Uses of Confrontation

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On the basis of my clinical work, I have become convinced that confrontation is useful in treating all borderline patients and essential to the progress of some. In this chapter I hope to convey what I have learned about the uses of confrontation. In the process I shall be discussing in some detail the characteristic defenses of borderline patients, and further clarifying their differences from narcissistic patients.

Definition of Confrontation

No single definition of "confrontation" is widely accepted, and some disagreements are the result of covert differences in the way the term is technically defined. Some problems also arise from the confusion of the technical meaning of confrontation with some of the meanings given in standard dictionaries. "To stand facing ... in challenge, defiance, opposition" is one such meaning (*Webster's New World Dictionary*, 1960). This confusion, also covert, leads to implications that, in confronting, the therapist necessarily endangers his selfobject relationship with the patient.

Another source of confusion arises from the use of clinical examples in teaching and writing about confrontation. These examples are complex. The specific confrontation is usually artfully integrated with other maneuvers, such as clarification or interpretation, and with the affects and personal style of the therapist. Separating out that which constitutes the confrontation can be quite difficult, and discussions about it can imperceptibly shade and shift into the pros and cons of the other elements, any of which may come to be mistaken for facets of confrontation.

In response to these problems, I have attempted to work out a definition. I approach it through the teachings and writings of Khantzian, Dalsimer, and Semrad (1969), Semrad (1954, 1968, 1969), Murray (1964, 1973), and E. Bibring (1954). Semrad's work concerned psychotic and borderline patients. He emphasized their reliance on certain defenses—denial, projection, and distortion—that he termed the "avoidance devices." These defenses operate to keep conscious and preconscious experiences out of awareness. As such, they are to be differentiated from other defenses, such as repression, that serve

to keep experiences not only out of awareness but also unconscious. To help patients become aware of avoided painful feelings, impulses, and experiences, Semrad used a combination of support and pressure. The support makes distress more bearable and thus lessens the need for avoidance. The pressure against avoidance is then applied directly and actively, usually by a series of questions along with various countermoves in response to the patient's evasions.

Murray (1964) wrote about work with borderline and neurotic patients who exhibit considerable regression to the pregenital level. An infantile, narcissistic entitlement to life on their terms is often a major force behind the resistance of these patients to clarifications, interpretations, and acceptance of the real world. Even after clarifications and interpretations have been thoroughly established, this kind of patient tries to maintain his pleasurable pregenital world by avoiding acknowledgment of what he now consciously knows. In the setting of support, Murray, like Semrad, applied pressure in various forms (surprise, humor, forceful manner) against these avoidances. Murray referred to this technique as "confrontation." It seems to us appropriate to apply the same term to Semrad's technique.

In his classic paper, E. Bibring (1954) listed five groups of basic techniques used in all psychotherapies. His categorization continues to be useful, although it was derived primarily from work with neurotic patients. He described a central technique, interpretation, for working with those defenses that keep material unconscious. But he included no method for working with defenses that simply prevent awareness of material that is already available in consciousness—that is, preconscious or conscious. One of Bibring's techniques, clarification, does deal with preconscious or conscious material—as a method for bringing into awareness or sharpening awareness of behavior patterns—but Bibring specified that the patient *does not resist acknowledging that which is clarified*. He accepts it readily. It is because avoidance devices are used so prominently by psychotic, borderline, and pregenitally regressed neurotic patients, and because confrontation, as employed by Semrad and Murray, is specifically designed to deal with these defenses, that I believe that confrontation should be added to Bibring's categories of techniques.

Accordingly, I would define confrontation as follows: Confrontation is a technique designed to gain a patient's attention to inner experiences or perceptions of outer reality of which he is conscious or is about to be made conscious. Its specific purpose is to counter resistances to recognizing what is, in fact,

available to awareness or about to be made available through clarification or interpretation. Although the purpose of confrontation is not to induce or force change in the patient's attitudes, decisions, or conduct, my definition resembles that of Myerson (1973) in that I believe confrontation to involve the use of force. My definition is, in fact, built upon his. The difference is that I am more explicit about the purposes for which the force is and is not to be employed.

Confrontation can be used in combination with other of the basic techniques. For example, when a patient can be expected to mobilize denial against a clarification that he otherwise would be able to grasp, the therapist may combine the clarification with a confrontation. Rather than deliver the clarification as a simple statement, the therapist may try to capture the patient's attention at the same time, perhaps by using a loud voice, an expletive, or an unusual phrase.

This definition of confrontation involves differentiating it especially from two of the techniques listed by Bibring (1954): suggestion and manipulation. Some clinical vignettes offered as examples of confrontation are, in fact, more accurately described by Bibring's accounts of these two techniques. They amount to forcefully executed suggestions or manipulations. Limit setting is one such maneuver. Often it is presented as a confrontation when it is well subsumed under the category of manipulation.

Description of Confrontation

There are, of course, very many methods used by patients for avoiding awareness of that which is consciously available. Suppression, denial, projection, and distortion are the ones classically described. Diversion through activity, superficial acknowledgment followed by changing the subject, rationalization, and intellectualization are a few more of the ways to avoid awareness. Any complete discussion of the topic of avoidance would carry us beyond the scope of this chapter. A. Freud (1936), Jacobson (1957), Bibring, Dwyer, Huntington, and Valenstein (1961), Lewin (1950), Vaillant (1971), and Semrad (1968, 1969) are among the authors contributing to my understanding of this subject.

I should, however, make a few more comments describing the technique of confrontation. Occasionally the verbal content of a confrontation is itself sufficient to claim the patient's attention. More frequently the manner of delivery is the effective agent. Surprise, humor, an unusual choice of words, or

an emphatic delivery may capture the patient's awareness. Or the therapist may choose to use a show of personal feelings, such as obvious person-to-person caring, sadness, frustration, or anger. Essentially, any departure from the usual tone or format can be used in the service of confrontation.

A caveat for the therapist was issued by Murray (1973) and Myerson (1973). It is specific for confrontations that involve expression of the therapist's feelings: The therapist's feelings must always be experienced as in the patient's behalf. This is especially true of anger. Otherwise the therapist violates his unspoken commitment to the selfobject relationship. Such violation constitutes a narcissistically based power play in the form of antitherapeutic suggestion or manipulation.

Libidinal Drives, Aggressive Drives, and Attendant Feelings

As we have seen, the borderline patient's psychopathology is founded on one fundamental belief: that he is, or will be, abandoned. He believes it because internalization of basic mother-infant caring is incomplete. His fundamental feeling is terror of utter aloneness, a condition that feels to him like annihilation. Concomitant and derivative experiences are emptiness, hunger, and coldness, within and without.

Abandonment by the person needed to sustain life— mother or her surrogate—is not simply terrifying; it is enraging. This rage may be simply destructive, but more often it is experienced along with desperate efforts to obtain the needed person permanently. This experience occurs in the mode of the infant at the oral level. The patient urgently, savagely, wants to kill that person, eat him, be eaten by him, or gain skin-to-skin contact to the extreme of merging through bodily absorption—either absorbing or being absorbed. This oral, raging acquisitiveness, mobilized in response to abandonment, brings in its wake further difficulties. Destroying his needed object mobilizes primitive guilt; it also threatens him again with helpless aloneness. He may attempt to save the object from his destructive urges by withdrawal. But that, too, threatens intolerable aloneness. He can call upon projection to deal with his rage. But projecting the rage onto another object now makes that object a dreaded source of danger. Once again the patient seeks self-protection by distancing and withdrawal, and again he faces the state of aloneness.

Methods of Defense

I have already described two of the borderline patient's methods of defense. One is projection of his oral destructiveness. By projecting, he achieves only the partial relief offered by externalizing; he still feels in danger, but now from without rather than from within. Related to this type of projection is projective identification, which includes projection plus the need to control the object in order to avoid the projected danger (Kernberg 1967). The other defense is mobilization of rage in the service of defense against expected abandonment or oral attack. This defense is very primitive, derived more from the id than from the ego. As such, it constitutes an impulse that is nearly as frightening to the patient as the threats against which it defends.

Kernberg (1967) elucidates the borderline patient's use of the splitting of his internal objects in an effort to deal with intense ambivalence. These patients also employ displacement and hostility against the self. A variety of other defenses, including repression, are also available to them. In my opinion, however, Semrad (1968) was correct in emphasizing the avoidance devices as these patients' main line of defense. Specific methods of avoidance, as he listed them are denial, distortion, and projection; they are put into operation against conscious content in an effort to keep it out of awareness. I would add yet another method: avoidance by taking action.

Having already described the borderline patient's use of projection, I can turn now to denial, distortion, and avoidance by taking action. Denial, as defined by Jacobson (1957) and Bibring, Dwyer, Huntington, and Valenstein (1961), may be employed lightly or may be used massively, to the point that the patient is unaware of any feeling or any impulse. Much the same can be said of distortion, whereby the patient not only denies inner or outer reality but also substitutes a fantasy version to suit his defensive purposes. Denial and distortion carry two serious defects. One is that they are brittle. When threatened with facing what he avoids, the patient can intensify his denial or distortion, but he is likely to become desperate in doing so. And when the defense is cracked, it can too readily give way altogether. The other defect is that these defenses heavily obfuscate reality.

Avoidance can also be achieved by discharging impulses and feelings through the medium of action. The action may be a more or less neutral form of outlet or it may express, at least in part, the nature of the feelings or impulses that the patient does not wish to acknowledge. Because it always involves

taking action without understanding, more or less blindly, this method of avoidance is hazardous. Through it the patient allows himself action that is directly destructive or places him in danger. Avoidance through action is commonly used along with massive denial of feelings, so that the patient may be in the especially dangerous situation of discharging impulses like an automaton, feeling nothing at all and even being utterly unaware of the nature and consequences of his acts. This problem will be discussed further in a later section.

On the basis of this description, we can make three general statements about the borderline patient's defenses: (1) They are often maintained at the sacrifice of being in touch with reality, which is a far greater sacrifice than that involved with higher level defenses; (2) they tend to be inadequate to maintain equilibrium, to be brittle, and to be in themselves a source of distress; and (3) they can place the patient in danger.

The Need for Confrontation in Treating Borderline Patients

CONFRONTATION IN EVERYDAY TREATMENT

Intensity and chaos characterize life as experienced at the borderline level. Most borderline patients occasionally experience their lives almost solely at that level, unmodified by more mature attainments. But usually their borderline problems are simply interwoven into the music of everyday life, sometimes in counterpoint and sometimes in harmony with healthier themes and rhythms. At times the problems swell to dominate the composition; at other times they are heard only softly in the background.

Most therapy hours are, then, characterized by steady, undramatic work by therapist and patient. Is confrontation needed, or useful, during these hours? In my opinion it is. The reason lies in the patient's extensive use of avoidance defenses.

The reader will recall the patient described in Chapter 4, a young social scientist who was progressing well professionally. Mr. A.'s specialty allowed him to remain relatively distant from people, but his inability to form stable relationships and his sense of aloneness and hopelessness had brought him to the brink of suicide. He entered psychotherapy and very quickly became deeply involved in borderline issues. The belief that he would be, and the feeling that indeed he was, abandoned by his

therapist dominated the work of the first year. At the same time he gradually and intermittently became aware of intense longing for the therapist. As treatment proceeded he recognized vague sexual feelings toward the therapist that resembled those that he had felt as a child when he stood close to his mother, pressing his head into her abdomen. He also became aware of urges to rush or fall into his therapist's chest; he was afraid because he felt that he might, in fact, destroy his therapist in this way, or perhaps be destroyed himself.

With these transference developments, he resumed an old practice of promiscuous, casual homosexual activities. He reported seeking to perform fellatio when he was under pressure of severe yearning to be with the therapist. In one treatment hour he described these feelings and activities as he had experienced them the night before, and then he added a new self-observation. Looking away to one side, he quietly, almost under his breath, said he had found himself "sucking like a baby." Generalized obfuscation followed this admission. Everything he said was vague, rambling, and indefinite. The therapist hoped that this new information could be kept conscious and available to awareness. It would be important for later interpretation of the infant-to-mother transference: that the patient was experiencing the same urgent need for sustenance from the therapist that he had continued since infancy to experience in relation to his mother—a need to suck milk from the breast-penis.

Later in the hour he returned to his experience the night before. Once again his narration became clear as he described his longing for the therapist and search for homosexual contact, but he omitted any mention of his infantile feelings and sucking activity. The therapist suspected that the patient had mobilized some method of avoiding, perhaps denial, or at least of withholding. In an attempt to counter this defense, the therapist made a confrontation. When the patient seemed to have finished retelling the story, the therapist directly, with emphasis and with minimal inflection, said, "And you found yourself sucking like a baby." The patient winced, turned his face away, and was briefly silent. Then he said, "Yes, I know." In another short silence he turned his head back toward the therapist; then he continued his associations. He did not directly pursue the matter that had been forced to his attention, but it was clear that he had fully acknowledged it and was aware that his therapist also knew about it. Because of the patient's fear of feeling close to the therapist, the therapist chose not to confront any further. He felt that any further attempt to hold the patient to the subject in that session would now be more threatening than constructive.

CONFRONTATION THAT IS URGENTLY REQUIRED

Work with borderline patients can be quite different from that just described. By contrast, some hours are characterized by intense involvement in one, several, or all aspects of life at the borderline level. Help may be urgently needed at these times to deal with two multiply determined problems: (1) the patient's becoming overwhelmed with the belief and feeling that he is in danger and (2) his taking unwitting action through which he puts himself in real danger. At these times he needs help to recognize (1) the actual safety afforded by reality, especially the reality of his relationship with the therapist, and (2) the actual danger involved in using certain pathological relationships, in taking action on fear and instinctual drive pressures, and in failing to acknowledge that what he fears arises only from within himself. Ordinarily one would expect a patient to accept reassuring, reality-oriented help of this kind. Paradoxically, the borderline patient may resist it, even fight it, mobilizing avoidance for that purpose. Then confrontation is required. Let us now consider this situation in detail.

The borderline patient's feeling of being in serious danger no matter which way he turns is of utmost importance. One leading determinant of this fear is his belief that he will be or is abandoned. Another is his impulses, which he feels threaten destruction of the objects he depends on. This threat in turn means being alone or being destroyed. Self-esteem at these times is demolished; his primitive superego threatens corporal or capital punishment. Simultaneously reality gains little recognition and holds little sway.

When overwhelmed or about to be overwhelmed with this complex experience, the patient needs the support of reality. Of course, I do not advocate empty reassurance. If his controls are so tenuous that a threatening situation really exists, steps in management are required to provide safety. For example, hospitalization may be indicated. In most cases, however, what the patient needs most of all is the real reassurance that he will not be abandoned and that no one will be destroyed. If the therapist tries to respond to this need with simply clarifying or reality testing, he often meets resistance. The patient avoids acknowledging the safety provided by reality, especially the reality of his relationship with his therapist. Confrontation is needed to meet this avoidance.

Why does the patient sometimes avoid acknowledging the safety afforded by reality—for example,

that his relationship with this therapist is secure? There are three reasons: (1) The fear of being abandoned (and destroyed) arises, for most borderline patients, out of real experiences over prolonged periods of time with primary objects. Through certain complex mechanisms this experience has been perpetuated throughout their lives in subsequent relationships that they have formed in the quest for sustenance. A large part of their experience, then, speaks against the therapist's version of reality. The patient fears to risk accepting the therapist's offer as if the therapist were leading him to destruction. (2) The force of the patient's raging hunger and his partial fixation at the level of magical thinking convince him that he really is a danger to people he cares about and needs. Even though he may acknowledge them to be of no danger to him, he fears using relationships when he so vividly believes that he will destroy his objects. (3) These patients use projection to avoid the recognition that the supposedly dangerous, raging hunger arises within themselves. The patient's acknowledgment that his object is safe, rather than dangerous, threatens the breakdown of this defense. These three fears may be experienced unconsciously or may be preconscious, conscious but denied, or even conscious and acknowledged.

Now let us turn to the problem of the borderline patient's putting himself in actual danger. Of course, danger in his life can spring from many sources. But the one germane to discussion of confrontation is his use of avoidance mechanisms, so that he remains insufficiently aware of the dangers as he acts. Specifically he employs avoidances against recognizing (1) the real danger in certain relationships, (2) the real danger in action used as a defense mechanism, and (3) the real danger in action used for discharge of impulses and feelings.

The potentially dangerous relationships are those he forms with other borderline or psychotic persons, persons who seek primarily after exclusive possession and succor. They are also ridden with fears and destructive urges upon which they tend to act. The patient may throw himself into togetherness with such borderline or psychotic persons, believing he has found a wonderful mutual closeness and perhaps feeling saved and exhilarated. In fact, the reality basis for the relationship is tenuous, if present at all. It simply provides the illusion, partially gained vicariously, of gratifying each other's needs for infantile closeness. Belief in the goodness and security of the partner may be maintained through the mechanism of splitting. Denial and distortion also may serve to obfuscate the partner's real ambivalence, instability, and untrustworthiness. Inevitably the partner will act destructively, independently, or in concert with the patient's own destructiveness. The least noxious

outcome is desertion by one or the other. In any event, with their high hopes they ride for a fall, one that precipitates the full borderline conflict, often in crisis proportions. The therapist must realize the risk in these relationships and try to show it to the patient; otherwise he must at least set limits. Often the patient will not acknowledge the reality that his therapist tries to bring to his attention and will not heed the limits set down. The lure of infant-mother closeness is too great. Furthermore, acting upon it with the friend may relieve by displacement his similar urges toward his therapist. But most important, acknowledging the real danger in such a relationship would mean giving it up and experiencing an abandonment following closely on the heels of wonderful hope. So the patient avoids the reality, and the therapist must return to confrontation.

Borderline patients are inclined to endanger themselves by resorting to action as a defensive measure. For example, if psychological avoidances become insufficient, the patient may take refuge in literal flight—perhaps run out of the therapist's office, fail to keep appointments, or travel to some distant place. If in the process he deprives himself of needed support from the therapist, he may be unable to check his frightening fantasies and impulses. Decompensation or other forms of harm may result. Another means of defensive flight is offered in drugs and alcohol; the dangers are obvious to the therapist. Some patients use displacement in order to allow their destructive impulses toward the therapist to be expressed in action. While avoiding acknowledgment of rage at the therapist, the patient can be unleashing it on the outside world. He may break windows, verbally attack policemen, or incite brawls, meanwhile mobilizing various rationalizations to justify his behavior. All the while he keeps out of awareness his bristling hostility toward his therapist.

The borderline patient may also use endangering action simply as a means of discharging a variety of highly pressing impulses. Through harmful activities, including selfdestruction, he can express all his various sources of destructive urges and his wishes to incorporate and merge. Drugs, alcohol, promiscuity, suicide to gain Nirvana, pregnancy, and obesity form a partial list of these harmful activities. The patient resists giving up both the destructive and the incorporative activities. To do so would mean bearing the pressure of unrelieved impulses.

In all these instances of using action in the service of defense or impulse discharge, the patient to some degree avoids recognizing that his actions are, in fact, dangerous to himself. If he knows this danger

intellectually, he is likely to say that he has no feeling about it, that it does not seem real, or that it does not matter. This avoidance allows him to pursue the endangering activity unchecked. Mere reality testing and limit setting will not induce him to recognize that he endangers himself and must work to give the activity up. By combining confrontation with reality testing and limit setting, however, the therapist can often break through the denial and accomplish this aim.

There remains one more danger in the use of avoidance mechanisms, one that was mentioned in an earlier section. This danger involves massive denial of intense feelings and impulses. It is true that much of the time there is no need to force a patient to face denied feelings and impulses, but there are occasions when it is urgently necessary to do so. For example, the patient may be under the extreme pressure of wanting to kill his therapist and, as a defensive alternative, may be on the verge of actually killing himself. In order not to be aware of such unbearable emotional and impulsive pressures, the patient is capable of massive use of denial and other avoidance devices. He may avoid to the point of literally eclipsing all feelings from his subjective view. Distressing as it is for him to face what he is avoiding, the nonhospitalized patient cannot be allowed this much denial; it is too dangerous. It is dangerous because totally denied intense impulses and feelings are especially subject to expression in uncontrollable, destructive action. This action may take place with a sudden burst of feelings, or it may occur in a robotlike state of nonfeeling. Clarification and reality testing are to no avail against massive denial. Confrontation is required. The therapist's aims are (1) to help the patient become aware of his impulses, so that he need not be subject to action without warning; (2) to help him gain temporary relief through abreaction; and (3) to help him gain a rational position from which he can exert self-control or seek help in maintaining control. At this point it is essential to provide the patient with sustaining support sufficient to enable him to bear the otherwise unbearable. It may not be possible to support adequately with the therapist-patient relationship alone; temporary hospitalization may be needed as an adjunct.

All facets of the urgent need for confrontation cannot be illustrated in a single clinical example, but two are involved in the vignette that follows. One involves the patient's being overwhelmed with the belief that he is in danger of abandonment; the other relates to his putting himself in danger by discharging feelings through action. The episode to be discussed took place a few weeks after the last reported session in the treatment of Mr. A.

It had become clear that Mr. A. used considerable repression and that he also depended heavily on avoidance devices, especially denial. But these devices were not enough to meet his needs for defense; he also consciously withheld thoughts and affects, was vague, and usually avoided looking at the therapist. Details of a traumatic childhood had emerged. For periods of up to a year he had been abandoned by his mother and left to the care of a childless and emotionally distant aunt and uncle. His mother had fluctuated widely in her attitude toward him, at times intensely close in a bodily seductive way, at other times uncaring or coldly hostile. She and his father made a practice of sneaking off for evenings after he had fallen asleep. To ensure that he would remain in the house, they removed the door knobs and took them with them. Repeatedly he awoke and found himself alone, trapped, and panicky for prolonged periods.

To summarize the earlier description, the most prominent quality of his transference was the belief that his therapist did not think about him or care about him. Outside the treatment hours, the patient frequently felt that the therapist did not exist. He suffered marked aloneness, yearning, and rage, increasingly centered around the person of the therapist. The therapist's work had primarily involved clarifying the emerging transference and relating it to early experiences and life patterns. The therapist also repeatedly implied that he, the therapist, was not like the patient's mother and not like the patient felt him to be; rather, he was solidly caring and trustworthy. The patient's feelings, however, intensified, and he began to seek relief by occasionally discharging them through action. It was at this time that he increased his homosexual activities, and the previously reported hour occurred. At the same time more rage was emerging. Many times the therapist interpreted that the patient's impulses and rage were so intense because he believed he was really alone, uncared for, and absent from the therapist's thoughts. Each time the reality of the relationship was also implied. But the patient seemed unable to accept it.

Before long the patient put himself in serious danger. Rage with the supposedly abandoning therapist dominated him. He got drunk, purposely drove recklessly across a bridge, and smashed his car on the guard rail. Although he himself showed little concern for his safety, he was concerned about how the therapist would react. Would the therapist be uncaring, as he expected?

Clarification, interpretation, and indication of the reality of the relationship had not been effective before. They would be less effective now. Certainly merely pointing out the danger of his action would

make little impression. The therapist elected to include confrontation in his efforts. First he repeated the interpretation: that the patient's erroneous belief that the therapist did not exist was the source of his intense anger. Next the therapist confronted the patient with the actual danger he had put himself in by discharging his rage in action. With emphatic concern the therapist said, "You could have been hurt, even killed! It was very dangerous for you to do that, and it is very important that it not happen again." Now the patient tacitly acknowledged the danger. Confrontation had succeeded. It was followed by a second confrontation, one designed to gain the patient's acknowledgment that the therapist really cared about him. The therapist said:

> The way to avoid this danger is to work with your feeling and belief that I do not care or do not exist. By all means, whenever you approach believing it, whenever you begin to feel the intense rage which naturally follows, call me up. Call me, talk with me, and in that way find out that I really do exist, that I am not gone.

Superficially this maneuver would seem to have been a manipulation, but in fact it was a confrontation, presented very concretely. Its message was that the therapist was in reality a reliable, caring person whom it was safe to trust. The patient responded with what seemed to be a halfhearted acknowledgment and agreement. But he did not again endanger himself in any similar way.

About three weeks later, however, he experienced the same very intense transference feelings and impulses. He drank heavily and made contact with a group of homosexuals who were strangers to him. He went with them to a loft in a slum section of the city and awoke there the next morning. He found himself alone, nude, and unaware of what had happened. He was frightened at the time, but not when he told his therapist about it. The therapist responded by first showing his feelings of strong concern as he agreed that it had been a dangerous experience. He thus presented what amounted to a confrontation against rather weak denial of danger and fright. Then he clarified the psychodynamic pattern along the lines already described; he showed the patient that he had put himself in danger by taking action to express his yearnings for, and rage with, his frustrating, supposedly uncaring, therapist. Next came a combination of limit setting and confrontation:

> This behavior is much too dangerous, and you must not allow yourself to take such risks again. You felt so intensely because you believed I did not care. Anytime you feel this way and are in danger of acting on it, contact me instead. It would be much better, much safer, to talk with me on the phone. Please do so, whenever it is necessary, at any time of day or night. See that I exist and that this relationship is real.

The patient gave the impression of neither agreeing nor disagreeing. He never called. But there were no recurrences of discharging intense feelings and impulses in any dangerous actions. Two months later the patient was overwhelmed with fears of closeness with the therapist, and he felt suicidal. But he took no action; instead, he requested a brief hospitalization. He was discharged at his own request after five days.