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EXPRESSION OF THE THERAPIST'S AGGRESSION AS A PSYCHOTHERAPEUTIC TECHNIQUE: A CLINICAL INVESTIGATION OF AGGRESSIVE CONFRONTATION

by

JOSEPH BAKST ZAHM

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Chairman of Examining Committee

5/5/77
date

Florence L. Denmark
Executive Officer

I. H. Paul, Ph.D.

H. Nechin, Ph.D.

A. Arkin, M.D.
Supervisory Committee

The City University of New York

PREFACE

At the beginning of my internship year (1974) at Albert Einstein College of Medicine, Bronx Municipal Hospital Center, I was assigned a long term out-patient treatment case, a young woman who was described as a "difficult" patient in that she was chronically angry and would "probably leave therapy in a very few sessions." Our work together, however, continued throughout the year, and the patient made substantial progress during that time.

Although she had been in therapy on and off since the age of five, my patient had no therapy for the five years prior to 1974. These were the years of college and graduate school. When she returned to therapy complaining of "confusion," she appeared unable to establish a useful therapeutic relationship. Early sessions were marked by provocative, angry behavior, and the first three months of treatment were characterized by efforts on my part to avoid becoming embroiled in arguments with her. During this time a slowly developing, tenuous working relationship was effected. Following a vacation hiatus around Christmas, however, the alliance appeared to break down, and sessions were marked by an increasing level of accusations against me.

Early in the seventh month, an event occurred which constituted a dramatic and significant turning point in therapy. Having for some time experienced a mounting anger at the patient, I decided to confront her, expressing my own aggression and calling into question her behavior during the sessions. What seemed critical to the positive outcome of both the confrontation and the subsequent treatment was

the conscious and direct expression of my aggression. There had been a stalemate. I was available to help, but seemingly unable to reach through her rigid defensive resistance. She was clearly unhappy, but apparently unable to accept help in the form offered. Following what I shall call the "aggressive confrontation," there appeared a quite stable, positive working relationship which yielded increased understanding, appreciation of inner life, recalled memories and shared experience. Moreover, her provocations ceased for the most part, and my aggressive confrontation never had to be repeated.

The thesis of my dissertation is that active expression of the therapist's aggression in the transference/countertransference situation can be a positive psychotherapeutic technique for some patients. I am referring to a specific, discrete aggressive confrontational episode and not a continuous or repeated expression of countertransferential aggression. Moreover, I will assume throughout this study that the therapist's aggression is in response to the patient's transference rather than the therapist's neurotic needs.

In my effort to examine this thesis, the dissertation is organized as follows: Chapter I is an examination of the relevant literature dealing with therapists' expression of aggression. Chapters II and III explore the case in order to understand the turning point which followed my aggressive confrontation. Specifically, Chapter II is a review of the patient's developmental history and previous treatment as well as a detailed summary of the course of her therapy with me. Chapter III is a discussion and evaluation of the therapy which

focuses on the aggressive confrontation; I formulate the turning point in terms of the meaning of aggression to the patient, and explore alternatives to my major formulation. Lastly, I consider some general issues raised by aggressive confrontation.

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To Ann whose love, confidence, patience and quiet strength have contributed in a manner which cannot be adequately described in words, but which I experience every day of my life.

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CHAPTER I

REVIEW OF THE LITERATURE

Relevant Literature*

Direct consideration of the therapist's expression of agression as a useful technique has traditionally been absent from the literature on the technique of psychotherapy. Although there is some anecdotal evidence that even in orthodox psychoanalytic psychotherapy aggression is expressed by analysts to their patients, little of it appears in print. There has been no rigorous, systematic clinical approach to this subject. Moreover, what reference exists is often blended in with other material such that the aggressive component is de-emphasized.

The traditional literature on technique of psychotherapy has been organized either around the diagnosis of the patient or else it ignores diagnosis completely. More often, broad diagnostic distinctions of schizophrenia, borderline schizophrenia and neurosis are used to differentiate patient populations. Techniques for treatment, then, are keyed to these categories. I will review the existing literature relevant to aggression expressed by the therapist following this diagnostic format. I want to emphasize, however, that diagnosis is, itself, imprecise and is subject to reconsideration throughout the course of psychotherapy. Cases reported in the literature are often categorized

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*The following literature review will focus, exclusively on analytic and analytic type therapies, defined as individual verbal, expressive psychotherapy which is conducted according to a psychoanalytically oriented theoretical framework.

by one or another diagnosis as if the diagnosis were a solid, immutable identitifcation of the patient, but rarely is the method of diagnosis specified. It is my impression that diagnosis often changes with the course of treatment as more material becomes available and as therapists become better acquainted with the inner world of their patients. I have, however, been unable to secure published research which addressed itself to re-diagnosis.

Particularly relevant to the thesis of my dissertation is the possibility that diagnosis may be adjusted in process as a response to a preceived requirement by the therapist to change treatment methods. Modifications to the traditional psychoanalytic technique are considerably more common in literature dealing with treatment of psychotic and borderline patients. Possibly due in part to early psychoanalytic thought that such patients are incapable of forming a transference neurosis (see Freud, S., 1914), modifications of technique were earlier and more easily introduced in the treatment of psychosis. It was thought that the interpretive mode was inappropriate for such severely disturbed patients. There appears to be a continued reluctance to alter the basic tenets of psychoanalytic technique. Rather, it is my impression that more patients are classified as borderline or ambulatory schizophrenic partly in order that psychoanalytic treatment be modified. I will be concerned with one such modification, the expression of aggression by the therapist within the treatment sessions. As the literature is more extensive and chronologically earlier, I will first review therapist's expressed aggression in the treatment of schizophrenic

patients. Following this, I will review aggressive expression by therapists in the treatment of borderline and neurotic patients, respectively.

Therapists' expressed aggression in the treatment of schizophrenia

More directly perhaps than any others, Harold Searles, M.D. confronts the issue of therapists' expression of aggression in the treatment of schizophrenic patients. In a paper on patient-therapist interaction (Searles, 1961), he outlines the normal expectable course of treatment with chronic schizophrenic patients. There regularly appear five stages: out of contact, ambivalent symbiosis, full or pre-ambivalent symbiosis, resolution of the symbiosis, and the late or working through phase. During the first two particularly, and the fourth of these to a lesser extent, both the patient and the therapist are characterized by intense feelings of hatred, rage, etc., according to Searles.

> ...the patient can never become deeply a whole person unless he has a chance to, in Hoedemaker's (1955) way of describing it, to identify with the therapist who survives the fullest intensity of this kind of attack to which the patient was exposed in childhood and from which he, the patient has to flee into psychosis. And complementarily, I have found that it is an equally essential part of this phase [ambivalent symbiosis] that the therapist finally comes, step by step, to express openly - even though not as often as he feels it within - the very fullest intensity of his own hatred, condemnation and contempt towards the patient. (Searles, 1961, p. 536).

It is Searles' contention that only by surviving these rageful feelings - expressed in therapeutic interaction - can therapy progress.

Theoretically, Searles links the early ambivalent symbiosis phase to distortions in infant/mother interaction, and to an effort at both boundary preservation and restitution. Characterized by both love and hate, the mother figure in the patient's development demonstrated enormous ambivalence around her own hostility. In treatment, according to Searles, it is vital that the therapist have no such conflict. Unlike the early mother, afraid of her own hatred, the therapist must use these feelings in a genuinely expressive manner. Since hatred, etc. experienced by the therapist represent an induction by the patient, the therapist need be especially in touch with them. Agreeing with M. B. Cohen (1952), Searles (1961) asserts that therapists respond to their patients' transference with behavior which is complementary to the transference. It is only through surviving these feelings, that useful therapeutic work can progress. This phase gives way ultimately to the full or pre-ambivalent symbiosis, characterized by lack of boundaries of both patient and therapist in their interaction. Interestingly, throughout his work, Searles suggests that the process of psychotherapy remains essentially the same for less pathological conditions, as well. For example, "...psychodynamics to be described here are not considered...to be specific to schizophrenia. Rather, I regard these psychodynamics as being at work, in varying degrees of affective intensity and psychopathological significance, in psychosis and neurosis in general" (Searles, 1962, p. 605). In phrases scattered throughout Searles' writing, he extends his own observation to less severe pathology; and although never providing clinical case

material, argues that the phases of treatment which he identified are universally valid in psychoanalytic psychotherapy.

But what does Searles mean operationally by the statement that the therapist must "express openly...the very fullest intensity of his own hatred, condemnation and contempt towards the patient "? In discussion of his own perplexity with respect to a female schizophrenic patient, Searles (1952) states that resolution of pervasive perplexity on both his part and the part of his patient was effected by the experiencing of anger in himself directed at the patient.

> The patient had been unusually defiant, whereupon I suddenly found myself suffused with anger, which I promptly ventilated to her. Prior to this incident I had frequently experienced an intense feeling of frustration, so much so that at times I felt like beating my fists upon the floor and walls of the office; but never had I expressed anger towards her - never had I felt a desire to, for example, hit her. (p. 79).

In another paper (1963, p. 650), he discusses a psychotherapy in which he found occasion, several times, to throw a cigarette lighter at the coat of his patient (as a substitute for the person of the patient). Although usually when enraged at this patient, he would "explode verbally," the patient was so infuriating that he threw the lighter several times. Clearly, therefore, when Searles discusses the expression of his own rage, he is speaking of verbal assault on his patient at least, and occasionally a thinly disguised physical one as well. He considers such expression not only to be acceptable and appropriate, but necessary to the effective conduct of psychotherapy.

Under what circumstances ought a therapist to express such feelings? Here Searles becomes less specific. At various times in

various of his papers, Searles suggests, as mentioned above, that feeling responses of the therapist in general follow phase expectations. Moreover, he consistently implies that rage - both from the patient and from the therapist - serve a defensive function which helps hide from awareness boundless feelings of love and oneness. Therefore, he states, one would expect an increase of such feelings as therapy approaches the phase of symbiotic-relatedness and, again, an exacerbation which signals the ending of this phase. But anger, rage, etc. are, according to Searles, expressions which are difficult for both patient and therapist to accept. This is particularly so for the therapist whose training and likely personality place negative value on such affect. He cautions therapists to be alert for dissociated affect, and provides extensive examples of such dissociations in himself and among his supervisees. For example, he mentions frustration, perplexity, confusion, reaction formations as among prominent defenses the therapist employs. These, and others of a considerably more pathological nature (delusions, hallucinations, fragmentation, etc.), are used defensively by patients.

In a paper to be published in a volume edited by Kenneth Frank later this year and first delivered April 1974 at Tufts University School of Medicine, Searles develops the notion that hatred, in both therapist and patient defend against love. Discussing a schizophrenic male patient, Searles describes the first several years of work as being characterized by "vitriolic tirades" by the patient which were "barely controllable" as well as a "pseudo stupidity" on the patient's

part. It required several years for Searles to become aware of his own contempt and rage toward the patient. Then:

> I took to resorting, with excellent therapeutic results, to goading him, contemptuously, about his defiant pseudo stupidity...On one occasion when his long silence was broken by a loud fart I said to him in furious contempt, 'Why don't you just shit here on the floor? Why don't you just make yourself comfortable? I don't understand why you go to the toilet if you're trying to be an animal.' (p. 15).

Following this period and lasting several months, there emerged wishes and fears of a homosexual romantic nature in the patient, and, "It required some years before I realized, sitting in one of the silences which still predominated our sessions, that it had now become conceivable for me to be tangibly related to him without my having to either fuck him or kill him." Progress, slow to be sure, however followed, and Searles asserts that the rage needed rage in return.

Among the many cited benefits associated with the therapist's expression of aggression, Searles includes, and considers of utmost importance, the patient's ambivalence around dependency needs. He states, "The therapist who is afraid of his patient's hostility, and of his own counterhostility, is likely to function in an overindulgent, smothering manner which is repetitive of the schizophrenic's pathogenic early experience with the original mother person" (1955, p. 148). Although Searles does not relate the notion of dependency ambivalence to his above cited ideas with respect to aggression in the ambivalent symbiosis phase of treatment, a parallel of sorts could be inferred. That is, the process of psychotherapy becomes essentially an undoing, in the transference, of the pathogenic experiences of infancy and early

childhood. The ambivalence around dependency, with it's associated fantasies of incorporation, becomes, for Searles, an appropriate area in which therapists need express the aggression induced within them by their patient's transference.

Searles writes of the therapeutic expression of his own aggressive countertransference as a normal and expectable part of treatment. Primarily because of his formulations and his openness with respect to this subject, his work is relevant to my thesis. However, there are considerable differences between his presentation and what I am referring to as aggressive confrontation. Searles writes of a continuing expression of expectable countertransference phenomenon. My impression is that during the out of contact, ambivalent symbiosis and resolution of the symbiosis phase, the interaction between therapist and patient is marked by much expression of aggression. In an effort to overcome the barriers to interpersonal relatedness which result from pathogenic early experiences, the anger and rage expressed by both therapist and patient represent a re-living of the early experience. Again, in the resolution phase, distance is achieved through the aggression, and the working through process can proceed in a more reality bound context. My thesis refers to a single, specific aggressive confrontation which may represent a turning point, a confrontation which is not repeated because it resolves an impasse.

It is possible that some of the differences between Searles' writing and aggressive confrontation as I use the term, may be the result of different patient populations. The more regressed, chronic

schizophrenic patients of whom Searles speaks are, I think, less able to effect an observing ego than are more normally functioning patients. The treatment which he offers appears to encourage regression to infantile behavior, and his responses to his patients seem geared to this extremely regressed level, allowing them thereby a "corrective emotional experience." Aggressive confrontation seeks to establish an observing ego in the situation of impasse.

In a recently published paper, Wexler (1975) reports an incident which occurred in 1948 at Menninger. Having undertaken the therapy of a chronic schizophrenic patient who had been considered by the attendant staff to be "incurable," Wexler attempted to work within Rosen's technique of "Direct Analysis." The patient was both incoherent and enormously hostile, and, according to Wexler, "one very sudden and monstrously aggressive assault by the patient triggered a response in me which was embarrassingly aggressive on my side. I actually slapped her in a kind of reflexive anger" (p. 162).

Wexler states that the incident was followed by "the first coherent, understandable words I had ever heard from her. She asked plaintively, 'Why did you do that?'" Although he never had occasion to repeat his physical attack, Wexler began to challenge her directly, allowing, proscribing and directing much of her behavior. He suggests that the slapping incident constituted a turning point both in his treatment of this patient (she recovered sufficiently to live and work outside of the hospital) and of his theoretical view of schizophrenia as well.

From his early notion that the slapping served to externally support "the superego in its war with the id," Wexler developed a deficiency theory of schizophrenia. Essentially concerned with an insidious and progressive loss of internal object representation in schizophrenia, his deficiency theory maintains that efforts in treatment ought be directed toward maintaining contact with the patient. Therefore, free association, use of the couch, and other "usual" psychoanalytic techniques are contra-indicated. The slapping, certainly unusual, nevertheless served to establish contact with this patient, according to Wexler.

Winnicott (1947), in an early paper entitled, "Hate in the Countertransference," suggests that countertransference can be divided into three types. The first two types are abnormality in the countertransference from repressions and identifications/tendencies from the analyst's personal development which make him a unique individual and provide a positive setting for his work. Winnicott suggests a thorough understanding of these through analysis in order to differentiate them from the third type of countertransference, objective countertransference. Objective countertransference is defined as "the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation" (p. 195). Developing the argument that particularly with psychotic patients, the need to hate constructively, and to communicate the hatred at the appropriate time is vital, Winnicott contends, "...in certain stages of certain analyses the analyst's hate is actually sought by the patient, and

what is then needed is hate that is objective. If the patient seeks objective or justified hate, he must be able to reach it, else he cannot feel he can reach objective love" (p. 199).

In his theoretical discussion of the constructive use of analyst's hatred, Winnicott draws the analogy of the analytic situation as a partially reparative mother/child relationship. In a normal mothering relationship, the mother is fully capable of hating her own child long before the infant is capable of even awareness of the hatred. And it is only in the environment which allows for hatred that love comes to have meaning. "It seems to me doubtful whether a human child as he develops is capable of tolerating the full extent of his own hate in a sentimental environment. He needs hate to hate" (1947, p. 202).

I think it is important that unlike Searles, Winnicott advises the storing of hatred for its eventual use interpretively. When he mentions the "appropriate time," Winnicott is suggesting an interpretation which reminds the patient of the time when he (the patient) sought the analyst's hate. Like the mother who must not express her hatred until the infant is capable of accepting it, the analyst, according to Winnicott, should hold off the expression of his own hatred. It seems to me that this is contradictory to the passage quoted above which states that when the patient seeks objective hatred, what is needed is hate. Winnicott leaves this apparent contradiction unresolved.

From a slightly different perspective, and without dealing with expression of aggression per se, Fromm-Reichmann (1948, 1952)

discusses her changed ideas about the psychoanalytic treatment of schizophrenia. In the first of these papers, Fromm-Reichmann refers to her earlier (1939) paper in which she stressed the vital importance of avoiding (on the part of schizophrenic patients) a feeling of rejection by their therapists. Therapy must be initiated and conducted in a permissive, giving and loving atmosphere, she argued in 1939, in order to overcome the reluctance of the schizophrenic to re-establish contact with the interpersonal world. Referring to this earlier approach, Fromm-Reichmann (1948) says: "Once a relationship with the patient was established, treatment was continued with as much acceptance, permissiveness, and as little rejection as could possibly be administered without damage to the institution and to personnel and other patients. Nothing short of actually destructive or suicidal action was prohibited" (p. 164). However, her thinking changed, and a primary reason for the change was that "this type of doctor-patient relationship addresses itself too much to the rejected child in the schizophrenic and too little to the grown up person before regressing" (p. 165). Basing her argument primarily on respect for the adult portion of the patient's personality, Fromm-Reichmann further states, "As for the approach to the patient, it holds true for the psychotic as well as the neurotic that the damage done to him early in life cannot be undone by therapeutically manufactured unlimited acceptance in later life but only the understanding of and insight into the nature of the early trauma" (p. 165).

What is implied by the changed approach outlined in Fromm-Reichmann's paper is a differential treatment which recognizes the disturbance in relatedness, but which includes an expectation of chronologically appropriate conduct. Moreover, an approach is advocated which considers the patient less delicate and brittle than had been previously thought. In fact, she states, "Lack of spontaneity or overcaution may be more detrimental than faulty directness, as long as the latter is serious and sincere in it's purpose. Clear directness is a necessary device in dealing with disturbed schizophrenics" (p. 167). And again, later in the paper, she states, "Nor should the psychiatrist expose himself to hostile action or violence on the part of the patient. Schizophrenic violence is seldom malevolent, but it should not be endured by the psychiatrist with the erroneous rationalization of therapeutic heroism. Avoidance, if possible, is advocated not only for reasons of the doctor's self-protection, but also to protect the patient's self-respect" (p. 174).

In the second of these papers, Fromm-Reichmann (1952) expands these ideas into a more complete outline for treatment. She does not, however, make clear what she means by avoidance of the patient's hostility. What she seems to be advocating is a substitution of structure and a more formalized therapist-patient relationship for the unqualified acceptance she previously reported. With the introduction of adult expectations there is, I think, the implication of unacceptable patient behavior; and, in her argument for a direct, unambiguous approach to the genetic/dynamic understanding of the patient's problems,

I think there is a focus of the work which had been absent.

With respect to the issue of therapist's expression of aggression, it appears that Fromm-Reichmann avoids the direct expression by substituting structure and formalized relatedness. For example, in a paper first published in 1954 (Fromm-Reichmann, 1959), she writes of a patient who urinated on her chair prior to her arrival for a session. Not aware of this, Fromm-Reichmann sat on the chair, thus soaking her clothing in the urine. She writes, "I thereupon expressed my disgust in no uncertain terms. Then I stated that I had to go home. The patient asked anxiously about my coming back, which I refused with the explanation that the time allotted for our interview would be over by the time I took a bath and attended to my soiled clothes" (p. 202). Although she states that she expressed her disgust, she does not expand on the manner of expression. And when her patient asked after her return, she spoke of the issues of changing her clothes and bathing rather than of her anger at what she states that she experienced as the patient's hostile act. Furthermore, she does not discuss the transferential nature of the patient's behavior. It appears clear to me that her affective involvement in this incident represents an alteration from her previously held position.

I think her changed views represent a significant step towards both flexibility of the therapist's responsiveness to the patient and the direct approach to dealing with hostile, aggressive patients. If no longer is the goal, "as much acceptance, permissiveness, and as little rejection as possible...," then patients are indeed subject to

therapeutic punishment, etc., in a direct and concrete manner.

With the addition of unacceptable behavior on the part of the patient, I think Fromm-Reichmann contributes (without specifically stating it) to the acceptance of the expression of therapists' agression as a valid and therapeutically useful technique in treatment. The example cited above suggests that in response to a particular, inappropriate action from the patient, she gave expression to her disgust. Directly and unambiguously she appears to have confronted her patient and to have withdrawn from the session in response to the inappropriate behavior.

Fromm-Reichmann contrasts her views with those of Rosen (1953) which focus on the dependency needs of the schizophrenic patient. Rosen and Fromm-Reichmann both view distortions of early mothering as fundamental to this pathology but Rosen offers that the therapist must address the infantile needs of the patient in order that a reconstructive experience "cure" be affected. Certainly the theoretical positions of Fromm-Reichmann and Rosen differ. Rosen states, "The therapist must be a loving, omnipotent protector and provider for the patient" (p. 8). This, his "governing principle" asserts, is that the therapist must be the good mother to the patient.

Although the positions differ theoretically, Rosen and Fromm-Reichmann appear to be less at odds when technical issues are considered. As one gets to know the patient, he says, the patient becomes like a family member. "In no healthy family is love the only feeling. You begin to fight with the patient; you withdraw from the patient;

you no longer make the same sacrifice for him" (1953, p. 11). Moreover, Rosen is quite clear that aggression is directly expressed in the technique he suggests. "Some of these therapeutic maneuvers contain harsh, aggressive and stubborn attitudes toward the patient, and it is not always easy to see in what way they are appropriate to the idealized mother" (p. 12). For example, in discussion of direct interpretation of transference, Rosen states that often female patients, in an effort to be males, will pull out their hair. Assuming the parental role, Rosen will, "...denounce their act with fury, announcing that if they become a boy I will hate them. As a man, I love only daughters" (p. 15).

Generally the role of omnipotent protector and provider seems to me to include considerable negative as well as positive affective expression on the part of the therapist. It is a total family system in which these regressed patients live with staff attendance to the patients on a full time basis. But clearly, it is not all gratification of the patients. "I used to wonder how my co-workers and I persisted in the treatment of a slovenly, dirty, antagonistic and, all in all physically repulsive person. I cannot say we do not react strongly to just such disgusting annoyances. We give vent to a considerable amount of anger and resentment..." (pp. 9-10).

The argument here is not that Fromm-Reichmann and Rosen treat their patients similarly. It is, rather, that dispite the major theoretical differences, both appear to me to include direct aggression as a therapeutically valid and useful technique. Perhaps both are

related to Winnicott's notion of "good enough mothering," in which it is the mother's function to both gratify and deprive her infant, in proper sequence, in order for healthy development to progress.

Others as well employ aggression. Hayward and Taylor (1956) suggest that use of aggression is useful. "When a patient is suffering, the decision whether to give comfort or attack is often very difficult; and Hayward's recovered schizophrenic patient tells him, in retrospect, 'you should never have let me torture you by crucifying myself and making you watch my suffering. You should have forced me to come down or at least throw rocks at me.'" Sechahaye (1951) offers that the therapist's expression of anger relives the patient's sense of guilt and helps the patient experience his needs as legitimate, no longer requiring repression. In discussion of paranoid patients, Heiman (1955) finds it of no use to attempt to convince patients of her "good will" due to the sadism involved in their suffering.

In summary, the literature which discusses the expression of the therapist's aggression in the treatment of psychotic patients tends to focus on the dependency themes and inappropriate behavior of the patients. Theoretically, the authors reveal considerable differences. Searles, Winnicott and Rosen seem to be advocating a reconstructive experience for the schizophrenic patient. Differing with respect to some dynamic issues, they appear to both allow and encourage the regression to infantile functioning. Fromm-Reichmann in a major change from her early writing on the treatment of schizophrenia, offers a formalized, structured doctor-patient relationship which addresses

itself to the chronologically adult portion of the schizophrenic regressed individual. She suggests an active and direct therapeutic approach.

Examination of their published case material reveals that they each express aggression which derives from the transference/counter-transference situation, and all appear to consider such expression an appropriate therapeutic intervention. As with Searles, it seems to me that they all view the expression of aggression as a continuing response to their patient's inappropriate behavior.

Therapists' expressed aggression in the treatment of borderline conditions and character disorders

The literature on treatment techniques for less regressed patients contains some reference to aggressive expression of the therapist. Coleman (1956) and Coleman and Nelson (1957) describe a direct technique in which aggression is expressed in treatment of borderline schizophrenic patients. Their technique, called "externalization of the toxic introject," assumes that early in the patient's development there existed a "traumatic parent." In therapy, the therapist re-creates this "toxic introject" by consciously and deliberately impersonating him (or her). It is in this context that treatment occurs, that the curative effect of the psychotherapy can take effect. It is felt by removing the struggle between the introjected parent and the healthy ego from intra-psychic conflict and placing it externally in the interpersonal situation, the healthy ego is strengthened and insight can be gained. In Coleman and Nelson's view, it is not the

therapist who is aggressive, but a role playing model of the original parent.

Often, they maintain, the shock or surprise of their technique leads to a turning point in treatment. Clinical material of such a turning point is provided, and it clearly demonstrates both the technique and the aggression expressed in it. A patient in relatively unproductive treatment for four years who had been consistently chastising herself during sessions was met with: "...in a tone of full conviction: 'You are quite right. You are not good, a failure. At least you recognize that everything is hopeless. You will never change. Give up'" (1956, p. 241). After a few moments of stunned silence, the patient fled the office. Returning the next day, the analysis continued as before, but several months later the patient recalled the incident, stated it was a turning point and continued: "Why did you wait four years before you said it. It is as if I was waiting for you to say exactly that... From then on everything changed. I've made more progress in four months than I did in four years." Coleman, in discussion of this vignette suggests, "For years she had tried to provoke the analyst to reflect, by open verbal agreement, her negativistic self (the unhealthy introject) as a step toward mobilizing her more positive impulses."

Although they clearly describe the technqiue, Coleman and Nelson leave a number of important inconsistencies. According to Coleman and Nelson, the role of parent is adopted without the patient's knowledge, and they defend the therapist's hidden agenda on the basis

that surprise is necessary for the technique to produce an affective response from the patient. Coleman (1956)states, "If this kind of interpretation is to be effective, it cannot be used too freely or the patient will come to recognize it as a technique and be armed against it" (p. 241). Later in the paper, however, caution is recommended against the shock of surprise, More importantly, I think they do not discuss the technique from the viewpoint of the patient's perception of the experience. They maintain that the therapist represents the toxic introject, but it is unclear if the patient perceives the interaction as representative of earlier conflict or of an aggressive therapist. Since the agenda remains hidden in order that the technique be used again, it seems to me that the experience cannot be explored fully in subsequent sessions. Furthermore, the affective state of the therapist remains ambiguous. Coleman and Nelson (1957) suggest that the therapist does experience aggression, "The therapist must have sufficient mastery of his own hostility to withhold it or express it as the situation warrants" (p. 37). However, at the time the technique is employed, it is unclear if the therapist experiences the hostility.

What does seem clear is that this is a technique which directly and deliberately expresses the therapist's aggressive feelings in interaction with the patient. The criticism I am offering speaks to important unanswered questions, but I think the papers provide both theoretical and clinical material which is directly relevant to therapists' expression of aggression.

Kernberg (1967, 1972, 1975) comprehensively describes and delineates his ideas on borderline conditions and their treatment psychoanalytically. Although agreeing that an essential dynamic in the etiology of borderline personality organization is a distorted, ambivalently hostile mothering, Kernberg asserts that treatment should be conducted in as nearly as possible a rigorous analytic setting. The expectable negative transference must be dealt with from the very first manifestation, but, he feels, interpretation in a more usual sense is best suited to this task. To Kernberg, it is not aggression of the therapist which is at issue, but the rageful, murderous, oral aggressive fantasy of the patient's transference which is to be interpreted at the earliest opportunity.

Nevertheless, in unusual circumstances, Kernberg describes modifications. Modifications are different from parameters in that they are alterations from psychoanalytic psychotherapy rather than from classical psychoanalysis. He argues that borderline conditions present unique difficulties in the establishment and maintenance of the therapeutic alliance because: "Establishment of the therapeutic alliance is equated with submitting to the therapist, a dangerous and powerful enemy, and this further reduces the capacity for activating the observing ego" (in Giovacchini, 1972, p. 266). And, later, he states:

> Instead of verbally expressing strong feelings of anger and reflecting on them, a patient may yell at the therapist, insult him and express his emotions in direct action over a period of weeks or months... Such unremitting transference acting out is highly resistent to interpretation because it

> also gratifies these patients' instinctual needs, especially those linked with the characteristic severe pre-oedipal drive derivatives... The acting out of the transference within the therapeutic relationship is the main resistence to further change in these patients, and parameters of technique required to control the acting out should be introduced in the treatment situation (pp. 268-270).

Although stressing a consistently analytic attitude, Kernberg equally stresses the necessity of consistent and forceful confrontation of the patient with the split-off negative transference. "The development of an observing ego appears to depend not on the therapist's offering himself as an unconditional friend, but as a consequence of focusing on the pathological cycles of projective and introjective process, on transference distortion and acting out, and on the observing ego itself" (p. 274).

Among the modifications of technique suggested by Kernberg in treatment of borderline patients, three are of particular interest with respect to the issue of therapists' expressed aggression. They are: confrontation with and interpretation of those pathological defensive operations which characterize borderline patients as they enter the negative transference; definitive structuring of the therapeutic situation with such active measures as are necessary to block the acting out of the transference within the therapy itself (for example, establishing limits under which the treatment is carried out and limiting the nonverbal aggression permitted in the hours); selective focusing on all those areas within the transference and the patient's life that illustrate the expression of pathological defensive operation

as they induce ego weakening and imply reduced reality testing (1972, pp. 257-258). According to Kernberg, modifications in general, and these three specifically, are at least partially in the service of preventing regression by the therapist which is induced by the transference/countertransference situation; and firmness and control over the situation appear to me to be dominant aspects of the modifications. Moreover, while not expressive directly of "counter-hostility" on the part of the therapist, modifications seem to be instituted in the cases where regression of the analyst is threatened, and treatment may be terminated. To summarize, modifications should be introduced when the therapist begins to experience feelings of regression within himself and the modifications themselves appear to be controlling, active, and rigid.

The therapist, according to Kernberg, should "try to remain as neutral as possible, but neutrality does not mean inactivity; beyond a certain degree of activity, the issue of whether the therapist is neutral or not becomes academic" (1972, p. 286). And he makes this point clearly in an example. A woman patient of Kernberg's persisted in coming late for appointments, leaving ashes all over the furniture and taking magazines home from the waiting room even after the behavior was called to her attention interpretively. In fact, she smilingly approved her therapist's perceptiveness. Only when "the therapist made it quite clear that there were definite limits he would tolerate did she become quite angry, expressing more openly her derrogatory thoughts about him..." (p. 284).

Kernberg's writings on the issue of therapists' aggression with respect to his patients are, however, equivocal. In the passage above, he indicates the notion of therapeutic neutrality is moot, but he also comments:

> In order to keep in emotional contact with the patient, an analyst who works with patients who present borderline personality organization has to be able to tolerate a regression within himself which on occasion may reactivate remnants of early conflict laden relationships in himself. Aggressive impulses tend to emerge in the analyst, which he has to control and utilize in gaining a better understanding of the patient (p. 271).

If what is meant by "utilize" is expression, in a controlled manner, of the countertransferential aggression, Kernberg appears to be supporting a therapeutic value to such expression. If, however, therapeutic neutrality is a goal, what is meant by utilization of the aggressive impulses of the therapist is unclear. Little (1951, 1960) recommends strongly that countertransference feelings be expressed within the treatment hours.

A question presents itself in Kernberg's writings, and those of a host of others, as to what precisely constitutes a proper analytic interpretation, a parameter, a modification, an extra analytic comment and so on. The literature in this area is vast and enormously contradictory. Yet, it is relevant to the issues of this review, as can be seen from the above discussion of Kernberg's work. Much of the literature focuses on the issue of the therapist's expression of his own feelings in the transference/countertransference relationship, and I intend not to review this work here except to call attention to the position that use of the therapist's affect expressively, has basis in

analytic literature as a legitimate interpretive mode.

Giovacchini (1975) speaks quite directly to the issue. He argues that statements and comments referring to his own affective state via the patient are, in effect, definitions of the analytic setting and the "definition of the analytic setting is, in itself, a variety of transference interpretation" (p. 312). They are transference interpretations in that they "lead eventually to a solid analytic introject." And it is this analytic introject which forms the basis of transference projections. Stone (1963) agrees that the analytic situation, which includes the conduct and personality of the analyst, is crucial to the establishment of the transference neurosis. Moreover, in response to a then prevailing literalness in interpretation of Freud, Stone specifically discusses the Freudian notions of "mirror," "scalpel" and "abstinence," suggesting the position that the "humanness" of the analyst is a vital factor in analytic therapy (see Stone, 1963, footnote #19).

To return to the expression of aggression by the therapist in the treatment of borderline personality patients, the work of Melanie Klein and her followers is relevant. Although not limited to borderline conditions, Klein and her followers address themselves primarily to the issue of character pathology, and therefore will be discussed here. Note, however, that the Kleinians specifically do not restrict their methods to borderline patients; a criticism often leveled at them is their lack of specificity (see Kernberg & Giovacchini). In their emphasis on the early interpretation of negative transference, they are

essentially in agreement with the ego oriented analysts; but in the nature, timing and content of the analyst's comments, there appears to be considerable controversy. The importance of the death instinct and the deep murderous rage at the analyst (associated with envy from the paranoid/schizoid position) form much of the theoretical rationale for the Kleinians interpretative style (see Klein, 1945, 1946, 1957; Racker, 1957; Segal, 1964, 1967). Claiming to by-pass the defenses, the British school analysts predominantly use transference interpretations of a pre-oedipal drive oriented nature. Often forceful, they are directed at deep unconscious transference fantasy. For example, Segal (167) cites a case illustration in which her patient, and analytic candidate, commented in the first session that he wanted to be qualified in the shortest possible time. Later during the session, he made a passing remark about digestive troubles. Interpretation, "that I was the cow, like the mother who breast fed him, and that he was going to empty me greedily, as fast as possible, of all my analysis-milk" followed.

The notion of countertransference use in treatment is of paramount importance to Kleinian analysts. Racker (1968) deals at length with the theoretical and technical implications of countertransference feelings. Arguing that affective involvement with patients is both unavoidable and enormously useful, Racker typifies the Kleinians. The countertransference, he suggests, is a product of the analyst's unresolved conflicts and induction by the transference/countertransference relationship. Following the Talionic law, "...every positive transfer-

ence is answered by a positive countertransference; to every negative transference there responds, in one part of the analyst, a negative countertransference" (p. 137). Constant awareness, then, of the analyst's own affective state, viz the patient helps avoid what Racker describes as "drowning in the countertransference." With respect to the objectivity of a specific countertransference, Racker suggests that distortions do occur, usually mild and usually amenable to analytic work of the analyst. In spite of the distortions however, "Whatever the analyst experiences emotionally, his reaction always bear some relation to the patient. Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations" (p. 171).

Racker, however, skirts the issue of expression of countertransference to patients:

> Much depends, of course, upon what, when, how, to whom, for what purpose, and in what conditions the analyst speaks about his countertransference....[He then states that it is usually better to obtain the benefits sought by such communication in the usual, interpretive manner]...But there are also situations in which communication of the countertransference is of value for the subsequent course of the treatment (pp. 172-173).

In the discussion of technique, Racker is more explicit. He states that when an analyst experiences a strong impulse to act a role which the patient (usually unconsciously) desires the analyst to fill, he (the analyst) should be especially wary of his own neurotic countertransference.

> But the situation is different when the impulse to act does not arise from an anxiety caused by determined material, but which originates in the more or less chronic inefficiency of the interpretations....What I am referring to here is a very different acting; it is not demanding or prohibiting, but a transitory performance of the role induced by the patient followed by an analysis of what had happened and what had been enacted (pp. 68-69).

There are a number of reasons and indications for this enactment according to Racker. Firstly, he states that the subsequent analytic work becomes more vivid. But more importantly, I think, he suggests that the patients for whom this is a useful technique are those who "unconsciously make use of the taboos we impose on ourselves." The usefulness of breaking the taboo by the analyst lies in the interruption of the defensive pattern.

> In other words, normally, the analysis acts therapeutically precisely because the analyst does not act, that is to say, because he does not enter into the patient's vicious circle, but only interprets. But in certain cases the patient's defensive mechanisms make use of precisely this fact for their own ends, and at the same time paralyze the influence of the interpretation. More than patients who act, they are patients who seek 'to be acted upon,' and the analyst's 'entering into the part suggested by the patient' - if the acting has been free (or nearly free) from anxiety and followed by interpretation of what was done by both sides - is at times useful in order to irrupt into this sui generis vicious circle. In such cases, the analyst's action itself may already act as a first interpretation, since at bottom it is an interpretation. It only takes the form of actions (Racker, 1968, p. 69).

With respect to transference gratification implied in the acting of a transferentially assigned role, as Racker states it, or of causing the analytic situation to serve an interpretive function, as Giovacchini prefers, the issue is contradictory and complex. Transference gratification is not specifically addressed by either author. The implication of their work, and the work of others who discuss the not overtly

response. Moreover, "therapeutic misalliances should be considered when the therapist senses a lack of progress or depth in the therapy, or in the unfolding of material from the patient....He is aware of notably seductive or aggressive feelings toward the patient which he is unable to resolve" (p. 91). Rather than any deviation in technique, Langs recommends in a companion paper (1975b) resolution of the misalliance through self analysis. In a lengthy discussion of the problems arising from deviations from classical analytic "ground rules," Langs argues that, "Tentatively it would appear that many of the therapeutic crises that prompt analysts to deviate in their technique are evolved by an interaction between the patient's psychopathology and that of the therapist" (p. 137).

Stating an opposing point of view, Havens (1973) traces the changes in psychotherapeutic practice in the past 50 years. The essential change is from a passive to an active role for the therapist, and the point is made that to some extent this change is related to the changed criteria for considering a patient suitable for analysis. Havens is in agreement with Stone (1961) that the personality of the therapist is the necessary medium for therapy to work (Havens, 1973, p. 240). In a pair of papers (Coltera & Ross, 1967; Kanzer & Blum, 1967), the technical papers of Freud to 1923 are traced and changes in technique since his death are discussed.

However, the purpose of this review is to focus on literature which asserts that not only is the experience of affective response to patients acceptable, but that, under certain circumstances, expression

psychotic patient appears to be that the gratification is more predominantly an issue in the continued provocative, defensive, resistive behavior of these patients. Therefore, although it is possible that action, expression on the part of the therapist, is gratifying transferentially, it is also necessary in order to make available the material for analytic work. I think that Racker's comments on the increased vividness are germaine in this context. Once the behavior becomes apparent within the transference relationship, it is real and available in a manner which did not exist before.

Therapists' expressed aggression in the treatment of neurosis

It is in the area of therapy with the least distrubed groups of patients, the neurotics, that the issue of the therapist's expression of aggression receives the least attention in the literature except as it relates to the countertransferential acting out of the therapist's unresolved conflicts. In that context, of course, opinion is universal in it's condemnation of the practice. There is, in addition, a traditional position which maintains that any affective response to the patient constitutes such a countertransference, and that virtually any deviation from a strictly interpretive position constitutes evidence of a therapeutic misalliance. Langs (1975a & b) explicates this stance and reviews the literature on the therapeutic relationship.

Viewing affective response which is characterized by especially negative or positive affect as clues that a misalliance may exist, Langs asserts that such misalliance is the result of patients' needs for transference gratification and therapists' countertransference

of aggression is appropriate and psychotherapeutically valid. Assuming, then, the positive, that with neurotic patients as well as with the more disturbed patients, the therapist's affective response has some basis in the patient's pathology, and that this affective response is useful with respect to understanding the patient, the relevant question is in what manner may it be employed psychotherapeutically.

Bird (1972), in a paper on transference, offers the hypothesis that transference is universal and is, in fact, an ego function. He differentiates transference-reactions from transference-neurosis in a quite literal sense.

> It [transference-reaction] is a means of displacing feelings and attachments from one object to another, and of repeating the past in the present....[In the transference-neurosis] the patient includes me somehow in the structure or part structure of his neurosis. As a result of this process, the identity difference between him and me is lost, and for the moment, for the particular area affected by the transference-neurosis, I come to represent the patient himself (p. 281).

Within the context of transference neurosis as he defines it, Bird discusses the transference difficulties in negative destructive tendencies of patients.

Suggesting that the transference is unable to reproduce "with any verity the full range of man's negative destructive tendencies," Bird links this lack with the possibility that these tendencies are g verned by the death instinct, and that this concept has received entirely too little attention in the literature. A more important reason, according to Bird, is that analysts tend to avoid the negative hostile feelings of patients and themselves. Bird sees this hostility in a concrete and literal sense, that is, the desire to murder, maim,

etc. Moreover, analysts, he believes, tend to close off such expression from their patients by interpretations aimed at keeping those feelings on a rather superficial level.

The destructive tendencies of the patients, however, do reveal themselves within the treatment.

> Tentatively I would like to suggest what may be a rather common, but generally unacknowledged way in which patients attempt to cause the analyst harm, and perhaps succeed more often than we think. This is to convert some element of the analytic situation into a weapon to use against the analyst.... The best known of these is the so-called negative therapeutic reaction (pp. 290-291).

It is Bird's position that the negative reactions are in fact, "not merely hostile fantasies, wishes or reactions, but very real destructive acts, actual attempts to injure us."

Although extraordinarily difficult, this situation forms the basis for considerable analytic work; but in order for this to prove fruitful, the analyst must allow for its development, and he must understand the transference neurosis character (as opposed to transference-reaction) of it. Rather than use this situation, often analysts struggle to preserve their "neutrality." But, according to Bird, "The analyst who remains constant as an objective, detached, uninvolved interpreter of the patient's productions is almost sure to bring about a salient but significant build up of the analyst's own unconscious negative destructive impulses" (p. 293). Further, he states that:

> By not confronting the patient with the actuality of the patient's secret silent obstruction of the analytic process, the analyst himself silently introduces even greater obstructions....[It is only when the analytic situation becomes, in a sense, an adversary situation, should we expect the kind of transference neurosis to

> develop that can admit to it a representation of destructive impulses strong enough and faithful enough to permit this aspect of the patient's neurosis to be effectively analyzed (p. 294).

The confrontation is an active and affective one. "In my experience, resolving this destructive situation depends upon speaking of it directly, even assertively, in terms of action" (Bird, 1972, p. 292). Once the conflict between analyst and patient is overt, it assumes a quality which feels real to the patient and is therefore, analyzable. I think it is important that Bird's position represents the therapist's "transference" involvement as crucial. Bird asserts that not only does "transference involvement" enable the therapist to accept his own destructive impulses, he can better understand the transference neurosis of his patient.

With respect to the treatment of structurally intact patients, I have been able to find little additional literature which is directly relevant to expression of the therapist's aggression in treatment sessions. Of course, as mentioned above, the distinction between diagnostic categories is crude to be sure, but, it is a useful categorization for discussion of technique since the technical aspects of treatment are often keyed to the level of regression of the patient. The important caveat is that, as with Searles, authors tend to be non-specific diagnostically, or, as with Kleinians, tend to be all-inclusive although dealing primarily with one or another group of patients.

The discussion of affective expression with respect to neurotic patients tends to focus on issues of how "real" the therapist ought to be or can be, an argument which will not be reviewed here. The major

thesis of this dissertation is not that the therapist ought to, under any conditions, become a "real," that is, fully three-dimensional person to his patient, but, rather, that within the therapeutic relationship, there are conditions which call for direct affective, and aggressive response to the patient's behavior within the therapy hours.

This form of aggression may be viewed as a special form of confrontation.

The literature on confrontation is equivocal even with respect to the definition of the term. In general, however, several elements are identifiable. Firstly, there is general agreement that confrontation at minimum must hold up to the patient some aspect of the patient's behavior which the patient has been reluctant to examine. Secondly, there is general agreement that some forcefulness is employed in the procedure. An exception is found in Corwin's (1973) paper which distinguishes routine from heroic confrontations and suggests that forcefulness is found only in heroic confrontation.

Although confrontation need not be an expression of the therapist's aggression, there is, I think, an implicit theme which pervades much of the literature and which suggests that much of confrontation expresses aggression. In general, confrontation as a psychotherapeutic technique, is considered to be a "last resort" procedure. Only when the therapist perceives the progress of psychotherapy to be stalled, is confrontation considered. Traditional practice holds that interpretation alone be used in verbal communication from therapist to patient. Confrontation, then, represents a "failure of the interpretive mode."

What appears to me to be striking is the sense of blame which is assigned to patients when it becomes necessary to confront.

Rather than experiencing the impasse as an impotence, therapists it seems to me, declare that interpretation alone will not "work." Confrontation is used with this rationalization, and I think, expresses anger as well as frustration that an impasse has occurred. I think that aggression expressed in this manner is similar to the rediagnosing of patients which I have discussed in the introduction to this chapter. As with the statement that interpretation will not work, rediagnosing seems to assign blame for the impasse to the patient and avoids the experience of helplessness on the part of the therapist. Giovacchini (1975) suggests that helplessness is a frequent accompaniment to psychotherapy of character disordered individuals. Corwin (1973) offers the heroic confrontation as a response to "narcissistic alliances" and to "impasses." He maintains that heroic confrontation is "an emergency procedure" which places the burden for immediate change on the patient. When it works to resolve the impasse, heroic confrontation relies on the fear of imminent abandonment by the therapist.

I think it is important to emphasize that rather than a "last resort," a "failure of the interpretive mode," a "reaction to frustration," a "response to narcissistic alliances," or an "emergency procedure," aggressive confrontation is positive therapeutic technique.

Havens (1973) observes that there are three kinds of confrontation: Confrontation with the past; confrontation between persons (therapist and patient), and confrontation with the resistences. Of

these, the latter two appear to me to be relevant to the issue of aggression. According to Havens, "Neutrality and passivity allow for transference neurosis only providing defenses allow for its emergence" (p. 241). A confrontation with resistences, he asserts, enables the formation of transference by helping to make behavior symptomatic. Confrontation between persons is discussed in terms of the "presence" of the therapist, but, there are implications with respect to the transference which are not discussed. That is, a resistence may well take the form of a chronic confrontation between persons as described, for example, by Kernberg quoted above. In such a situation, confrontation with resistences and confrontation between persons seem to me to be inseparable. Boris (1973) suggests an approach to patients based on "confrontation with the id." Essentially this technique attempts to by-pass the defenses associated with ego functioning, thus avoiding transference complications until an alliance has been established with the patient's unconscious. Only later is the transference analyzed in the usual, interpretive manner. Offering the usual caveat with respect to countertransference, Boris goes on to state the following:

> On the other hand, such austere neutrality conveys in great potential the possibility of exciting the patient to a very considerable envy of the self contained therapist. ...One can forestall the envy sufficiently to appease it by becoming partisan - by caring, feeling thwarted, getting angry and, in the end, socially confronting the patient's confrontation of oneself (p. 198).

So, then, if confrontation includes expression of these partisan feelings, there appears to be (as he describes in case material), an

aggressive element which is rooted in the here and now relationship with the therapist as well as the transference.

Welpton's (1973) comments on the angry confrontation are relevant. He suggests that two basic processes within the therapist contribute to angry confrontations. Either he dislikes the patient's behavior or he feels a need to change the patient's behavior. Arguing that the patient provokes these angry confrontations, essentially a sado-masochistic dynamic, seduces the therapist into the aggressor role. Nevertheless, these, according to Welpton can be extremely positive. "Indeed, it often seems that when an angry confrontation can be pursued fully by both therapist and patient, it opens up for discussion a previously obscure aspect of the patient's behavior, and the force of the confrontation enables the patient to see something he would otherwise ignore" (p. 257).

Although the evidence from psychological literature is spotty with regard to therapists' expression of aggression, there are some references in treatment of all the major diagnostic groups. In the remainder of this study, I shall present and discuss a single case in which the expressed, direct aggression of the therapist clearly constituted a turning point in the therapy.

CHAPTER II

THE PSYCHOTHERAPY OF SALLY D., INCLUDING DEVELOPMENTAL HISTORY, HISTORY OF THE PREVIOUS TREATMENT

Introduction

The basis for the discussion of my thesis, that active expression of the therapist's aggression directed at his patient can be a positive therapeutic technique, is the following comprehensive examination of a treatment in which such expression provided a turning point.

Early in the seventh month of therapy at the height of a serious impasse, I aggressively confronted my patient with her behavior during session. I gave expression to a mounting anger which had been developing within me for the previous several months. In a deliberate, controlled manner, I clearly and unambiguously attacked her rigid and brittle resistance. A turning point occurred following this session, and the remaining three months of therapy were characterized by a trusting working relationship between us.

This chapter is intended to provide the case data which I evaluate in the discussion chapter following it. Below is a summary of the developmental history, previous treatment, and course of my treatment of this patient. I will focus on the problems encountered in the process, attempted solutions to those problems and the transference/countertransference situation as it developed. Consistent with the focus on process, I will present the treatment chronologically, subdividing stages, as they logically occur in retrospect, but with awareness that the process was an ongoing one.

Sally D. is a 23 year old white, single, Jewish woman who holds a Master of Education degree. She presented at the Rousso Mental Health Clinic, Albert Einstein College of Medicine in July 1974 with vague complaints of feeling "depressed and confused." I followed her in intensive psychotherapy from early September 1974 through mid-June 1975. Supervision was provided throughout by Donald Gerard, M.D. In all, Sally and I met 58 times on a twice per week schedule.

Treatment was difficult, and sometimes quite stormy. Themes and issues were constantly in flux. Transference and particularly countertransference issues were salient throughout the treatment. Goals of the therapy required constant re-evaluation, and techniques to achieve those goals were changed several times. The patient exemplifies a group of patients who are highly problematic. Although differing greatly with respect to their life situations, this group of patients shares a number of basic similarities. They are bright, verbal, function on a relatively high level and seek treatment for vague characterological problems. They are motivated, as evidenced by reliable attendance at sessions, but the nature of the character pathology makes them both unusually resistent to treatment and defensively non-psychologically minded.

Developmental History and History of Previous Treatment

As will become clear later in this paper, the patient does not have clear memories of her childhood; moreover, she is reluctant to explore those memories she does have. She has been in treatment on several previous occasions, and primarily from those records, the follow-

ing history has been culled.

She is the second of two daughters of middle class Jewish parents. Mr. D. has been steadily employed throughout her lifetime, first as a salesman and later as manager of a lumber company. Mrs. D. has never been employed out of the home. Both parents completed high school; neither attended college. When Pam, the elder child was six months old, Mrs. D. suffered her first attack of multiple sclerosis, an attack lasting almost six months, during which she was totally incapacitated. Mr. D. was told his wife's diagnosis, but Mrs. D. was informed only that she had "an inflamation of the nerve ends which might recur." Mr. and Mrs. D. decided to have another child as soon as possible in order to "complete the family."

Born in 1951 when her sister was 29 months old, Sally was a full term normal baby. Birth weight was 6 lbs., 3 oz. and there were no unusual neo-natal problems noted. She was described as "a good baby" in contrast to her sister who was "a pest." When she was 6 weeks of age, Mrs. D. developed a partial facial paralysis, the precursor to another m.s. attack which left her without vision in one eye. Again the attack passed only to be followed by another when Sally was about one year old. This third attack lasted several motnhs and left Mrs. D. with gross motor coordination deficits and weakness in her left arm. Throughout the first year of her life, Sally was cared for almost exclusively by her father and household activities were performed by him as well. At the age of seven months, she began to walk around her crib, and as soon as she could walk, began to "get into her sister's toys."

Problems began at around one year of age. She became a poor eater, a head banger, and had occasional temper tantrums.

Nevertheless, during the first 5 1/2 years of her life, she is remembered as being a bright, active, alert child who was both stubborn and independent. The major family problems were with Pam who was slow, plodding, and had difficulty learning to speak. It was remembered that Pam was consistently the center of attention.

She started kindergarten at age 5 1/2 and had no difficulty separating. She enjoyed school and had several friends. In the spring of her kindergarten year, however, she developed a cough. In that era of "polio scares," the parents of the other children refused to allow her classmates to associate with Sally, fearing contagion. Mother reported that she kept her home from school, but the cough did not get better. After the summer, she returned to school and complained that the other children avoided her. During the school year, the family noted her becoming irritable, restless and argumentative with both playmates and family. She frequently cried, yelled; she and her sister were fighting most of the time.

In November 1957, Sally was referred to Jacobi Hospital Mental Hygiene Clinic by Jewish Family Service. Presenting problems at the time were irritability, restlessness, arguments with playmates and family, etc. In addition, tantrums were frequent and she periodically refused to eat or awaken on time. Psychological testing at the time revealed " a child of average intelligence who is reacting as if she were constantly being traumatized." Anal and Oedipal issues appeared

predominant in projective material, as did conflict related to the battle with her mother. Play therapy was recommended, the goal being to help her express her feelings toward her mother. Counselling was suggested for Mrs. D. in order to help her see that the anger and guilt expressed in evaluation sessions toward her daughter were "not justified and were interfering with her relationship with her daughter." Diagnosis at the time was "behavior disorder with hyperactivity and tantrums." These recommendations were implemented on a once per month basis for the remainder of the school year. It was then recommended that she be seen in intensive psychotherapy following a summer hiatus.

Beginning in September 1958, and continuing through June 1959, the patient was seen once per week. Records of this treatment are sketchy. However, when treatment was terminated, the therapist felt "the child is much too frightened and restricted, but future treatment might be necessary, either at puberty or at the time of her mother's death." Gains, however, were noted. Mrs. D. reported that her daughter's grades improved in school and that she was able to make and keep friends. Problems at home continued with her sister, as did periodic outbursts of the type for which she was brought to treatment.

She continued to do well in school throughout latency and the continuing difficulties at home were not sufficiently disruptive to bring her again to professional attention. Summers were spent at sleep-away camp where she reportedly enjoyed herself. Records from the camp, however, suggest a somewhat belligerent, stubborn child who became "a negative leader." For example, it was noted by her counsellor during the

Summer of 1960 that she, at first being somewhat of an "outsider" among the campers, became the leader of a group of girls who scapegoated a deaf child. She simply could not understand or empathize with the other girl's handicap. Moreover, her counsellor noted her difficulty relating to authority. "When camp first began, Sally was belligerent to the counsellors. She was constantly testing us and would have to be scolded before she would listen to us....On one occasion when she was fresh to me, I explained to her that friends don't speak to each other that way and that I had never been fresh to her. While I was speaking to her, she began crying and seemed quite ashamed of her behavior."

The progression of her mother's multiple sclerosis was expectable. Throughout latency there were numerous, unpredictable attacks and remissions, sometimes returning Mrs. D. to a functional level the same as before the attack, more often with lingering or permanent loss of motoric function. Mrs. D. continued to see a social worker weekly but was not informed of her diagnosis. The patient, as well, was ignorant of the true nature of her mother's condition. There was apparently little discussion of mother's condition: denial pervaded the family system. Although a nurse/housekeeper was employed on a part time basis and several aunts helped as well, the patient assumed a major housekeeping role. Pam refused to participate, and this became a major area of conflict between the sisters.

Menarch began at age 12 1/2. She was prepared for it by her sister and maintained that she was "unaffected by the change." Later records, however, reveal that substantial changes in her behavior

occurred at this time. She began to take an interest in clothing, wanting to "dress older." She entered an all girls junior high school in Fall 1963, and with some girl friends, joined the "Y" in order to expand their social life. They went to several co-ed parties, but stopped after only a few when she "lost interest." She joined the color guard at school, but quit soon after, refusing to give an explanation.

In early 1963, at about the same time as the above events, Mrs. D. suffered a severe attack of m.s. She experienced numbness of her entire body, and she was unable to move. The attack lasted several months during which the patient had to dress her mother each day before she left for school. In addition, two other events of major significance occurred during the next year. Mr. D. developed a nose and ear infection lasting several weeks which distorted one side of his face; and during the Summer of 1964, Pam required surgical incision of a breast abcess.

In October 1964, Mrs. D. again suffered an m.s. attack. She had dizzy spells, stumbling as she walked. Her physician suggested exercises and orthopedic shoes. Mrs. D. reported the following reaction by her daughter:

> She watches how I walk. She wants to help with my exercises...She doesn't want to go out with her friends, she says there are too many things to do around the house. She never used to be close to me, but now she wants to be around all the time, especially on weekends. I've been falling a lot lately; Sally looks worried and scared.

The patient was once again brought to the Mental Hygiene Clinic in January of 1965. Evaluation at the time revealed much of the above information. Chief complaints at the time were continued difficulty

getting along with her sister, parents and classmates. Her school performance had declined during the past term, and she continued to prefer to remain at home rather than to socialize. She discussed her problems from her point of view during evaluation interviews. "I worry and think about my mother all the time. That's all I can think of during school. I worry about her falling. I worry about her dying. My school work is terrible. I might flunk French and Science." Diagnosis was: 1) reactive depression, 2) chronic anxiety.

Once again, individual psychotherapy with a female therapist was suggested. It was felt that treatment should be long term and should help her deal both with "the vicissitudes of her mother's illness" and "the task of puberty." In addition, separate counselling for Mr. and Mrs. D. was recommended. Due to staff shortages, no therapist was available to see her on a once per week basis, and contact with the evaluating resident was continued throughout the year (1965) once per month. Mr. and Mrs. D. were seen separately for individual treatment by a social worker.

Apparently, she was able quickly to establish a strong, positive relationship with this therapist. The format of treatment, a format which I feel has had important sequelae in my treatment of the patient, was one of a rather passive patient and a therapist who, according to her notes, "assumed a rather active role, often verbalizing for her what I felt were some of her fears and worries concerning her mother." She continued to do badly in French. Treatment revealed that the difficulties in French were related to feelings about the French teacher, a

woman who was described as strictly punitive, having her own family troubles, etc. She frequently embarrassed the patient in front of her classmates by calling on her for answers she could not know. It seemed clear at the time that her feelings were a displacement from her mother. For example, she would regularly change theme in therapy sessions from her mother to this French teacher. She did, in fact, fail the French course, having to repeat it the following year.

The following year, after a summer at camp, she returned to the same therapist, this time on a twice per month basis. In the resumed treatment, she seemed less interested in problems of school, friends, etc. Rather, according to records, she "seemed driven to learn the truth about her mother's illness." A decision was made to work toward ending the "conspiracy of denial and secrecy." She vacillated between thinking her mother was seriously ill and thinking "my mother is just nervous, that's all."

In October and November, themes in treatment were primarily: 1) arguments with her mother of the usual teenage sort but associated with extreme guilt and 2) her mother's illness. December brought continued discussion of these themes and, in addition, concern over going to see a therapist since only "crazy people" need treatment. In late December, she continued to pressure to learn of mother's diagnosis. Possibly precipitated by an exacerbation of her mother's condition, she expressed not only the need to know, but the decision to be told by her therapist. Mr. D. was consulted. He agreed that she should be told, and suggested his wife be told as well. Mrs. D.'s neurologist

felt that telling his patient the true nature of her condition would be contra-indicated, and Mrs. D. was only informed that she had a "disease of the spinal cord which comes and goes." As far as I can ascertain from the records, Mrs. D. was never given the diagnosis, though Sally's therapist stated in a summary that "probably Mrs. D. knows her true diagnosis."

In January, when she asked, the patient was told by her therapist of her mother's illness. She cried, revealed that she had thought it was arthritis, and expressed guilty feelings for her treatment of her mother. She asked if her sister knew and was furious when informed that Pam did not. Expressing the fantasy that she would be the one to tell Pam, she became even more angry about her sister's "stupidity." Several sessions later, she was clearly depressed. Repeated probing revealed that she had read about m.s. in the encyclopedia. She had few questions about m.s. or about her mother. It seemed that she was unable to deal emotionally with more information at that time.

With her therapist's encouragement, she was able, during the next several motnhs, to ask and receive much factual information about m.s. Her therapist explicitly took the stance of information provider. Intersperced with this informational dialogue, the patient apparently shared wishes that her mother would get better as well as wishes that her mother die. The latter wish produced extreme guilt, and she became concerned that she might become sick as punishment for her wishes. Moreover, she worried that m.s. might be hereditary.

The therapist was to finish her fellowship in June, and in

April began termination. As I read the records, it seemed clear that she was working well in treatment, that her fantasies with respect to her mother, her mother's illness, and her relationships with other family members which had long been denied were becoming available to her. When her therapist was forced by circumstances to impose termination, the patient was, according to the record, "beginning to show signs of self-punitive behavior, guilt feelings of being punished." She reacted to being told of the impending end of the treatment by crying profusely. She was further upset when, in the same session, further treatment with another therapist was recommended. She remained affectively unavailable for the remainder of the session. She became silent when her therapist interpreted feelings of being rejected, and then cancelled the next scheduled appointment by telephone.

Later the same week, the patient telephoned her therapist to terminate the treatment. She was convinced to come in and talk about the termination at which time she stated that she was better off when she knew nothing of her mother's condition, that it did no good to talk. In an apparent effort to "calm the troubled waters," she stated repeatedly that she had only the same problems that all girls her age have. Efforts were made to discuss the effect of her therapist's leaving, but she steadfastly maintained a rigid posture, denying (at least overtly) that it was hard for her to leave treatment, that she needed to condemn the treatment to make the loss easier to bear.

The final session brought a recapitulation of the themes of the past six months. She cried, discussed many of the fears of punishment,

contagion, suspicions of her mother's really being sick, etc. It was felt that "it is encouraging that Sally was able to talk about these feelings in this very emotionally charged session." A final conference with Mr. and Mrs. D. revealed that they were quite pleased with the changes they saw in their daughter's behavior. She was less moody, socializing better, a help at home, pleasant to be around, etc.

Following summer at camp, she was once again brought to the clinic in September 1966 as was suggested the previous spring. She came for ten weekly appointments, but apparently was unable to establish a working relationship with her new therapist. According to records, treatment focused almost exclusively on her "resistance to treatment," and the patient was reported as belligerent in manner, absolutely steadfast in her refusal to discuss any of the themes which appeared so sensitive the previous spring. Once again, her attitude became one of "talking does not change anything." Late in the summer, following a period of relative remission, Mrs. D.'s m.s. became active. Sally again assumed major housekeeping responsibilities, and, it was felt, was blocked in efforts to achieve the appropriate measure of independence for a 15 year old girl. She resented the enforced domestic duties, but was unable to express the resentment directly. She fought with her mother about "little things," however, life at home was reported to be relatively tranquil, including relations with Pam.

At this time, she was in the 10th grade. Although performing quite well academically, she insisted on changing her program to a commercial course. She refused to discuss this with her therapist,

but speculation at the time was that she changed course in an attempt to avoid taking more French.

Almost exactly one year later, at age 17, she again came to the clinic at the insistence of her father. Problems, as seen by Mr. D. were: "increased irritability at home, anxiety, and lack of social life." Appointments were scheduled once per week, and for the first month she was a "school reporter." According to the treatment summary: "In February, Sally responded to my attempts at explaining therapy. I recommended twice weekly visits, and she abandoned her defense of isolation, talking in a heated manner of her sister whom she called 'a dope, a slob.'" It was felt that the aggression toward her sister was an affective opening to the treatment, and with the increase in session frequency, content became more personal.

She began to discuss dating, describing her first exciting sexual encounter. A boy whom she had known for some time kissed her and she experienced sexual excitement for the first time. Strikingly, she stated, "I'm glad I can feel. I never thought I could. I am human." The relationship with this boy was short lived, however, with it's end, she became depressed, spoke in sessions about Viet Nam and reported an increase in fights with her sister. Moreover, she described feeling hopeless about treatment. "How can I understand if I don't know the words?"

Fantasies about death were revealed (prompted by the death of an uncle). She reported that she did not expect to live past age 26 (the age at which her mother had the first m.s. attack). She recalled

being told that she was born with "the cord around my neck," wondering why the doctor "bothered to save me." She wondered about her flat chestedness compared to her sister and mother, stating "maybe I shouldn't have been a girl."

As the school year ended, Sally's depression lifted as well. She looked for and found a summer job, began to interest herself in clothes and parties, and sealed off the previous material from treatment hours. Although due to resume therapy after a summer hiatus, she did not return to treatment until July 1974, following college and graduate school. She presented herself at walk-in clinic and was evaluated by a fellow intern and referred to me for "insight-oriented psychotherapy."

First Session

The patient arrived 15 minutes early for the first session. I recall thinking when I saw her for the first time that she is a strikingly beautiful, tall, slim young woman. She was dressed in a summer suit, having, I learned, come from an earlier job interview. She wore no make-up and presented the rather prim appearance appropriate for a job interview. When she introduced herself, however, I was surprised by the sound of her voice, which was whiney, shrill and reminiscent of an adolescent. As we entered my office, she rearranged the chair so that she would be seated at a 90° angle from me, rather than the face to face position the chairs were in when she arrived. She sat, placing her sweater in her lap protectively, and immediately

began to speak. This ritual of rearranging the chairs and placing her sweater or coat in her lap was repeated at the beginning of every session.

"I have no idea what you know from Marc [the evaluating intern]," was her first sentence, and, without waiting for an answer, she launched into a 10 minute discussion of having no idea what I knew and therefore no idea where to start. When I was able to interrupt, I commented that I knew some of what she told him, but that no doubt we would be going over much of it again. She replied that this really bothered her, that it was a waste of time. Rather than interpret what appeared to me to be, at least on the surface, a reaction to being "one down," I expressed some understanding that it is upsetting to have to go over and over the same things with different people. I said that I knew she was "nervous and upset" when she came to walk-in clinic and asked her to tell me how things have been for her since then. She began to cry profusely; she stated, through her tears that she had told Marc she was "confused" and that my incorrect word choice is exactly what she is uptight about, that talking doesn't help because there is no way to really understand. Taking a tissue from the table seemed to help her regain composure, and she continued without stopping to describe precisely and exactly what she expected from a therapist. She had, she said, told all this to Marc, but now needed to tell me directly. She informed me that she had many girl friends in therapy and that they called their therapists by first name. The therapists give advice, etc. She went on to describe her last treatment, stating scornfully that her

therapist used "cookbook therapy." She expected me to be forthright and to answer questions.

I outlined my role to her, stating, "You can tell me the things you want to tell me. It's up to you. I will listen and try to understand. When I have something useful to say, I'll say it." I then asked for her ideas of how therapy might be helpful to her. She again stated her anger at "not knowing what I know" about her. This time she added that this makes her feel "at a disadvantage." I commented: "beginnings seem difficult for you." She said, "not always, but I don't know what you know." Continuing, she spoke for the remaining few minutes of the session. We made a tentative schedule of morning appointments pending rescheduling when she began working.

To say that I was surprised by her behavior during the first session would not really be correct. I was prepared for the onslaught of negative, belligerent behavior. However, I was overwhelmed by it. Not only did I feel unconnected to the patient, but, by the end of the hour, somewhat unconnected even to myself. I recall wondering after she left whether there was anything in my attitude or behavior which called for her bellicosity. No, I thought. It must be something within her or within the interpersonal situation.

I have presented this session in considerable detail and will present the next as well because the pattern of her behavior persisted throughout seven months of treatment. Sessions were marked by a negative, withholding, argumentative quality which became, at times, paralyzing to the treatment. Note that in the session, she arrived, began speaking

immediately, took great offense of any comment, ignored questions, and rejected interpretive statements. Moreover, she revealed little about herself or her life, defensively controlling through demands.

In the second session, much of this pattern was repeated. She spoke for 15 minutes about the difficulty in finding a non-boring job, and about how she hated being bored. She was looking for a secretarial job although trained as a teacher (there were no teaching jobs available). She then told me about a professor at graduate school who had told her that people are bored with themselves, not with jobs. She looked up from her hands and told me that she did not want me to say this. Until this point in the session, I had been silent; now I asked if she had expected me to say that. She replied that she only wanted me to know that things can be boring from the outside.

She discussed the problems of moving from the home of her parents to her own apartment. Abruptly, she stopped speaking for several seconds. After this, the first silence, she said that something was wrong in her life, that something was "missing." She began crying, stating that she was frightened because she did not know what "it" is. In response to my question, she revealed that she felt this all the time, even when, like Saturday, Phil (her married boy friend) was with her. She said structure and activity helped her. Speaking at length about structure (job, etc.), she commented derisively about her friends who are satisfied "just getting up and going to bed." I reflected my sense that she seemed uncomfortable to some extent in all situations. She quickly told me that was not true, that she never had trouble "on

vacations traveling."

I asked her to describe "something missing." She said she could not. There were no words to describe it, but she was sure there was "something more" and she knew she could find it traveling. Time for the session ended.

These sessions were discussed thoroughly in supervision. Clearly, the sessions were rich in interpretive material. For example: the continuing theme of "not knowing what you know" was most likely related to family secrets about her mother's illness. Transference elements, most likely carried over from the previous therapy, were salient in the sessions. And it was noted that an important affective change occurred following mention of moving from the home of her parents to her own apartment. It was just as clearly pre-mature for such interpretations. The more immediate problem facing even the continuation of treatment was the striking lack of introspection evidenced. She behaved; she did not reflect on the behavior. Moreover, on the occasion that she shared her sense of "something missing," crying while doing so, she could not or would not pursue the feeling within. She went on to discuss structure, control, and verbal aggression directed at friends who wanted no more from life.

The decision to focus on helping her to develop the observing ego which seemed lacking constituted the initial goal of treatment. Since she did not ask of herself the questions which were required for introspective treatment, it became my position to ask them for her, demonstrating. Further, since she appeared ready at all times to argue,

moving away from a therapeutic alliance, I avoided any and all arguments or interpretation of negative transference.

The next session began with her arguing that the two dollar fee set by the clinic was too high since she was not yet working. My reply to her argument was a reiteration of clinic policy followed by a question about her sense of the therapy being worth something. She spoke about not being sure what she would get from the treatment, and having "gotten worse." She said she is always asking why of things and only wanted to know why she asks why. She agreed to pay the fee and then asked accusingly about what would happen when she began working. I stated we would re-evaluate at that time. She returned to the issue of "why," beginning to cry. As she cried, she said she does not know why she cries when discussing things with me--she never does when she talks to friends at home.

Consistent with the approach outlined above, I replied, "Yes, that is curious. I wonder what it is about you that causes this." She spoke about her friends not wanting to hurt and hence saying soothing things, giving advice. I remained silent and she continued speaking of "people telling you how to feel." I asked if this has been true in earlier years. She told me her aunts always told her how to feel. She never was able to talk back. I asked if she felt that way now. She said, "no--with other therapists" she did, but now she, "wants to get somewhere."

As if she were revealing too much of herself, she abruptly stated that this was a waste of time, that talking about therapy is

not therapy. This theme persisted throughout the remainder of the session. When time was up, she stated that our appointment Monday was okay, but that she wonders what would happen if there were a conflict with a job appointment. I said we could talk about it Monday if she wished.

With the Jewish holidays approaching, she became upset about an appointment scheduled for one of the holy days. I told her changing would be possible, but that I would be available for our regular appointment. She became quite angry at me for putting the decision on her, and she struggled with her parents' expected anger for "going out" on the holiday vs. my expected negative reaction for changing the appointment. Finally she kept her appointment, and her parents thought nothing of it. When I asked what were her fantasies associated with the expected reaction of others, she stated emphatically that there were no fantasies--only the realistic problems of going out on a Jewish holiday.

About a week or so later, she found a job as an executive secretary, and she stated that now she had "no evenings to myself." She began to speak about arguments she was having with friends. For example: Her friends tell her how tired they are after work, but she simply cannot understand that. They are so stupid. Discussion of the argument revealed that the friend's position was that she had more to do than Sally since she was married. Again, I asked about her feelings during this argument. Again, she stated, "I have no feelings about it." I replied, "Isn't that curious. Do you wonder why you had no feelings during the argument"?

She said she wanted to relax. She was trying as hard as possible to relax in her new apartment. For the first time, she mentioned that Phil was coming to visit that evening. She was looking forward to it, and, in answer to my question about how they spend their time together, she replied vaguely that they just "do nothing--go shopping or maybe watch TV or something." However, she was always able to relax when he was there.

For several weeks, she arrived 10-15 minutes late for each session, sat down and began speaking immediately of arguments, fights with co-workers, friends. Occasionally, she made mention of a fellow named Don whom she knew from college. Apparently he was calling her for dates even though he was aware of her relationship with Phil. Whenever she spoke about Don, it was in a scornful tone. She frequently commented that the mere thought of his touching her made her sick. Once, when speaking of Don, she commented off-handedly that his calling reminded her of Phil when they first met. I took this opportunity to mention that I knew little of the relationship with Phil. She told me that he asked her out for 10 weeks before she agreed to see him. However, when I asked about what attracted her to him, what her feelings were when they began to date, Sally replied that her old therapist was "always bugging me for feelings." She complimented me for (and warned me against) not "pressing" as much, but never did deal with the question.

During the third week in October, she got paid for the first time and we arranged a new fee of five dollars. The clinic policy

called for a $10 fee, flexible, subject to therapist recommendation. Since she maintained she could afford only $5, we investigated the reasons, including (on suggestion of Dr. Gerard) a detailed budget. I recall the discussion well, most specifically that I felt like a father discussing budget with a daughter. Sally had made a list of expenses which we went over. Her request for a $5 fee was quite reasonable and it was agreed. There was a short silence following which she asked if it would be possible to schedule an extra session. She asked of there would be an extra charge. I inquired about her question, and she revealed that sometimes, when she gets upset, she thinks it is a long time 'til the next session. She said she always decides not to call because she despises her friends who are always phoning their therapists about every little thing. Time was up for the session, and I recall wondering whether something in the earlier part of the session enabled her to express the dependency (and the importance of treatment to her) or whether she was telling me that she could have afforded a higher fee. There was ample evidence for either hypothesis.

This theme was continued in the following session. Shortly after it began, the phone rang and since the receptionist had left earlier, I answered the phone, making the call as brief as possible. She immediately asked if we could change the appointment time--making it later. I wondered if the phone call prompted her question. She told me her former therapist was greatly annoyed at calls during sessions and questioned me about my feelings. I avoided the trans-

ference interpretation, suggesting that her feelings were important. After several attempts to avoid the issue, she said she was annoyed by the call. I commented that it was interesting that she found it difficult to know her own feelings right here in the room. She told me I was wrong--that there is a difference between knowing and expressing. She knew; she was not able to express. Time is important, she continued, and gets upset when she doesn't get all her time.

As she spoke, she became quite tearful. She said she was awake most of the night before, crying. A television show she had watched made her think about the future and this upset her. She spoke about Phil, her job, teaching. Then she abruptly stopped crying and stated that she felt men had some nerve just calling up women they hardly knew. She continued, stating an incident that had happened with a man at work.

I commented on her change in mood, wondering aloud how we began to speak of this topic. She became upset again, spoke of the future with Phil. She talked angrily about not being able to call him at home and of his continued promises to leave his wife. I asked what about her got her into and kept her in the relationship. She wept profusely until the end of the session, needing in fact several minutes to compose herself before leaving the office.

The following session found her quite depressed. She spoke of not feeling competent, but backed away from this theme saying she might just be making problems for herself. Better to leave these things alone. I inquired about this and she revealed that to open

this area of life is to invite pain. She reminded me of a story told by Nietze of a man who looked for an answer, found it finally, and committed suicide. I asked if she felt that way about herself. She said she would not kill herself, but was afraid she would not be able to deal with a truth if she found it. In the next session, she asked me what we had been speaking about last session. After some difficulty, she remembered, wondering aloud why she "can't keep working on my problems--working to try to understand." She went on to spend the rest of the session discussing her relationship with Phil, mostly from a somewhat more introspective viewpoint.

It was clear that she had begun to be engaged in the treatment process. Still, there were no mentions of either early experiences, dreams, or, in fact, any mention of her family other than an occasional reference. Her mood had become somewhat depressed during our sessions, and she frequently cried. Since she so quickly sealed over affective states, and since she had now begun in sessions to ask questions of her own motivation, I began more often questioning of her experiences during sessions when she became upset.

On November 12, I told her that we would not be meeting on Thanksgiving day since the clinic was closed. She said that was okay and went on to discuss an argument which had occurred at work; I noted to myself that she stiffened and seemed tense at this point.

In the next session, she began speaking of avoiding things she did not like. I reminded her of the session we were to miss, commented that she had not mentioned it, and wondered if this were an example.

She said, "You therapists are all alike. My former therapist did the same thing, made a big deal out of vacation." She went on to state that she expected me to force her to have feelings about this. I reminded her that we were talking about the here and now in this room, noting that she seemed upset. She said she could not speak about everything at once, that she was "confused." She pleaded with me to give her a chance. She needed time, she said, and couldn't be pushed. She never did speak of her feelings of the missed session.

During sessions in the next few weeks, she struggled with her relationship with Phil revealing her own worries about the relationship. When possible, I helped her focus on her involvement rather than his transgressions of not phoning her when he promised, etc. Sessions were full of stories of Sally giving Phil a "hard time." She frequently reported arguments between them which started when she accused Phil of one infraction or another. It seemed to me that as she came to argue less with me, she argued more with Phil.

In early December, she began reporting that her friends were always calling her for advice. Jobs, love-lives, whatever the question, they always called her, and she felt a considerable burden. After several sessions in which this was a major theme, I commented that her feeling about her friends may be related to her feelings about therapy. She started to cry; spoke about feeling herself too independent for any real relationship. Speaking in terms, not of treatment, but of marriage, she slid away from the interpretation but spoke clearly of her sense of dependency and her inability to sustain closeness. Re-

turning to the issue of burden which had begun the session, she said that although she does not feel understanding is any good, that it doesn't change things, she has found herself recommending therapy to all her friends. However, she continued, therapists are not really people, they are only there to talk to. She had no thoughts that she might be a burden on me. That's my job, and so I must like it.

Phil continued to be Sally's major focus until Christmas. She became overtly mistrustful of him, trying to catch him lying to her. She revealed much about her experience of an inability to leave Phil. She hoped he would become so enraged at her constantly picking fights, that he would tire of her. On several occasions, when she did catch him in a lie, she tried to end the relationship, but each time, she found herself succumbing to his entreaties to return. Moreover, she began to wonder whether she would react positively even if he did, as promised, leave his wife. Reflecting on this possibility, she expressed the fear that she might lose interest in him if he were really available. She told me of a number of past boy friends who were "too available."

With the approach of Christmas, I brought up the fact that I would be taking a vacation between December 13 and January 2. She displayed no reaction, never mentioning the vacation, never expressing any interest during sessions (although I invited it several times). In the final session before the holidays, she was pre-occupied with her relationship with Phil. She had resolved to end the relationship, stating over and over his faults and her need to "take control of my own life--be strong enough to live without him." Again, consistent with

the basically non-interpretive approach I had been following, I did not connect her apparent need to be strong and controlled with the hiatus in treatment.

I recall considering the treatment during my vacation. The pressures of both the treatment and the internship were lessened. During the three months of Fall, I had been variously pleased with individual sessions and depressed when I was successfully engaged in arguments with her. Given the distance of vacation, I was, in general, pleased with the work. Although still not working interpretively, I felt that initial goals of treatment were realistic and appropriate. Moreover, the patient seemed to be making progress. She was less argumentative with me, less brittlely defensive to my comments. She had begun to consider her own part in her unhappiness and was actively struggling with her characterological style. I felt that an alliance of sorts had been accomplished. Although there had been occasional references to her family, she still was not able to confront her childhood or adolescence; and this fact was a source of frustration to me. To some extent, I felt inadequate as a therapist since she was unable to discuss these areas which were clearly so important and painful. Realistically, of course, the inadequacy I felt was an echo of her inadequate feelings. Still, I wondered, why can't she feel comfortable enough in treatment (with me) to face these areas of herself.

Following vacation, the first session in January set the course of the next several months work. She began the session by informing me that she had decided to take several adult education courses, that the

time committment was such that she would have no evenings to herself if she continued in therapy two times per week, and that she thought she would like one time per week. I replied that two times per week therapy is for herself, that I strongly urged the continuance of the schedule, but that it must be her decision. She said she would let me know and went on to discuss the fact that she was still seeing Phil. It was as if much of what she had told me about her resolve to break up with him had simply never even been thought much less resolved. She also apoke at length about another man whom she had dated several times and whom she won't be seeing again. Apparently the "new" man became angered at her "coldness." In fact, she reported that she spent the entire evenings with him attempting to avoid situations in which they would be "close." She worried all the time about his trying to kiss her goodnight.

I recall thinking during the session that this theme was likely related to the vacation hiatus and her growing involvement with treatment. However, I had learned that such interpretations were excuses for several sessions of arguments. I avoided this, asking instead about her sense of coldness and avoidance of this man. She was unable to deal with her own feelings. Instead, she spoke for the rest of the session of the man's innuendoes, sexual and otherwise.

For several sessions, she reported on arguments at work with bosses and co-workers. In the middle of January, she became silent following one of the "argument reports." Breaking the uncharacteristic silence, she told me she and her friend had been discussing therapy--

what type is best. With this introduction, she launched into a diatribe about therapy and therapists which lasted several sessions. Much of what she said was material previously reported. However, the vehemence of her sustained attack was unusual. She demanded "feedback" from me when she "reaches" a dead end. She accused me of being a "stone wall." I interpreted the affect, stating she seemed angry. She insisted she was not angry--only frustrated. She could not be angry, she said, because I am not a person--only a therapist--and there is "desk between us." I shared with her the sense that she was attempting to put me in a position of being unable to respond, being on the one hand a "non-person" whose words did not matter, and on the other hand demanding of me feedback. She replied that I should be "a wall which gives feedback." She went on to reveal an important fantasy. She knew of a friend's therapist who calls her friend at home, who visits her friend's home, who goes to movies with her friend, etc. I commented that this seemed important to her, and I asked her to tell me more about it. She replied only that she would like something in between this and that. Somehow, therapy should be more helpful. This therapy really is not. She revealed that she expected to miss treatment over the vacation but did not. She told me of her "indifference," asking about other forms of therapy.

Session after session went by, characterized by her alternately insulting or arguing with me and pleading for advice on how to proceed in therapy. Her behavior seemed both a dependent manipulation of the therapy (a position probably with important dynamic derivation) and a

defensive lack of introspective style. Even though she had been in treatment on and off for her entire life, it was felt that she had very little education in the process of therapy from the point of view of how the patient works. Consistent with this position, I undertook to teach what treatment is about. In the third week of January, during one of her complaints that she was at a "dead end," and that therapy is useless, I recalled her initial complaint and told her that therapy was the two of us working together to try to understand what about her made her have these problems.

She reponded immediately, grinning and stating that no one ever told her that before. "If only someone had it might have been different." I noted her expression of pleasure and asked her about it. She said I was the first to answer her question. Moreover, all other therapists only asked what her ideas were. I replied that her ideas were important--"part of what we do is discover what your ideas are." She restated that when she reaches a dead end, she needs help getting started again.

I recalled that in a sense we had hit a "dead end" at vacation, that she had been working, but could not get started again. She agreed, but said that therapy really was helping. Even her friends noticed, she said, what a change there was in her. She grinned again and said it was "part of the game." She said she was testing--to see if I listen. I said I was listening, but wondered about the game. She went on to speak about her friend and her friend's therapist.

A few minutes later, she returned to my question about her

friend's therapist. She was sure, she stated aggressively, that my question was prompted by my own curiosity to know about other therapists and their patients. She then demonstrated her "game" by telling me that there was more that her friend had told her, but in confidence, and she could not tell me.

In the next session, after several stories of arguments, she spoke at length about her parents. She had argued with her father over some trivial matter and commented to me that this represented a change, the result of therapy. I asked for clarification, and she said she never would have done that before. I looked puzzled. She said, "that's another thing--I don't know where to begin." I told her that I would ask if I didn't follow something. For the rest of the session she spoke about the family's response to mother's m.s. Sally insisted over and over that she needed to be the strong one who accepted the fact of the illness. Everyone else was always upset and would never accept the illness. She even recalled an early memory of her mother speaking on the phone informing a friend that "it's serious, but the doctors don't know what it is." Although clearly upset, she remained in control all her life because no one else could. Mother lost the will to fight when she was told that she had a "disease of the spinal cord." She became "helpless." As she said the word "helpless," she became tearful, a fact on which I commented. She said she was upset because she hated helplessness more than anything. I repeated that it was she, right now who seemed upset. She replied that she never feels--she can't afford to. She then told me a story of a discussion with her aunts years ago

about euthanasia. Sally believed in it, and she told her aunts that it's "okay to get rid of vegetables." She reported that her aunts think her cold, but that she feels it's only realistic.

Reaction to this tremendously important session was immediate. The next session began with 20 minutes of non-stop reports of boredom at work. I commented that I was puzzled why she was talking about this now. Sally launched into an attack of: "I expected you to want me to continue from last time." Moreover, she claimed I was not interested in the present, only the past. Indeed, she continued, she really had no idea what I knew from previous records or even what I knew about m.s. I attempted to draw her out rather than engage the argument, and she revealed her fantasy (of course not as a fantasy) that I had gone to the library to look up m.s. I asked if she had done that. She replied, "a million times."

In session after session resistance was extreme even for this patient. It seemed that having begun to explore her own feelings, she was now struggling to close over the past. In her characteristic way, she took to the offensive, and much of my efforts were devoted to keeping out of arguments. Having seen her by this time for six months, I had become adept at this task. However, the more successful I was, the more she escalated the level of her anger, and the more frustrated I became. In supervision, I began questioning the approach I had been using. It seemed to me that we were, in a sense, locked in a vicious circle, accomplishing virtually nothing. For example, she arrived one day toward the end of February and announced that she would only come

one time per week because she had "no time to herself." She had gotten a part time job teaching typing in the evening--at a time which did not conflict with therapy, and was feeling "tired all the time." Once again I attempted to draw her out on other thoughts about treatment. She revealed that she did think the more you come, the more you need treatment. She wanted to "see if she could do without it." She then insisted that there was no "deep reason for not wanting to come," and recalled her former therapist making a big deal of lateness. She began speaking of not trusting me because she never knows what I am thinking, that I was probably thinking she came late because of some deep reason. To all of this, I said nothing, and she became more and more furious. When I commented on her affect, she insisted I was telling her to speak about something else. She said further, that she felt she was being graded on feelings, revealing that her former therapist required her to imagine feelings, (for example, her mother's funeral). When I asked after that experience, she said it was not important any longer. Of course, not every minute of every session was filled with arguments, but, in general, those that were not, had a vacuous quality of words for their own sake. Whenever she began to focus on herself, whenever she revealed a significant fact or memory to herself (or me), she reacted with a fierce non-interpretable resistance.

At the beginning of March, Dr. Gerard and I were going over several recent sessions in supervision. As I presented the material, he became angry at her, and I exclaimed that he was expressing what I had been feeling for weeks. We set about assessing the therapy anew.

Several things seemed clear. She was not likely to leave treatment. In fact, we speculated that there was some dynamic gratification in the constant abuse she was able to heap on me. Further, any radical change in approach would have consequences in the transference. It was decided to confront her directly with her treatment of me, an approach which both delighted me in that I would be able to "get back" at her and with which I was most uncomfortable for the very same reason. I felt (and still do) that interpretation rather than confrontation is the appropriate model for psychotherapeutic intervention, but, with Dr. Gerard's encouragement, I decided that this approach was worth a try.

Following supervision, I though a great deal about my own anger and about using that anger in a confrontation with my patient. During the next several days, I realized that my own experience was one of distance from her. My anger served to distance me, to separate me from the world of my patient. I was actually uncomfortable about this at first, but within a few minutes, it occurred to me that Sally may well have been using anger in this fashion. I felt that anger served an enormously important defensive function for her, and that since the Christmas vacation she had been increasingly employing aggression in the service of distance. I became more comfortable with my own anger, and I realized that confronting her aggressively might reach her affectively in a manner which I had previously experienced as impossible.

Her attacks reached a fever pitch toward the end of the next

session. She has been speaking with one of her friends who was also a clinic patient and "discovered" that I would be leaving in June (a fact which was made clear to her in the evaluation interview and in the first session). She insisted that she had been "tricked" and spoke again of wanting to come only once per week. Moreover, she accused me of insisting on a twice per week schedule, not for her benefit, but for my own as I "needed a certain number of hours to pass the course." Speaking in an almost hysterical manner, she stated that, "You need me more than I need you."

She began the following session as if the session before had not occurred. She chatted about her starting her new teaching job, about how excited she is to be "doing for myself." After a few minutes, I commented on the session before stating only that it seemed to me we had been discussing important things. She launched into the expected tirade. I stopped her and said that I had a few things to say. She stopped and listened.

The Confrontation

As discussed in supervision, I began by telling her she had a great deal of nerve questioning my motives, that in the first place I had never given her reason to do so and in the second place, regardless of her previous therapy, I was a separate individual. I said I considered it my job, not to tell her how to feel, but to help her understand the feeling and thoughts she does have. Moreover, if she really felt 100% of the lack of trust she stated, it was curious that she sought and continues to come to therapy. It was my feeling, I offered,

that her behavior in therapy must serve some other purpose; I said my sense was that she felt I was "lying in wait--waiting for her to slip."

I told her that the purpose of psychotherapy was for the two of us to attempt to unravel the reasons for her own misery. Reminding her of the reasons for seeking therapy and reviewing her comments about her experience of emptiness and of "something being missing," I spoke clearly and directly of her unremitting provocations of me whenever I attempted to focus the session on her experience and said that if she wanted to argue here, in treatment, exactly as she reported arguments elsewhere in her life, we would, in fact, not progress in what I felt psychotherapy ought to be. What I thought therapy was all about, I offered, was for us to try to examine her world, her feelings, her memories, not to bicker and argue.

Then I shared with her my feeling that there had been a change since the vacation, a change for the worse. I reviewed my sense that there had been a slow bond developing, but that something seemed to have happened to change that.

She seemed slightly taken aback, but only slightly. Again, she questioned my motives, repeating much of her litany about my "doing well in the course." Since she planned to meet with a professor of hers in the next scheduled therapy time, she decided to keep that appointment, missing therapy. In addition, she would miss the Thursday session for at least the next few weeks, she said, "to see how it works out." I told her my recommendation was and is twice per week, that she would be billed for missed sessions, and that I would be in my office during her

sessions if she wanted to use the time. Time was up for the session. She left as angry as I had ever seen her. She did not show for her next session--nor did she call--and I was sure I had no patient.

She did, however, show for her appointment one week later. She began speaking at once about her father, a subject which was prompted by her father's abuse of her mother at a family dinner. She spoke in urgent tones, clearly speaking of important things. Again, I did not draw the connection between the "abuse" of the session before and her choice of topic. I listened while she poured out memories of her father's treatment of her mother throughout the years. As she spoke, she stated that she had never mentioned any of this to another person. She even questioned why she is saying it now since she can't do anything about it. In fact, she cannot even talk back to her father, she simply acquiesces to his incessant and capricious demands. At the end of the session, she commented, "see you Thursday." Thursday she showed up on time, continuing the exposition of her relationship with her father for the first part of the session. About half way into the hour, she told me she was worried about a competency exam she was to take for her special education license to teach, a license necessary to keep the newly found job. In the course of this, she asked that the session time be changed on the day of the exam. I agreed since the time conflicted, and because I felt some accomodation was appropriate.

Turning to her relationship with Phil, she spent the remainder of the session introspectively concerned with her involvement with him.

There was clearly a new quality to the way she spoke. She wondered what kept her in a relationship she knew was "going nowhere," wondered what held her. She said that the therapy was helping her understand that she did not want to continue with him (although I did not know how), but she felt unable to call an end to it.

Over the next several weeks, this change persisted. There were no significant arguments with me, and she reported much about the relationship with Phil. Although still not really providing a three-dimensional picture of the relationship, she seemed to be struggling with her own feelings in therapy. I felt an important reason that I was not getting a full understanding of Phil was that in a sense, he was not a real person to Sally. He was a bundle of fantasy, dynamically determined, but far from available. What seemed important was continued focus on process, continued pointing to her behavior during the hours and encouragement of introspection. When, for example, she reported that she was becoming indifferent to whether Phil came over on the weekend in the same session in which she spoke at length about fights with one of the bosses at work, I offered the following: "Isn't it curious that you seem to need an area of fighting in your life. As you become more indifferent to Phil and stop arguing here in therapy, you begin arguing with a boss at work." She was able to see the connection, adding, "Well, I guess it's true, I did have 'an attitude' at work."

In April, her teaching job prompted much material relating to her own experience in school. One day she spontaneously offered the comment that "maybe early experiences are important." Several history

sessions followed in which were recounted much of the school material reported in the historical section of this chapter. She spoke at length, and with genuine involvement of the French teacher and of her own feelings of humiliation in the classroom. For the most part, I listened, only intervening when she turned outward describing rather than reflecting. She both enjoyed being a teacher and, curiously, felt uncomfortable in the role. She described not being able to take herself seriously as a teacher. When, for example, students called her Miss D., she sometimes did not answer because she thought, "it must be another Miss D."

In an important session at the end of April, Sally said she was sad quite often because she had been thinking of her old French teacher. When she called on one of her students in class, the student had a look of terror on her face and it reminded her of herself with the French teacher. I commented that it seemed she was having lots of thoughts and feelings which she had not thought about for a long time. She agreed, stating that what bothers her is that she doesn't understand them. If only she could find the key to understanding, she would be less sad. Continuing, she said she thought the feelings she was having were related to her feelings about herself, but she could not find the "key." She said she felt now that the past is connected but she has no memory of it.

The next session brought a memory of being sick with a cold sometime in elementary school. She remembered not ever being sick enough to be taken care of, or even to stay home from school. She then

told me about her friend who is "super-depressed," does not know why and is "going nuts." She said, "I tried to get her to look to the history of it. I was to her as you are to me." She advised her friend to enter therapy and told me the constant bad mood would soon make her (Sally) angry if the friend d d nothing about it.

I was relatively pleased with her involvement in treatment. As Dr. Gerard stated in supervision, "She is becoming a patient. Starting from minus 100 on a scale, she is now approaching 0, the beginning point." However, although the beginning point was being reached, so was the end point--at least for the therapy with me. By the beginning of May, I was experiencing uncomfortable feeling that termination had not been a salient issue for at least one month. Since at the time, I saw no way of continuing with her, as I was unsure of my own plans following internship, I resolved to bring up termination in the next session.

On arrival, she stated immediately that she had something to talk about. What, she wanted to know, would happen in June when I left. I told her that only the slimmest of possibilities existed for us to be able to continue and that we should plan to stop. She asked, "What then?" I suggested further therapy at the clinic or referral to a private therapist. I asked after her feelings and for the rest of the session, she struggled with the end. Private treatment was out, too expensive, and she did not want to start with anyone new at the clinic. I drew her out on what that might be like. She revealed her fantasy that it would be the same thing all over again. She called it "the testing." In answer to my request for clarification, she stated, "You

know, the picking, the arguments. All the things which changed when you confronted me." Following this statement, she asked over and over about the administrative procedure for transfer; who would decide? When? She went into a long list of grievances about the way her "case" was handled, stating if she knew it was "terminal," she might have insisted on a "permanent" person. (I did not comment on her slip.) Becoming angry as she spoke, she stated that she knew I would hassle her about her feelings, all the others did. I commented that she was doing what she had done earlier, pre-judging. She agreed, but said she could not help it.

She said she felt glad as well as sad about the termination, explaining that she has gotten much from the therapy. Now, she is able to face her feelings in a way she never could before. Perhaps, she said, she would not continue at all since she can't continue with me. I acknowledged her mixed feelings and added that she seemed puzzled by them. I reminded her that this issue of "should and shouldn't feel" had come up before, in the context of her aunt's telling her what not to feel. She became tearful, remembering those events and commenting on them for the remainder of the session.

In the following session, she demonstrated a dependence which she had only previously hinted at. Stating she was "bored" with work, she asked if I knew of any job counselling places or books which would help her change careers. I questioned her request, stating that she knew how to find such books or services. I wondered aloud what prompted her request. She said only that she was bored at work. There was a

short silence, ended by her saying she had wondered what would happen to her students when the course she was teaching ended. She thought it a little like therapy and put herself in my position. It made her think that not only does she have feelings about ending therapy, but I probably do too, since we are both human. I remained silent; she continued stating that she has both sad and glad feelings about the end of the semester. She offered the fantasy that even though I have had training in "terminals" I must have feelings too. I asked what thoughts she has had. She offered that I might have different feelings about different patients. In a somewhat obsessional manner, she went over and over her thought that I, too, probably had mixed feelings. After several minutes, I asked if she wondered if I did, in fact, have such feelings. The uncertainty of an answer was too much, however, and she stated flatly that she knew I did but that my training had taught me how to handle the feelings. The closeness of the previous few minutes seemed unbearable for her. She sat up straight, looked first at her hands and then at me; she launched into a verbal attack on me, stating that I had told her that she could speak about anything, that she had wanted to speak about changing careers, and that I had "forced her" to speak of "terminal." The session ended with Sally angry.

Between this session and the next, it became possible for me to transfer Sally to the Psychological Center at the College of the City of New York. At the beginning of the session, I presented this possibility. She reacted by saying she would think about it, but that she was unsure whether or not she wanted to continue therapy at all. The re-

mainder of the hour was spent with her informing me that she had given Phil a "super hard time" over the previous weekend and is sure he will never call again. I related her "solving all her problems" to the ending of treatment. She rejected the interpretation, stating that she was pushing him away because she was "indifferent" to him. She went into detail of the hard time she gave him, and I felt by the end of the session, that she had acted out her feelings about me and about termination over the weekend. Further, I recall being acutely aware of the process which was occurring, but feeling completely unable to make it available to her. There were only two sessions remaining, and the possibility of her continuing was now extremely remote.

She missed the second to last session. A torrential downpour snarled traffic, preventing her from arriving. I was convinced, as I sat in my office waiting, that she had chosen this as the least painful way of terminating. Although aware of the traffic problems, it never occurred to me that she could be experiencing difficulties with subways. The next morning I received a message that she had not kept the appointment because of the weather. Somehow, the surprise of this message made salient my own involvement in the termination process. Clearly the final session in this stormy treatment was to be a difficult and painful experience for me as well, one perhaps I had wished to avoid.

She arrived a few minutes late for the last session. She said she had spoken to her family and friends about transferring to the Psychological Center. They all agreed that the neighborhood was entirely too dangerous, that the benefit of continuing treatment was

outweighed by the danger. In fact, she said she knew she would accomplish nothing because she would be worrying all through the session that she would be mugged when she left. I reminded her that many thousands of people attend C.C.N.Y., for the most part without incident. I wondered if there might be other reasons as well. She said she wasn't sure but she thought she could do without therapy now. Things were much better in her life. I agreed, but continued to comment that she had made a beginning, not an end. I recalled that much changed in her ability to look at herself, but that much was left for her to do. She became quite tearful, saying she had no idea how to begin. She tries, but she needs help doing it. I told her that my recommendation would be for continued therapy and that I would make the suggestion to the clinic administration. She asked if I would select the therapist and I told her no, but that my recommendations would be specific, according to my assessment. Crying, she asked what would happen with a new therapist. I responded by telling her that much depends on her investment in change, and reminded her that she often came to sessions only to struggle not to reveal herself. Additionally, I reminded her of her sense of therapists "lying in wait" in the harmful way and suggested that these are feelings which might be problematic. She choked out that she needs help with this. She became less tearful, looked up from her folded hands, and told me that I had helped her see so much of herself. Maybe she would continue with a new therapist, but maybe not. She thought she would take a vacation over the summer, then, in the fall, she would make the decision. I repeated my recommendation, told

her that I too felt our work together had been productive, wished her luck, and stood up. The chapter was ended; I wondered if there would be another for this young woman who wants and needs help so much, but who fights with such fury against herself.

Postscript

Through the process of reviewing literally hundreds of pages of notes, I now feel this therapy represented a positive experience for Sally. Certainly no success in terms of accomplishment of therapeutic understanding, the treatment did, nevertheless, provide important experiences for her. First, she learned to be a patient, as Dr. Gerard so aptly pointed out to me. The process which occurred, helped her to know the style of self-questioning necessary for psychotherapy. She was beginning to make tentative steps toward examining painful memories, convinced, I believe, that the experience would destroy neither her nor me. The questioning, non-interpretive role I assumed and the aggressive confrontation permitted the patient to begin to experience an inner world, a world which she had struggled to deny. Unlike her previous therapists, I did not interpret in a manner which she could construe (as she all too easily did) as an attack. She was in no way ready to come to grips with unconscious process; her entire defensive style was organized around the denial and projection of feeling.

It was at this level which I encountered her, and the confrontation which occurred in March was overtly directed at style, but addressed itself to earlier developmental levels as well. I believe

that expressed aggression allowed the patient to establish the therapeutic alliance which permitted her to be, to own her feelings.

Termination issues were expectably deined. Much of her difficulty centers on the long term progressive illness of her mother. Death and fantasies of death no doubt played a large role in her childhood (see for example, her memory of the euthanasia discussion with her aunts). In attempting to cope with termination of therapy, her slips using the word "terminal" for terminate further suggest the valence this issue had for her. She defensively returned to the argumentative rejection of me which transferentially recapitulated her relationships in childhood. However, rather than abandon the approach to the therapy I had been following all along, I again focused on the process. It was my feeling at the time that this approach had the highest probability of maintaining her motivation for continued therapy. I have recently been in touch with the Mental Hygiene Clinic and was informed that she has, in fact, continued in therapy with a current Psychology Intern. To the extent that she was helped to continue therapy with a changed perspective, I feel the goals were achieved.

The key aspect in the changed perspective, I think, resulted from the aggressive confrontation. It's meanings and effect will be the focus of the next chapter. I will attempt to demonstrate the thesis that the expressive use of my anger provided the necessary and sufficient conditions for this changed perspective.

CHAPTER III

DISCUSSION: The Expression of the Therapist's Aggression as a Psychotherapeutic Technique in the Context of the Case

Introduction

It is the thesis of this dissertation that the therapist's feelings of aggression toward his patient can, under certain circumstances, be therapeutically employed through direct verbal expression in the treatment hours. In the case of Sally, a turning point occurred following my aggressive confrontation of her. With the case as data, I will discuss the positive effect of using aggressive confrontation actively. My intent is to thoroughly review this case in an effort to stimulate interest in investigation of a technical procedure which, though not unheard of, is unusual in the literature. To my knowledge, no other presentation of this scope is currently available.

In order to gain some generality from my examination, I will use the term psychotherapy to mean a traditional, dynamically oriented individual form of psychotherapy in which the therapist and patient interact primarily in the verbal mode. Although not restricted to psychoanalysis per se, what I will be referring to as therapy will be psychoanalytically oriented forms of psychotherapy. Futhermore, I will assume the therapist, in giving expression of aggression is sufficiently in touch with himself to be reasonably comfortable and accurate in the assertion that his aggression is in response to the patient's transference and is not a product of his own neurotic needs.

I am referring to the behavior of the therapist in which aggression is consciously involved. Certainly it is common for therapists to experience a range of affects toward their patients. The literature in this area is extensive and suggests that therapists' feelings about their patients provide significant material for understanding the patient. However, expressed aggression has been dealt with primarily in terms of counter-transference neurosis, as a problem with which the therapist has to come to terms without burdening his patients.

Aggression is a concept which suffers from both over use and lack of precision. Throughout history scholarly and scientific arguments have focused attention on it's basic nature, it's direction and it's purpose, but aggression remains an elusive concept. I shall neither review thoroughly nor discuss this literature in depth. However, in order to define my behavior and my patient's response to the aggressive confrontation, a short discussion of aggression is necessary background.

Psychoanalytic theory states that aggression is derived from the death instinct. Early writings of Freud suggested that aggression is a part of the sexual instinct, but by 1915, a separate aggressive drive was postulated. In 1920 this was elaborated into the death instinct. A postulate of considerable controversy, the death instinct, was thought of as a drive toward self-destruction, and externally directed aggression was conceived of as a re-direction of the organism's innate striving for the tensionless state of death. Throughout life,

a being was, to a great extent, the product of the vicissitudes of the struggle between the twin separate and distinct drives of sexuality and aggression.

The Kleinian analysts emphasized that aggression is a fundamental motivational force from the moment of birth. Postulating an innate externally directed basic aggressive drive, they suggested that much of the infant's world is a function of hate, rage, envy, etc., as well as of love.

Although the death instinct and the Kleinian theory of aggression remain highly controversial today within analytic theory, the generally accepted notion is that to behave aggressively is to give form to the basic drive to annihilate, to destroy. The aggression itself, as an energy source, is not directly observable. Rather, affects (anger, rage, etc.) and physiological changes (respiration, heartbeat, etc.) are behaviorally manifested.

Comparative psychology, anthropology, sociology and other disciplines concern themselves primarily with the precipitants of aggression and focus attention on their effects. Less concerned with overall theory of personality, the nonpsychoanalytic disciplines employ numerous, sometimes mutually exclusive definitions of aggression. Such definitions range from physiological to territorial.

Webster's dictionary (1966) is vague. Defined as "an offensive procedure; esp. an unprovoked attack," the term includes scholarly definitions, but avoids issues of motivation.

Aggression in an interpersonal event is an enormously complex

process. At minimum, it requires an aggressor, an object of aggression, and an aggressive message. However, it is often not a clear and unambiguous process. In order to examine the effect of my aggressive confrontation with my patient, each of these elements needs separate consideration.

An aggressor can form an attack in a number of ways. The form can be located on a continuum from active to passive and from direct to indirect. For example, malicious gossip between two persons with reference to a third may be an example of active but direct aggression. It is active in the sense that action (the gossip) is expressed, but it is indirect in that the recipient is not the object. A therapist's inappropriate silence could be passive direct aggression. It is passive in the sense that the silence is not an action but a withholding of the action. It is direct in the sense that the object is the direct recipient of the aggression.

Intent and awareness of aggression are also aggressor variables, and they may affect the interpersonal event as well. In the examples cited above, it is possible that the intent of the gossip was not primarily aggressive to the third person, but rather any of a number of other intents; and the therapist may not have been intending attack. Awareness complicates the issue further. Even if the aggression is unconsciously motivated, the aggressor may not be consciously aware of it.

From the viewpoint of the object of aggression, perception of the event is salient. Regardless of aggressor variables, the object

may not perceive the event as aggressive, may perceive it as aggressive but deny the aggression, or may directly perceive it accurately and respond to it. Moreover, aggression may be perceived where none exists.

Aggressive content is, of course, variable as well. It may be mild reproach or it may well be physical attack. The issue here is not to categorize all the possible forms of aggression, but rather to suggest the complexity of the term. Each variable is independently identifiable; yet each interacts with the others in any interpersonal event containing "aggression."

Although usually a word with negative connotations, aggression can be seen positively as well. Storr (1969, 1972), for example, links aggression to the need for mastery, for dominance over the environment. He suggests that aggression in the service of mastery is responsible for considerable human productivity. According to this view, aggression turned to destructiveness is an aberrant state rather than a normal innate drive. Clara Thompson (1964) states, "Aggression is not necessarily destructive at all. It springs from an innate tendency to grow and master life which seems to be characteristic of all living matter. Only when this life force is obstructed in its development do ingredients of anger, rage or hate become connected to it" (p. 179).

Throughout history cultural folklore provides anecdotes reflecting positive aspects of aggression. Young children are told by their parents, "This hurts me more than it does you," when spankings and other punishments are administered. The relationship between

Jehovah and the Jewish people provides amplification of this positive connotation. Certainly not a supportive or forgiving God, Jehovah demands a great deal from his followers. Nevertheless, the Jewish people have maintained their faith in the face of almost unbelievable suffering on account of it. There is aggression, I think, implied in the harsh, punitive relationship of Jehovah to the Jews. However, there is more. There is a specialness explicit in the belief that the Jewish people are "the chosen people of God." In the name of specialness, I think more is expected and punishment (aggression) results from not living up to the higher expectations.

This relationship between specialness, heightened expectation, and punishment for failure to achieve the higher expectations occurs in more commonplace situations as well. In any group the special chosen one assumes a place of increased perquisites, but also increased responsibilities. For example, in a classroom the "teacher's pet" is often punished more severely for minor rule infractions than are other children. Higher expectations are bound up in the role of the special, and aggression results from disappointment when the special one does not live up to the higher expectations. Thus, the aggression assumes a meaning of caring, of specialness, and of high expectations.

In the discussion above, it was my intent to suggest that as a concept, aggression is multi-faceted, and not easily definable. In the context of the case I intend to discuss, I shall use the term aggression because it most nearly describes my behavior at the critical

turning point. That is, I clearly attacked my patient verbally in a direct, angry manner. The confrontation was not, however, aggressive in the classical psychoanalytic sense of the term. I did not intend to destroy, and I will argue below that my patient did not perceive the aggression in the sense of attempted annihilation. From my perspective, a conscious, deliberate decision was made to use my anger actively and therapeutically in the context of a serious impasse. Following supervisory consultation I was comfortable with the decision, and comfortable as well that use of my aggression was motivated by my assessment of the patient's best interests.

The confrontation itself will be the focus of this chapter, and the chapter is organized as follows. First, to expand on the case presentation above, I will review briefly the treatment prior to the confrontation, present the confrontation session in considerable detail, and review briefly subsequent events. Secondly, I will discuss the issue of my patient's perception of my behavior during the session. I will suggest that she not only perceived the aggression, but that such perception was crucial to the positive resolution of the impasse. Following this, the major formulation of the case will be presented. I will examine the meaning of my aggression to the patient and will suggest that in it's meaning an understanding of the turning point is found. Fourthly, I will discuss several alternative formulations, although less plausible, I think they provide some input for understanding the use of aggression in psychotherapy.

Assuming that aggressive confrontation did provide a turning point, I will then investigate whether the case reasonably could have been treated without my expression of aggression. Considerations of process follow. Lastly, I will discuss general indications and contra-indications for the use of expressed aggression by the therapist.

Summary of the Course of Treatment and Review of the Aggressive Confrontation

The patient entered psychotherapy with both a pre-formed negative transference and an aggressive combative style of interaction. Defenses of denial, projection and isolation of affect predominated. In spite of that, she attended her sessions regularly and appeared to be suffering in her adaptation to life's demands. Throughout the first three months of treatment she seemed to be making slow progress toward developing a trusting working relationship in therapy. During this period I had been following an approach of helping her develop a questioning attitude about her own behavior while simultaneously avoiding her numerous provocations to argument. The vacation hiatus at Christmas seemed to rupture the developing bond, and sessions after resumption were characterized by an escalating assault of accusations toward me and therapy. Her unremitting direct aggression and her projection of aggression onto me resulted in a serious impasse.

Although unconscious determinates of her aggression were likely a function of life-long feelings of abandonment by her chronically ill mother and her ineffective, though bellicose father, which were re-integrated in the transference as the result of the "abandonment" of

vacation, she was not in touch with these feelings. She denied the loss and experienced only rage, projecting aggression onto me as well. Session after session saw the level of attack increasing inversely to my efforts to avoid arguments. What became increasingly clear was that a different approach had to be tried.

I decided upon a direct confrontative approach in which her aggression, her tone, and the inappropriate nature of her behavior were forcedly reflected to her. The key phrase here is "forcedly reflected." There can be no question that I expressed anger. The tone, the word choice, the forcefulness in the interaction were unmistakably aggressive in the sense described above. Furthermore, there is no doubt that in the context of this treatment and at this stage in the process I experienced anger and frustration. I also experienced gratification in the expression of my anger. Now it is important to note the context. Months of unremitting intractable hostile behavior had been directed at me each time I commented or made an observation during sessions, my meaning was ignored and a tirade of abuse was unleashed. Although I was successful in not colluding by arguing, there was nevertheless a collusion in not doing therapeutic work. A stalemate was effected to the detriment of the therapy and the frustration of the therapist and patient.

The session following my decision to aggressively confront provided the opportunity. She opened the session with a "chatty" discussion of her new teaching position, a dramatic change from the end of the pervious session which was filled with almost hysterical

accusations against me. I commented that "we had been discussing important things last time." She responded with the, by now, expectable tirade. I stopped her almost immediately, stating that I had a few things to say. I began by saying she had a great deal of nerve questioning my motivation since I had never given her reason to do so and that no matter what her previous experience with therapy had been I was a separate individual. Furthermore, I said, I considered it my job not to tell her how to feel but to help her understand the thoughts and feelings she does have. Continuing, I commented that if she really felt the lack of trust which she claims to experience, it was curious that she regularly attends therapy. Therefore, it was my belief, I said, that her behavior must serve some other purpose; possibly she felt that I was lying in wait, waiting for her to slip.

I told her that the purpose of psychotherapy was for the two of us to attempt to unravel the reasons for her own misery. Reminding her of the reasons for seeking therapy and reviewing her comments about her experience of emptiness and of "something being missing," I spoke clearly and directly of her unremitting provocations of me whenever I attempted to focus the session on her experience and said that if she wanted to argue here, in treatment, exactly as she reported arguments elsewhere in her life, we would, in fact, not progress in what I felt psychotherapy ought to be. What I thought therapy was all about, I offered, was for us to try to examine her world, her feelings, her memories, not to bicker and argue.

Then I shared with her my feeling that there had been a change since the vacation, a change for the worse. I reviewed my sense that there had been a slow bond developing, but that something seemed to have happened to change that.

She was slightly taken aback judging from the surprised expression on her face and the several second delay before she recovered sufficiently to again question my motives. Recover she did, however, and she told me angrily that she would, as planned, skip the following session as well as the Thursday sessions for the next several weeks "to see how it works out." I firmly told her that my recommendation was two sessions per week, that I would be in my office during the sessions if she wanted to use the time, and that she would be billed for missed sessions. Time was up for the session and she left the office as angry as I had ever seen her.

She did not, in fact, attend the next session, nor did she telephone. One week following the confrontation, however, she arrived on time. It was immediately apparent that some change had occurred. She spoke at once about her father, and she spoke in urgent tones, a change from previous sessions which were often marked by a whining, almost childish tone of voice. The entire session was taken up with memories of his incessant and capricious demands and of her inability to "even talk back to him." This was new material. She had avoided talking about her family until this session, and rarely before had there been spontaneous recall of memories.

The changed behavior persisted. Although she had stated pre-

viously that she would miss every other session, I decided not to interrupt in order to discuss the confrontation. She did not mention it either. Nor did she miss the next session. Again, arriving on time, she spoke of both her father and her boyfriend. There was a sense of collaboration between us which was new. She began to examine her own behavior, her own motivation. There was a quality of introspection and of involvement now.

My own role returned to an essentially passive receptive one. Whenever possible, I encouraged the process which she had begun. I occasionally asked questions such as, "Isn't it curious that you need an area of fighting in your life?" but my behavior never again became attacking.

Several months later, termination issues exacerbated the difficulties she experienced around loss. However, she raised the termination issue in the session and although the possibility of continuing the treatment at City College was rejected, she dealt with termination appropriately. That is, there was a brief period in which she stated "grievances" at the clinic for not giving her a "permanent" person, but she was able to discuss her feelings about termination. She was even able to express fantasy material relating to the feelings she imagined I had on leaving.

From the confrontation to the final session, there was a clear, persistent positive change in the psychotherapy. A turning point had occurred at that session, and it is my thesis that the aggression I expressed was crucial to the positive outcome. Throughout the remainder

of this paper, I will refer to this session as the aggressive confrontation since my intent was to attack. The outcome of the aggressive confrontation depended, however, on the patient's response to it. Her response was a function of her perception of the event and of it's meaning to her.

Perception of the Aggressive Confrontation

The initial question about her perception of the event is whether she was able to perceive aggression at all. There was no evidence of any significant impairment of her reality testing. Therefore, there should be no question as to her ability to perceive aggression. Since she organized much of her affective world around her own hostile feelings, she was especially aware of aggression, projecting aggression and being hypervigilant to it in others. A clear example of this orientation is the continuing theme of the hostility of her co-workers. On a number of occasions she complained bitterly of being abused by one of her bosses who required that she water the plants in his office and to perform other non-secretarial functions. She was convinced that he did this because he didn't like her, and that he was attacking her for no good reason. Of course, there is no way of verifying the accuracy of her report; what she labeled as aggressive may have been mislabeled. However, she was able to identify and label as aggressive the behavior of others.

The ability to label, is not sufficient. It is possible to inaccurately label behavior as aggressive while concurrently not perceiving actual aggression. This does not seem to be the case. Rather

than simply misperceiving behavior as aggressive, she appeared to have organized interpersonal events in a manner which provoked actual aggression from others. She then perceived the aggression, focused on it and denied her own provocation. Previous records noted this pattern of behavior. She reported to me numerous fights of a minor nature with friends which followed this pattern, and her behavior in treatment with me was clearly provocative. The point, to review, is that this was not a psychotic patient. She was hypervigilant to aggression, correctly assessing it's presence as well as inferring it often in it's absence.

The distinctive, and I think, crucial aspect of the confrontation was the aggressive tone I employed. She had been confronted many times in previous therapy. That is, her behavior both in and out of the treatment hours had been held up for her examination. However, confrontations in the past were, as far as I can determine from the records, never conducted in the interpersonal situation of an angry therapist, but rather, conducted in the more usual empathic manner. Confrontation alone does not appear to explain the turning point. Since a turning point occurred, since the distinctive aspect seems to have been my affective tone, and since it is likely that she was able to accurately perceive the affect as aggressive, the question of the meaning to her of my affective expression becomes the key to understanding her positive response.

The Meaning of Aggression to the Patient: Major Formulation of the Turning Point

Aggression seemed to serve this patient in both defensive functioning and as a gratification. In a general sense she reported being distressed by the aggression of others. According to her own report, she was furious about it much of the time. However, there was a curious lack of pain involved in the distress. She did not consider the aggression which was so much a part of her world as a major problem and, although often rageful, she appeared to be almost comfortable with her fury. When she spoke about her numerous arguments, there was often a subtle smile evident.

There are two factors which I think played key roles in the turning point which resulted from my aggressive confrontation, and both of them are functions of the meaning of aggression to this patient. On a conscious or pre-conscious level, I think she experienced my aggression in the sense of caring, of being special as discussed above rather than as an intent to destroy. On a much deeper level, I think aggression served a distancing function. That is, it served to maintain ego boundaries which were threatened by interpersonal closeness. Although they existed concurrently and I will discuss each of these factors separately, I think their interaction was necessary for the positive effect. First I will consider the factor of caring.

For months prior to the aggressive confrontation I had been listening attentively, working within acceptable technique and at-

tempting to communicate understanding. By the time of the aggressive confrontation, Sally had become accustomed to my essentially passive receptive role. The aggressive confrontation was special, it was out of the expectable role. I think it is likely that when I behaved in an angry, aggressive manner, she interpreted my behavior as caring enough to become angry. As with the child who hears, "This hurts me more than it does you," from parents, she experienced the anger as evidence that I cared for her not only as one of many patients, but as special enough to be the object of my anger. There is evidence that she fantasied the narcissistic gratification of a special role in therapy. On a number of occasions, for example, she alluded to the special relationship between a friend and the friend's therapist. Stating that they called each other on the telephone and visited each other's homes, she appeared envious of the relationship. Her pointed and provocative comments with respect to how much I needed her further suggest the narcissistic element.

Throughout her life, aggression seems to have been invested with the meaning of caring. According to the history she competed with her mother and sister for her father's attention, first by head banging and later by temper tantrums. However, she never seems to have experienced sufficient caring. She spoke once of "never being sick enough to stay home from school, to have breakfast made for me."

The content as well as the tone of the confrontation contributed to her experience of it as my caring. Although I was angry, and although I expressed the anger, I did not threaten termination

of therapy. I believe there was no rejection and no threat implied in the aggressive confrontation. On the contrary, I clearly and forcefully reiterated the recommendation for a two session per week schedule and underscored my availability with the statement that I would remain in my office during the hours scheduled for her sessions. What I said to her, in essence, was, "Look how you are abusing me and look how miserable you are. It doesn't have to be so, and I expect you to be able to change this." My continuing concern was, I think, implicit, and I think that the anger without rejection facilitated her experience of my care and concern.

In the transference fantasies I think the aggressive confrontation served to gratify the caring and special qualities she appeared to have chronically sought. The material which followed the aggressive confrontation suggests a trust which had been absent previously. She revealed material which made her vulnerable for the first time. Were she to have experienced the aggression as an intent to destroy, it would be unlikely that this trust would have developed.

The second factor in this major formulation, the distancing meaning of aggression, is far more fundamental to the turning point as I understand it. Distancing through aggression is, I think, a core factor in this patient's personality structure, and I will examine it in considerable detail. I intend to suggest that she was engaged in a lifelong struggle to preserve ego boundaries; this struggle was masked clinically by an acceptable level of functioning in her daily living, apparently stable object relationships, and

seemingly strong, well formed goals. Her return to New York and to the home of her parents exacerbated her conflicts around separation/individuation, and this brought her again into therapy. The initial stage of therapy represented an acceptable structure for the discharge of her aggression, a "safe" way of re-assuring herself of her own individuality. In the transference, my vacation represented an abandonment. Her fears of and wishes for merging became unbearable, and the months between my return from vacation and the aggressive confrontation saw the level of her aggression escalate to almost hysterical proportions in an effort to make the aggression restore her threatened sense of individuality.

My own mounting anger signalled an impasse, and with the understanding that aggression was an important distancing device for her, I decided to confront. In this context, the aggressive confrontation served as a support, a relief, and as an experience of insight. It is my understanding that she experienced the distance as assurance of her own separation.

The use of aggression as defense against merging is the foundation of this formulation. I think the evidence for this clinically masked deficit is strong, and it seems to reflect a failure to adequately separate from mother. As an infant, mothering was likely insufficient. Recall from the history that when she was six months old, mother suffered a rather severe attack of multiple sclerosis. The attack left her almost totally incapacitated for more than one year, and during that time father was left with the responsibility to keep

house, earn a living, and care for two young children. It is likely that the burden and worry about his wife's health left inadequate time for attention to the infants' development.

Aggression as a defense against merging was manifested in her life long pattern of living in a psychological space populated by antagonists. Throughout her life, aggression was exacerbated by forced contact with others, particularly emotionally significant persons. For example, as a child and adolescent, she was forced into close contact with others by the structure imposed through regular school attendance and by the responsibilities she assumed within her family. Both of these areas reflected her aggressive distancing defense. Previous records suggest that she was "a negative leader" at school who picked on weaker children her own age. She was reportedly uncooperative with teachers as well. At home she assumed many of the household responsibilities which her mother was unable to perform, and she helped in her mother's physical therapy program. The closeness to her mother, the merging of roles and involvement in her physical therapy seem to have precipitated such aggressive behavior that she was repeatedly brought to Jacobi Hospital Clinic.

It is notable in this connection that when she was able to regulate close contact, her behavior apparently became less overtly aggressive, and she seemed to experience less need for psychotherapy. She was not in therapy during college, a time in which structured contact with others is at a minimum. Nor was she in therapy during the year of graduate school when, in addition to lessened structure, she

was living away from home. In an early session with me she stated that her "confusion" was "gone" when she was traveling on vacation; an additional experience of unstructured living.

The structure of a job and the proximity to her parents seem to have been major factors in her return to psychotherapy. It was shortly after returning to New York, to her parents' home and to an active search for employment that she came to walk-in clinic complaining of "confusion." I think her need for psychotherapy was precipitated by these events. As a college student, she was capable of regulating her involvement with others considerably more successfully than as an employee. The structure of work served, again, to force contact with others and it was likely that she found it increasingly necessary to act-out in an effort to achieve distance. Furthermore, while living at school, the salience of her conflicts with respect to separation/individuation were lessened somewhat by physical distance from her parents. Her return to New York and to close proximity with her parents must have reawakened these conflicts, and the increased strain on her defenses seem to have exacerbated her aggression in an effort to distance.

The developmentally early pathology was, I think, partially obscured by her relatively adequate functioning in daily life. As mentioned previously, there was no evidence of psychosis. She appeared goal-oriented and capable. When she came for treatment, she was actively seeking a job and planning to move to her own apartment, and within a few weeks, both of these goals were accomplished. Moreover,

she seemed involved in numerous petty arguments, it was, to a great extent, within herself that the separation and bitter, hateful feelings resided. She was able to maintain her behavior within acceptable limits of society. As a young adult, at least, she was never in serious difficulty as the result of the acting-out behavior.

Another factor which obscured her deeper pathology was an apparent capacity for the maintenance of object relationships over long periods of time. During intake interviews and in early psychotherapy sessions, she spoke of friendships which dated ten years or more. The friendships appeared stable and durable at first. It became apparent only with time that her behavior with friends reflected enormous efforts at control. Her inner experience of these friends, as reported to me, was clearly hateful. She regularly complained about them in sessions, and when her feelings became apparent to her friends, arguments and bickering resulted. Even with these long term friends, then, there seemed to be evidence of the need to distance.

Looking at the seemingly stable object relations, relatively adequate daily functioning and apparently strong, well formed goals, I think she was evaluated as more intact than she was. Therapists, including myself, treated her erroneously as a neurotic patient. The evidence suggests, however, that she was engaged in a constant struggle to preserve ego boundaries. The splitting of the ego in the service of psychotherapy, therefore, initially constituted more of a threat than she could bear. Separation/individuation had not been achieved,

and she could not tolerate significant regression without the overwhelming feeling of imminent destruction. Faced with such a terrifying prospect, she would have struggled against the very closeness and trust which, on another level, she so desparately sought. In an effort to restore a sense of intactness, she would likely have used the provocative, argumentative defense which characterized her significant object relationships throughout life.

I think her return to psychotherapy was at least partly motivated by a need to express the rage which served to protect her sense of self. Unable to directly vent her rage at work or at home, she sought an outlet within therapy. As long as she maintained a balance in which her rage found expression in psychotherapy, she was able to function more or less adequately in daily living. Isolation of affect and displacement of it onto me provided relief in that gratification was found within psychotherapy sessions.

The gratification she found in psychotherapy served to block therapeutic work. She managed to isolate the therapy from her daily living, complained bitterly about the lack of help and sustained considerable gratification from the contact and the complaints. The constant arguing, bickering and provoking served to prevent her from facing the need for psychotherapy, and most importantly, helped her maintain a sense of separateness. This pattern of gratification is notable in her relationship with her boyfriend, as well. He, too, was an unavailable object, maintained at and chosen for his distance. He, too, was the object of her overtly provocative behavior, and of

her complaints of unavailability. With him as well, I think she sustained considerable gratification in the contact and the complaints.

Closeness, then, represented an intolerable burden, a burden which she struggled to avoid throughout her life. The more she moved toward closeness in therapy, the more terrified she became and the more she struggled to maintain ego boundaries through increased aggression. The nature of the therapy contributed to her increasing panic. The more understanding and avoidant of arguments I was, the more the specter of merging threatened the tenuous adjustment she had effected. As her fantasies became overwhelming, she became more desparate in her attempts to distance.

This is likely the situation which existed in January after my vacation. Faced with the experience of my abandonment at a time when she was forced by the holidays to closer contact with her family, she likely experienced the dependency, loss and fears of merging. Unable to cope with these feelings, she denied them and experienced consciously only the aggression. Struggling against the experience of loss and fears of merging in the manner she had always used, she argued, fought and provoked.

These were two factors, I think, which prevented her defense from functioning adequately. More importantly, the transference was powerful and primitive. The rage and hatefulness she experienced was projected onto me in the transference. Identified with the projected rage, she became increasingly terrified of our mutual destruction.

Secondly, her complaints and accusations against me had an empty, unreal quality. There were, in fact, few reality-based complaints she could marshal. Appointments were kept. There was a consistency to the therapy. Moreover, in spite of months of clearly provocative behavior, I continued to be available and attentive during sessions. In effect, then, the more "helpful" and "accepting" I behaved, the more terrified she became.

During the time between my vacation and the aggressive confrontation I found myself becoming increasingly angry. Although I was able to identify the anger and to recognize that it was a function of frustration and disappointment with the change in the therapy since the holiday, I was unable to understand the meaning of my anger in the transference/counter-transference situation. When she spoke of decreasing session frequency to one per week, I recognized that my aggression, too, was in the service of distancing. Several months had passed during which I was, in fact, out of touch with her. Although I was consistently attempting to follow her, I was clearly aware that my helpful attitude was not helpful.

I was aware from the first session that her aggressive behavior was a resistance, but it seemed so powerful and so rigid that I experienced it as unapproachable. When I recognized that my own aggression in the transference/counter-transference situation was in the service of distance, I realized that this reflected her use of aggression as well. Far from being helpful, my attitude had been additionally stressful to her weakened ego resources; and I was then able to

consider alternatives.

I decided to use my anger confrontatively, and I think she experienced the aggressive manner as an enormous relief as well as an act of therapeutic understanding. As I understand it, the crucial message contained in the aggressive confrontation was that she and I were separate, distinct individuals. Moreover, there were boundaries between us which she could maintain, and that I expected her to do so. No less important was the message that I could and would maintain the separation as well. I think it is likely that for the first time she was able to experience separation from a transferentially invested figure. This allowed her to soften somewhat her lifelong defensive position of separation through aggression.

In this context, she was able to experience the caring and concern which had been in the situation all along but which had represented a major threat. Paradoxically, the very distancing which my aggression implied served to enable her to move closer in the sense of basic trust. She was then able to allow herself to experience the effect of the past, to relive and remember in therapy without the ever present threat of annihilation.

I think a structural change occurred as the result of the aggressive confrontation. This is evidenced in the remarkably changed nature of the material which followed. Previous records suggest that she knew well how to proceed in psychotherapy. Each of the therapists, including myself, endeavored to help her examine her inner world and the world of her relationships with others. As far as I can determine,

rarely had she spoken spontaneously of these areas in therapy. The very stridency of her early comments to me about the past not making any difference suggests how very important it was to her. Following the aggressive confrontation, she spontaneously remembered events, experiences and relationships in a manner which suggested that the material had been long kept from awareness. What she spoke of, predominantly relationships with family and teachers, was recalled with genuine affective involvement. The termination process further suggests that a lasting structural change occurred. Although prior to my vacation, she evidenced denial of loss and rigid pseudo-independence, the period prior to termination was characterized by appropriate work. She brought up the issue of termination, and she was able to discuss many of her feelings in an affectively genuine manner. Moreover, in spite of continuing conflict around loss and abandonment, she was able to share her fantasies about the effect of termination on me as well as on herself. There seemed to be a clear distinction between us, and the fantasy projections had a changed quality. There was less projected identification and she was able to express the fantasy projections without the need for rigid negativism which had previously characterized them.

To summarize, I am suggesting that there were two major factors which contributed to the positive outcome of the aggressive confrontation. In the context of anger expressed in the service of the patient, Sally was able to perceive the anger as my caring enough to become angry. Rather than as an intent to destroy, it is likely that

she experienced the aggression as a narcissistic gratification. I think she experienced herself as special enough to move me from the usual therapeutically neutral role she had come to expect. The second factor, far more fundamental, I think, was the experience of distance. As a young woman who appeared considerably more structurally intact than she actually was, she used both her own aggression and that which she provoked from others in the service of maintaining often threatened ego boundaries. In psychotherapy particularly, the wish for and fear of merging unconsciously produced a situation in which aggression toward me served to protect the boundaries between us and to allow discharge of the anger displaced from outside treatment. The more I avoided the provocations, the more threatened she became. When I confronted her aggressively, her experience was likely one of relief in that she was assured that I could maintain distance, that I expected she could do so, and that in fact I demanded that she do so. The interaction between these major contributing factors allowed her, for the first time, to experience psychotherapy without the need to defend against non-being, and, thus, to participate in a trusting therapeutic alliance in which she could regress and re-experience childhood memories.

It is my contention that not only confrontation, but aggressive confrontation provided necessary and sufficient conditions for the turning point which occurred. Later in this chapter, I will discuss the necessity for aggression along with indications and contra-indications for it's use. There are, however, two alternative formulations to account for the changed behavior which deserve consideration. I do

not think these formulations adequately describe the outcome, but each has some substance as regards the potential effect of active aggressive confrontation. I will, therefore, present and discuss the merits of each formulation in the context of the case. The first formulation is that the patient complied with what she experienced as my demands as a response to the aggressive confrontation. The other, that of a sado-masochistic transference, will be presented second.

Alternative Formulations

Compliance

That the patient responded to my aggressive confrontation with compliance is perhaps the most obvious formulation, and it suggests that fear motivated the changed behavior. It is possible that she experienced the anger as a threat of abandonment through termination. Alternatively, she might have complied through fear of repeated attack. Were this the situation, she might have complied with an implied demand for changed behavior without a concomitant change in her inner experience of therapy.

Compliance, then, would have served a number of functions simultaneously. First, it would have neutralized my aggression, thus maintaining contact. Secondly, it may be seen as a form of passive counteraggression. Although outwardly compliant, according to this formulation, her resistance would secretly remain unchanged.

I have established in a previous section, I think, a pattern

of dependency on therapy as a gratifying outlet. She attended sessions regularly and seemed to have sustained gratification from the venting in the sessions of her angry aggressive feelings. Moreover, she appears to have experienced a need to act-in in the treatment hours as a condition for continued functioning in her daily living. Genetically, abandonment and loss were especially charged issues.

When I aggressively confronted her, she might have complied with the demand that she change or terminate. Faced with two such unacceptable alternatives, she might have coped regressively in the manner of a child who does what he is told although narcissistically maintaining his resistance unchanged. Though submitting to the authority, the child, and my patient would remain essentially unaltered.

This argument can be refuted by an examination of subsequent case material. Although angry with me at the session's end, she returned one week later with profoundly changed material. Even if one speculates that she perceived the aggressive confrontation as threatened termination (and I have suggested above that no such rejection was implied), it would be unlikely that the quality and involvement in the treatment process would have changed so dramatically. Recall that she began to reveal material about her father, and she recalled memories which she had previously withheld. It was clear that she knew from the beginning of treatment that that material was appropriate for therapeutic examination. When she first came for treatment she stated emphatically that "the past is over. There is no point in talking about it." Moreover, following the confrontation, she

spontaneously began to connect session to session and to her behavior outside of the treatment hours.

If she was complying due to fear of further attack, one would expect the session content to take on a blandness and non-productiveness in an effort to protect herself from further assault. Unable to break off treatment due to dependency factors discussed above, she could have coped by compliance, by submission to overwhelming power. She would thus maintain contact. It would be paradoxical, however, to predict a deepening alliance--which is what occurred. She began to trust me with material which made her "vulnerable" for the first time. It seems that compliance alone is an inadequate formulation.

Sado-Masochism

It is possible that sado-masochistic transference was effected as the result of the aggressive confrontation. There is evidence that she organized much of her life around masochistic needs, and this formulation requires exploration from several viewpoints. Classical psychoanalytic theory holds that masochism derives from unconscious guilt resulting from Oedipal wishes. Based on distortion of the pleasure principle and the death instinct, masochism is a symptom which developmentally originates in conflicts of the oedipal period. I will examine this formulation first. Object relations theorists assert that masochistic orientation may derive from pre-genital conflicts. This formulation, more in line, I think, with the case data, will be explored second.

According to the history, she seems to have assumed much of her mother's role in the household, and, further, she seems to have suffered guiltily as a result. Her mother was chronically and progressively ill, unable to adequately keep house for the family. As she grew and her mother became progressively less able to function, the patient became increasingly important to the running of the home. Previous treatment records reveal that fantasies of mother's death were prominent during childhood and, moreover, that these fantasies found behavioral representation around the time of puberty in what may well have been an obsessive preoccupation with death. Recall that she did not know the true nature of her mother's condition. She became extremely solicitous about mother's physical therapy, unwilling to engage in after-school parties, dances, etc. She preferred to remain at home with her mother. At the time, she told her therapist, "I worry and think about my mother all the time. That's all I can think of during school. I worry about her falling. I worry about her dying."

Once the "secret" of her mother's illness was revealed, she shared with her therapist fantasy wishes for her mother's death. That she also experienced guilt about these wishes was evidenced by her own expressed fears of dying. The suffering may well have taken on an element of gratification in that there was an expectation of punishment both for the replacement of her mother in the household duties and for the wishes for her mother's death. Guilt and suffering may well have been gratifying in the "lesser evil" sense of protection

of sexual organs.

In the relationship with her boy friend, a similar pattern can be seen. As with her father, she both had him and didn't have him. As with her father, he was married and, hence, unavailable. Moreover, there is evidence that she perceived the relationship with her boyfriend as characterized by his abuse of her. She complained frequently of his not phoning when he promised and not keeping appointments, and she was sure he was often lying to her. She was, however, unable to end the relationship. The masochistic pattern of suffering was, I think, evident in that she hated the relationship, suffered within it, yet was unable to free herself.

She reported being unsatisfied with men who were available. For example, she spoke of Don, a man whom she rejected because he was "too nice." On a number of occasions she commented that as soon as she gained the unqualified affections of a man, she lost interest in him. She even speculated that she might lose interest in her boyfriend were he to actually leave his wife as he often promised.

In her relations with people throughout her life, there was a style, previously discussed, of provoking aggression. Wherever she went, fighting and argumentativeness occurred, however, she never considered it a major problem. Recall that when discussing these arguments in therapy, content indicating abuse of her was accompanied by a smile on her face.

Psychotherapy may well be seen as masochistic gratification. Although in and out of treatment for most of her life, little progress

was made in the direction of psychotherapeutic exploration of her unhappiness. Her long standing resistance to effective psychotherapy may well have constituted a "negative therapeutic reaction" in which the treatment itself assumed the role of punishment. Although aggressive and combative in style rather than pitiable and long-suffering, it was, whenever she began to reflect on her own world, that the argumentativeness increased. I think it is a reasonable speculation that she sought gratification in suffering.

According to this formulation, the aggressive confrontation represented a further transferential gratification of her masochism. For months she had been provoking me in order to obtain the aggression which finally occurred at the aggressive confrontation. Representing her over-bearing, capricious father in the transference, then, I would have been gratifying the need for punishment she sought chronically. Although hurt by my aggression, she would have experienced it as gratification and a decrease in the tension caused by my neutral, helpful role.

There are several aspects to the refutation of this formulation. First, masochistic instinctual gratification assumed a neurotic level of functioning and, secondly, one would expect a recurrence of provocation in an effort to repeat the gratifying attack. I have discussed above the argument around the level of her functioning, but I will briefly amplify that discussion before turning to the second aspect.

In spite of a rather high level of daily functioning, her conflicts seem to have been primarily of a pre-genital nature. Her

first professional contact occurred at age five, and at the time, problems were dated to head banging at age one; this suggests pre-genital onset. From the history, it is evident that early mothering care seems to have been inadequate to achieve structural integrity. That is, as discussed above, her mother suffered a rather severe attack of multiple sclerosis when the patient was six weeks old, leaving father to earn a living, keep house, and care for the two children. As a young adult, archaic defenses predominated, and there was a heightened sensitivity to issues of loss and abandonment. Her evident lack of effective flexibility and the brittle quality of her characterological style suggest further that developmentally early conflicts were salient.

This neurotic level of formulation suggests that it is punishment for her incestuous wishes which are gratifying. According to the pleasure principle, masochistic gratification is derived by a substitution of a lesser punishment for the castration which is feared. A requirement of this formulation is that the suffering be experienced as the result of attempted destruction, of murderous intent. Above, I have discussed her perception of the aggressive confrontation, and I think that were she to have experienced my aggression as an intent to destroy, the very material which emerged would have been shut off. The trust, openness, and sharing quality which characterized the later transference would have been unlikely.

Clinically, there appeared little gratification in the aggressive confrontation. She did not seem to have suffered as the

result of my attack. She became angry, did not attend the next session, and did not mention it in terms of suffering when she returned one week later.

Were the transference to have been characterized by masochistic gratification, one would anticipate a continuing pattern of provocation in an effort to repeat the gratification. However, this, too, was contradicted by the material. Where there had been provocations and arguments, there appeared a more modulated affect in sessions. There was a balance of memories, current perceptions, and experience which had been lacking. Furthermore, as far as I could determine, there did not seem to be a displacement. She did not report acting-out of aggression now shut out of the treatment hours. Rather, what she reported was an extension of her introspection orientation to her daily living. She spoke of "putting herself in other's places" and of attempts to modify her behavior in the direction of "seeing the other side."

In summary, then, she did not seem to be responding to the aggressive confrontation as a masochistic gratification of instinctual wishes primarily. Although there was a likely masochistic element to her personality, the formulation that the turning point in the treatment occurred primarily because of this dynamic seems inadequate on at least two bases. First, assuming an oedipal level of functioning, appears inconsistent with the clinical evaluation. Secondly, there was no repeated provocation to aggression as would be anticipated were masochistic gratification the dominant experience of the aggressive confrontation.

Object relations theorists provide some illumination of her masochistic component (see, for example, Berliner, B., 1947; Asch, S. S., 1976). Masochism has been extended to pre-genital conflict, and it is associated with ego and super-ego pathology. Specifically, masochistic character may be the result of attempts to gain the love and approval of the primitive sadistic love object which has become incorporated into the ego-ideal. The only means of gaining the approval of such an object is through suffering, and the suffering becomes libidinized. A second pre-oedipal etiology is that masochistic character may result from unconscious guilt associated with pre-oedipal crimes. Essentially, an extension of classical psychoanalytic theory, pre-oedipal guilt may attach to any event in the normal developmental sequence. For example, early death wish fantasies of a newborn sibling or fantasies of damaging mother by one's own birth are common. Mothers of these patients typically tend to be intensely and symbiotically related to their children, and the intensity of the involvement as well as the mother's narcissistically heightened expectations of the child produce rageful fantasies in the child. When, in the rageful context the "damage" done to mother is experienced, guilt results. The child's primitive ego identifies with the victim of it's own vengeance. Separation comes to represent destruction of the object, and separation is abandoned in an effort to prevent the destruction. Instead of neutralized for use in separation, the aggression is turned inward against the self/object representation. Suffering and failure come to represent both gratifying defeat and

victory over the hated object.

I have been unable to find confirmation that my patient was seeking love and approval of a sadistic love object. One may speculate that the affective changeability and depression associated with multiple sclerosis may have provided such a model in her mother. And her father, previously described as capricious and overbearing, may have constituted such an object. However, there is little evidence in case material or previous records to support such a formulation.

The notion of pre-oedipal unconscious guilt appears to better fit the data of the case. At the time of puberty, she reported to her therapist that she felt her birth had caused her mother's illness. Especially in the absence of accurate knowledge of mother's condition, fantasies of causing the illness were apparently overwhelming; and this, at least partially, motivated her therapist at the time to press for revelation of the "secret."

It should be noted that this pre-oedipal formulation of her masochistic character provides further evidence to support the major formulation of distancing which I have presented above. If her need to suffer were an expression of a failure to establish a separate identity, transferential fantasies of merging would be expectable. The aggressive confrontation would have provided the distance necessary to re-establish ego boundaries. I do not mean to imply that pre-oedipal masochism was gratified by my aggression, and that this led to a turning point in treatment. Rather, her characterological masochism, formulated as a response to unconscious pre-oedipal guilt, is consistent

with the wish for and fear of fusion presented above.

Consideration of Alternative Treatment Plans

It is my position that this case provides evidence, not only of the potential benefit of active, aggressive confrontation by therapists, but of it's necessity as well. There is considerable evidence that the aggressive confrontation was a turning point in this treatment. Furthermore, previous treatment records and the patient's own reports to me suggest that this event provided an entirely altered experience of the psychotherapeutic process in that she no longer used psychotherapy as a pathological gratification but now experienced a collaborative effort at understanding. Much of this has been discussed in detail above, and the importance of aggressive confrontation was emphasized.

As a psychotherapeutic technique, aggressive confrontation should be considered an heroic measure. There is danger of abuse, and there is danger of misuse. Patients, by the very nature of the psychotherapeutic relationship are vulnerable to assault by their therapists. Although emotional suffering is concomitant with psychotherapeutic exploration, pain and suffering are not goals of treatment, and the necessity of patients sharing intimate, personal experience, make the psychotherapist's responsibility a particularly delicate one. A therapist who uses aggressive confrontation may inadvertently destroy the trust that is necessary for sharing.

However, as an heroic measure, I think aggressive confrontation is a valid technique if used only when psychotherapy can proceed

helpfully in no other way. It is relevant then, to consider alternative treatment plans which would not have included the necessity for aggressive confrontation. I could have interpreted the negative transference early in treatment; I could have treated her supportively; or I could have set limits on her acting-in. I will explore each of these alternatives, concluding that none was appropriate.

The first possibility would have been to interpret the provocative behavior early in the therapy, as early, perhaps, as session one or two. Certainly there is extensive literature suggesting interpretation of the negative transference early in treatment of borderline conditions. Her behavior, I think, constituted a relatively clear negative transference phenomenon. I decided not to interpret at all in the early stages of treatment. Instead, I attempted to provide an external observing ego by asking the introspective questions she did not seem to ask of herself.

I think early interpretation of negative transference would have been an unproductive plan. From the beginning, treatment was tenuous. There was no therapeutic alliance, and she appeared to have little ability to reflect on her experience. Rather than participate in a psychotherapeutic endeavor, I think she sought a "safe" outlet for her aggression. Precipitated by her return to her parents' home and the other factors discussed above, anxiety which led her back to therapy was likely a function of fears of merging. The provocative behavior she evidenced was, then, in the service of preserving ego boundaries. To have attempted to destroy this primitive defense early

in the treatment would, I think, have either resulted in an acute psychotic episode or in early termination.

The more likely of these results is early termination. She had little commitment to therapy, and she evidenced her readiness to flee treatment in screening interviews when she set criteria for her therapist. Recall that she insisted on a "male who would provide feedback and not answer questions with questions." I think she was capable of termination and of seeking relief in other forms. Under such conditions, it is possible that her weakened ego resources would have led to pathological, possibly dangerous acting-out. However, even if she were to have sought therapy elsewhere, there is no reason to assume the pattern of behavior would have significantly differed. It would have served no purpose to have interpreted negative transference and precipitated early termination.

I think she needed the distancing of her own aggressive behavior in the early stage of treatment. For this reason, clarification, interpretation, and confrontation were all rejected. Almost without expectation, whatever I said was met with resistant, argumentative, and hostile behavior. She responded to even the mildest of inquiries as if they were confrontations. During the first three months of treatment, there was slight movement in the direction of a therapeutic alliance, but it seemed that each time she became slightly more open and trusting, there followed renewed accusations against me. I think, therefore, in light of the extreme, brittle, and hypersensitive defenses, early interpretation of the negative transference was contraindicated.

The second alternative approach might have been to be more supportive and encouraging. I might have been more open about myself, and more interactive with her. Often, in fact, she pleaded and/or demanded that I provide directive reassurance. For example, she told me that she needed help in "deciding what to talk about when stuck." I think it is reasonably clear, however, that there were non-therapeutic requests. Were I to have used such techniques, she might have initially responded with relief and perhaps even gratitude. When the support failed to solve her "confusion," as it would have inevitably failed, likely she would have renewed her externalization of blame with vigor. Responsibility for her change would have been mine rather than hers, and therapy would have been other than an endeavor to extend ego autonomy. Moreover, support and encouragement from me might have made it most difficult for her to express the negative transference. Her primitive aggression would likely have mounted, and increased acting-out would have been expectable. This approach, too, I think, would have been contra-indicated.

The third alternative to aggressive confrontation is the imposition of limits. Intended to make available to verbal expression affects which are being acted-out, limits suppress behavior. Limits allow treatment to continue when it is threatened by either intolerable behavior or by dangerous, life threatening behavior. There is a chronicity implied in limit setting, and there is an expectation that limits will be tested. In addition, with severely disturbed patients, limits are employed as an aid to distinguishing

between "me" and "not me."

Notably, when behavior of a patient becomes intolerable to the therapist, the imposition of limits can be used to prevent the therapist from becoming angry--too angry to empathically listen to the patient. The behavior is suppressed, and the therapist's aggressive feelings are neutralized. To the extent that limit setting expresses aggression, there is abuse of the procedure.

It is precisely the suppression aspect of limit setting which I think made it contra-indicated in this case. The psychotherapeutic process is rooted in the patient's freedom to speak freely of whatever is of importance as defined by the patient. Were I to have set limits on the provocative, argumentative behavior during sessions, it is likely that this freedom would have been seriously decreased. In essence, I would have been stating that she was not permitted to express negative feelings about me. In addition, the situation did not fulfill the other criteria for limit setting. Her behavior was neither intolerable nor life-threatening. The acting-in was verbal, and I think rules would not have helped her reflect on it. What was needed was a specific impasse resolution rather than a chronic limit setting, and I think it is of considerable importance that the aggressive confrontation did not demand a change in her behavior as limit setting does. At no time did I state or imply that she suppress negative feelings about me, and there was no attempt to inhibit expression of fantasy about me. It was precisely the limited range of her communication which was called into question. I highlighted the

inappropriate nature of her behavior, and it's self-destructiveness.

Although the transference was not the focus of the work after the aggressive confrontation, it appears that she did not experience suppression of material about me. Recall, for example, that she spoke of the fact that I was trained to handle terminations so I would not be upset by it.

In summary, none of these alternative treatment plans seems to be appropriate to the case. Interpretation of the negative transference early in the treatment would likely have resulted in premature termination. Supportive psychotherapy would likely have produced initial relief followed by exacerbation of her argumentative behavior. Limit setting, inappropriate to the situation, would probably have served to suppress expression of the negative transference to a serious extent.

Faced with an impasse which appeared to have been unavoidable, I think expression of my anger in the aggressive confrontation provided necessary and sufficient conditions for the continuation of therapy in a productive manner. Under such conditions, the aggressive confrontation was valid. If used to further therapy, it seems a turning point can occur to the benefit of the patient.

Issues of Timing, Form and Degree in Aggressive Confrontation

Since the timing of aggressive confrontation, it's form and it's degree of expression are process variables, I will consider them together. First, I will discuss the form and degree. Following that,

I will discuss the timing.

As discussed early in this chapter, aggression can assume almost limitless forms. In the context of psychotherapy, however, I think that aggression is useful to the patient only if it is expressed in an open, direct, unambiguous manner. Not unlike any other psychotherapeutic intervention, accurate communication is sought. To the extent that the therapist's aggression is open to misinterpretation, the purpose of the technique is lost. One of the crucial communications in aggressive confrontation is the anger of the therapist, and ambiguity is precisely opposite to it's purpose.

In addition to anger, however, aggressive confrontation includes an interpretation of the patient's active involvement in the interaction. In the context of psychotherapy, aggressive confrontation is a highly unusual event, and it is of utmost importance, I think, that the patient experiences the event as an active partner. When I confronted my patient with my anger, there was an explicit message that it was she who precipitated the aggression. In the transference, I think she experienced an ability to affect her environment.

A major component of her provocative behavior was likely a life-long experience of being unable to effect her environment, particularly within her family. When I expressed anger, one of her perceptions was, I think, that she could effect me. This factor may well have contributed to the experience of caring which I think was crucial to the positive outcome. There is supporting evidence from previous treatment records and case material. Firstly, she was unable to effect

the progression of her mother's illness. Secondly, she spoke to me of her father's overbearing manner. Recall her memories of never being sick enough to be taken care of. My open, unambiguous anger was interpretive as well as affective.

Degree of expression is considerably more complex because it is more difficult to specify. As little aggression as necessary is consistent with only using aggressive confrontation as an heroic measure. However, if the anger is to be meaningful to the patient, it must be experienced as such. The patient has to be aware of the anger but must experience it as controlled. That is, anger of the therapist could, I think, easily overwhelm and terrify a patient. Again, this would render the purpose of the technique ineffective. To avoid such a situation, a therapist should feel comfortable with his own expression and his own control.

It should be noted that aggressive confrontation is a controlled technique. Between the experience of anger and it's expression is a decision making process which enables a therapist to have sufficient distance from the affect. In this context, controlled expression is possible; degree of expression can be assessed in process and modulated accordingly.

In essence, then, issues of form and degree can be addressed only in terms of the specific clinical situation. Form, I think, should be direct, open and unambiguous. Degree should be sufficient for there to be no ambiguity, but in the context of control.

The timing of any psychotherapeutic intervention is a matter

which requires considerable sensitivity. A product of countless variables specific to the clinical situation, there have thus far been no hard rules of technique which provide formulae for correct timing. There have been guidelines of a general sort offered, but the complexity of interaction have precluded more specific rules. Nevertheless, timing is generally considered crucial to psychotherapy. This discussion of the timing of the aggressive confrontation is an effort to suggest relevant variables for consideration.

Perhaps the most salient aspect of the timing of aggressive confrontation is that the therapist must experience aggression in the transference/countertransference situation. Trained to both expect and accept with equanimity a wide range of affect from patients, therapists ordinarily deal with negative transferential feelings of their patients without expressing counter-transferential anger. Assuming, as I have throughout this work, that the therapist is free of neurotic needs, the experience of mounting anger may serve as a signal that there is an impasse. However, to experience anger is not sufficient for its expression. An understanding of it's purpose to the patient is necessary as well.

As discussed in the formulations above, my anger mounted during the three months following the vacation hiatus. I experienced frustration and aggression in the transference/counter-transference, but I was unable to discover it's purpose. The distancing aspect of my anger became clear only when my patient spoke of discussing the session frequency. At this point in the process it became apparent that I was

taking distance in resonance. With this insight into the transference I was able to use the anger therapeutically. Importantly, under these conditions, I was able to modulate my expression and frame the confrontation in a manner which did not imply rejection of my patient. To have aggressively confronted her earlier, would have likely been destructive because it would have been responding much as other figures throughout her life had responded. It would, I think, have provided the distance without resolving the impasse.

The second variable in the timing of the aggressive confrontation is the nature of the transference and of the therapeutic alliance. Essentially the correct timing of any intervention depends on the ability of the patient to explore the material presented. Correct timing implies assessment of the state of the patient's readiness to use the intervention in addition to assessment of the accuracy of the material. It is accepted technique that interpretation be from the surface first. Aggressive confrontation, it seems to me, follows this requirement of any intervention, but since it is an heroic measure, even more consideration ought to be exercised in assessment of the patient's ability to understand the meaning as not rejecting. An interpretation can be offered in a most tentative manner. By it's very nature, expressing aggression involves the active use of the therapist's affect in the interaction. It is not tentative, but forceful. It demands attention by it's forcefulness and is therefore not easily ignored or rejected. Moreover in the formulation of the case, the aggressive confrontation addressed itself to a developmen-

tally early level, not to the surface.

Were I to have aggressively confronted early in the treatment, she probably would have been unable to perceive the concern and caring which I think contributed to the positive outcome. When I first experienced the anger following the vacation hiatus, there was little alliance between us. She stated on my return that she "got along fine" in my absence. Intermixed with distancing attempts to provoke me, there was a theme of denial of dependency which I experienced as unapproachable because of the aggressive, non-cooperative manner she evidenced. Deciding to continue the approach to therapy which I had been using before the hiatus, I did not confront her with the denial. I think that this prevented her characterological defenses from functioning adequately. That is, in the situation of continued provocations, I remained attentive, caring, and consistent. The distancing failed to provide relief from her anxiety, and the anxiety mounted. Drawn closer by the experience of loss during the vacation and afraid of the merging implied in closeness, she struggled to distance. For perhaps the first time, however, the provocation failed to produce it's expected response.

As the weeks went on, and as the defense was less able to control her anxiety, a point was reached which became intolerable. There is a limit to the amount of verbal abuse possible. She could not increase her attacks as they had reached almost hysterical proportions. What remained as a defense, I think, was physical distance, and in the session prior to the aggressive confrontation, she announced

that she was "only coming once a week." Partially, this could be understood as another provocation. I think, however, that it represented a testing of termination, a physical distancing also.

The aggressive confrontation occurred at a time when her defenses were most strained. When characterological distancing was not working and anxiety was at it's highest level, the defensive use of her provocation was forcefully made apparent to her. It is my understanding that aggressive confrontation at that time was effective because it provided support in the context of distance and because it occurred in the context of my good intentions. The content of the aggressive confrontation was basically interpretive. I drew attention to the defense at a moment when it's defensive nature was not syntonic.

Although there is no way of demonstrating that later confrontation would have been ineffective, it is likely that her defenses would have solidified as she physically distanced herself from the therapy. Either she would have terminated soon after de-intensifying the transference or, more likely, she would have continued in a once per week schedule. Earlier use of aggressive confrontation would not have been effective because defenses were functioning adequately. Her behavior was syntonic.

In summary, I think the timing of aggressive confrontation requires consideration of both therapist and patient variables in their interaction. As with other psychotherapeutic interventions, timing of aggressive confrontation requires sensitivity to the current transference/counter-transference situation. But, since aggressive confron-

tation is forced and demands attention, special sensitivity needs to be paid to the potential for the patient's experiencing the aggression as rejecting.

In this case, the timing seemed to be partly a function of her experiencing the hysterical level of her provocations and of their empty self defeating quality. Equally important, however, was my awareness of both my anger and of the reasons for it. In the context of demonstrated good intentions, she was then able to insightfully use the content of the aggressive confrontation.

Indications and Contra-Indications: General Considerations

Not all provocative, aggressive, hostile patients would benefit from aggressive confrontation. For some, such an experience would be devastating and for others it would likely be trivial. As with any technique, dependent upon the interaction of two personalities in the process of psychotherapy, specific criteria for it's use will be difficult to delimit. And of course, only the most speculative and tentative suggestions can be offered from the detailed consideration of a single case. What is needed is not only a dialogue with respect to the issue, but a sharing of other case histories and controlled empirical research. From this case, however, a number of factors seem relevant. Although considered separately, it is noted that in psychotherapy all the factors interact. An overall clinical assessment is a prerequisite, but in order to gain some generality from my examination, the following are offered as general considerations for indications and contra-indications.

Firstly, an assessment of the need for departure from the interpretive mode is required. There is no question, it seems to me, that from the point of view of psychotherapy with the goal of increased ego autonomy, interpretation is the single most useful technique. Furthermore, departure from the interpretive mode introduces complications in the transference which can assume major proportions. Using the therapist's aggression actively can be especially disruptive. To depart from interpretation, an impasse which threatens the continuation of the therapy is required. Moreover, an assessment of the usefulness of continuing therapy with the same therapist should be made. In this case, an impasse had been reached which threatened continuation, and transfer would not have resolved the issue therapeutically.

Secondly, present ego functioning outside of therapy must be considered. Aggressive confrontation of patient's outside of institutions requires such consideration because of the time between sessions. Without the ego strength to function outside therapy in a reasonably adequate manner, therapists' active use of aggression may invite serious and potentially destructive acting-out. In this case, the very pathology which isolated the treatment sessions from the rest of her life and from each other, also served to help maintain her functioning outside treatment. Although borderline functioning was evident in the therapy sessions, she appeared less pathological when able to regulate her involvement with other less transferentially invested objects. Moreover, assessment of ego functioning is necessary

to help determine the need for departure at all. If the aggression is seen as a support or relief as in this case, it is understood that the necessity for such a departure be given serious consideration in terms of the consequences for continued functioning without it's introduction.

Thirdly, assessment of the current transference situation is important as well. In effect, the question of who is aggressing against whom must be addressed. Moreover, the level of regression within the transference is a corollary.

I think one of the factors contributing to the turning point in this case was that regression in the transference had become overwhelming. Maintenance of defensive functioning was becoming increasingly difficult. My aggressive confrontation addressed itself to this rather severely regressed transference, providing support. I think there was a structural change which followed, a change at least partially dependent on the developmentally early level at which it was experienced. The reinforcement of ego boundaries within the transference, according to my formulation, provided increased ego strength which could be used to do therapeutic work.

A fourth consideration is the patient's likely experience of the therapist's aggression. Since aggression, as with any affective state, is multi-faceted, it is important to consider how it will be experienced by the patient. My patient used aggression primarily for the distancing it provided as a protection against merging. My aggression in this context was, I think, experienced as a relief and

a support. Importantly, aggression was expressed in a comfortable, controlled manner and at no time were threats of termination or demands for behavioral change made. The distancing aspect of my aggression was likely experienced in the service of continuation of treatment. Boundaries were strengthened within this context, and defenses against abandonment by her mother/therapist were therefore not exacerbated. Instead, they were relieved.

It is not necessarily the case that aggression is experienced as support. In fact, I think it is more commonly associated with rejection. The confluence of dynamics of this patient, the transference situation, and the process provided the context in which aggressive confrontation was supportive.

In summary, I have been able to identify four factors specific to this case which seemed highly relevant for consideration in the decision with respect to aggressive confrontation. They are: the need for departure from the interpretive mode; present ego functioning of the patient outside therapy sessions; status of the transference; and likely experience of the aggression by the patient.

There are no doubt, a number of other variables as well, and it is hoped that further dialogue will both identify them and specify the four above more completely.

Summary

Aggressive confrontation appears to be the major factor which led to a positive turning point in the treatment of this twenty-three year old woman. In an effort to examine the process by which the

turning point occurred, I have formulated the case in terms of the dynamic meaning of aggression to her.

Two major aspects of the meaning of aggression have emerged. Firstly, my aggressive behavior during the confrontation seems to have been experienced as caring and as concern. Secondly, this patient characterologically employed aggression in the service of distance. According to my formulation, her need to distance through aggressive behavior stemmed from structurally weak ego boundaries which were threatened by wishes for and fears of merging.

In the context of exacerbated anxiety around issues of loss, my aggressive confrontation seems to have been experienced as support, as a developmental step within the transference. That is, it appears that a lasting sturctural change occurred which allowed for the development of a therapeutic alliance and for the initial steps of psychotherapeutic investigation. As I understand the aggressive confrontation, it enabled her to experience herself as separate and distinct from a transferentially invested object for the first time. No longer needing to preserve an intact self, she could allow the process of psychotherapy to unfold.

It is, I think, notable that many years of psychotherapy had failed in efforts to engage this patient in a process of self-examination. As I understand the "negative therapeutic reaction," the process of psychotherapy itself provided gratification and an outlet for restoring weakened ego boundaries. In the context of an ongoing, rather traditional psychotherapy, her experience of my anger seems

to have provided support and structural reorganization. The introduction of this parameter seems to have by-passed the more neurotic level of functioning, being experienced by the patient as an achievement of separation.

I have presented two alternative formulations, compliance and sado-masochistic gratification, which seem inadequate to account for the changed nature of the therapy. Both, however, are plausible; and both seem especially relevant as considerations when a therapist contemplates using aggressive confrontation.

I have suggested that expression of aggression, properly considered and timed can be a useful therapeutic technique with patients who meet certain criteria. Some borderline patients who maintain ego boundaries by unremitting reinforcement of distance through their own aggression may benefit from aggressive confrontation. However, certain other criteria suggest themselves from examination of this case.

In order for the aggression to be perceived as caring in addition to distance, patients may require sufficient experience of their therapists's patience and understanding. In addition, the abandonment which preceeded exacerbation of my patient's aggression suggests that aggressive confrontation may require that core conflicts around separation/individuation be especially salient.

I have presented a discussion of form and degree in aggressive confrontation which offered several suggestions. In terms of form, control and avoidance of rejection are key factors. Control requires understanding on the therapist's part of the meaning of his anger in

the transference situation. Avoidance of rejection implies a caring and continued concern as well as helping to prevent exacerbation of conflicts around loss. I have limited the aggressive confrontation to an open, verbal d rect expression. Clinical judgment was emphasized with respect to the degree of aggression expressed. As with any pscyh-otherapeutic intervention, the least necessary was offered as a guide.

Considerations for indications and contra-indications were tentatively suggested. I have identified the following four: Need for departure from interpretation; present ego functioning; status of the transference; and the patient's likely experience of the aggression.

It has been the purpose of this examination to stimulate further work in the area of aggressive confrontation specifically and counter-transference expression more generally. From my investigation it appears that some patients who have particularly poor prognosis for change by traditional psychotherapeutic technique may be helped by the introduction of this parameter, and it is this possibility to which I have addressed myself.

As I have discussed in Chapter I, little literature currently exists which specifically examines the potential benefit of expression of the therapist's affect in the transference/counter-transference relationship, and I think specific hypothesis testing research is premature. What is needed, I think, is survey research which questions practicing therapists about their experiences of counter-transferential expression. Such a survey, however, would be a complex matter as expression of countertransference has traditionally been considered poor

practice. Questionnaires should be especially sensitive to this bias. Moreover, by the limited nature of information which can be contained in survey questionnaires, much clinical richness is likely to be lost.

To this point, I would suggest the sharing in print of case material such as the case I have presented in this study. The less limited format provides sufficient expression of clinical material. Were enough cases shared, the potential of aggressive confrontation could be assessed more carefully, and ultimately, empirical research formulated to investigate the salient variables.

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