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Clinical Interventions

SITUATIONS OF CONFLICT

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

1. The patient is obviously upset but is trying hard not to cry.
2. The patient knows that his therapist will not laugh at him but finds himself fearing that the therapist might.
3. The patient is upset with his therapist and knows, on some level, that he must eventually confront the reality of just how disappointed he really is, but he would like to think that he could get better without having to do that.

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

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

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

Here we are naming something that was not previously named, in an effort to make the patient more conscious of an anxiety-provoking reality that he both does and doesn't know. Actually, we are naming something that the patient really does know (on some level) but against which he defends himself.

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

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

In each of these instances, we are choosing, for the moment, to go with the resistance by naming the defense, in an experience-near, nonjudgmental, nonshaming way. In order to name the defense, we must be able to enter into the patient's internal experience and be willing to experience the world as he does, so that we can articulate, on behalf of the patient, his stance.

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

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

Such statements I refer to as *conflict statements*. In each instance, the conflict is between the patient's knowledge of reality and his experience of it. The conflict statement says, in essence, "Even though your knowledge is that . . . , nonetheless your experience is that . . . " or "Even though you know that . . . , nonetheless you feel that . . . "

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

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

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

THE CONFLICT STATEMENT

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

work to be done involves confronting certain painful interpersonal realities.

Then you name the force that says no, the negative force, the defense, the resistance. In the first situation, the patient's defense is his determination not to cry, his determination not to feel the intensity of his sadness. In the second, the patient's defense is the assumption that the transference object will turn out to be just as the patient expected him to be (expectations arising, presumably, from earlier experiences at the hands of the infantile object). In the third, the patient's defense is his hope that he can get better without having to face certain painful realities. The therapist names the patient's defense in a way that highlights the fact of it, without implying that there is something wrong with it.

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

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

WORKING WITH THE PATIENT'S DEFENSES

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

The therapist knows that the previous session was very hard for the patient and that, despite the patient's protests to the contrary, the patient must on some level have feelings about that. The therapist could choose to explore some of those feelings. The patient, in response to the therapist's attempts to ferret out his underlying feelings, might perhaps be forthcoming about such feelings, but more probably the therapist's probing would make the patient dig in his

heels, would make him even more defensive. After all, the patient has already insisted, with some vehemence, that his lateness has nothing to do with mixed feelings about being there.

Let us imagine that the therapist decides instead to take the patient at his word and not to insist that the patient admit to having negative feelings about the previous session. The therapist recognizes that the locus of the patient's affect in the moment is his distress, his concern that he will not be believed—thus his vehement insistence that it was important to him to be there. And so the therapist says, "It's important to you that I understand just how much you wanted to be here today, and on time." Here, the therapist is going with the resistance, by resonating, in a respectful way, with the patient's need to have the therapist believe that he wanted very much to come. The patient will feel relieved, because the therapist has appreciated how important it was to him that he be taken at his word.

The therapist must learn to be patient; he must not need the patient to be constantly acknowledging how he is really feeling. There will be time enough to explore how the patient is really feeling when and as the patient becomes less anxious, less defensive. As it happens, later in the session just described the patient began to talk about how difficult it was for him to be in a subservient position in relation to his boss at work and how particularly humiliating it was for him to have to punch in and out on a time clock. The patient went on to volunteer that it was sometimes difficult for him, in the therapy sessions, to be limited to the 50-minute hour, that in the previous session, for example, he had been struggling to recover some painful memories from his childhood and had experienced the arrival of the end of the hour as extremely disruptive. The patient talked about how painful it is for him in the sessions when he finally "gets going" and begins to get into deep material, only to discover that his time is up. The therapist was then able to direct the patient's attention to his relationship with his father, a man who was very much wrapped up in his own concerns and unable to give his son much time. The patient wept as he remembered a time when he had been excited about a science project he was working on for school, had asked his father to come up to his room to admire it, and had been bitterly disappointed when his father would not even make the time to look at it.

The therapist, by not insisting that the patient 'fess up to how angry he was from the previous session and by being willing to take the patient at his word, was able to create a space within which the patient

was able, when he felt ready, to find his own way to what really mattered to him, namely, that it was very painful for him that there was never enough therapy time, just as it had been painful for him that there was never enough time with his father. Had the therapist interpreted the patient's lateness as an instance of acting out negative feelings, as speaking to the patient's need to avoid dealing with how he was really feeling, or as arising from a wish to limit his therapy time, then the therapist might never have given the patient an opportunity to acknowledge that in fact it was difficult for him to be limited to so little time. (Shortly afterward, patient and therapist decided to shift from once a week to twice a week.)

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

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

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

"You are determined not to let me matter that much."

"You are determined not to let anyone matter that much."

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

"You're not sure you have all that much to say about the termination."

"You are not someone who gets angry without good reason."

"It's important to you that you be able, always, to feel in control."

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

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

When we go with the patient's resistance, we are careful not to challenge it. We are not interpreting the patient's defensive posture; we are naming it, highlighting it, defining it. It is his way of constructing his world, and we are respectful of it. We frame our interventions in such a fashion that the patient will feel understood and may even gain further understanding as well. We do what we can to use verbs that emphasize the element of choice in what the patient is doing/feeling; we want the patient, over time, to recognize and to own the power he has to decide how he wants to experience his world. When we suggest, for example, that the patient is determined not to be angry, or when we suggest that the patient does not want to be someone who is dependent, we are attempting to name the power he has and to make him aware of the choices he is making.

Think about the difference between "You do not have all that much to say about the termination and "You are not sure that you have all that much to say about the termination." The advantage to the second intervention is that it lends the patient a little more dignity, highlights the element of choice in the way the patient is dealing with the termination. More generally, whenever we name the patient's defense, we want to make him ever more conscious of the volitional component to his experience of himself and his objects; in essence, we want him to move ever closer to owning the ways in which he constructs himself and his world.

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

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

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

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

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

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

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

"You are not yet convinced that I can be trusted."

"Your fear is that you will be judged."

"Your fear is that I will judge you."

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

"You want so desperately to be understood."

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

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

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

"You feel that you must have guarantees."

"You want me to tell you what to do."

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

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

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

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

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

OWNING OF RESPONSIBILITY AND MOVING ON

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

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

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

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

Such a patient may say to us, with incredible anguish, "What do I do now? I understand why I am as I am. I understand how my past has

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

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

THE DAMAGED-FOR-LIFE STATEMENT

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

The patient may experience himself as having been victimized by bad parenting early on; he may experience himself, more generally, as always a victim of injustice, a victim of fate, a victim of unfortunate external circumstances; or he may experience himself as having an inborn, constitutional deficiency. In any event, he has a distorted sense of himself as damaged, incapacitated, rendered impotent.

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

A damaged-for-life statement, then, attempts to articulate some of the underlying distortions to which the patient clings as unconscious justification for his inability or unwillingness to take responsibility for his life. Because such distortions constitute part of the patient's resistance to moving forward in his life, it is obviously important that they be uncovered and named.

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

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

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

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

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

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

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

THE COMPENSATION STATEMENT

Many patients feel, on some level, that they become complete only by way of input from the outside. They feel that because of damage sustained early on at the hands of their parents, they are now limited in terms of their own resources; there is nothing they can do to get

themselves better and must therefore rely on input from the outside in order to make up the difference. In what I refer to as a *compensation statement,* the therapist calls attention to the patient's wish to be compensated now for damage sustained early on; the therapist highlights the patient's illusions about being able to find someone on the outside who can make up the difference to him. Whereas the damaged-for-life statement highlights the fact of the patient's distortion, his misperception of himself as a helpless victim, the compensation statement underlines the patient's illusion that the object is a potential provider of the magic, the answers, the love, the reassurance, the things that will heal him and rectify the damage done early on.

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

Examples of compensation statements are:

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

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

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

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

"You wish that I could tell you what to do."

"You wish that I would tell you what to do."

"You feel you can't do much more on your own. At this point you wish that I could do something to help you out."

"You feel you can't do much more on your own. At this point you would like someone else to tell you what to do."

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

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

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

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

THE ENTITLEMENT STATEMENT

The third intervention is what I call an *entitlement statement.* In it the therapist recognizes that the patient not only wishes for input from the outside but also feels entitled to such input, feels that it is his due, his right, his privilege to have someone from the outside make up the difference to him. Because he feels so cheated from long ago, he believes that he is now entitled to compensation in order to make up for the environmental failures early on.

Examples of entitlement statements are:

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

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

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

"Your father never supported you and was always critical; at this point, you won't be satisfied until he can acknowledge that he was wrong and that he owes you an apology."

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

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

In sum, the patient's distorted sense of himself as so damaged from early on that he is not now responsible, his illusory sense of his objects as able to compensate him now for that early damage, and his sense of being owed that compensation need to be uncovered and named, so that the patient will be able to overcome his resistance to moving forward in the treatment and in his life.

RESPECTING THE PATIENT'S INTERNAL EXPERIENCE

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

It is relatively easy for the therapist to empathize with people like himself, much harder to empathize with people unlike himself. When the patient experiences the world as the therapist experiences it and reacts as the therapist would react, it is not too difficult for the therapist to enter into the patient's experience and to be with him in that. But when the patient is different from the therapist, then it is a lot more difficult for the therapist to enter into the patient's experience

and come to understand, deeply, why he feels as he does and does what he does.

For example, it is not too hard to be empathic with a patient who is in a great deal of distress because her boyfriend physically abuses her. It is much more difficult to be empathic when she tells us that she cannot leave him. This latter situation requires of us that we let go of our investment in thinking that things should be a certain way; it means being willing to put ourselves in her place so that we can deeply understand why she needs this man in her life. Even though there are times when he makes her feel horrible, it may well be that at other times she feels loved by him in ways that she has never before felt loved. Perhaps when he is loving her he makes her feel special. Perhaps she feels that she is deeply unlovable and should be grateful for whatever love she can find. Perhaps she does not realize that it could be different.

Perhaps being in the relationship with this man enables her to hold on to her hope that maybe someday, if she is good enough, she may yet be able to get him (a stand-in for her father) to love her as she so desperately yearns to be loved. She does not like the abuse but is willing to put up with it if it means being able to hold on to her hope that someday she may be able to get what she has wanted for so long. When people have had the experience of abuse early on, it is usually not enough that they now find a good (loving) object who will treat them well. The investment is in finding a bad (abusive) object who can be made into a good object. The truly empathic therapist will be able to appreciate that while the unhealthy part of the patient is invested in recreating the early-on traumatic failure situation, the healthy part of the patient needs first to re-create it and then to have the experience of a different resolution this time. In that is healing.

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

As another example, if the patient is blocked in his affect and/or does not let things get to him, it may be difficult for the therapist to be empathic with the patient's need to be this way, because it is so different from how the therapist is and what he believes in. Nonetheless, it is important that the therapist, over time, be able to appreciate why the patient needs to avoid feeling his anger, his hurt, his

disappointment, or his pain and why the patient needs to remain untouched.

In order to understand how and why the patient has come to be as he is, the therapist must listen very carefully both to what the patient is saying and to what he is not saying. Perhaps the patient is afraid that if he were to let himself really feel, he would lose control entirely, would be rendered helpless and disabled, and would never come out of it. Perhaps the patient's fear is that if he were to access his true feelings, he would discover not just anger, hurt, disappointment, and pain, but murderous rage, anguished despair, and devastating heartbreak. The patient may or may not know this about himself. Or perhaps the patient has derived a fair measure of his self-esteem from being able to remain in control, on top of things, relatively unaffected by what happens around him—and is therefore not about to give up his stance of proud self-sufficiency and iron-willed self-control.

More generally, the truly empathic therapist must be ever respectful of the patient's needs, albeit defensive ones, to be as he is. The more different the patient is from the therapist, the more difficult it may be for the therapist to empathize with the patient. But whether that task is easy or hard, the therapist must be able to come to the point where he can deeply understand why the patient needs the defenses that he has, why the patient protects himself in the ways that he does, why the patient will not let himself know the truth about himself and his objects, why the patient remains stuck, why the patient keeps repeating that which he would rather not, and why the patient cannot let himself do that which he should. It is this respect for the patient and what motivates him that informs the interventions the therapist then makes.

SUPPORTING THE PATIENT'S DEFENSE

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

Therapist: I wanted to let you know that I'll be away for four weeks in August.
Patient: Oh, I'm glad you'll have a chance to get away this summer.

If the therapist were to try to interpret the id material, namely, to try to make the patient aware of her underlying feelings, he might then say something like "I think you may also be angry and upset that I'll be away for so long," to which the patient might respond with "You might be right, but I'm not aware of feeling that way."

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

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

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

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

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

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

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

Patient: (very sad, with tears) Yes.

This example provides a powerful illustration of how effective it can be when the therapist simply goes with the resistance by coming down on the side of the defense. When the therapist says, "And it's important to you that it not bother you—my being away this summer," he is letting the patient know that he understands, that he knows how important it is to the patient that she not let herself feel bad about her therapist's upcoming absence.

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

When the therapist says, "Even if it did get a little lonely sometimes, you knew you could do it if you had to," he is using a conflict statement, first gently suggesting he knows that the child must have felt lonely sometimes and then respectfully acknowledging the pride that the little girl must have felt at being able to do it all on her own. By juxtaposing the thing being defended against because it provokes anxiety and the thing doing the defending, the therapist is able to bring more closely together the two sides of the conflict with which the patient is struggling.

THE DEFENSE-AGAINST-AFFECTS STATEMENT

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

For now, let us think about the situation that arises when the patient is resistant to acknowledging the presence of an anxiety-provoking affect. In that situation we may want to use a particular kind of conflict statement, something I refer to as a *defense-against-affects statement.* I shall discuss such an intervention in order to demonstrate more generally the ways in which conflict statements can be used,

whether to highlight defenses against anxiety-provoking intrapsychic realities (as this defense-against-affects statement does) or to highlight defenses against anxiety-provoking interpersonal realities (as do most of the statements discussed later).

The defense-against-affects statement is an attempt by the therapist to articulate, in a way that will make sense to the patient, the conflict the therapist senses the patient is having around allowing himself to experience an intolerable affect. In making the statement, the therapist is trying to engage both the patient's experiencing ego and his observing ego; the therapist wants both to validate the patient's experience and to enhance the patient's knowledge. To that end, the therapist both resonates with his senses of where the patient is (thus providing validation) and articulates, on the patient's behalf, his understanding of the conflict with which the patient is struggling (thus enhancing the patient's knowledge of himself and his internal process). The goal is to make the patient ever more aware of the conflict within him—that is, the internal tension between the affects against which he defends himself and the defenses that protect him from having to feel them.

Examples of defense-against-affects statements are:

"You are sad, but you are determined not to cry."

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

"It bothers you when your mother says things like that, but you feel it's important that you not let her get to you."

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

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

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

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

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

On the other hand, if we can appreciate that of course he has many feelings about his mother and if we can help him express both sides of his conflicted feelings, both his gratitude and his anger, then we have freed him up to acknowledge and explore the whole range of feelings he has toward his mother. And so we might say something like "Although there must be times when you find yourself feeling impatient with your mother and annoyed by all her demands, for the most part you are deeply grateful to her for all that she has given you over the years."

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

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

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

"Right now you are hurting so bad inside, but you're afraid that you would come apart at the seams if you were to let yourself feel just how sad you really are."

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

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

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

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

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

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

Regarding the first portion of the defense-against-affects statement, there will be times when the therapist might choose to say something like "You are sad . . . " and other times when the therapist feels more inclined to say "You know that you are sad. . . . " Both convey about the same thing but have slightly different emphases. In the second intervention, the emphasis is a little more on the patient's knowledge of what he is feeling than on his actual experience of it. The patient is being subtly encouraged to step back from his experience of the moment in order to observe how he is feeling; paradoxically, by giving him a little more distance, that wording may well free up the patient to acknowledge an affect that he might not otherwise have felt comfortable acknowledging.

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

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

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

THE STRUCTURE OF THE CONFLICT STATEMENT

More generally, the conflict statement (of which the defense-against-affects statement is a specific instance) is intended to empower the patient or, rather, to encourage the patient to own the power he already has; the therapist is gently encouraging the patient to take ownership of his conflict and of the tension within him between feeling and not feeling, between doing the right thing and not doing it, between acknowledging reality and needing to defend against it. Furthermore, the therapist is suggesting, indirectly, that the locus of responsibility is an internal one—something over which the patient has ultimate control. By so doing, the therapist is facilitating internalization of the conflict; the conflict should be not an external one between the patient and his objects but rather an internal one, within the patient. Also, by juxtaposing the two sides of the patient's conflict, the therapist is attempting to pique the curiosity of the patient's observing ego. The therapist is encouraging the patient to observe himself and to recognize discrepancies between his knowledge of reality and his experience of it.

The structure of the conflict statement and some examples follow:

"Although . . . , nonetheless . . . "

"A part of you . . . , while another part of you . . . "

"On some level . . . , but on another level . . . "

"On the one hand . . . , but on the other hand . . . "

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

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

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

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

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

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

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

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

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

"Even though it bothers you when she treats you the way she does, you love her so much that you cannot imagine leaving her."

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

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

More generally, in a conflict statement the therapist articulates, on behalf of the patient, his understanding of the conflict with which the patient is struggling. He attempts to convey to the patient his respect for, and his deep appreciation of, the difficult choices the patient confronts. The therapist is not forcing the patient to take a stand, either to defend his current stance or to protest his wish to change. The therapist is maintaining his neutrality, positioning himself "at a point equidistant from the id, the ego, and the superego" (Freud 1936, p. 28).

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

By juxtaposing the force that says yes and the counterforce that says no, we are offering the patient an opportunity to elaborate upon either his investment in doing/feeling the things that would constitute mental health or his investment in doing/feeling the things that constitute his pathology. Now we are speaking not just to the conflict within the

patient between feeling and not feeling but, more generally, to the conflict within the patient between his knowledge of reality and his experience of it (in other words, the conflict within him between his ability to perceive reality as it is and his need for illusion and distortion). In response to the conflict statement, the patient either can go on to elaborate upon what he knows to be right (whether a feeling, an action, or a perception) or can explore his investment in maintaining things as they are.

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

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

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

THE PATH-OF-LEAST-RESISTANCE STATEMENT

As we know, a conflict statement highlights two sets of forces within the patient, both the anxiety-provoking healthy force which impels the

patient forward, and the anxiety-assuaging resistive force, which impedes such progress and constitutes the patient's pathology:

> "Although you know that you must eventually come to terms with just how angry you are with me, for now it feels too overwhelming to think about ever being able to do that."
>
> "Even though you know that you have paid a steep price in terms of how you now feel about yourself because of how impatient and critical your father often was, you tell yourself that he did the best he could because he had so many other, more important things on his mind."

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

> "Even though you know, on some level, that you must also be angry, nonetheless your experience is simply that you are sad."
>
> "Although on some level you know that there are some things you could choose to do, you tell yourself that none of those things would make a real difference."

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

A conflict statement that highlights the patient's choice between two alternatives lends itself nicely to being translated into a *path-of-least-resistance statement,* in which the therapist highlights the fact that it is easier for the patient to do what is old and familiar, even if pathological, than for the patient to do something different, new, more healthy. Such statements are in the nature of a confrontation and can be used to highlight the fact of the patient's choice; the therapist wants the patient to take ownership of the decisions he makes.

The prototypical path-of-least-resistance statement first names the defense and then names the healthy force defended against: "It is easier to . . . than to . . . ." In the examples that follow, the first

statement in each pair is a conflict statement; the second is the path-of-least-resistance statement derived from it. Note that the conflict statement is often the more cumbersome of the two.

1. "Even though you know, on some level, that you must also be angry, nonetheless your experience is simply that you are sad."
2. "It is easier to be sad than to acknowledge how angry you must also be."

1. "Although on some level you know that there are some things you could choose to do, you tell yourself that none of those things would make a real difference."
2. "It is easier to tell yourself that there is nothing you can do to make a difference than to admit that there really might be something you could do."

1. "Although you know you could have done things differently, you find yourself wanting to blame everyone else."
2. "It is easier to blame everyone around you than to look at what it is you might have done differently."

1. "Although you know that you could try to talk about just how upset you are, it is hard not to retreat."
2. "It is easier to retreat than to talk about just how upset you are."

1. "Although you know that there are things you could do, you find yourself feeling overwhelmed by helplessness."
2. "It is easier to feel overwhelmed by your helplessness than to confront the reality that there are things you could do."

1. "Even though you know there are options, you find yourself feeling hopeless."
2. "It is easier to feel hopeless than to think about options that you have."

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

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

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

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

THE PRICE-PAID CONFLICT STATEMENT

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

"You know that you will be limiting the benefit you can get from therapy by coming every other week, but you're feeling that you cannot at this time commit to coming each week."

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

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

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

"You know that your difficulty speaking up has created problems for you in your relationships, but it makes you anxious to think about really putting yourself out there."

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

If the therapist senses that the patient has begun to see that there may be something problematic about how he has been living his life, something problematic about the ways in which he has been limiting both himself and his possibilities, the therapist may formulate a price-paid conflict statement in which he attempts to create further tension within the patient by emphasizing the cost to the patient of defending himself in the ways that he does. He directs the patient's attention, therefore, to the price he pays for refusing to confront certain painful realities (past and present) in his life. Whereas in the first part of the intervention the therapist directs the patient's attention to something the patient would rather he did not, in the second part the therapist resonates with the patient's need to maintain the status quo of things. Whereas most of the other conflict statements that I have discussed strive to be more balanced in terms of first provoking and then easing the patient's anxiety, in a price-paid conflict statement the therapist (sensing that his alliance with the patient is strong enough to tolerate such an intervention) aims to create further tension within the patient in order to make the defense more ego-dystonic. The therapist is hoping to make it increasingly difficult for the patient to remain attached to his defense.

CONFRONTATION AND PARADOX

In essence, a conflict statement is made up of two parts, a part that confronts and a part that expresses a paradox. The first portion of the

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

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

The following are examples of confrontation:

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

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

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

Here the therapist is coming down solidly on the side of the force that needs eventually to be acknowledged, confronted, dealt with, worked through. The therapist recognizes that, in so doing, he is increasing the patient's anxiety, but there will be times when the therapist deems it appropriate to name, rather forcefully, the thing the patient is so obviously not dealing with or the work the patient must ultimately do before he can get on with his life. The therapist decides where to put the emphasis based on his sense of what the patient, in the moment, most needs and/or can tolerate.

The following are examples of expressing the paradox:

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

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

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

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

TITRATION OF ANXIETY

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

At any given point in time and for each patient, there is probably an optimal level of anxiety. Too little produces no impetus for movement of any kind, while too much produces immobilization and leads to an intensification of the patient's defensive efforts. By emphasizing either the ego-dystonic aspects of the patient's conflict (in the first portion of the conflict statement) or the ego-syntonic aspects (in the second portion), the therapist can modulate the level of the patient's anxiety.

What the optimal level of anxiety is depends on many things—the patient's ego strength, the depth of understanding he has acquired about his conflict, how motivated he is to get better, how solid the therapeutic alliance is, and how interested the patient is in gaining

insight, to name a few. From moment to moment, the therapist must assess just what that optimal level is.

Early on in the treatment, the patient may well be more invested in preserving the status quo of things than in changing. Consequently, the more anxiety-provoking side of the patient's conflict (his wish to change) is put in the first portion of the conflict statement, while the less anxiety-provoking side (his resistance to change) is put in the second part. Later on, as the patient comes to understand both his investment in the defense and the price he pays for maintaining that investment, he may be at a point where it is more anxiety-provoking for him to be reminded of his resistance to change than to be reminded of his wish to change.

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

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

1. "Even though it makes you feel uncomfortable when she hurts you, you also know that no woman has ever made you this happy before."
2. "You know that no woman has ever made you this happy before, but you are finding that you feel increasingly uncomfortable about how much she hurts you."

1. "Although there must be times when you wonder why you don't just leave her, you can't bear the thought of not having her in your life because she makes you feel special and loved in a way that you have never before felt."
2. "You know that you can't bear the thought of not having her in your life because she makes you feel special and loved in a way that you have never before felt, but you are beginning to think more and more about leaving her."

The second statement in each pair, the inverted conflict statement, is addressed to a patient who is becoming increasingly uncomfortable with the abuse he has been tolerating for a long time. Meanwhile he is becoming increasingly comfortable acknowledging the outrage he feels

about just how hurtful his girlfriend is. Such a patient will be receptive to an inverted conflict statement because he has made enough progress in the treatment that now his wish to get better (even if it means leaving his girlfriend) is stronger than his fear of change. Whereas before it was the thought of leaving his girlfriend that filled him with anxiety and dread, now it is the thought of not getting better, the thought of remaining stuck, that fills him with anxiety and dread.

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

RECONNECTING CONFLICTING ELEMENTS

Throughout this book we will be exploring the various uses for conflict statements. Whatever the particular situation, each statement emphasizes a different aspect of the conflict within the patient. But each statement highlights tension between something anxiety-provoking and something anxiety-assuaging; each either makes the patient increasingly aware of the forces within him that press yes or makes the patient increasingly aware of how he clings to defenses that oppose forward movement—or does both.

Many of the conflict statements that the therapist uses are attempts to reconnect elements that have been defensively disconnected. Schlesinger (1982) writes about the patient's defensive "disjunction," the defensive breaking of connections between ideas as a particular ploy that the resistance uses to obscure and to confuse. From this it then follows that the work of interpretation, as he notes, is "to restore the sense of relatedness that has been removed by defense. The most common way for this task to be accomplished is for the therapist to summarize his understanding of what the patient has been telling him. In doing so he condenses the patient's verbiage. In the therapist's boiled-down version, the patient's major ideas are much closer together. Their interrelationships thus become more obvious and their collective impact correspondingly greater" (p. 32).

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Understanding and Being Understood

MOMENT BY MOMENT

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

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

Balint (1968) encouraged therapists to assume an "unobtrusive" stance, so that the patient would be able "to discover *his* way to the world of objects—and not be shown the 'right' way by some profound or correct interpretation" (p. 180). And Winnicott (1958) observed