unappreciated, misunderstood, deeply wronged, treated unfairly, violated, victimized. In fact, part of what fuels the person's outrage is his conviction that he has been abused.

The sadomasochist reacts to what he perceives to be the devastating injury with the retaliative unleashing of a torrent of abuse directed, on the one hand, toward himself (for having failed to get what he so desperately wanted) and, on the other hand, toward the disappointing object (for having failed him). Unable to make the bad object good, he now rages at himself for being so woefully inadequate in terms of his ability to get what he wants, and/or he rages mercilessly at the object for being so withholding. He alternates between enraged protests at his own inadequacy and angry

reproaches against the object for having failed him. He is unable to accept the reality of his own limitations, as he is unable to accept the reality of the object's limitations.

The self-abuse takes the form of self-denigration, self-contempt, self-destructiveness; the object-directed abuse is either in fact or in fantasy and may take a variety of forms, like devaluation, hostile criticism, perhaps contemptuous dismissal of the object. Whereas the masochistic stance is characterized by hope and feelings of omnipotence (that one will be able, eventually, to get the object to be forthcoming), the sadistic stance is characterized by hopelessness and feelings of helplessness.

The cycle is repeated if the object throws the person a few crumbs. The exciting/rejecting object often does just that. The sadomasochist, a real

sucker for such crumbs, is once again hooked and reverts to his original stance of suffering, sacrifice, and surrender in a repeat attempt to get what he so desperately wants.

The sadomasochist brings to all his relationships certain infantile needs that he feels he must have gratified. He is relentless in his pursuit of their gratification; he has not been able to face that the world will never give him what he so desperately wants, will never give him what he should have gotten way back but never did.

As I mentioned earlier, he has an uncanny knack for choosing the very people who will not be able to give him what he yearns to have. More specifically, in the relationship with the therapist he finds himself yearning to have the very thing he will never be able to get; he becomes relentless in his pursuit of that which he feels is owed him now

because it was so steadfastly denied him early on. He feels he must have gratification of his need in order to preserve the integrity of his very self.

The narcissistic defense of relentless entitlement arises in the context of the patient's refusal to confront the reality of who his objects are. Unable to sit with the pain of his disappointment, he clings to the illusion that his objects will someday be forthcoming and to his sense of entitlement, that such is his due. He is relentless in his pursuit of the goodies and relentless in his outrage when the goodies are not forthcoming.

The patient whose underlying psychodynamics are sadomasochistic will be particularly prone to employ the defense of relentless entitlement, because of his particular penchant for re-creating in his current relationships the early-on

experience of seduction at the hands of an object that initially excites and then traumatically disappoints. Although the therapist may not in fact be seductive, the patient's experience of him will be that the therapist initially offered the enticing promise of something good and then reneged on that offer.

WORKING THROUGH THE DEFENSE OF RELENTLESS ENTITLEMENT

As we know, in order to work through the transference, both the disrupted positive transference and the negative transference, the patient must at some point be able to sit with the pain of his grief about who his objects were and are. The defense of relentless entitlement interferes with the grieving the patient must eventually do in order to make his peace with reality as it is.

In order to lay the groundwork for working through the defense of relentless entitlement, the therapist must tease out and name, in an experience-near, nonjudgmental fashion, the patient's illusions—illusions to which the patient clings in order not to have to confront the reality of his disillusionment. Such illusion statements might include any of the following:

“You want desperately to find now the kind of understanding you were denied growing up.”

“You so wish that you could find someone who would be able to take the pain away, at least for a while.”

“You are hoping that you will be able to find someone who will know what you should do.”

Also useful are entitlement statements, in which the therapist frames the patient's unhealthy conviction of entitlement as an understandable

response to having been denied things as a child to which he was legitimately entitled. Entitlement statements can be used, then, to highlight a cause-and-effect relationship between the patient's early-on experience of having been deprived and his present-day expectation that he should be compensated now:

“Because you were denied things early on that were your due, you are feeling that you deserve to have that difference made up to you now.”

“Because you never felt taken care of as a child, of course your expectation now is that you should be able to find someone who will be willing to attend thoughtfully to your needs.”

As I noted earlier, the defense of relentless entitlement has both a masochistic aspect and a sadistic aspect; the relentlessness of the patient's pursuit of the object speaks to his masochism and

the intensity of his outrage in the face of being denied speaks to his sadism. Especially helpful for working through the defense of relentless entitlement is the masochism statement, which is used to confront the patient's entitlement when he is in the throes of relentlessly hoping against hope, and the sadism statement, which is used to get named what happens for the patient when he understands that what he wanted so desperately is not going to be forthcoming.

THE MASOCHISM STATEMENT

The *masochism statement* is similar in structure to the modification statement, discussed in the preceding chapter. But whereas a modification statement challenges the patient's distortions, a masochism statement challenges not the patient's distortions but the patient's illusions (or entitlement). Whereas a modification

statement highlights the discrepancy between reality and distortion, a masochism statement highlights the discrepancy between reality and illusion (reality and entitlement).

In the first part of the masochism statement the therapist gently reminds the patient of what he really does know to be the reality of the situation, even if sometimes he would rather deny it. In the second portion the therapist articulates, on the patient's behalf, the latter's longing to have reality be other than it is. That is, the therapist challenges the patient's illusions by juxtaposing what the patient knows to be real with what he wishes were real:

“Even though you know that ..., nonetheless you
would wish that ...”

“Even though you know that ..., nonetheless you
would have wished that ...”

“Although you know that ..., nonetheless you

keep hoping that ...”

“Although you know that ..., nonetheless you
would have hoped that ...”

Examples of masochism statements are:

“Even though you know that I don’t give advice,
you keep hoping that I will.”

“Although you know that I don’t give advice, you
find yourself continuing to hope that
perhaps I will.”

“Even though you know that I don’t have all the
answers, you would wish that I did.”

“Although you knew that I might not have the
magic answer, you were hoping that I
might.”

“Although you know that I don’t give answers, it
reassures you to be thinking that I will.”

As with any conflict statement, the therapist
addresses first the patient’s observing ego and
then his experiencing ego; the therapist first
directs the patient’s attention to something the

patient would rather the therapist did not and then resonates with where the patient is. The therapist first names an anxiety-provoking reality and then comes down on the side of the defense by naming, in an experience-near, nonjudgmental fashion, what the patient is hoping for:

“Although you know that it’s up to you to use these sessions in whatever way you think will be most useful to you, nonetheless you find yourself wishing that I could do that for you.”

“Although you know that your mother may never be able to acknowledge just how much she has hurt you, you find yourself continuing to believe that, if you could only be convincing enough, she might someday see the light.”

“Even though you know that she treats you shabbily, you find yourself unable to let go because you keep hoping that someday she’ll change and will come to appreciate you for who you are.”

In a positive transference the therapist allows the patient to hold on to his illusions and does not challenge their legitimacy. The illusions relate to an object that is experienced as gratifying. Both patient and therapist enjoy a positive transference; and, as I have said, the positive transference is an important backdrop for the inevitable disillusionment and its working through.

Whereas the therapist does not challenge the patient's illusions when a positive transference is in place and the patient is experiencing the therapist as the good parent he never had, the therapist does challenge the patient's illusions when they are being used in a clearly defensive manner to protect the patient from the pain of his disillusionment. When the patient is being motivated by the defense of relentless entitlement, his illusions serve him differently from the way

they serve him when a positive transference is in place. Now they are clung to in order to defend the patient against his underlying experience of the object as disappointing. Now they are clung to so that the patient does not have to feel the pain of his disappointment, even though it is becoming increasingly clear that gratification is not going to be forthcoming. When the patient is being motivated by the defense of relentless entitlement, the therapist often finds himself feeling uncomfortable in the face of the intensity with which the patient clings to his infantile needs and the relentlessness with which he pursues their gratification.

Masochism statements, by putting a wedge between reality and illusion, reality and entitlement, attempt to highlight for the patient the fact of his defense:

“Even though you know that I do not give hugs,

you are feeling that you will not be able to trust me until I do.”

“Although you know that you will need, ultimately, to discover your own answers, it feels as if, since you’re paying me to be the expert, I should tell you what to do.”

“Even though you know that I don’t give answers, you would wish that I did and are relentless in your insistence that I should.”

“Although you know that I don’t give answers, you would wish that I did and it enrages you that I don’t.”

It is hoped that in response to a masochism statement the patient will go on either to acknowledge, even if reluctantly, his awareness of the reality against which he has been defending himself or to elaborate upon his need for illusion. Or perhaps he will reiterate his conviction that he is owed all sorts of things now but will seem more aware of the connection between his sense of

entitlement and the early-on privation, deprivation, and injury. For example, the patient may clarify that his sense of outrage at having been “ripped off” all his life makes him now feel entitled to everything he can get. He may remember, with heartfelt anguish, times when he, as a child, was denied what he so desperately wanted; with bitterness, he may declare his right in the present to be compensated for the damage he sustained early on.

Over time, he comes to appreciate that a lot of his unhealthy sense of entitlement in the here and now derives from early-on experiences of having been denied things to which he was truly entitled; he comes to recognize that his behavior now is an attempt to extract from his current objects what he could never secure from the infantile object. He may even gain insight into the price he pays for clinging so tenaciously to his feelings of

entitlement and his search for recompense. It becomes increasingly difficult for him to maintain his illusions and his sense of entitlement in the face of pretty clear evidence that what he was hoping to attain is at odds with what he can reasonably expect. It becomes clearer and clearer that he is consigning himself to a lifetime of rageful disappointment and bitter helplessness as long as he refuses to confront certain realities and persists in his conviction that he is owed.

THE SADISM (TIT-FOR-TAT) STATEMENT

Sadism statements can be used in conjunction with masochism statements to highlight the patient's underlying psychodynamics. Unlike the masochism statement, which is a particular kind of conflict statement, the sadism statement is a particular kind of legitimization statement. It attempts to frame the patient's sadism as a

response to his experience of having been misunderstood, slighted, provoked, wronged, or victimized. The sadism statement acknowledges the tit-for-tat retaliatory response of the patient to his feeling of having been unjustly provoked. In other words, a tit-for-tat statement attempts to contextualize the patient's vindictiveness by suggesting that it is the patient's defensive reaction to an unbearably painful disappointment experienced at the hands of an offending object. The sadism statement frames the patient's sadistic response as understandable in light of what came before. Examples are:

“When you’re feeling this misunderstood, you feel that it is your right to lash back.”

“When you’re this disappointed, you feel entitled to retaliate in whatever way you want.”

“When you have been provoked, your first impulse is to respond in kind.”

“When you have been provoked, you feel that your wish to retaliate is entirely justifiable.”

“When you are feeling misunderstood in this way and unappreciated by me, you start hating me and find yourself wanting to say things in an attempt to hurt me.”

“When you feel that you’ve been wronged, you figure that you won’t get angry but you’ll get even.”

“When you have been denied something that was your due, you will go to whatever lengths you need to in order to get retribution.”

The sadistic patient knows, on some level, that he has the potential to get ugly. He knows that when he feels he has been wronged or provoked, he can get dirty if he has to. He is often someone with a keen sense of justice, someone who is acutely aware of who is owed what by whom. He keeps a ledger; when someone fails to come

through, it is remembered, and attempts are made to rectify the situation.

The sadist may initially balk but is usually relieved to be able to acknowledge the fact of his vindictiveness, his wish to retaliate, his wish for revenge, his wish to even the score. Framing the patient's vindictiveness as an understandable response to his feeling of having been wronged enables him to talk more freely about this aspect of his character:

“When you're feeling unappreciated, you start hating everybody and stop caring so much about how they might be feeling.”

“When you've been let down by someone as you have just now been let down by me, you figure, what's left to lose, and are tempted to lash out at the world for being such a disappointing and horrible place.”

The therapist may want to highlight the

patient's tendency to become self-abusive in the aftermath of a disappointment that he does not know how to process or work through, a disappointment that he does not know how to grieve:

“When you have been hurt by someone you love, it hurts so much and fills you with such despair that you stop caring about yourself and then behave in very self-destructive ways.”

“Whenever I don't seem to understand or get it just right, you are furious at me and think about killing yourself in order to show me how enraged you are.”

“When you feel this disappointed, you think about giving up—Why bother? Why keep trying if it's going to hurt this much?”

The first portion of a tit-for-tat statement resonates with the patient's experience of disappointment, of being misunderstood,

wronged, victimized. The second portion dares to do a bit of confronting, but that confrontation is framed in the context of the therapist's recognition of the patient's justifiable wish to retaliate when provoked.

The sadism statement, then, is in the format of a legitimization statement, in which the patient's current feelings are explained as an understandable response to a previous experience. Given that the patient feels provoked, misunderstood, wronged, unappreciated, of course he is outraged and feels that he is entitled to retaliate. The patient's retaliative outrage is understood as a legitimate response to disappointment experienced at the hands of an object experienced as having "it" to give but withholding it.

RESOLUTION

The defense of relentless entitlement is worked through as the patient, within the context of a relationship in which he feels accepted and contained, gains an appreciation of the extent to which he is motivated by his need not to feel the pain of his disappointment, acquires insight into the origins of such entitlement, and achieves an understanding of just how relentless and provocative he can be. As he gains an ever greater awareness of the extent to which he protects himself against his grief by way of clinging to his defense of relentless entitlement, it becomes harder and harder to maintain his attachment to the defense and to deny the fact of how hurt he is inside. Belatedly, he grieves for the small child he once was; he confronts at last the reality of just how starved that small child was for recognition,

understanding, and appreciation. The defense becomes less and less necessary as the patient accepts that things were as they were and are as they are, even if he has wished that they could be otherwise.

The Attainment of Mature Hope

A healthy capacity for hope is founded ... in past experiences of the successful integrating of disappointments—past experiences, that is, of successful grieving.

—Harold Searles,
“The Development of Mature Hope in the Patient-
Therapist Relationship”

THE WORK OF THE TREATMENT

The goal of treatment, I have suggested, is transformation of the patient's infantile need for his objects to be other than they are into the mature capacity to experience them as they are. Need is transformed into capacity by way of working through the transference. More

specifically, it is by way of working through disruptions of the positive transference (and adding new good) that the patient is able to let go of his need for illusion, and by way of working through the negative transference (and changing old bad) that the patient is able to let go of his need for distortion. As structural growth and structural change are effected, the patient relinquishes his attachment to his defenses, the resistance is overcome, and the patient moves forward, toward health.

In order to understand the process of structural growth and the working through of disrupted positive transferences, we turn to selfpsychology. Empathic failure, against a backdrop of gratification, is thought to provide the impetus for the adding of new good. Mastering the pain of disillusionment involves internalizations that occur as part of the grieving process. As the

patient grieves, he takes in the good that was there prior to the introduction of the bad, which enables him to preserve internally a piece of the original experience of external goodness. Such internalizations are part of the grieving process and are the way the patient masters his experience of the therapist's failure of him.

Transmuting internalization and accretion of internal structure result from the experience of having had and then lost. Within the context of the safety provided by the relationship with his therapist, the patient is able, finally, to feel the pain against which he has been defending himself for so long.

As part of the grieving he must do, he must come to accept the fact that he is ultimately powerless to do anything to make his objects, both past and present, different. He must feel, to the

very depths of his soul, his anguish and his outrage that his parent was as he was, his therapist is as he is, the world is as it is, and, ultimately, he is himself as he is. Such is the work of grieving.

Transmuting internalization (taking in the good that was) enables the patient to make internal what was once external, enables the patient, ultimately, to do for himself what he once needed his objects to do for him. As the patient becomes for himself the good parent he never had, his need to have his objects be perfect becomes transformed into a capacity to accept them as they are, imperfect to be sure but nonetheless plenty good enough. The patient's transference need for illusion becomes transformed into a mature capacity to accept reality as it is.

Optimal disillusionment. Transmuting internalization. The working through of the

disrupted positive transference. Structural growth.
The addition of new healthy structure.

In order to understand the process of structured change and the working through of negative transferences, we turn to object relations theory. The patient's intense attachments to his internal bad objects color and distort his experience of reality, including, of course, his experience of the therapist. The therapist constantly highlights the discrepancy between what the patient is coming to know (based on his positive experience with the therapist in the present) and that which the patient was assuming (based on his negative experience with the infantile object in the past).

As the patient comes to recognize that the therapist is, in fact, a new good object and not an old bad object at all, the patient finds himself in a

real bind. To remain attached to his infantile object is to deny the reality of the present situation; but to accept the reality of the present situation is to let go of his ties to the past. It is the synthetic function of the ego that makes necessary the eventual letting go of the past, the eventual renunciation of infantile attachments, the giving up of distortions to which the patient has clung since earliest childhood in order not to know the truth about his parents. In the face of increasingly clear evidence that what the patient imagined to be real is at variance with what turns out to be real, it becomes more and more difficult for the patient to remain attached to the past, ignoring the reality of the present situation. It becomes more and more difficult for him to maintain his investment in his old ways of experiencing himself and his world of objects.

And so it is that, by way of a combination of

insight and corrective experience, the patient is gradually enabled to feel, in the context of the real relationship with the therapist, that the therapist is a new good object, not an old bad one. As the patient comes to understand what might have been, he begins to feel the horror of what was, and his heart breaks. He must grieve for the wounded child he once was and the damaged adult he then became. Belatedly he grieves, feeling, to the very depths of his soul, his anguish and his outrage about just how bad his parents really were, feeling now ail of what he could not possibly let himself feel as a child.

As the patient finally comes to terms with the way things were and no longer needs to deny the reality of it, he becomes freer to experience his objects as they really are. The patient's transferenceal need for distortion becomes transformed into a mature capacity to experience reality as it is.

The working through of the negative transference. Serial dilutions. Detoxification of internal bad objects. The giving up of distortion. Structural change. The modification of existent pathological structures.

As structural growth and structural change occur by way of working through the transference, the patient relinquishes the distortions and illusions to which he has clung in order not to know the truth about his objects. The patient's infantile (and defensive) need to experience reality in ways determined by his past becomes transformed into a mature capacity to know and accept reality as it is, uncontaminated by a need for it to be otherwise.

EMPATHIC FAILURES DETERMINED BY THE PATIENT'S HISTORY

It was only recently that I came to understand

something very important about the *empathic failures* described by the self psychologists. I knew that, inevitably, selfobject (or positive) transferences were disrupted by the therapist's empathic failures. I knew that the therapist had empathically failed a patient when the therapist failed to perform the selfobject function assigned him by the patient. But I assumed that such failures were more or less random events—that a punctual therapist who had never been late might one day be late, which would be devastating for the patient, or that a therapist who was not ordinarily critical might one day say something that either seemed to the patient to be critical or was actually critical, which would also be devastating for the patient.

Now, however, I am coming to understand that, in fact, the therapist's so-called inevitable

empathic failures are not random events but are very much determined by the patient's history; the therapist, indeed, fails the patient in ways determined by the patient's history. The therapist will fail the patient repeatedly, will make many mistakes. But the mistakes that the patient picks up on (and experiences as devastatingly unempathic) will be ones to which the patient is particularly sensitized because of his early-on history. Furthermore, the patient exerts pressure on the therapist to become the bad parent the patient had, to conform thereby to the patient's worst expectations.

Under the sway of the repetition compulsion, the patient delivers into the transference his need to be failed; he compulsively recapitulates in the transference the early-on traumatic failure situation. By way of accepting the patient's projections, the therapist may unwittingly allow

himself to be drawn into the patient's internal drama. The therapist, now a participant in the reenactment, is in the position of failing the patient in ways specifically determined by the patient's history. In other words, the patient's need to have the therapist be the bad parent he had puts the therapist at risk for failing the patient in exactly those ways that the patient needs to be failed. In fact, we could think of the therapist's failures as arising from the therapist's empathic attunement to what the patient most needs.

Remember, the need has both an unhealthy component and a healthy component. The unhealthy piece has to do with the patient's need to re-create more of same because that is all the patient has ever known, and the healthy piece has to do with the patient's need to re-create more of same in the hope that this time the outcome will be different, the resolution a healthier one. Thus

the therapist's failures of the patient in those ways specifically determined by the patient's history offer the patient an opportunity to achieve belated mastery.

I am talking, then, about the connection between the deficiency-compensation model of self psychology that places in the limelight the therapist's inevitable empathic failures (or optimal disillusionments) and the relational-conflict model that involves the patient's recreation in the here and now of the early-on traumatic failure situation in the hope that the resolution this time will be different. I am talking about the relationship between empathic failure and projection/projective identification, the relationship between a positive transference disrupted and a negative transference.

Winnicott (1963b) captures beautifully the

essence of this when he writes: “corrective provision is never enough.... In the end the patient uses the analyst’s failures, often quite small ones, perhaps manoeuvred by the patient.... The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant’s area of omnipotent control but that is *now* staged in the transference. So in the end we succeed by failing—failing the patient’s way. This is a long distance from the simple theory of cure by corrective experience” (p. 258).

In the end, the therapist fails the patient in the ways that his parent failed him. It is crucial that we let the patient make us fail him in such ways. The patient choreographs our moves, and we dance them. The patient’s upset has to do with both his experience of the therapist as indeed the bad parent he had (negative transference) and his

experience of the therapist as not the good parent he would have wished to have (positive transference disrupted). It is therefore doubly painful for the patient.

But, as part of the working-through process, the patient both comes to terms with the reality of the therapist's (and, before him, the parent's) very real limitations and comes to understand his own investment in getting his objects to fail him, his compulsive need to re-create with his contemporary objects the early-on traumatic failure situation. As part of working through the therapist's failures of the patient, the patient has an opportunity both to add new good structure and to modify existent pathological structure.

UNREALISTIC OR REALISTIC HOPE?

The process of structural growth and change is accompanied by transformation of unrealistic

hope into realistic hope, infantile hope into mature hope. Infantile hope relates to the patient's wish for his objects to be other than they are. According to Searles (1979), mature hope arises in the context of surviving the experience of disappointment. Whereas infantile hope is a hallmark of mental illness, mature hope is a hallmark of mental health.

Mature hope emerges as a consequence of confronting certain intolerably painful realities head on and discovering that one survives the experience. In fact, it is in the context of being “held” that the patient can let himself feel, in the present, in the therapeutic setting, the pain and the outrage he feels about his therapist's (nontraumatic) disappointment of him and his parent's early-on (traumatic) disappointment of him. It is by way of facing his disappointment, his discouragement, and his despair—and finding that

he survives it—that the patient is able to find his way to a healthy capacity for hope, based on realistic aspirations, not inappropriate, unattainable, unrealistic pipe dreams. The mature hope that results from the experience of mastering disillusionment has to do with attaining something that is realizable. By having the experience of grief and discovering that he can triumph over it, the patient finds his way toward health.

As the patient discovers that he survives his confrontations with reality, the defenses to which he has clung since earliest childhood in order not to have to feel the pain of his knowing those truths become ever less necessary. As he lets go of his defenses and his infantile attachments, as he overcomes his resistance, he becomes freer to experience reality as it is. Infantile, unrealistic hope is transformed into mature, realistic hope. Need is transformed into capacity, as the need to

experience reality in ways determined by the past is transformed into the capacity to know and to accept reality as it is. The repetition compulsion is transformed into a capacity to experience things anew.

And so, to return to the Portia Nelson poem with which we started, as the patient lets go of his compulsion to repeat that which he would rather not, then it is that he is able to walk down new streets that are without those deep holes in the sidewalk.

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