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Of course there is no reason to confront a patient, short of desperation. But desperation is an important event, not generally experienced unless push has come to shove. Why should the analyst preempt it? Paradoxically it is usually only after he feels himself afflicted by such desperation that analyst wants to shove it back—but why did he take it on in the first place?

And yet I do not think, outside of naked curiosity, that I would like to meet the therapist who is invariant in respect to patients. I have listened to arrant nonsense over the years from therapists who explain why they are being “flexible” or using this or that “parameter,” but as often as not the nonsense was in the conceptualization and not in the intuition. Therapists camp on a fault. As with the San Andreas fault there are powerful upheavals in store as the earth develops and rearranges itself. The therapist must develop a lightness of being, if he is not to become a Canute raging at waves.

Joining in on a slow shift to chronicity, however, does no one a favor. Nor does an entitling of entitlements. The course of a therapy engages both parties in an ongoing act of mourning: both are frustrated and sad that there cannot be more to their relationship; yet it is exactly that limit which fuels the analysis. Indeed, the therapist is distinguishable from the patient only with respect to his ability to tolerate those limits without reprisal. Without that, no amount of clever talk helps.

That patients must employ confrontation with their therapists may be more understandable. The Wolf Man, burdened with an analyst more occupied with wolfishly proving the importance of the Primal Scene to his beloved detractors than with his patient, felt he had to freeze Freud in his tracks. And while it may look as if Franz Alexander (whose classic paper was much cited at the conference at which this paper was first presented) was the one who confronted his smelly, entitled young patient, it is likelier that shambles of a young man was pushing Alexander (who was at that time, probably for all manner of reasons, anyway thinking how to shorten the analytic process) toward an edge of resentful despair. So too was the patient I discuss in this paper obliged to give me an emphatic nudge when I could not take account of my hatred and see that it did have to do with her and not the concurrent events in the family onto which I had fobbed it.[1]

I heard from this patient a decade after her termination because the pharmacologic agent she had been given did not keep her from yearning for the good old days of psychotherapy which, she asserted, she could no longer afford.

“Is it the old therapy you miss or a new one you don’t have?”

“Oh, Mr. Boris, that is exactly it. I always want what you showed me I want: I want everything to be new and exciting and better.”

“So you have probably stopped mining the therapy we did have.”

“Going over it and over it again you mean? Yes, I suppose I have. Probably you would say I am undermining it! Oh, Mr. Boris, it is so good to talk to you. You never change. Even after all these years you are there, sturdy as a rock in a sculpture garden. I will call you again in a year or two. You can hang up on me if you don’t want to talk to me. That’s it! I can trust you to hang up on me if you don’t want to talk to me. Do you

have any idea—I'm sure you do—how terrific it is to be able to count on that?"

She seemed pleased that I continued to have hold of the hatred she had to confront me with.

In this chapter I am groping toward an idea of what the psychoanalytic datum might be. But I am too busy with technique to get very far. I couldn't at the time of the therapy understand this patient's feelings of being wrongfully alive, except as split-off hostility. But that it was both that and something else was immediately clear to me later, in even so brief an encounter. I might do better by her now. Still, there is more for her in the first therapy, if she feels so inclined.

My sturdiness—she might have wanted to say "stubbornness"—in defense of the work we did together is an important "confrontation." It can be seen that she began directly to reconstitute the work she had been tempted to undermine. Yet I have found that colleagues often routinely take on anyone's ex-patient without so much as a phone call, as if there is no harm in endorsing a devaluation of the prior experience. The analyst I consulted when I came to Boston would not agree to see me further until I talked to the analyst I had worked with in Chicago, and even then the question of why I did not remove to Chicago if I wanted further analysis was ever on her lips. It was very aggravating—Who the hell was he, who the hell was she—until I could use it. Good questions, who indeed?

The practice of psychoanalytically oriented psychotherapy has by now accumulated a wealth of very useful technical precepts. Among these, one is to work from the surface downward. Another is to analyze defense before impulse. A third is to fashion a working or therapeutic alliance before going on to interpret certain material, particularly aspects of the transference. And there are, of course, others.

The value of these principles lies in their capacity to achieve certain ends. But in the course of time a kind of displacement has occurred in which these means to those ends have become valued almost more than the ends that they were originated to serve. The result of this displacement is that the principles such as I have mentioned have been given a weight unbecoming to a bit of technology, with the further consequence that alternative precepts that serve the same ends have become controversial. Such is the case, I think, for the technical device of confrontation.

At the same time, it is equally true that of the variety of measures the psychotherapist can employ, not every one of them will prove interchangeable with others; not all roads lead to Rome. Nor is a hodgepodge of eclecticism likely to serve the ends in view. Technical approaches work their effects in close complementation to one another. An integrated approach will accomplish more than a simple assembly of mediations. It is such an approach, with confrontation as its centerpiece, that I shall present here.

Departures from "standard" practice become most attractive when, of course, standard practice is least able to induce its effects. One such circumstance obtains when the patient is experiencing little or no inner conflict. This

circumstance has two aspects. One is in effect when the patient, is mourning or in love, experiences matters as if all that is good and important is outside of him. The other, in essence the opposite side of the same coin, is the one that shall interest us primarily. This is when the patient feels that all that is bad is outside of himself. People who have failed to internalize one side of a potential conflict such that superego lacunae are notable and people who have all too well contrived to re-externalize conflicting factors come within this category. When either aspect of this circumstance exists, the people so arranged do not ordinarily present themselves for treatment. Instead, they direct their energies in attempts to do business with the environment. Those for whom the badness lies without will generally be busy either with psychopathic carryings on or with attempts to effect massive changes in and of their environments respectively.

But from time to time, "externalizers" do find their way into treatment, sometimes under a misapprehension, sometimes out of moral or legal requirement, but sometimes too, out of an experience of inner conflict, if one that is expended by the very application for assistance. Once there, however, such patients are by no means a breed apart, but stand in a matter of degree from probably all patients. Ignoring for the moment the countertransference implications of the phrase, the problem they pose for the therapist is that the patient so arranged cannot fathom the business of looking at and into himself. As such, the patient and therapist will both feel a distressing absence of something to meet about, indeed a degree of potential conflict over what there is for them to do. The therapist may feel the patient a threat to his therapeutic intents and procedures, and the patient almost certainly will experience the therapist as a most frightful (if potential) threat to his particular arrangements. If the therapist does not get rid of the patient on grounds of a lack of motivation or a deficit in psychology-mindedness, then what to do?

Clearly the therapist will attempt to induce the patient into undertaking that subdivision whereby part (the observing ego) of the patient joins with the observing therapist in a scrutiny of the remainder, or alien part, of the patient. But this, we must by definition assume, is not proceeding well enough to give the therapist reason to hope; and the itch to tell the patient, "Look, you're the one who is crazy, sick, impossible, wrong," is getting stronger.

If the therapist does finally convey something of this sort to the patient, he will be employing, to use Eissler's term (Eissler 1953, 1958), a parameter additional to and different from his usual clarifications and interpretations. He will be using one form of confrontation, the form that I think of as social confrontation.

Unlike interpretation, the function of which is to *resolve* internal conflicts by bringing unconscious fantasies or

feelings to the patient’s attention, social confrontation is designed to *induce* internal conflict.

The ego, as Freud observed, is Janus-shaped. One face looks outward to the external, real, or social world. The other, if only to avert its gaze, looks inward to feelings and fantasies, acting upon these as if they too had the hard, incontrovertible substance of fact. If interpretation presents to the inner face what it has failed to see of what is within and behind, social confrontation exposes to the outer face what it has failed to see of what has been externalized or left external. Both attempt to convey to the attending ego information that it has failed to acknowledge, assimilate, and take account of. In that sense, the undoing of a projection and a piece of a repression or the undoing of a denial and a reaction formation have much in common, the only difference consisting of the face, inner or outer, to which the information is conveyed.

And yet there is an important, even fateful, difference between an interpretation and a social confrontation. It is the difference between saying, “This is the third session you have wasted this week,” and “You are once more reacting as if only bad can come from our work together.” Although both statements deal with how the patient is using the sessions, the first derives from the judge’s bench, the second from the translator’s booth. The first unmistakably proscribes, the second describes something of which the therapist tries to make sense. To assent to the first, the patient must accept both the fact and the therapist, since the statement inextricably contains both. To assent to the second, the patient need only acknowledge the fact.

Social confrontation, then, is intended to oblige an internalization of the therapist. The patient is to identify his ego with the therapist’s or, perhaps, to introject the therapist into his superego. Now it is true that patients sometimes receive an interpretation in the same way. But when the patient does regard an interpretation as conveying some design or intent of the therapist, it will be out of some motive of the patient’s own; and, as such, the confusion can be clarified and the motive analyzed at any propitious time. A social confrontation, however, far from being a fantasy on the patient’s part, is on the therapist’s part an entirely deliberate fusion of content and intent, specifically contrived to convey particular force. As such, even supposing the therapist might subsequently wish to analyze its effects, it will prove far less susceptible to analysis. For though the patient may, in time, come to feel the confrontation to be far less assaultive than he initially felt it to be, will he have equal luck in understanding the meaning and function of his internalizing-externalizing propensities? It is with these propensities, after all, that the therapist felt himself to be confronted. Yet it was precisely these vehicles on which the therapist counted. Faced with the patient’s use of externalization as a vehicle to keep truths out and away, the therapist turned the vehicle around

and sent it right back, with himself now in the driver's seat.

Will it come clear to the patient, assuming it to be true of the therapist, that the therapist was not endorsing the patient's internalization-externalization dynamic? Or will the patient believe that the therapist was hoping only to reverse the flow of traffic and perhaps the choice of what the patient takes in and sends out?

Much of the undoubted effectiveness of social confrontation will be of value only to the extent that one also prefers or is prepared to risk its rather special sequel. Putting aside the more obvious possibilities—among which is that the patient may redouble his need first to externalize, then keep his distance from the external badness, and so leave therapy—one outcome may be that not only the alliance but the subsequent "cure" is effected via introjection. If the tough but good therapist is used internally to overshadow previously established internalizations, the patient may go on to conduct so ardent a relationship with the internal therapist as to manically triumph over his previous introjects. Under these circumstances, it is clear that therapy of the ordinary sort may subsequently prove impossible. Like the transference "cure," cures by introjection, even identification, are coin-flips of the original neurosis. In the latter two, the cast of characters in the internal drama may change, changing the effect *upon* the ego; but the helplessness of the ego *in regard to* the scenario will not have changed at all.

These special sequels to confrontation may or may not be acceptable to the therapist, depending, one supposes, on the degree to which the patient's symptomatology and previous inertness in therapy pose a technical or personal problem for the therapist. To the personal issue, there is little to say beyond asking why the problem a patient poses to the therapist becomes the therapist's problem; but to the technical issue posed by the relative absence of internal conflict, there is an alternative beyond social confrontation. This is confrontation of a different sort, the usages of which I propose to consider first where it is least necessary and then where, in my view, it may prove quite necessary indeed.

Let us suppose that we accept for treatment a twenty-year-old girl who comes complaining of a general depression, growing difficulty with her school work, and an uneasy relationship with her roommates. Let us further suppose that in taking the history the evidence becomes clear that her roommates stand for her sister who, in turn, stands for her mother and that the uneasiness in those relationships is of a fairly typical oedipal nature, with the problem in school work participating, at least to some extent, in the form of a success neurosis in which to succeed means to outdo mother and thus constitutes a strong source for guilt.

The precepts I alluded to earlier would translate into a course of treatment something like this. We would begin with the derivatives, on which the girl's affect is most strongly centered and out of which would flow the initial motivation for her willingness to work. Initially she would express her feelings about her roommates and convey her complaints. Encouraged by our respectful attention, those feelings would tend to heighten and broaden, taking on at times a mildly paranoid flavor. Transference feelings toward us would begin to emerge, casting us as the father, who must spurn these bad, jealous, and envious women. As this happens, her demands on us would increase to the point that listening and mildly commenting would not be enough. The situation now would increase in intensity, bring more painful affects to the surface. We would then begin to engage her further in an alliance, the thrust of which would be to have her look with us at the meaning and function for her of what she is and has been going through—to turn inward. As tactfully as we could, we would help her focus attention on the work of those attributes in herself that she found most alien. Fairly soon self-understanding, still vis-à-vis the roommates as derivatives, would begin to ease some aspects of her overinvolvement. As a result, she would begin not only to experience some relief but also to come further toward accepting the alliance for self-study that we are the while fashioning and exercising with her. In time, we would begin to demonstrate the displacements, on the one hand, and the derivatives of the conscious feelings, on the other. We would point out connections between perceptions of and feelings about the roommates and her sister and help her to move, thereby, toward a consideration of father's role in those latter feelings. As she became more immersed in this undertaking, we would show her the gaps in her feelings toward her sister that have been left by repression, splitting, or denied. The recovery of these lost feelings would bring the initial object, mother, more into view. And so it would go on until, depending on our assessment of her needs and vulnerabilities, we either took some of these issues further with her or began to taper the process off before further regressions could take place as the heirs and preludes to earlier experiences.

In the procedure I have just outlined, confrontation has found no place. But it is worth considering whether it could have a place! On the face of it, the answer would seem to be no. If, for example, we directly confronted this patient with the fact that it is her mother who is really at issue, we would likely be met either with massive disbelief, which would be a credit to her defenses, or with profound outrage. Outrage would, among other sources, come from her narcissistically well-wrought conviction that she has outgrown mother and all those old, dreary preoccupations with father; and we would be flying head-on into an already fragile self-esteem. Indeed, if we pressed the interpretation, it is not unlikely that the patient would abruptly terminate treatment. We are thus well cautioned against wild interpretations.

But if we go back over these consequences, we see the depressive and persecutory anxieties to which the patient would be subject were we to in fact make interpretations from, as it were, the id. Let us focus on these anxieties for a few moments. It is plain enough that we could have aroused these anxieties by wild interpretations, interpretations from the id. But are they not there in potential anyway? So what if, rather than beginning with where the patient is in terms of the real-life situation, we began with where the patient is in terms of her apprehensions about therapy—the very apprehensions we have been so carefully allaying or treating with so delicately in the use of our usual principles?

Now we can be sure that we are not the only ones who are trying to find ways around the encounter with these anxieties: the patient is, too. She will be doing so in the material she presents, the way she presents it, the means she uses to offset the potential threat we could present—in short, by the actions she takes.

If we race headlong into making wild interpretations, we would mobilize these anxieties and see them all too clearly for the brief moment before her emergency countering action would take place. But we do not need to see these anxieties directly. They are easily inferred from the precautionary actions the patient is taking in, round, and about the manifest content of the therapy. And though they occur instantly in the first session—really because they occur so immediately—only to recede in the face of the reality of our presence, they are transference anxieties. Their capacity to give way as our presence becomes felt and the alliance becomes wrought argues generally for the good reality functioning of the ego. But before the ego does its work, the anxieties and the fantasies that accompany them are very nearly delusional even in so basically neurotic a patient as is the young lady we have been considering. Her capacity to act appropriately obscures this for us, as the success of her active responses to her anxieties enables her to barely feel them and even less to become aware of the fantasies about herself in relation to us, and vice versa.

Now in time, were it a searching psychoanalysis we were assisting her in, these would reemerge at the depths of the transference neurosis. But there are patients, borderline and frankly psychotic, in whom these anxieties are foremost and are not susceptible either to delay or to therapeutically appropriate countering actions. I shall deal with these instances later. The point I wish to make here is that such anxieties are immediately present and in good evidence with any patient and that they can be dealt with immediately, should one wish to confront the patient with them.

Now the device of confrontation too has its principles, because the use of confrontation in therapy, however

unfamiliar it is to therapists generally, is by no means unique. Winnicott (1962) subsumes the process as one that "leads from the Unconscious" (p. 297). Others of a more rigorously Kleinian bent suggest interpreting the psychotic anxieties first (cf. Klein 1957). But notice that when we are going to deal with psychotic anxieties or unconscious material we have to talk the language of the unconscious and of psychosis. This, as most of us know, is a very concrete language, and one with very active verbs in it. Its syntax is never elliptical, conditional, nor does it contain any negatives. It is causal and effective, in which the subject does something active to the predicate because. Action is the essence of the experience; reed or fantasied countering actions are the defense.

Now as to the anxieties themselves. They will be of two basic sorts: (1) the talion anxiety, out of which the fearful, underlying wish is projected and the threat experienced as originating externally and (2) the depressive anxiety, in which the source of the fear is experienced as internal and originating from an internalized object. I would call this, with Anna Freud (1965), a superego anxiety, were it not for the archaic nature of some of these anxieties, which are more reasonably termed superego precursor anxieties. These two anxieties, though phenomenologically different, are, at root, really one. But projections and introjections do relocate the object that is experienced as the source of persecution and hence, the felt experience. It is of considerable importance to determine who the persecutor is, or at least where he, she, or it is located, and hence, the kind of anxiety—depressive or talion—that is being experienced or warded off.

If the principle of confrontation involves interpreting the patient's anxieties in terms that describe the unconscious fantasies that engender the anxieties, let me now go on to say why.

In confrontation, as I am using the term, one does without the usual therapeutic alliance. Insofar as one does fashion an alliance, it is not, as in the more familiar procedure, with a part of the patient's conscious, observing ego. It is rather with the repressed unconscious, that pathway to the id.

The ego, after all, is at least partly the agency that offers resistance to the repressed aspects of the impulse life, which transfigures them with its defensive maneuvers and which, in its narcissistic preoccupations and love-hate affairs with the internal objects, diverts them from realization and discharge. Rather than attempting to allay its vigilance with an alliance built up of the patient's identification with us and our therapeutic procedures, confrontation interferes with the defenses and bypasses that aspect of the ego. In using confrontation, the therapist reaches across to what lies beneath the ego. This is, of course, the restless stirring of the impulses, which, as much

as they are held siege by the ego, hold it, in the symptomatic or characterological impasse, no less captive. That state of affairs reduces the autonomy of the ego, the restoration of which constitutes our therapeutic goal.

The autonomy of the ego, as Rapaport (1957) among others has shown, is comprised in two directions. As it tries to gather strength against the upward, outward push of the impulses, it throws itself into the arms of social reality for proscriptions, limits, indeed frustration. But once there, its autonomy threatens to be compromised from that direction also, for to be a "good" person all too often means excessive renunciations of the impulse gratifications that enrich and enliven the ego and give it a base of strength of its own. Thus, it must retreat and defend against the strictures of reality too, usually via denials and introjections, ultimately the formation of the superego. This increase of distance and hence autonomy from the social world can preclude impulse gratification, thus raising inner pressures again.

In effecting the usual therapeutic alliance, we offer a professional and sometimes a more explicitly real self together with a set of ego procedures to a patient whose own self and ego have been too well compromised in its mediative attempts to adapt impulses to reality. The benefits of this are obvious.

Not so obvious are the costs, for in fashioning the alliance we palliate the pressures the patient experiences and hence deprive him of the need to bring forth essential material. The balance between amelioration and cure is too much in favor of salving. But more questionable even than that is whether the identification with the therapist, the therapy, or the social values of the therapeutic system, so adaptive to us and our needs, is not at the same time a symptom for the patient that fails to get analyzed. In asking the patient to take a given attitude or in demanding he renounce one, in being real for the patient or even therapeutic, do we *unnecessarily* compromise his autonomy? Social confrontation seems to me to contain more of this risk than the inculcation of the alliance in usual ways. But, on the other hand, it is so pronounced a measure that it stands out and calls both therapist's and patient's attention to it. As Bion (1966) has observed, it rather is the countertransferences that the profession shares that escape recognition and analysis; surely the widespread, unquestioning belief in the therapeutic alliance is one of these.

Thus, if it is not necessary to inculcate identifications, we may do more for the patient by not doing so. The question is, then, can we avoid the traditional alliance?

With confrontation one can and does. As I noted with the patient we were considering, the effect of bypassing the ego is an immediate rise in anxiety. But there is also another effect. The transference-rooted longings

immediately gravitate to the therapist, so much so that they directly occupy center stage; and it is his sense of this propensity that all the anxiety is warning the patient against. But the transference longings themselves can form a bond stronger and more adhesive than the usual therapeutic alliance. Thus, while the patient may consciously resist, he unconsciously cooperates with treatment. The easiest example of unconscious cooperation is the slip of the tongue, which, in indecent haste, infiltrates the ego's machinery of wary vigilance. But that kind of infiltration is not the only pathway; the ego is filled with interstices. Nonverbal behavior, silences, transitions, gaps in secondary process communication till reveal in their absences the presence of unconscious cooperation.

By attending to this, despite the disinclined ego, one cements the allegiance from the patient's unconscious. The resulting anxiety, however, must continually be interpreted. Its interpretation marks the difference between the "wild analysis" of the unabashed beginner and the careful crafting of confrontation.

The conscious aspect—the observing ego—listens in on these interpretations. Nothing more is asked of it in the way of participation. In this sense, its autonomy is respected. Though it will find some measure of relief from anxiety and guilt from understanding what it experiences, the object of the procedure is to enable it to assimilate the wishes it has warded off.

When it does assimilate and integrate the impulses, its captivity by social reality, internalized and external, is reduced. It can act more autonomously, with greater true distance and perspective. One need not, then, concern oneself with matters and experiences external to the analysis of the transference. One need only—and that just in the first stages of treatment—actively interpret the anxieties that constitute the resistance to the transference neurosis or psychosis. After that, the transference becomes the sole preoccupation of the patient.

It is, however, important, even vital, not to provoke, induce, or elicit the transference actively. One does not replace one alliance with another, but remains impartial. So however active one may be in clearing the way for the development of the transference by the interpretation of the meaning and function of the anxieties that comprise the resistance, the interpretation of the transference wishes themselves must closely follow the patient's own material. Wild interpretations, as I noted, are out.

In confrontation, then, one bypasses defense analysis, goes to the analysis of those anxieties that resist the full flowering of transference, and then goes on to interpret the transference (and only the transference) in the ordinary way. Thus it brings one to where one is going on behalf of the patient via allegiance from the unconscious,

achieving the same ends by almost inverse means.

With these alternative precepts in prospect, let me now return to the young lady we were considering earlier. But this time we will eschew the procedure I earlier supposed—and with it, taking the history and making an evaluation. Instead, we shall get, as it were, right down to work.

The first thing one will notice is that she is experiencing some anxiety, and so one quite gently calls this to her attention. She gives a half laugh, allowing some of the tension to discharge and acknowledging that she feels a little nervous. Something frightening could happen here? One half says, half asks. This, however, she denies and then instead offers her story. But now one interrupts: "Talking about being frightened is frightening?" one asks.

Her response to this is a fugitive move of impatience, a hesitation, during which one may well imagine she is deciding how best to deal with one's intrusion; and then, having decided another denial would put her in a bad light, she says merely, "I guess so," and prepares to go on with what she came to do.

She goes on, then, with her story; and this time one does not interrupt, at least for a while. Interrupting directly would be experienced as so assaultive as to make the transference and the reality too difficult for her to distinguish.

As one then briefly retires to listen to her story, one listens less to the facts and figures (for we would hear all this again, and anyway, it is likely to be quite distorted in its present rendition) than for what effects her narrative is designed to have on one. Her narrative is a countering action to what she imagines one to be up to and about. It has its defensive components, designed to forestall or allay, and it has its courtship components, calculated to allure and entice. From these we can fairly readily infer what her anxieties are, especially if one, on his part, fails to comply with the intentions she has of her narrative. The restraint one places on his own inclinations to respond with um-hums, questions, nods, or the taking of notes, will bring his own impulses more clearly to mind. And, adding these data to what one has inferred from what the patient is attempting will make matters reasonably plain.

As the patient proceeds and as one makes no compliance, one will soon see the eruption of anxiety once again; and this will serve as a cue. The eruption will be experienced by the patient as ego-alien, as if an undesirable symptom; and so one's intervention at this point will be experienced as less intrusive than if one had not waited.

One might say, “You are disappointed.” If she tentatively acknowledges this, one would add, “You had hoped for better?” If she denies that she is disappointed, one deals with the anxiety that prompts the denial: “It is better not to care—one could get hurt.” Or, “It is better not to care, because one can hate oneself for not succeeding.”

She is likely to give either of these a mixed response, as if to say, “Yes, I care but don’t want to.” And one says, “For fear of disappointment.” If she acknowledges this, one will say, “From whom?” She will say, “From myself.” One then will say, “It is not right to hope for better from me?”

With this the anxiety that was temporarily allayed by our empathic clarification of her disappointment will rise again with the guilt over what will seem to her our permission to let loose her transference wishes. And so, with this the issue is joined. The anxiety is high, the defensive maneuver curtailed, and the only thing in the circumstance that will offer some relief is the further emergence of the unconscious transference wishes.

From this point on, with one reaching backward, not into her history, but back to the beginning of this first session, there will be a counterpoint between the expression and interpretation of anxieties and then the expression and interpretation of wishes. The first will open the way to the second, and the second will engender the first. One can feel that the alliance has been really joined when she tells of the fantasies about this first session that she had before even the initiating phone call.

If I am correct that in cases like that which I have described, the choice between approaches amounts to six of one and half dozen of the other, such may not be the case in procedures open to us in working with borderline and psychotic patients. For there we have, on the one hand, approaches that attempt to buttress the besieged ego through doses of reality, supportive relationships, and facilitative interjections of counsel or limits—all of these intermixed with the painstaking elicitation of affects; and then, on the other, we have a confrontative procedure that reaches beyond the strenuated ego to the fantasies and feelings it so valiantly, though quixotically, is attempting to ward off. Both may be said to strengthen the ego: the first, by support, as it were, from the outside and above; the second, by facing the averted ego inward, from within and below. But beyond this shared strategy, through implementation, a difference may exist. Supportive approaches tend, generally speaking, to reinforce defenses against the return of the repressed, and intervene primarily with such troubling defenses as denial and projection. But confrontation here too tends, by and large, to facilitate the emergence of the unconscious by attending to the anxieties that induce not only the denials, regressions, and projections but the repressions as well. This can only have an outcome different from

traditional ego-supportive measures. If, therefore, there is controversy over means here, it is likely to be a displacement from convictions about either their comfort or the possibility of the achievability of the ends.

However, since the prime medium of all therapeutic work is the therapist himself, his position in respect to the patient will be the governing factor in the workability of this, as of any procedure. The method I am discussing must be rooted in the absence of a very particular sort of countertransference. It requires that to the largest extent one can, one wants nothing for or from one's patient. Only under these circumstances can confrontation escape being a preemption in which "one strolls about the other's mind as if it were one's own flat."

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. Once aroused, envy's urgent need to be quenched and its no less imperative need to bite the hand that feeds it can foil or despoil any therapeutic attempt until the entire therapy is frozen in an unending stalemate.

One can forestall 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. Or one can analyze envy in the measure to which it arises and, by so doing, maintain the neutrality upon which confrontation of the transference resistance so utterly depends.

This point is illustrated in the example of confrontation I shall shortly describe. The case is one where the choices among approaches might each have led to different ends—a foreclosure of fuller effects in the more usual approach and what continues to look like an opening to a reasonably thorough therapeutic analysis through confrontation. But note, too, the effect of my countertransference reaction in the fourth session.

Since I am interested in conveying what I can of the feeling of the encounters that comprise the vignette, I shall not present background or historical material except as it was presented to me.

Miss Gallet phoned one evening to tell me that she was about to commit herself to a state hospital because she was very fearful of hurting herself but wanted, before doing so, to see me and thereby arrange for treatment that she could return to on her release some ten days later. I agreed to see her between appointments the following day, and she duly presented herself for the twenty minutes I could arrange.

I was at once struck by her eyes, which were almost flamboyantly made up. The next of her features to catch my attention were her teeth. For the rest, she was a somewhat statuesque young woman in her middle or late twenties who, though dressed with some style, had outgained her clothes. Since the meeting was to be simply one in which to make arrangements, I simply sat back to hear what she had to propose.

She told me that she had just broken up with her boyfriend, on whom she had been very dependent; and she was afraid that unless she did something else, she would do what she did the last time she had broken up with a boyfriend and withdraw into a comer, as she put it, in a very masochistic way, for four years; and she just couldn't do that again.

But having said that, she interrupted herself to ask me what I thought of "Thyrozine," as she called Thorazine.

I said: "You have some thoughts about it."

She said: "What do you think of Preludin?"

I said: "Preludin and Thorazine."

She said: "That's just it!" And laughed.

It then developed that Preludin, which is an appetite suppressant, and Thorazine were felt by the patient to be at odds. Her medicine was Preludin, but the doctors (five psychiatrists, it turned out, had been involved in the last several weeks) gave her Thorazine, which she felt to undermine Preludin.

I said: "What kind of doctor am I? One who puts into you the wish to grow fat and sleepy and fill yourself up with mother and food, or one who will help you become independent?"

She sent her high arcing peal of laughter up again and then said simply, "Yes."

The second session was held two days later. The patient said that she had gone to the state hospital, but without an admission slip, and was therefore not admitted. She had then returned to her second psychiatrist, who filled out the paper; but now, handing me the paper, she came to ask me what I thought.

I said: "What kind of doctor I am?"

She said: "Yes."

I said: "You are asking because you are afraid."

She said: "Yes."

I said: "Of?"

She said: "That you think I should go into the hospital."

I said: "Like who?"

She said: "Them."

I said: "Them?"

She said: "The people."

These, it developed, were a considerable assembly who were testing her, giving her messages, and otherwise controlling her life.

I said: "You are worried about testing me with your questions, about giving me messages about taking me over. Doctors have Thorazine and hospitals and other things to put into people, and you are worried that you don't. So that you are worried that I can hurt you with my things worse than, in self-protection, you can influence me with yours."

She responded to this with another question: Could I do two things for her? One, go to Children's Hospital and get the records of when she was a patient at age four or five; two, find out if her birth certificate is authentic.

I said: "What do you wish?"

She said: "I just want you to see if they did something to my head. And I want you to see who my parents really are."

I said again: “What do you wish? What do you hope I would find?” She responded to this then saying that her parents wouldn’t be her real ones and that something had been taken out of her head.

I said: “That is the other side of what you said before. Sometimes you feel that you are missing something and want people to put it back into you, and sometimes you feel you have ideas that you wish were taken out of you. And these feelings have to do with your parents; sometimes you want to put ideas into them and sometimes to take them out, and always you are afraid of what you believe they can do back to you.” The patient then went on to elaborate on the meaning of the wishes concerning her head and her parents, something that was to occupy her for some weeks. Later, while she was in the hospital over the severe depression the abandonment of the splitting and projection introduced, she reconstructed the experiences of incest that had taken place between herself and her father, and the delusional material stopped abruptly.

But before this could happen one other episode had to be confronted. This took place before and then during what was to be our fifth session. The fourth had been in my office at home at six o’clock meeting time. There was an aura of reticence throughout, which I could not properly identify, partly because during that week I was preoccupied with certain occurrences in my own family. These were much with me, and I kept nodding to them and telling them I would hold an audience for them later. I didn’t manage to see that their presence had also to do with this patient.

On the Friday of the fifth session the patient’s mother called to say that the patient had barricaded herself in her room and taken “a whole lot” of sleeping pills and tranquilizers, had gone to sleep, but had wakened to tell her to call me to say that she wasn’t coming.

But I insisted that she come and, when the mother said she didn’t feel her daughter was in a condition to drive, told the mother to put her into a cab.

And so the patient came, looking bloated and pasty and altogether hag-ridden. Her mouth was dry and she had difficulty working it. She sat slumped in silence, but I noticed that she looked at the clock from time to time in an intent sort of way.

I had the fantasy that she had swallowed my clock, so I said: “You have feelings about the clock—it worries you.”

She nodded.

I asked her what worried her, but she seemed confused and shook her head.

I said: “You hate the idea you had about the clock and have attacked the idea and so confused yourself.”

She sat up straighter and said, “Something about six o’clock.”

“Six o’clock,” I repeated, “and about swallowing.”

“It’s suppertime,” she said.

“Whose?” I asked.

“Yours?” she asked.

“So you are keeping me from my supper?” I asked. “That worries you?”

She nodded.

“Tell me,” I said.

She tried to work her mouth, but gave up and sort of shook her head.

“You are worried that I might eat you,” I asked, “instead of my supper?”

Now came the sudden peal of laughter. She sat forward now.

“I suppose you think that that’s because I want to eat you,” she said. “Is that why I took the pills?”

“Is it?” I asked.

It then developed that she was valiantly trying to diet, had been feeling starved, had envied my ability to eat, had wanted to deprive me of my supper, had felt some compunction, had felt hungry for me in an endless sort of way—being afraid of the long-seeming weekend—was afraid of these feelings, had put them into me, was afraid to come

for fear that she would experience them again, and so had eaten her doctor-pills and spared me.

Further working through of this material opened the way for an emergence of more genital wishes and the intense depressive anxieties she experienced in relation to them. The regressive maternal transference shifted somewhat and new material came to the fore. But of particular note is that though the patient's life situation had been very difficult—including a 2½ month hiatus in treatment—she had managed to maintain the depressive position and keep her paranoid proclivities at bay.

Now, in conclusion, I thought I would like to say what brought me to try to learn the confrontational approach to begin with. It was not the task of working with neurotic patients where it is a six-of-one-half-dozen-of-the-other option, nor even that of working with borderline or psychotic patients, where it is often the approach of choice. Nor was it to work with groups, where I myself use it quite extensively, even exclusively. It was, of all things, to meet the task of trying to begin work with what statistically speaking is the normal person: the people of the community with whom, if anything is to be done, one must take the initiative and painstakingly develop a working relationship. For in such work, the consultant himself often becomes the epiproblem for the consultee. If one is not, therefore, to settle for working with the self-referred, the self-selected, and the coercively referred, one must, or so I feel I have learned, develop a method very like that which I have been discussing; for analysis of transference anxieties, which would otherwise induce in the consultee massive sorts of resistance and be managed, most usually, by avoiding the relationship altogether, proved to open the way to reaching and engaging with the very hardest of the so-called hard to reach (Boris 1971).

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Notes

[1] I was lucky also in my first adult patient, a man who was having rather a time of it with some voices when I introduced myself to him as his therapist. "I am out of contact, hallucinating, incontinent," he told me, "and you ask if I mind if you smoke!"