You are encouraged to read the whole book, and please make a proper citation if needed.

Bugental, J. F. (1987). *The art of the psychotherapist*. WW Norton & Company.

The subjectivity of patients is the site of the most important, most demanding, and most threat-arousing work of life-changing psychotherapy. Concentrating work in this area distinguishes therapists more deeply engaged with their patients, just as it challenges them with the most difficult and personally confronting issues. Because
much of this realm is implicit rather than explicit and because in this realm we rely heavily on our own subjectivity, therapists need to season awhile before attempting to work in depth with patient subjectivity.(Bugental,1986,p.ix)

There are three stages in the development of therapists:
1. They learn the rudiments of conducting therapeutic interviews.
2. They develop increasing sensitivity and skill in helping patients move from everyday kinds of conversations to deeply invested disclosures of subjective experiencing.
3. They come to appreciate the living experiences which underlie systematic views of personality, pathology, and therapy.(Bugental,1986,P.x)

This focus calls for continual attention to the patient's inner experiencing, and it recognizes that the prime instrument needed for that attention is the therapist's own subjectivity.

Life-changing psychotherapy, more than most other forms of therapy, demands that we recognize the patient's subjectivity as the true site of our endeavors.(Bugental,1986,p.3)

Life-changing therapy gives primary attention to the patient's subjective experiencing and does so by making the therapist's own subjective experiencing central to the work.(Bugental,1986,p.4)

Each person must in some way answer the basic questions life puts to us all:
"Who and what am I? What is this world in which I live?"
We answer these questions with our lives, with how we identify ourselves, how we use our powers, how we relate to others, how we face all the possibilities and limitations of being human. We collect the materials from which to form our answers from our parents, our brothers, sisters, and other family members, our teachers and age fellows, from our reading, including fiction in all its forms, from our churches and our memberships in

various organizations. Throughout our lives we collect these materials, form and revise our answers, and continually carry this process up to the final question, which we answer with our deaths.(Bugental,1986,p.5)

Life-changing psychotherapy is the effort of patient and therapist to help the former examine the manner in which he has answered life's existential questions and to attempt to revise some of those answers in ways which will make the patient's life more authentic and thus more fulfilling.(Bugental 1986,p.6)

Subjectivity is that inner, separate, and private realm in which we live most genuinely. The furnishings or structures of this realm are our perceptions, thoughts, feelings and emotions, values and preferences, anticipations and apprehensions, fantasies and dreams, and all else that goes on endlessly night and day, waking and sleeping, and so determines what we do in the external world and what we make of
what happens to us there. Significantly for psychotherapy, subjectivity is the closer bank on which must be founded the bridge of relationship to others and to the world. To change the metaphor, subjectivity is the seedbed of the concerns which impel us to undertake therapy, and it is the root system of our intentionality, which must be mobiI lized and focused if our therapeutic quest is to succeed.

Therein lies the ultimate meaning: It is the autonomy of human beings which escapes the cages of objective determinism and which resides in our subjectivity.

Although all humans share many more or less objective characteristics, the more we know them as individuals, the more we recognize how each is ultimately unique. Yet the more we know a particular individual, the more we realize he cannot be fully
known by anyone (including himself). This final unknowability arises from the reality that we humans are not empty containers filled from the outside only. We are, in ourselves, sources of phenomena (ideas, feelings, perceptions, relations, etc.) which alter expected sequences and upset predictions.(Bugental,1986,p.7)

All of this can be summarized by recognizing that in their deepest nature, human beings are causes; not simply caused. Thus there is a crucial difference between the subjective and the objective views of humans. Table 1.1 makes exaggerated contrasts as it summarizes some of these observations in terms of their implications for psychotherapy.

• I believe that patient process needs to be the main focus of my attention, with content not unimportant but definitely secondary (see Section III).

• I find the recognition of levels of consciousness valuable clinically,
although I recognize that the usual divisions -conscious, preconscious, and unconscious - have certain conceptual limitations.
• The central importance of work with the resistance (see Chapter 10)
seems to me to be a hallmark of genuine life-changing therapy.
• The inevitability of transference and countertransference phenomena and the great values in working with them are almost as manifest.
• The necessity of frequency of contact is something I insist on less
than formerly, but I still believe that twice a week is minimal, with only rare exceptions.
• Emotions are inevitable, valuable clues and to be respected ,but I do not see them as central, in themselves, to our work.
(Bugental,1986,p.8)

•Intentionality, the directionality of persons' lives, is a much more meaningful and therefore powerful explanatory notion than is causality. The latter, unthinkingly or unwisely carried over from objective physical science, misses the very essence of the human experience.
• The goals of the kind of therapy with which this book is concerned are aiding patient to experience himself as larger and more potent in his life, and thus as having choice, where formerly he experienced compulsion. Symptom reduction or problem solution may or may not occur as such. The disruptive effects of symptoms and problems, however, are markedly lessened when our work goes well.
(Bugental,1986,p.9)

We have examined some of the most obvious contrasts between the objective and the subjective perspectives and some of the significances of the latter for understanding human psychology and the workings of depth psychotherapy. Now we need to consider ways in which we develop bridges between these two realms, bridges which aid therapists and patients in gaining access to the inner worlds of those who are committed to self-knowledge and greater actualization of their potentials.

There is a crucial difference between attending to patient reports of subjective experience and actually coming into immediate intersubjective communication. That phrase does not necessarily imply extrasensory contact; it does mean being open to intuitive sensing of what is happening in the patient back of his words and, often, back of his conscious awareness. What the therapist must bring into action -in degrees which vary from patient to patient, even from session to session -is an appreciation for the patient's immediate experiencing, for the intentions implicit in his participation, for the

ways he structures his own life, and for his accessibility at any given moment. This is the normal sensitivity that all of us have in relating with others, but it is that normal sensitivity carried to greater than normal acuity. (Bugental,1986, p.10-11)

Intrapsychic Processes
• Concern (Chapter 11) is a name for the gestalt of patient feelings
and intentions which must be mobilized if true life change is to result from therapy. Complementing aspects of therapist concern are also identified.
• Intentionality (Chapter 12) is recognized as a principal patient process which must be influenced if the patient is to find more satisfying ways of having his life.
(Bugental,1986,p.13)

Such therapy produces clients who know a lot about themselves but experience little lasting change in what they do or how
they feel in their lives.

A summarizing notion that includes all of these is the concept of presence.
(Bugental,1986,p.26)

Presence is a name for the quality of being in a situation or relationship in which one intends at a deep level to participate as fully as she is able. Presence is expressed through mobilization of one's sensitivity- both inner (to the subjective) and outer (to the situation and the other person(s) in it)- and through bringing into action one's
capacity for response.

Accessibility designates the extent to which one intends that what happens in a situation will matter, will have an effect on her. This calls for a reduction of our usual defenses against being influenced by others; thus, it involves a measure of commitment. Opening oneself to another's influence is significantly investing in that relation. Expressiveness has to do with the extent to which one intends to let oneself be truly known by the other(s) in a situation. This involves disclosing without disguise some of one's subjective experiencing, and it requires a willingness to put forth some effort.(Bugental,1986,p.27)

"collective unconscious,"as proposed by Jung, suggests that underlying all of our experience is a species-wide bond of archaic but unconscious perceptual material. This is a useful conception, even though one need not accept all that is attributed to it. It is manifest that we share a common heritage in varying degrees and that this issues forth

in the various phenomena of our conscious living. Graphically to represent it accurately is impossible; thus I have chosen to use the
central point. (Bugental,1986,p.28)

Sometimes, when highly emotional work has been going on and the client needs to decompress before leaving, the transition may be in the opposite direction. In this latter instance, the therapist moves to this level as a way of aiding the client's preparing to face the outer world again. Here is an example of how this might be done.(Bugental,1986,p.33)

Standard conversations provide the balance point between concern for one's image and involvement in expressing one's inner experiencing.(Bugental,1986,p.35)

If therapy is to result in significant life changes, much work needs to be done at the critical occasions level. Only when the client makes herself truly accessible to the impact of these conversations, only when the client seeks truly to express to the therapist her inner experiencing, and only when the therapist genuinely meets the client in this depth- only when these essential conditions are met can one
reasonably expect lasting changes and growth to occur.(Bugental,1086,p.38)

In that enterprise- and particularly in its earlier phase- therapist verbal activity often needs to be kept to a minimum, so that the client can focus attention on his own subjective flow.(Bugental,1986,p.50)

This book is describing some of the ways I've found that help in the process of aiding my clients to contact their own inner resources and that facilitate my being with them when they are in their truest being, their subjective sovereignty. One of the foremost of those ways is that of helping my client to be fully and concernedly present in his own life and in his own therapy.(Bugental,1986,p.66)

Topical paralleling directs attention to a simple comparison of the degree to which one speaker- therapist or patient – deals with essentially the same subject matter as did the immediately preceding speaker.(Bugental,1986,p.95)

Paralleling is a way of thinking about the content being dealt with in the therapeutic conversation. It provides a perspective for under. standing that content more fully and for using its development through the interview to form hunches about the patient's intentions, the health of the relationship between patient and therapist, and the likely

course of the talk.(Bugental,1986,p.96)

I am using the term "paralleling to refer to how much or how little one speaker - therapist or patient - phrases the content of what he says in the same general way as has the previous speaker in the conversation. When they are talking about the same things in about the same way, we may say they are "'in parallel" or "paralleling each other." When they are not so in phase, we can speak of the conversation as showing little paralleling.
(Bugental,1986,p.99)

In something of an oversimplification, we can recognize that whatever a person says has both feelingful (affective) and ideational (cognitive) aspects.(Bugental,1986,p.111)

Being in parallel in feelings means that one speaker gives about as much attention to the client's affect as did the preceding speaker. Two things are important about this definition: It is the client's feelings with which this dimension is concerned, and the comparison is always -as it is for all paralleling forms- with the immediately previous response. (Bugental,1986,p.112)

With most people it is relatively easy to elicit emotions. Most, if not all, adults have at least some stored up feelings of pain, disappointment, loneliness, self-blame, and existential anxiety which can be tapped into with a modicum of kindness and persistence. The question that is too seldom asked is: When those emotions are brought forward, what is then to be done? I said above that emotions are importantly part of the process but are not its purpose. That purpose is, I believe, to increase living awareness - in plain words, the consciousness of one's own being, one's own powers and choices, and one's own limits.' In the pursuit of that increase we must help our clients become aware of how they are constricting their lives and their awareness and of the possibilities that are latent for them. That process of becoming aware is inevitably guided and accompanied by strong feelings of fear, pain, guilt, remorse, hope, apprehension, and fulfillment.(Bugental,1986,p.114)

The process of attending to the frame within which something is said provides conversations with a zoom lens.

In each of these instances, the therapist is well advised to frame the content at several levels of generality or specificity, not being content with any single frame. In each also, the assumption is implicit that there is latent in the client more information or other

subjective material (e.g., attitude, emotions, unconscious associations) than will be presented in any single response. The zoom lens effect of shifting frames will aid the client in accessing that material and bringing it out.

Enlarging the frame. Sometimes the task is aided by opening the frame so that a wider picture displays connections that might otherwise not be seen. We can illustrate this by using the same first few responses but then having the therapist broaden (at TH-32B). (Bugental,1986,p.123-124)

Of the many possible loci for patient attention, we identify four and consider their roles: focus on the patient's inner living, focus on the relation between the patient and the therapist, focus on the patient's relationships with others, and focus on the therapist.(Bugental,1986,p.132)

Everything that therapist and patient say directs attention to one or the other of them or their relationships with each other or with the outer world. We use the term locus to designate that object of attention.
(Bugental,1986,p.133)

Placement on the Interpersonal:
Patient/Others

This area includes all persons other than patient and therapist, as well as objects with which the patient concerns herself in the therapeutic work. Obviously this is a tremendous range, with an extensive scope of possible feelings and attitudes potentially available.(Bugental,1986,p.134)

Patients vary widely in the comfort with which they can talk about their relation with the therapist. Some find this familiar and readily express themselves; others, quite to the contrary, are hesitant and threatened. Moreover, some patients address or refer to the therapists explicitly without engaging him genuinely.(Bugental,1986,p.136)

We can smile at the paradox of Frank's insight, but the ironic truth of his outburst is his recognition that he depends on his angry stance to provide him a place in the world, to let him feel he has some power in a life in which there are many frustrations and disappointments.(Bugental,1986,p.139)

While references to the therapist may be frequent, they often are not reflective of a

genuine focusing of the patient's perceptual field on the professional. Rather they may be passing allusions, tangential inclusions, or intended courtesies. These are not what is meant by this locus.(Bugental,1986,p.140-141)

Patterns Objectifying the Concern
• Naming
• Describing
Valuing
Patterns Tending Toward Objectification
• Associating Functionally
Associating Causally or Analytically
Detailing History or Life Events
Patterns Tending Toward Subjectivity
• Bodily Awareness and Associating
• Describing Dreams and Fantasies
• Emotional Associating
• Recognition in Process
Largely Subjective Patterns
• Spontaneous Fantasy
• Free Association
Concern-Guided Searching
(Bugental,1986,p.150)

The subjectivity of a person is the seat of his uniqueness, his individuality. When the patient makes himself but an interchangeable observer of his own condition, it is evident that he is objectifying himself and that condition. To objectify oneself in this fashion means to render oneself impotent to do anything about the concern.(Bugental 1986,p.152)

Maybe I want Janet or somebody to take responsibility for my decisions.(Bugental,1986,p.156)

Rationalistic analyses or causal theories are interesting and provide a trap for the unwary therapist, for they can lead one to sterile cognitive formulations from which no apparent emotional or behavioral changes result.(Bugental,1986,p.157)

Typical of this cluster are speculations about causes and recounting of memories or other events in a search for clues to solve the issue.(Bugental,1986,p.158)

It takes a degree of sophistication about one's own nature to let go of the familiar body-mind separation built into much of the everyday, objective way of treating ourselves and each other. Use of this maneuver with patients lacking that sophistication is unwise and futile. It is best to wait until they have begun to appreciate the difference between inner awareness and outer thinking-about themselves. Premature instruction of this kind often means increasing patient resistance and making it more difficult to use this resource later on.

My practice is to ask for a careful telling of the dream or fantasy, followed by a relating of all spontaneous associations that the patient can discover. Usually at this point I will have noted some words or images that seem to be particularly poignant or which were spoken in a manner suggesting affective loading. I feed these back, asking the patient simply to allow them to trigger whatever they will ;meantime I kept alert to intercept any tendency to move toward objectifying or logically analyzing the material.(Bugental,1986,p.160)

It is impossible to specify what form such imagery will take. Sometimes it will be as positive as Andy's experience; other times it may be frightening, anxiety-evoking, or discouraging. Sometimes the images will be sharp and the action clear-cut; other times everything remains vague and indecipherable. Usually, if the patient can yield to the flow of inner, undirected awareness, there will be material of pertinence to his current concerns. But that's an important "if.? The whole key to
using spontaneous imagery is helping the patient truly open himself to what may issue into consciousness.(Bugental,1986,p.165)

Concern-guided searching is a developed form of free association. Recognizing the impossibility of a patient's saying all that comes into consciousness, a touchstone is required to serve as a way of selecting from the abundance that is potential. That function is fulfilled by the experience of concern.
Concern is the experience of letting oneself really care about some life issue, of being willing to invest oneself in it, and being ready to work to bring about desired changes. (Chapter 11 deals further with this important concept.) Its value is as an empowering and guiding force in the therapeutic exploration of one's subjectivity.
Three conditions are required for effective searching to take place:
(a) The patient must identify a life issue which he wishes to explore more deeply and fully and describe it to the therapist completely and often, repeatedly. (b) The patient must be as deeply immersed as

possible while carrying out this description - remaining at the critical occasions level as much as he can. (c) The patient must maintain an expectancy of discovery, a readiness to be surprised.(Bugental,1986,p.167)

These things I assert:
One: We do not truly know our own identities. We are much more than our conscious awareness. We do not know how to access or bring to use much that is latently ours.
Two: If we can revise our sense of identity to include what is not conscious or objective (i.e., to truly incorporate the unknown and the subjective), we may begin to gain access to more of our potential. Our need to deny the unknown acts to keep it unknown and inaccessible.
Three: The runaway preoccupation with objectivity in our times and our culture is a genuine cancer which may very well destroy our species and even our planet. It is a growth, not toxic in itself, which so intrudes on other, healthy processes that it cripples and destroys them.
The demand to make everything objective(and explicit, a form of objectification) destroys much that is ineffable and subtle.
Earlier generations believed in a god who knew every thing- including what lay
«in the hearts of men." This meant that we could not escape responsibility for our thoughts and intentions as well as our deeds. Liberated from that external
responsibility, we have been slow to pick up intrinsic responsibility.
Four: Despair has been the most frequent route to tapping the unrealized potential within us. When tapped, it has resulted in paradigm shifts and other creative outcomes. Perhaps the imminence of Armageddon may bring us to the despair needed to jump past our prejudices. Perhaps only the despair of worldwide cataclysm can do that. Can it occur while there is anything to save?
Five: Fully recognizing the deeper, more inclusive, more fundamental role of the subjective means establishing a whole new paradigm - not only for psychology, but for science; not only for science, but for being human; and, perhaps, not only for being human, but for beingness itself.(Bugental,1986,p.171,172)

Obviously, so conceived, resistance is a universal, normal, and even desirable part of the way in which we deal with our experience. That is an important recognition to keep in mind. Who does not seek to reduce threat? The sequel questions are the distinguishing ones: What is perceived as threatening and therefore to be resisted? How are the threats reduced? At what cost?
(Bugental,1986,p.174)

Resistance is the impulse to protect one's familiar identity and known world against perceived threat. In depth psychotherapy, resistance is those ways in which the client avoids being truly subjectively present- accessible and expressive- in the therapeutic work. The conscious or unconscious threat is that immersion will bring challenges to the client's being in her world.(Bugental,1986,p.175)

Of course; that's the point: The discovery that the life-pattern resistances are operative outside the consulting room makes plain the importance of bringing them into the therapeutic discourse.
The in-therapy resistance is no longer to be seen only as an isolated matter, a troublesome but unimportant habit; now we recognize it as a segment of a larger life pattern. Figure 10.2 puts the interview resistance within this larger framework.

Life-limiting processes. The next step is the crucial one that gives resistance its importance to depth therapy. Working together, the therapeutic partners find that there are other life patterns which also operate to keep her from immersion in herself, which interfere with her self-discovery, which pervade her life outside therapy. In other words, it becomes evident that the life-pattern resistances are intrinsic to the distresses in the client's life which, directly or indirectly, may have led to her coming to therapy. Moreover, we come to realize that these patterns are not separate difficulties but form a constellation which acts to limit the client's world (including her self-concept), to let her feel that she is safe and able to manage her life. This is sometimes referred to as the "transference neurosis, in that it represents in miniature in the office the larger neurotic gestalt which is disabling the client's life. The recognition of this constellation of patterns which so limits the self-and-
world concept of the client is a recognition of immense significance, as it helps us understand the deepest function of the resistance, to recognize its positive aspects, and to orient our therapeutic interventions in a way which is most apt to be successful.
(Bugental,1986,p.176-177)

The self-and-world construct system." Each of us must develop or construct a conception of who and what she is and of what her world is, how it operates, and how she can make her way in it. We come to have some notion of our own strengths and weaknesses, our own needs, the dangers which particularly threaten us, and the kinds of things or states of being we will seek or avoid. The potential world is immense; always we must make some compromise with possibility to secure the liveable.
(Bugental,1986,p.178)

The resistance discloses a therapeutically central aspect of the way the client identifies herself and structures her world. The pathologic or distress-producing elements thus displayed are immediately present in the therapeutic hour for direct attention by the therapeutic partners. This gives the work immediate impact on the client's life (as contrasted with work which requires transfer of therapeutic gains to the client's out-of-therapy life).
The further significance of this perspective is that it calls our attention to the constructive, life-serving aspects of the whole self-and- world construct system and reminds us that the resistive aspects are only that - aspects. The structures to which they adhere have positive aspects as well.(Bugental,1986,p.180)

However, the therapist needs to recognize that he is not the opponent of the resistance and is not seeking to defeat it. Instead, he hopes to find the constructive aspects and reinforce those while helping the client reduce the crippling aspects.(Bugental,1986,p.181)

• That the client is genuinely motivated to change, although that motivation may not be available at this point.
• That simple verbal reporting (feedback) to the client about a resistance pattern is not likely to be effective.
• That displaying to the client the fact of and psychological cost of a resistance is a key to helping the client change it.
• That awareness growing out of repeated occasions of immediate experiencing in some depth is apt to have an impact.
• That awareness of single resistive patterns is less effective than recognition of constellations of patterns in relation to the deeper need structures they serve.
(Bugental,1986,p.183)

• You're feeling confused now.
• You just changed the subject.
• Now you've switched your attention to me and away from yourself.
• You're wishing I would tell you what to talk about now.
• You've lost the train of thought.
Tagging the resistance is a matter of again and again pointing to the resistive pattern as it is occurring. This means that the pattern chosen for therapist attention must be one that is manifested frequently and is interfering currently with the client's inquiry into her own subjectivity. This means also that it is usually best to select only one such pattern for attention at any given point. Later, when several patterns

have been identified, each for a period, then more than one can be tagged.

• Again you find yourself confused.
• Did you notice that you changed the subject once more?
• Here we go again: moving from your inner work to focus on me.
• We're back to trying to get me to direct you, aren't we?
• Once again, you've lost the train of thought.
(Bugental,1986,p.184)

As the client becomes aware, through the tagging, of how frequently she relies on the pattern, the tagging needs to be extended to show how it affects the work. This usually means pointing to how the resistance causes the client to objectify herself, to decrease emotional involvement, or to otherwise lessen subjective centering. Notice that the effect involved here is immediate and limited to what is manifest.
At a later stage the motivation of the resistance will be disclosed, but to do that now will frequently result in an unavailing discussion, or even argument, about whether the suggested, but assuredly unconscious, intention was indeed the cause of the blocking.(Bugental,1986,p.185)

but the therapist does not attempt to teach its effect until that effect is actual in the moment (i.e., TH-2s, the teaching response, comes after the client is experiencing the blocking, CL-25, not when client is only talking about it, CL-22).(Bugental,1986,p.186)

The confusion, in this case, has been seen as something unwanted; now she is being counseled to approach rather than reject it. This step is often a difficult one for clients, but with gentle but insistent encouragement they can learn to take a different attitude toward the resistance. This is important progress, for it is part of bringing in a changed internal climate in which client energies are less divided and conflicted.
(Bugental,1986,p.187-188)

The therapist is beginning here to teach an important lesson (TH-12): The resistance pattern has served the client well in the past, has positive values, but it has become compulsive and escaped the control of her intention. With this comes the opportunity to teach the client that she does not have to abandon control if she becomes more open to herself and to the therapist. Such therapist comments as the following aid this recognition:

• "Your need to figure things out goes into gear before you have a chance to decide if

that's what will help."
• "To let yourself have your feelings here and when you're with yourself doesn't have to mean that you have to have them anywhere at anytime. You still can choose.?
"To you it's been as though not depending solely on your reasoning was making yourself an emotional slob. That's not very reasonable, is it?" (said with a smile).
• "Of course, you need control; we all do. The trouble is you've only known how to control by slapping your feelings in prison."
(Bugental,1986,p.189)

As the work of tagging repeatedly, demonstrating the effects of the resistance patterns, and beginning to suggest alternatives goes on, subtle changes will likely be occurring in the client's self exploration in therapy. The compulsive, unconscious hold of the resistance pattern will begin to loosen; at times it will be less constricting and occasionally it will not occur at all. Another likely and important development may be that the client becomes more aware of the centrality of the subjective and how therapist interpretations of the resistance clearly are designed to protect it. With that recognition the client may see that, despite her conscious intention to explore fully and openly, there are unconscious impulses that impede that work. She may also begin to identify her own resistances and to experiment with hanging in through them, keeping in touch with her inner experiencing to some extent even as the resistance operates.
Freed to find the values in the resistive behavior and not feeling that she must abandon all control or limits, the client begins to open new areas of herself to her own and the therapist's understanding.
This facet of the work may go on with greater and lesser intensity at various periods throughout the course of therapy. Other work will, of course, be carried on concurrently, but always the need for maintaining significant depth (usually
"critical occasions" level) is the criterion to decide relative emphasis between work on the resistance and other tasks.
So far I have spoken of resistance patterns as though each existed separately. Nothing could be less true. These patterns are interwoven with each other and are layered over each other. The work of peeling back these layers is a distinguishing aspect of depth psychotherapy and is essential if genuine life changes are to result.(Bugental,1986,p.190-191)

The transitional step from work directed solely to reducing resistance to work with underlying neurotic structures is the step of helping the client disclose the deeper purpose of the resistance. To understand the meaning of this important step, we begin by stepping back a bit from our close concentration on clinical procedure.

One of the central ways in which we make these bridges is to develop and continually tend the self-and-world construct system. If it is solidly anchored at both ends, then our life experiences generally work out fulfillingly. If, however, the match between the system and either our internal or our external realities is faulty, then we experience anxiety and other distress.

The self-and-world construct system, as we have seen, defines what and who we are and the nature of the world in which we live. If I define myself as a person of generous and loving nature who cares about others, and all of my experience confirms this view, well and good. But what if I fly into a rage at one of my children? What if I take unfair advantage of another person? In other words, what happens when I go against that self-definition?(Bugental,1986,p.193)

When incoming experience of myself or of the world does not accord with the way I define myself and my world, then I may do any of several things: I can recognize the mismatch and set about amending my construct system to make it more realistic. I can experience the mismatch at a preconscious level but find it too upsetting to my construct system and so repress the event. When experience is repressed, kept from consciousness, then it must be kept out by some means. Here the familiar "defense mechanisms"of psychoanalytic theory are very descriptive - projection, denial, and other distortions are used.

Depth psychotherapy, however, calls for exploration of the client's subjectivity, which includes those parts of the subconscious which are conflictual. This task directly threatens the repressed disjunctures between one's self-and-world definitions and one's actual experience.

The resistance comes into play to forestall the confrontations, which seems too upsetting to endure. In brief, the resistance seeks to preserve the way the client has defined herself and her world and therefore the very identity of the client herself. It is a life-preserving impulse - although one which has escaped aware control.(Bugental,1986,p.194)

More on the self-and-world construct system. Of course, the therapist's understanding of the client's ways of seeing herself and her world is not something that can be attained by direct questioning. It requires quiet observation of what is implicitly demonstrated in the client's self-report, in her relating with the therapist and others, and in what she chooses to discuss and not to discuss in therapy. One of the most important areas needing exploration is what the client believes would be overwhelming threat. Gradually the therapist forms some impression of what the chief attributes are in the

client's way of seeing herself, in the client's value system, in the client's way of conceiving the world in which she lives, in what she believes to be the sources of power or effectiveness, in what she seeks to gain or to avoid, and so on.(Bugental,1986,p.195)

The essentials at this stage can be listed: First, the therapeutic alliance needs to be strong and assured for the client's support. Second, the client's own pace for making the confrontation and working with it should be respected, so long as the resistances which erupt are identified as such. Third, the therapist must maintain firm respect for the client's autonomy and avoid inappropriate intrusion on the working through of the confrontation. Reassurance, suggestions for action, or interpretations are seldom appropriate. Finally, the therapist needs to monitor and handle his own countertransference and personal responses to the confrontations, for these will often have an impact on him as well.(Bugental,1986,p.196)

Concern is a name for the attitude and emotional set of a person who seriously considers his own life and the course it is taking. Concern is a constellation of feelings, thoughts, and intentions which is organized by an evaluative-anticipatory perspective on one's experience of being. Concern may eventuate in efforts to bring about changes in one's way of being, in the circumstances or relations of one's life, or in the inner orientation of one's living.

Concern and intentionality are powerful conceptual and therapeutic tools precisely because they are the most direct ways we have for observing and affecting the client's mode of being in and managing his life. Therapists who fully comprehend these processes and have developed the sensitivities and skills to use that comprehension are able to influence their clients in profound ways. This, then, is an
undertaking that calls for a high level of personal and professional responsibility.

As we have seen, concern is a subjective state which has cognitive, emotional, and intentional aspects and which is manifested when client soberly considers the course of his life. So conceived, concern, as a unity or gestalt, has four chief facets: pain, hope, commitment, and inwardness.
(Bugental,1986,p.202)

Clients come with pain of many kinds and intensities, and sometimes the pain is masked when they first enter our offices. Therapists may need to remind themselves of this when a seemingly comfortable client dismisses his concern. Generally, we do well to assume that the person who asks our help is hurting and is hurting sufficiently to have

overcome a number of obstacles to be sitting here now.

Yet pain cannot be taken for granted, nor can we let it govern our work. Simply to reduce pain is not therapy. Pain is a natural signal that something has gone wrong with the human system and needs attention. Simply quieting pain is as unwise as pasting cardboard over a persistently flashing red light on the car's instrument panel. Over time, the therapist will come to understand the client's distress in terms of its intensity, the forms it takes (nagging worry, pervasive anxiety, obsessive thoughts, rages or other outbursts, or physical distress), its history, any changes that have occurred in it, and how the client himself views it. This is a gradual process, not a formal inquiry. (Bugental,1986,p.203)

Saying this another way, the denial of hope is a resistance which must be dealt with as are other resistances (see Chapter 10) and which requires careful therapeutic management to avoid precipitating client flight. This is not something to be accomplished in a single session, nor is it a task that can be done in isolation from responding to the client's general presentation of himself.(Bugental,1986,p.206)

The first order of business in this therapy is to assess the extent to which all aspects of the client's concern are available and brought to bear on the work. The second order of business is to disclose and reduce the resistances which keep any aspects of concern from being so directed.(Bugental,1986,p.215)

My own belief is that fully mobilized client concern is the best compass for guidance of the work. In the ideal circumstance, the client's very involvement (concern) with his life magnetically draws him to the matters needing his attention, without his needing to "draw back" to judge which of several possible topics to take up. This process proceeds largely unconsciously in the fully immersed and genuinely concerned client.

Often, at these points, the client looks to therapist for guidance, What should I talk about? . . . Should I tell you about my dream or about the argument with my wife?" Typically, my answer to such questions is along these lines:You have the only valid compass, so look into yourself and see what (or which) really matters to you right now." Sometimes I link that up with a reflection, "You seem to feel that I know what's important to you better than you do. That's a startling idea. Do you really believe that? (Bugental,1986,p.216)

Among the most distinguishing capacities of humans is that of having intentions, of

conceiving purposes and values, and of taking actions to bring some of these into realization. Therapists' work with these processes is aided by conceiving a sequence in which impulses emerge from the unconscious and go through a series of "gates" which prune many away to allow some to become part of actuality. Our description of this sequence emphasizes the gates through which intentions must pass to move forward and thus it displays ways in which the blocked purposes of our patients may be freed.

I propose four subjective stages in this process - unconscious roots, wishes, wants, and willed intentions - and three externalized phases -preliminary actions, actualization, and interaction.(Bugental,1986,p.226)

So I am compelled to be a kind of translator. I listen to that inner voice whose archaic language I have always known but never spoken. Then I look at the outer world, which uses quite a different language, and I try to translate the one into the other.
(Bugental,1986,p.227)

Saying this another way, human life is importantly characterized by intentionality.' "Importantly" because intention is a central element in the direction our lives. Just as our lives are ultimately process, so the processes of our lives express our intentionality. In simplest terms: Intentionality is the meaning we create/ express by our living.(Bugental,1986,p.228)

Wishes. From this pool of potential, some impulses emerge as generalized "wishes."
A wish is usually a rather nonspecific, loosely envisioned seeking toward experience which has been examined for its reality.

Wants. Some wishes are tested against reality, and those that survive may be termed "wants." A want is an impulse toward experience which has been examined for its reality.

Willed intentions. We must make the life-and-death decisions which will do so much to determine the courses our lives will take. These choices we term "willed" intentions. Willing means killing off some possibilities so that others can be on our agendas for ourselves.(Bugental,1986,p.230)

Actualization. On the other hand, perhaps the book indeed deals with what I want to learn about, and so I read it fully. This makes the reading of that book a part of actuality, and what is -an "actualization." It is manifestly important to distinguish preliminary and

tentative forays into actuality from committed undertakings.

Interaction. Actualizations inevitably cause shifting further back in the sequence. Because I am reading this book fully, three others drop from willed intentions to wishes. This is the final step, "interaction." Each actualized impulse sets in motion ripples evoking adjustments of other impulses. (Bugental,1986,p.231)

In the course of psychotherapy it is always essential to bring into consciousness the ways in which the patient is making these actuality/oblivion choices around certain key areas of her life. This is familiar practice in many perspectives, although, to be sure, not usually described in these terms or carried out in a formal way.(Bugental,1986,p.231)

Thus, the closer an impulse is to attaining reality, the greater the resulting loss of spiritedness if that impulse becomes blocked.(Bugental,1986,p.233)

This kind of forced action, deprived of its roots in unconscious and deep intentionality, is seldom successful, rarely yields satisfaction for those who try it, and may actually be destructive, as it increases self-alienation. Those who attempt to by-pass the blocked intentionality by this route often find their experience unsatisfying, false, or meaningless.(Bugental,1986,p.234)

First Phase: Presence

An early task of therapy, in such instances, is to deal with this lack of presence. Doing so identifies the detachment (tertiary reaction) as the outermost layer of the resistance. It must be frequently labeled as such and repeatedly brought forcefully to the patient's awareness.(Bugental,1986,p.236)

Second Phase: Dealing With Secondary Reactions

As patients begin to let go of their detachment, attention needs to be directed to their secondary reactions - the ways in which they react to their own dispiritedness. This process involves identifying and reducing the blame, guilt,, rationalizations, or whatever pattern is disclosed. In this work, catharsis of emotional blockage is important to freeing up the spiritedness and revitalizing the intentionality processes. The following account illustrates this reaction and the therapeutic work involved in dealing with it.(Bugental,1986,p.237)

When work with the secondary reactions has progressed sufficiently that patients recognize that they are reacting to their own dispiritedness, the therapeutic task is to encourage patients to accept the dispiritedness without complicating it. Only in this way can the relinquishments and grief be truly worked through so that the blocked intentionality can be reinspirited. This is more easily said than done. It requires continual alertness to the attitude and presence with which the patient experiences the life inertia. It calls for quiet confidence and steady presence on the part of therapist.

While helping the patient experience dispiritedness and avoid distracting responses to it, the therapist may recognize that the patient is beginning to confront a new kind of anxiety, Fears of non-being, death, the emptiness of the universe, of meaninglessness, or of ultimate aloneness may begin to surface. These are, of course, forms of existential anxiety. The presence of this anxiety often signals readiness for deeper therapeutic work.(Bugental,1986,p.238)

First, I seek to be committed in my own being in the encounter with my patient. (Bugental,1986,p.250)

When working long-term with someone, I remind myself from time to time to consider the impact of our efforts on the others in the patient's life. Many times this occurs spontaneously as the patient describes interactions with those people. Sometimes, when it seems to me that a spouse is being severely threatened by changes and emotional flareups, I have watched for opportunities to suggest to the patient that the spouse be invited to a session in which we will give some perspective and support to him or her. These are always joint sessions (I would not see the spouse alone except under very unusual circumstances), and I try to have the patient take the major responsibility for informing the spouse. (Bugental,1986,p.255)

In contrast, when I learn that a patient is sexually molesting or physically abusing a child or a helpless elder, I have no hesitation about my stance. Quite aside from the increasing legal mandates (and, indeed, this was my practice before their enactment), I move in strongly to enjoin any continuation of these acts, to make certain that they have ended, and to secure legal enforcement if I am not assured of their ending. (Bugental,1986,p.256)