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CONFRONTATION IN PSYCHOTHERAPY

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This chapter will address itself to the issue of the real person of the therapist as a critical variable in treatment outcome. For neurotic patients with a solid reality sense, the person of the analyst does not appear to be of central importance to our understanding of treatment outcome. An expectant interpretive technique that pays primary attention to intrapsychic issues should lead to adequate conflict resolution. As we deal with patients with a less firm hold on reality, however, we run into limited ego capacities based on structural defects. In general, these are patients who do not have a stabilized sense of self based on introjections, incorporations, and identifications formed out of solid experience with real, responsive, caring, and important people in their developmental past (Zetzel, 1971). For these patients, real characteristics of the therapist may be critical elements in the restructuring of the internal objects necessary for adequate ego functioning; and the confrontation of these characteristics in the therapist-patient interaction may be a major aspect of the treatment process.

Patients who have had unstable early object relationships are not ordinarily accepted for analysis because of their predictable difficulty in maintaining a functional psychic distance from their regressive transference

wishes. Diagnostically, some are grouped as “borderline,” others as acting out character disorders. Eissler (1950) has suggested that a phase of psychotherapy in which the therapist functions as a primary object can be a preliminary to later analysis. In such cases, the real gratifications and confrontations of the first relationship provide a basis for continuing reality sense in the face of the later transference regression. More or less extended preliminary psychotherapy has become a standard technique in cases where suitability for analysis is in doubt.

In some cases a period of psychotherapy after analysis may be necessary to consolidate the formation of “the capacity to bring before the mind once more something that has once been perceived, by reproducing it as a presentation without the external object having still to be there” (Freud, 1925, p. 237). Freud (1925) defines such a capacity as a necessary prerequisite for reality testing. The case to be reported here was referred for a second analysis after the first analyst had reached a regressive impasse. The most striking feature of the post-analytic phase was the inclusion of the figure of the therapist as a participant in a changing masturbatory fantasy. The development and organization of this fantasy was accompanied *pari passu* by marked changes in clinical behavior.

A male analyst terminated with a thirty-five-year-old female unmarried architect who had been in analysis for four years. Before termination he had

obtained several consultations because of the patient's increasingly regressive behavior. Following each consultation the patient showed some transient improvement, and the analyst was encouraged to continue the case but with the introduction of several parameters (Eissler, 1953). The parameters revolved around his efforts to differentiate himself from intense regressive expectations. To this end he revealed to the patient many aspects of his own life and interests. As will be noted, the patient had experienced gross rejection at the hands of both parents and saw the analyst and the analysis as promising to make amends for her deprived childhood. The analyst, an unusually kind and giving man, was unable convincingly to confront the patient with the hopelessness of these expectations. Ultimately, on further consultation, he was advised to transfer the patient.

The argument that I will make here is that this kind of confrontation must be consistent with the real state of the analyst's attitudes. The capacity to be lovingly interested, while it may be of enormous therapeutic value for some patients, can become for others an unbearable temptation to ego regression. With this patient the regressed behavior persisted accompanied by increasing demands for time, attention, and displays of affection.

The patient had her first appointment with her new analyst, also a man, one week after termination. Her appearance was neat and well-groomed, but she was clearly frightened to the point of near mutism; her movements were

uneven; her behavior furtive. She glanced at the therapist, then kept her eyes riveted on the floor, alternately shaded her eyes and covered her mouth, twisted in the chair, turned to the wall, and answered questions with monosyllables.

This state of near panic had been her condition for at least the past year. She had been taking 400mg. of meprobamate per day for several years. She had stopped working over a year before, rarely left the house except to go to her hour, had stopped seeing all of her friends except for one boyfriend with whom she had been "going steady" for ten years. She claimed that she had gotten increasingly worse during the analysis and confirmed that her analyst had obtained four consultations on the question of whether to continue the analysis. Although the patient had been referred for further analysis, her condition seemed sufficiently unstable so that some initial psychotherapy seemed in order.

The second analyst saw her for almost two years in twice a week psychotherapy. She worked regularly for a year, was off medication, was seriously considering marriage to her boyfriend, and was relatively symptom free at termination.

In attempting to reconstruct what happened, several possibilities should be considered. The psychotherapy can be seen from one point of view

as the termination phase of an analysis that had been unsuccessfully terminated. In spite of her increasing anxiety and the persistence of her regressive behavior at the time she left the first analyst, the patient was in possession of considerable insight. She had remembered with appropriate affect her earliest experiences and recognized the persistence of the early struggles in her current difficulties. For example, although she was relieved at the termination, the first analyst had been kind to her and apparently in the course of the analysis had tried to be "real" and supportive. She felt she knew a great deal about his life—his family, his child, his interests. She believed, however, that his periodic illnesses made him too fragile for her to attack. Her anger focused on her transference convictions that he didn't like her, that he liked his other patients better, that she was ugly and awkward and uninteresting. She recognized clearly that the transference feelings were in direct continuity with her struggles to find some kind of stable relationship with her father, a relationship that had remained highly seductive on both sides and had strong anal overtones; but during her first analysis she was unable to use this insight. She remembered the ways she would provoke her father to spank her and the sexual excitement involved. The development of her anal preoccupations were well delineated in memories of earlier struggles around toilet training. Her mother had turned her early care over to a sadistic nurse, who tried to control this hyperactive little girl by rubbing her nose in feces whenever the child soiled. She recognized in the analysis how

many of the early themes interwove themselves in her subsequent development and the way they distorted her relationship to her first analyst. It was interesting that she was fully aware that she expected Dr. A. to treat her as the favorite child she had longed to be. She was able to recognize that her accusations that he liked his other patients better were identical to and continuous with her sibling jealousy. It was not clear at the time either to her or to her former analyst that he was conveying in his style a promise of actually fulfilling her wishes.

In contrast to the coherence of historical themes, the nature of her current experience seemed totally fragmented. On medication (which she recognized as the magical incorporation of her former analyst) she could function for hours with limited anxiety. She could and did read a great deal, went for walks alone; then an incident like the following would occur. A man whom she had met many times at a fruit stand said "hello" to her. She answered. They chatted for a moment and she continued her walk. Within minutes she was flooded with anxiety. She recognized that the anxiety was a response to exciting feelings in her vagina and anus. She knew that it must have to do with the man she met, but there was no fantasy.

The fact that the feeling was partially or dominantly in her anus, she felt was shameful, had to be hidden, and "showed" on her face, which she would hide. The sexual excitement stood in isolation from fantasy or feeling about

people, an isolation that was characteristic of most of her moods or affects. She would have flashes of anger at her boyfriend for no apparent reason or she could become suddenly depressed or anxious or terribly suspicious that everyone hated her. The episodes might last for minutes to days; but all had a strange unrelated quality for her, unrelated in the sense that the affect states were devoid of content (fantasy or memory). Her responses to these unpredictable rushes of feeling had been an increasing restriction on her life and inhibition of her behavior so that she appeared withdrawn and almost frozen.

Her second therapist compared his work with the patient to knitting together the strands of torn fabric and used this analogy with her. She clearly knew the historical strands. The fabric of her life was, however, in tatters. It was clear that she had done a great deal with analyst A (which she persistently denied) and that she had access to many primitive feelings that she had spent much time rediscovering. The second therapist suggested that she might play with the feelings, get to know them in a different way. They then might not need to be so isolated; maybe she could use them. In his approach to the patient, the new analyst took up the shame and guilt aspects of her response to sensuous feeling. He questioned her condemnation of the anal eroticism and reminded her that this could be an important component of "sexuality." He suggested that she enjoy the anal aspects of her sexuality as a means of integrating these experiences into her life. He also asked her to try

to construct fantasies that might correspond to the bodily sensations she was having. The maneuver gave permission to the patient not only to allow the anal fantasy into consciousness but also to confront and explore the anal activities as a means of stimulating the fantasy. The approach had the intent of modifying the intensity of the superego response (Strachey, 1934). The resistance in the first analysis had centered on the patient's inability to maintain sufficient hold on reality in the face of a regressive transference. In Strachey's discussion of the nature of therapeutic action in psychoanalysis he states that the superego occupies a key position in analytic therapy and is a part of the patient's mind that is especially subject to the analyst's influence. Or, to state it another way, variations in superego attitudes toward impulse expression vary to a significant extent depending upon current object relationships. In this case there appears to have been a significant difference between the two analysts on the matter of expression of anal impulses. The first analyst tended to treat the patient as someone who had indeed been so rejected that only some kind of "corrective emotional experience" could be reparative. His "accepting" attitude was intended to provide a new kind of relationship in which she could develop. In effect, he agreed with her superego attitudes that the shittiness was bad and had to be put aside. The second analyst was more comfortable with her anal pleasures and preoccupations and encouraged her to accept them as important libidinal components of her life.

The therapist's presence in the face to face encounter served to modify the potential seductiveness of this intervention by confronting her with the realities of the treatment situation and with the reality of his inability and unwillingness to "make up" for her early deprivation. Thus there were (1) significant differences in the formal aspects of the treatment "situation, (2) significant differences in the specific attitudes of the two analysts toward a central issue of conflict in the patient, and (3) differences in therapeutic intent, with the second analyst deliberately offering himself as an object in fantasy in an effort to stop the regression.

During the two years with the second analyst, each shift in the patient's clinical behavior was accompanied (or perhaps preceded) by a modification of the structure of her sexual fantasies. The most significant changes in the fantasy included the therapist as an increasingly active participant. During most of her adult life and persisting throughout the analytic phase of her treatment, the patient was able to achieve orgasm only by means of a masturbatory ritual in which she would defecate on paper in the middle of her living room and then lightly spank herself. The ritual was accompanied by enormous shame and guilt, but there was no attendant fantasy.

After the therapist encouraged her to "play" with her anal sensations, she gradually shifted to direct anal stimulation with a carrot (still without fantasy). The changes in the ritual seemed to be followed by her having more

freedom to get out of her apartment. Her increasing freedom appears to have been based on a shift of attitudes in relation to her "shameful" anal preoccupations. Part of her withdrawal to her apartment was based on a concern that people could tell by looking at her face that she was "shitty"; *i.e.*, preoccupied with the ritual. Several months later, she reported another shift in the ritual in which the therapist appeared in fantasy.

At this point, she would lie on her back in bed, masturbate by clitoral stimulation, spank herself lightly, saying "You are a constipated girl" (a phrase the therapist had used in describing her difficulty in talking) while the therapist watched her "without moving." She also reported that she was now able to have orgasm by clitoral masturbation during intercourse. The therapist's position and function in the fantasy seemed to reflect his introjection as a superego modification. He is now a functional part of a fantasy that allows the patient to integrate into more genital eroticism, previously isolated and condemned aspects of her anal preoccupations.

With this shift, she experienced a significant lifting of her chronic anxiety and depression and began to cut down on her medication. She also reluctantly returned to work. Several months later she was off medication and struggling actively with angry feelings toward her boyfriend, father, and therapist. The therapist by this time had raised the issue of termination as a further device for maintaining the reality of the situation: "You may

incorporate my attitudes and keep the memory, but you will have to say good-bye to me in reality." At that time the fantasy had undergone further modification. The change was primarily in the position and function of the therapist. He was no longer rigidly immobile but was engaged first, in giving enemas, filling her with water, and later, in having anal intercourse with her. The shift in the masturbation fantasy was accompanied by transient episodes of abdominal distention and later by the wish to have the therapist's child—a part of the therapist she could always keep. (The memories might not be enough.)

Why was she unable to use her first analyst in the same way to stabilize her functioning? The repeated consultations reflected his concern about the progress of the analysis. His efforts to be "real" with the patient, however, seemed to add to the difficulties. The more he showed of his "real" self the greater the regression. The analytic situation at the time was quite clear. The patient was demanding that the analyst love her and devote himself to her in a way that would fill the sense of emptiness left by what she felt was her parents' rejection. In spite of his efforts to confront her with the limitations of the treatment situation, she had managed to elicit his great capacity for *real* devotion. In the face of an impasse, he insisted on continuing with the conviction that he could in fact somehow fulfill these infantile needs. I am suggesting that the confrontation could not work because it was "out of character" for the first analyst. To be effective a confrontation with an aspect

of reality (in this instance—the therapist's refusal to provide unlimited love) must reflect the convictions of the therapist.

Analyst A is an intuitive and gifted man who has a capacity for conveying socially a sense of welcome to people that makes them feel close even on short acquaintance. He is always "available," setting no sharp limits between his work and personal time. These personal characteristics of the first analyst were increasingly revealed in his efforts to halt the transference regression and subverted his efforts. An important aspect of the patient's anxiety was her fear that she would "fall into" people, that she would like them or be stimulated by them and want "too much" from them. At meetings she would often have to leave the room to avoid physically falling off her chair —as if pulled into the arms of the person she was talking to.

The real intuitive openness of her first analyst made it difficult for her to use him to structure primitive impulses. When she tried to use him in fantasy the real promise of gratification pulled her further into a regressive flight from the threat of fusion. The more "real" he became, the more frightened she was.

Her second therapist states that even in her present state of good functioning, the patient is clearly borderline. She has great difficulty in placing the origins of affects; her anger shifts back and forth easily from self to

paranoid perception of others. There is persistent anxiety about fusion alternating with feelings of rejection. The welcoming, warm, intuitive quality of her first analyst, which contributes to his unusual talent in the treatment of neurotic patients, seems to have militated against his usefulness in this situation.

The patient also reported a striking difference in "firmness" of the two therapists. She felt it was easier to be angry with the second because he seemed to insist on her growing up and treated her angry outbursts as important aspects of herself in her everyday functioning. She also felt that the physical differences in the two analysts were important, the "healthy" aura of the second analyst reassured her that her anger could be contained. He is at the same time less "open and accepting" in his approach to patients, tends to wait and see before allowing a patient to develop a close relationship. He keeps sharper limits between his work and personal life.

The formal differences in the setting and real differences in the "persons" of the two analysts were reinforced by significant differences in therapeutic style. A recent vignette from her second analyst reveals a confrontational aspect of his style that the patient found useful in putting her current life into perspective.

The patient often cried in the office and would wait until she was quite

wet with tears and would then ask for a paper towel, which the therapist would hand her. After several months, during which time the anxiety had diminished, the therapist did not hand her the towel immediately but asked instead why she wanted to use his towels. The patient became frightened, felt she was being attacked and criticized. If that's how the therapist felt, she didn't need his "damned towels." She'd bring one in from the bathroom from now on. He pointed out that she'd still be using his towels to wipe herself and that seemed important to her. At this point her anger subsided sufficiently for her to express the fantasy: "Maybe I want you to wipe my ass! " The therapist reminded her that she felt that her shittiness showed on her face. The anger subsided further, and she associated again to the memories of messing her pants and the conviction that her father couldn't stand her.

The next hour she reported that she had less anxiety than she'd had in weeks and that the weekend with her boyfriend had gone much better than it had in a long time. She was less angry at him, felt closer and more sexually responsive. She also reported that the therapist, who had previously been "rigid," was now seen as moving in the fantasy that accompanied the anal perversion.

The therapist's confrontation about the towels contained not only his positive wishes that the patient rely more on herself but also a statement that his tolerance of her dependent wishes had limits. "What is the meaning of

your wish to lean on me?" was a clear message. This aggressive aspect of the therapist's confrontation seems to have been similar in some respects to her perception of her rejecting father. In effect, the therapist, though very different, was enough like the father to allow the further completion of an early identification. The father appears to have been highly seductive with both affectionate physical contact and frequent exciting (to both?) spankings. At the same time he was (and still is) extremely critical of any signs of clinging or dependence in the patient or displays of physical sensuality. The quality of the towel incident appears to have been a regular characteristic of the therapy. Her response was to include the therapist as an increasingly active figure in the masturbatory fantasy, where he represented a superego modification. The second therapist also confronted the patient quite early with the limited nature of the therapeutic commitment. Aware of her regressive response to the open-ended psychoanalytic situation and cognizant of the potential dependency relationship that might accompany his incorporation into the fantasy, he took up the question of termination as soon as her reality situation was reasonably stable.

During the termination, which lasted for eighteen months, she had recurrent episodes of return of anxiety that she would characterize as having "lost the therapist" (a sense of his not being with her). In what sense did she "have him" when she was feeling well? The therapist quotes her as follows:

> I have a sense of how you are with people. You tried to think with me about what we are doing. As if it were a puzzle that could be figured out.... I try to think through my anxiety now, the way I figure you would if you were there. It wasn't that you cared so much about me…but you seemed to assume that I could get better. I told my boyfriend that you (a male therapist) were just the kind of mother I needed…. There are times that mothers just expect their kids to grow up.

Those characteristics of the therapist that allowed him to be used as the "mother of separation" (Stone, 1961) seemed to permit the later fantasy development in which he became the father of her "anal" child. He had first to be delineated as a person separate from herself, a process that involved repeated confrontations around the therapist's unwillingness to respond to her demands, before he could be incorporated into the fantasy structure.

Several issues in this case stand out because of the opportunity to contrast not only the formal aspects of psychoanalysis and psychotherapy but also the style of the two therapists and the use of their real qualities by the patient.

(1) Definition of the therapist as a real person separate from the transference depends on his capacity to position himself as a modified part of the patient's superego. The early maneuver in relation to her shame and guilt about anal impulses was to this end.

(2) The psychic distance normally assumed by the second therapist

appears to have allowed the patient to accept his independent reality. These real qualities appeared to be a necessary substructure for effective confrontation and limit setting. She was then able to identify with and incorporate some of his attitudes while maintaining her relationship to him as a separate person.

(3) In other cases such psychic distancing might be inappropriate and be seen as "cold" or rejecting. The welcoming, accepting attitude of the first analyst in contrast might be more appropriate.

(4) We need to incorporate the notion of the therapist's style and personal qualities as a major element in the evaluation of patients for psychoanalysis and hopefully in time we can develop a typology of "fit" between patient and therapist, which would be a useful addition to the arts of referral patient selection.

Cases like this one make the point that for some patients to be able to create ego and superego structures in therapy highly specific real qualities may be required in the therapist, such as specific character attitudes toward impulse expression. The patient's capacity to use those qualities was certainly enhanced in the therapy situation (in contrast to the psychoanalytic situation) and was also influenced by the technical interventions described. Characteristics of the analyst like the welcoming attitude and the general

quality of psychic distance are probably not subject to more than minimal change in the course of training. They represent permanent features of the personal terrain of the analyst, aspects of his development that interpenetrate all the facets of his life. They are certainly not subject to very much conscious manipulation on the part of the therapist as a matter of technique.

Each therapist develops techniques around his core attitudes and hopefully selects those patients with whom he can work best. The style of the second therapist says to the patient, “I am no crutch. You can grow up and lean on yourself.” The other says, “I accept you, warts and all.” Every clinician will recognize that neither model is appropriate for all cases.

The development and subsequent modification of psychic structure are dependent on the age and appropriate responsiveness of the environment to shifting instinctual demands. Critical elements in the environment of the psychotherapy session, viewed as a maturational experience, are the real personal qualities of the therapist (less so in analysis). Confrontation with these qualities may also influence the way a patient can dare to include the therapist as a participant in erotic fantasy. The elaborated fantasy, in turn, reflects a growth in ego structure that can modulate instinctual expression. This process is described in a borderline patient whose perversion-related fantasies were modified in the course of post-analytic psychotherapy. The progressive appearance of the therapist in the fantasy was accompanied by a

marked improvement in symptoms and each change in the activity of the therapist in the fantasy was accompanied by significant changes in mood and function.

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