

# The Patient Who 'Refuses' to Change: An Innovative Approach

*Paul P. Shultz*

*Many of us who practise long-term, reconstructive psychotherapy are familiar with a particular kind of patient: someone who progresses well in understanding and ability to observe transference reactions to the therapist, but who none the less seems to be refusing to change. This paper follows the treatment of one such patient who seemed determined not to give up his passive way of relating to his psychotherapy group and the world, even after the dynamics of the self-destructive passivity had long since become clear to him. A new concept, called the 'push against progressing' is used to help understand the dynamics of this 'refusal', and how to treat it.*

The 'push against progressing' is defined as:

the persistent refusal to grow up and acquire mastery, and it may be conscious or unconscious. It is also the persistent refusal to mother oneself appropriately and lovingly. (Bar-Levav, 1988: 328)

This is distinguished from the 'pull of regression', which is the well known wish to be mothered perfectly and unconditionally by another. The 'pull of regression' is normal and exists in all human beings, regardless of emotional health; all of us have at least a vestigial wish that Santa Claus might really exist.

In contrast to the 'pull of regression', which is essentially normal, the 'push against progressing' is pathogenic. All of us have within us at least a vestige of this as well, as when we really would like to stay in bed on a cold, rainy morning. But one who actually refuses to get up and go to work acts out the wish by 'self-coupling', instead of attending to reality. This push against progressing 'blossoms fully' in the absence of fair and firm fathering

which instils the self-discipline appropriate to proper self-care (Bar-Levav, 1988: 329). Very serious psychopathology results when a child's mother is overindulgent, babying her child well beyond the appropriate years, and when the father is either ineffectual, unrealistically harsh or absent altogether. Such a child grows up truly believing (often unconsciously) that the wish to be mothered perfectly and unconditionally is realistic, legitimate, and fulfillable. (Obviously, we generalize. Sometimes a male 'mothers' and a female 'fathers'.)

Efforts to help the grown child become self-sufficient are usually quite frustrating, since the individual acts out his or her refusal to change in behaviour which is often self-destructive. Perhaps the saddest, most socially destructive examples of this can be found in inner-city children who have no father present at all, are materially and maternally deprived, and very early in life learn to live almost exclusively by the pleasure principle, becoming mortally ill drug addicts by their teens.

The clinical example of Leo, presented here, applies the concepts discussed and demonstrates specific techniques used in handling both the 'pull of regression' and the 'push against progressing'.

### **Clinical Setting**

All our patients are seen at least once a week individually, and meet twice weekly in psychotherapy groups lasting one-and-a-half hours. Generally the therapeutic work in the dyadic setting follows traditional lines: the patient presents himself, and the therapist responds. The individual therapist usually comes to be experienced as a 'good mother', potentially able to mother perfectly. We follow the usual dictum, keeping details of our personal lives private. However, since we use an approach which requires active involvement, our patients none the less usually come to also know us as real human beings who have our own particular limitations and strengths. Essential to this relationship is the therapist's ability to recognize his or her own errors and limitations as they present themselves in the process, and to openly acknowledge and correct them. Since we also use the group setting, our individual characters become even more evident. This facilitates the development of an unusually strong relationship against which the patient can compare and contrast his or her transference reactions to us.

Co-therapy teamwork in the group makes possible a wide variety

of interventions which are often difficult or even impossible with only one therapist present. For example, one therapist may help a patient speak openly of his or her secret thoughts about the co-therapist. Generally, the group is experienced and lived by the patients as a microcosm of the real world: their characteristic ways of living real life, out of therapy, come to be lived out in the group. It follows that the manner in which the 'pull of regression' and the 'push against progressing' are expressed in the patient's life are also expressed in the group. The patient's wish for perfect mothering, partially gratified by the exclusivity of the dyadic setting, is often frustrated in the group setting where the open competition typical of real life dominates. Therefore, deprivation is experienced most strongly in the group setting. Therapeutic interventions are titrated to help keep the group from being overly supportive and comforting, or unrealistically depriving. In other words, while the dyadic setting is usually easier for the patient to experience as 'mothering', the group setting is a 'safe' version of real life, like an automotive testing track where the patient can experiment with new ways of being, without any actual danger.

To ensure that there is no actual danger, each patient is expected to agree to a no-acting contract before entering the group and is required to adhere to that agreement strictly. Small infractions, such as coming late to a session, are addressed *first* in terms of the contract ('We cannot help you if your feelings come out in actions!'), and only later in terms of the underlying meaning. Patients are free to express anything vocally but they are not free to behave inappropriately. This contract, as will be seen below, not only maintains a safe working environment, but is crucial since it provides a lever for working with the 'push against progressing'.

### The Treatment: Early Stages

When Leo first came to treatment in our offices, he was withdrawn, very quiet, and lived a socially isolated existence, save for his relationship with his girlfriend, also quiet and withdrawn. Employed as an engineer with a major corporation, Leo's goals were very narrow. Aged thirty-one, he did not seek advancement or additional responsibility on the job, finding no real joy there, only the quiet peace of working at his computer terminal, engrossed in mathematical calculations. Obsessively preoccupied with money, he amassed savings in excess of \$100,000 by the time he came to us. Living in an upstairs flat in a dilapidated section of the city, he spent little of his hard-earned money on the

amenities of life. As he complained that his girlfriend manipulated the relationship by use of her helplessness, I knew he probably did the same with her. Clearly, theirs was a relationship of two frightened children clinging to one another as a child clings to a teddy bear, not that of two adults consciously choosing a partner.

My primary objective in individual sessions during the early months was to provide a safe haven for Leo. Within this context I could begin to help him see how driven he was by anxiety. At the same time, I would frequently ask Leo how he felt about me, hoping to stimulate his yearnings. Sometimes he was very difficult to understand; he made poor contact with the outside world, often presenting ruminations meant not to resolve anything, but only to provide a form of self-connected solace. During this phase of his treatment, the aim was to move him from an essentially self-preoccupied position, to a transference attachment to me as his mothering figure.

Slowly, Leo began to feel safe enough to become involved with me, speaking about all sorts of private, secret things. He told of sometimes 'mulling' obsessively for days about some minor incident that hurt his feelings. Sometimes losing himself in fantasy, he seemed not to miss human relationships. Yet, as he spoke openly about his self-preoccupation, he was beginning to leave his private cocoon. Finally, he felt safe enough to bring up the issue of his money. Paying me meant less money to save. Again and again he asked himself the question. What was giving him more security, his relationship with Shultz or his savings account? Suspiciously, he began to challenge me: 'Maybe you just want to get me involved in therapy here so you can get my money!' These strong suspicions were an indication of how shaky had been Leo's early mothering, and how important it had been for him as a child to find a safe haven by withdrawing into his internal world. He was truly frightened of leaving this internal world, over which he had complete control, and of 'connecting' with me, over whom he had relatively little control. Repeatedly weighing his developing real relationship with me against his transference expectations, he began to see that he experienced me as his manipulative, infantilizing mother.

Father was remembered as weak, ineffectual and distant. Mother had built relationships with her four sons by encouraging them to be overly dependent on her, including doing unrequested favours even when they were adults in order to manipulate them with guilt. With pain and embarrassment, Leo revealed that when he was little she had nicknamed him her 'sickly one'. Slowly, he began to see that this nickname represented the tie that bound him and his mother together. In other words, his particular way of getting his mother involved with him depended upon his being successfully the most 'sickly one' of the bunch.

All of the issues dealt with in the individual sessions came to be lived out and experienced in the psychotherapy group, just as we had hoped. Faced with competition from fellow group members, unlike in the individual sessions

where he had me all to himself, he rarely spoke, often appearing to be lost in his thoughts. His demeanour was that of one incapable of successfully competing for a place in the sun. More and more frequently he was able to speak in his individual sessions of his wish to be 'taken care of' in the group, and began to recognize his passivity as a silent attempt to manipulate 'mother'. None the less, his behaviour in the group (and in his actual life) was slow to change.

Meticulously tracking Leo's progress in the group, my co-therapist and I were careful not to help too much lest we reinforce his living in the group as the 'sickly one'. Sometimes he was left to sit silently. Faced with this frustration, since his therapists did not treat him as the 'sickly one', he avoided his hurt and anger at being deprived by drifting off into his own private world. Rather than strive to connect himself with reality and find some satisfaction there, he 'coupled' with himself. Yet we had to judge carefully lest the group experience be a countertherapeutic failure for him. Sometimes we worked with him quite actively, helping him to observe his way of being and what it meant. He became able to speak in the group of his passivity as an unconscious attempt to be the most 'sickly one' and therefore claim special attention. Slowly, tentatively, Leo began to leave his old ways behind, experimenting with asserting his right to talk about himself in the group, and beginning to see that adult involvement with his fellow group members was more satisfying than 'self-coupling'.

During this phase of treatment, which lasted several years, the nature of my real relationship with Leo became abundantly clear to him: I truly liked him, had his best interests at heart, and was committed to sticking with him as he struggled with himself. Over the years of reality-testing his relationship with me, he had slowly begun to see that his feelings often had very little to do with me. As his reality-testing improved, he was able to experience his fear, anger and yearnings even more intensely and at the same time speak of them reflectively. He had begun the separation/individuation process, beginning to separate his adult self from the infantile yearnings he had cautiously attached to external objects such as his girlfriend, and now myself.

The further along in the separation/individuation process Leo went, the greater his freedom to feel and express his yearnings and fears openly, and the less he was compelled to act out those conflicting feelings in his real relationships with people. And yet, as a patient becomes more aware of the unconscious motives which have driven him or her, and gains freedom from them, he or she does not necessarily wish to embrace that freedom.

### **The Treatment: Later Stages**

Leo had progressed well over his five years of therapy. Frequently speaking spontaneously in his individual sessions about his wish to

be taken care of he was consistently self-observant; reality-testing his relationship with me, he contrasted it to the transference. All seemed to be going well. Not only was he resolving his transference, but rarely was he lost in 'self-coupling'. In the groups, he was often very involved, from time to time quite vocal, looking and sounding as though he was almost ready to leave therapy. However, he did not involve himself this way often, and his life outside therapy was essentially unchanged. Still living in the same place, he was reluctant to accept challenges on the job, and — since his girlfriend had outgrown and left him — he did not date women. It was clear that the dyadic setting continued to be gratifying to Leo, since there was no competition, and in the group he continued to act out rather than speak of the same wish expressed in his daily living: his wish to remain his mother's 'sickly one'. But there was more involved than Leo's wish to be cared for.

Pressed both in his individual sessions and in the group to examine why he was exerting so little effort to change his way of being, he claimed to be too frightened to leave his limited little world. Clinical material, however, made clear that it was not fear holding him back.

One individual session began with Leo complaining: 'I don't want to do any work. I just want to be taken care of. My supervisor wants me to take charge of a new project, and that will be a lot of extra work for me. I don't want to do it!' As the session progressed, I reminded him that he was continually dissatisfied with doing what he called 'boring bonehead work'. Obviously, this was an opportunity to expand his horizons by not living as the 'sickly one'. He then fell back on an old claim: 'I'm too *afraid* to make any changes.'

Suspecting Leo was using the vestiges of his old fear to hide a push against progressing, I decided to challenge his claim: 'That's no longer true!' He reacted by complaining: 'You hurt me. You're so insensitive to me.' But I challenged that as well, suspecting he was not really so hurt. His pathetic demeanour changed, eyes flashing as he told me: 'Go to hell! You're just like my mother! You want me to do it *your* way! And I don't want to!'

Since he had rarely been so openly angry, his freedom to do so now indicated he was no longer the frightened Leo who had come to us years ago. What presented itself now was an openly defiant two-year-old who simply did not want to grow up, and claimed he was too frightened to change. This defiance was probably being

expressed with continued passivity when he presented himself in group as the 'sickly one'. A pattern became clear. If a therapist or fellow patient approached Leo, patiently and gently encouraging him to speak about himself, he would claim he was 'too scared'. With further encouragement, Leo, dragging his feet, would finally speak about himself; and when he finally did speak, he often came to life, becoming spontaneous, openly sensitive and sometimes even witty and charming. Yet if no one approached him, if no one encouraged him, he would almost always sit through the entire ninety-minute session, looking like the Leo of five years ago.

When confronted in the group with this inconsistency, Leo would seem not to understand the issue, usually claiming to be 'scared'. Meanwhile, he became increasingly reflective in his individual sessions about what was happening in group.

'I know you're not my mother, Mr Shultz. But sometimes it *feels* so much like you are.' Anger at his manipulative mother, embarrassment over his ~~wish to please and be accepted by her~~, hurt that she was insensitive to him, fear that she would abandon him — all of these reactions would arise within Leo, depending upon the situation presenting itself in the group. Most important, however, was Leo's continuing to react to all of these feelings with the same old defence: withdrawal into a 'self-coupled' state. Rather than even attempting to observe and speak openly about these feelings, he automatically gave in to them without a fight, seeming to 'forget' everything he had come to know about himself, making no outward attempt to observe what was happening to him. He looked more and more like a recovering car accident victim: temporarily paralysed by the accident, he was beginning to regain the use of his legs; but since it was hard work to exercise his recovering legs, he preferred the wheelchair at the expense of getting better. This assessment was confirmed in other ways.

One morning, Leo began his individual session thus: 'I'm sort of out of it today. I don't want to work. I liked the cosiness of sitting by myself in the waiting room reading a magazine.' After a pause, he looked at me: 'I don't feel like that now, though. This is the first time I speak to another person today. I like it.' We went on to look together at how habitual and 'natural' was his tendency to withdraw from human contact. From that withdrawn posture, he thought he didn't 'want to work' to approach the outside world. And yet, he could see that it really had taken very little effort to do so. All he had to do was look at me and talk honestly about what was happening to him, and he became involved in an adult, human interchange, which he liked. When I asked him to consider why he didn't use these strengths, so obvious here, in the group, he flushed: 'I guess

I really *do* want you to take care of me there. But I hate that.' He began to cry: 'I make things so hard on myself. Things could be so much easier.'

Since he was so open, I asked him to talk more about what goes on with him in the group: 'Perhaps there is something we're missing, Leo.' I wanted to double-check, to make sure my hypothesis was not in error. 'Is your fear too big for you to overcome? Maybe your shame or embarrassment gets in the way.' Leo's response helped to further verify my clinical impression.

'I am scared in the group, often. But that's not the real problem. It's just that facing these things about myself is difficult. I'm not so sure I want to do it. Sometimes I think I'd just as soon stay the way I am for the rest of my life. That wouldn't be so bad.'

'Are you afraid you're too sick to change?'

'It's not that', he said. 'Maybe I can change more. It's just that I'm not sure it's worth the effort. And I know you can't promise anything.'

'That's right', I responded. 'In the final analysis you're the one who has to do the lion's share of the work.'

'Yeah,' said Leo with a sheepish grin, 'that's just the problem. I don't *want* to do the work.'

'Your mother used to do it for you.'

'Yeah, and now I want *you* to do it. And you, you bastard, won't do it. In fact, you *can't* do it. That's what pisses me off!'

'Well, all of this makes good sense. But why don't you *talk* about this in the group? Why don't you *complain* there instead of expressing it with your passivity?'

'I don't want to do that, even. It's too much work.'

'Then you won't change.'

'I know.'

'Then why continue to pay all this money, and drive down here three times a week?'

'Because you won't let me leave. You're just like my mother!'

Once again he was trying to take refuge in old ways, hoping to skirt the issue.

'It doesn't wash anymore, Leo. That's old stuff and you know it. No one is forcing you to be a patient here. If in fact you *really* don't want to go further in therapy, you can decide to leave at any time. After all, I am your employee, and you can discharge me anytime you want to.'

'I'm not sure *what* I want to do', said Leo.

'When will you decide?' I asked.

'I don't know', said Leo, lapsing into passivity.

'This is what led to your girlfriend leaving you', I reminded him. 'She wanted to get married, but you remained indecisive for so long she finally gave up on you.'

'I know', said Leo, tears filling his eyes. 'And I don't blame her for giving up on me. But it hurts me.'

'I know it hurts you. That's nothing new, unfortunately.' While the pain was real, his tears were *now* just another way of avoiding the issue. 'But what you still have not faced is your unrealistic expectation that adult relationships be unconditional. You want this relationship with me to continue on unrealistic terms, as if you were *really* my child. Meanwhile, years can go by, you'll pay me thousands of dollars, and you still won't change.'

'I know.'

'Then it would make sense to terminate, wouldn't it?'

'I'm not sure.'

'You hide in your passivity with this one too, Leo. You don't want to struggle with it.'

'That's right.'

'You want me to decide?'

'See, you *are* like my mother! You want to get rid of me!' Leo remained resolutely determined to not face the issue, right up to the end of the session.

This and subsequent sessions helped to verify that Leo was pre-consciously staging in the group a last ditch effort to remain his mother's 'sickly one', even though he had the health to go further. While I experienced some frustration I also recognized what an important opportunity this was for Leo. If he were to go beyond this point, he would actually complete the separation and individuation process, giving up and mourning the loss of his internal mother, his image of himself as her 'sickly one', and of course his transference relationship to me. Naturally, he would rather continue to fight with me, as his manipulative mother, than accept the responsibilities of true freedom. Nowhere was this more clear than in the group where he often still managed to look like the same confused, semi-paranoid Leo of five years ago. From time to time he yet again complained, 'If I had the strength, I'd quit here! You're just holding on to me to get my money!'

Finally, after repeated efforts in group sessions to mobilize Leo's healthy ego, all of the therapists in the practice met to discuss the case. We first looked closely at the possibility that an unrecognized countertransference was interfering with the treatment. Our weekly self-supervision group was especially helpful. Finding no evidence of countertransference, we then carefully reviewed his dynamics. We suspected that while he looked and sounded truly paranoid at times, these were not moments of psychotic confusion at all, but moments of self-indulgence. That is, rather than exerting the relatively small effort it would take him to mobilize his observing ego, Leo allowed himself to lose himself in his feelings, like a two-year-old who refuses to come out of his pout. All of this fitted our understanding of his dynamics quite well. Poorly fathered, he had developed little self-discipline, attending to reality if fear compelled him to, but not because he had accepted and embraced the reality principle. Rarely had he faced an unpleasant task merely because he knew it had to be faced.

Now, he was trying to avoid the next, and final phase of the separation/individuation process; accepting full responsibility for being his own mother *and* his own father. That is, his struggle lay not with the 'pull of regression', but the 'push against progressing'. We decided to confront Leo rather forcefully in the next group session.

Shortly after the start of the next group, I told Leo about our meeting. We knew, I explained, that he had the ability to make far better use of these groups, and that his not doing so was an expression of self-indulgence, not of fear. We were not blaming him for this, but it was a feature of his illness resulting from his upbringing. None the less, such behaviour was in clear violation of the no-acting contract that he had agreed to before beginning treatment with us: 'Unless you take it upon yourself, Leo, to come out of your passivity, use your strengths for yourself, there is no point in your being here.'

Such a comment obviously threatened the integrity of the relationship, and the vestiges of Leo's fears of abandonment were likely to be stimulated. Sure enough, Leo's response was: 'You're just like my mother! You just want me to do things *your* way, and you don't care about me!'

'You know better than that, Leo.' Underscoring the present reality of the therapist-patient relationship, I went on: 'You have the right to live your life any way you want to. I can't and won't try to stop you if you decide to live this way. However, I have the right to refuse to live with you this way and to take your money for it. You made an agreement when you came here to therapy to not act on the basis of your feelings, and I will not continue to work with you this way.'

No longer pale and withdrawn, Leo's demeanour changed. We were not going to let him get away with it! He was furious about that! A co-therapist asked Leo what he felt. 'I'm angry at Shultz!' With the co-therapist's encouragement, Leo clenched his fists and yelled at the top of his lungs: 'Go to hell!' Again and again he yelled as he had never done before, looking me straight in the eye. Then, he sat back, crying softly. 'I know you're right, but I hate to admit it.' He cried softly a bit more, then continued: 'I just want you to take care of me, Mr Shultz. I hate to have to do it by myself.' He cried more.

Over the following weeks, Leo was much more free with his anger, complaining openly that we had not helped him enough;

after all these years and all that money, he now had been forced to face the fact that final responsibility for changing lay on his shoulders alone, not mine.

Obviously, Leo was not out of the woods yet. But he was far more amenable to using the group appropriately. From time to time he still presented the worn-out paranoid claims, but easily put them aside. Noticeably more involved in the group, he spoke up more frequently, often catching and interpreting aloud his moments of passivity. At the same time, he became freer in his expressions of anger at me and others, but with no loss of self-observation. Likewise, he became freer to cry openly in the group, sometimes sobbing deeply for the years of his life lost to living in his private world and for the loss of his boyhood. In spite of his social clumsiness, he began to date more widely, and moved into a better section of town. Professionally, he began to move up the ladder. Clearly, he was pushing himself to do things difficult yet necessary to his development as a competent adult.

The themes, of course, recurred. About a year later Leo did not attend an important professional meeting, claiming that he had other things to do. It was clear from his presentation that he was using this as an excuse to not push himself. Confronted with this, he again complained: 'You *are* like my mother!' I immediately confronted this, too, and he responded loudly: 'Go to hell! Get off my back! I should'a quit here years ago!' Little more was said of this in that session. Yet, in the next group meeting, Leo sat himself forward, found an opening, and told me he knew I had been right in the last session. He then said something he had never once said in all his years of therapy: 'I'm glad I'm here and that you don't let me get away with my temper tantrums. There are so many things I want to work on in my therapy. I want to stay here until I really finish with them.'

## Reference

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## 'The Patient Who "Refuses" to Change: An Innovative Approach'

*Adele Mittwoch*

This paper (*Group Analysis* 24(2): 147-58) gives a lively description of a patient who after lengthy intensive reconstructive psychotherapy remained stuck. Treatment was conjoint: the patient had one weekly individual session with author Paul Shultz, and two weekly sessions in a group conducted by Shultz with a co-therapist. Although able to recognize the transference, the patient was reluctant to take responsibility for himself. A positive shift came about when the therapist gave up the 'good mother' rôle and resorted to confrontation. Further developments were favourable and gratifying. Nevertheless I would like to challenge the author to respond to a few points.

The confrontations, although skilfully handled, could not be described as a new technique. From a firmly established base of his caring attitude the therapist mobilized the patient's anger. This enabled the therapist to call the patient's bluff about his everlasting fear. The confrontations then gained in momentum, from 'why continue [in treatment] . . . you can decide to leave at any time', until finally 'I will not continue to work with you in this way'. This kind of ultimatum surely is a well-tried technique in education and in psychotherapy, although when ill-timed or carelessly dosed such confrontations can misfire.

What is innovative is the concept of 'push against progressing', which helped Shultz and his team to understand the patient's psychopathology. But does this new concept advance our understanding of this case further than the classic concepts of Klein (1959)? I find this patient's slow progress in therapy intelligible enough when considered in the light of her comment:

The envious patient grudges the analyst the success of his work . . . he cannot introject him sufficiently as a good object nor accept his interpretations with real conviction and assimilate them. Real conviction . . . implies gratitude for a gift received. (Klein, 1959: 11-12)

I am not sure whether this patient's envy was conscious or not. For me it is axiomatic that the overdependent person must envy the object of dependence. In this case envy no doubt reared its ugly head when, as Shultz put it, 'paying his therapist meant less money to save'. It is also interesting that when right at the end the blockage yielded, the patient for the first time expressed gratitude: 'I'm glad I'm here and that you don't let me get away with my temper tantrums'.

Again in the words of Klein (1959: 34): 'If (primary) envy is not excessive, jealousy in the Oedipus situation becomes a means of working it through'. The therapeutic group is of course the ideal arena in which oedipal rivalries can be fought out. In my experience it is more than that: even the most deep-seated envy can be worked on in the group. The analysis of envy is difficult when the patient is unduly ashamed, but in the group shame can be alleviated when others speak of their own envy.

It is a pity therefore that Shultz gives us no clear picture of the functioning of his group. He mentions no interventions other than those of the therapists, except when group members echo those of the therapists. We learn of no interaction other than that between Shultz himself and this particular patient. Although Shultz acknowledges the element of competition in the group, he refers solely to members competing for the therapist's attention. In this context it would be of interest to know whether any other group members were in one-to-one treatment with him. Above all it seems blinkered to relate the patient's position as the sickly one in the group entirely to his history, without a regard to a possible unconscious collusion on the part of the others. Do groups not secretly relish a sick one in their midst?

Lastly I note that patient and therapist use different modes of address, calling one another 'Mr Shultz' and 'Leo', respectively. This could have evolved not by design, but out of the patient's wish to be the therapist's child. On the other hand the forms of address could be an integral part of the structure, that is, all patients were known by their first names and therapists by their surnames. If that were the case would not the setting in itself foster regression?

I hope that Paul Shultz will rise to the challenge and elaborate on these issues.

**Reference**

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## 'The Patient who "Refuses" to Change': The Author Responds

*Paul P. Shultz*

Adele Mittwoch's critique (*Group Analysis* 24(4): 479-81) has helped me clarify and further isolate the real issues I was trying to address in 'The Patient Who "Refuses" to Change' (*Group Analysis* 24(2): 147-158). Rather than focus primarily on theoretical issues of underlying dynamics, I think it is best to clarify those practical, technical issues which are truly innovative in our approach. Melanie Klein's observations on envy and gratitude do add to our understanding of a 'Leo', but unfortunately understanding alone does not affect real change. Many years of clinical experience have convinced me, and probably many readers, of that. The point of my article is that real change in many, if not all cases requires the application of an external force to overcome inertia, just as in physics. Why is this?

Nobody wants the hard work and pain of struggling to modify one's own character. Much easier is it to keep alive the delusion that the therapist's interpretations will somehow, magically, lead to real character changes. They will not. At best, the patient will learn to imitate what he or she believes is the therapist's version of what he or she should be. Only when the patient accepts the unpleasant fact that no one can change him or her but him-or-herself, *and* also accepts the responsibility to actually work on it, can real change occur.

Central to our work is the conviction that real change occurs only when the psychotherapist is free to bring force to bear upon the 'push against progressing'. This process is similar to that of the limit setting of actual fathering, but obviously differs in that the therapeutic relationship is not that of parent-child, but only feels that way sometimes. Most early work in psychotherapy revolves around issues

of mothering. In later stages of treatment, however, when the patient has essentially overcome irrational fears, he or she then has much greater freedom to assume a defiant position: 'I want to do what I want to do, regardless of reality.' For example, what success Leo found in life had been in order to be a 'good little boy' who pleased his mother. But 'pleasing' is often only a defence against displeasing a parent who, seen as the Kleinian 'good breast', can easily become punitive or abandoning. The terror this entails is so great, one often is willing to do anything, including being a co-operative patient who appears to get better in order to forestall abandonment. If psychotherapy is successful, this fear of abandonment slowly diminishes, and patients eventually are no longer compelled by fear to be 'good children' or 'good patients'. Indeed, such changes often, if not usually, result in the patient being sufficiently free from fear to live his or her regressive wishes not so much as an unconscious, defensive acting out, but as a preconscious or even conscious self-indulgence. That is, the patient likes having the therapist available to 'suck' on, but eschews further progress in handling reality since that would require even further effort.

Leo had reached this stage of treatment at which it becomes necessary for the therapist to actively intrude upon what is now essentially self-indulgence. The principle of 'therapeutic neutrality', questionable in its own right, clearly does not belong here, since the therapist's position is decidedly non-neutral: 'The reality principle must come first in this relationship. If not, I am willing to end it, unilaterally.' Obviously, such a position would be countertherapeutic if it were not absolutely clear that the patient is essentially freed from compulsive responses to the transference. Otherwise, the patient would comply out of fear of abandonment, rather than actually embracing the reality principle.

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