Psychotherapies

an Overview

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Psychotherapies: An Overview[1]

The emergence of numerous competing systems of psychotherapy during the last few decades has been cited as one of the principal problem areas in the field (1). In 1975 Parloff polled more than 140 presumable forms of currently practiced psychotherapy (2). Although London described this confusing proliferation as a reflection of changing times in answer to pervasive repression, anxiety, and/or boredom of man (3), the specific ways in which each new modality may or may not differ from its predecessors are far from clear. For the most part, dogmatic partisan claims of the superiority of each successive system continue to persist in spite of increasing evidence that such separatist claims may be largely unfounded (4, 5).

In attempts to comprehend the therapeutic influence in the total range of psychological treatments that have made their appearance at various points in the course of time, many authors have focused on the nonspecific or uncommon elements that all psychotherapies are presumed to share (4, 6-19). The following features have been repeatedly cited as basic to all psychotherapies: an emotionally charged, confiding relationship; a therapeutic rationale (myth) that is accepted by patient and therapist; the provision of new information, which may be transmitted by precept, example, and/or self-discovery; the strengthening of the patient's expectation of help; the provision of success experiences; and the facilitation of the arousal of one's emotions (9).

Alternatively, Wittkower and Warnes pointed out that "while such universal features undoubtedly exist, it seems absurd to minimize differences in psychotherapy" (19). The originators and strong proponents of individual systems of psychotherapy who felt the need to differentiate and/or dissociate themselves from their predecessors and peers to justify their efforts might share

this view (20-23). In addition, comparative conceptual studies of various forms of psychotherapy typically cite striking contrasts among various therapies (24-33). More recently, experimental studies of different schools have lent some scientific support to the separatist stance. Exemplary of such findings are the systematic studies of analytically oriented psychotherapy versus behavior therapy supporting the view that these are, in total, highly contrasting styles of treatment (34, 35). Moreover, the treatment procedures created, developed, and chosen in one society or within the context of a particular belief system may not be transposable to another. This is especially evident in attempts at cross-cultural psychotherapy (19, 36).

The current state of the art attests to the lack of clarity and lack of resolution of the specificity versus common elements controversy in explaining what is the quintessence of the therapeutic cure. This conflicting state of affairs is further compounded by those comparative studies of various psychotherapies which suggest that one's espoused theoretical orientation regarding the nature of the healing process may not always be synchronous with one's actual practices (37-39). For example, a comparison study of Freudian, Kleinian, Jungian, and Gestaltist therapists found that descriptive ratings of the different approaches in action did not differentiate the respective schools of thought as well as the investigators (and, no doubt, the proponents themselves) would have expected (39).

As treatments useful in one area of human disturbance are found to be less valuable in another (5, 40), efforts are made to arrive at better criteria for selecting patients for particular forms of therapy and for modifying existing forms. Here the stated task for the future is to achieve greater specificity concerning the effects of particular kinds of interventions (13). Thus the tantalizing need for increased examination and clarification of the therapeutic process continues.

Doubtless there are many ways to slice the therapeutic pie. In early

attempts to schematize the many psychotherapeutic methods and techniques throughout history, Menninger (41) and Bromberg (42) ultimately subsumed the various forms under two dichotomous heads: those which they thought used a principle of suppression in their treatment approach versus those which represented the use of a principle of expression.

Beginning where Menninger and Bromberg left off, Harper's descriptive overview of 36 established Freudian and post-Freudian psychotherapeutic schools, or systems of psychotherapy, attempted to divide the various approaches into two overriding categories: those which reflected emotionally oriented or affective forms of treatment versus those which Harper considered essentially intellectually oriented or cognitive (28). On a more philosophical plane, Rychlak addressed the possible implications of ideology for methodology and assessed psychotherapies on the basis of whether they represented therapeutic models that were essentially Lockean (mechanistic) or Kantian (humanistic) (43). Rychlak also conceptualized psychotherapies according to a comparison of their respective motives: those with a scholarly motive, which are primarily concerned with unraveling the depths of man's nature; those with an ethical motive, which concern themselves primarily with man's self and his values; and those with a curative motive, which directly aim at scientifically derived cure (44). Offenkrantz and Tobin's configuration is more implicit. They suggested that all learning (including psychotherapeutic learning) occurs in three modes: by identification, by conditioning, and by insight (45). Thus one might assume to unite the various psychotherapies on the basis of their primary modes of therapeutic learning or the major ways in which they presume to effect change in or cure of the patient.

With the preceding topographies in mind, I shall organize the morass of systems practiced today according to a troika of basic themes around which each school may be said to broadly, but distinctively, pivot. These, representing a composite of dimensions, are referred to as dynamic, behavioral, and experiential (see Table 1). Although these rubrics per se are not completely new (2, 46), to my

knowledge no study has attempted to portray schematically their respective features in relation to the increasing array of modalities being practiced today. A number of contrasting dimensions constitute or reside behind these three themes (see Table 2). Each theme represents something of a unity, that is, one's conceptual framework or belief system regarding the nature of man and his ills will have a bearing on one's concept of therapeutic modes or curative processes and the nature of the therapeutic relationship between patient and therapist and, ultimately, on one's methods or techniques of treatment.

Table 1
*Examples of Three Therapeutic Themes in the Psychotherapies and Their Variations**

Dynamic		Behavioral		Experiential	
Theme or Variation	**Representative**	**Theme or Variation**	**Representative**	**Theme or Variation**	**Representat**
Classical psychoanalysis	Freud	Reciprocal inhibition therapy	Wolpe	Existential analysis	Binswanger
Analytical psychology	Jung	Implosive therapy	Stampfl	Daseinanalysis	Boss
Will therapy	Rank	Conditioned reflex therapy	Salter	Logotherapy	Frankl
Active analytical therapy	Stekel	Learning theory therapy	Dollard	Client-centered therapy	Rogers
Individual psychology	Adler	Social learning psychotherapy	Rotter	Gestalt therapy	Perls
Interpersonal psychiatry	Sullivan	Modeling therapy	Bandura	Psycho-imagination therapy	Shorr
Intensive psychotherapy	Fromm-Reichmann	Directive psychotherapy	Thorne	Experiential therapy	Whitaker
Character analysis	Horney	Direct decision therapy	Greenwald	Experiential therapy	Gendlin
Cultural school	Fromm	Confrontation problem-solving	Garner	Primal scream therapy	Janov
Ego analysis	Klein	Assertion-structured therapy	Phillips	Bioenergetic analysis	Lowen
Chicago school	Alexander, French	Personal construct therapy	Kelly	Structural analysis	Rolf
Sector therapy	Deutsch	Rational therapy	Ellis	Autogenic training	Luthe
Objective psychotherapy	Karpman	Integrity therapy	Drakeford	Transcendental Meditation	
Short-term psychotherapy	Sifneos, Malan, Bellak	Reality therapy	Glasser	Nirvana therapy	
Direct analysis	Rosen	Philosophical psychotherapy	Sahakian	Zen psychotherapy	Watts
Psychobiological therapy	Meyer	Biofeedback training	Green	Psychedelic therapy	Osmond

Biodynamic therapy	Masserman
Adaptational psychodynamics	Rado
Hypnoanalysis	Wolberg
Character analysis, vegetotherapy	Reich

* Although some of the more recent psychotherapies may combine individual and group techniques, this organization of psychotherapeutic systems focuses on modalities that are essentially dyadic in nature. It therefore does not include family, group, or milieu therapies per se, nor such adjunct therapies as art, music, and dance.

Table 2

Summary of Thematic Dimensions of Three Kinds of Psychotherapy

Theme	Dynamic	Behavioral	Experiential
Prime concern	Sexual repression	Anxiety	Alienation
Concept of pathology	Instinctual conflicts: early libidinal drives and wishes that remain out of awareness, i.e., unconscious	Learned habits: excess or deficit behaviors that have been environmentally reinforced	Existential despair: human loss of possibilities, fragmentation of self, lack of congruence with one's experiences
Concept of health	Resolution of underlying conflicts: victory of ego over id, i.e., ego strength	Symptom removal: absence of specific symptom and/or reduction of anxiety	Actualization of potential: self-growth, authenticity, and spontaneity
Mode of change	Depth insight: understanding of the early past, i.e., intellectual-emotional knowledge	Direct learning: behaving in the current present, i.e., action or performance	Immediate experiencing: sensing or feeling in the immediate moment, i.e., spontaneous expression of experience
Time approach and focus	Historical: subjective past	Nonhistorical: objective present	Ahistorical: phenomenological moment
Type of treatment	Long-term and intense	Short-term and not intense	Short-term and intense
Therapist's task	To comprehend unconscious mental content and its historical and hidden meanings	To program, reward, inhibit, or shape specific behavioral responses to anxiety-producing stimuli	To interact in a mutually accepting atmosphere for arousal of self-expression (from somatic to spiritual)
Primary tools techniques	Interpretation: free association, analysis of transference, resistance, slips, and dreams	Conditioning: systematic desensitization, positive and negative reinforcements, shaping	Encounter: shared dialogue, experiments or games, dramatization or playing out of feelings
Treatment model	Medical: doctor-patient or parent-infant (authoritarian), i.e., therapeutic alliance	Educational: teacher-student or parent-child (authoritarian), i.e., learning alliance	Existential: human peer-human peer or adult-adult (egalitarian), i.e., human alliance
Nature of relationship to cure	Transferential and primary for cure: unreal relationship	Real but secondary for cure: no relationship	Real and primary for cure: real relationship
Therapist's role and stance	Interpreter-reflector: indirect, dispassionate, or frustrating	Shaper-adviser: direct, problem-solving, or practical	Interactor-acceptor: mutually permissive or gratifying

The Dynamic Theme

The Nature of Man and His Ills

The dynamic point of view, as originally conceived in the context of physics, subscribes to the idea that all mental phenomena are the result of an interaction of forces (47). It pertains to an appreciation of the complexity of man as reactor to or victim of turbulent intrapsychic forces from which he continually struggles to be set free. Freud described the major force of this struggle in the origin of the neuroses of man according to the theory of instinctual conflict: "From the very first we have said that human beings fall ill of a conflict between the claims of instinctual life and the resistance which arises within them against it" (48, p. 57). More specifically, Freud considered the etiology of the neuroses of man to be decidedly sexual in nature: "No neurosis is possible with a normal *vita sexualis*" (49, p. 276). In the orthodox dynamic tradition man is portrayed as fraught with inner and unknown urgings and contradictions, subject to and resisting against a reservoir of impulses largely inaccessible to his conscious self.

The psychoanalytic perspective typically incorporates five fundamental principles, i.e., dynamic, economic, structural, developmental, and adaptive (50). Taken together, these principles offer an analytic legacy that includes the following allegiances: 1) a primary concern with the vicissitudes of man's instinctual impulses, their expression and transformation, and, more crucially, their repression, by which is meant the pervasive avoidance of painful feelings or experiences by keeping unpleasant thoughts, wishes, and affect from awareness; 2) the belief that such repression is of an essentially sexual nature and that the roots of disturbance reside in faulty libidinal or psychosexual development; 3) the idea that faulty psychosexual development has its origins in early past and childhood conflicts or traumata, especially those concerning a parental oedipal configuration as manifested in the classic desire for one's opposite-sexed parent; 4) the belief in the resilience, persistence, and inaccessibility of oedipal yearnings (i.e., these underlying conflicts remain alive and ever active but out of awareness or unconscious; man's consciousness describes the exceptional rather than the standard state of affairs); 5) the idea that we are dealing essentially with the psychic struggle and torments of biological man's innate impulses or instincts

(id), their derivatives, and the primarily defensive mediation with external reality (ego) in light of one's moral precepts or standards (superego) ; and, finally, 6) an adherence to a concept of psychic determinism or causality according to which mental phenomena as well as behaviors are decidedly not chance occurrences but meaningfully related to events that preceded them and, unless made conscious, unwittingly subject to repetition.

Therapeutic Change or Curative Processes

In accordance with these tenets, for the dynamic therapist the ultimate task in its most parsimonious and famous form is to make conscious the unconscious. This means that it is the ongoing therapeutic charge of the therapist who subscribes to the dynamic view to facilitate the emergence and comprehension of unconscious and largely libidinal content. That is, the dynamic therapist seeks to undo the essentially sexual repression of the patient and to overcome the patient's natural resistances to this endeavor. The dynamic therapist attempts to accomplish this by means of a slow and scrupulous unraveling of the largely historical meanings of mental events and the devious ways in which they may serve to ward off the underlying conflicts through defensive camouflage. Understandably, the dynamic goal is thereby a long-range one, perhaps even interminable. At best this concept of cure means opting for total personality reorganization in the final resolution of neurotic conflicts. The most crucial manifestation of this is the resolution of the oedipal conflict, which is traditionally regarded as requisite for a healthy personality. This ultimate integration of personality would translate itself into final mastery of ego over id impulses or, as classically stated, where id was, there ego shall be.

Greenson defined the therapeutic process as "an interrelated series of psychic events within the patient, a continuity of psychic forces which have a remedial aim or effect" (51, p. 7). The dynamic psychotherapeutic systems have consecutively considered as their hallmarks of change the processes of catharsis (following abreaction) and insight. Harper broadly defined insight as "the

process by which the meaning, significance, pattern, or use of an experience becomes clear—or the understanding which results from this process" (28, p. 163). He defined catharsis as "the release of tension and *anxiety* by recounting and/or *acting out* past experiences" (28, p. 158; author's italics).

Although both processes have been considered in the psychodynamic tradition, it may be noted that Freud never used the term "insight" per se. The therapeutic process transferred its emphasis from the primary importance of abreaction (catharsis) to the removal of amnesia and the recovery of repressed memories. Following this shift, Greenson pointed out, "catharsis [is] no longer the ultimate aim of therapy" (51, p. 13). In its stead, the process of insight has been extensively singled out not only to refer to a phenomenon specially applicable to the psychodynamic therapies in contrast to other therapies (51-53) but also as the patient's ultimate aspiration.

According to Hutchinson, there are four successive stages in attaining therapeutic insight: 1) a stage of preparation, which is characterized by frustration, anxiety, a feeling of ineptness, and despair and may be followed by much trial-and-error activity relevant to the solution of a certain problem and the falling into habitual patterns or ways of thinking, foreseeing no apparent solution to the problem; 2) a stage of incubation or renunciation in which one desires to hide or escape from the problem and one is resistant or unmotivated in therapeutic or insightful efforts; 3) a stage of aspiration or illumination in which the whole problem becomes illuminated and a solution or solutions suggest themselves (often there is a flood of vivid ideas and a sense of finality accompanied by a conviction in the truth of the insight); and 4) a stage of elaboration and evaluation in which the validity of the insight is checked against external reality (54).

Although the third stage tends to be most frequently identified with the idea of insight (suggesting an essentially eureka phenomenon), Ludwig pointed out that

> during the typical course of psychotherapy, it is much more common for the patient to experience insight in a… drawn out emotionally attenuated form. The sudden tidal wave of illumination or enlightenment is rare compared to the numerous small ripples of insights which are experienced and intellectually assimilated over a long period of time. Moreover, the therapeutic insights tend to be circumscribed and specific to certain problem areas that the profound and general eureka experiences, such as those described to occur during religious conversion or revelation in which the "whole truth" suddenly is revealed (55, p. 315).

In terms of the therapeutic value of the process of insight, Ludwig noted that "there is no necessary relationship between the truth or falseness of insight and therapeutic results" (55, p. 313). In addition, since intellectual insight alone is felt to be of minimal value, attempts have been made to distinguish between intellectual and emotional insight. However, it is difficult to validate such a distinction (56).

In brief, Ludwig hypothesized that insight is therapeutic when it meets all of the following specifications: 1) consistency, that is, the deductions based on the original insight are stable and logically sound regardless of the truth or falsity of the particular content of the insight; 2) continuity, that is, insights must take place within some existing theoretical framework or stream of tradition in which the insight can be tested; 3) personal consequences, that is, the insight must be judged by the fruit it bears in terms of the ultimate use to which the insight is put; and 4) social consequences, that is, the acquisition of insight should allow the person to interact with others in a more honest and meaningful manner (55).

Although analysts have confidence in the role of insight as a therapeutic agent, doubt has been cast on the "insight leads to change" dictum. Schonbar, for example, has observed that "not all change is attributable to insight" and "not all insight leads to change" (57). However, the fact that insight, even as an ultimate change agent, does not occur in isolation is more important for consideration of the analytic therapies. Intricately embedded in the psychodynamic curative process is the critical role of the therapeutic relationship, expressly manifested in the phenomenon of the transference relationship.

The Nature of the Therapeutic Relationship

In 1970 Strupp noted, "There can be no doubt that the patient's relationship to the therapist… embodies one of the most powerful forces in the therapeutic enterprise…. Psychotherapeutic changes always occur in the context of an interpersonal relationship, and are to some extent inextricable from it" (13, pp. 396, 400). The specific therapeutic agent, according to Rosen, seems to be the "complex, emotionally-charged parent-child kind of relationship between the psychiatrist and the individual whom lie is treating" (58, p. 126). In terms of the special nature of that therapeutic relationship, it should be pointed out that deliberate systematic attention to the vicissitudes of the special relationship between therapist and patient is crucial to the conduct of the psychoanalytic psychotherapies. It constitutes both the subject and the object of analysis.

Historically, two roles or stances for the therapist have been described in portraying the psychodynamic psychotherapies: the primary stance with regard to the making of the transference relationship and, more recently, the secondary stance with regard to the making of a working or therapeutic alliance. Despite increasing acceptance of the latter into the therapeutic situation, these represent dual postures, which Greenson explicitly depicted as antithetical to each other, both in their essential purposes and in the actual requirements they make of the therapist (51).

The primary stance reflects Freud's original recommendations 1) that the analyst be like a mirror to the patient, reflecting only what is reflected to him/her by the patient and not bringing his/her own feelings (attitudes, values, personal life) into play (59) and 2) that the analyst follow a posture of privation or rule of abstinence, that is, technical motives must unite with ethical ones in preventing the therapist from offering the patient the "love" that the patient will necessarily come to crave (59, pp. 157-171).

These dictums have been taken to mean that two basic requirements are

traditionally made of the analyst if he/she is to best accomplish the therapeutic task: 1) he/she must continue to judiciously frustrate and avoid gratifying the wishes of the patient; and 2) he/she must remain relatively removed and anonymous, a deliberately dispassionate observer and reflector of the patient's feelings. The therapeutic relationship is asymmetrical. Henry and associates described the relationship as follows:

> Only the patient is supposed to reveal the intimate details of his life. The psychotherapist is not only free to determine what he will reveal and conceal about himself, but also to choose how to react to what the patient is saying, if indeed he decides to respond at all. The relationship is also asymmetrical in that only the therapist is supposed to interpret and impute meaning to what the patient is saying and only the therapist can evaluate the degree to which therapeutic objectives are being achieved in the relationship (60, p. 218).

Conversely, within the same framework, the more recent concept of a working or therapeutic alliance reflects an alternatively nonregressive, rational relationship between patient and therapist. Although still in the service of analyzing transference and resistances, according to Chessick it means "that the therapist aims at forming a real and mature alliance with the conscious adult ego of the patient and encourages him to be a scientific partner in the exploration of his difficulties" (53). The real object need of the patient, deliberately frustrated by the transference relationship, is satisfied by the therapeutic alliance.

Techniques and Methods

Bellis' statement that "no technique is therapeutic in itself…. Every clinician must understand and calibrate his own instruments" (61) bears repeating in a discussion of the techniques of dynamic psychotherapy.

The major instruments of the prototypic dynamic approach are primarily verbal in nature. They rest in part on the proverbial talking cure and may be regarded as free association on the part of the patient and analysis of transference reactions and resistances on the part of the therapist. Analysis, the task of the therapist, is facilitated by four specific procedures: confrontation,

clarification, interpretation, and working-through. It is the third of these, interpretation, that, according to Greenson, is regarded as the "ultimate and decisive instrument" (51).

With regard to the input of the patient, the technique of free association early reflected the major vehicle for the communication of uncensored content from patient to therapist. It has constituted the primary procedure for eliciting the raw material on which the analysis ultimately rests. This includes the eliciting of dreams, which Freud regarded as "the royal road to a knowledge of the unconscious activities of the mind" (62, p. 608). Methodically, the attempt to solicit free associations and dreams from the patient accounts for the most notorious material ingredient of the analytic method in classical analysis—the couch. Having the patient in a supine position out of direct view of the therapist and without extrinsic environmental intrusions is meant to create conditions of relative sensory deprivation that in turn serve to maximize the evocation of repressed memories.

With regard to the therapist's task and response to the verbal material elicited from the patient, the crux of the psychoanalytic method remains the analysis of transference, which comprises the major instrument of analysis as well as its major obstacle. The deliberate elucidation of transference reactions results in inevitable resistances to this endeavor, which must also be overcome as part of the treatment. Methodologically, the reflective, ambiguous stance of the therapist in concert with the high frequency and regularity of contacts between patient and therapist are meant to encourage the regressive transference process and the intensity of feelings in the treatment situation.

Despite the endowment of the value of interpretation, the therapeutic path must be carefully paved in order for it to have its most beneficial effects. In this regard, the role of the techniques of confrontation, clarification, and working-through have been noted. Confrontation refers to having the patient discern or face the particular mental event to be investigated: clarification refers to placing

the same event in sharp focus, separating important aspects from insignificant ones (both of these processes prepare for the actual interpretation); interpretation then goes beyond the manifest material by assigning an underlying meaning or cause to the event or phenomenon in question; finally, working-through refers to the repetitive, progressive, and elaborate explorations of the interpretations and resistances to them until the presented material has become fully integrated into the patient's understanding. This is perhaps the most time-consuming aspect of dynamic psychotherapy. Although the major thrust of treatment occurs within the therapist's office, working-through necessarily includes the tacit work done by the patient outside of the therapeutic hour.

In terms of comparisons with other forms of treatment and their reputed curing powers, certain techniques or procedures are considered to be expressly anti-analytic, i.e., to block or lessen one's understanding or insight rather than facilitating it. Foremost in this regard are (perhaps ironically) abreaction, which may still be used but is not felt to directly bring insight; direct suggestion or advice, which is only useful to the extent that it is openly acknowledged and analyzed within the therapy setting; manipulation, allowable only to the extent that it can be brought into the analytic arena and does not occur without the ultimate knowledge of the patient; and the deliberate or conscious assumption of roles or attitudes that create an unanalyzable situation by their very nature.

Variations on the Dynamic Theme

The prototypic embodiment of the psychodynamic theme is, of course, classical psychoanalysis. The variations on the dynamic theme reflect overt and covert modifications of theoretical conceptualizations as well as methodological and technical applications in practice. These include attempts to partially or completely transcend the biological focus of Freud with more interpersonal, social, ethical, and cultural considerations (e.g., Adler, Horney, Sullivan, Fromm, Fromm-Reichmann, Meyer, and Masserman); to extend or enhance the ego with

earlier or more adaptive endowments (e.g., Federn and Klein); to enlarge man's temporality with a time focus on his primordial past (e.g., Jung), his present, and/or his future (e.g., Adler, Stekel, Rank, and Rado) ; to expand treatment procedures by altering the range and goals of treatment (e.g., Rank, Alexander, Deutsch, and Karpman); to develop guidelines for his short-term psychotherapy with anxiety-provoking techniques (e.g., Sifneos) and even brief treatment of serious illness within the context of a single interview (e.g., Malan) (63-67); to revise the role of the therapist's personality and relationship to the patient by making the therapist a more direct, flexible, and/or active participant (e.g., Adler, Sullivan, Rank, Alexander, Stekel, Ferenczi, and Rosen); and, at perhaps the opposing end of the analytic spectrum, to restore the psychophysical balance of man by focusing equally on the physical half of the psychophysical split (e.g., Rado and Masserman) and/or substituting an approach to therapeutic cure from the somatic side by trading the traditional change mode of insight for a reversal back to the earlier catharsis by means of the bodily release of conflictual tensions (e.g., Reich).

The Behavioral Theme

The Nature of Man and His Ills

The behavioral theme presumes that all behavior, both normal and abnormal, is a product of what man has learned or not learned. Neuroses or neurotic symptoms are construed as simple learned habits, involuntarily acquired, repeated, reinforced responses to specific stimuli in the environment. Indeed, Eysenck said, "there is no neurosis underlying the symptom, but merely the symptom itself" (68). Conversely, since external behaviors constitute the essence of the therapeutic problem, the therapeutic cure is simple: "Get rid of the symptom and you base eliminated the neurosis" (68).

Behavioral psychotherapy is an outgrowth of animal laboratory experiments on classically conditioned responses in which animals were

observed to have habits that were like human phobias. Traditionally, behavioral psychotherapy also presumes that human neuroses have the same basic vicissitudes as those of the animal, in which anxiety (equated with fear) is regarded as its central manifestation (69).

Thus behavioral man is reducible to stimulus-response connections that can be isolated and altered in a piecemeal manner by reinserting new associations. Viewed in this way, behavioral man is infinitely manipulable and therefore controllable by external events in the environment.

The prototype of orthodox behavior therapy is exemplified in Wolpe's reciprocal inhibition therapy, which is based on a classical conditioning paradigm.[2] Wolpe's main thesis is that neurotic symptoms are all essentially phobias based on the adverse learning of unrealistic fears. In behavioral theory this means that anxiety has been conditioned during highly disturbing or traumatic experiences. Wolpe would regard a complex symptom like neurotic passivity as a learned fear of rejection or disapproval reflecting one form of a phobic or anxious reaction to others.

Therapeutic or Change Processes

For the behaviorist all problems are construed as pedagogical in nature and therefore alterable only through direct teaching and learning of new behavioral associations, i.e., stimulus-response connections. The patient must be taught new alternatives that must be repeated and practiced within as well as outside of the therapy situation. These alternative modes of functioning do not occur simply as a concomitant of cognitive or emotional understanding of one's problems; the patient must rehearse the new alternatives directly. Thus, in direct contrast to the psychodynamic schools, the behavioral approaches, according to Cautela, tend to sustain the view that insight is not only unnecessary but usually hinders the treatment for deviant behavior (70). Wolpe's principle of reciprocal inhibition implies the rejection of catharsis as well. Wolpe sees abreaction (the

symbolic re-evocation of a fearful past experience) as a special case in point, asserting that no permanent effects are achieved if unrelieved terror is the only emotional factor involved and is not counterposed by relaxation responses.

One implication of this view of the mode of therapeutic change is that change can presumably occur within a short period of time. In contrast to the dynamic theme, Eysenck stated that "all treatment of neurotic disorders is concerned with habits existing in the present; their historical development is largely irrelevant" (68). Moreover, Cautela stated, "In fact, it is possible to have a situation in which symptoms have been removed with no knowledge at all of the etiology" (70).

Although all behaviorists may be viewed as seeking change through direct conditioning, shaping, or training, Wolpe, in accordance with his classical conditioning paradigm, sees all therapeutic learning or change (not just behavior therapy) as occurring within the reciprocal inhibition framework per se. All therapies necessarily incorporate the substitution of relaxation for anxiety in the reduction or elimination of symptoms. However, more critically, the difference between behavior therapy and other therapeutic situations is that in the latter, counterconditioning of relaxation over anxiety occurs fortuitously or unsystematically, whereas in behavior therapy this process is overt, systematic, and under the direct control of the therapist.

The Nature of the Therapeutic Relationship

The nature of the therapeutic relationship between therapist and patient in the behavioral therapies is, according to Hollander, an essentially "educative, teacher-pupil relationship" (71). In contrast to the psychodynamic transferential relationship but comparable to the working or therapeutic alliance in certain respects, the behavioral relationship may be portrayed as a deliberately structured learning alliance, in which, at its best, attention is drawn to the more current and presumably constructive aspects of the patient's personality in

collaborating on the course of therapy.

Krasner depicted the behavior therapist as a learning technician or "social reinforcement machine" (72). Although this rubric may apply to all therapies to greater or lesser degrees, usually the behavioral therapist openly regards himself/herself as an instrument of direct behavioral influence or control, one who directly and systematically manipulates, shapes, and/or inserts his/her own values in the therapeutic encounter In a comparable context, the therapist shapes his/her own behavior so as to be a social reinforcer for the patient. If the therapy does not proceed smoothly and effectively, the behavior therapist revises the behavioral plan or schedule to better fit the patient to treatment (71).

Behavior therapy deliberately does not dwell on the therapist-patient relationship; at most, it does so secondarily, that is, according to APA's Task Force on Behavior Therapy, "only to the extent that this is seen to be important in securing the patient's cooperation with the therapist's treatment plan" (73, p. 27).

The behavior therapist's use of warmth, acceptance, and any other relationship skills is common but relegated to the realm of secondary "relationship skills" that are not crucial therapeutic requirements for desired change to occur in the patient (71).

Techniques and Methods

In Ehrenwald's words, the behavioral schools of psychotherapy actively relinquish "the methods of the couch" and replace them with "the methods of the classroom and the pulpit" (7). The behavior therapist has at his/her disposal a large variety of conditioning, training, and other directive techniques. This repertoire may include any or all of the following: the more classical conditioning techniques of systematic desensitization combined with deep muscle relaxation, implosion, or assertiveness training; the operant techniques of positive or

negative reinforcement; aversiveness training; shaping or modeling; and/or the more flexible directive techniques pertaining to the direct transmission of advice, guidance, persuasion, and exhortation. The latter methods more typically reflect the means by which behavior modification has been extended recently to the teaching or conditioning of cognitive behaviors or attitudes underlying specific behaviors, methods of philosophical indoctrination, or cognitive programming.

More generally, the behaviorist initially sets out to identify the patient's specific target behaviors or responses that need to be modified. These, in conjunction with the stimuli or environmental situations that give rise to the specific behaviors, constitute a behavioral formulation that may be regarded as the behaviorist's counterpart of psychodynamic formulation. The behavioral formulation is used for the purpose of setting specific treatment goals, which are usually made explicit to the patient at the outset. The initial interview typically aims to specify what situations or factors contribute to the maintenance of the particular responses in question and on what occasions those responses are most likely elicited. On this basis the behavioral conditioning program can then begin.

Wolpe's classical reciprocal inhibition therapy, which has as its direct aim the reduction or inhibition of anxiety responses through the substitution of relaxation responses for anxiety, typically uses two basic techniques for the purpose of juxtaposing relaxation with anxiety. The first technique is progressive deep muscle relaxation training and the second is systematic desensitization of anxiety through imagination. The patient is instructed to relax and then tense up for intervals of 10-15 seconds each; the patient repeats this maneuver using various different muscle groups or parts of the body followed by breathing exercises. Then, after discussing with the patient which real-life situations arouse the phobic symptoms, the therapist incorporates each scene into an anxiety list or anxiety hierarchy; this list constitutes the basic therapeutic tool. (Each scene or situation is arranged hierarchically on the basis of level of anxiety generated in the patient, with a ranking system of 1-10). Starting with the weakest elicitor of anxiety in the hierarchy, the therapist asks the patient to imagine the anxious

circumstance for a few minutes and then instructs the patient to concentrate on relaxing; this process is repeated until the patient can imagine the scene without feeling any anxiety. The therapist ascends the anxiety list item by item in the same manner. When this process is finished, the real-life situation that has created the phobia has lost its capacity to elicit anxiety.

A more recent variation of this approach is, ironically, a direct reversal of this procedure. The therapist starts not with the bottom but with the top of the anxiety continuum; the patient is flooded with the strongest anxiety-eliciting stimulus situation of his/her imagination and keeps this in mind until the anxiety dissipates. Then, with successive repetitions of the same scene, the patient's anxiety progressively lessens until he/she is immune to anxiety in that situation. This basic technique is referred to as implosion (Stampfl's implosive therapy).

A cognitive variation of this approach is the technique of thought- stopping. In this variation the patient puts into words the anxiety-producing situations instead of merely imagining them. As the patient speaks about himself/herself in these situations the therapist suddenly interrupts the train of anxious verbalizations by shouting "Stop!" This procedure is repeated on successive occasions until the patient validates the fact that this overt suppression has indeed served to reduce the frequency of the anxiety-loaded thoughts. Ellis' rational therapy represents an elaboration of this cognitive approach on a larger and more varied scale.

The behavioral counterpart of the psychodynamic procedure of working-through is behavioral rehearsal within the confines of therapy as well as assignments to be worked on outside of therapy; these are important parts of the total behavioral treatment. For example, the patient might be directly trained in certain social skills that may first be role-played or rehearsed within the course of therapy as well as explicitly instructed, tested out in outside real-life situations, and reviewed in subsequent sessions.

A special instance of this method is assertiveness training, a technique of instruction and practice of interpersonal behaviors involving the relatively direct expression of one's positive and negative responses to others. Wolpe claimed that assertive responses constitute a major class of behaviors that could be used as an alternative to relaxation responses in the function of reciprocally inhibiting anxiety. Assertive training by means of behavior rehearsal, whether or not it is used as a technique for expressly countering anxiety, has been incorporated into a variety of schools that use the methods of the behavioral laboratory.

Variations on the Behavioral Theme

Three broad types of behavior therapies or behavior modification are considered under the umbrella of the behavioral theme (74): one, based on the early classical Pavlovian paradigm, primarily uses systematic desensitization or extinction of anxiety techniques (e.g., Wolpe's reciprocal inhibition therapy); a second type, based on an operant Skinnerian paradigm, uses direct reinforcement by means of reward/punishment procedures (e.g., Allyon and Azrin's token economy); and a third type, based on a human social learning paradigm, is contingent on direct modeling or shaping procedures (e.g., Bandura's modeling therapy). The latter type of therapy extends to a variety of new systems of directive psychotherapy that expressly aim at attitudinal or philosophical restructuring, using methods of the behaviorist's laboratory. Such so-called integrity therapies, although they share the fundamental learning or problem-solving stance, are usually more actively advisory and/or exhortative in their therapeutic techniques (e.g., Ellis' rational therapy, Glasser's reality therapy, and Sahakian's philosophic psychotherapy).

Another way of viewing the scope of these behavioral variations is through the evolution of their targets of change from external to internal alterations in man's learnings. The earlier behavior therapeutic systems addressed overt behaviors and fears (e.g., Wolpe); the more recent systems are directed to more covert values and beliefs (e.g., Ellis). The most recent approaches venture into

the reaches of the most inaccessible and involuntary mental and physiological states and responses, such as heart rate, blood pressure, and brain waves (e.g., biofeedback).

The Experiential Theme

The Nature of Man and His Ills

In terms of therapeutic ideology, a major source of divergence and disagreement for the founders of schools of psychotherapy since Freud has been their inability to reconcile what they regard as a largely deterministic or defeatist image of man. This includes the renunciation of a dynamic conceptualization of man as a predominantly passive or instinctually regressive recipient of his conflictual drives, subservient to the less conscious aspects of himself. The experientialists criticize classical psychotherapy's overcommitment to the canons of science and its concurrent underplaying of man's ethical dimension, that is, his will, choices, and moral relation to others. Through psychotherapeutic practices and overemphasis on technique, man becomes impersonalized, compartmentalized, calculated, managed, and/or analyzed and thereby diminished instead of truly experienced by others or himself (20, 26, 53, 75).

Haigh, an experientialist, has criticized the behavioral conceptualization as follows:

> The therapeutic process [is] essentially concerned with the experiential anguish of isolation and alienation. These experiences of isolation, encapsulation, alienation derive from social programming.... The central problem cannot be understood exclusively at the level of overt behavior, [but] must be understood as involving incongruence between overt behavior and inner experience. Reinforcement learning theory is inadequate for translating this central problem because it doesn't include concepts representing human experience. The behavioral therapy techniques associated with reinforcement learning theory are potentially harmful because they involve the very same programming approach which induced these neurotic problems in the first place (76).

The experiential conceptualization represents an increasingly emerging exaltation of man in order to counter alienation, that is, the fostering of the fullest

exploration of the unique and universal nature of man's self. It is expressly devoted to the self-transcendent quality of human experience. In Frankl's words, "Man is basically striving to find and fulfill meaning and purpose in life" (77, p. 252).

This reaching out involves a transpersonal as well as intrapersonal dimension. According to Arendsen-Hein, the intrapersonal refers to an "ego-centered level… where the main concern is the discovery of one's individuality, of one's emotional states and their representation in the physical body"; the transpersonal, on the other hand, is "spiritually oriented towards ultimate reality,… unity on the human, universal, or cosmic plane ... in which [the person] experiences a transcendence of his ego boundaries into a universal consciousness" (78).

The experientialist tends to view man as an inherently active, striving, self-affirming, and self-potentiating entity with almost limitless capacity for positive growth, and the experiential therapies typically opt for growth and not mere healing of illness. Their therapeutic goal is attaining maximal awareness or a higher state of consciousness, in which, according to May and associates, "to be aware of one's world means at the same time to be designing it" (20, p. 60). Experientialists therefore direct themselves to such expansive dimensions as self-determination, creativity, and authenticity and make use of a potpourri of methodologies that aspire to an ultimate integration of the mind, body, and more recently, soul of fragmented man.

The experiential stance historically reflects the incorporation of the basic philosophy of the European existentialist, with his/her concern for the essential issues of man's being or becoming; the methodology of the phenomenologist, who attempts to address data as given in order to tap their meaning and to examine patients on their own terms without recourse to preconceived theoretical formulations of a causal or diagnostic nature; and, now more than ever, the religious teachings and techniques of the Eastern mystic, who presumes

to bridge the mind-body split in seeking man's spiritual center. All, according to May and associates, focus on "man's most immediate experience… [i.e.,] that to fully know *what* we are doing, to feel it, to experience it all through our being, is much more important than to know *why.* For they hold, if we fully know the *what,* the *why* will come along by itself" (20, p. 83).

Pathology is regarded as the reduced expression of one's potential, the result of blocking and the loss of congruence with or repressing of one's internal self-experience. Both the psychodynamic and the experiential (essentially existential) themes depict the neurotic personality as suffering from repression and fragmentation. The dynamic view postulates repression of instinctual drives, especially sexual ones, while the experiential view construes repression as an ontological phenomenon, "the loss of a sense of being, together with the truncation of awareness and the locking up of potentialities which are the manifestation of this being" (20, p. 86).

Neurosis is a fundamental universal despair resulting from the individual's estrangement from himself and Iris society (or world). Comparably, anxiety, in marked contrast with the behavioral equation of anxiety with specific circumscribed fears, refers to "the anxiety of man facing the limits of his existence with the fullest implications… death, nothingness" (20, p. 118). Such anxiety manifests itself at every moment as man stands against the reaches of his own possibilities. Moreover, the origin of guilt accrues from the forfeiting of one's potential, for which the person alone is responsible.

In Maslow's words, pathology is "human diminution" (instead of neurosis), "the loss or not-yet-actualization of human capacities and possibilities" (79, p. 124). Thus health and illness, including all of the standard psychiatric categories, reside on a continuum—the differential between what one construes himself to be versus what one can become. The overall ideal or ultimate state of health refers to man as maximally conscious and real at every moment, to wit, according to Denes-Radomisli, man as "vital, immediate, spontaneous, authentic, and

active" (80, p. 104).

Therapeutic or Change Processes

The experiential schools of psychotherapy trade intellectual cognition and insight for emotion and experience, forsaking the there-and-then of the distant past for the here-and-now of the immediate present.

Experiencing is a process of feeling rather than knowing or verbalizing; occurs in the immediate present; is private and unobservable but can be directly referred to by an individual as a felt datum in his own phenomenal field; acts as a guide to conceptualization; is implicitly meaningful, although it may not become explicitly so until later; and is a preconceptual organismic process. The many implicit meanings of a moment's experiencing are regarded not as already conceptual and then repressed; rather, they are considered in the awareness but as yet undifferentiated. In total, according to Gendlin, "therapeutic change occurs as a result of a process [of experiencing] in which implicit meanings are in awareness, and are intensely felt, directly referred to, and changed, without ever being put into words" (81, p. 239).

Therapeutic change through experiencing usually occurs by means of a real or congruent interpersonal relationship between the patient and therapist. In the latter regard, May and associates said,

> Beyond all considerations of unconscious determinism—which are true in their partial context—the only thing that will grasp the patient, and in the long run make it possible [for him/her] to change, is to experience fully and deeply that [he/she] is doing precisely this to a real person ... in this real moment (20, p. 83).

One variation of this thesis, especially applicable to Rogers' client- centered therapy, reflects the underlying positive belief that every organism has an inborn tendency to develop its optimal capacities as long as it is placed in an optimal environment. Thus, according to Hoehn-Saric, the patient is offered "an optimistic self-image; he understands that he is basically good and full of

potentials…. Therefore, the therapist does not need to challenge or shape the patient, he has only to provide the warm and understanding milieu which will enable the patient to unfold his latent potentials" (82, p. 261).

Unlike transference, which is dependent on the revival of a former interpersonal relationship, experiential encounter works "through the very fact of its novelty." Through encounter the therapist serves as a catalyst in whose presence the patient comes to realize his own latent and best abilities for shaping his own self (20).

The Nature of the Therapeutic Relationship

Although methods may vary, the real here-and-now therapeutic dialogue or mutual encounter between therapist and patient is the sine qua non of many of the experiential schools. It is, according to Ford and Urban, "an emotionally-arousing human relationship in which each person tries to communicate honestly with the other both verbally and nonverbally" (26, p. 470).

Rogers described the flavor of the therapeutic encounter as follows:

> I let myself go into the immediacy of the relationship where it is my total organism which takes over and is sensitive to the relationship, not simply my consciousness. I am not consciously responding in a planful or analytic way, but simply in an unreflective way to the other individual, my reaction being based (but not consciously) on my total organismic sensitivity to this other person. I live the relationship on this basis (83, pp. 267-268).

These approaches to psychotherapy ideologically aspire to an egalitarian treatment model. The human alliance is not of physician to patient or teacher to student but of human being to human being. May and associates presented the following rationale: "The therapist is assumedly an expert; but, if he is not first of all a human being, his expertness will be irrelevant and quite possibly harmful" (20, p. 82). Rogers stated that if the patient is viewed as an object the patient will tend to become an object (83). Therefore, the therapist says, "I enter the relationship not as a scientist, not as a physician who can accurately diagnose

and cure, but as a person, entering into a personal relationship" (83, p. 267). Naturally, what one construes to fall within the domain of personal or real in a therapeutic relationship is open to interpretation.

In sum, although Seguin pointed out that the quality of the healer-patient relationship (and the form of therapeutic love or eros that is transmitted) is "different from the one between father and son, teacher and pupil, friends, and, of course, lovers" (84), the experiential theme rejects the paradigm of the parent-child relationship of the dynamic theme and the teacher-student paradigm of the behavioral theme and opts for something closer to the latter conceptualization (i.e., friends and lovers) in its paradigm of the therapeutic relationship.

Techniques and Methods

There is an assortment of schools of psychotherapy within the experiential theme that recoils at the idea of therapeutic technology. These schools, which are predominantly existential, renounce technique as part of their philosophy of understanding human existence. They feel that the chief block in the understanding of man in Western cultures has been an overemphasis on technique and a concomitant tendency to believe that understanding is a function of or related to technique. Rather, according to May and associates, they feel that "what distinguishes [forms of] existential therapy is not what the therapist would specifically do,… but rather the *context* of his therapy" (20, p. 77). That is, according to Chessick, it is "not so much what the therapist says [or does] as what he *is"* (58, p. 243). Indeed, in this regard the existential schools of psychotherapy have been criticized for their vagueness regarding technical matters in the conduct of psychotherapy. Ford and Urban's analysis of their approach concluded that "they have developed a new way of thinking about patients, but it does not lead them to *do* anything different in treatment" (26, p. 469).

Less harshly, the experiential schools aspire to flexibility or innovation in

their actual methods as long as these methods are useful in the therapist's attempt to experience and share as far as possible the being of the patient. Here the aim or rationale of all techniques would be to enter the phenomenological world of the patient. In direct contrast to the view of the dynamic therapist, the experiential therapist does not concern himself/herself with the patient's past, the matter of diagnosis, the aspiration of insight, the issue of interpretation, or the subtle vicissitudes of transference and countertransference. Unlike the behavioral therapist, the experiential therapist expressly does not set goals for the patient and does not direct, confront, or otherwise impose his/her personality on the patient with directives in the form of behavioral instructions or problem-solving preferences. Techniques that involve placing the therapist's judgments or values above those of the patient are considered anathema to the requirements of unconditional acceptance of the patient and placing the locus of control within the patient. It may also be noted here that Rogerian methods as well as others within the more classically existential framework retain a methodological framework of essentially verbal interchange between therapist and patient.

Although they share the same basic faith in the therapeutic encounter and the emphasis on feelings, other schools under the experiential umbrella are often antiverbal in approach. Such schools (e.g., Gestalt therapy), view overintellectualization as part of the patient's problem, i.e., a manifestation of defense against experiencing or feeling, and discourage it as part of the therapeutic endeavor. These therapies attempt to accentuate activity over reflection, emphasize doing rather than saying, or, at the minimum, aim to combine action with introspection. The goal of experiencing oneself includes developing the patient's awareness of bodily sensations, postures, tensions, and movements, with an emphasis on somatic processes. Awareness of oneself as manifested in one's body can be a highly mobilizing influence. The main thrust of therapy is therefore to actively arouse, agitate, or excite the patient's experience of himself/herself, not simply let it happen.

Among the techniques for expressing one's self-experience in such schools is the combination of direct confrontation with dramatization, i.e., role-playing and the living out of fantasy in the therapeutic situation. This means that under the direction (and often the creation) of the therapist the patient is encouraged to play out parts of himself/herself, including physical parts, by inventing dialogues between them. Performing fantasies and dreams is typical and considered preferable to their mere verbal expression, interpretation, and cognitive comprehension. In variations of the somatic stance, body and sensory awareness may be fostered through methods of direct release of physical tension and even manipulations of the body to expel and/or intensify feeling.

In yet other attempts to unify mind, body, and more especially, spirit, the immediate experience of oneself by focusing on one's spiritual dimension is sought. This is most often accomplished through the primary technique of meditation. The ultimate state of profound rest serves to transcend the world of the individual ego in that it is a higher reality or state of consciousness that the individual ego subserves. Major methods of will training and attention focused on a special word-sound or mantra, for example, serve to create an egoless or nonegocentered transcendent state.

Variations of the Experiential Theme

The therapeutic systems that have evolved under the experiential theme represent various approaches, each propelled by the immediate moment and geared toward the ultimate unity of man. These include the following: 1) a philosophic type, which reflects existential tenets as a basis for the conduct of psychotherapy and pivots on the here-and-now mutual dialogue or encounter while retaining essentially verbal techniques (e.g., Rogers' client-centered therapy and Frankl's logotherapy); 2) a somatic type, which reflects a subscription of nonverbal methods and aspiration to an integration of self by means of focusing attention on subjective body stimuli and sensory responses (e.g., Perls' Gestalt therapy) and/or physical-motor modes of intense abreaction

and emotional flooding in which the emphasis is on the bodily arousal and release of feeling (e.g., Lowen's bioenergetic analyses and Janov's primal scream therapy); and, finally, 3) a spiritual type, which emphasizes the final affirmation of self as a transcendental or transpersonal experience, extending man's experience of himself to higher cosmic levels of consciousness that ultimately aim to unify him with the universe. This is primarily accomplished by means of the renunciation of the individual ego in the establishment of an egoless state by meditation (i.e., relaxation plus focused attention), in which one reaches a state of profound rest (e.g., Transcendental Meditation), a spiritual synthesis that may be amplified by various techniques of self-discipline and will-training and practice of disidentification (e.g., Assagioli's psychosynthesis).

Conclusions

Individual names given to different schools of psychotherapy often attempt to capture, if not exalt, their uniqueness; at the same time, the very names may serve to mask their derivations and the similarities they share with other systems. The schema presented here subsumes a large array of therapeutic schools that have proliferated under three broad themes since Freud. Each major theme as depicted here in its prototypic or pure form has a unity of its own; each dimension is broadly congruent with the others in its domain and is overtly antithetical to those dimensions described in the other two themes. However, in reality these are rarely categorical distinctions. Therapeutic boundaries in actual practice can and do overlap.

The systematic approach presented in this paper allows us to consider the dimensions of greatest departure as well as convergence in the ever- expanding field of the psychotherapies. In so doing, it is hoped that psychotherapeutic schools and their therapeutic processes will be more closely and critically explored.

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Notes

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2 The terms "classical" versus "operant" conditioning procedures refer essentially to the respective sequence in the application of the stimulus. In classical conditioning the stimulus precedes and in operant conditioning the stimulus follows the behavioral response to be changed.