THE TECHNIQUE OF PSYCHOTHERAPY

RECONSTRUCTIVE THERAPY

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From *The Technique of Psychotherapy* Lewis R. Wolberg

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An ultimate goal of psychotherapy is to reduce the force of irrational impulses and strivings and bring them under control, to increase the repertoire of defenses and make them more flexible, and to lessen the severity of the conscience, altering value systems so as to enable the patients to adapt to reality and their inner needs. These aims are formidable because the various components of personality are so forged into a conditioned system as to be almost impervious to outside influence. Homeostatic balances are maintained to safeguard neurotic adjustment. Resistances block attempts to interfere with coping mechanisms and defenses. To cut into the neurotic system in order to modify the structure of personality and to expand the potentials of the individual in all required dimensions are difficult and frequently unrewarding undertakings. Reconstructive psychotherapy is aimed at these objectives.

Reconstructive psychotherapy is more or less traditionally rooted in the theoretical soil of a genetic-dynamic model of personality. This purports that past inimical experiences and conditionings have retarded the normal psychosocial growth process and are now promoting in the individual immature strivings and emotions that come into conflict with reality, on the one hand, and, on the other, with the person's own incorporated system of ideals and standards. Resultant are tensions, catastrophic feelings of helplessness, and expectations of injury that in turn invoke protective devices, most common of which is repression, a sealing-off process that blankets offending impulses, attitudes, and memories from awareness. However noble the attempt, repression of unacceptable strivings rarely succeeds in annihilating them, for their expression is sought, from time to time, by powerful motivations of impelling need. The filtering of offensive impulses into conscious life promotes bouts of anxiety and whips up the defenses of the ego, which, while ameliorating anxiety, may be destructive of adjustment. Additionally, repressed strivings may express themselves as symptoms. The direct or disguised operations of repudiated strivings, and the defenses that are mobilized against them, promote attitudes and values that disorganize interpersonal relationships. Reactions develop that are opposed to judgment and common sense. While individuals may assume they are acting like adults, emotionally they are behaving like children, projecting into their present life the same kinds of fears, misinterpretations, and expectations of hurt that confronted them in their early years, as if neither time nor reality considerations

have altered materially the patterns learned in the past. As long as individuals protect themselves from fancied hurt by circumscribing their activities, they may manage to get along; but should they venture beyond their habitual zone of safety, the precarious balances they have erected will be upset.

Were we to treat a patient according to this hypothesis, we would consider that his or her symptoms were manifestations of a general collapse in adaptation, and our therapeutic effort would be directed toward correcting disorganizing drives that were destructive to the patient's total adjustment. The objective, therefore, would be expanded toward personality growth and maturation, toward heightened assertiveness and greater self-esteem, and toward more harmonious interpersonal relationships. In quest of these objectives, we would strive for a strengthening of the patient's ego, which, involved hitherto in warding off anxiety through the marshalling of neurotic defenses, has been unable to attend to the individual's essential needs. Instrumentalities toward ego strengthening are, first, greater self-understanding and, second, the living through with a new kind of authority, as vested in the therapist, of experiences that rectify residual distortions in attitudes, feelings, values, and behavior.

Increasingly, psychotherapists, directing their efforts toward reconstructive changes, have drawn for inspiration on psychoanalytic theories and methods, although some have tended to label the ideas and tactics that they employ with tags that mask their origin. Accordingly, during the past half century, many ingredients of psychoanalytic thinking have permeated into the very fiber of American psychiatry and psychology and have fashioned a good number of its trends. In turn, psychoanalysis has been influenced by contemporary developments in the psychiatric and psychological fields. It has consequently lost many of its esoteric qualities while acquiring a firmer anchoring in scientific experiment.

Reconstructive psychotherapy is distinguished from supportive and reeducative therapy by the degree and quality of insight mobilized. In supportive therapy efforts at insight are minimal. In reeducative therapy they are more extensive, but they are focused on relatively conscious problems. The traditional objective in reconstructive therapy is to bring the individual to an awareness of crucial unconscious conflicts and their derivatives. Reconstructive psychotherapy strives not only to bring about a restoration of the individual to effective life functioning, through the resolution of disabling symptoms and disturbed interpersonal relationships, but also to promote maturation of emotional development

with the creation of new adaptive potentialities.

The methods employed in bringing unconscious aspects to awareness were originally developed and described by Sigmund Freud, who had the happy faculty of illuminating the most obscure concepts with a refreshing verbal simplicity. Included are such techniques as free association, dream interpretation, the analysis of the evolving transference, the use of strategically timed interpretations, and dealing with resistances to the content of unconscious material. An understanding of the genetic determinants of the individual's personality and of the relationship of these determinants to the operative present-day character structure are component aspects of the therapeutic process.

To do reconstructive therapy, the therapist must have received special training, which ideally includes a personal psychoanalysis and the successful treatment of a number of patients under the supervision of an experienced psychoanalyst.

As has been indicated previously, reconstructive personality changes sometimes occur spontaneously during the course of supportive and reeducative therapies or upon completion of these treatments as a consequence of more congenial relationships with people. For instance, the individual may work out serendipitously, in the medium of a relationship with a helping agency or reeducative therapist, such archaic strivings as infantile dependency needs, unyielding fears of rejection or overprotection, intense detachment, and untoward aggression. The patient may even spontaneously connect the origin of such impulses with unfortunate childhood conditionings and experiences. Any changes developing in this way, however, are more or less fortuitous. In reconstructive psychotherapy, the treatment situation is deliberately planned to encourage change by a living through, with insight, of the deepest fears and conflicts.

There are four main "types" of insight therapy with reconstructive goals: (1) "Freudian psychoanalysis," (2) "ego analysis," (3) "non-Freudian" or "neo-Freudian psychoanalysis," and (4) "psychoanalytically oriented psychotherapy. All of these therapies aim at reconstructive alterations in the personality. They differ, however, as to the methods by which this objective is realized. Freudian psychoanalysis is, more or less, the original technique of Sigmund Freud. Ego analysis, while retaining the classical therapeutic form, focuses on the adaptive functions of the ego. Neo-Freudian psychoanalysis,

which includes the approaches of Horney, Sullivan, Rank, Jung, and Adler, is a modified, more active technique. Psychoanalytically oriented psychotherapy is the most active of the reconstructive therapies. In addition to these main types, there are a number of modifications, such as Kleinian and transactional analysis. Derived from Kleinian theory are object relations therapy, therapy oriented around self-psychology, and some forms of transactional analysis.

FREUDIAN PSYCHOANALYSIS

From recorded history it is obvious that there were people in every age and in almost every culture who had some understanding of the significance of people's psychic life in the scheme of things. The Bible and the writings of the early philosophers contain a wealth of psychological wisdom. But none of the insights was integrated into an organized form until a man from Moravia. Sigmund Freud, through his genius for understanding people's inner motivations and his unflagging determination in the face of violent opposition, broke through and laid a foundation for the science of the psychic processes in what is known today as psychoanalysis.

In 1880 Joseph Breuer discovered that when a hysterical girl under hypnosis was induced to speak freely, she expressed profound emotion and experienced relief from her symptoms. Under the impression that her hysteria originated in certain painful experiences while caring for her sick father, Breuer enjoined her, while she was in an hypnotic state, to remember and to relive the traumatic scenes in her past. This seemed to produce a cure for her hysteria.

Ten years later, in conjunction with Freud, Breuer continued his research, and in 1895 the two men published their observations in a book, *Studien Uber Hysteria* (1936). Their conclusions were that hysterical symptoms developed as a result of experiences so traumatic to the individual that they were repressed. The mental energy associated with the experiences was blocked off, and not being able to reach consciousness was converted into bodily innervations. The discharge of strangulated emotions (abreaction), through normal channels during hypnosis, would relieve the need to divert the energy into symptoms. This method was termed "catharsis."

Freud soon found that equally good therapeutic results could be obtained without hypnosis by

permitting the patient to talk freely, expressing whatever ideas came to mind. Freud invented the term "psychoanalysis" for the process of uncovering and permitting the verbal expression of hidden traumatic experiences. Freud found that there were forces that kept memories from invading consciousness, and he discovered that it was necessary to neutralize the repressing forces before recall was possible. An effective way to overcome resistances was to permit the patient to relax and to talk freely about any ideas or fantasy that entered his or her mind, no matter how trivial or absurd. Freud could observe in this "free association" a sequential theme that gave clues to the nature of the repressed material.

Mainly through an introspective analysis of his own dreams, Freud (1938) was able to show how dreams were expressions of unconscious wishes and fears that evaded the barriers of repression through the assumption of symbolic disguises. He perfected a technique of arriving at the meaning of the unconscious material through the translation of symbols.

Freud also observed that when patients were encouraged to say whatever came to mind, irrational attitudes toward the therapist—such as deep love, fear, hate, overvaluation, expectancy, disappointment, and other strivings that were not justified by the reality situation—were verbalized. He noted, too, that patients identified the therapist with significant personages in their past, particularly their parents, and that this identification motivated the transfer over to the therapist of attitudes similar to those that they originally had toward their parents. This phenomenon Freud called "transference." For example, a male patient with a phobia of being subject to imminent but indefinable injury might, at a certain phase in his analysis, begin to develop an aversion toward and dread of the analyst, expressed in fears of being mutilated. At the same time incestuous wishes for the mother might appear in dreams. Analysis of the relationship with the analyst (transference) would then possibly reveal an identification of the analyst with the patient's father. It would then become apparent that the patient secretly feared injury by the father for his forbidden wish to possess the mother and that his phobia was an expression of this fear of mutilation that had been dissociated from awareness by repression. The hope was that bringing patients' attention to the sources of their fears, and their realization of its irrational nature, would result in an amelioration or cure of their neurosis.

The material uncovered by Freud from his studies of free association, dream interpretation, and analysis of the transference suggested to him that there was a dynamic portion of the psyche, closely

associated with the emotional disorder, that did not follow the normal laws of mental functioning. Freud called this aspect of the mind the "unconscious," and he set about to determine the unique laws that dominated the repressed psychic component.[1] To aid him in this task he formulated a topography of the mind by dividing it into three zones or systems: the unconscious (Ucs.), the pre-conscious (Pcs.), and the conscious (Cs.). The preconscious contained thoughts that could be revived into consciousness with some effort, in contrast to the unconscious, which contained material barricaded from consciousness by an obstructive force.

In studying the symbols issuing from the unconscious, Freud noted that they were concerned chiefly with sexual material, and he concluded from this that the unconscious was preoccupied for the most part with sexual wishes and fears. Consequently, he assumed that the most important traumatic events that had been repressed were sexual in nature. It was largely on this evidence that he evolved his "theory of instincts" or the "libido theory."

In his theory of instincts Freud (1930a) postulated that all energy had its origin in instincts that persistently expressed themselves (repetition compulsion) and were represented mentally as ideas with an emotional charge (cathexis). A fundamental instinct was that of *eros,* the sexual or life instinct, manifesting itself in a force called "libido." Freud hypothesized a permeation of the body by this vital instinctual force, the "libido," which powered the individual's development toward mature sexuality. Libido was, however, subject to many developmental vicissitudes in its destined course to adult genitality. During the first year of life it concentrated itself around the oral zone—the mouth and lips—the child gaining a kind of erotic pleasure by sucking and later by biting. At the end of the first year there was a partial shift in libido to the anal zone, and intense pleasures were derived from the retention and expulsion of feces. During this period the child's interests were more or less concentrated on oneself (narcissism), and satisfactions were localized primarily within his or her own body (autoerotism). Relationships with people were primitive, being circumscribed to only part of the parent (part-object relationships), like the nipple or breast instead of the entire parent.

Around the age of 3, libido was centered around the phallic zone—the penis or clitoris. "Object relationships" were less primitive and were extended to a more complete relatedness with the parent. Yet, fundamentally, the child was ambivalent, responding to parents and other people with a mixture of

love and hate.

This stage of psychosexual growth continued into the Oedipal period, during which the little boy developed toward his mother a profound interest, with strong sexual overtones and desires for exclusive ownership. The little girl, envying men for their possession of a penis, created in part by a desire to repudiate her femininity and to become a male (penis envy), and resenting the fact that she had no penis, accused the mother of responsibility for this deprivation and turned to the father with an intensified sexual interest. In the case of the boy, hostility toward the father, due to a desire to eliminate him as a rival, generated a fear of counterhostility, and particularly a fear of castration, which inspired such anxiety as to induce him to give up his interest in the mother and to make friends with his father. The intensity of fear became so overwhelming and so unendurable that the boy was forced to yield to his more powerful competitor by renouncing, repudiating, and repressing sexual feelings toward the maternal love object. He was obliged also to repress concomitant hostile impulses toward the father. The little girl similarly resolved her enmity toward her mother as well as her sexual interest in her father. This drama, known as the Oedipus complex, was to Freud the crucial nuclear conflict in the development of the personality contributing to both character formation and neurotic symptoms.

The incorporation of parental injunctions and prohibitions and the repudiation of sexual and hostile aims as related to the parents resulted in the crystallization of an aspect of the psyche that took over the judging, prohibiting, and punitive functions hitherto vested in the parents. This aspect became the conscience or superego. The adequate resolution of the Oedipus complex was associated with channelization of libido into the genital zone, with capacities for complete, mature, unambivalent, "whole-object" relationships.

After the Oedipal period was an era characterized by the neutralization of sexual impulses, which Freud called the "latency period." With the advent of puberty, however, increased libido, due to the heightened activity of the genital glands, reactivated the old Oedipal interests. The person then lived through the revived early Oedipal conflict, and the capacity to solve this anew was determined by the extent of previous vicissitudes and the adequacy with which the conflict had formerly been resolved. In "normal" solutions the child transferred his or her sexual interest to extrafamilial persons of the opposite sex. In Freud's pattern of behavior the little girl renounced her boyish interests and accepted a passive

female role.

Under certain conditions normal psychosexual development was impeded by a "fixation" of libido onto oral, anal, and phallic zones. The libido, bound down in this way, was unable to participate in the development of full genitality. Freud believed that both constitutional and experiential factors were responsible for this. Most prominent were excessive gratifications or inordinate frustrations experienced at an early stage of growth. Not only did libidinal fixations interfere with the development of mature sexuality, but they constituted stations to which the individual might return when confronted with overwhelming stress or frustration. Under these circumstances the libidinal stream was said to undergo "regression" to pregenital fixation points. When this happened, there were revived attitudes and interests characteristic of childhood, with immature sexual strivings, interest in "part objects," and narcissism.[2]

In addition to the libido theory described above, Freud elaborated the theory of the death instinct to account for phenomena not explicable in terms of libido. He postulated that it was this second instinct that prompted aggressive and destructive drives. This instinct manifested itself in a "repetition compulsion" to undo the forward evolutionary development of the organism and to return it to its primordial inorganic state. The death instinct, though sometimes libidinized (sadism), was totally different from the sexual instinct. Largely because of his studies on sadism and masochism, Freud came to the conclusion that the sexual and aggressive drives could be fused to foster both normal and pathological activities. The aggressive drive was also subject to vicissitudes in its development through oral (biting), anal (soiling and retention), and phallic phases, during which fixations could occur to which regression was later possible.

Freud conceived of the mental apparatus as an organ that prevented the damming up of energy. Pain was related to an increase of energy and pleasure to a decrease. To help understand the operations of the mental apparatus, Freud elaborated, apart from his topographical theory, a structural theory of the psyche. According to this theory, the psyche involved (1) a reservoir of instinctual energy, the *id;* (2) a supervisory area serving a censoring and sanctioning function, the *superego;* and (3) a body that mediated internal and external adjustments, the *ego.* Although recognized by Freud as arbitrary, empiric, and metapsychologic, these subdivisions were retained by him as a conceptual necessity (Freud,

1930a).

Freud classified the id as the original undifferentiated mind, the repository of inherited urges and instinctual energy. It contained the instincts of Eros—the life or sexual instinct—and Thanatos—the death instinct. It provided the individual with dynamic energy (libido), which vitalized every organ and tissue and sought expression in response to a "pleasure principle," along whatever channels were available for it. Through impressions received by the perceptual organs, the id underwent modifications immediately after birth. Differentiation by the child of himself or herself as an entity apart from the world was in keeping with the evolution of the ego, which increasingly assumed the function of an executive organ, harnessing the id to the demands of reality (reality principle). Important impressions, particularly those related to experiences with parents or their surrogates, and frustrations created by prohibitions of pleasure strivings, registered themselves on the child's psyche and stimulated primitive mechanisms of projection and introjection. In projection, aggression was discharged outward and directed toward parents; in introjection, the frustrating parental agencies were "incorporated" within the child's psychic apparatus. Through these mechanisms, rudiments of a superego developed that later, with the resolution of the Oedipus complex, crystallized and took over the guiding and prohibitive functions of the parents. One aspect of the superego contained constructive ideals toward which the individual felt driven (ego ideals). The superego, oriented as it was around childish concepts of reality, evaluated actions in terms of whether they had approbatory or punitive potentials. It was the guardian of a primitive morality attended at all times by a custodian of guilt. Unconscious disapproval by the superego gave rise to a host of disturbances, including a need for punishment, feelings of inadequacy, and low self-esteem.

Under the lash of the superego the ego created repressions against libidinal strivings and their ideational representatives. Such repressions served to avoid conflict. When, however, for any reason, repression relaxed or proved insufficient, the ego was invaded with some of the content of the repressed. This threat to the individual's security inspired anxiety, a danger signal that indicated a breakthrough of the repressed material.

As Freud continued his work, he laid less and less stress on strangulated emotions due to early traumatic experiences as the primary cause of neurosis. More and more he became cognizant of the

purposeful nature of symptoms, and in 1926 he revised his theory of neurosis drastically, claiming that symptoms were not only manifestations of repressed instinctive strivings but also represented defenses against these strivings (Freud, 1936).

Freud contended, however, that the essence of a neurosis was a repression of infantile fears and experiences that continually forced the individual to act in the present as if living in the past. The neurotic seemed to be dominated by past anxieties that, split off, operated autonomously and served no further function in reality.

The accent on the ego and its responses to anxiety moved the emphasis away from the id. Anxiety, a biologically inherited pattern, appeared under two sets of circumstances: "traumatic situations" and "danger situations." The prototype of the former was the birth trauma. During infancy the influx of stimuli often was too great for the individual to handle and sponsored the development of a stimulus barrier. As the ego developed, recognition of danger situations enabled the child to anticipate them with anxiety ("signal anxiety"). The ego mobilized its defenses in response to such signals. Typical danger situations during infancy were a threatened loss of the love object (breast-mother); around 18 months, loss of love and good will from the love object (parents and other significant persons); around the end of age 3, injury to the genitals (castration anxiety) and deprivation of its gratifications; and after 5 years of age, disapproval and punishment from the superego. These dangers persisted unconsciously throughout the life of the individual.

Three types of anxiety could be distinguished: real or objective anxiety (in which the danger was external), neurotic anxiety (the danger here was the eruption of id impulses that the ego considered harmful), and moral anxiety (in which punishment from the superego was threatened). The sources of anxiety were unconscious in nature and were usually highly disguised, rationalized, and shielded from awareness. Neurotic anxiety manifested itself in free-floating anxiety (vague and unfixed), phobic anxiety (irrationally displaced to symbolic situations), and panic anxiety (acting out of id impulses impossible to control—for instance, aggressive and sexual drives). The latter could activate moral anxiety with needs for punishment.

The examination of defenses that the ego evolved to cope with anxiety revealed a variety of

mechanisms, including:

1. *Repression*—neutralization of cathexis of psychic energy from the id by countercathexis, thus barricading the ego from unacceptable impulses.

2. *Projection*—transferring responsibility for one's own inner impulses to others.

3. *Introjection*—incorporating qualities of others into the self.

4. *Rationalization*—seeking amnesty by disguising motives.

5. *Regression*—reverting to earlier forms of fulfillment and defense.

6. *Isolation*—splitting emotion or thought associations off from a memory, fantasy, or impulse.

7. *Turning against the self*—redirecting aggressive wishes toward others through self-castigation.

8. *Reaction formation*—neutralization of one drive by conscious expression of a diametrically opposite one.

9. *Denial of reality*—distortion of facts to support inner wishes.

A weak ego, due to constitutional defects and/or severe overindulgence or frustration in childhood, could exhaust the psychic energy and stimulate defenses, such as repression, depriving the id of essential gratifications and diverting the ego from an adaptive dealing with reality. This was often complicated by problems in superego formation due to an inability to resolve the Oedipal struggle. Thus, the superego could be excessively harsh and destructive, sponsoring excessive guilt and inferiority feelings, or it might be underdeveloped, leading to impulsive, psychopathic, amoralistic, and delinquent behavior. A harmonious balance of superego-ego-id led to a character structure that permitted constructive relationships and a proper adaptation. Imbalance led to psychopathology.

Internal dangers were constantly threatened by the efforts of the id to discharge accumulated tension. Such discharge was opposed by the mental force of the superego in the form of repression to prevent the release of tension. Repression was a dynamic force that attempted to seal off internal dangers. The maintenance of repression, however, required an enormous expenditure of energy. The ego derived this energy from the id in a subversive manner. Thus, an idea or tendency invested with

libido (cathexis) would be stripped of libido and this energy used to oppose the idea or tendency (anticathexis).

Subtle mechanisms, such as symbolization, condensation, distortion, and displacement, were employed to evade repressive forces and to provide a substitutive discharge of repressed energy and a consequent relief of tension. Fantasies, dreams, and symptoms were expressions of such mechanisms. Where the substitutive expression was in harmony with social values and superego ideals, it provided a suitable means of relief (sublimation). Where it was not in harmony, conflict resulted and repressive mechanisms were again invoked. If repression proved ineffective in mediating tension, a return to earlier modes of adaptation was possible. This happened particularly where the individual was confronted by experiences similar to, or representative of, those that initiated anxiety in childhood. The ego reacted automatically to these experiences, as if the reality conditionings of later years had had no corrective effect on the original danger situation. It responded with essentially the same defenses of childhood, even though these were now inappropriate.

At puberty and at menopause certain instincts became powerfully reinforced and flooded the capacities of the ego. Even normal people could become neurotic at these times when, for physiological reasons, the instincts were too strong. Accidental influences at any other time might also make them too powerful. All repressions developed in childhood as "primitive defensive measures adopted by the immature, feeble ego." In later years no fresh repressions occurred, but the old ones persisted and were employed by the ego to master instinct.

A retention of a relationship to reality at the expense of an intrapsychic balance produced a psychoneurotic disturbance. The existing conflict here was between the ego and the id. If an intrapsychic balance developed at the expense of reality relationships, the consequence was psychosis. The latter resulted when the ego was overwhelmed by id forces, the conflict being between the ego and the environment.

Freudian psychoanalytic therapy is based on the libido theory described above. It rests on the hypothesis that neurotic illness is nurtured by the repression of vital aspects of the self and its experiences— particularly oral, anal, and sexual (including Oedipal) experiences in relation to

important parental agencies. This repression is sponsored by fear of the loss of love or of punishment from the parents, which has been internalized in the superego. Repressed feelings, attitudes, and fears, and the early experiences associated with them, continue to strive for conscious recognition, but they are kept from awareness by dread of repetition of parental loss of love or punishment now invested in the superego. Their removal from the mainstream of consciousness makes it impossible for the individual to come to grips with basic conflicts. They remain in their pristine state, uncorrected by reality and by later experiences. The energy required to maintain repression, as well as to sustain other defenses against anxiety, robs the individual of energy that could be used to nurture psychosexual development.

In his last clinical paper, "Analysis Terminable and Interminable," (1952), Freud emphasized that the essence of the analytic situation was the entry by the analyst into an alliance with the ego of the patient in order to subdue certain uncontrolled parts of the id and ultimately to include them in the synthesis of the ego. Reviewing this, Freud contended that the ego acted as an intermediary between the id and the external world "to protect the id from the dangers of the external world." In the process the ego tended to "adopt a defensive attitude towards its own id and to treat the instinctual demands of the latter like external dangers...." The child's ego thus learned "to shift the scene of the battle from outside to inside and to master the *inner* danger before it becomes *external*" by elaborating defensive mechanisms, such as repression, to avoid danger, anxiety, and unpleasure. Moreover, a defensive falsification of inner perceptions rendered "an imperfect and travestied picture of the id." Unfortunately, defensive mechanisms, while averting danger, could themselves become dangerous. They consumed enormous expenditures of energy, and they imposed ego restrictions that burdened the psychic economy. The services rendered by the defenses thus entailed too high a price.

Mechanisms of defense were varied, and each individual selected those that satisfied his or her needs. They became fixated in the ego and reappeared as characteristic reactions under situations similar to those that originally invoked them. Even though they had outlived their usefulness, they persistently survived "like outmoded institutions which contaminate a modern society." The adult ego "continues to defend itself against dangers which no longer exist in reality and even finds itself impelled to seek out real situations which may serve as a substitute for the original danger, so as to be able to justify its clinging to its habitual modes of reaction." Thus the defensive mechanisms distorted perceptions of reality and undermined the ego to a point where neurosis finally broke out.

During analysis the individual exhibited customary defense mechanisms, the dealing with which constituted half of the analytic task. The other half "is the revelation of what is hidden in the id. Our therapeutic work swings to and fro during the treatment like a pendulum, analyzing now a fragment of the id and now a fragment of the ego. The mechanisms of defense recur in analysis in the shape of *resistances* to cure. It follows that the ego treats recovery itself as a new danger." The resistances, unconscious in nature, constantly blocked the therapeutic task of making conscious what was repressed within the id. The effect of unpleasurable impulses in the patient "when his defensive conflicts are once more roused may be that negative transferences gain the upper hand and break up the whole analytic situation." The patient regarded the analyst as an alien personality in whom he had no confidence.

Some of the resistances were peculiarities of the ego determined by heredity. Some were acquired in defensive conflicts. Some, such as the ease or stubbornness with which libidinal cathexes were released from one object and displaced to another, were due to "changes in some rhythm in the development of psychical life which we have not yet apprehended." Some of the resistances that prevented a release from illness were manifestations of "the behavior of the two primal instincts, Eros and the death instinct, their distribution, fusion and defusion," which permeated all provinces of the mental apparatus—id, ego, and superego. The sense of guilt and need for punishment, a product of the ego's relation to the superego, which accounted for the phenomena of masochism and negative therapeutic reaction, was only one expression of this resistance.

Freud considered that the etiology of all neurosis "was a mixed one; either the patient's instincts are excessively strong and refuse to submit to the taming influence of his ego or else he is suffering from the effects of premature traumas, by which I mean traumas which his immature ego was unable to surmount." A relationship existed between these two factors; i.e., the stronger the constitutional strength of instincts, the more easily could a trauma lead to fixation and a disturbance in development. If the instinctual life was normal, severe trauma alone might suffice to create neurosis. Analysis had a better chance of strengthening the ego where the traumatic factor predominated. Prejudicial to analysis and fostering its interminability was "a constitutional strength of instinct and an unfavourable modification of the ego in the defensive conflict." Also a reinforcement of instinctual energy at some later period in life made demands on the ego it could not tolerate. It was then difficult to achieve the goal of analysis, the taming of instincts and bringing them into harmony with the ego.

The two themes that gave the analyst the greatest difficulty were penis envy in women and in men the struggle against their passive or feminine attitude toward other men. In women, normally, large portions of the striving for masculinity underwent a transformation. The unsatisfied wish for a penis became converted into a wish for a child and for a man who possessed a penis. Often, however, the masculine wish persisted, repressed in the unconscious, exercising itself disturbingly. In men the passive attitude often continued to signify castration. Where these drives had not been satisfactorily resolved, they could persist doggedly throughout analysis, frustrating the analyst's most dedicated attempts at resolution. Many resistances arose out of a female patient's refusal to give up the wish for a penis and the masculine protest. When these drives were elucidated in analysis, "we have penetrated all the psychological strata and reached 'bedrock.' " Then the analytic task was accomplished, and analysts could console themselves "that everything possible has been done to encourage the patient to examine and to change his attitude to the question."

All people were bisexual since "their libido is distributed between objects of both sexes, either in a manifest or a latent form." Why conflict developed with a restriction of the love object. Freud attributed to the "intervention of an element of aggressiveness…a manifestation of the destructive or aggressive instinct."

Quite modestly, Freud admitted the reason for "the variable results of analytic therapy might be that our success in replacing insecure repressions by reliable and ego-syntonic controls is not always complete, i.e., is not radical enough. A change does occur, but it is often only partial: parts of the old mechanisms remain untouched by analysis." While "analysis is always right in theory in its claim to cure neurosis by ensuring control over instinct ... in practice its claim is not always justified." This is because the instincts continue to be so strong that the ego fails in its tasks, "for the power of analysis is not infinite; it is limited, and the final result always depends on the relative strength of the conflicting psychical agencies."

Adequate criteria for the termination of psychoanalysis were, first, symptom relief with overcoming of various anxieties and inhibitions, and, second, the opinion on the part of the analyst that so much repressed material had been made conscious, with sufficient evidence that that which was inexplicable is now elucidated, and enough inner resistance eliminated, that we need fear no repetition of the

patient's specific pathological processes. The latter criterion for the "end" of analysis was ambitious in its scope. "According to it we have to answer the question whether the effect upon the patient has been so profound that no further change would take place in him if his analysis were continued." This, Freud added, implied that through analysis one could achieve absolute psychical normality, with a lifting of all the patient's repressions and a filling of every gap in the memory. "If the patient who has made such a good recovery never produces any more symptoms calling for analysis, it still, of course, remains an open question how much of this immunity is due to a benevolent fate which spares him too searching a test."

In analytic practice treatment had to be carried out "in a state of abstinence" to bring the "conflict to a head" by increasing the "instinctual energy available for its solution." Yet, "a prophylactic treatment of instinctual conflicts" was not to be fostered by subjecting the patient to cruel experiments, since "in conditions of acute crisis it is, to all intents and purposes, impossible to use analysis." Fresh conflicts "will only make the analysis longer and more difficult." During analysis the strengthening of the ego permits a review of old repressions "with the result that some are lifted, while others are accepted but reconstructed from more solid material ... they will not so easily give way before the floodtide of instinct." Sometimes analysis counteracted an increase in the instinctual strength; sometimes it raised the resistances so they could take a greater instinctual strain.

The Technique of Classical Psychoanalysis

It is generally accepted that classical psychoanalysis is useful only in persons who have reached a relatively mature state of personality development. They must have experienced the traditional triangular (Oedipal) conflict that in resolution has enabled them to sustain a reasonably meaningful relationship with both their parents. If the pre-oedipal relationship with the mother was too severely ambivalent, the regression during psychoanalysis will provoke anxiety and depression so great as to interfere with the management of the transference neurosis.

Not all persons are capable of establishing an initial therapeutic alliance, which is the preliminary requisite for psychoanalysis. Defensive mistrust and frustration at the lack of immediate gratification of needs and demands may block progress. The therapist's seemingly cruel and unfeeling behavior may be looked upon as a sign of a harsh perversity, and the patient may be unwilling to give up his or her

detachment and need for control. The analytic situation may therefore never get off the ground. Those patients who are capable of establishing a therapeutic alliance have an opportunity to be helped through the next phase of regression, in which infantile conflicts are revived and a transference neurosis develops that enables the patient to work through and resolve the conflicts. The techniques of free association, lying on the couch, passivity on the part of the analyst, are purposely designed to encourage passive dependence and regression. The inevitable resistance of the patient is managed by timed interpretations. Unresolved conflicts emerge in the transference, and their understanding is helped by proper interpretation. Slowly the original infantile conflict emerges and is definitively resolved. The termination phase involves an ability to separate from therapy and the analyst and to assume independence and autonomy.

Freud's formulations are more or less accepted as the basis for present-day classical psychoanalysis. It is believed essential that the patient recognize the derivatives of the repressed since these represent, in an attenuated form, the warded-off material. To minimize the distortion of these derivatives, the obtrusion of current situations and other reality influences must be kept at a minimum.

The core of Freudian psychoanalysis lies in what is perhaps Freud's most vital discovery—that of transference. As has previously been indicated, Freud found that patients, if not interfered with, inevitably projected into the therapeutic situation feelings and attitudes that were parcels of their past. Sometimes transference manifestations became so intense that they actually reproduced and reenacted with the therapist important conflictual situations and traumatic experiences (transference neurosis) that had been subject to infantile amnesia. By recovering and recognizing these repressed experiences and conflictual situations that had never been resolved and by living through them with a new, less neurotic, and non-punitive parental agency, the superego was believed to undergo modification. The individual became tolerant of his or her id and more capable of altering ego defenses that had crippled adaptation. There occurred, finally, a mastery of early conflicts and a liberation of fixated libido that could then enter into the development of a mature personality.

Since the Oedipus complex is considered to be the nucleus of every neurosis, its analysis and resolution in transference constitutes a primary focus. Where the Oedipus complex is not revealed, where its pathologic manifestations are not thoroughly analyzed and worked through, and where

forgotten memories of early childhood experiences are not restored, treatment is considered incomplete.

Because Freudian psychoanalysis is transference analysis, all means of facilitating transference are employed. These include the assumption by the therapist of an extremely passive role, the verbalization by the patient of a special kind of communication—"free association"—the analysis of dream material, the maintenance of an intense contact with the patient during no less than four or five visits weekly, and the employment of the recumbent couch position.

Passivity on the part of the therapist is judiciously maintained even through long periods of silence. The therapist also refrains from reacting emotionally or responding positively or negatively to any verbalized or nonverbalized attitude or feeling expressed by the patient. Strict anonymity is observed, and no personal information is supplied to the patient irrespective of how importunate he or she may become. A nonjudgmental, non-punitive, non-condoning attitude by the therapist is adhered to, dogmatic utterances of any kind being forbidden.

The chief "rule" the patient is asked to obey is the "basic rule" or "fundamental rule" of verbalizing whatever comes to mind, however fleeting, repulsive, or seemingly inconsequential it may seem (free association). This undirected kind of thinking is a most important means of tapping the unconscious and of reviving unconscious conflicts and the memories that are related to their origin. Most important, free association, like passivity, enhances the evolution of transference. As long as the patient continues to associate freely, the therapist keeps silent, even though much time may pass without a comment. The therapist fights off all temptations toward "small talk" or impulses to expound on theory. The therapist interferes only when resistances to free association develop and until the patient proceeds with undirected verbalizations.

Dream analysis is used constantly as another means of penetrating the unconscious. By activating repressed material and working on defenses as they are revealed in dream structure, the therapist aids the development of transference.

The frequency of visits in Freudian psychoanalysis is important, to encourage transference, no fewer than four or five visits weekly are required. Fewer visits than this encourage "acting-out" and other resistances to transference.

The use of the recumbent couch position enables the patient to concentrate on the task of free association with as few encumbrances of reality as possible. It helps the therapist, also, to focus on the unconscious content underlying the patient's verbalizations without having to adjust to the demands such as would exist in a face-to-face position. Concentrating on the patient's inner life, rather than on external reality, helps to bring on the phenomenon of transference.

During the early stages of analysis the main task is to observe—from free associations and dreams—manifestations of conflicts and the types of defenses employed, which form a kind of blueprint of the unconscious problems of the patient. This blueprint is used later at the stage of transference. Since repression is threatened by the operation of exploring the unconscious, anxiety is apt to appear, stimulating defensive mechanisms. These function as resistances to productivity, and even to verbalization. Free association may consequently cease, and the patient may exhibit other manifestations that oppose cooperation with the treatment endeavor. Such resistances are dealt with by interpretation. Through interpretation the patient is brought to an awareness of how and why he or she is resisting and the conflicts that make resistance necessary.

Sooner or later the patient will "transfer" past attitudes and feelings into the present relationship with the analyst. Observance of the "basic rule," the attack on resistances through interpretation, and the consideration of unconscious material in dreams and free associations remove habitual protective devices and facades that permit the patient to maintain a conventional relationship. The patient is most apt to express strivings toward the therapist rooted in past experiences, perhaps even reproducing the past in the present. Thus, a revival of pathogenic past conflicts is instituted. Unlike supportive and reeducative therapy, in which transference may be used as a therapeutic vehicle, the transference is interpreted to the patient in order to expose its nature. This is the chief means of resolving resistance, of bringing the individual to an awareness of the warded-off content, and of realizing the historical origin of conflicts.

The development of transference may occur insidiously and manifest itself indirectly, or it may suddenly break out in stark form. It often shows itself in changes in the content of free associations, from inner feelings and past relationships with parents to more innocuous topics, like current events and situations. This shift is evidence of resistance to deeper material activated by the erupting transference

feelings. Sometimes free association may cease entirely, with long stubborn silences prevailing that are engendered by an inability to talk about feelings in relation to the therapist. The purpose of superficial talk or silence is to keep from awareness repressed emotions and forgotten memories associated with early childhood, particularly the Oedipus complex. Until these can be brought out into the open, the emotions relating to them discharged, and the associated memories reclaimed, the conflictual base of neurosis will survive. The transference neurosis offers an opportunity for this revivification since, in the relationship with the therapist, the patient will expose loves, fears, and hates that were characteristic of his or her own experiences during the Oedipal period.

Transference, however, acts as a source of powerful resistances that impede therapeutic progress. Once the patient is in the grip of such resistances, he or she is usually determined to cling to them at the expense of any other motivation, including that of getting well. On the positive side, transference is important diagnostically since it reveals a most accurate picture of the patient's inner conflicts. Additionally, it induces a coming to grips with and a working through in a much more favorable setting of those unresolved conflicts that have blocked maturation. The resolution of transference is felt by Freudian psychoanalysts to be the most powerful vehicle known today for producing structural alterations in the personality.

Active interpretations of the transference are essential to its resolution. These include the interpretation of its manifestations, its source, and its original and present purposes. The working through of transference is accompanied by a recollection of forgotten infantile and childhood experiences—a recounting of distortions in relationships with parents or parental surrogates. The accuracy of interpretations will usually be denied at first as part of the resistance manifestation. Acknowledgment of the unreal nature of transference is usually opposed by the patient because this either constitutes too great a threat or because the patient does not want to relinquish transference gratifications that are deemed essential to life itself. As long as he or she continues to deny transference, the analysis will remain interminable, unless forcefully terminated by either participant. With persistence on the part of the therapist, interpretations usually take hold and the patient is rewarded with greater insight, an increased sense of mastery, liberation from neurotic symptoms, and genuine growth in maturity.

The therapist must also constantly guard against manifestations of destructive countertransference, which, disguised and varied, are mobilized by unresolved problems and pressing needs within the therapist. Common forms of countertransference are subtle sadistic attacks on the patient, impulses to be pompous and omnipotent, or desires to reject the patient or to detach oneself from the relationship. Because of countertransference, a personal analysis is considered essential for analysts so that they can deal with their own unconscious tendencies and resistances precipitated by contact with their patients.

As the ego of the patient is strengthened by an alliance with the therapist, it becomes more and more capable of tolerating less and less distorted derivatives of unconscious conflict. The continued interpretation by the therapist of the patient's unconscious feelings and attitudes, as well as the defensive devices that the patient employs against them, enables the patient to work through problems by seeing how they condition every aspect of his or her life. In the medium of the therapeutic relationship the individual is helped to come to grips with early fears and misconceptions, resolving these by living them through in the transference. The patient is finally able to resolve libidinal fixations and to liberate energy that should originally have gone into the formation of a mature sexual organization (Freud, 1920, 1924, 1930b, 1933, 1936, 1937, 1938a, b; Jones E, 1924; Glover E, 1927; Strachey, 1934; Balint, 1936; Bibring-Lehner, 1936; Glover et al, 1937; LaForgue, 1937; Schmideberg, 1938; Zilboorg, 1939; Sterba, 1940; Fenichel, 1941; Lorand, 1946; Berg, C, 1948; Nunberg, 1948; Kubie, 1950b).

A number of additions and modifications of Freudian theory have been introduced, especially as they relate to sicker patients. Most notable is the focus on object relations during the pregenital period and residues of existing distortions in adult life. Interferences with instinctual development brought about by difficulties with the parenting objects have been especially explicated by Anna Freud and Margeret Mahler. According to Mahler (1971), children who fail to resolve the rapproachement aspect of the separation-individuation process may incorporate "bad" introjects laden with derivatives of aggressive drive that encourage a splitting of the object world into "good" and "bad" objects. This splitting is characteristic of the transference experience in most borderline cases. Mahler (1958) contends that during the first three months of the life of the infant, in the "presymbiotic" or "normal-autistic" phase, the mother acts as an "external executive ego." At the end of this stage the infant enters the "phase of symbiosis," during which the mother is dimly perceived as a "need-satisfying-quasi-

extension-of-the-self." The infant's and mother's body-ego boundaries seem fused. Mother and infant are "an omnipotent symbiotic dual unity" (Mahler et al, 1959). Toward the end of the first year, coincident with locomotion and the beginning of language, the process of separation-individuation takes place; at 18 months ego boundaries begin to crystallize; and during the second year reality testing consolidates toward a "clear distinction between the self and the object world." A disturbed mother-child relationship during these early phases disrupts the normal progression toward separation-individuation and reality testing.

E. Jacobson (1967) has further expanded on the dynamics of the psychotic process. She states that whereas both the neurotic and psychotic possess pre-Oedipal narcissistic fixations and are subject to pregenital and ambivalence conflicts, the relative stability of these defenses in the neurotic (particularly the repressive capacity and the intactness of boundaries between self and object representations) help prevent not only drive defusion and drive deneutralization but also flooding of the ego with sexual, destructive, and self-destructive forces. These forces in the poorly defended psychotic lead to a regressive dissolution of the psychic structures. In the latter case, an increase of free aggression weakens the ego's ability to resist the assault of the instinctual forces, particularly outward destructive and self-destructive impulses. The basic intrapsychic conflict in the psychotic relates to the "struggle between active and passive, sadistic and masochistic, destructive and self-destructive tendencies, and in general between sexual and aggressive impulses," which may at varying times be employed as defenses against each other.

Many psychoanalysts today have attempted to incorporate in their thinking and practices some of the new advances in the behavioral sciences. A survey conducted by Hofling and Meyers (1972) of the opinions of 90 American psychoanalysts of the most important information and technical advances made in their field since Freud's death indicated that, although there was some doubt as to the value and originality of most of the work, substantive contributions had been made by Hartmann (on ego autonomy), Erikson (on identity and psychosocial development), Mahler (on separation-individuation), Kohut (on narcissism), Anna Freud (on early infancy and lines of development), and Jacobson (on object-relations theory). Kernberg (1973) has written extensively about problems of the borderline patient.

Disagreement with certain psychoanalytic concepts is common among contemporary

psychoanalysts. Even those analysts who consider themselves to be "orthodox" Freudians are not in complete accord with Freud in theory and method. Many analysts challenge the death instinct hypothesis, for instance. Insofar as technique is concerned, practically every analyst implements psychoanalytic methods in his or her own specific way. Many years ago an extensive questionnaire distributed by Glover (1940) to a representative group of practicing psychoanalysts demonstrated that deviations from orthodox techniques were extensive even then. There were differences in the form, timing, and amount and depth of interpretation. The degree of adherence to free association varied, as did the assumption of passivity and anonymity, the use of reassurance, and the management of transference. Variation in methods of doing psychoanalysis was indicated by the fact that out of 82 questions, there was general agreement on only 6, and even here there was not complete conformity. Glover (1964) has emphasized repeatedly that established principles of psychoanalysis are difficult to delineate even for avowed classical analysts. T. W. Mitchell's (1927) contention that a psychoanalyst can be defined as one who accepts the ideas of the unconscious, infantile sexuality, repression, conflict, and transference would not be considered adequate for a British Kleinian, who would insist on explorations and analysis in depth through the 3-to-6-month-old "depressive position" and the later infantile "paranoid-schizoid" phases.

Drawing inspiration from Levi-Strauss's structuralism, Lacan (1953, 1964, 1977, 1978; Leavy, 1977; Miel, 1966; Wilden, 1973; Muller, 1985) attempted a mating of linguistics with psychoanalysis. The amalgam resulted in writings notable for their obscurity of meaning. Nonetheless, Lacan's dedication and energy resulted in the development of a popular school of analysis. According to Lacan, psychopathology is rooted in developmental defects, particularly around the "mirror stage," which occurs between the ages of 8 to 18 months and consists of visual perceptions of one's body form as seen in a mirror at an early stage in life (Lacan, 1949). Disturbances in this perception may result in a false recognition of the self and the assumption that there is another being shadowing the self (the "other"), which is principally responsible for self-alienation. An ego structure develops that is defensive and maladaptive, and the self becomes increasingly identified with the "other." Therapy consists, through language, of clarifying this distortion and liberating the true self from the "other," which manifests itself in many ways, including identification with the analyst.

Lacan resigned from the Psychoanalytic Society of Paris to found his own school and popular

training institute, the "Freudian Cause." His methods, which include shortening the traditional 50-minute session, and his writings, which are difficult to understand, have made him a controversial figure. Some consider him a genius; others, such as members of the International Psychoanalytic Society, which expelled him for "deviant practices," believe that he is grossly incompetent. Except for using the couch position in the treatment of a majority of his patients, Lacan deviates from practically all other accepted Freudian methodological principles, although he pays homage to the greatness of the master and calls himself a *true* Freudian. The shortening of the session is perhaps the key issue around which clinicians organize their criticism. Lacan provides a rationale for the abbreviated therapeutic session (which is sometimes as short as 3 minutes) by avowing that dismissing a patient before the end of the hour is an effective way of dealing with verbal resistances and that such dismissal actually solidifies the therapeutic relationship. It is difficult to say how much of Lacan's success was due to his charisma, or to disagreement of his followers with classical psychoanalytic theory and method, or to the validity of his developmental theory of the "mirror stage." Because Lacan's explanations are too obscure for one to be certain of their true meaning, his concepts have been subject to many interpretations. Many of his statements are revolutionary, such as that good therapy should strengthen not overcome the ego, since it is a distorting organization. It will be interesting to observe how many of his theories and practices survive Lacan's death.

Some analysts still practice classical psychoanalytic technique, but, by and large, many, perhaps most, analysts employ a modified psychoanalytic technique that differs from the orthodox form. Questionnaires sent out by the Research Committee on Psychoanalytic Practice of the American Academy of Psychoanalysis (Tabachnick, 1973) to a sizable number of therapists indicated that only 6 percent of the patients being treated by the respondees were seen four times a week and a mere 1 percent were seen five times a week. The great majority of the patients were treated in the sitting-up rather than the recumbent position. Group, family, and marital therapy were occasionally used, and *94 percent of those polled sometimes prescribed drugs.* We might speculate from these findings that either the majority of patients were not suited for intensive psychoanalytic work, or that the analysts in the survey believed that psychoanalysis could be done with less than the classical four to five sessions per week, or that most patients could not afford to pay for more frequent visits, or that the members of the American Academy of Psychoanalysis were less rigorous than their colleagues in the more orthodox American Psychoanalytic

Association. If this survey truly reflects what is going on in contemporary psychoanalysis, most therapists who call themselves psychoanalysts are not using the classical technique for most of their patients. One would conclude that a sizable group of psychoanalysts of various schools are providing a psychoanalytically oriented treatment rather than the classical type, irrespective of what the analysts themselves say they are doing. Whether we can apply the term "psychoanalysis" to these modifications is a matter of opinion.

Criticism of Freudian Psychoanalysis

Perhaps no branch of psychotherapy has created so great a furor among professionals and laity, or is as responsible for so great a polemic, as Freudian psychoanalysis. "Superlative," "finest," "unique," "peerless," "incomparable," "insipid," "senseless," "absurd," "inconsistent," "prejudiced"—in these words, from the mouths and pens of its devotees and critics, psychoanalysis is qualified in both transcendent and opprobrious terms. While the brilliance of Freud's clinical observations is acknowledged by even his sternest critics, the theoretical cement that binds his concepts together is considered by many to be fragile (Bieber, 1958). Such concepts are considered by some to be rooted in nineteenth-century physics and biology. Objection is voiced to the thesis (1) that a human being, frustrated by the sexual impasse imposed by inimical events in childhood, spends the rest of his or her life fruitlessly trying to repair this damage, (2) that, blocked in this quest by a false friend, the mechanism of repression, the individual aimlessly wanders through the circuitous by-paths of life, seeking vicarious and infantile satisfactions, and (3) that, while constantly casting in the present the shadows of the past, the individual defends himself or herself with capricious maneuvers, relentlessly marching on to inevitable psychological doom. A person's destiny, it is claimed, is not so dismal. Neo-Freudians and existential analysts particularly, stress one's "responsibility" for one's own fate and future. They have also accused Freud of minimizing the social determinants of psychic phenomena. A scientific approach to the study of personality must consider that the basic biological forces of humanity are shaped and fashioned through the social environment. Freudians counter with the explanation that although Freud did not elaborate too fully on them, he did not neglect cultural influences while stressing instinctual processes. Fenichel (1945, p. 6), for example, has pointed out that Freud was fully aware of how instinctual attitudes, objects, and aims were constantly being altered as a result of social experience.

A search through Freud's voluminous writings easily reveals passages that can sustain almost any variant version of psychodynamics. As is so often done with Shakespeare and the Bible, the practice is common of plucking of statements out of context and exploiting them for prejudiced purposes. One may in various volumes find contradictory passages among Freud's contributions, in the form of contrasting sentiments and revisions. Such amendments are in the highest traditions of science, which demand alteration of old conclusions as new hypotheses are advanced.

In the richness of his contributions Freud developed a variety of theoretical configurations. In some quarters, however, obsolescent models have been retained even as more functional ones evolved. This superimposition of model upon model makes for a certain grotesqueness of concepts. In the main, Freud's dynamic theoretical premises have been accepted more enthusiastically than either his topological constructs of the mental apparatus or his economic theories, which relate intrapsychic and interpersonal transactions to energy distributions issuing from libidinal and aggressive instincts.

Dealing with so many disparate aspects, psychoanalysis has suffered by the tendency to judge its whole by the weakness of some of its parts. For instance, its theoretical inconsistencies have led to a minimization of its therapeutic potential. Conversely, the fact that it fails as a treatment procedure in certain problems has tended to devalue psychoanalysis as reflecting a reasonable theory of behavior. Its limitations as a model for the interpretation of anthropologic, historical, educational, religious, and literary data have invited the repudiation of psychoanalysis as a whole.

Some of Freud's ideas have gained a wide acceptance and continue to ring as true today as they did when he originally formulated them. Others are outmoded, and like any other human concepts have undergone revision and reformulation. Freud framed many of his notions in a tentative and speculative mood, and he preferred them with the cautious warning that they would undoubtedly later be altered or discarded. "Psycho-analysis," he wrote, "has never set itself up as a panacea and has never claimed to perform miracles" (Freud, S, 1959).

One of the problems in the evolution of a school is the resistance of the founder to countenance changes in his formulations by any person other than himself. Freud was no exception. While he took great liberties with his own postulates, transforming and discarding many of his pronouncements, he

was not so generous with innovations introduced by his contemporaries. The abandonment of anonymity and passivity by Ferenczi with assumption of a "caring" and loving attitude toward his patients, the active involvement in therapeutic maneuvers by Stekel, the concern with mystical philosophy by Jung, the drift away from infantile sexuality toward inferiority feelings by Adler, the elaboration of the birth trauma and separation anxiety by Rank all brought forth the sternest criticism from Freud. This tendency of denying validity to approaches that deviate from formal doctrine has continued in psychoanalysis to the present day.

It sponsors the commonly voiced criticism of Freudian method that analysts insist upon wedging their patients into a preconceived theoretic structure. When the patient does not produce appropriate material that substantiates accepted notions of dynamics or refuses to accept interpretations, he or she is credited with being in an obstinate state of resistance. A sentiment expressed by non-Freudians is that, in their eagerness to smuggle "deep" insights into patients, certain "orthodox" analysts make dogmatic interpretations that patients feel obliged to accept. This practice may mobilize intense anxiety that can disorganize patients with weak ego structures. Another criticism is that many classical analysts are intolerant toward those who practice therapies other than Freudian psychoanalysis, considering these to be superficial and of little real value. Accordingly, they are inclined to depreciate treatment by non-analysts as well as by analysts of non-Freudian orientation.

What is interpreted as a lack of flexibility, however, is actually a staunch defense of a theoretical position that "psychoanalysis" is a specific mode of treatment in which the focus is on the unconscious, revealed through the transference, uncovered by resolution of resistance, and centered on the bringing to the surface and working through of buried childhood conflicts. Obstinacy in retaining this position is derived not from cantankerousness but from a passionate conviction that this is the most effective way of achieving extensive restructuring of the psychic apparatus.

Opinions vary about the effectiveness of classical psychoanalysis because countless characteristics of patients and therapists influence outcome. It is often avowed that current pessimistic impressions of the potential of psychoanalysis as a therapy result from the inclusion of reports of outcome made by inexperienced practitioners (Gedo, 1979). Are there any reliable reports of experienced analysts? Summarizing his own work of two decades as an experienced full-time analyst, Gedo is convinced of the

effectiveness of the method. His data are drawn from a total caseload of 36 people treated over 20 years of practice, 28 of whom terminated analysis with a "consensus about the satisfactory outcome of the enterprise." The patients were primarily in the higher socioeconomic class. The technique was classical psychoanalysis four or five times weekly, for 600 to 1000 sessions in three to seven years. There was no systematic follow-up study, but the author estimates that failure to contact him "argues for the probability that those who have not been heard from are not simply withholding unfavorable tidings." The author cryptically concludes with the statement that an analyst should not approach clinical work with a personal need to be a healer since "to require patients to improve is an illegitimate infringement on their autonomy."

In reviewing the presented statistics of 28 out of 36 patients improved over a period of 20 years of practice, one would estimate that, irrespective of whether the results justify the conclusion of a "matchless usefulness of the analytic method as a means for personal growth," the classical technique, for economic reasons, is definitely not designed for the great majority of patients seeking help for emotional problems. This does not in any way invalidate the incorporation of analytic principles in a lesser than long-term program.

My own impression is that, given a carefully screened patient and a well-trained analyst, the results with classical analysis can justify the expense and effort. On the other hand, the great majority of patients can be effectively helped by less intensive and costly methods. Where poor results have been obtained with classical psychoanalysis, the chances are that it was employed with patients who were unsuited for the technique or that the therapist was by training or personality not capable of working with the method.

A discreet appraisal of its therapeutic merit indicates that classical psychoanalysis constitutes a serviceable, though by no means exclusive, insight-oriented approach to problems of an emotional nature. In some cases, and in the hands of qualified and experienced psychoanalysts, it may be the most consummate of all treatments. In other cases it may fail miserably to benefit patients in the least. It is useful in individuals who are not too sick emotionally, whose conflicts are severely and obstinately repressed, who are capable of understanding abstract concepts, who have the time and money to invest in long-term therapy, and who are willing to expose themselves to the rigors of the method. This limits

the number of patients to a small percentage of those who require psychotherapy. Accordingly, therapists trained in the classical method often adopt techniques from other approaches (somatic, group, family, active interviewing, etc.) when they are obliged to treat patients who are not suited for the formal analytic procedure. Its qualification in transcendent terms is not only undeserved, but contrary to the spirit of its founder, who cautiously wrote in one of his last depositions: "The future will probably attribute far greater importance to psychoanalysis as the science of the unconscious than as a therapeutic procedure" (Freud, 1926).

The homage paid Freud is, nevertheless, truly deserving. Despite his intolerance of nonconformity, his was a truly great mind, reflected in his pioneer writings by his sparkling prose, his brilliant wit, and his unique and penetrating insights into human behavior. Humanity owes this extraordinary man an enormous debt for opening up new psychological vistas and for bringing to science of the mind the same dignity and grandeur that Darwin brought to biology and Harvey to physiology. The concept of the unconscious, the dynamic nature of repression, the importance of psychic determinism, the goal-directed nature of behavior, the relation of psychosocial development to personality evolution, the consociation of abnormal mental symptoms and normal mental processes, the meaning of anxiety, the role of symbolism, the significance of dreams, and the phenomena of transference and resistance—these have proved themselves to be of revolutionary importance and have provided us with tools for the investigation of intrapsychic and interpersonal activities. One may easily understand the esteem in which his contemporaries and students have held Freud and why those who have known him personally and from his writings talk about him with such love and reverence. While many of Freud's findings have been challenged and some altered, his discoveries have paved the way to a better understanding of human beings' psychological nature. They have stimulated independent and productive research for the benefit of all humanity.

Freudian psychoanalysis is practiced extensively throughout most of the world, especially in the United States and England. The parent organization is the International Psychoanalytic Association, which publishes the *International Journal for Psychoanalysis.* The American Psychoanalytic Association, which sponsors the *American Journal of Psychoanalysis,* is composed of a number of local societies throughout the country.

KLEINIAN PSYCHOANALYSIS

By analyzing the free-associational play of young children in the 1920s, Melanie Klein developed a biological theory that has gained a great deal of prominence among English psychoanalysts. She has a large following in South America, Spain, and Switzerland. Some authorities believe that an understanding of Kleinian principles is basic to a dynamic conception of child psychology as well as adult psychopathology, particularly the phenomena of schizophrenia and manic-depressive psychosis.

Freud contended that the superego of children was evolved by taking over (introjecting) the parental attitude at the time of the resolution of the Oedipus complex, around the age of 4 years. According to Melanie Klein's theory (1932, 1946, 1948, 1952, 1955, 1957, 1960, 1961, 1963), the Oedipus complex emerges during the first year of life. The superego, too, is organized soon after birth. In the initial contacts with reality, the child fuses emotional feelings in relation to objects (mother, breast, nipple, etc.) with the objects themselves. Thus objects that inspire pleasure are "good objects"; those that provoke pain are "bad objects." The first object within the infant's perceptual range is the mother's breast ("breast" is used as an inclusive term—for breast, nipple of a bottle, mother's body, and her closeness). Since hunger is an unbearable tension state for the infant, the breast and everything associated with it become a chief means of allaying the child's discomfort. But the breast is not always forthcoming on demand. The infant does not have the knowledge "that loss, frustration, pain and discomfort are usually temporary and will be followed by relief." The slightest change in the tension-alleviating state, such as a less easy grasp of the nipple or diminution in the flow of milk, will suffice to change the pleasant stimulus into an unpleasant, dissatisfying one. The child will then love and hate the breast and mother simultaneously on the basis of an all-or-nothing principle. The world for the child is peopled with good objects that satisfy and bring relief and with bad objects that frustrate and provoke suffering.

Among the child's earliest concepts, incorporation (taking in milk) and expulsion (giving out feces) are most prominent; these processes come to play a vital role in ideas of oneself and the world. A rudimentary sense of the world and objects (breast of mother, bottle and nipple, mother's body, his or her own feces and urine, genital organs, the closeness and absence of mother) surrounds the child, along with dim phylogenetically determined images of the penis, vagina, coitus, and childbirth. Reacting to the Oedipus complex, the infant fears destruction by the Oedipal rival. The infant conceives of coitus as an

act of biting, with oral incorporation of the penis by the mother. Penis and vagina are regarded as dangerous weapons; the penis equated with breast, the vagina with a biting mouth. The infant desires to take in (incorporate, introject) "good objects," such as the pleasurable and satisfying breast, and in doing so conceives of himself or herself as good and whole. The assault on the breast (around the sixth month passive sucking is replaced in part by active biting) enables the infant to react to anxiety with attack. This oral sadism is vital to personality development, and rage issuing from frustration serves to strengthen the sadistic instincts. Operation of the death instinct inspires active aggression against the self; in self-protection there is a projection outward against the breast, or "persecutors." Introjection of the breast is also a means of controlling and destroying "bad objects." This leads to guilt and to efforts to deal with aggression by projection or destruction. The infant's notion of aggression is at first centered around the oral function. Fantasies of sucking and biting tend to be externalized, as are the hatred and "envy" of the mother. These return as fear of the mother destroying, tearing, and eviscerating the child. A persecutory "paranoid-schizoid position" prevails when the bad objects, the product of the child's own aggression, in being projected, come back to torment the child ("projective identification"). The "paranoid position" that occupies the first 4 months of life makes for the first active relationship with the world. A primitive form of the adult paranoidal persecutory delusion, it is usually outgrown, though remnants remain in the psyche to be affiliated with a later developing sense of guilt.

Such conceptual formulations are concocted during a stage in the child's mental life when ideas are diffuse and undifferentiated. The incorporated desires toward the part object "good breast" and aggressive wishes toward the part object "bad breast" are soon directed toward the whole object, the mother, the person the child needs and loves. The mother is conceived of as being both good and bad; if one attacks the bad mother, one also destroys the good mother. The "whole object" is at this time introjected. The fear that the child has destroyed or may destroy the mother leads to guilt, fear of loss, and feelings of depression. This "depressive position," which occurs at about 6 months to a year, is so painful that the child tends to regress to the "paranoid position" of separate good and bad objects. Eventually the child realizes that the aggressive wishes have not and will not destroy the mother, and the depression ceases, though residues of the depressive position remain in the form of guilt feelings. Defenses against the depressive conflict bring about a return of paranoid-schizoid phenomena, and the individual may fluctuate between two states. The paranoid-schizoid position gives way to the depressive

position, particularly when external reality provides a preponderance of good experiences. This enables the ego of the child to acquire belief in the prevalence of ideal objects over persecutory objects. The introjection of these ideal objects also helps to modify the internal persecutory objects and death instinct. As the ego of the child strengthens, it can cope with internal and external anxieties more easily without recourse or violent mechanisms of defense and extreme splitting.

Under favorable conditions, the infant feels that his or her ideal object and libidinal impulses are stronger than the bad object and bad impulses, and he or she will be able more and more to identify with the ideal object. The child is less frightened of bad impulses and less driven to project them outside. Integration proceeds, and finally a phase of development takes place during which the infant recognizes and relates to the whole object. Originally this is the mother; later there is cognizance of other people in the environment. In contrast to the infant's perceiving the mother only as bits and pieces—breast, hands, and eyes— she is conceived of in her entirety. She is also accepted as the same mother who can at times be good, at times bad; present and absent; loved and hated. The infant begins to see that good and bad experiences do not proceed from two sources but rather from the same mother. Thus, ambivalence develops. The child will also realize at this time that the mother is an individual with a life of her own and with other relationships. This leads to feelings of jealousy and painful feelings of dependency. As the mother becomes a whole object, the infant's ego becomes whole and fragmentation diminishes.

In the paranoid-schizoid position the main anxiety is that the ego will be destroyed by bad objects; in the depressive position, anxieties spring from ambivalence and from the fear that the child's destructive impulses will destroy or have destroyed the object he or she loves and depends on. Mourning occurs, despair is felt, and guilt arises connected to destructive feelings toward the good object. As the depressive position is worked through by the child, the relationship to objects alters and the child acquires the capacity to love and to respect people as separate and differentiated individuals. The child has concern for objects, which helps to control impulses and to regulate activities toward self and objects. Regression supersedes splitting, and neurotic mechanisms rather than psychotic ones take over. Symbol formation also begins as the infant inhibits the instincts and displaces them onto substitutes.

The development of the child is influenced by both internal and external factors. External deprivations, physical or mental, clearly influence the child in various ways, but even when the

environment is bountiful and should be conducive to satisfactory growth, development may still be modified or prevented by internal factors.

Melanie Klein describes one such factor as "envy," which she believes operates from birth and affects the infant's earliest experiences. While Freud recognized and paid a great deal of attention to penis envy in women, other needs of envy, for example man's envy of females and both sexes' envy of one another, were not so specifically recognized and described. There has been a strong tendency, both in the literature and in everyday practice, to confuse "envy" with jealousy. In her book *Envy and Gratitude,* Melanie Klein (1957b) makes a distinction between the emotions of "envy" and jealousy. She considers "envy" the earlier of the two, and she believes it to be one of the most primitive and fundamental emotions. She differentiates it clearly from jealousy and greed:

Jealousy is based on love; it aims at the possession of the loved object and the removal of the rival. It always exists in a triangular relationship and therefore occurs at a time when objects can be clearly recognized and differentiated from one another.

Envy is a two-person relationship in which the subject begrudges the object for some possession or quality. It may be experienced in terms of part-object as well as whole-object relationships.

Greed, on the one hand, aims at the possession of all the goodness that can be extracted from the object. It may result in the destruction and "spoiling" of the object, but this destruction is not directed at, and is only incidental to, ruthless acquisition. Envy, on the other hand, aims at being as good as the object, and, if this is not possible, at blemishing the goodness of the object.

It is this spoiling aspect of "envy" that is so destructive to development, since the very source of goodness that the infant depends on, i.e., the breast in the first instance, and the good things to be achieved from it, is turned bad by envious attacks. As the source of good things is spoiled, so the capacity to obtain good things from the source, i.e., by introjection, is seriously interfered with. The infant is really attacking the very source of life, and this phenomenon can be considered to be the earliest direct externalization of the death instinct. It stirs as soon as the infant becomes aware of the breast, and, paradoxically, the better the good experience has been, the more powerful the envious attacks that may be levied at the breast. Sometimes the infant will attack the "goodness" after it has been incorporated,

envying what has been obtained. Envy operates mainly by projection, and the fantasy of attacking the breast is supported by such physiological processes as spitting, urinating, defecating, the passage of wind, and penetrating looking. Even the Oedipal situation may be dominated by envy rather than jealousy, the child attacking the parents and their relationship out of envy of what they have rather than the love that the child feels has been lost (jealousy). Strong feelings of envy prevent the child from differentiating good and bad things because the good things are attacked and turned bad. This leads to confusion between good and bad and often results in despair. Because no ideal object can be found, there appears to be no hope of love or help.

It is apparent from Melanie Klein's theories about child development that aggression is regarded in large measure as hereditary and that mistrust, fear of attack, and depression are inevitable, irrespective of the upbringing the child has experienced. "The repeated attempts," wrote Melanie Klein, "that have been made to improve humanity—in particular to make it more peaceful—have failed, because nobody has understood the full depth and vigour of the instincts of aggression innate in each individual." The only means of resolving infantile anxiety, and of socially modifying the aggressive impulses, she concludes, is by universal child analysis. Any adult analysis, she insists, that does not deal with and resolve infantile anxiety and aggressiveness is incomplete.

Clinical Implications

Kleinian theory holds that neurotic difficulties that occur during and beyond childhood are manifestations of paranoid-schizoid or depressive patterns. Neurotic defenses are evolved around paranoid-schizoid or depressive personalities, i.e., the determining way in which object relations are integrated, part or whole. An important mechanism in Kleinian theory is called "projective identification," in which parts of the self and internal objects are split off and projected into an important external object for the purpose of possessing and controlling it. Projective identification is also aimed at avoiding separation from the ideal object by uniting with it. Bad parts of the self may be projected to get rid of them and good parts to keep them safe or to avoid separation. At certain times when normal mechanisms fail to protect the ego from anxiety, the ego may disintegrate as a defensive measure and then project the fragmented pieces. Extensive use of this mechanism is made in more severely disturbed children and in psychotics. The use of projective identification produces its own anxieties, i.e., the fear

that the object will retaliate and also that the parts of the self that are projected will be imprisoned and trapped inside the object, thus leading to claustrophobic anxieties.

One of the main features of the paranoid-schizoid position is "splitting," which allows the ego to order its experiences and begin to integrate. This process usually starts by differentiating objects into good and bad. Splitting is the basis of what later is called repression; providing it is not excessive and rigid but an important mechanism of defense it functions in a modified form throughout life.

An example of projective identification is provided by Albert Mason (1966), a Kleinian psychoanalyst. The patient was a 25-year-old nurse who had recovered from two schizophrenic breakdowns. Though she was not acutely psychotic at the moment, her dreams and fantasy material showed marked psychotic mechanisms.

> For example, one dream was of her being at a party when she caught site of an Arum Lily. She screamed and fainted and a tall, slim carpenter with a pot-belly came out of the water to comfort her. The dream then changed to her seeing a baby sitting at one end of a carriage. The baby had a huge penis. The mother of the baby, and Indian lady, was wrapped in a white sari. The breast of the mother had a purple engorged look like a genital. It appeared that the mother had just finished feeding the baby. The patient's feeling in the dream was of overwhelming frustration.
>
> Her associations made it fairly easy to interpret confidently that the tall slim pot-bellied man stood for the penis of her father that she extracts from the parental intercourse (Arum Lily—associated with marriage) by her scream. The scream, which is an evacuation of part of herself, is the equivalent of the child's angry evacuation of excretia, which is felt to get into the mother and push out the father. The man comes out of the water. The baby (baby part of herself) then feels it possesses the father's genital and can push it into the mother's breast (Indian woman in sari = pigmented nipple surrounded by white breast) in an infantile representation of intercourse. She screams with frustration because although she fantasizes that she possesses the mother sexually, the baby part of herself gets frustrated because it will not be fed by this kind of relationship.
>
> One can see clearly in this dream how father is really a part object, a tall, thin man with a pot belly representing a penis and scrotum. Mother likewise is a breast, merely a pigmented head surrounded by a white sari.
>
> During the session with me the patient felt that her stomach was distended (confusion with pot-bellied man) and felt on occasion that I was cutting her sentences short and thrusting my opinions down her throat. She cuts off the penis and appropriates it (baby with penis) and now feels that I cut off her speech. She feels I push my analytical penis into her violently, just as she pushed the penis into the mother's breast in the dream. At one moment in the session my interpretations excited her and made her lose track of an association that she thought was helpful to me. Here she is confused with [i.e., identifies with] the breast that she excited by thrusting sexuality into it and seducing it away from the feeding situation, i.e., I am felt to be putting things into her which excite and seduce her mind away from the thought which could feed the analysis.

> One sees over and over in this kind of relationship how she becomes confused with her objects and how *she* feels the feeling that her objects—breast and penis in this instance—are experiencing in her dreams and phantasies. At one point in the session she remembered testing urine for sugar and noticing the doctor looking at her, as she thought, sexily. Again the confusion with me is clear. She becomes the analyst of patient's material who is being penetrated by a doctor's sexy look. (In the dream she penetrates me as the mother, with the genital).
>
> Another patient, a paranoid homosexual of twenty four, continually feels that his words are dirty and excite me, i.e., dirty my mind. This is then followed in the session by intense irritation and preoccupation with his anus with a mixture of pain and excitation. This he feels I cause by interpretations which he feels humiliate him, penetrate to his core, and get on top of him. He continually makes jokes and quips in the session, i.e., he buggers the analysis about and immediately feels my interpretations are aimed at making him small, exhibiting my skill (penis) and in fact buggering him rather than nourishing and feeding his mind. He often gets claustrophobic on these occasions and feels in despair because he is not sure whether he is not telling me the truth of whether my interpretations are true or just a load of "phoney crap" as he puts it.
>
> One can see here how he projects parts of himself into me and immediately becomes confused with me and feels penetrated and projected into by me. He also feels trapped inside me and the mess he produces which he pretends is exciting (faeces presented as something sexual or good to eat) become hopelessly confused with my analytical food, so that that is suspected of being phoney, i.e. not true food but disguised "crap." This kind of confusion which is based upon the infant's envy of the breast and feeding qualities of the mother, and which are then confused with its own excretory activities, is a common and persistent characteristic of many homosexuals and needs careful analysis for any resolution of the homosexuality to become possible.

The primitive emotion of envy is often said to be the root of negative therapeutic reactions and interminable treatment; the patient is unable to tolerate help from the analysis and destroys it outside or inside his or her own mind. Good interpretations, felt to be like the nipple putting good food in to nourish the patient's mind, or like the potent father's penis, which can satisfy or create, are both attacked and destroyed when envy is strong.

A frequent defense against envy and one that makes itself felt very commonly in the analytic situation is contempt, which is an effort to defend the patient against unbearable envy and hostility. Envy is very often unconscious, and considerable working through of it is needed before it appears in awareness. "The making of the unconscious envy conscious," says Mason, "will usually result in the mobilization of more love and concern for the attacked object and therefore some diminution of destructive envious attacks."

The further understanding of early mechanisms in the mental life of the child brought about by Melanie Klein's work has encouraged several of her followers to apply her findings to the treatment of psychotics. Notable among these is Herbert Rosenfeld, whose book *Psychotic States* (1965) outlines some of his work. What emerges most clearly is Rosenfeld's strict adherence to classical analytic procedure and

principles. The understanding of the psychotic transference is considered essential to maintain contact with schizophrenics and to analyze them without resorting to artificial means. Freud (1953) and Abraham believed that schizophrenics were incapable of forming a transference to the autoerotic level of development because they were regressed. Nurnberg (1955), O'Malley (1931), Barkas (1925), LaForgue (1937), and later Sullivan (1962) (1962) (1939) (1954), Fromm-Reichmann, Knight, and their collaborators have, however, described the importance of the transference in schizophrenia.

Rosenfeld demonstrates that the acute schizophrenic patient is capable of forming both a positive and negative transference, which may be interpreted and can produce clear responses from the patient. He states that in all schizophrenics whom he has observed one particular form of object relationship appears very clearly: "As soon as the schizophrenic approaches any object in love or hate, he becomes confused with this object (projective identification). This is due not only to identification by introjection, but to impulses and fantasies of entering the object with the whole or part of the self in order to control it." Agreeing with Melanie Klein, Rosenfeld believes that this is the most primitive type of object relationship and that it begins at birth. He contends that the withdrawal of the schizophrenic is not simply an autoerotic regression; it may be a defense against external persecutors, or it may be due to identification with an object involving both introjection and projection. In a state of projective identification, which may be experienced by the patient as confusion, the patient is aware of being mixed up with someone else (his or her object). Rosenfeld believes that in the analysis of acute psychosis the psychotic manifestations attach themselves to the transference and a transference psychosis develops. The transference phenomena can be interpreted to the patient only when they are comprehended. The full understanding of projective identification enables one to do this.

In his book Rosenfeld also has interesting chapters on drug addiction and hypochondriasis. He believes that drug addiction is closely related to manic-depressive states but is not identical with them. Drug addicts use manic and depressive mechanisms that are reinforced and consequently altered by the drugs. Drugs have both a symbolic meaning, relating to unconscious fantasies, and a pharmacotoxic effect, which increases the omnipotence of the prevailing impulses and mechanisms. The use of such mechanisms as idealization, identification with ideal objects, and denial of persecutory and depressive anxieties is associated with a positive or defensive aspect of mania. Also, the destructive phases in drug addiction are closely allied to the destructive aspects of mania. An important feature of drug addiction is

the projection of good and bad parts of the self. Rosenfeld reveals that crises of severe drugging may occur when a drug addict is making progress in analysis and a splitting of the ego diminishes. This leads to aggressive acting-out and can be regarded as an envious attack on the therapist. On the surface, the Oedipal conflict and homosexuality play an important part in the psychopathology of the drug addict, but the overwhelming force of these conflicts can be understood only by examining their basis in the very earliest conflicts and mechanisms of the infant.

Rosenfeld considers the hypochondriac state as constituting a defense against schizophrenic or paranoid conditions and confusional anxieties. The ego seems to be unable to work through the confusional state that it projects, including internal objects and parts of the self, into external objects. These are then immediately reintrojected into the body and body organs. A characteristic of the chronic hypochondriac is the inability to obtain proper oral gratification. This frustration is displaced into and complicates the genital sphere of activity. The anxiety created by the patient's genital frustration increases the tendency to regression and mobilizes early confusional anxieties. As a defense against this, the hypochondriac state becomes manifest.

Another of Klein's followers is W. R. Bion (1962, 1963, 1965, 1967, 1970). He has made certain contributions, especially in the field of thinking and thought disorder. His first book, *Experiences in Groups* (1961), has become a standard work among group therapists and demonstrates his use of Kleinian theory in the group process. He notes in detail the use of omnipotent fantasies present in groups and how these fantasies are used to deal with the frustrations concomitant with contact with reality. These omnipotent fantasies are similar to those Klein described that she observed in the infant and its responses to the outside world. Bion also made important observations on the effect of the "genius" or "Messiah" in a group and described how this genius could enlarge or improve the group and be enlarged and improved by it or, conversely, how they could destroy each other.

Bion's work on psychoses essentially supported that of Klein and Rosenfeld, and he demonstrated that a strict analytic and interpretive technique could be utilized successfully with psychotics, as Rosenfeld had also done. He linked the phenomenon of projective identification with the development of thinking. He also described certain pathological forms of projective identification and postulated that these produced a failure of development of verbal thought and thus played a part in the development of

schizophrenic illnesses. Klein's concept "that the infant treats the absence of the good breast as the presence of a bad breast to be evacuated" was explored and expanded by Bion and was the central theme in many of his papers. He also believed that this fantasy plays an important part in the development of psychosis. Bion examines the nature of thoughts and thinking in several of his books and has written extensively about the nature of hallucinations and hallucinosis. He has described the problem of the patient who cannot learn from experience and, therefore, cannot grow, and he has linked this phenomenon with Klein's work on envy.

Donald Meltzer has worked extensively with children and, from his experience, has written several books (1973a & b, 1975). He sets out to revise the psychoanalytic theory of sexuality as formulated by Freud. In so doing, he contends that the original nebulous formulation of the infantile polymorphous-perverse disposition (and genetic concepts of stages of psycho-sexual development and erogenous zone primacies, eventuating in a genital primacy) is shown to resolve itself. Through delineation of the distinction between adult and infantile structures of the mind, criteria of a purely psychoanalytic variety are evolved for assessing the significance of sexual states of mind and consequent behavior. Meltzer discusses the nature of autism and the specific technique of obsessional dismantling of the sensory apparatus of the ego that brings it about. He also examines the origins of mutism as part of the natural history of the disorder and the implications of all these findings for psychoanalytic theory and practice in general. His understanding and clarification of the perversions and their link to perverse states of mind are believed by some to be an important synthesis of the work of Freud, Abraham, Klein, and Bion and a major contribution to the understanding and treatment of psychoses, perversions, and addictions.

Elliot Jaques has written eight books on the implications of Melanie Klein's work to the fields of industry, sociology, and law. In addition, he has written papers about social justice, art, and creativity and is one of the leading applicants of psychoanalytic theory to everyday life. Other Kleinians whose works have dealt with art and anthropology, as well as the treatment of patients, are Roger Money-Kyrle and Hanna Segal. Bion, Rosenfeld, Meltzer, Jaques, Money-Kyrle, and Segal were all analyzed by Klein.

Criticism of Kleinian Analysis

Both Freudians and non-Freudians believe that the concept of phylogenetically determined images of the genitals, breasts, and primal scene and the description of incorporative and projective symbolic thought processes in infancy are fanciful projections of a theoretically biased therapist. They insist also that focusing all psychopathology on distortions developed during the first year of life is too limiting. There are some who accept aspects of Kleinian theory, for example, the basic paranoid and depressive positions, while rejecting such aspects as pregenital Oedipal conflict and formulations related to the death instinct.

In spite of the criticisms levied against Melanie Klein, her contributions have had a great impact on analytic theory and practice. She was instrumental in showing how the superego formed itself from environmental rather than biological sources, the vitality of intrapsychic struggles between introjected good and bad objects, how object relations were prejudiced by projections from these objects, and the impact of aggression on pathological development, the infantile precursor of structural entities. Most important, her work acted as a basis for present-day ego analysis and object relations theory.

EGO ANALYSIS

Fairbairn (1946a & b; 1954) was one of the pioneers in emphasizing the importance of the ego. He developed an *object-relations theory*, patterned after some of the conceptions of Melanie Klein, which posited a splitting of the ego in early infancy as a consequence of reciprocal action of introjected good and bad objects. While the ego was whole at birth (rather than incomplete as in classical theory), unfortunate relationships with the mother fostered this splitting. The function of the instincts (libido) was to seek good objects. This was needed to promote ego growth. Aggression was a reaction to frustration of the libidinal drive in this quest. Aggression, therefore, was a defense rather than an instinct (as in classical theory). Loss of ego integrity through the process of splitting and evolvement of internal ego-object relations created pathology. The developmental process was thus bracketed to vicissitudes of objects rather than vicissitudes of instincts. Early interactions of mother and child as a basis for ego development was also emphasized by Winnicott (1958).

Among the contentions of these early adherents of ego psychology such as Fairbairn was the idea

that objects were not casual figures who served merely as conduits for infantile need gratification, but rather an integral part of the infant's nature and instinctually sought out from the start. In this way Fairbairn anticipated what later researchers in human development demonstrated, namely, that the newborn child was object-related from the moment of birth. Instead of considering structure (the ego) and energy (the id) as distinct entities, Fairbairn contended that they were intimately bound together. Libido was not pleasure-seeking as much as object-seeking, and this was a biological survival mechanism. A so-called primary narcissistic objectless initial stage of development was an empty abstraction, because object-seeking, albeit disorganized at first, was the primary aim of the infant. Relations with an object were the key to survival of the individual (mouth to breast) and later to the survival of the race (genitals to genitals). Adaptation was the product of a good relationship between individual and object; psychopathology, the consequence of a poor relationship.

The conviction that human behavior is too complex to be accounted for purely in terms of instinctual processes gradually turned a body of Freudians toward the focal consideration of dimensions of personality other than the id, particularly the ego, while retaining fidelity to the dynamic, structural, economic, topographic, and other basic psychoanalytic concepts, including the libido theory. Among the first of these "ego analysts" were Anna Freud (1946), Erikson (1946, 1950), Hartmann (1950a & b, 1951, 1958), Rapaport (1950, 1951, 1958, 1960), Kris (1951), and Loewenstein (1953). The direction of the ego analysts has been less introspective and speculative than it has been empirical, based on factual investigations, the systematic gathering of data, and organized experiments. Attempts have been made to avoid philosophical issues and implications in order to deal more scientifically with facts. This has led to intensive studies of the child and particularly responses to various child-rearing practices, interactions within the family, as well as the influence of the community. Sociological and anthropological vectors have accordingly entered into some of the emerging formulations, although the orientation is definitely a biological one.

Although primary psychological drives are considered basic and important, these are dealt with in the context of the molding and modifying influence of the environment, which is believed to play a decisive role in eliciting behavior independent of instinctual forces. Building on Freud's conceptions of instinct, ego analysts regard behavior as undifferentiated at birth, at which time the infant possesses certain response potentials, innately derived but requiring the influence of environment to arouse and

consolidate them into adaptive sequences. Among the groupings of responses are certain internal and external elicitors of behavior that are distinctive from instincts— those that deal with responses to perceptual stimuli and those that serve organizing, integrating, and controlling functions. Response patterns serve to adjust the individual to the particular environment. Responses such as awareness and thought, which serve to control and direct behavior, are also innately determined. Learned responses soon displace instinctual and automatic reactions. Behavior is more than a means of reduction of sexual and aggressive energies. Ego functions can be pleasurable in their own right. Among the most important ego functions are those that mediate perceptions and sensation and support operations that maintain contact with the external and internal environment; there are those that deal with awareness and attention (which can help delay or inhibit impulses), those that govern thinking and communicating (verbal response), and others that control action and motility, enabling management of one's environment. The ego in its synthetic, integrating, and organizing operations fosters a controlled, thoughtful, planned, and efficient mediation of behavior directed at consciously selected goals.

Though psychosocial development is crucial during the first five years of life, laying down patterns that will determine behavior throughout the remainder of an individual's existence, these patterns are not as completely fixed and unmodifiable as the earlier Freudian theorists supposed. Nevertheless, at certain stages of growth environmental experiences can have a decisive influence on the total personality structure.

Ego development occurs immediately after birth as the child discriminates between inner responses and the influences of the environment, for instance, in feeding. Gradually the child differentiates self from the environment and anticipates future events. Frustrations encourage self-control. The child develops the ability to recall past situations in which delay in gratification was followed by fulfillment. Habitual response patterns are developed in relation to surrounding objects enabling the child to win their approval and to control feelings from within. A sense of personal continuity and identity emerge. Problem solving and coping are aided by imitation (identification). The social milieu becomes incorporated within the individual, seducing the child, as Erikson has put it, to its particular life style. Self-esteem is built from exercise of different skills and the fulfilling of interpersonal experiences. Defense mechanisms are evolved to control fear and the situations in which it becomes conditioned. The signal of anxiety serves to mobilize defenses in the repertory of the child, and although

the early conditions that fostered them no longer exist, the individual may continue to employ them throughout life. Learned patterns of behavior are established as "hierarchial structures" from the base of the earliest patterns to the apex of the latest responses, the original ones never being completely ablated but merely replaced by the later ones. This applies also to thoughts, at the foundation of which are primitive "primary-process" thought patterns concerned with instinctual drive reduction; these are replaced gradually by logical thought. Furthermore, the mechanisms of defense are in hierarchial arrangements. Their antecedents reside in physiological responses, and their latest representations are in the form of creative thought.

Behavior is considered to be neither the by-product of instinctual energies nor the result of situational events. Rather, it is a mode that reflects and yet gradually achieves relative independence from both through the development of autonomous stable response structures. Healthy behavior is under conscious control. When the ego loses its autonomy from the id or from reality, behavior is no longer under conscious control and pathology may ensue. This is particularly the case when residual stable behavior patterns are insufficient to deal with an existing stress situation. A variety of circumstances contribute to the formation and maintenance of learned adaptive structures, and a consideration of these is vital to the understanding of behavior pathology.

In therapy that is conducted under orthodox Freudian rules, an added goal is an attempt at expansion of the repertory of learned patterns to enhance conscious control of behavior in relation to both inner impulses and environmental pressures. Hartmann has speculated that eventually a technique system will be evolved that can keep abreast of new theoretical developments. Under such a system an effort would be made to understand not only pathological but also adaptive behavior patterns and to examine the interrelationship between the conflict and nonconflict aspects of the ego while tracing the antecedents of neurotic anxiety. There is an implication in some of the writings of ego analysts that therapy should embody more active procedures than the orthodox techniques employ. For instance, interpretations should be couched in terms of specific events rather than in abstract concepts. A focus on immediate problems in the current life situation and on character defenses that influence interpersonal relationships can be productive.

In summary, the basic contributions of the "ego analysts," as these analysts have become known, are

the following:

1. Behavior is determined by forces other than instinct in the form of response sequences encompassed under the classification of "ego."

2. The ego as an entity has an autonomy separate from both instinct and reality.

3. The ego supports drives for environmental mastery and adaptive learning that are divorced from sexual and aggressive instincts.

4. The adaptive aspects of learned behavior are as important as instinctual behavior and lead to important gratifications in their own right.

5. A greater emphasis must be put on the environment and on healthy, as opposed to pathological, behavior than is found in orthodox Freudian approaches. An understanding of pathological behavior in relation to normal behavior is vital.

6. Personality is more plastic and modifiable, even beyond the period of childhood, than is traditionally supposed. A more hopeful prognosis is consequently forecast.

7. The human being is the master of his or her destiny and can control and select behavioral patterns to achieve differentiated goals.

8. Society is a force that does not necessarily emerge from a human being's expressions of instinct; nor does it always thwart the biologic nature of a human being. It can exert a constructive influence on the individual while modifying primitive instinctual drives.

9. Conscious and learned responses are basic to a person's adjustment.

10. Technical innovations in the direction of greater activity are sometimes necessary.

Criticisms of Ego Analysis

Many non-Freudians contend that ego analysts essentially have not really abandoned the archaic classical model. They have merely altered it to fit into a more palatable framework of development and learning. While the structural hypothesis of id, ego, and superego conceptualizes some aspects of behavioral function, by no means does it encompass all aspects. The mechanisms of adaptation are so complex and involve so many facets of behavior that simplistic models cover only limited areas of

operation. There are also flaws in the related epigenetic theory that identifies sequential stages of learning in the developmental process and organizes a diagnostic system around these stages. Of course, assessment of development levels and existing fixations is a convenient way of looking at pathology, but inferences drawn from this regarding coping capacities are not always correct, and in fact may be misleading.

Freudians, on the other hand, insist that Freud in no way minimized the importance of external objects and their function in molding the inner organization. They believe that putting the ego at the helm of the entire psychic structure neglects other important and perhaps more determining components. The ego should be considered a substructure, a part of the total apparatus, emerging from the original primary narcissism, gradually evolving as an aggregate of functions.

NEO-FREUDIAN AND NON-FREUDIAN PSYCHOANALYSIS

Classical psychoanalysis as a specialized form of psychotherapy, devised by Sigmund Freud, consists, as indicated previously, of a group of organized procedures whose objective is to activate in the relationship with the therapist (transference neurosis) the conflicts experienced during the early formative years (infantile neurosis) that, sealed off in the unconscious by repression, dissipate energy and foster an unrealistic adaptation. By interpreting and "working through" the regressive transference neurosis (that embodies distortions in relationships with parental agencies), an attempt is made to resolve the infantile neurosis, liberating the individual from fixations in personality growth toward greater self-actualization.

As a technique, classical (Freudian) psychoanalysis is applicable to a class of patients who are able to devote themselves to and tolerate the rigors of a long-term intensive exploratory process. In essence, therapeutic results depend upon the replacement of unconscious mental acts by conscious ones through the overcoming of internal resistances in the patient's mind. The vanquishing of resistances is brought about by the use of special techniques that are employed with the object: first, reviving memories of past experiences, particularly those of childhood, which, due to their painful content, have been repudiated and repressed; and, second, activating and transferring over to the analyst the early "infantile neurosis" responsible for the unconscious conflicts that continue to blight the patient in the here and now.

These conventional characteristics of therapeutic psychoanalysis have been disputed by some factions of the psychoanalytic fraternity. Operating under the rubric of "neo-Freudian psychoanalysis," these analysts challenge the economic, dynamic and topographic formulations of Freud, including the instinct theory, the significance of infantile sexuality, and the ubiquity of the Oedipus complex. The very existence of the unconscious itself is questioned by some. These deviations have sponsored combinations of orthodox techniques with more active and supportive measures, such as shifting the focus from the past to the present, reducing the number of weekly sessions, veering from free association to more structured interviewing, and minimizing the need for transference neurosis. Understandably, some consecrated Freudians have responded to these adulterations with consternation, insisting that neo-Freudians, in removing the pillars of psychoanalytic structure and in altering the orthodox procedure, have no right to call their therapeutic maneuvers "psychoanalysis."

Rigorously speaking, psychoanalysis in its "pure" form consists of the creation, by a professional person thoroughly trained in the method, of a transference neurosis through the maintenance of neutrality, anonymity, and passivity in the relationship with the patient. As already noted, this method includes frequent sessions (four to five times weekly), the use of the couch, the adoption of the "fundamental rule" of free association, the employment of dreams, the focus on early significant memories, and the detection and interpretation of resistance. Patients are thus afforded an opportunity to experience, to understand, and to resolve in a dynamic, protected atmosphere conflicts of which they were previously unaware.

Contaminations of the purity of psychoanalysis have been fomented by an increasingly large body of psychoanalysts who have introduced ideas from social theory, role theory, group dynamics, cultural anthropology, field theory, and even philosophy. Deviations from Freudian psychoanalysis vary from minor divergences related to one aspect of theory to major disagreements in which substitute hypotheses or therapeutic methods appear to depart radically from commonly accepted definitions of psychoanalysis.

Among the propositions of the neo-Freudians are the following:

1. Personality is fashioned principally by cultural rather than instinctual forces; the value systems of society are incorporated in the individual's character structure and

determine the individual's action tendencies; conflict is a product of diverse factors within and outside of the person and involves both conscious and unconscious factors.

2. The myriad elements—social, interpersonal, intrapsychic—entering into character organization necessitate a comprehensive and holistic view of personality theory, together with a concern for healthy as well as abnormal adaptation.

3. The libido and death-instinct theories are formulations that cannot explain either normal or abnormal behavior; infantile sexuality alone cannot account for an individual's basic conflicts or for the lines along which character structure develops.

4. Female sexuality is an entity on a parity with, rather than inferior to, male sexuality.

5. The classical topography does not explain the structure of the psychic apparatus.

6. The therapeutic encounter is more than a means of repeating and working through early traumatic experiences; it is an experience in a relationship, containing positive growth potentials that can lead to greater self-actualization.

7. Activity and flexibility in the therapeutic approach are essential; this encourages eclecticism in method.

8. An optimistic, rather than pessimistic, viewpoint is justified regarding a human being's potentials as a creative, loving, and peaceful being.

Primacy of Cultural Factors in Personality Development

The concept, in the words of Geza Roheim, that "culture is the creation of a substitute object" embodying solutions for pre-Oedipal and Oedipal conflicts has not gained too wide acceptance among sociologists and anthropologists. While Freudian ideas about individual development and the unconscious are considered credible, those that apply to cultural theories and social process are more or less rejected. Interesting accounts of how society, particularly through its child-rearing practices, molds personality structure are found in Kardiner's writings (1939). Elaborated is a delineation from comparative studies of a number of different societies that reveals personality characteristics as reflective of, and congenial with, the total range of institutions within a culture, although an individual character structure may show certain variations in response to personal experience. Ruth Benedict (1953) and Margaret Mead (1939, 1952) in extensive field studies, have shown that stages of personality

development that have been accepted as universal are not applicable to certain cultures. For example. Mead (1939, 1952) in studying adolescent girls in Samoa observed that the traditional tumultuous adolescent upheaval did not exist, possibly because few restraints were put on self-expression and sexuality. Personality characteristics usually credited to male and female are shown to be more the product of social role than biological forces. Disturbances of society, such as delinquency, crime, drug addition, and sex offenses, as L. K. Frank (1957) has pointed out, should not be regarded as distortions of the instincts or signs of human wickedness but as manifestations of disintegrating forces in the environment.

Stressing concepts from field theory, neo-Freudians do not regard the environment as a projection vehicle that is molded by instinctual needs and demands. Rather, they look on it as a cardinal force in itself that shapes personality. Behavior is conceived as the product of many vectors, both biologic and social. Constitutional and hereditary elements, while present, do not determine an individual's destiny. This is mediated principally by experiences in life. Attention must be focused, therefore, not on the unconscious—on instincts and their vicissitudes—but on the relationship of the individual with the significant persons in the early and later development who are carriers of the value systems of his or her culture. Personal values reflect these systems. Distortions in relationships and in values are registered in the character structure, disparate operations of which act as a potent source of conflict. Though there is general agreement among the various neo-Freudian groups who hold these ideas, there are discrepancies as to the most important cultural determinants, the specific effects that are registered on character structure, and the consequences of such impacts. The existence, role, and content of the unconscious are also matters about which there is disagreement.

The Holistic Viewpoint in Abnormal and Healthy Adaptation

The concept of character as fashioned by the culture has directed attention to the institutions and values of society that foster healthy and unhealthy adaptation. Instead of viewing healthy aspects of personality through the lens of pathological distortion, neo-Freudians have tended to investigate what goes on in the "normal" or healthy individual, drawing inferences from data dealing with adaptive rather than sick behavior. Abnormal behavior is considered within the framework of understanding "normal" behavior rather than the reverse. This has widened the horizons of progressive personality

research to include pertinent areas of sociology, social psychology, ecology, anthropology, ethology, and philosophy. The focus of inquiry is on the intricate network of organizational units—interpersonal, familial, group, national, and international—as well as the sum total of institutions that constitute society as a whole. Behavioral studies are encouraged that scrutinize the interaction of individuals and groups in a variety of settings. The habits, manners, mores, and customs of people in primitive and civilized organizations are surveyed, and cross-cultural data on child-rearing practices are analyzed. Modes of reacting to aspects of the environment that constitute the individual's life space and ecological patterns of such phenomena as crime, delinquency, poverty, and insanity are examined. The behavior of animals in their natural habitat is observed to determine the relative roles of instincts and social learning. Finally, studies of aesthetic, moral, ethical, and spiritual promptings, of social values and how they are internalized and influence behavior, bring the behavioral scientist into the fields of philosophy and religion. Scientists from diverse fields, cooperating together in interdisciplinary research, foster a better integration of the biological and social sciences. By considering the human being as a totality, neo-Freudian approaches support a holistic and Gestalt point of view. The individual is considered to be a tapestry of biochemical, physiological, psychological, sociological, and spiritual systems, each of which has a feedback onto the others.

Shortcomings of the Instinct Theory

The libido theory as a developmental as well as therapeutic model, ingenious as it is, is considered by neo-Freudians to be inadequate in explaining what goes on in all personality operations. It is believed to be highly overgeneralized, extending itself into zones of energy exchange that cannot possibly deal with the complexities of human relationships. For instance, pregenital instinctual drives are not considered to be the basic elements involved in character organization. Parental attitudes and practices, on the other hand, do have a determining effect upon feeding, excretory, assertive, aggressive, and sexual patterns—indeed a greater impact than forces of maturation. Experiences in the family are the cradle of faulty conditionings. Personality functions are best conceived of in an interactional or transactional framework. This calls for a different perspective on such phenomena as infantile sexuality. All bodily activities should not be regarded as manifestations of sexuality. For example, pleasure in feeding and excreting cannot conceivably be sexual even in the broadest sense of the word. Evidence of

the sexualization of certain bodily activities during analysis does not necessarily prove the case for pansexual development in childhood. Even frank genital exploration and manipulation in childhood may be less a sign of true sexuality than a mark of curiosity and the seeking of knowledge of how the body is constituted. Where childhood sexual aberrancies develop and persist, this is evidence of a disturbed upbringing, precocious erotic stimulation, and response to anxiety rather than anarchical sexual instincts.

The presence of the Oedipus complex during psychosocial development is not disputed, but its universality and ultimate destiny are questioned. Some neo-Freudians accept firmly the ubiquitous biological nature of the Oedipus complex, but they contend that its form is influenced by the particular culture in which the child is reared. Others believe that the Oedipus complex is not a biological phenomenon but rather the product of provocative conditioning, particularly in families in which strong dependent attitudes are encouraged in the children or in which the child encounters excessive sexual stimulation through the overfondling activities of the parents. Cultures in which such dependency or sexually seductive attitudes do not exist do not foster the Oedipus complex in children. When the Oedipus complex develops, it may be a manifestation of discord and distrust between the parents, resulting in their utilizing the child as a vehicle for frustrated love needs. Emotions of jealousy and hostility emerge in the child as a by-product of the conflict that is engendered in the child. The child selects the "strong" and dominant parent—mother or father—as an identification vehicle, and when mothers play the dominant role, the child will, for security's sake, tend to identify with the mother. This can create problems in sexual identification for the boy. The Oedipus complex may accordingly be understood in cultural terms as a reaction to anxiety, and not necessarily as a manifestation of the libido.

The death instinct also is labeled a metaphysical concept rather than a plausible theory to account for aggression, masochism, and sadism. It has little theoretical or clinical usefulness. Aggression is not a primary drive but, as has been repeatedly pointed out, a secondary reaction to drive frustration. Masochism is a special kind of defensive response to anxiety marshalled by certain interpersonal conflicts.

Dualistic formulations regarding sexuality and aggressiveness are not considered adequate in explaining the complexity of these drives. For instance, bisexuality is not universal as some authorities

insist. Though physical rudiments of the opposite sex are present in an individual, this does not justify the notion that they must influence the individual's mental life (Lillie, 1931; Rado, 1956). The idea of universal latent homosexuality has led to therapeutic nihilism in treating homosexual problems. Placing a higher biological value on the aggressive quality of the male genital is also unjustified; the crediting of superiority to the penis as compared to the female genital is a cultural phenomenon that can easily shift with a change in social values.

A Positive Approach to Female Psychology

Male-oriented concepts of female psychology that regard women as arrested males, frustrated by their biological inferiority, are alleged to be a product of the cultural consideration of women as an inferior species. Under these circumstances penis envy, when it develops, is a manifestation of the underdog philosophy foisted on females by the dominant males. By possessing a fantasized penis and masculine strivings, a woman compensates for her feelings of social inferiority. Similarly, the designation of passivity, dependency, and masochism as female characteristics does not reveal their true nonsexual dynamic qualities. Female psychology, therefore, can be explained purely in cultural rather than biological terms. On the other hand, there are biological differences between males and females, and there are variant social roles that they must assume. For instance, motherhood imposes certain demands on women that makes for characteristics distinct from those of males.

The Structure of the Psychic Apparatus

While convenient for categorizing broad groups of mental activity, the structural conception of the mental apparatus in terms of superego, ego, and id is not believed to be adequate for explaining psychic functions. Overweighting of the superego and id in conventional analytic formulations has left the ego a barren area. Moreover, breathing life into the id-ego-super-ego trinity, giving it substance and location, and charging it with human lusts, fears, hostilities and jealousies are both animistic and clinically untenable. The id is not the core of all human energy and activity. The concept of the superego is a confusing one since it incorporates both the healthy elements of the conscience and the neurotic, compulsive qualities. The values embraced by the superego are not a mere facsimile of standards incorporated from parental agencies, but reflect a variety of other conditionings.

The Therapeutic Encounter as a Positive Growth Experience

The therapeutic relationship is a two-way transaction in which there is a feedback of feeling between therapist and patient. What is effective in therapy is not the expulsion from the unconscious of material that results in startling insights, but the emotional experience of two individuals relating to each other in a productive way. The therapeutic interpersonal relationship has a healing effect that mobilizes the patient's capacities to solve his or her own problems. The therapist is never neutral during this process. Values and prejudices filter through irrespective of how much the therapist tries to act as a neutral screen. Nonverbal responses, the emphasis on certain kinds of content, and the nature of interpretations all reflect personal standards that will influence the lines along which the patient thinks, the kinds of ideas that will be retained, and the direction the patient will follow in revising his or her life style. This has led to a deliberate abandonment of anonymity on the part of the neo-Freudian analyst, interpersonal spontaneity, and the ability to reveal personal values that are proffered as potential contingencies rather than as absolute mandates.

The expression of hostility by the patient during analysis is not always considered necessarily an index of good therapy, marking the release of repressed, transferential energy. It may be a manifestation of provocations inspired by the therapist's rejecting and detached attitude. Aggression is regarded as a secondary reaction to frustration and a defense against anxiety. When it occurs in therapy, it is usually being mobilized as a response to conflict within the immediate interpersonal relationship. Rather than helping, it may be a detriment to therapeutic progress. There is a tendency among neo-Freudians to regard conscious aspects of experience as important, if not more important, than unconscious operations in the formation of conflict. Indeed, some neo-Freudians depreciate the value of probing into unconscious ideation. Also important to many neo-Freudian theorists is the question of "responsibility" of a patient for his or her own actions.

"Eclecticism" in Therapeutic Method

The realization that most patients cannot avail themselves of the opportunity of coming to sessions four to five times weekly, and that, of those who can, many are not suited for intensive probing and the rigors of a transference neurosis, has led to a reduction in the number of sessions, greater activity and

flexibility in the therapist's tactics, relaxation of the fundamental rule of free association, and the introduction of a variety of adjunctive procedures within the framework of treatment. Without arguing the points as to whether such stratagems convert the gold of psychoanalysis into a baser metal, whether results of this "eclecticism" are more superficial because they are based on suggestion, or whether reconstruction of personality is bypassed in favor of symptom relief and the expediency of environmental adjustment, the amalgam has, it is claimed, proven helpful to more patients than could otherwise be reached (Abroms, 1969).

A Constructive Philosophy Toward Humankind

In minimizing the fixity of behavior in instincts, a different philosophy toward humankind is encouraged. A human being is more than an animal whose biological heritage chains him or her to the limitations of inner strivings. A human being is not basically lecherous or destructive. These characteristics, if they occur, are environmentally nurtured. Emphasis on the essential goodness of humankind, not as a reaction formation to aggressive and destructive instincts but as a quality in its own right, emphasizes positive values as determining forces in the creation and molding of personality. It substantiates the human being as a creature who has needs to receive and to extend "tenderness," "care," and "love" for others.

Discussion

Little uniformity of opinion exists among the different neo-Freudian groups and even among members of the same school regarding the above points. Ideas range from a practically complete acceptance of the basic Freudian tenets, differing only slightly in how they are formulated, to extensive deviations, which include denying the existence of the Oedipus complex and even of the unconscious. Some analysts believe in a treatment process focused around the mobilization of a transference neurosis (although the explanation of the nature of the infantile neurosis is more inclusive than the Oedipus complex), and hence they employ the traditional tactics of frequent sessions, therapist anonymity and passivity, free association, concentration on infantile and early experiences, dream analysis, and interpretive focus on transference and resistance. Others depreciate the rationale of transference neurosis and contend that dealing with conscious material focused on the present is more effective than

delving into the past with discursive explorations of the unconscious.

The introduction of supportive procedures and activity in the relationship, the abandonment of free association and the couch position, the breaking up of transference before it gets out of hand, and the violation of the most traditional rules of psychoanalytic technique constitute the methodology employed. To the consternation of orthodox analysts, there is insistence on the part of some apostates that their instituted modifications be accepted as legitimate variations of psychoanalytic techniques. In some instances, even substitution of philosophic precepts for analytic techniques are presented under the title of "psychoanalysis." A number of neo-Freudian groups have dedicated themselves to "exploring more scientific approaches to psychoanalysis." To support an interchange of ideas they have organized a rival group to the Freudian American Psychoanalytic Association called the American Academy of Psychoanalysis and publish their own journal, *The Journal of the American Academy of Psychoanalysis.*

The technical modifications employed by many of those who have deviated from orthodox Freudian theory and method include the following:

1. Passivity in the relationship is superseded by activity in order to deal more adequately with resistance and to subdue the development of neurotic transference. Anonymity of the therapist is, for the same reason, not completely observed.

2. Free association is abandoned as a "fundamental rule," and the interview is focused in nature.

3. The couch position is replaced completely or partly by a sitting-up, face-to-face position.

4. The number of visits may be reduced to as few as three sessions weekly, sometimes to even two or one.

5. The therapeutic relationship is handled in a manner so as to resolve transference as soon as it begins to operate as resistance. An attempt is made to minimize the development of a transference neurosis. Positive elements in the relationship may be encouraged as a catalyst to therapy. The relationship is regarded not only as a mirror that reflects unconscious strivings, but also as a vehicle that has values in itself as a growth experience.

6. The focus in therapy is on both unconscious and conscious aspects of personality. Current problems and situations are stressed as much as past experiences.

7. There is a blending of analytic techniques with methods derived from supportive and reeducative approaches.

The most notable non-Freudian contributions to dynamic psychiatry have been made by Adler, Jung, Ferenczi, Rank, Stekel, Reich, Rado, and members of the "dynamic-cultural school," including Fromm, Horney, and Sullivan. Though the followers of these schools generally subscribe to the basic principles of the movement with which they affiliate themselves, wide degrees of difference exist among members of the same school as to interpretation of these principles. This is to be expected since each therapist will introduce individual unique ideas, many of which may deviate from the classical tenets of the founders of his or her school. More significant, each therapist will practice with his or her own style, often blending orthodox techniques with those of other schools of thought, sometimes to a point where an impartial observer may not be able to identify the professed ideology.

THE "INDIVIDUAL PSYCHOLOGY" OF ALFRED ADLER

Alfred Adler was the earliest contributor of ego psychology. He is rarely given credit for his pioneer work in child guidance, group therapy, family therapy, community psychiatry, social therapy, and a host of original theoretical ideas that have been widely adopted by the various schools. About 1910 Adler broke with Freud over the importance of infantile sexuality and the validity of the libido theory. He insisted that human development was conditioned by the social environment rather than by biological forces. Because each person was unique, his or her psychology was an "individual psychology." Adler propounded a theory of neurosis based on the idea that behavior must be examined, both historically from the viewpoint of past causes and teleologically from the standpoint of goals. Body and mind were a unity, indivisible and goal-directed, without separation of id, ego, and superego. This biosocial-psychological approach did not ignore the importance of cause but viewed it in the service of life's objectives.

According to Adler's theory (1917a & b, 1929, 1930, 1938), the basic helplessness of the human infant, magnified by existing body or organ defects, by the child's interpretation of his or her inadvantageous ordinal position in the family, or by parental neglect or rejection, creates feelings of inferiority. Since inferiority feelings oppose security and a sense of well-being, the individual attempts to cope with them by elaborating compensatory attitudes and patterns of behavior. One extreme neurotic

compensation is a "will to power" characterized by irrational strivings for power, dominance, and superiority. This, the "aggressive" way of dealing with inferiority feelings, in the minds of both males and females is equated with "masculinity." A "submissive" way of handling inferiority is to conceal, deny, or escape from it through fantasy and rationalization. Unable to gain self-esteem or power through other means, the individual may attempt to achieve objectives by a "flight from reality" and the development of neurotic symptoms. Since the feminine role is associated with inferiority, both men and women exhibit a "masculine protest" to compensate for their feminine characteristics, either by trying to subdue the other or by denying their own sociosexual roles. Sexual symptoms, including the Oedipus complex, are comprehensible only as manifestations of an inferiority-superiority continuum.

Adler rejected the concept of "penis envy." He regarded women's "masculine protest" often as objecting to their subordinate economic and social roles. The present-day feminist movement is in accord with Adler's view that cultural rather than biological trends have created inferiority feelings in women. Adler acknowledged the importance but not the primacy of sex roles. The neo-Freudians are in agreement with Adler in the lesser emphasis on the libido.

The constellation of impulses, attitudes, and strivings marshalled to overcome inferiority and to achieve power, originally elaborated in relation to significant persons in the environment, are organized into an elaborate "life style" or "life plan" that influences the individual in every dimension. In accordance with the "concept of unity and purpose" there is a total involvement in pursuit of one's "life style." This "personal purposive pattern" has for its goal power and social significance that may be crystallized in (1) successful compensation and a good adjustment, (2) overcompensation with various kinds of faulty adjustment, and (3) "Active goals," such as retreat into illness as a means to power. The improper operation of one's "life style" may interfere with the healthy growth of the person and with good social and community relationships.

Adler fostered the idea that the school is the extended arm of the family, and he founded child guidance clinics in the schools of Vienna, instituting a type of family therapy. His pioneer ideas on child guidance and family therapy have not been fully acknowledged.

The technique of Adlerian therapy is organized around the exploration and detection of the "life

style" of the individual, including the aims, motivations, and compensatory strivings that operate in both negative and positive ways. The past, while considered of historical interest is relegated to a position less important than the present or the future, except for the "earliest recollections," which are used to identify the source of the "life style." Once the "life style" is identified, the patient is guided into more effective ways of functioning in order to aspire to greater potentialities through "normal" means. In the course of this educational process, strivings for power diminish and are replaced by social feelings and interests that lead to healthier attitudes toward the self and the community. Social integration is one of the most important facets of Adlerian theory (*Gemeinschaftsgefuehl).*

The basic tools are interpretation of early recollections, the family constellation, and recurrent and recent dreams (Deutsch, D, 1966). Early remembrances help to detect the point at which the biased apperception originated. Family constellation offers a clue to the individual's perception of his or her role within the family and other social settings. Recurrent dreams expose and reinforce the patient's self-doubts and vulnerabilities as well as strengths; recent dreams serve as indicators of the amount of insight gained and the degree of therapeutic progress. The healthy aspects of the patient's personality and strivings toward improvement are emphasized.

The relationship of the therapist to the patient is considered to be of great importance. The therapist ideally should represent to the patient a benevolent, empathic, trustworthy person, making up for real or imaginary disappointments in early childhood. A cooperative exploration into the past is encouraged, during which the therapist endeavors to correct the patient's distorted views of past happenings and relationships. Adler warned against fostering too intense a relationship, finding it more beneficial for the patient to keep the interaction on a reality level.

Adlerian concepts can be applied to short-term or long-term therapy, depending on the nature of the disturbance. The therapist may utilize analytic, active, passive, directive, and nondirective methods. The course of therapy can extend from counseling and the solving of acute situational problems to a more extensive reconstruction of personality that is intended to lead to self-actualization.

The functioning of the individual in major life areas is used as the yardstick of improvement and readiness for termination. Termination by the patient, however, even if seemingly premature, is not

necessarily interpreted as resistance. It is accepted that some individuals can change without continued treatment by utilizing on their own the therapeutic insights that they have already gained. The door is left open, however, so that they can return at any time they feel it is necessary. In this way people may return to therapy at different critical periods in their lives, beginning with problems in nursery school and continuing through marriage and parenthood. Thus, therapy serves as a *support* for life, avoiding the danger of becoming a *substitute* for life.

Adler's theory, according to H. Papanek (1966), "is based on carefully observed clinical data from which he abstracted broad generalizations. He was less interested in constructing a tightly fitting system of speculative thinking than Freud. His aim was to bring together, to achieve a synthesis of the multitude and variety of psychological facts. This creative thinking and intuitive understanding of the living organism has resulted in a theory which anticipates many viewpoints and hypotheses of present-day psychology: to mention among others Gestalt and Field psychology."

Criticisms of Adler's theory and method are organized around the following contentions: first, that only one of manifold human strivings is stressed—that of feelings of inferiority; second, that not enough credence is given to deep unconscious forces; and, third, that goals in therapy tend to be reeducative rather than reconstructive in nature. Adlerians answer these criticisms by insisting that Adler used terms like inferiority in the broadest sense, including connotations of insecurity and anxiety. Moreover, results of therapy are often reconstructive.

At present, "individual psychology" is practiced by a multidisciplinary group, who, like the Freudian group, are strongly loyal to their founder. Adlerian associations in New York, New Jersey, Washington, D.C., Chicago, and Los Angeles maintain training institutes and mental hygiene centers. There are also important Adlerian groups in Oregon and Wilmington, Delaware. The parent organization is the American Society of Adlerian Psychology, which conducts annual meetings and publishes *The Journal of Individual Psychology* as well as *The Individual Psychologist*. Adlerian groups in Austria, Italy, England, France, Holland, Switzerland, and Israel, together with the American Society, form the International Association of Individual Psychology.

Alexandra Adler and Kurt Adler, both psychiatrists and the children of Alfred Adler, contributed to

the growth of "individual psychology" through teaching, writing, and leadership in the above organizations, as had their associates Danica Deutsch and Helene Papanek. Among the better-known contributions to the Adlerian literature are those by Alexandra Adler (1948), K. Adler and Deutsch (1959), Ansbacher and Rowena (1956), Bottome (1957), Dreikurs (1957), Farau (1962), Orgler (1963), E. Papanek and H. Papanek (1961), and H. Papanek (1965). Rudolf Dreikurs made a major contribution introducing Adlerian psychology to American educational institutions.

THE "ANALYTICAL PSYCHOLOGY" OF CARL JUNG

Freud contended that each individual in childhood repeated in an abbreviated form the whole course of evolution of the human race. In psychological development each person acted out the racial tragedy of incest and retaliation. This conflict, being biologically ordained, occurred universally. It constituted a psychological hurdle that suspended the individual inexorably between passion and reason. Primary congenital variations, Freud explained, existed in the ego. "Indeed, analytic experience convinces us that particular psychical contents, such as symbolism, have no other source than hereditary transmission…there are other, no less specialized, deposits from primitive human development present in our archaic heritage."

Carl Jung (1916, 1923) expounded these areas in great detail, while rejecting the general phases of Freud's biological and genetic approach for a teleological point of view. Although he acknowledged the existence of bodily libido, he contended that it is issued, not from the sexual instinct, but from a universal force or "life urge." He recognized that neurotic parents promoted neurosis in their offspring, but he minimized the effect of sexual intimidation as well as the general importance of infantile sexuality.

Observing that the symbolic productions of neurotics and psychotics bore a resemblance to those of primitive people, Jung speculated on the existence of a collective unconscious—a hereditary portion of the mind that contained the imprints of ancestral experience. A study by Jung of associations, dreams, fantasies, and drawings seemed to substantiate the presence of instinctive thought processes. These appeared in the form of primordial images, which Jung called "archetypes." Prominent, for instance, was the quadruple "mandala" symbolism, which throughout recorded history appeared as a "magic circle" in legend, art, literature, and religion. Repetitive configurations of a circle in a square, or a square in a circle,

containing groupings of radial or spherical components, the mandala symbol was viewed by Jung as an archetypal manifestation of the collective unconscious that, not based on tradition or model, was determined by archetypal ideas unknown to their creators: "Mandalas are symbols of order, unity, totality. As magic circles they bind and subdue the lawless powers belonging to the world of darkness, depict or create an order that transforms the chaos into a cosmos." Among the archetypes that emerge in myths, legends, dreams, and other symbolisms are the *earth-mother* or *witch-mother;* the *old wise man;* the *hero figure* (such as Hercules, Siegfried, and St. George); the *night journey under the sea* (appearing in such forms as Jonah and the whale); the *Anima,* the mate ideal of the male psyche, and the *Animus,* the mate ideal of the female psyche. Human beings are influenced not only by values and motives acquired through personal experience (residing in their personal unconscious) but also by the collective experience of the human race embedded in their neural structure.

Jung compartmentalized the psyche in different terms than Freud. He divided it into a superficial part, the *persona,* which was a social mask assumed by the individual, made up of social interests and sanctions; a less superficial aspect, the *ego,* which was only to some extent conscious and reflected pastpersonal experiences; and a deeply unconscious part, which had within it the *collective unconscious* and contained archetypes.

Difficulties developed when an improper balance of masculine Animus elements and feminine Anima elements prevailed. Difficulties also occurred when there was a lack of harmony among the persona, the ego, and the collective unconscious. Jung conceived of the idea that baser elements of the soul were present in the collective unconscious, and he characterized these as "the Shadow." He believed also that the collective unconscious contained creative founts of energy. Primitive fears and other untoward manifestations of the unconscious invaded the patient's conscious mind and created tensions and various neurotic symptoms that were attempts at self-cure. The collective unconscious, unleashed, constituted a source of danger for the person.

Another area of conflict was residual in the way personality structure functioned. Jung evolved a theory of character, dividing people into two types: introverts and extroverts. The introvert's interests centered on himself or herself; the extrovert's interests were on the external world. Each type was further subdivided into feeling, thinking, intuition, and sensation subtypes. Problems developed when

an individual pursued his or her own personality type or subtype too thoroughly, with extreme inhibition of other reactions. Complexes were formed by a blending of innate dispositions with external circumstances. Charged with affect, they influenced the individual for the good or bad. Only when they became autonomous and operated like separate egos did they threaten the ego-supremacy.

A human being, said Jung, had an innate religious craving which powered the need for self-realization. There was, he explained, no retreat from life's burdens other than to find refuge in spiritual strivings with "acceptance of the irrational and unbelievable." By experiencing the collective unconscious, an individual no longer would experience personal sorrow "but the sorrow of the world, no longer a personal isolating pain, but pain without bitterness, binding all human beings together." We are brought "back to ourselves as an existing, living something, stretched as it were between two worlds of images, from which forces proceed that are only dimly discerned but are all the more clearly felt. This something, though strange to us, is yet so near, it is altogether ourselves and yet unrecognizable, a virtual middlepoint of such a mysterious constitution that it can demand anything, relationship with animals and with gods, with crystals and with stars." These ideas were elaborated by Jung (1961) in his last book, *Memories, Dreams, Reflections,* a fascinating autobiographical document that explains his relationship with Freud and gives us a broader understanding of the essence and meaning of his work.

Jungian psychoanalytic therapy presupposes a basic attitude toward neurosis that is regarded as an attempt by the organism to promote growth as well as illness. The Jungian process is essentially nonsystematic, although Jung stated that analysis consisted of four stages: catharsis, explanation, education, and transformation. Therapy involves an exploration, with the help of dream interpretation and art analysis, of various aspects of the psyche, including elements of the personal and collective unconscious. Particularly, an effort is made to explore "archetypes" in order to determine how these imprints contaminate the patient's present life and interfere with self-development and self-realization (individuation). Bringing the individual into contact with his or her collective unconscious is said to help liberate creative forces that will have a constructive effect on adjustment. Once nonconscious elements are recognized, an attempt is made to guide the patient actively into a productive relationship with the unconscious. In this way, a balance of masculine and feminine components is restored within the personality. Regressive impulses, such as desires for return to the womb and impulses for rebirth, become dissipated. For instance, Jung cites the case of a man with panic attacks who produced mandalas in

dreams and waking fantasies. Jung consulted a 400-year-old book which contained a woodcut that was an exact duplication of the patient's symbol. Explained Jung, "You see, your dream is no secret. You are not...separated from mankind by an inexplicable psychosis. You are merely ignorant of certain experiences well within human knowledge and understanding." It may be necessary to help patients work through a long series of mandalas until they stop following an ideal from the past and move toward the world of reality. Neurosis is related to the hold on the individual of archetype processes. As individuals grope for wholeness and fulfillment, they are said invariably to come upon the ancient geometrical designs and symbols of their evolving selves.

Emphasis in treatment is not only on the unconscious but also on current difficulties. Dreams, for instance, are regarded as reflecting present strivings as well as future plans of action. Activity is the keynote in therapy, and the relationship is kept on a positive level, transference neurosis being avoided as much as possible. Free association is secondary to a focusing of the interview along specific lines. The therapeutic approach varies with the personality type. The introvert is presumed to need elaborate coherent interpretations, while the extrovert is said to achieve adjustment on a much more pragmatic basis. The development of an intellectually satisfying religion is often considered an essential part of therapy, since religion is believed capable of reconciling existing "archetypes" with an ethical system.

In their actual working with patients, modern Jungians proceed along transactional lines, minimizing theory. A great deal of variability reigns in the way modern Jungian analysis proceeds, with session frequency ranging from one to six times weekly. Group therapy is commonly employed. Some Jungians follow the format of classical Freudian analysis and use the couch. Others use face-to-face interviews. Artistic productions, sometimes via a sandtray, paintings, drawings, sculptures, and especially dreams are freely utilized for exploration of the unconscious. The dream is regarded as a vital means not only of approaching the past but also of understanding complexes in the present through a synthesis of the inherent images and associations. Archetypal motifs are discerned through transference as well as through "amplification" of personal productions with mythological, religious, and anthropological themes. Countertransference is often considered a positive force that can help in the transformation process, which ultimately is directed toward greater individuation.

The abandoning of therapist authoritarianism and the use of the vis-à-vis position, as opposed to

the couch, expedite rapport and even reactivity on the part of the analyst. The effectiveness of therapy stems "from the reality-based interpersonal exchange between analysand and therapist. This also means that the two people in the transaction are partners, jointly engaged in a struggle to explore and dispel the neurosis that affects the patient, including the resolution of the transference. It involves making an alliance with the healthy aspects of the patient ... [which] need to be activated and encouraged throughout the therapeutic procedure. ... It seems to me important to hold theory in abeyance so that nothing will stand between patient and therapist, and interfere with the immediacy of contract" (Wheelwright, 1956).

Criticisms of the Jungian approach relate to its metaphysical content, to the religious-like elements with which therapy is imbued, and to a tendency for some patients to become preoccupied with a mystic philosophy toward life and with speculations of "archetypes" and other manifestations of their racial past. On the whole, however, Jungian therapy achieves results comparable to those of other analytic treatments.

Jungian principles have recently gained great popularity in the United States, possibly because of the enhanced interest in mysticism. Jungian centers exist in New York City and on the West Coast. Jungian therapy is practiced in various parts of the world, drawing its inspiration from the writings of its founder (Groesback, 1983).

THERAPEUTIC MODIFICATIONS OF SANDOR FERENCZI

Sandor Ferenczi (1950a, b, c, & d, 1952), while remaining loyal to Freud's theories, introduced certain modifications of method. Finding that transference did not develop readily in many patients, Ferenczi advocated "active" therapy in the form of an embargo on physical and sexual gratifications. He believed that this restriction would block libido and make it available for projection into the transference. The patient was consequently enjoined to abstain from sexual satisfactions of all kinds, and even to limit toilet activities. The release of resentment and aggression directed toward the therapist was felt to be of therapeutic importance. Experience soon proved the method to be of little value, however, and Ferenczi himself abandoned it. Instead, he substituted a completely permissive atmosphere by acting as a tolerant "good" parental figure who acceded to many of the patient's wishes and demands. He urged that the

therapist admit his or her own faults and shortcomings to the patient in order to convince the latter that all authority was not harsh, intolerant, nor incapable of admitting to failings. A mutual analysis often resulted.

To help patients to an awareness of their past, Ferenczi also encouraged them to relive it by dramatizing childhood situations, while he remained tolerant to the patients' "acting-out." Thus patients would relive their childhood, play with dolls, and engage in baby talk, while Ferenczi joined in the play. He regarded relationships as a two-way interaction, and his writings stimulated interest in what later was expanded by Sullivan in the concept of the interpersonal relationship. Ferenczi recognized that the analyst's personal feelings about the patient and attitudes toward the patient often determined the nature of the latter's reactions. He advocated that the therapist consider the patient's responses as being conditioned both by transference and by reality provocations for which the therapist should admit responsibility. Collaborating with Rank (1925), Ferenczi advised setting a time limit to analysis as a means of accelerating the end of treatment.

Ferenczi's technical innovations are still employed by some therapists, some of whom chance upon identical methods and then claim originality for them.

THE "WILL THERAPY" OF OTTO RANK

Otto Rank was responsible for a number of important technical innovations, and, with Stekel, may be considered an innovator of short-term psychoanalytic therapy. He advocated a flexible, active, patient-oriented treatment process, with the patient determining the particular mode of reaching self-direction and self-determination. Some of the present-day transactional approaches draw their tactics from Rank, while client-centered therapy appears to have absorbed much of his philosophy regarding "self-realization." The functional school of casework was also oriented around dynamic concepts of what Rank called the "helping process" (Taft, 1933, 1948; Allen, F. 1942; Kasius, 1950; Karpf, 1953).

To Rank (1929, 1947), Freud's original idea that the process of birth, with forceful separation of the child from the mother, constituted a trauma from which the individual never recovered was of crucial importance. Two sets of strivings resulted from the "birth trauma": the first, an impulse to return to the

womb in order to restore prenatal conditionings of security; the second, an impulse for rebirth or separation from a maternal object so as to achieve independence. The first group of impulses stimulated the establishment of relationships of a dependent, infantile, and clinging nature. The second group appeared as a "will" to grow, to achieve "individuation," and to separate oneself from confining relationships. The life of the person was governed by these contradictory strivings to unite and to separate.

The primordial anxiety of separation from the mother, rooted in the original birth trauma, was revived at all subsequent experiences of separation, such as weaning, castration threats, and removal from close relationships with people. The need to restore unity with the maternal figure was contained in a desire to submit oneself in human relationships, including sexual relationships, while the need for assertive individuality was residual in an impulse to fight off the desire to unite with another person. Separation anxiety manifested itself (1) as the "life fear," when "the person recognized creative capacities within himself which would threaten to separate him from others lighting up the fear of having to live as an isolated person," and (2) the "death fear," manifested by terror of losing one's individuality and being swallowed by others.

Rank classified personality into "normal," "neurotic," and "creative artist" types. "Normal" people subordinated their own will to that of the group in contrast to "neurotics" who refused to yield their will to the group. This reluctance, coupled with an inability to break out of the trap between dependency and individual autonomy, made it impossible to utilize their will in the direction of developing into "creative artists." Thus, unable to achieve latent creative aspirations and the will to be themselves, they were forced to evolve their own standards and to stand alone if necessary.

Rank emphasized that the analytic hour offered the patient a unique opportunity to live through with the therapist past experiences, particularly the birth trauma, and to move toward a more complete individuation. Psychotherapy was thus essentially a therapist-patient relationship during which the therapist as a helper mobilized the patient's "creative will impulse" for positive self-realization. The relationship itself served as a corrective experience for the patient, revelation of unconscious material and insight being secondary. Patterns of reaction rather than specific content were to be studied. The therapeutic situation was to be adapted to the unique and individual needs of each patient.

Rankian analysis, according to Karpf (1957), "must be patient-centered, not therapist-centered; it must be flexible, adaptable, alert to the new and unexpected—a genuinely creative experience for both patient and therapist. ... In essence it is a view which has a special appeal to non-authoritarian therapists who respect patients as self-reliant and self-responsible persons... ." The process of therapy was entirely centered in the patient-therapist relationship, the focus being on the patient's feelings toward the therapist. The analysis was an experience from which the patient would eventually separate and then go on to a new experience. The reactions of the patient to the inevitable circumstance of separation were studied carefully, with the object of working through fear of, and guilt toward, the separation as well as needs to control and to be controlled. The struggle of the will was also studied as it was reflected in the desire to continue therapy and to be dependent as well as to discontinue treatment and to separate oneself from a dependent relationship.

The emphasis in therapy, thus, was on the present rather than the past. Activity in treatment was the keynote, the patient being encouraged to assert himself or herself in order to develop and strengthen his or her own will. An effort was made to mobilize constructive elements in the personality and to transfer the negative expression of will into positive and creative will. A time limit to therapy was usually set. This was believed to act as a catalyst to the union-separation conflict. No effort was made to bring out sexual material. Resistance was accepted as an inevitable expression of the will. It was not met with counterresistance or explanatory interpretation. Transference was also accepted as an aspect of the growth process in which there was a strengthening of the "will" to be oneself.

Guilt and fear were gradually resolved through this experience in the relationship, which liberated the will from its one-sided expression and resulted in a "utilization of its own contrariness." The acceptance of responsibility for one's ambivalence reduced guilt and fear to a point compatible with living. The patient eventually learned to tolerate separation from the therapist and with strengthened will achieved independence and growth.

Certain Rankian principles have been incorporated into a number of psychotherapeutic approaches, including psychobiological therapy, client-centered therapy, neo-Freudian analysis, short-term dynamic psychotherapy (Mann, 1973), and psychoanalytically oriented psychotherapy. The theory of the birth trauma is not as generally accepted as are Rank's concepts of therapy, particularly those that

deal with the importance of the patient-therapist relationship as a positive growth experience.

An Otto Rank Association exists in Doylestown, Pennsylvania, under leadership of Virginia Robinson and Anita Faatz, and a biannual *Journal of the Otto Rank Association* is published. As social work has shifted from clinical to community work, the once prominent functional casework method, drawing its inspiration from Rank, has lost its appeal. His ideas on short-term therapy, however, are undergoing a revival.

Criticisms of Rankian analysis are expressed by those who object to the activity involved and to the focus on union and separation to the neglect of other personality aspects. The abrupt insistence that the patient stand on his or her own feet under any circumstances is said to have an unfortunate effect on persons with weak ego structures who may require a great deal of support in early phases of treatment.

THE "ACTIVE PSYCHOANALYSIS" OF WILHELM STEKEL

Wilhelm Stekel (1950) is responsible for a number of original techniques in analytic psychotherapy that have been assimilated in many current systems of short-term psychotherapy (Lowy & Gutheil, 1956). Possessed of an uncanny intuition as well as an active personality, Stekel related himself perceptively and rapidly to the immediate problems of his patients, and he utilized himself forcefully to bring them to an awareness of their conflicts. He was particularly interested in sexual disorders ("paraphilias"), and his volumes on sadomasochism (1929), fetishism (1949), impotence (1927), frigidity (1926), and exhibitionism (1952) are best known. His book on psychopathic behavior, which he called "impulsions" (1924), is also popular.

While Stekel retained Freud's basic concepts of unconscious conflict, transference, and resistance, he believed that the libido theory did not explain the multiform conflicts of the human mind, and he felt that the castration complex was not nearly as ubiquitous as Freud had assumed. He declared that current life conflicts were as important as past conflicts and that absolute unconscious elements were not the only foci of neurosis; rather, aspects of the conscious mind might be repressed and transformed by a wide variety of symbols. Stekel emphasized certain formulations, such as the "central idea of the neurosis," which varied in each person, and the inevitable anchoring of mental conflict in the immediate life

situation. Emotional disturbance was often a product of competition of inharmonious "motives." Glimpses of these might be captured from dreams and free associations. Anticipating later characterologic approaches, Stekel remarked that the future of analysis was residual in an analysis of character.

The chief contributions of Stekel, however, were in the field of technique. Perhaps the greatest of these was in the area of dream interpretation, his studies on symbolism being acknowledged by Freud as unique. In employing dreams, Stekel enjoined his patients to bring them recorded to each session. At first, resistance elements were discussed in terms of the patient's desire to remain ill or to avoid facing reality. Then the therapist applied himself to the patient's past involvements and unconscious designs for the future. His flair for symbolism enabled him to pinpoint important conflicts that, sooner or later, were brought to the attention of the patient.

Stekel often remarked that it was not the particular method that cured but rather the personality of the therapist employing it. He stressed what we now call "countertransference." The general therapeutic formula propounded was this: "Recall what originated your trouble, recognize your morbid attitude, and surmount it." Stekel alleged that resistance prevented the patient from recognizing morbid attitudes, from recalling their origins, and above all, from surmounting difficulty. Resistance, however, could not be resolved by the orthodox analyst's manner of remaining a passive spectator to the patient's free associations and dreams. This was the fallacy of passive psychoanalysis. The therapist must actively interfere in breaking up repression. It is necessary to collaborate actively with the patient in the interpretation of free associations and dreams. Through "sympathy" and "imaginative insight" (qualities Stekel subsumed under the term "intuition") the therapist must be alerted to repressed complexes and must intervene actively to make the patient aware of them. The intuitive facility with which the symbolic meaning of the neurosis was determined and the skill with which interpretation was offered influenced the speed of therapy. The therapist's main function, then, was as an intuitive artist probing his or her way into the psyche. Stekel admitted that active analysis presupposed that the analyst was endowed with an intuitive faculty, but he avowed that this faculty was more widespread than had been presumed.

Abandonment of the analyst's passive role was associated with activity and directiveness, even to the point of advice giving and exhortation. While free association was utilized, the patient could not be permitted to ramble along into blind channels; instead, selection of pertinent topics for discussion was in

order. The use of the face-to-face, sitting-up position was also advocated. Emphasis was put on the interpretation of dreams, but the therapist's intuition had to be relied on in order to divine what eluded free associations to the latent content. The use of adjuvants in therapy was also indicated; Stekel insisted that it was essential to adopt methods to the particular case rather than to force the patient to abide by a particular method. With active methods Stekel believed that it was rare for more than 6 months to be required for analysis. This short period avoided interminable analyses and prevented the development of untoward, ill-fated, unmanageable reactions.

The importance of transference was recognized by Stekel as an essential part of every analysis. Indeed, he felt that analysis was impossible without transference. Transference, however, could serve two functions—that of expediting therapy and that of acting as resistance to therapy. Only when transference functioned as resistance was its handling justified.

A frequently heard criticism of Stekel's system of psychotherapy is that the activity of the therapist may sponsor an excessively disciplinary, prohibitive, and punitive attitude toward the patient. Objections are also expressed in regard to the maximal 6-month time limit to therapy on the basis that character reconstruction is long-term. The few followers of Stekel who remain have revised his temporal limitation and often do long-term therapy.

The "intuitive" aspects of active analysis may also come under questioning. Many observers would contend that what makes a therapist intuitive is a high degree of sensitivity that enables the therapist rapidly to perceive nuances in the interpersonal process and, on the basis of extensive experience, to translate these into valid deductions. Not all persons, however, would be capable of doing this, irrespective of the extent of training and experience. The intuitive aspects of the Stekelian system, therefore, would be limited to a restricted number of "intuitive" analysts, who could hypothesize constructs with a high degree of probability. A less intuitive analyst who tried this would indulge in guesswork that might be disastrous to the therapeutic objective because it would foist faulty interpretations on the patient. To use Stekel's system effectively, then, the therapist required an extremely high degree of analytic training, an extraordinary flexibility in personality, a deep sensitivity that would enable the perception of nuances, and, above all, good judgment, which would permit the judicious employment of active procedures.

At the present time, Stekelian analysts are not organized into a special analytic school. There have been many modifications of the Stekelian method as Stekelian analysts have introduced into their work contributions from various other psychiatric groups.

THE "CHARACTER ANALYSIS" OF WILHELM REICH

The basic theoretic orientation of Wilhelm Reich at first followed along the lines of Freud's earliest formulations of the libido theory. This contended that neurosis was due to a conflict between repressed instinctual desires—usually infantile sexual desires—and ego-repressing forces. The resulting conflict produced a stagnation of libido that was converted into anxiety and that subsequently engendered neurotic symptoms or neurotic character traits. Therapy involved the making conscious of unconscious conflict in an effort to liberate strangulated libido. Defensive forces of the ego, however, acted as resistance to the return of the repressed. Before unconscious elements could be restored to awareness, it was essential to eliminate resistances. Through interpretation, patients were helped to see how their resistances operated, their nature and purpose.

Character formation was conceived of by Reich as a kind of psychic armor that protected the individual from the disturbing stimuli of the outside world and from inner libidinal strivings (Reich, 1927, 1928). During psychoanalysis the patient's character served the interests of resistance against the repressed. Before one could tap the unconscious, therefore, it was essential to break down "character resistances" until the individual was denuded of defenses that barricaded repressed material. Character resistance revealed itself in attitudes and behavior toward the analyst and the analytic situation. Reich, in his book, *Character Analysis* (1949), described the analysis of resistance, including character resistance, and he insisted that this was necessary before the patient could accept and integrate the content of the unconscious.

Four main types of character defenses were apparent. First, the *hysterical character,* fashioned by a defense against incest, was manifested by a passive-feminine orientation with subversive expressions of sexuality at the same time that an open avowal of sexual interest was avoided. Second, the *compulsive character,* determined by a defense against sadistic and aggressive impulses, displayed a penchant for orderliness, cleanliness, and thriftiness. Third, the *phallic-narcissistic character,* conditioned by a defense

against passive-feminine tendencies, exhibited a cold, arrogant, and derisively aggressive manner; active homosexuality and schizophrenia could develop in such individuals. Fourth, the *masochistic character,* which was sponsored by a defense (substitutive punishment) against fantasied recriminations from the conscience, avoided anxiety by forcing others to treat him or her badly so as to be able to reproach them while experiencing self-damage and self-depreciation. The masochist wanted to be loved but disguised this in grandiose provocations of the love object.

Reich also classified character types according to how they managed to resolve the problems existing during earlier stages of their development. In terms of libido, an *oral-receptive character* existed as a sublimation of the earliest sucking stage; he or she was friendly and optimistic and looked upon the world and people as mothering objects. The *oral-aggressive character,* a sublimation of the oral biting stage, manifested itself in aggressiveness, envy, ambition, and a need to exploit others. The *anal character,* a sublimation of the anal period, was pedantic, overly clean, and miserly. The *phallic character* sublimated the phallic stage through cold, arrogant behavior. The *urethral character,* often showed symptoms of bed wetting and a burning ambition and was boastful about his or her achievements. The *genital character* was mature and capable of relating in an adult way to others.

Reich, like Trigant Burrow, pointed out that body tensions were evidences of emotional states and reflected characteristic ways of reacting. Posture, gait, facial expression, and other muscular manifestations revealed certain resistances and had to be attacked by calling attention to them before formal analytic procedures could be effective.

Although the theoretical basis for Reich's method has been discounted by many analysts, the techniques of character analysis have proven themselves to be invaluable. Followers of the "dynamic-cultural" school, particularly, find the analysis of character vital, apart from its resistance-disintegrating virtues. Emphasis is placed on the neurotic nature of character trends, analysis of which constitutes a chief objective rather than a means to deeper repressed material.

Reich, however, coincident with his reported discovery of a "cosmic substance, orgone" tended later to depreciate his contributions on character in favor of a newer "physiological" orientation to therapy (1942). The establishment of orgastic potency was felt by Reich to be the most important goal in therapy.

He described the therapeutic process as a consecutive loosening of the character armor, a breakthrough of repressed and affect-laden material released by activation of infantile sexual conflicts, a working through of infantile genital anxieties, a dealing with orgasm anxiety, and, finally, a developing of full orgastic potency. Character analysis in itself, however, he claimed was incapable of achieving the desired goal of orgastic potency. This was because another form of armor besides character armor shielded the unconscious. This was "muscular armor," which, in the form of chronically fixed muscular attitudes, increased tonus and rigidity and shielded components of sexuality and aggression from awareness Therapy, to be effective, had to provide for a loosening of the muscular armor.

These new ideas made necessary a reformulation of his hypothesis. Character was developed from a binding of "bio-energy." Therapy remobilized "bio-energy" from character armor through character analysis, and from muscular armor through "vegetotherapy." The resulting liberation of emotions produced a mobilization of "orgone energy," which vitalized orgastic potency. This was "orgone therapy," and it reached the biological depths of the human being, bringing an awareness of both organ sensations and muscular armoring, with an eventual destruction of the armor, a reestablishment of "plasma motility," and an appearance of "orgasm reflex."

In orgone therapy the muscles of the patient's back, chest, jaw, abdomen, and extremities are pressed firmly by the therapist to elicit emotional reactions and to liberate associations and memories. The patient's reactions are then interpreted. Sometimes the therapist imitates the patient's mannerisms of behavior or encourages "acting-out" tendencies. Verbalization of fantasies, memories, and feelings associated with the "muscular armor" is said to dissipate the armor and to allow the patient to deal with direct impulses, of which the muscular manifestations are defenses and resistances.

Although character analysis has gained wide acceptance among many analysts, the validity of the theory and technique of orgone therapy is generally considered controversial; it is currently practiced under the term "vegetotherapy" (Konia, 1975). Alexander Lowen (1958), while breaking away from some formulations of Reich, has elaborated his own techniques of releasing energy through muscle activity ("bio-energetics") and thus relating character disturbances to muscle armoring.

ADAPTATIONAL PSYCHODYNAMICS AND PSYCHOANALYSIS

A biologically oriented theory of human behavior has been developed principally by Rado (1939, 1949, 1950, 1956, 1962), Rado and Daniels (1956), Kardiner et al. (1945), and D. Levy (1956). It deals with the functions of the ego and the mechanisms that are involved in the process of adaptation.

Essentially the theory purports that the individual is constantly in a state of shifting homeostasis. Physiological drives and social needs must constantly be satisfied in order for the organism to survive. Unfulfilled strivings generate tensions and upset the homeostatic balance. This gives rise to a series of mechanisms, which Kardiner calls "action systems," conditioned by past successful activities toward satisfying the same drives and needs. As gratification takes place, emotionally charged memory traces are recorded that will later be activated when homeostasis is again upset. At the same time, feelings of mastery bolster the self-image. "Perception of the sources of stimulation changes according to the degree of gratification and comfort which has been achieved" (Karush, 1961).

Rado's structural model of adaptational psychodynamics introduces several gradations of psychological defense associated with different levels of nerve integration. The most primitive, the "hedonic" level, which phylogenetically antedates all other levels, deals with pain and pleasure and is activated by physiological and instinctual tension states. The second division is the "emotional" level, which registers itself in four basic effects: rage, fear, grief, and love. This is a more advanced phylogenetic level and is associated with greater capacities in the organism to alter his or her environment. The next stage of integration incorporates the cerebral cortex and replaces emotion and "emotional thought" with higher-thought "self-attributive" processes. This supports the ability to anticipate and organize means of attack or withdrawal. The emotional and thought levels constantly intermingle. Feedback occurs among all three levels of defensive integration. Stimulation of pain thus arouses the hedonic level, but it also activates the emotional and thought levels. This permits anticipatory and adaptive reactions.

According to Rado, neurosis is the product of faulty responses of the organism to danger registered as "failures in emergency adjustment." A signaling arrangement, evoked by any kind of pain threatening the organism or by the anticipation of pain, is the basis for the development of "emergency behavior." Of all motivations, emergency behavior is the strongest: it takes precedence over any other motivation. In disturbed emotional states, however, this rule may be violated.

On the "hedonic" level of organization, pain evokes the "riddance response" in the form of physiological reactions to rid oneself of offensive agents. Vomiting, diarrhea, spitting, sneezing, and coughing are manifestations of these reactions. The psychic correlate of the "riddance principle" is the mechanism of repression. Fear and rage are conditioned by an anticipation of pain. They warn of impending damage, and they inspire protective responses of flight (in fear) and of fight (in rage). On a social level, flight may be into dependency relationships with, and submission to, authority; fight may be expressed in terms of defiance of authority. On the level of "emotional thought," emotions are tempered to some degree with ensuing apprehensive and angry thought patterns. Discrimination and analysis promote greater flexibility of performance. The person is still subject to escape and combat mechanisms, however, in response to painful stimuli. Basic emergency reactions on the level of "unemotional thought" are controlled to some extent by the intellect. There is an advance detection of threats to the organism with an appraisal of its powers to cope with the threats. On the highest or "self-attributive" level, heightened pride accompanies rage responses or awareness of self-strength, while diminished pride follows fear reactions or awareness of self-weakness.

The development of the individual's conscience issues out of disciplinary rewards and punishments in relation to parents. Fear of punishment and the restraints it inspires become automatized, and in adult life continue in force. Obedience and the moral pride consequent to it also persist as adaptive patterns. Fear of one's conscience is a residue of fear of parental punishment.

Temptation may release rage and defiance, however, which, by overwhelming the fear of one's conscience, may drive the individual to disobedience. A fear of condign punishment may then eventuate for such defiance. This may lead to a desire to reinstate oneself. Defiant rage, consequently, may be turned inward with self-reproach, confession, remorse, and pleas for forgiveness. The hope is to be restored to the good graces of the parents. This expiatory pattern may become fixed so that the individual seeks forgiveness by self-punishment. More pernicious are the phenomena of self-punishment for imagined guilt and of advance painful punishment as a release for gratification of forbidden desires. Sometimes rage breaks loose with an abandonment of self-reproach and an attack on the person who is feared.

Failures of emergency control may be caused by an overproduction of fear, rage, and pain. Resultant

are overreactions to existing danger and emergency responses in the absence of real danger. An overproduction of emergency emotions may express itself in an outflow of emotions. To stop the overproduction, the organism may have to resort to repression and other automatic "riddance" mechanisms. All disordered behavior is the consequence of such failures in emergency adjustment.

Rado, in his later contributions, has continued to stress that the human being is by nature equipped with a survival mechanism that operates through patterns of adaptation. These change with age in both strength and form. Schematically, the period of youth is characterized by dependent patterns; the adult period, by patterns of self-reliance; the period of aging, by patterns of declining adaptation. In early life survival dictates subordination of inner desires to parental demands. Tactics to mollify or to deceive or to coerce, and expiatory and aggressive modes of coping with actual or anticipated rejection, may be evolved. Cravings for magical fulfillment of dependent needs occur with refusal to accept the reality of limitations in parental powers. Civilization dictates a taming of the child's rage response, and disciplines are imposed by the parent to contain the child's reactions and to bring them under control. The mechanism of conscience is built up on the basis of these conditionings, and it helps in fostering the development of responsible independence. This sponsors emergency control, realistic thinking, and behavior replacing emotional thinking and activity; self-reliance displaces dependency.

The implications of adaptational psychodynamic theory for treatment stem from its stress on ego functions. This supports the contention that all material uncovered in analysis must be related to current problems of adaptation. In an emotional matrix of "welfare emotions" (love, compassion), controlled by reason ("adaptive insight"), therapy is directed toward supportive, reeducative (reparative), or reconstructive goals depending on the patient's level of motivation. Four categories of motivation are apparent that will determine what kind of technical processes are best adapted to the individual. These motivational forms are allied to stages of personality development (Rado, 1965). The first level, "magical craving" for an idealized parent, will make possible such suggestive techniques as hypnosis. The second level, characteristic of a somewhat higher stage of development, "parental invocation," also addresses itself to limited goals, permitting persuasive and educational measures. The third level, that of "cooperative striving," and the fourth level, of "realistic self-reliance," permit techniques geared toward reconstructive objectives.

It is possible through therapy to bring patients from a limiting motivation to one that is more mature. When the patient is motivated to develop, reconstructive therapy, which deals with inner conflict, may be employed with the objective of bringing the patient to the highest degree of self-reliance. A prime focus here is recognition and resolution of the patient's rage, expressed or repressed, as well as excessive fear of punishment. Awareness of how rooted present-day behavior is in childish experience and misconceptions is an essential ingredient in reconstructive therapy, although the value of memory probing and the focus on insight is questioned. During treatment the therapist constantly must be on the alert for regressive thrusts toward dependency, helping the patient return to a self-reliant motivation. Indeed, advantage is taken of the patient's dependency needs to promote emotional learning through educational tactics. The therapist constantly interprets the difference between realistic and infantile aspects of the patient's behavior in and out of the treatment situation. Rather than considering transference as a manifestation of the repetition compulsion as in classical theory, it is regarded as arising from the patient's reacting regressively (through a parentified relationship) to faulty emergency responses as a result of a present failure in adaptation (Ovesey, 1954, 1965). The tracing of the origins of faulty emergency reactions and the "emotional redefinition" of memories are aided by proper interpretations. Transference is handled by helping the patient to recognize that helplessness and anger in relation to the therapist are really directed toward past personages. The patient is encouraged to reproduce in memory the actual rage-provoking scenes "with the original cast," to be self-reliant, and to expand a realistic adaptation. Dreams are considered to be compensatory reactions to unresolved conflicts from the previous day, a "pressure gauge of the patient's latent emotional tensions." Activity by the therapist is encouraged, particularly in an educational role.

Critics of adaptational psychodynamics contend that, in their attempt to reinterpret Freudian formulations, adaptational theorists have succeeded merely in introducing further metaphysical concepts into the literature rather than in contributing to a greater understanding of psychodynamics. The active handling of transference is exprobated with the contention that self-reliance can be brought about more readily by a noncontributory and nonstructuring therapist. "Priming" the patient's reactions toward operating on a more mature motivational level is also disputed as more ego reinforcing than analytic and hence more in keeping with reeducative rather than reconstructive goals. On the whole, however, there is a general consensus that adaptational psychodynamics has introduced a fresh way of

looking at the phenomenon of adaptation. It has also evolved some special techniques for helping the patient arrive at distortions in ways of relating. Particularly interesting is its approach to sexual problems such as homosexuality, cravings for omnipotence, and strivings for power and dependency (Ovesey, 1954, 1965). Rado's adaptational theories have been utilized as a means of approaching studies on the brain physiology of behavior (Heath et al, 1974).

The theoretical concepts of the adaptational school of Rado have been taught at the Psychoanalytic Clinic for Training and Research at Columbia University.

THE "DYNAMIC-CULTURAL" SCHOOL OF PSYCHOANALYSIS

Freud's theoretical speculations were originally based on the investigation of symptoms and other "ego-alien" phenomena. During psychoanalytic treatment the consideration of resistances and the mechanisms of defense focused investigations on certain "ego-syntonic" transpirations, such as character manifestations. Concentration on dynamisms employed by the ego in its adjustment led to the development of "ego psychology." The contributions of Reich (1949), Fromm (1932, 1936), and Anna Freud (1937) have been utilized by sociologically minded professionals, who, forming what has come to be known as the "dynamic-cultural" school, have made a significant contribution to ego psychology.

This school is characterized by a shift in theoretical emphasis from biological to sociological events, from concern with past experiences to the patient's present-day contacts with people, from consideration of the vicissitudes in sexual development to character patterns that, though of early origin, influence current interpersonal relationships, from preoccupation with fixations of libido to concentration on growth and maturation.

It is the contention of the "dynamic-cultural" school that Freud (1947) confused cultural phenomena with biological instinctual manifestations. Challenged also is the sexual nature of infantile urges. Orally centered activities of the newborn infant, for instance, are believed to stem not from an urge for erotic satisfaction, but rather from the fact that the mouth and the cortical area governing the mouth are more highly developed at birth than any of the other bodily areas. The oral zone, consequently, serves as a primary means of contact with the world. The shift of interest to the anal area is regarded not

as a biological transfer of libido to this locality, but as a pattern characteristic of the emphasis put on toilet training in Western civilization. Instead of pleasures in fecal retention or excretion, the focus is put on struggles with parental disciplines. The phenomena of the latency period are also said to be culturally determined, in that field studies of anthropologists demonstrate the absence of a latency period in some societies. The Oedipus complex is regarded as a neurotic reaction, a consequence of incongruities in a monogamous patriarchal society. Sexual feelings in the child for the parent are excited when neurotic needs cause the parents to overstimulate and overfondle the child. The child's responses are provoked by attitudes of the parents, punitive or disapproving reactions precipitating exaggerated fear of the loss of love and terror of castration. Penis envy is explained not by a craving on the part of the girl for a penis, but rather by the desire for privileges that masculinity awards the individual in our culture. The child's reactions during puberty are also determined by cultural factors. For example, homosexual interests are much less where boys and girls are freely allowed to relate to each other. The resentment a girl feels at accepting her femininity is stimulated not by a need to renounce interest in being a girl or in transfering clitoral to vaginal pleasures, but rather by pressures and demands put on her by the environment because she is a girl. Experiential and sociological factors, rather than biological influences, are thus regarded of prime etiological importance in conflict formation. Fundamental to a human being is an inner urge to fulfill potentialities and thus achieve "real self." The individual is blocked, however, in reaching his or her goal, both by destructive factors in personal upbringing and by repressive elements in the environment that put a taboo on certain traits, such as lovingness and tenderness, and that encourage other traits, such as hostility and aggression, that may alienate the individual from others and from self.

The "dynamic-cultural" school accents character structure above all other aspects of personality. Character, the fusion of conditionings with the constitutional makeup, is organized in complex behavior tendencies that regulate one's relationships with other people and the environment. Most character strivings pattern themselves around the demands of the culture as vested in the disciplines, prohibitions, and commands of the parents. Among their aims is propitiating needs for security and self-esteem. Tension and anxiety may result should a character drive fail to function or should one important drive conflict with another. Distorted character drives make for defects in interpersonal relationships and oppose normal biological and social needs. In this way, they are considered by the dynamic-cultural school to be the core of the neurotic process.

Erich Fromm (1941, 1947, 1950, 1955, 1959a, b, & c) contributed to the dynamic-cultural school a view of human behavior from the perspective of social psychology. Unlike Freud, he did not believe that there was an essential disparity between the individual and society, that human nature was evil in essence, or that civilization was the product of the sublimation of instincts. Personality, though circumscribed by human biology, is not created by it. Individuals, according to Fromm, reflect the values of their society. Since their needs are economically dependent for fulfillment on interaction with others, individuals must pattern themselves by, and their character structure then reflects, the conditions under which they have to live. They must give and take, "buy and sell" by the rules of their social system. Modern industrial society resists any attempt to impose on it a rational order. This mobilizes aloneness and helplessness in the individual that forces the adoption of such psychic mechanisms as destructiveness, sadism, masochism, and conformity, through which the individual attempts to relate to people and to the world. A person's relationship with society, the basis of one's conflicts, is never a static one: it is constantly changing with the social process. Traits, such as drives for power and puritanism reflect this change. This is why "human nature" has shifted in its form at different historical epochs. A person, Fromm insisted, is not an innocent victim of sociological forces: his or her energies are constantly molding society to the special needs of one's personality.

Inherited behavior patterns are present in lower animals, but such behavior has been replaced in higher animals by learned patterns. Inherited drives, such as hunger and sex, are present, but the extent and means of their satisfaction is determined by the culture. Moreover, the culture creates new needs that may be more powerful than biological needs, for example, loyalty to one's country or religious piety. Unlike other animals, a human being is both blessed and burdened by a sense of awareness. The capacity for symbolization enables a person to store past experience and to project beyond the range of the senses into the future. The environment is so complex that one cannot be bound by the fixed solutions of instinct; reason and imagination are the chief means of adaptation. Yet awareness of one's helplessness in the massive universe and the inevitability of death imposes on existence a sense of futility and adds an "existential dichotomy" to the "historical dichotomy" (war, poverty, disease, etc.). One may rebel against contradictions of our society, or one may try to adapt by rationalizing or denying them, soaking up the ideologies of the ruling classes who have a stake in maintaining the status quo. To establish one's equilibrium in the face of conflict stirred up by this inescapable dilemma, the individual reaches for a

frame of orientation in some philosophy or for devotion to some religion, supernatural or secular. This enables the individual to relate more easily to the world, to people, and to self. Instead of religion being a universal neurosis, as Freud believed, neurosis becomes a kind of personally designed, disorganized, and potentially disorganizing religion.

Social forces thus encourage irrational mechanisms in a person's relationships with the group and promote the isolation of the person from others. A primary need is for closeness with, and approval from, a significant individual. Fear of disapproval from this individual, as originally was the case with the parental agency causes the person to deny or to repress any feeling, impulse, attitude, or reaction that inspires disapproval, no matter how constructive or important it may be. A number of character strivings are elaborated to cope with the reactions of the significant parental figure. Fromm conceives of character types as rooted in certain fundamental attitudes, such as dependent, masochistic, exploitative, (aggressive, sadistic, power-driven), hoarding (meticulous, pedantic), marketing (opportunistic), and productive (loving, mature), conditioned by experiences with parents who exerted a specific influence over the child that led one to develop these attitudes as security mechanisms. Basic anxiety issues form a conflict between a need for approval from a parental figure and a need for independence.

Fromm emphasizes the value in therapy of discovering what healthy aspects of self have been eliminated as a result of environmental restriction or condemnation. The therapist helps the patient to understand and to rectify the need to cling to irrational authority, with the end result of encouraging a character organization that permits the patient to relate to the group in a healthy and productive way. Learning the difference between rational and irrational authority through the relationship with the therapist is the essence of the therapeutic process. This releases the patient's potentialities for fulfillment through relationships with other human beings; it resolves neurotic strictures on productivity and creativity. The goal of psychotherapy is not too different from that of a constructive religion. The latter, an affirmation of a human's faith, which is a basic requirement for human existence, like psychotherapy encourages self-actualizing tendencies. Psychotherapy and religion are thus mutually compatible rather than antagonistic, since they both strive to remove blocks to loving and to being loved.

School of Karen Horney

Karen Horney played a unique role from many standpoints in the history of psychoanalysis. While appreciating Freud's contributions, she was among the first psychoanalysts to organize and present her theoretical objections based on her dissatisfaction with clinical results. She led the way for the first expansion of American psychoanalysis beyond the orthodox view into other schools of psychoanalytic thought.

Horney viewed neurosis as a special form of human development that, because of the resulting waste of constructive energies, made it antithetical to human growth. Growing in a healthy way meant to Horney the liberating of those evolutionary constructive forces inherent in every human being that urge each one forward to realize given potentialities (the "Real Self'). No matter how impressed we may be with evidence of pathology, we must never forget, however buried or inactive they may be, these potentials for healthier growing.

This optimistic, positive, life-affirming approach led to Horney's concept of "a morality of evolution." Rather than seeing humans as by nature sinful or ridden by primitive instincts that must be tamed, each person is seen as neither good nor evil but with the moral obligation and privilege of evolving toward self-realization by ever-increasing awareness and understanding of oneself, by being truthful to oneself, active and productive, relating to others in the spirit of mutuality, and assuming responsibility for oneself (Horney, 1950).

In her early emphasis on the role of culture, Horney felt that neurosis must be viewed sociologically as well as psychologically since each culture determines its norms, which vary within the culture temporarily and according to sex and status. People are considered neurotic to the degree to which they deviate from the pattern common to their culture. At the dynamic center of neurosis is anxiety, much of which is generated by the culture. The four principal devices that we use to escape anxiety are rationalization, denial, use of narcotics and the avoidance of thoughts, feelings, and impulses that produce anxiety. Since the latter are so frequent and dangerous, they must be repressed, which leads to more anxiety (Horney, 1937).

The evolution of the neurotic process begins early in infancy as children begin to sense that they

are not being accepted for themselves. The actions and attitudes of the parents arouse a basic hostility that has to be repressed. This leads to an insidiously increasing all-pervading feeling of being isolated and helpless in a hostile world. This "Basic Anxiety," one of the essential concepts in Horney theory, is inseparably interwoven with the basic hostility and lies unconsciously at the core of the neurotic process (Cantor, 1967).

The child's normal experience of immediacy leads the child to organize behavior by moving *toward* others, *against* others, or *away from* others. How these functions are used depends on the shifting way the child feels about himself or herself. Healthy children who feel loved and accepted are able to move flexibly toward another person when they want contact or support. They are also able to oppose others when they feel their attitudes are respected. And they can move away to be alone (but not lonely) when they feel they can depend on themselves while alone, while depending on others being there for them when they return. These fundamental ways of relating can be spontaneous and interchangeable. They allow for a sense of integration and genuine satisfaction within oneself and in relation to one's environment.

To the extent that the child is operating under the lash of basic anxiety satisfaction based on inner needs, wishes, and feelings cannot be freely fulfilled. Directions for safety are pursued in ways that are compulsive, indiscriminate, and insatiable. These become rigidified into characterological attitudes (trends), each related to a specific aspect of the basic anxiety that is being overemphasized. Healthy moving toward people now becomes "compulsive compliancy" as the child accepts helplessness and tries to cope with it by clinging, submitting, and obeying. Healthy moving against others now becomes "compulsive aggressiveness" as the surrounding hostility is taken for granted and the child has to defy, attack, and rebel against others. Healthy moving away from others becomes "compulsive detachment" in which isolation is accepted as fact and the child tries to avoid either belonging or fighting by secrecy, uninvolvement, and distancing.

Since these ways of relating are no longer spontaneous or freely interchangeable, the child is now caught up in an interpersonal "Basic Conflict" between mutually exclusive, contradictory, compulsive drives, each absolute in their demand for fulfillment. Horney (1945) saw four kinds of automatic, unconscious attempts at solution of this conflict. First, the child may repress two of the drives while

streamlining the third in order to become predominantly organized around this one set of needs, qualities, sensitivities, and inhibitions in an attempt to achieve a sense of value and identity. This entails radical changes in personality, the development of a Gestalt, which, although Horney described it in specific detail, for purposes of simplicity, she cautioned was not an attempt at typology since there are no "pure forms." There are differing unique degrees to which one trend may be in the foreground. The other two, although in the background, subversively exert their influence. While the child attempts to deny the repressed trends, they continue to affect operating, manifested by contradictory thoughts, confusion, acting-out, physical, or psychological symptoms.

A second way of dealing with the "basic conflict" is to withdraw as much as possible from relating to others so as not to have to confront the conflict. To do away with the feelings of being divided, weak, and confused, a third attempted solution is unconsciously to create an "Idealized Image" of oneself. Through imagination the child becomes a conglomerate of an idealized person (the predominant trend). Compulsive submissiveness may become saintliness; compulsive disparaging of others becomes strength and honesty; compulsive detachment becomes independence. Glorifying the aspects of interpersonal conflict makes it temporarily possible for the child to combine the incompatibles into one apparently harmonious whole so that he or she can feel spuriously self-confident, superior, meaningful, and, above all, unconflicted: In her last book. *Neurosis and Human Growth* (1950), Horney expanded on the consequences of the "idealized image" as the essential intrapsychic process within the development of the neurotic; this will be discussed shortly.

The fourth attempted solution of the "Basic Conflict" is "externalization," the experiencing of inner processes as if they were external ones. This is more comprehensive than the term "projection," which refers to shifting blame and responsibility for subjectively rejected qualities. In externalizing, *all* feelings, including positive ones, are seen as externally derived. Externalizing is essentially an active process of self-elimination that creates further conflicts between the individual and the external world.

This unstable equilibrium designates what Horney called *"auxiliary* approaches to artificial harmony." These include

1. "Blindspots" to avoid seeing obvious contradictions

2. “Compartmentalization or psychic fragmentation” so that the differences in how the person lives simply seem to be parts of himself or herself that are not contradictory

3. “Rationalization”

4. “Excessive self-control” to hold back being flooded by contradictory emotions

5. “Arbitrary rightness” to eliminate doubt from within and influence from without

6. “Elusiveness”

7. “Cynicism” to deny and deride moral values so that nothing counts but appearances and not getting caught

Since conflicts can be resolved only by changing the conditions within the person which brought them into being, all the aforementioned attempts at developing a protective structure ultimately lead to further unsatisfactory consequences, for instance, to a multitude of fears that the tenuous equilibrium of the protective structure will be disturbed. These fears manifest themselves in fears of exposure, ridicule, humiliation, and, above all, of changing things within oneself. Further consequences of unresolved conflict are the impoverishment of personality through the waste of human energies, indecisiveness, ineffectualness, and inertia.

In addition, there is moral impairment as the person becomes less sincere and more egocentric. Substituting for authentic ideals are unconscious pretenses of love, goodness, interest, knowledge, honesty, and suffering. Along with this is unconscious arrogance in that the person may not be aware that he or she feels entitled to act demanding and derogatory toward others. Moral impairment makes it difficult for the person to take a definite stand. The person may become undependable since he or she has no appreciation of genuine responsibility. An ultimate product of unresolved conflicts is hopelessness, deeply rooted in the despair of ever being wholehearted and undivided. A person without hope may become destructive and at the same time make an attempt at restitution by living vicariously through others. This Horney saw as the basis of sadistic trends. Such a view of moral problems in neurosis and sadism is quite different from Freud’s views.

The culmination of all Horney’s previous works was contained in her volume *Neurosis and Human Growth* (1950). She focused on the “Real Self’ as that central inner force common to all human beings,

with a uniqueness in each that is a deep source of growth, sponsoring free healthy development in accordance with the potentials of one's individual nature. Homeostatic equilibrium is avoided by maintaining the imbalance of an open system that moves the person toward higher forms of order and organization. The "Real Self' is not a concrete entity but an abstract approximation, a direction toward which one can move to varying degrees were it not for the obstructive internal and external forces, past and present, affecting the individual.

In an attempt to find a sense of wholeness and identity, the person's idealized image becomes an "Idealized Self," which becomes more real to the individual than the "Real Self," not primarily because it is more appealing, but because it seems to answer all the person's stringent needs. The energies driving toward self-realization are shifted to the aims of actualizing the "Idealized Self," which molds the whole personality and may be entirely unconscious. Because it becomes a total plan of behavior around which a person organized all functions of life compulsively, Horney referred to it as the "comprehensive solution of the search for glory." With self-idealization as its nucleus, the search for glory has three essential elements: (1) the need for perfection according to the special features of one's "Idealized Image," (2) neurotic ambition, the drive toward external success, and (3) the drive for vindictive triumph to put others to shame or defeat them through one's success. The motivating force for the vindictiveness stems from impulses to take revenge for humiliations suffered in childhood that are augmented during later neurotic development.

To reinforce the search for glory, needs become "neurotic claims" that are irrational because they assume an entitlement that does not exist in reality. Demands are made without regard for the possibility of their fulfillment (e.g., claims to be exempt from illness, old age, and death). These claims are expected to be fulfilled without the individual making adequate efforts and must be asserted as one's guarantee for future glory. Vindictiveness is the response to their frustration.

Whereas neurotic claims delineate the search for glory in terms of the outer world, the person is simultaneously trying to become an image of perfection by a system of "shoulds" and "should nots," which Horney called "the tyranny of the shoulds."

For all these efforts, the neurotic does not get what is needed most—self-confidence and self-

respect—and is left with "neurotic pride," which is very vulnerable as it is based on spurious premises. Reality (the individual's "Actual Self' and how that person is empirically existing in the world) is always threatening to prove the falseness of the neurotic's "Idealized Self." The inevitable consequence here is "self-hate" with merciless self-accusations, self-contempt, self-frustration, self-torment, and self-destructiveness. Neurotic pride and self-hate belong inseparably together as one process, which Horney called the "Pride System."

Everything involved in the neurotic search for glory involves "alienation from self," something much more pervasive than feelings of unreality and states of depersonalization. All that is compulsive in neurosis moves the person further away from his or her "Actual Self," the material self (the body, and possessions), and especially the "Real Self." As long as neurotic pride dictates what one should and should not feel, one loses the capacity to be aware of real feelings, to direct life rather than be driven, and to assume responsibility for oneself. Alienation from self is also an active process to relieve the tensions created by the disruptive conflicts and unbearable tensions.

Alienation and the previously discussed approaches for artificial harmony are still only partial solutions. Something of an encompassing character is necessary to give form and direction to the whole personality, to deal with the *intrapsychic* conflict of how the person identifies with his or her glorified self or despised self. There are three *major solutions* to this conflict. These are to be differentiated from the three trends (compulsive compliancy, aggressiveness, or detachment), which attempt to solve the *interpersonal* "Basic Conflict." Here again Horney cautioned against the rigid usage of "types" since what we see are mainly mixed types. The major solutions are more properly directions of development that determine the kinds of satisfactions attainable, what is to be avoided, the hierarchy of values established, and how the person will relate to himself or herself and others.

Horney felt that curative forces are as inherent in the mind as they are in the body. The analyst's task is to give the patient a helping hand in sanctioning constructive forces of the "Real Self' that support an opportunity to grow. It is essential to help the patient identify on an experiential level the neurotic character structure, the complex defensive mechanisms, and underlying psychodynamic conflicts, as well as talents, capacities, and assets that have evidenced themselves in past and present life, including in dreams.

In the early phase of analysis the Horney analyst first addresses the patient's original motivations for therapy, which may be to remove a symptom, to dissolve the anxiety resulting from a conflict the patient is unable to resolve and that thus prevents living comfortably.

In quest of bolstering the Pride System and perfecting the Idealized Self the patient may have to be helped to build up healthy pride and to manage self-hate. Constant reminders enjoin that there is no magic cure, that intellectual "knowing" will not automatically dissolve difficulties, and that immediate relief cannot be obtained through "answers". Efforts are made to promote basic trust in the therapist in order to facilitate progress. The immediate objective is to deal with what is of most immediate concern to the patient. The ultimate objective is to consolidate emotional security, a functioning without pretense, and the putting of the whole of oneself into feelings, work beliefs, and relationships. The therapist engages the patient in diagnosing, prognosticating, sensing and measuring motivation and availability of resources for moving forward (Kelman 1971). How much one can do depends on the patient's ability to "let go" of some externalizing, rigid self-idealizing, and self-hate (M.B. Cantor 1976).

At the time of her death in 1952 Horney was still in the process of further formulating and extending her concepts about psychoanalytic therapy. Her colleagues and students at the American Institute for Psychoanalysis, which she founded, have continued her work along her basic lines, adding more current developments from recent findings in the biological, social, and physical sciences. Noteworthy have been contributions by Muriel Ivimey, Harry Gershman, Frederick Weiss, Alexander Martin, Jack Rubins, Harold Kelman, David Shainberg, Joseph Vollmerhausen, Ralph Slater, Morton Cantor, and Sara Sheiner.

School of Harry Stack Sullivan

By reporting on observable events in human interactions, Harry Stack Sullivan (1947, 1948, 1949, 1953, 1954, 1956) attempted to take psychoanalysis out of the realm of fanciful speculation and establish it in the empirical sciences. In fulfillment of this goal, Sullivan contributed original ideas about normal personality development, a theory of psychodynamics, and a body of technical procedures, particularly in the field of interviewing.

Emotional illness, Sullivan stresses, is both nurtured by and manifested through disturbances in interpersonal relationships. These develop out of frustrating early experiences with parents and other significant adults. Their effect is registered in interference with proper assessment of reality and suitable communication patterns. Aberrant reactions (parataxic distortions), which are elaborated to maintain security, bear upon all later reactions and lead to other accumulated distortions. Rejecting the libido theory, Sullivan tends to regard sexual disturbances as one aspect of interpersonal disorganization.

A basic factor that molds personality is the need to maintain a sense of well-being or "euphoria," loss of which is associated with tension and anxiety. Early in life the continuance or loss of "euphoria" becomes conditioned to approval or disapproval from parental agencies. To preserve "euphoria," the child imbibes the attitudes, values, and standards dictated by parental sanctions (these become personified as the "good me"), while inhibiting and dissociating traits and tendencies that meet with parental disapproval and punishment (which become personified as the "bad me" and especially an anxiety-provoking "not me"). Demands for social conformity cause the child to respond compliantly to avoid hurt, even though the child is confused as to the meaning of such demands. The "self-system" that is eventually established contains special anxiety-provoking aspects that, repudiated as alien to the self, are either tentatively suppressed or actually barricaded from awareness by repression. Reverberations of the "good me," "bad me," and "not me" influence everyday behavior and become exaggerated in neurosis. Startling personifications of these entities often become apparent in the psychoses.

An important function of the self-system is to reduce anxiety. This would presuppose a repudiation of the "bad me." When an activity charged with pleasure becomes equated with being "bad," however, the individual, to retain gratification, may become resigned to accepting the "bad me" as a worthy penalty for indulgence. The "not-me" personification is, however, too devastating to permit acknowledgment; experiences that relate to it are dissociated or repressed, appearing only in dreams or during the dislodging of repression, as in psychosis. In our culture sexual behavior is especially forbidden in childhood and becomes a "not-me" experience, producing inhibitions in functioning. A vulnerable self-system hinges on opinions of persons significant to the individual ("reflected appraisals") or what the individual imagines their attitudes to be. While productive relationships later in life may alter some attitudes toward the self, a constricted self-system does not permit such rectification readily.

The various stages of development are characterized by the emergence of new aptitudes that increase the repertoire of the child's capacities, particularly those that regulate relationships with other human beings. Maturation, contingent on the inherent ripening of motor, sensory, and physiological functions, is stimulated by the need to avoid anxiety. Provided it is not too strong, anxiety, consequently, is to some extent a positive stimulant that encourages personality growth. Intense anxiety, on the other hand, paralyzes learning and fosters neurotic defense mechanisms. While a human being is an animal at the mercy of biological needs, human development is shaped almost exclusively by cultural forces. Unlike other animals, humans participate in cultural interchange with their fellow creatures. The vehicle of such interchange is communication. The communicative process, to a large extent nonverbal, begins immediately following birth when the child experiences the closeness and tenderness of the mother. A milieu of empathy embraces both mother and child.

Being both a biological and cultural creature, the child is motivated to pursue biological goals in gratifying such demands as for food and freedom from pain as well as cultural requirements and satisfaction of personal security needs. These become increasingly complex with the growth of the child. They have to do not only with disposing of anxiety, but also with maintaining self-esteem, status, and approval. Sexual needs are secondary to the need for acceptance. Need tensions give rise to goal-directed strivings that, if successful, result in "integrating" or "conjunctive" activities ("dynamisms"); if they are not successful, they result in "disintegrating" and "disjunctive" solutions that augment tension and create conflict and anxiety, particularly when security needs are frustrated. Integrating dynamisms may employ bodily zones (eyes, mouth, ears, anus, urethra, genitals) through which the individual interacts with the environment. During infancy the child, not recognizing himself or herself as separate from the environment, experiences a kind of cosmic identification ("the prototaxic mode"). Later the child relates events serially rather than logically ("the parataxic mode"). For instance, thunder occurring simultaneously with the closing of a door creates the idea that the door caused the thunder. Parataxic reasoning, while present to some extent in adjusted people, may become pathological, as in autistic and paranoid thinking. The last stage of development is that of logical and rational thinking ("the syntaxic mode"). Residues of the prototaxic and parataxic modes persist in all persons, contaminating rational thinking.

When anxiety is not adequately controlled, it may disrupt the learning process. The self-system

becomes constricted through concentrating on reducing anxiety rather than on expanding the potentials of the individual. Anxiety is always generated in an interpersonal frame, usually because of feelings of low self-esteem and fear of disapproval from real or imagined personages. It may not be reality determined but be conditioned by prototaxis or parataxic modes of thinking. When it occurs, it sets into motion operations toward its reduction or elimination. To forestall anxiety, the individual develops techniques of gaining approval and avoiding disapproval, for instance, by recognizing and responding to cues such as "forbidding gestures" as anticipatory to disapproval. Anticipatory cues, in neurotic conditions, may be generated from within when prototaxic or parataxic modes come into play. The individual may consequently react as if self-esteem is vitiated or as though he or she has incurred disapproval, even when apparent reasons are lacking. An aura of disapproval often invests certain childish exploratory and pleasure activities, for instance, thumb sucking (an important means of gaining self-satisfaction as a substitute for the nipple) and genital and anal exploration. Disapproving gestures from the parent may imbue these operations with anxiety and lead to their inhibition. The self-system operates to reduce anxiety by defensive processes of selective inattention and dissociation, distorting awareness and blunting reactions to events and people. In this way the self-system circumscribes the creative potential of the individual and fosters the neurotic process.

As the child matures and is expected to adapt to the demands of society, the integrity of self-system and the degree of anxiety harbored will determine the measure of how he or she adjusts, sublimates, subdues fear, manages anger, and handles contradictory standards in the culture. When anxiety is not too great and opportunities are propitious, much constructive learning and relearning can occur. This is particularly the case during the juvenile period (5 to 9 years of age) when the child is exposed to compeers, with whom one competes, and teachers whose attention he or she must learn to share. Experiences of cooperation, compromise, belonging to an in-group and out-group, and competition expand the self-system, increase facilities for dealing with people, and promote greater introspectiveness and self-criticism. Around the preadolescent period *(8V2* to 12 years) there is a blossoming of the capacity to relate and love. Nonsexual intimacies with members of the same sex are the rule, and an interchange of ideas, experiences, and values in the medium of a warm relationship expands the child's horizons. With the maturing of the sexual organs, minor discursive explorations of the opposite sex occur, but the child returns to same-sex friends for safety and companionship. Toward the end of the

preadolescent period there is characteristically experienced a strong emotion of loneliness as feelings of separation and distance develop toward friends who are also in the process of breaking away from their preadolescent ties.

With genital maturity the stormy period of adolescence begins. New and complicated adjustments are required. For one thing, the upsurge of sexual feelings ("lust") may drive the youth to express them with or without true interpersonal intimacy. Emergent are a host of responses— fulfilling, frustrating, productive, neurotic—that reflect residual patterns. Masturbation with all of its attending associations becomes a way of relief, indeed, it may become a chief means of dispelling tension. When relationships with the opposite sex are invested with anxieties that are too strong for resolution by the self-system, the youth may retreat to the safety of same-sex intimacies, releasing sexual drives in homosexual affinities. A chief reason for such anxieties is conditioned disgust and shame related to one's own genitals, which produces loathing and fear of opposite-sex genital organs. Homosexuality is thus more than a sexual problem: it is a disturbance that invests the total personality, making relationships with the less frightening genital equipment of the same-sex members more palatable. Other sexual deviations may similarly be regarded as selective responses to anxiety.

Complementing the need for sexual adjustment is the ubiquitous adolescent struggle for independence in an economic world that necessitates dependency on parents. Conformity and a need to please alternates with rebellion and a need to disobey. Insurgency, though punished, serves the end of imagined personal freedom. Obsequiousness, however humiliating, fulfills security needs. Caught in this conflict, the youth begins to question the values and standards of society to which he or she has been dedicated. Bursts of religious and philosophical interests, concern with ethics and morality, persistent questioning and self-searching constitute the stormy process of growing up, a goal unfortunately that many adolescents never reach, although physically they may mature into adults. Such "chronic adolescents" travel through life as discontented rebels, constantly trying to find peace and the meaning of existence in a world of frustration that provokes feelings of being misunderstood. Adolescents who are successful in attaining maturity display harmony between their inner selves and the demands of their group. Self-respect and the ability to relate intimately, lovingly, and cooperatively with others are the end result of successful group interactions.

Interpersonal relationships are determined by the many characterological traits that the individual has elaborated as consonant with or alien to the self. Some "parataxic distortions," reflecting attitudes toward significant past persons, are automatically projected into all interpersonal relationships.

The psychotherapeutic interview is an interpersonal experience in which the therapist as a "participant observer" engages with the patient in a joint effort to examine difficulties in relating as they are reflected in the therapist-patient encounter and in the patient's interactions in general. In his volume *The Psychiatric Interview* (1954) Sullivan delineates a variety of techniques. Essentially what is important is to help resolve the patient's anxieties in order to overcome avoidance patterns and to release learning potentials. Learning requires that the patient understand his or her behavior in conceptual terms in order to evaluate it accurately. Patients come into therapy with a number of assumptions that may block their effective use of the therapeutic situation; for example, they may assume that they should not need help, that they should be at all times governed by logic, that they should not be ruled by the difficulties of their early life; and that they must at all times be self-sufficient and independent. These assumptions will require clarification. A wide range of problems may be reviewed: areas of "selective inattention," dissociations, parataxic distortions, false personifications, and inaccurate perceptions of one's behavior or anxiety. The area of focus will be the particular complaint that concerns the patient most. The therapist is alert to inappropriate self-evaluations, inaccurate identification of events, perceptual distortions, and other neurotic patterns that come out during the interview. Once patients commit to therapy and agree to report on their thoughts, they are encouraged to talk about their perceptions, ideas, feelings, and acts in relation to people and to themselves. Areas of difficulty (anxiety and anxiety avoidance) are spotted by the therapist and are bracketed to customary interpersonal reactions. An attempt is made to establish a consociation of events in order to conceptualize them as accurately as possible. On the basis of this understanding, the patient eventually will discuss plans and make appropriate changes in behavioral patterns outside of therapy.

The initial phases of therapy are concerned with the establishment of a diagnosis and the estimate of the tentative prognosis to determine whether therapy can have a constructive influence. Rather than establishing a sterile diagnosis, the therapist appraises the existing problems in living and the assets of the patient in contrast with liabilities. An estimate is then made of what may be accomplished by psychotherapy. Once the probable effectiveness of psychotherapy is decided, a systematic inquiry

follows. The developmental history is examined in relation to current areas of anxiety, the prevailing anxiety-avoidance responses and security operations, and the circumstances that bring these about. The therapist is sensitive to manifestations that appear within the therapeutic interpersonal relationship. When convinced that these reflect basic patterns, the therapist focuses the patient's attention on their nature and origins. A variety of questions probe pockets of anxiety. Hypothetical situations are posed, such as "How would you feel if your employer depreciated your services?"; and tentative interpretations are made, such as "I wonder if this doesn't make you want to run away?"

In the therapeutic encounter, as in any other situation, the patient acts out "parataxic distortions." Bringing these to the awareness of the patient helps the patient separate the present from the past and appreciate the attitudes and values that are a part of a self that he or she tends to repudiate. The origins, manifestations, and consequences of the patient's defenses are actively explored. The patient experiences emotionally what has been dissociated, and in this way is enabled to evaluate, toward their possible reacceptance, aspects of himself or herself that have been split off from awareness. While the current situation is actively considered, childhood experiences and conditionings are also constantly prospected in order to expedite separation of the past from the present. In these ways new and healthier interpersonal relationships may be constituted.

The management of patients in therapy is more flexible and active than in Freudian psychoanalysis. Thus, patients may assume a sitting or recumbent position; may use free associations or deal with specific aspects of their experience; and may work with present reality problems as well as early childhood memories and productions from the unconscious, such as dreams. The emphasis is on the character structure and problems in interpersonal relationships, although genetic origins are not neglected. Relaxation of the "basic rule" permits a focusing of the interview on significant material. The therapeutic situation is considered a real relationship that has values in itself in addition to serving as an arena for transference. The manner of the therapist, Sullivan believes, should never be stilted or blank; it should reflect the therapist's inner feelings, even though annoyance, irritation, or pleasure are mobilized. The skillful use of satire may be employed, where indicated. Even provocatively inaccurate statements may be presented to stimulate corrective responses from the patient. Exploited also may be a strategic shifting of the stream of thought into an unexpected area before the patient's defenses are mobilized.

Skill in interviewing, Sullivan insists, is dependent on the therapist's drawing the patient out by pointed questions, identifying parataxic distortions in the relationship, demonstrating the unreasonableness of the patient's reactions in view of what actually has been going on in therapy, speculating on whether feelings of a similar nature occurred in the past, examining the assumptions the patient is making through transference reactions, and exploring important past relationships associated with the origins of the patient's trends. Particularly important is the uncovering of dissociated systems that have been repressed because of their anxiety content. Here a frontal attack is useless since the patient's defenses can easily ward this off. Rather, slow and indirect interviewing may eventually uncover these systems. Skill is required in dealing with and circumventing the patient's verbal defenses, such as rambling about irrelevances. Sullivan recommends only brief questions and brief comments by the therapist while encouraging lengthy responses from the patient; long dissertations by the therapist are not in order. Clarification of communication is mandatory as is activity as a "participant observer, the therapist utilizing his countertransference in a constructive way" (Crowley, 1971).

Much of the theory and method of Sullivan are at present adopted by the William Alanson White School for Psychiatry, Psychoanalysis and Psychology, which is located in New York.

Criticism of the "Dynamic-Cultural" School

Criticism of the "dynamic-cultural" school stems mostly from Freudian psychoanalysts who regard the diversion into the sociological field a form of resistance against the biological-sexual hypotheses of Freud. This revolt against classical thinking is considered by some to be a manifestation either of unresolved transference in the "renegade" analyst, a product of an incomplete personal analysis, or a manifestation of an entrenched narcissism that spawns the evolvement of ambitious, albeit faulty, new systems. Others attack neo-Freudian concepts along conceptual lines. For example, Franz Alexander questioned Horney's attack on the libido theory on the basis that it substituted for the mystic biological substance of libido an equally empty sociological slogan of culture (Alexander F, 1940).

There is a general feeling among Freudians that sociological-cultural approaches are loose and myopic preconscious generalizations that deal with only one facet of human experience and do not consider the basic infantile sexual conflicts, which are the nuclei of neuroses. While analysis of character

is said to be helpful, it does not eradicate the deepest sources of conflict. Freudians contend that distortions in interpersonal relationships and defense mechanisms as a whole cannot be understood or helped unless we deal with their unconscious roots, a formality often overlooked or not considered essential in the methodologies of some of the neo-Freudians. Therapy conducted in accordance with principles of the dynamic-cultural school is, therefore, considered "superficial" and of reeducative rather than reconstructive influence. Particularly deplored is the discrediting of sexuality as a vital force in personality development by assigning it to its traditional place as a manifestation appearing with the maturation of the genitals. This retrogression to an atavistic conception of sexuality denies clinical findings that indicate that infantile sexual drives are present, powerful, and persistent, shaping not only the expression of adult sexuality, but the individual's personality as a whole.

Divergencies, it is claimed, are often more apparent than real; certainly this is so in technique. But even in theory, once the semantics are clarified, differences are more a matter of emphasis than of explicit contrast. A fine line of distinction may reside in the elaborateness of description by the neo-Freudians of the phenomenological nature and consequences of defenses and character traits. The generalizations drawn from these variances, however, are often expanded into global doctrines that seek to account for the whole of life. But what is even more confounding, it is claimed, is that some deviants from Freud tend to utilize the hypotheses and terminology of Freud whenever it suits their convenience. Indeed, there is a tendency to recast Freudian formulations in novel, excruciatingly complicated neologisms and to concentrate on nuances, torturing these into broad theorems that cannot possibly explain the complexities of behavior, while ignoring those psychopathological areas that do not fit into the renovated scheme of things. There is also a tendency on the part of some neo-Freudians to attack an orthodoxy that no longer exists, particularly among the younger psychoanalysts.

Criticism is also leveled at those, such as Harry Stack Sullivan, who decry the delving into the inaccessible and unobservable, insisting that the material for study be purely that which is apparent and demonstrable, such as interpersonal relationships. Yet such concepts as "self-fulfillment" and "self-actualization" border on the metaphysical and require postulates that remove them from the zone of science. To the charge of the neo-Freudians that classical hypotheses are farfetched, it is obvious in studying them, say the Freudians, that some of the concepts of the neo-Freudians vie for absurdity with the most fanciful contentions of the orthodox school.

To the neo-Freudians these charges are considered as further evidence of the basic intolerance of the Freudians. They are also branded as rationalizations for clinging to an outmoded theory that has lost its clinical usefulness. On the contrary, they insist, neo-Freudian theories support methodologies that expand the therapeutic spectrum to a wide group of patients not suited for classical techniques (Wolman, 1967; Marmor, 1968).

EXISTENTIAL ANALYSIS

Existential "analysis," a more depth-oriented approach than existential "therapy," is, as is the latter, rooted in the precepts of existentialism. This philosophy attempts to solve a human's apparently insoluble quandary through a search for the meaning of one's existence. It posits that only by finding purpose in one's life, even in the face of catastrophe, can one experience that true sense of "being" that fuses the physical, psychological, and spiritual natures. Such elements operating individually isolate humans from their selves and from the world; they sponsor a profound contradiction. For the spiritual self demands freedom, unlimited choice, and responsibility, while the psychological and physical selves dictate finite restrictions, restricting one to one's own endowment, past history, and conditionings. Although anxiety and despair are inescapable products of this "existential predicament," a human being has the capacity, responsibility, and the freedom of choice to deal with the disruptive forces that tend to unbalance an individual. The crisis in one's existence urges the individual onward toward some solution that is generally registered in terms of greater "self-realization." A human being cannot approach problems of existence solely through objective means, for example, the methods of science; what is required is a search for ultimate values that may be achieved only through moral, ethical, and spiritual means. Only then can one cope with one's ever present anxiety or resolve some of the riddles of one's identity, adapt to life's purpose, and accept the inevitability of death.

These concepts have been expressed in various ways over and over again as far back as the first philosophical speculative conceptions about the meaning of life. They were most clearly organized into a system by such philosophers as Søren Kierkegaard, Edmund Husserl, Martin Heidegger, Karl Jaspers, Jean-Paul Sartre, Martin Buber, and Paul Tillich, each contributing his own unique mode of viewing the nature of existence and the means by which a human being may solve its ambiguities. It was Husserl (1962) who was principally responsible for the "phenomenological method" of viewing the behavior of

a person without preconceived theories or notions of causation while describing phenomena as they were observed. This, with Heidegger's contribution (1962), served as foundations for the existential analytic approach which rapidly advanced in Europe largely because of the influence and writings of Ludwig Binswanger (1942, 1947, 1956) and Medard Boss (1957, 1963) and in this country Rollo May (1950, 1960). These authorities concede that, while biochemical, neurophysiological, and psychological mechanisms are important in describing the functions of the human organism, they cannot be dissociated from the existence of the experiencing individual and from the understanding of his or her ontology. Nor can one, as Buber (1937) has emphasized in his "I-thou" duality, conceive of humans as separated from other humans or apart from their world. Humans are shaped by their world and in turn fashion their world to bring it into focus with their needs.

By applying a phenomenological approach to the technical problems of psychotherapy, existential analysts claim to go beyond conventional ways of managing neurotic problems. This is not because their methods are different from, or superior to, those of other psychotherapists (since the techniques employed are essentially the same), but rather because they feel that they approach their patients from a more constructive and comprehensive standpoint.

Patients are generally encouraged to perceive of their behavior in the context of the "what" it is that one is experiencing rather than the "why." While the genesis of the individual's problem is considered important, as are the mechanisms of defense, they are regarded as only one aspect of the patient's "being-in-the-world." The crux is the functioning, experiencing person in the present. "Therapy, then, is not primarily an uncovering process, but a creative one. It is the self-making aspects of being that are in the foreground—one's decisions, commitments, and responsibility. The existential therapist is not content with the elimination of undesirable aspects of functioning, such as inhibitions, frustrations, and symptoms, but has the larger goal of the creation of positive values" (Basescu, 1963).

The patient-therapist relationship, unlike that of Freudian psychoanalysis, is predicated on activity. It is in essence an "encounter" in which both participants extend their "full being in the world of the other, without treating the other as an object subordinated to some purpose of one's own." This means complete freedom in mutual self-revelation and an openness in the therapist's approach to the patient, in which the therapist exposes himself or herself as a real person, not as the traditionally

tolerant authority. Unconditional acceptance does not preclude criticizing the patient for "self-imposed limitations on being. Patients are not innocent victims of circumstances. They have a responsibility for their own destinies, even to overcoming self-limitations. This requires resolution and fortitude, for if one loses one's courage, one loses one's being (Tillich, 1952). The active "encounter," in which the therapist engages with the patient without assuming an artificial and studied role, releases the "courage to be." As Tillich has remarked, "A person becomes a person in the encounter with other persons, and in no other way. This interdependence of man and man in the process of becoming human is a judgment against a psychotherapeutic method in which the patient is a mere object for the analyst as a subject."

In the conduct of therapy no preconceived theories are admissible. "There is nothing other than a person's definition of self for which that person alone is responsible. The work of therapy is the illumination of the person's view of the way things are (the personal myth) and the way in which that person's suffering incarnates that cosmology" (Ofman, 1985). The patient describes his or her "world of being" and the therapist shows nonjudgmental interest. What the patient does as a consequence of gaining increasing understanding is entirely left up to him or her. No pressure or manipulation is admissible. As the patient gains an awareness of personal myths that control his or her existence, modes of self-deception, and means of denial of personal autonomy and freedom, in short of the "self-created world of perpetual crises," he or she is helped by authentic relating with the therapist to avoid self-rebuke and spurious ploys and to assume complete responsibility for the distortions.

Essential, then, is a complete acceptance of the patient who is in the process of "becoming," irrespective of his or her behavior and problems. In the words of Martin Buber (1948), "conforming the other" means accepting one's potentialities as well as the person that he has been and is now, in the light of the capacity to develop, for "when something, no matter how imperceptible, happens between two men so that each becomes aware of the other and his world is related to him in such a way that he does not use him as his object but as his partner in a living event, the fact of this encounter can never be entirely eliminated" (Buber, 1957).

In the medium of such unadulterated acceptance various techniques may be employed, including psychoanalytic techniques. What is necessary at all times, however, is a unique kind of phenomenological observation during which the therapist comes to terms with the patient's (as well as the therapist's own)

problems of being human without preconceived and structured formulations. The therapist goes beyond *what* patients believe and perceive about themselves to *how* they experience themselves in the world.

The neurotic patient, sick as he or she is, first needs to be "cared for" by the therapist. Only as one grows strong in the relationship does one develop the courage to move toward ontological self-realization. The patient is helped by the therapist's extending to the patient a "humanness" in the relationship, a "being-togetherness," and a "standing-on-the-same-level-of-existence" through meaningful communication. During this process repressions blockading the sense of being are gradually lifted.

The existential system of analysis is oriented around the uniqueness of each individual and is not impeded by adherence to scientific determinism or the search for systematic regularity (Holt H, 1965). An understanding of human experience, including the human commitment to independence, freedom, and "being-in-the-world," is acquired most fruitfully by recognizing three types of basic experience: the biological body world ("*Umwelt*"), interpersonal relationships ("*Mitwelt*"), and self-recognition ("*Eigenwelt*"). A unification of these three is essential for a complete feeling of authentic existence (May et al, 1958). Unity in these three modes of existence is lost as a result of inescapable basic "ontological" anxiety (Burton, 1965). Integration of the different elements of self, essential for what Iago Galdston (1963) has described as a "healthy ontological thrust toward maturity," is achieved as the therapist moves into the patient's life and helps one experience oneself in terms of the universe around one, including the biological substance and instincts, the world of meaning in relation to others, and the private area of self. Binswanger implies that psychoanalysis deals with the first dimension, partly with the second, but not with the third, i.e., how the self relates to the self. On the other hand, existential analysis applies itself to all three modes and, in their liberation and harmonization, brings to the individual a true alteration in the sense of values and more positive purpose in relationships with people.

Essentially, existential analysis is an approach to *how* the therapist applies himself or herself to therapy rather than a technique in itself. The therapist conceives of the goal in treatment as the restoration of the patient to "bodily-togetherness-with-others-in-the-world."

The cornerstone of existential constructs are embedded in concepts of *will* and *decision* (May, 1960). The patient is at all times aware of free choice in perceiving wishes and in "willing" their fulfillment toward doing something about them. "This is the level of accepting one's self as having a world. If I experience the fact that my wishes are not simply blind pushes toward someone or something, that I am the one who stands in the world where touch, nourishment, sexual pleasure and relatedness may be possible between me and other persons, I can begin to see how I may do something about these wishes" (May & Van Kaam, 1963). In moving toward a better integration, the patient is helped to appreciate the forces of *decision* and *responsibility* "within a nexus of relationships upon which the individual himself depends not only for his fulfillment but for his existence."

The application of the existential philosophy to therapeutic process will vary with the therapist (Holt H, 1968, 1972b: Havens, 1972; Wenkart, 1972). In a number of important ways, however, we can detect a similarity in operation. First, there is a focus on the inner experience of the patient. Second, there is recognition that the therapist cannot remain aloof and detached from this experience, that the therapist is privileged to emote and to feel torments and dilemmas, many similar to those of the patient. In the ensuing encounter the therapist's feelings are bound to be communicated. This will foster engagement in sympathy, challenge, and confrontation at the same time that the relationship is exposed to investigation. What eventuates is the humanness of the therapist, the therapist's "being-where-the-patient-is," and empathy sharing the inner experiences and desperation of the patient. An emotional clash often occurs as empathy and understanding temporarily recede, and in the ensuing struggle new understandings occur and change is brought about both in the patient and the therapist.

Entering the patient's world and communicating with him or her deeply and humanely help to penetrate the defenses of sicker patients, such as schizophrenics. Experiencing the dissociated elements of the patient's personality is a potent force in their reuniting. "Because the existential therapist tries to stay with the patient, he must be willing to 'encounter' or confront aspects of the patient not so comfortably assimilated" (Havens, 1972).

Existential analysis has not been formalized into a special school, but it has attracted a number of followers, particularly those oriented toward the theories of Jung, Horney, Sullivan, and Fromm. The "third-force" movement of humanistic psychology is oriented around existential analytic ideas.

Criticism of Existential Analysis

A rift is inevitable between existentialism and traditional Western psychotherapeutic approaches that promote both objective scientific naturalism and subjective human psychology. Existential analysis "tries for insightful, intuitive and cross-sectional *descriptions* of the experiencing self," a kind of ontological unfolding (Opler, 1963a) sponsored by intuition, which is foreign to the training and ideologies particularly of the American psychiatrist and psychologist. Criticisms are consequently directed at existential analysis as being a "subjectivist melange" that avoids regularities in process and hence does not help us in arriving at a scientific understanding of how human beings function, get ill, and get well again. Western psychotherapists express irritation at the language of existentialism and accuse its practitioners of diffuseness in concepts and of depending for their therapeutic effects on faith and the profits of a helping relationship. Existential analysis is not considered to be "analysis," but merely a descriptive exploration of problems in self-realization. There is a feeling that existential approaches constitute a regressive movement, a throwback to a prescientific era from which the mental health field has painstakingly tried to liberate itself.

To an extent this intolerance is stimulated by an inability on the part of existential analysts to communicate adequately; the coining of new words and phrases without appropriate definition and clarification has been particularly confounding. To an extent the prejudice is due to sectarianism and a need to defend personal theories against all external assaults. We must remember that most of the therapists who have become attracted to existential analysis have been trained in dynamic and other systems with a scientific pretension. Ludwig Binswanger, for example, was a psychoanalyst and a close friend of Freud. A principal reason why therapists have turned to approaches different from those in which they have been schooled has been that they were disappointed with therapeutic results. In exploiting the existential method, many therapists claim to have found their work more successful and rewarding. This, of course, may be due to the affinity they feel with existentialism because of personal needs. A methodology that has significant meanings for a therapist will enable the therapist to relate more sincerely to patients, who will sense genuineness and then respond appreciatively to the therapist's efforts.

Therapists who practice existential analysis continue to utilize their old techniques on the basis

that traditional and existential methods are not mutually exclusive: they influence different aspects of the psyche, hence they actually reinforce each other. Whether or not therapists need to introduce into their modes of working stratagems from different systems is contingent on the systems' helping or hindering their functioning. All progressive psychotherapists incorporate into their operations techniques that yield for them the best results. Somatic therapies, tactics that expose the unconscious, maneuvers in interpersonal relationships, and devices that influence spiritual strivings and alter moral values are often blended into an eclectic framework that is applied flexibly to patients in accordance with their needs. If any approach enhances results, therapists may pragmatically incorporate it into their therapeutic armamentarium. Danger arises, however, from the tendency to overvalue any of the systems, including existential analysis. Many therapists cannot be taught maneuvers and attitudes essential for their functioning as existential analysts. They will then do better with approaches with which they feel more comfortable.

Actually, when we cut through the semantic persiflage and consider the goals and methods of existential analysis, we find that they differ little from those of other forms of psychoanalytic psychotherapy in which patients are encouraged to observe thoughts, feelings, and behavior in the context of their immediate experiences, not merely in terms of whence and why they arise. There is a focus on the present, which is regarded of primary importance in serving as a repository of the past. The patient's mechanisms of defense are considered to be aspects of the total behavior and meaningless in themselves. The objectives are not solely the relief of symptoms and intellectual insight into one's problems, but the utilization of understanding in the direction of change, particularly toward the altering of value systems to promote the greatest possible self-actualization. The relationship with the patient is predicated on measured activity. The therapist on occasion may reveal that he or she has some personal difficulties or that the therapist has made mistakes. Like other therapists, however, most existential analysts do not purposefully display their neurotic distortions or act out destructive feelings that emerge from countertransference. They do not consider their patients helpless puppets dragooned to everlasting suffering by an inimical past, but rather as active participants in perpetrating their neuroses. Patients have a responsibility in making constructive choices and in getting well. The presence of some anxiety is an inevitable consequence of personal and social conflict, even in healthy people, but existential analysts and seasoned therapists of other schools differentiate between grades of anxiety—

between productive and neurotic reactions to anxiety.

In short, a properly working psychotherapist incorporates into his or her system of therapy essentially the same essences of "meaning" and of method as a good existential analyst, or a good Freudian psychoanalyst, or a good neo-Freudian analyst. This presupposes flexibility in approach and full intelligence in the use of oneself in the therapeutic relationship. The language that therapists employ in describing what they do, and the theories they invent to explain why they do it, do not alter the fact that essentially the same healing processes will have to be implemented, or will spontaneously come into operation, if a patient is to get well.

OBJECT RELATIONS APPROACHES

Freud's early drive theory viewed psychopathology as revolving around the nebulous orbit of psychic energy. This explained some of the phenomena encountered in clinical practice, particularly in hysterical and phobic disorders. In working with pre-Oedipal problems, however, the limitations of the drive model became apparent. Attempts were then made to fill in the gap by appending to the instinct hypothesis theories of interpersonal relations. Finding this combination troublesome, some authorities dissociated themselves from Freud's early formulations while retaining his dynamic view that a multitude of motivational forces, originating in prior experiences and conditionings, operating harmoniously or in conflict, consciously or outside of awareness, express themselves in relationships with other human beings.

The direction of psychoanalysis shifted from the capriciousness of instincts to the regulatory operations of the ego and its defenses. The early work of Nurnberg (1955) on the synthetic functions of the ego, of Waelder (1936) on its multiple operations, of Anna Freud (1937) on its ingenious maneuvers to contain primitive drives, and of Heinz Hartmann (1958, 1964) on its transactions with the total personality, as well as of Fairbairn and other ego analysts, led to the enhancement of ideas about the ego and to what has become known as "object relations theory."

Fairbairn (1954), for example, evolved a developmental model that included many of the components of present-day object relations theory. His contention was that during the first two months of

life a child was emotionally fused with the mother. This "primary identification" with the internalized mother figure (the "object") had to be resolved and renunciated in the course of development if mature growth was to be achieved. Otherwise the ego (or "self') would not evolve from infantile dependence to normal conditional dependence with differentiated objects. The relationship with the mother had gratifying and enticing aspects, as well as ungratifying components. Internalization of the relationship into the "ideal object" (gratifying), the "exciting or libidinal object" (promising and enticing), and the "rejecting anti-libidinal object" (depriving and withholding) was accompanied by a threefold split of the ego from its binding to each aspect. Ego and object became inseparable.

If too much was incorporated of the "bad" exciting or rejecting mother, efforts to control and preserve relations with the real mother were prevented and the ego was unable to bind satisfactorily with the "ideal object." There was thus a splitting and fragmentation of the ego, interference in relationships with people, and tendencies toward psychopathology. The battle with the rejecting, depriving antilibidinal mother and the enticing, exciting libidinal object was carried on internally. The frustrated antilibidinal ego hated and attacked the libidinal ego as well as the exciting object, in this way perpetuating self-destructive, self-punitive behavior. As a result of this battle, hateful attitudes were produced that through transference were extended outward toward maternal representatives, including the analyst. Adjustment was thus compromised by the conflict between object-related libidinal desires, object-related antilibidinal, hateful impulses, and object-related idealizations. The threefold splitting of the ego helped the child maintain a good relationship with the mother but created a disunity that continued throughout the life of the individual. The "splitting" paradigm established with the mother followed through also with the father, and to complicate matters the resulting internalized paternal object was fused with that of the mother and the combination was then projected onto both parents. The continued need for nurturance fostered persistent dependency, which might be sexualized as a defense. The basic conflict that underlined all psychopathology, therefore, was dependency and not through the classical Oedipal situation. Failure in object relations in the early oral phase produced frustrated love and schizoid withdrawal; failure later during the oral biting phase contributed to one's hating one's parents and resulted in depressive manifestations.

Somewhat later, Fairbairn modified his ideas about how internalized objects were developed. He added the notion that since children had to maintain an illusion of the "goodness" of parents for their

own security needs, realization of parental seductiveness, rejection, nongivingness, or cruelty was repudiated or repressed by blaming inherent "badness" on themselves. The resulting "bad" internal objects, with which the ego identified (primary identification) to a greater or lesser degree, were repressed with the elaboration of such defenses as splitting and guilt to protect the ego. Attempts to work through painful memories and past experiences with the parents fostered a choice of love objects with similar bad qualities, encouraging disappointing outcomes. The individual through his or her own character distortions provoked rejecting and sadistic behavior on the part of parental surrogates, further aggravating the distress and convictions of hopelessness and despair.

The contributions of Winnicott (1965) revolve about the evolution of the self with speculations of what must be on the infant's mind during this process. The mother is conceived of as a physical and emotional "holding" environment for the child, who, if she has sufficient devotion and provides demonstrable caring, serves as a means of satisfying the child's illusions of power and sense of omnipotence, which in being gratified become the foundation for building of the healthy self. The mother also acts as a mirror, reflecting the child's own "personalizations." Inability of the mother to provide a reasonably "perfect" ("good-enough-mothering") environment usually interferes with the growth of self. Once a nucleus of "hallucinatory omnipotence" is established, further development of the self necessitates coping with limitations and frustrations in the environment and adapting to a loss of control. This is the second stage of development and encourages separateness from the mother. The use of "transitional objects" (blanket, teddy bear, etc.) over which the child can execute control and that allows the child to experience other people for what they are proceeding from "object relating" to "object usage," helps to ease the transition from total involvement with the mother to separation from her. Serious failures in this process of evolution encourage fragmentation and splitting of the self into a "true self' that becomes impoverished and a "false self that is artificially compliant and provides an illusion of security. The essential shifting from dependence to independence, from omnipotent fantasy to realistic thinking, is thwarted. Life thereafter is spent in searching for the missing parental provisions that should have existed in one's early development. The curative factor in psychoanalysis is that it can be conducted in an environment that can supply these missing emotional ingredients. Unlike classical analysis, in which the analyst does not allow regressive gratifications, Winnicott alleges that to liberate the self the therapist must function as a maternal caretaker.

In these early excursions in object relations theory there was no intention of abandoning the biological orientation of drive theory. The ego, though predominant, was considered a derivative of fundamental biological forces concerned with the maintenance of homeostasis. The Freudian dynamic, economic, and typographic models were in large degree retained while crediting to the ego greater autonomy from the id and better control over forces in reality (Hartmann & Kris, 1964).

This swing toward the ego was abetted by such developmental researchers as Margaret Mahler (1941, 1975). Early developmental theorists conceived of the infant as a helpless blob of palpitating flesh totally bent on needs gratification ("autoerotism," "primary narcissism," "absolute dependence") through an emotional umbilical cord. Severance of this cord was resisted desperately, and, because of maternal immaturity and faulty child care practices, sometimes never occurred. This accounted for the survival into adulthood of chaotic traits that seriously interfered with realistic adaptation. The road from autoerotism to full genital maturity was paved with many stumbling blocks, not the least of which was failure to resolve the Oedipal complex. This anchored the individual symbiotically to archaic objects and blocked proper separation-individuation (Mahler et al, 1975).

According to Mahler, the first weeks of the infant's life are occupied autistically with hallucinatory wish fulfillment and obliviousness to external stimulation. At three to four weeks there is some response to external stimulation (e.g., smiling in response to the mother's face), indicating some awareness of the environment. This constitutes a normal symbiotic phase when there is no differentiation between the self and the object (the mother). There is some registration of "good" and "bad" environmental happenings. From 4 or 5 months to 10 months a "hatching phase" initiates early differentiation, marked by discrimination between self and object and between perceptual and inner sensations. At the end of this phase a "practicing" subphase is initiated, characterized by bodily movements such as crawling and thrusts into the environment away from the object. This aids initial separation-individuation. There is interest in one's body ("secondary narcissism") as well as in the world around. This subphase is encouraged when the mother is willing to accept the child's independence; it is discouraged when the parent refuses to grant her child autonomy. During this period there are indications that the child does not consider the mother a distinctive entity. Between 15 and 18 months, the child begins to realize his or her own helplessness as the child sees the mother as a person separate from himself or herself. This is a "rapprochement" subphase that around 18 to 24 months of age leads to a crisis in separation and

individuation with ambivalent clinging to the mother (symbiosis) and resistance of her efforts at separation. Resolution of this ambivalence is crucial to the child's development since failure leads to splitting of "good" and "bad" object representations. The mother's role during this period is vital, and how she deals with the child's shifting between symbiosis and separation will crucially influence what happens. Coincident with this individuation struggle is the refinement of verbal communication, cognizance of sexual differences (eventually leading to gender identity), and greater awareness of the father. During the third year of life, self and object become more separate and their internalized representations become more unified ("libidinal object constancy"). Differences in the degree of resolution of symbiosis and separateness can occur so that the one is much more advanced than the other, complicating adaptation.

A derivative of object relations theory has emphasized self-representations as distinguished from object representations (Hartmann, 1964; Mahler & McDevitt, 1982). This has encouraged explorations into "self-psychology," of which the most prominent contributors have been Edith Jacobson, Otto Kernberg, Heinz Kohut, and Joseph Sandler. According to Jacobson (1964), the desire of the infant and child to relieve tension (unpleasure) and to secure gratification of needs with resulting pleasure leads to the internalization of the object in the form of bad (frustrating) and good (gratifying) images toward which the child responds as variantly and as intensely as if they existed in reality. Frustrated and aggressive feelings are liberated toward the bad object; a desire to possess and merge with it toward the good. The representational worlds of the self and the object are intricately intertwined and lead to the establishment of a sense of identity and the building of the intrapsychic structure, whereas the mature ego resists fantasies of merging with the object. Situations within the representational world may weaken reality testing and tempt a return to earlier, less differentiated ego states. Retaining some of the elements of drive theory, Jacobson has fused them with a phenomenological approach that makes for a rather complicated structure.

Drawing some substance from the ideas of both Mahler and Jacobson, Otto Kernberg (1976, 1980) has contributed some interesting ideas to contemporary object relations theory while retaining a fidelity to classical metapsychology. From the stormy transferences of narcissistic and borderline personality disorders, the chaotic nature of self and object representations, the use of primitive defense mechanisms, such as splitting, projective identification, and archaic ambivalences, assumptions are made by Kernberg

that early object configurations have not been properly "metabolized." This is the reason why they precipitate out rapidly in the transference. The original self and object images as well as the affective colorations of drive derivatives constitute the "internalization system." The representatational world consists of bad and good self and object images, as well as components of the ideal self and object. As the ego consolidates through the employment of such devices as introjection, the defense of repression relegates unacceptable representations and identifications along with their affective charges to the unconscious. Splitting separates ambivalent introjects. These processes are accompanied by strengthening of the superego, formed from hostile object internalization, the ego ideal (combined ideal self and object representations), and realistic parental introjections (commands, values, etc.). The "self," an intrapsychic structure originating from the ego, consists of the total of self-representations that connect with the total of object representations (Kernberg, 1982). In working with sicker patients during psychoanalysis, one consistently has to deal with transference paradigms, the product of unmetabolized early relationships, as well as with such surviving primitive mechanisms as splitting and ambivalent self-object configurations, with the hope of achieving a better integration.

Heinz Kohut (1971, 1977), a former president of the American Psychoanalytic Association, avowed that severe narcissistic personality disorders, which ordinarily have not been considered susceptible to psychoanalysis, could be treated analytically. What was required, he insisted, was a revision of classical theoretical and methodological concepts, while retaining fundamental premises of the drive theory. Leaning toward a relationship model, Kohut promoted a "self-psychology" that subordinated the structures of id, ego, and superego to the active manipulations of the self. The self evolves out of participation with others ("selfobjects") with whom the child merges and whose feeling states (empathic responsiveness) the child incorporates. The child's fundamental narcissistic needs (omnipotence and grandiosity) require that the child be admired for his or her capabilities by the idealized selfobject (a kind of "mirroring" phenomenon), which enhances fusion of the self-image with the idealized selfobject ("you are perfect, and I am part of you."). Disappointments in "mirroring" by the selfobject hamper idealization but contribute to the development of the self structure ("transmitting internalization"). In one line (pole) of self-development the grandiose exhibitionistic anlage becomes expressed as healthy assertiveness and ambition; in a second alternative line (pole) the idealization of the selfobject results in healthy ideals and values. Failure to develop adequately along either pole impairs self-development,

with resulting damage to the self-image and self-esteem. If, because of parental pathology, proper empathy is not displayed, self-development in the child is thwarted, with psychopathological consequences. The theoretical premises of Kohut have provided a rationale for empathic activity in treatment. Since deficits exist in the constitution of the self, transference in either mirroring or idealizing modes provides an opportunity to rectify these deficits. By acting empathically, the therapist gives the patient a second chance to incorporate healthy structures and thus overcome the original selfobject failures. Gradually, the narcissistic elements are resolved as the therapist slowly adopts a decreasing empathic role and the patient needs the therapist less and less as a selfobject. What is responsible for character reconstruction, according to Kohut, is a fruitful experience with an empathic and idealized therapist (the transferential selfobject) rather than interpretation, the touted classical agency that presumably brings about change.

Instead of conceiving of the development of the psyche in terms of the conflict between primary drives within the individual and the socializing demands of parental authority, self-psychology thus focuses on the vicissitudes of the self and object representations in their archaic and mature forms. Agreeing with Kohut, Ornstein (1984) conceives of the first pole of the bipolar self as the grandiose exhibitionistic self, which becomes the nucleus of later self-assertive tendencies, regulation of self-esteem, enjoyment of mental and physical activities, and successful pursuit of goals and purposes. The second pole involves the idealized parental image incorporated in the selfobject matrix, which becomes the basis for values and guiding ideals, helps regulate inner tension, contains and channels drive needs and affects, and fosters enthusiasm and idealization of one's values and edifying principles. Psychopathology is the product of developmental arrests or derailments that produce disturbances in the bipolar self and failure of maturation. Resultant is a continued dependence on archaic selfobjects and an inability to harmonize one's directive values and ideals with innate skills and talents toward satisfaction of one's self-assertive ambitions. The psychoanalytic cure consists of mobilizing the regressive transference neurosis in the usual analytic way and of employing it to "break the bondage that formerly tied the archaic self to the archaic selfobject" and then establishing "empathic in-tuneness between self and selfobject on adult, mature levels."

A growing number of analysts have climbed onto the bandwagon of object relations theory. Utilizing some of the formulations of Sullivan, Klein, Mahler, Fairbairn, Winnicott, Kernberg, Kohut, and others,

they have expanded on and enriched certain elements of the theory. Some contemporary theorists have seemingly forgotten the contributions of the earlier workers who presented the original formulations. Others have paid proper tribute to the innovators who preceded them. Among these contemporaries are Joseph Sandler, who has elaborated on how the child's representatational world evolves, develops, and forms the basis for the organization of later experience (Sandler & Rosenblatt, 1962) and (Sandler & Sandler, 1978). His formulations are clearly expressed and possess a clinical utility. The phenomenological viewpoint of Stolorow and Atwood (1979) and the work on developmental arrests by Stolorow and Lachman (1980) are of interest. Greenberg and Mitchell (1983) have done an excellent job of showing how object relations theory evolved from ego psychology and of integrating the contributions of the various authorities in the field.

There is some evidence that an object relations orientation adds a dimension to classical structural analytic theory, particularly in relation to self and object representations and to the identification in borderline cases of such pathological defenses as "splitting" and "projective identification." The value of modern object-relations theory is obscured, however, by the use of confusing language that lends anbiguity to its inherent concepts. Some, but by no means unanimous, agreement exists that an object relations approach is better designed for problems that date back to early ("pre-Oedipal") life and that classical methods are more applicable to difficulties originating around a later ("Oedipal") period. There is a difference of opinion as to whether the improvement achieved with borderline, narcissistic, and other serious personality problems may not be due to the greater activity and empathic involvement of the therapist with the patient rather than to the insights emerging from analysis of the transference. Moreover, conflicting claims continue to be made that narcissistic problems are actually variants of the Oedipal neurosis. Thus the introduction of object relations and other theories of personality beyond classical metapsychology is felt by many orthodox analysts to be unnecessary.

In clinical practice most object relations analysts play a more active role than do their classical counterparts. Instead of operating as a blank screen onto which displacements from the past are projected, they actively participate in the relationship, and some actually play the role of the patient's previous objects or of aspects of the patient's self. In this way they influence the nature of the transference. Countertransference is actively watched and used, providing a keen view of the projective activities of the patient. Except for the repetition of old patterns, the relationship in object relations

therapy possesses a momentum of its own.

There is agreement that a regression occurs so that patients live over early developmental stages. At first there is repetition in the transference of the state of fusion with the protective mother figure in the form of projection onto the therapist of the need for total need fulfillment. Separation anxiety is apt to emerge. As therapy progresses, ambivalence develops and the "good breast"-"bad breast" duality emerges toward the therapist or, as in group therapy, a dissociation of the opposing attitudes, one focused on the therapist-leader, the other on the group. The therapist must have the ability to tolerate and "contain" the products of the patient's "projective identification." The hope is that the patient will eventually be strong enough to reabsorb and tolerate disavowed aspects into the self-image. As the "good-bad" split becomes absorbed into the self, the "depressive position" develops. Soon concern about how the patient affects others and guilt feelings emerge, and jealousy replaces envy. Earlier identifications become integrated into the self, which in becoming consolidated enable the person to perceive others more clearly.

A number of attempts have been made to apply object relations theory to group work with children (Soo, 1985) and adults (Alonso & Rutan, 1984).

Criticism of Object Relations Approaches

Some therapists consider the contributions of object relations theorists advanced and brilliant. On the other hand, a gathering group of dissenters, while admitting the ingeniousness of the developmental theories, question their validity. Perhaps the most extensive criticisms have come from Heimann (1966) and Calef and Weinshel (1979), the latter expressing reservations about the clarity of the theoretical conceptualizations and the usefulness of the advocated technical procedures. Others have branded current ideas about object relations pejoratively as a jerrybuilt structure of metaphor upon metaphor compounded out of a pseudo-synthesis of Kleinian, Bionian, ego-psychological, object relations, and other theories. These criticisms, it seems to me, are altogether harsh, for if the authors under criticism have done nothing else, they have challenged the sanctity of some existing metapsychological credendas and opened the way to a reassessment of their value. This does not certify concepts that modern researchers on development would consider questionable, such as some ideas about infantile

development and ideation. Object relations theory is perhaps more tenable than tripartite structural theory in accounting for some phenomena of the borderline state, but it still does not embrace the multiple variables that enter into borderline personality formation.

Although some object relations theorists continue to pay homage to classical drive theory, there is a feeling among classical analysts that most tend to replace fundamental concepts with an overlay of secondary and derivative issues. The focus on "good" and "bad" maternal qualities, on basic dependency, and on developmental deprivation as the principal if not exclusive dynamic is considered myopic since it minimizes other crucial factors in the evolution of personality. Substitution of an innate need for attachment to an object (Bowlby, 1964, 1969; Bulent, 1968) for an instinctual libidinal drive is merely another way of saying the same thing with different linguistic terms. Similarly, Melanie Klein's challenge of primary narcissism, that the infant is involved with inner objects rather than oriented toward the self, is felt to be merely tautological. Repudiation of instinctual aggression by such theorists as Fairbairn evades the findings of neurophysiologists of subcortical centers for aggression. Reinterpretation of the Oedipus complex as less instinctually derived but rather rooted in loving and hateful attitudes toward objects, or due to conflict between warring aspects of the self, are labeled exercises in circumlocution and operations of verbal legerdemain. Kohut's emphasis on infantile grandiosity and idealization as developmentally normal characteristics, rather than regressive and defensive operations, and his justification of playing an active empathic role to make up developmental deficits have been considered by classical analysts as an abandonment of some basic psychoanalytic tenets. The clinical data are interesting, but some therapists find the language and descriptions of self-psychology complex and confusing. They contend that Kohut has evolved a dynamic to justify his use of activity in his relationship with his patients. Since activity and empathy are very helpful in the treatment of sicker patients, such as those with borderline and narcissistic personality disorders, modifying the conventional passive psychoanalytic stance is helpful but does not require a modification of the classical developmental theory. Doing this has not endeared Kohut to the hearts of many orthodox believers.

The severest criticism has been leveled at the additions to developmental theory of ideas related to representational differentiation and integration of self and external objects. Here it is presumed that neonates cannot differentiate themselves from others nor discriminate between their own and their object's sensations. The first task of development, according to this idea, is to distinguish and separate self

from object representations (usually the mother). This common notion is believed by certain authorities to be speculative and not in keeping with their opinions of child development, decidedly substantiated by modern developmental research (Kagan, 1971, 1978a, 1978b; Kagan et al, 1978) who point out that object relations theory comes from observations of psychotics and of patients in deep regression (as during a transference psychosis) who are *presumed* to be repeating what the normal person goes through in infancy. Studies of development, they contend, indicate that neonates are highly capable of differentiating themselves from objects. They downgrade the notion that infants are unable to integrate contrasting emotions as related to object representations (i.e., positive affects associated with the "all good mother" and negative affects associated with the "bad mother") or that infants are at first unable to synthesize "good" and "bad" affects into a combined representation of the total mother figure.

The second developmental task, according to object relations theorists, is to effect synthesis of the "good" and "bad" mother, as well as the self-representations that issue from the developmental incorporation of the mother figure (the maternal introject). Under favorable conditions, this synthesis occurs with the evolvement of "object constancy" and the valuing of other persons for their true positive and negative qualities. This makes for consolidation of the self-image, acceptance of "good-bad" qualities within oneself, and a solid sense of identity and positive self-esteem. Failure in such integration is presumed to result in "splitting," an absence of self-object differentiation and delusional merging of self and object images predisposing to psychosis (Kernberg, 1975; Kohut, 1971; Searles, 1966). Causes of such failure are variantly attributed to constitutional predisposition, severe maternal deprivation, inconsistencies in care, mishandling, and cruelty. Milder difficulties in self-representation other than psychosis are said to occur where the damage is not so serious, resulting in (1) narcissistic personality disorders, who will require special kinds of management therapeutically (Kohut, 1971), and (2) borderline personality disorders (Kernberg, 1975) in whom "allgood" and "all-bad" self and object representations alternate and who also need special techniques. Again, these concepts derive from work on borderline and psychotic adults and have not been substantiated by modern researchers in child development (Bower, 1977; Condon and Sander, 1974; Dunn, 1977; Kagan et al, 1978; Le-win, 1975; Thomas and Chess, 1980).

Alternative explanations have been offered founded on empirical studies. For instance, detailed observations of infants have shown the presence of a need for investigation and exploration as a means

to task mastery. The urge for social relationships seems also to be basic, and this is satisfied by mutual interactions of the infant and mothering figures, not as a fused image, but as separate and individually functioning beings. This does not detract from the ingenuity of the object relations formulations and even their usefulness in giving the therapist some model around which to organize interventions and to enhance confidence in what he or she is doing. Attempts that have been made, however, to explicate these ideas in "metapsychological verifications of psychic structures, cathectic shifts, or fusions and defusions of drive-energies" (Stolorow and Atwood, 1979) are extremely confusing.

PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

The utilization of supportive and reeducative tactics within a psychoanalytic framework has come to be known by a number of designations, such as "dynamic psychotherapy," "psychoanalytically oriented psychotherapy," and "insight therapy." Conceptually and operationally, psychoanalysis and psychoanalytically oriented psychotherapy are distinguishable (Gill, 1951, 1954; Bibring, 1954; Greenson, 1967). Nevertheless, there has been a tendency to lump them together under the banner of psychoanalysis, some analysts quoting Freudian scripture to justify this amalgamation (Fromm-Reichmann, 1950, 1954). Much debate and controversy has crystallized around these issues (Glover E, 1931; Alexander, 1954; Bibring, 1954; Fromm-Reichmann, 1954; Knight, 1954a & b; Rangell, 1954; Waelder, 1960; Tarachow, 1963; Wallerstein, 1966; DeWald, 1964). Nevertheless, the clinical usefulness of modified approaches is conceded since classical analysis is contraindicated in certain conditions. Uncovering and exploratory techniques that do not penetrate into infantile genetic sources or sponsor a regressive transference neurosis are considered helpful in patients with circumscribed symptom and character neuroses who possess sufficient ego strength to endure probing procedures. Here the therapist does not fully present as an object through whom gratifications are sought and obtained, as in supportive therapy; nor does the therapist stimulate the patient's unconscious fantasy system by posing obdurate therapeutic interpretation barriers to all transferential demands until a transference neurosis erupts, as in Freudian psychoanalysis. Rather, the therapist takes an intermediate position, offering himself or herself as a projective vehicle for some transference gratification while doing as much analytically interpretive work as the patient can tolerate.

Psychoanalytically oriented psychotherapy is thus the most active of all analytic therapies and

maintains the greatest flexibility in the techniques employed (Stewart, 1985). By focusing on pertinent data, using active means of dealing with resistance, and bringing unconscious conflicts to awareness without resorting to deep regression to invoke a transference neurosis, much unnecessary time is claimed to be saved. The relationship is accordingly actively manipulated, transference is controlled, and certain aspects of the relationship are stimulated. The focus is generally more on the present than the past and deals with limited rather than complete aspects of the personality. Recent conflicts more than past ones are in the forefront. Frequent weekly sessions, the couch position, and free association are only occasionally employed, if at all. Practical goals of bolstering defenses, promoting enhanced adaptation, and encouraging more effective interpersonal relationships are considered adequate, and a complete overhauling of the personality structure is considered a fortunate but serendipitous happening. Psychoanalytic psychotherapy therefore has a broader range of application than formal analysis and is adaptable both to problems of relatively healthy individuals and to sicker patients with whom psychoanalysis cannot be employed. The use of adjuncts, such as drugs, family therapy, and behavior approaches, is often resorted to as indicated by the immediate needs of the patient. Flexibility of operation is the keynote. Consequently, there is no accepted format, the design of treatment being determined by the therapist based on what is indicated at the time and his or her expertise with special adjunctive methods.

Perhaps the best known system of psychoanalytically oriented psychotherapy has been set forth by Alexander, French, and other members of the Chicago Institute for Psychoanalysis (1946). The therapy described, though of a short-term nature, is believed by the authors to yield results comparable to long-term standard psychoanalysis. Alexander and French stress the fact that they utilize the therapeutic situation as a corrective emotional experience. It provides a new and more favorable medium in which the patient is exposed to, relives, and finally masters the conflicts and emotional problems he or she was unable to handle as a child. This is achieved either in the transference relationship or outside of therapy in real life. Not only does the patient overcome unresolved childhood conflicts by reliving them—which makes them less acute—but the therapist also responds to the patient and to the patient's behavior in a manner totally different from that of the parent. This gives the patient an opportunity to revive his or her past and to face conflicts over and over again under the guiding aegis of the therapist. Activity in the therapeutic situation is said to accentuate the corrective experience.

The authors recommend such modifications in technique as direct interviewing, in addition to free association; the regulating of the number of sessions each week; the offering to the patient of advice and suggestions about certain aspects of his or her life; the interrupting of therapy for a variable period prior to ending treatment; the manipulating of the transference in each patient in accordance with the needs of the patient; and the employing of real-life experiences as a part of the treatment process. Flexibility in method is advocated with a change of technique periodically to suit the patient's personality as well as problems. While the transference relationship is believed to be important, extratherapeutic experiences are considered of equal importance. Positive transference is encouraged to establish rapport and to enhance therapeutic progress. Negative transference is analyzed when it blocks the process of therapy. Emphasis is more on the relationship than it is on the transference neurosis. The experience of mutual frankness and sincerity in relationship to the therapist makes it possible for the patient to reorient to other human contacts.

F. Alexander (1965) has reemphasized that psychoanalytic psychotherapy acts as a restitutive medium that the therapist actively manipulates, scrupulously avoiding repeating the traumatizing circumstances of the patient's childhood no matter how provocative he or she may be. Once the therapist becomes alerted to the nature of past hurtful experiences with parental figures, the therapist may, by design, act in a way completely opposite to that of the parent so as not to bring to pass the patient's expectations. Control of transference is vital. Another technique is to change the frequency of interviews at certain phases of treatment to make the patient conscious of dependency needs by frustrating them. Experimental temporary interruptions in therapy are also useful. Overtreatment, with its regressive dependency, should be avoided by reminding the patient that treatment will be made as short as possible. This discourages procrastination in facing up to important issues. The search for early memories is not as important as dealing with the present and with immediate life problems. Avoidance of a "parentifying" transference so as to enable the patient to take over his or her own life management as rapidly as is feasible is urgent. While these techniques are not applicable in all cases, the majority of patients, according to Alexander, can benefit from them. Results justify the modification of formal psychoanalysis in many patients.

Psychoanalytic psychotherapy supports many different modes of operation unique to the personalities and styles of therapists. These are sometimes unjustifiably described as revolutionary, but

almost invariably they are merely adaptations of earlier forms of treatment. For example, many have drawn inspiration from the "sector therapy" of Felix Deutsch (1949a & b; Deutsch & Murphy, 1955). This is a goal-limited therapy "conducted so as to work on the unconscious factors that influence the reality situation rather than the reality situation itself." Focus is on a limited portion of the total problem, the object being to adjust the patient to an aspect of life that hitherto he or she has been unable to master. An "induced positive transference" is employed, and "associative anamnesis used in lieu of free association." Here the technique essentially involves a focusing of the interview on symptoms and conflicts by accenting key words and phrases that the patient has used and that reflect basic problems (Deutsch, 1939). The therapist picks a few of the most frequently employed words or expressions, incorporates them into the conversation, and observes the reactions of the patient. The key words and phrases uttered by the therapist usually stimulate associative ramifications in the form of free associations. The associations are guided, however, and their continuity is maintained. Through this means, manifest symptoms and current problems are linked with underlying conflicts. The constant confrontations by the therapist serve some of the purposes of interpretation. Memories are revived; associative chains are broken up and replaced with new ones. Through this form of interviewing, the patient purportedly learns to discriminate the past from the present and his or her ego is induced to alter its defensive attitudes.

Illustrative of the many innovations that have been introduced into psychoanalytically oriented psychotherapy is the "objective psychotherapy" described by Karpman (1949). He assigns to the patient a series of written questions dealing with the patient's history, attitudes, and feelings. The patient is requested to write out detailed answers to these questions. After reading them, the therapist picks out pertinent points and formulates new questions to which the patient is expected to reply. Reading material may be given to the patient that is related to his or her problem, and the patient's reactions in writing are requested. Dreams are written by the patient, and interpretations to these are handed in written form back to the patient for leisurely study. Formulations of the dynamics are made in writing from time to time by the therapist, and the patient is requested to study these and to turn in written comments. *Focal therapy* is the name given by Balint et al. (1972) for a concentrated short-term form of insight therapy. To qualify for this treatment according to the authors, a patient has to be able to establish a reliable therapeutic relationship with the therapist, the illness needs to be ego-dystonic and not a

valuable part of the patient's personality, interpretations made by the therapist must be acceptable to and acted on by the patient, t.nd both parties should agree on a suitable specific focus (a "meeting of two minds"). The focus often is on crucial unconscious conflicts, the resolution of which will, one hopes, make at least a limited impact on the patient's character structure. Occasionally, as therapy proceeds, the focus has to be modified and even changed. The technique calls for greater manipulativeness than is customary in psychoanalysis, although interpretation is still the basic intervention. The theory of treatment and of the involved psychopathology are psychoanalytic, but the method is distinguished from true psychoanalysis by its inherent activity, the abandonment of free association, and the avoidance of a transference neurosis. Since its early presentation, the term "focal therapy" has been appropriated by therapists of various orientations as a label for short-term treatment targeted at various foci (symptoms, behavior difficulties, personality problems, situational crises), and psychoanalytic techniques are commonly employed.

George Goldman (1956) has written on "reparative psychotherapy," which is eclectic in nature, utilizing various supportive and insight approaches depending on the needs of the patient. The external manifestations of the problem are first handled in dealing with the disturbed behavior and reality situation. Gradually there is a working toward emotional factors, including the defenses. The primary aim of "reparative therapy" is the modification or relief of symptoms. A secondary goal is improvement of adaptive functioning. A hoped-for objective is growth of the individual toward greater maturity or capacity. Deep-seated characterological change is not considered a target in reparative therapy, although reconstructive successes may on occasion be scored.

An interesting psychoanalytically oriented "humanistic" "third force" approach is that of *Gestalt therapy*. Drawing from gestalt theory and employing concepts from psychoanalysis, Perls, Hefferline, and Goodman (1951) evolved a transactional form of therapy that proposed to bring fragmented elements of personality into a unified whole. Ideally, it was theorized, an object ("figure") and its field ("ground") should blend into a harmonious assemblage (Gestalt), the interplay constituting a balanced unit of emerging and receding "figure" and "ground." According to this theory, neurotic and psychotic individuals, because to their rigidity (fixation) or imperfect "figure" formation (repression), are burdened with defective split-off Gestalts. These make for confusion, anxiety, and the various symptoms of emotional illness. It follows that the psychotherapeutic focus must take into account both the

individual and the environment as well as their subtle interaction with one another. This task necessitates a search for repressed material, the mechanisms through which repression is maintained, as well as the specific needs for repression. To organize a mature figure-ground Gestalt, which is the essence of maturity, it is essential that the individual restore to his or her total being the split-off and dissociated aspects of himself or herself. Guidance in bringing these to awareness is indispensible. More important, an adjustment to the present situation is fostered by presenting actively to the patient a series of "therapeutic experiments" that provide a dynamic educational experience. Not only does the patient learn through this about the repressed and repressing self, but he or she is also faced with graded challenges that help in mastering fears and blocks. The creative resolution of elements of unawareness, which is fostered by the experiments, is said to restore the individual to personality integration and constructive contact with reality.

The function of many of the experiments is to integrate alienated aspects of the self. One technique is to animate and hold conversations with parts of one's body that feel tense or people and objects in dreams, or one with fantasized parents and other important personages. During this dialogue, the patient acts, feels and talks as if he or she is actually the object or part object. Sometimes the "empty chair" technique is used, the patient being urged to imagine a parental or other important figure sitting in a nearby empty chair and then to talk to, upbraid, or question the visionary occupant. This may be followed by changing seats and acting the part of the person or object with whom there has been a dialogue. A great deal of emotion may be liberated in the process. The therapist in the meantime questions, challenges, and confronts the patient about the behavior and evasions, at all times insisting that he or she take responsibility for his or her actions. Group work may be an integral part of therapy, and many of the techniques of psychodrama, such as role reversal, are employed. J. A. Greenwald (1972) has outlined a number of useful ground rules for Gestalt therapy.

During the last years of his life Perls was active at Esalen Institute in California, elaborating on a number of active techniques and gathering around him a large number of followers who enthusiastically worked with his methods, the flavor of which may be gathered only from reading recordings of his interviews, listening to his cassettes, or watching his films. An interesting conversation with Perls is published by Clements (1968).

Gestalt therapy enjoys a great popularity among younger generations of psychotherapists principally because of its dramatic techniques. Gestalt Therapy Institutes have been organized in various parts of the country offering workshops in the method. Some of the Gestalt techniques are utilized periodically by therapists of various schools as a means of stirring up activity in treatment when movement is deemed necessary. Not all therapists are capable of doing this, however, particularly if they have no confidence in the methods or believe that they are too contrived and artificial. Not all patients can handle the challenging and confronting manner of the Gestalt therapist. A good working relationship is required for this, and if attacks on neurotic ego-syntonic behavior are launched prematurely, the patient may be driven out of treatment. Borderline patients particularly cannot tolerate the attacks. The anti-intellectual stance of Gestalt therapy has as its emphasis the undiluted, direct experiencing of emotions. The gimmicky quality of the techniques have come under attack by more conventional therapists. Some of the Gestalt techniques have nevertheless been incorporated into other therapies. Such therapies draw from the inventiveness of the leader in devising interventions toward integration of split-off aspects of the self. Responsibility for one's actions is constantly stressed with the need to resolve the "unfinished business of the past," to abandon "phoniness" for true self-awareness, to liberate oneself from the "computer" within one's mind which delivers false messages, to discard useless hoped-for illusions and goals, to stop looking for the "why" instead of the "what" and "how," and to give up banking on help from others (including the therapist) rather than oneself since that is a "sick game."

Used by qualified professionals, selected Gestalt techniques may, during individual therapy or in groups, help break through resistance in rigid, guarded individuals who are then provided with opportunities to work through their liberated memories and emotions. Rigid adherence to the theories of the founders of the Gestalt movement may tie the therapist into a bind, however, particularly in relation to the management of the ubiquitous transference and countertransference eruptions encouraged by the great activity inherent in the treatment process.

Other analytically oriented approaches have been designed, limited only by the originality of the authors, that employ various degrees of activity. These range from a mere pointing out by the therapist of destructive coping mechanisms (which may be helpful to some patients with a strong readiness toward change) to interpersonal provocations within the therapeutic relationship that are calculated to mobilize defenses and resistances. Instead of responding to these in traditional ways, the therapist challenges and

even opposes them. Deliberately created by the therapist in some cases is a state of crisis to which the patient will react with frustration, bewilderment, rage, and other reactions which are superimposed on his or her habitual defensive operations. It is at this point that the skill and stability of the therapist are taxed to the limit. If a working relationship and good communication with the patient has been established, with appropriate management of any countertransference, the therapist may be able to support the patient through the upheaval, firmly standing ground, while manifesting empathy and understanding. The patient is confronted with two situations: either he or she leaves therapy or changes. One hopes the latter contingency will prevail.

Criticism of Psychoanalytically Oriented Psychotherapy

The marriage of non-analytic and analytic techniques has, in some circles, not been too happily received, non-analytic therapy being regarded as a kind of ravenous cormorant who eventually swallows, digests, and destroys its marital partner (Waelder, 1960). The progeny of this wedlock, too, in the form of specific procedures, are regarded by some analysts as monstrosities conceived through the mating of opportunism with clinical expediency. Criticism is expressed to the effect that transference is watered down by the active techniques employed. The consequence of avoidance of a transference neurosis is said to be a limitation of the extent of insight achieved. The inevitability of circumscribed goals in treatment is also presented as an objection. Additionally, the concentrated short-term techniques employed are believed to be dangerous in the hands of any other than the most highly trained and experienced psychoanalysts. They are unfortunately apt to appeal to therapists who, while not trained in psychoanalysis, are searching for dramatic unrealistic psychoanalytic shortcuts. To these criticisms adherents of psychoanalytically oriented psychotherapy reply with accounts of greater effectiveness in the management of patients, over a relatively brief period, who would not be suited for the classical approach, which is applicable to a limited number of individuals.

TRANSACTIONAL MODELS OF PSYCHOTHERAPY

In recent years a form of psychotherapy has come into prominence, the therapeutic focus being the ongoing transactions that take place between patient and therapist. The elicitation of defenses that the patient employs, the understanding of the roles that he or she plays, and their "working through" within

the relationship have been credited with influencing various dimensions of personality, including interpersonal and intrapsychic components. In establishing the theoretical foundation for transactional therapy, concepts have been adapted from field theory, communication theory, game theory, and role theory, especially the latter two.

Game theory, which was developed by Emile Borel, John von Neumann, and Oskar Morgenstern for the study of competitive economic behavior, attempts to analyze conflict in mathematical terms by abstracting common strategic elements controlled by the participants. The theory is applied to various kinds of conflict situations, including neurotic behavior and patient-therapist transactions, conceiving of the maneuvers as chosen strategies employed by the "players" under established "rules" that will bring about a favorable outcome ("payoff"). Rationality is stressed, the players presumably taking into account in their "bargaining" situations various calculations of risk.

In role theory society is regarded as an aggregate of persons with common goals whose positions enjoin them to assume specialized roles. The individual, constituted of values, traits, and attitudes (including "self'), develops action systems as a result of the interplay of self and role. Role theory deals with reciprocal relationships that go on between people. It also embraces the interaction of self and role. It contemplates personality as a tapestry of role behavior, of role perception, and of self-perception in the matrix of role.

The conventional definition of role as employed G. H. Mead (1934) regards it as the pattern of attitudes and actions an individual exhibits in social situations. This is molded by one's status or position in the social structure, which obliges one to behave in certain ways. Special actions are expected of persons occupying certain roles ("role expectations") that meet some need in the social system (Parsons & Shils, 1951). The individual consequently organizes behavior in order to fulfill role expectations. Thus the student assumes with the teacher the role of learner; the teacher, the role of educator. The child learns that under set circumstances behavior in certain ways is expected. Conformity brings rewards: revolt results in punishment. The little boy finds that his roles in society, his privileges, and his liberties differ from those of a little girl. As he matures, his role expectations and behavior change. Juveniles, adolescents, and adults perform differently both through intentional instruction and through incidental learning.

The individual ("ego") utilizes many roles at various times and under varied situations with different people ("alters"). When a role coordinates with that which the individual is expected to play, he or she is in relative equilibrium (a state of "complementarity"). When role complementarity is upset, disequilibrium follows with ensuing tension and anxiety that nurture neurotic disturbances in self-evaluation and difficulties in interpersonal and group relations. Roles may be conscious and explicit or shunted from awareness and more or less implicit. In the latter case the roles usually reflect early identifications, such as mother-child, teacher-child relationships. These identifications are only partly expressed in social roles; some are neutralized and locked in. The expressed roles force the individual to repeat compulsively time-worn and habitual pathological patterns.

Ambiguous role expectations lead to conflict and to socially invalid role enactments. For example, many women in our culture, tending to equate some aspects of the feminine role with inferiority, resist complying with certain role expectations. Indeed they may seek a solution to their conflict by assuming a masculine role in some areas of adjustment. Role conflicts in such instances are inevitable. To some extent role conflicts encompass all human beings, since in certain areas of functioning every individual occupies two or more positions simultaneously and is unable to live up to all of his or her role expectations. The degree of role conflict and the inability of the individual to evolve adequate defenses to the dilemmas posed by one's ambivalencies will determine their pathogenicity.

The role an individual believes must be played in a social context is a product of perceptual and conceptual fields, which involve past experiences and embrace many intrapsychic processes. The overt factors of role perception (for instance, the acts and appearance of others) are colored and even distorted by internal needs and conflicts. Thus, when excessive dependency is a lingering impulse not resolved in the course of maturation, the individual will implicitly assume the role of child with any person whom he or she perceives as an actual or potential parental substitute. The specific position assigned to the parental symbol will be that of authority. When the symbol does not come up to the demanded role expectation of being and acting as the authority, conflict may ensue.

Though the unconscious is not acknowledged by some role theorists, its operations are present, prompting motivations that dragoon the individual to act out roles in opposition to traditional role expectations. Role enactment then may not validate the expectations of the person or persons with whom

the individual is relating. This can give rise to conflict leading to mutual retaliation and other defenses. Multiple roles are the rule: the richer the repertory of role potential, the more flexible and integrated the individual (Gough, 1948; Cameron & Margaret, 1951).

Role theorists regard the self as an intervening variable that can be approached through role concepts. The elusive entity of the self is an aspect of the total cognitive organization, an inference derived from interaction with other persons, objects, and events. The self evolves as an organization of qualities, the result of maturational and personal-social experiences. Its formation is involved with the principle of "constancy," the need for homeostasis in the child bringing about responses that invoke the aid and intervention of other individuals. Awareness by the child of the "somatic self' that embraces tensions is the basis of the differentiation of self from noneself. External events become associated with tension reduction, and the child's perception that certain motor activities on his or her part in relation to others lead to events that eliminate tension acts as further support for the foundation of self. Toward the end of the first year a new cognitive structure is laid down in the form of gestures and other forms of communication that enable the child to differentiate persons and objects from the acts of persons. At the same time there is discrimination between self-acts that are approved or disapproved. Perceiving, identifying, and conceptualizing of roles and role expectations are elaborated as symbolic development expands. The self-concept in role theory is thus intricately related to the socialization process and to reciprocal role playing with many significant persons. Out of such interactions there evolves the "social self." Difficulties in development result in "fixations" of the self concept on primitive or less mature levels than the "social self."

An interesting finding issuing from psychoanalysis that relates to the development of role expectations is that the child will divine, by uncanny perception, the verbally unexpressed but, nevertheless, obvious unconscious designs of the parent with whom he or she identifies. There is an acting out either as a child or later in life, some of the unconscious parental needs and demands. Antisocial tendencies are often a reflection of the unconscious urges of parents, who, in their eagerness to conceal these promptings, give them undue emphasis in the form of warnings, reaction formations, defenses, and symbolized expressions of repudiated drives. The parent may also confuse the child as to roles by alternately encouraging (seducing) and punishing (rejecting) the child.

Harmony between the self and role enactment is one of the measures of adaptation. Performances to satisfy role expectations that are incongruent with the self (self-role conflicts), or two or more role expectations that clash with one another (role-role conflicts), will interfere with adjustment. Ego-defense mechanisms are elaborated to reconcile such differences and to maintain a constancy of the self in the face of expressing such discordant role expectations. Many self-maintaining mechanisms, such as the evolvement of a rationalizing philosophy, are implemented to support incongruent roles that are regarded as essential for adjustment. When self-maintaining mechanisms fail, neurotic defenses may be exploited to bolster the self. If "constancy" (homeostasis) is still precarious, autistic and desocialized role enactment may come about. When two or more roles are incompatible, and institutionalized forms are not available to reconcile opposing role enactments, conflicts may also ensue with eventuating defensive and disorganizing tendencies. A number of transactional models have appeared. Illustrative are those elaborated by Berne, Grinker, Haley, J. Rosen, and Whitaker and Malone.

The Transactional Model of Grinker

A transactional approach is described by Roy Grinker (1961) that consists essentially of focusing on the roles the patient and therapist are playing with each other while taking into account the current environmental influences.

Posing the question as to whether it is possible to set up a model of psychotherapy based on empirical operations rather than on a theory of psychodynamics or diagnosis, Grinker contends that personality cannot be understood through intrapsychic processes; rather, it is best considered as a system of interactions among human beings within a social organization. In therapy both explicit and implicit roles constitute the transactions between therapist and patient. Complementarity of roles is evidence of stability and permits communication of information. Noncomplementarity may lead to disequilibrium, which then promotes the establishment of a new system and modification of roles. During the therapist-patient transaction old roles, preconscious and unconscious, are revived and their origins in past experiences come up for discussion. Both therapist and patient are involved in this transactional process, each acting on the other with a constant feedback of respective roles. As the patient reveals through communication the desired relationship with the therapist, the latter interprets the designs of the patient in the hope that this learning will generalize to other relationships. In the communication with

the patient the therapist freely discusses his or her positive and negative feelings. Refusal to play the role demanded by the patient will mobilize defensive reactions in the patient. But if the therapist stands firm, new solutions will be sought. Among the techniques are the following: focusing of the interview on the ongoing transactions in therapy rather than past experiences; the use of pointed directiveness, confrontations, and challenges; a firm curbing of acting-out; avoidance of silences; employment of dreams only as a source of information without interpretation; the extension of support when needed; and avoidance of a transference neurosis. The patient is discouraged from using childish and immature forms of communication by interpreting their function and is encouraged to experiment in relationships outside the therapeutic situation. This orientation, writes Grinker, "facilitates a vivid, current understanding of the patient without recourse to reified variables, of unconscious, transference, countertransference, resistance, topological foci, processes involving energy, or any past functions of the human being in behavior."

The Transactional Model of Haley

Another approach is that of Jay Haley (1963b), who considers the therapeutic process a communicative transaction between the therapist and patient. According to Haley, the essence of what happens in all forms of treatment is the determined struggle for control between therapist and patient. Each of the participants is bent on winning this contest: the patient, through the ploys of symptoms; the therapist, through varied contradictory confrontations ("therapeutic paradoxes") presented to the patient adversary.

Human beings relate through an interchange of messages that define the nature of their relationship. A "symmetrical" relationship is one in which each person initiates action, criticizes, offers advice, and otherwise shows essentially the same type of behavior. Such a relationship tends to be competitive. A "complementary" relationship is one in which different types of behavior exist, interlocking with each other: for example, one teaching, the other learning; one giving advice, and so on. Relationships are never completely stable; they keep shifting as people grope for a definition of their relationship. Maneuvers in a relationship consist of requests, commands, and suggestions that another person think, say, feel, and act in certain ways, as well as comments about the partner's communicative behavior. Relationships become pathological when one person attempts to circumscribe the other's

behavior while denying that he or she is doing this. For example, a directive may be delivered, then qualified with the statement that it does not have to be followed. Out of this conflict a series of paradoxical communication patterns evolve.

Psychopathology may be viewed as a set of maneuvers to gain an advantage, namely, the control of a relationship. Psychiatric symptoms offer the patient advantages by setting the rules for relationships and by making the social world more predictable. Under these circumstances therapy must aim at preventing this usage of symptoms while encouraging other ways of handling relationships. Exposing himself or herself to therapy, however, poses for the patient the threat of giving up his or her habitual control over relationships. A duel for control can be expected, therefore, though this may be vigorously denied by both patient and therapist. It is vitally necessary, however, that the therapist deal successfully with the question as to who will control the relationship—the therapist or the patient. The resolution of this question is the basis for therapeutic change. If the patient wins, he or she will perpetuate the problems by governing the relationship with the symptoms. If the therapist gains control, the patient will have an opportunity to change. The stratagems that the therapist must employ in winning control are, therefore, the crux of treatment.

Stratagems are used in all therapies. In directive approaches, for instance, the therapist may tentatively align with the resistances of the patient and his or her need to retain symptoms. Permission having been given the patient to embrace the symptoms on the therapist's terms, the patient is then extorted into yielding them by various devices. In deconditioning techniques the principal agency is not desensitization, but the therapist's taking control over the patient's behavior and the patient obeying the prescriptions of the therapist and operating under the latter's terms. In nondirective therapy, therapists, even though they imagine themselves to be uncontrolling, do not give in to the controllingness of the patient and actually establish themselves as the agency in control. Insight leading to self-awareness is not essential; transference interpretations need not be made; and connections established between the patient's past and present are dispensable.

Thus, in evaluating the effects of psychoanalysis, Haley suggests that exploration of the human psyche in quest of insight is irrelevant to change. It is not self-awareness that promotes health; interpersonal transactions alone are responsible for any transformation that develops. Emphasis on

internal processes (such as the unconscious), resistances, and mechanisms of defense are diversionary from what is more significant, namely, that in silence and nondirectiveness the therapist is subtly demonstrating that the patient cannot control the analyst's behavior. From the start the analyst gains the upper hand, though there is denial that the patient is being directed, thereby facing the patient with a paradox. Another way of establishing control is for the analyst to interpret that which the patient ostensibly knows nothing about—his or her unconscious. Any disagreement is classified as resistance. Moreover, crediting the patient's symptoms to deep symbolic forces within the patient prevents the patient from manipulating the therapist through the symptoms. Even philosophical therapies, such as Zen Buddhism, operate through the principle of changing the student's conception of reality by controlling the student's thinking through the setting up of paradoxical situations.

In summary, Haley contends that what causes change in psychotherapy is not self-awareness brought about through the divulging of the operative dynamics, conscious or unconscious, or deconditioning, or any of the other factors commonly ascribed to the healing process, but the resolution of the therapeutic paradoxes that appear in the relationship between psychotherapist and patient. During therapy a number of paradoxes are presented to the patient in the form of contradictory demands (these are deliberately planned therapeutic strategies that generally take the form of wresting control from the patient) to which adjustment will be required with completely different problem-solving tactics than are customary for him or her. Cure is registered when the patient does not really care whether the therapist is controlling or whether the patient is at the helm. Effectuated then are new and healthier strategies in interpersonal relationships. In the process of resolving the paradoxes in therapy the individual stops employing symptoms as modes of control. The first paradox that confronts the patient during treatment is that he or she enters "voluntarily" into a therapeutic relationship that, at the same time, is actually compulsory in terms of the rules that are being set. The second paradox is that the therapist who professes an interest in the patient actually is performing a paid service. Is he or she seeing the patient because of desire or because of discharging a duty? Why, if as interested as the therapist seems to be, will the therapist not socialize with the patient? The focus of the therapeutic process is the relationship with the therapist. Regardless of the theoretical system and the techniques employed, the real drama is shifting the balance of control from the patient (by symptoms) to the therapist. Gradually the balance tilts from a helper-recipient (complementary) relationship to a cooperative (symmetrical) one. It matters

little, according to Haley, what particular brand of therapy one practices so long as strategies employed wrest control from the patient. Diverted from customary modes of manipulating relationships through the perpetuation of symptoms, the patient progresses toward different and more realistic approaches to problem solving.

The Transactional Model of Berne

Eric Berne (1961), utilizing concepts from psychoanalysis, communication theory, and game theory, has succeeded in developing a system of "transactional analysis" that delineates some of the processes operating in interpersonal relationships in simplified terms, which makes them palatable to the average person. By restricting and focusing transactional operations on several common and universal groupings, it is possible with this technique to bring patients to an awareness of certain basic characterological defects in themselves and others in a rapid and dramatic way. Because the transactions between people are described as "pastimes," "games," and "scripts," and because they are tagged with humorous, salty, and quippish labels, the patient develops a tolerant and understanding attitude toward the frivolities of other human beings, while becoming critically understanding of his or her own histrionic interplay with people. Ego-syntonic attitudes, ordinarily difficult to acknowledge, are then isolated as playful absurdities that yield a dubious "payoff." The patient learns to laugh at himself or herself and soon to inhibit various operations as ego-alien. As a short-term process, practiced individually and particularly in groups, easily taught to professionals, "transactional analysis" may serve a useful purpose for some patients, provided that it is not blown up as the ultimate answer to all the problems in psychotherapy.

Berne conceives of human relationships as repetitive sets of social maneuvers that serve a defensive function and yield important gratifications. Such maneuvers take the form of "pastimes" or "games" that people play. These may be simple stunts, or they may be elaborate exercises that follow an unconscious life plan or "script."

Manifested in all persons are three different "ego states": first, the *child* within the person, a regressive relic of the individual's archaic past, hence an aspect of his or her "archaeopsyche"; second, the external parental agency *(parent*), whom the person has incorporated through identification, the

"exteropsyche"; third, the grown-up, mature, reasonable "data-processing" *adult* self, the "neopsyche." Each of these aspects of the person perceives reality differently: the child part, prelogically and distortedly; the parent part, judgmentally; the adult part, comprehensively on the basis of past experience. The three states are constantly operating in response to the needs of the person and the kinds of pastimes and games that he or she is indulging at the time. For example, in response to a story about embezzlers, the *parent* acts moralistically (i.e., plays the game "Blemish"), the *adult* is interested in how the embezzlement was managed (i.e., plays the game "Accountant"), the *child* acts naively and thinks of how interesting it would be to perpetrate the embezzlement (i.e., plays the game "Cops and Robbers"). The three ego states may come into conflict with each other, symptoms being the consequences of relics of the *child* struggling with relics of the *parent*, both "contaminating" the *adult*.

During therapy, the three ego states, displayed in the relationship with the therapist, are interpreted to the patient. The function of *child* and *parent* within the patient and the origin of these states in the life history are ventilated. The irrational defenses the patient employs to justify them as adult operations eventually become clear. Ultimately the *adult* becomes stronger and displaces the *child* and *parent*.

Prior to engaging in transactional analysis, the therapist makes a diagnosis through "structural analysis," by becoming sensitized to the patient's demeanor, gestures, vocabulary, and voice in order to determine which ego state is exhibiting the symptom or is responsible for disturbing characterological features. Psychopathology is designated and rephrased in terms of the *parent-adult-child* trilogy ("the cathexis of anthropomorphic precipitates"). Thus, hallucinations are usually exhibitions of the *parents,* utilizing the audience of the *child* and sometimes the contaminated *adult*. Delusions are generally exhibitions of the *child,* which contaminate the *adult*. Depersonalization is a manifestation of somatic stimuli, distorted by the confused *child,* which are incomprehensible to the *adult*. If the stimuli become ego-syntonic to the *adult*, they are transformed into delusions of bodily change. In hypomania the *child* excludes the *parent* with the cooperation of the contaminated *adult*. If this changes to mania, the *adult* as well as the *parent* become overpowered by the "hypercathected" *child.* Conversion hysteria is an exhibition of the *child* that has excluded the *adult* through repression. Character disorders and psychopathies are manifestations of the *child* living in agreement with the *adult*. Impulse neuroses are eruptions of the *child* without the cooperation of the *adult* or *parent*.

The therapist also operates with maneuvers from his or her *parent*, *adult*, and *child*. It is presumed that these will act in concert for the benefit of the patient. Often the *child* in the therapist will be able to perceive aspects of the patient's *child* and *parent* intuitively and subconsciously. The function of the therapist depends on the problem being considered; for instance, the therapist may, where repression dominates, have to break down the barrier to enable the *child* in the patient and therapist to talk together in the presence of the acting *adult*. The internal operations of the patient are regarded as akin to those of a multiple personality, the patient eventually learning to view personal maneuvers through the lens of whichever of the three ego-states are active at the time.

The preliminary "structural analytic work" of the therapist (which incidentally is usually accomplished in two or three individual sessions), in addition to making a diagnosis, consists of "decontamination," "boundary work," and "stabilization" to enable the *adult* to control the personality in the face of stress. Thereafter "transactional analysis" is employed, often in a group setting, to help the *adult* maintain social control despite the activities of other people who seek to stimulate the patient's *child* or *parent*. Transactional analysis in a group is usually followed by "game analysis" and, ultimately, by "script analysis" in which complicated life plans exist. In the group the transactions among the constituent members, consisting of a transactional stimulus and transactional response, are analyzed. A stimulus from one *adult* may be made to another *adult*, but the *response* in the latter may be that of the *child* or *parent* ("crossed transaction"). The stimulus may be from *child* to *child* or *parent* to *parent*. As long as the vectors are not crossed, the conversation will proceed smoothly ("complementary transactions"). Crossed transactions may be interrupted by the intervention of another member of the group or by the therapist, who attempts to bring the transactions back to the *adult* level. In this way the group members learn to diagnose each other's ego states as well as their own.

The engagements within the group (indeed in all social intercourse) are in the form of pastimes (when transactions are straightforward), games (in which dissimulation is introduced), and scripts (complex sets of transactions). Pastimes are generally *parental* or *adult*. For instance, a *parental* type of pastime is "PTA" in which projections ("Isn't it awful?") of delinquency by others are mouthed, such as delinquent juveniles, delinquent husbands, or delinquent wives; or they may be adult, in which introjections of "Me too!" are admitted ("Why can't I be a good mother, father, hostess, whatever?"). Other pastimes are "psychiatry" ("Here's what you're doing") and its introjective parts ("Why do I do this?" and

"Which part of me said that?"). The "Small-Talk" pastime consists of bits like "General Motors" (comparing cars), "Who Won" (man-talk), "Grocery," and "Kitchen" (lady-talk). Pastimes are indulged for a variety of reasons, for instance, as a way of diversion, getting satisfactions, warding off guilt, and easing quiet desperation. In group therapy pastimes are considered a waste of efforts, although they are a preliminary means through which the group members size each other up before the "games" begin.

Transactions are of several types: complementary (well structured) and "ulterior." Games are ulterior transactions, containing a concealed motivation ("gimmick"). A common game played in a group is "Why don't you ... yes, but." *(Parent:* "Why don't you go to school if you want to be better educated?" *Child:* "Yes, but then I won't have time to bowl.") The "gimmick" in presenting an adultlike request for information or for solutions here is to gratify the *child* who presents himself or herself as inadequate to meet the situation. Other games (which are infinite) are "Schlemiel," "Alcoholic," "Wooden Leg," "Uproar," "Ain't it awful," "If it weren't for you," "You got me into this," "There I go again," "Let's put one over on Joey," "Do me something," "Gee, but you're wonderful, professor," "Harass," "Rapo," and "Now I've got the son-of-a-bitch." Each game involves a goal-directed set of exploitative complementary transactions. Patients may enter into various alternative roles in the games that they play. Complex sets of games (scripts) are transference phenomena, manifestations of infantile reactions and experiences derived from the need to repeat in acts the transference drama. For instance, women whose fathers were alcoholics often follow the script based on the "rescue fantasy" of marrying one alcoholic after another. Pastimes, games, and scripts are played out and analyzed as integral parts of the group process.

In summary, transactional analysis is a technique felt by Berne to be superior to current supportive and insight therapies, helping the patient rapidly to tolerate and control anxieties and to circumscribe acting-out, while retaining the values of rational therapy. Moreover, he believes it to be applicable to problems that are difficult to reach by conventional therapies, for example, psychopathic personality, borderline cases, mental retardation, and manic-depressive disorders. The technique is easy to grasp. (Berne claims it may be learned in 10 weeks and perfected in a year of supervision.) In addition, it is well accepted by many patients. Its claim of universal applicability is, however, challengeable.

Several major schools of transactional analysis exist at present, most importantly (1) the Berne approach, (2) the Schiff "Reparenting" approach, (3) the Asklepieion approach, and (4) the "Redecision"

approach, the latter three introducing modifications in emphasis and techniques in the original Berne method (Goulding, 1976).

Experiential Therapy

Experiential approaches downgrade experimental, technical, and intellectual methods as nonmeaningful in the treatment process. What is considered important is bringing up and expressing feelings. According to its exponents, only through this means can one actualize one's potential and thereby cure emotional illness. The traditional therapeutic doctor-patient alliance is rejected as the basis for personality change. Instead of anonymity, manipulativeness, or detached noninterference, the climate of the therapeutic relationship is one of empathic warmth, friendship, expressed emotion, and regard for the patient. Neither the problems of the developmental past nor the promulgation of present insights are considered important. The emotional encounter between client and therapist is the basis for significant movement, and defenses against proper relating are dealt with by confrontation and the assignment of tasks. Experiencing the encounter as a different mode of relating eventually leads to self-actualization.

The role of the therapist, it is proclaimed, is to liberate the affects of the patient that have been frozen and cause paralysis. This is best accomplished, not by interpretation, but by establishing a meaningful, deep, affective relationship through the therapist's playing a role with the patient that is different from the conventional "You need me; I don't need you" role. Toward this goal the therapist does not set himself or herself up as a "healthy authority," a paradigm of personality virtues who is falsely "objective" (usually a cover-up for the therapist's neurotic omniscience and omnipotence), a pose that is rejecting of the patient and demeaning to himself or herself as an adult. There is no reason, it is claimed, why therapy should not be a mutual growth process, the therapist exhibiting his or her sickness and relating to what remains of the patient's healthy soundness, as well as the reverse. Such sincerity, it is presumed, can be remarkably ego-building for the patient.

Important exponents of this point of view are Whitaker and Malone (1963), who insist that the roots of psychotherapy are embedded in the matrix of the individual's biological being. Penetration to this dimension requires a unique management of the transactions between patient and therapist in

which heightened emotional tension is maintained. Attitudinal and behavioral change are secured by a modification of the customary interpersonal relationship during the therapeutic hour. This experience incorporates emotional penetrations into the therapist's own child-self, which, projected onto the patient, results in self-treatment of certain aspects of the therapist through the patient. In the course of this complex interaction, the patient is said to liberate himself or herself from socially restricting reality-inhibiting roles. Acting-out by both therapist and patient is accepted and even encouraged, releasing energies previously entrapped in emotional conflict. An interlocking of the unconscious (id) aspects of the participants reflects itself in a joint fantasy experience characterized by mass body sensations and a primitive level of communication. In depth, this encounter is believed to be of the profoundest therapeutic advantage. The patient's acceptance of his or her unconscious fantasies and their unification with the conscious self is encouraged by the role of the therapist as a "good" parent who sees the patient as part of himself or herself. The techniques employed by the therapist are not as important as the activities in facilitating symbolic unconscious meanings. This is accomplished by the therapist's dissociating as many of the realities as possible from the immediate therapeutic experience.

At the start of treatment the therapist may respond to the patient with silence and nonverbal communication as a way of promoting transference and of understanding the symbolic meaning of the patient's communications and behavior. The therapist encourages the patient's plunge into fantasy by pointing out to the patient the therapist's own limitations and immaturities.

Various forms of physical contact, including aggression, may be executed by the experiential therapist. Such objects as clay and rubber knives may be used, and sleeping during the session may take place, with a reporting of any dreams by therapist and patient as a way of promoting the mutual fantasy experience and "clearing things up." Out of the mutual encounter at the "gateways of unreality," therapist and patient are presumed to arrive at a better understanding of themselves and to achieve a heightened capacity to cope with reality.

Experiential therapy is often conducted in a group setting (see "Encounter and Marathon Group," Chapter 52) and may include many ordinary or unusual nonverbal interchanges.

In "direct psychoanalysis" J. M. Rosen (1947, 1962, 1964) has introduced a means of entering the

private world of the psychotic and of interrupting the deeply neurotic or psychotic regression (pregenital and neoinfantile) in which the patient is seeking a hallucinatory or symbolic representation of the indispensable, exalted but deadly mother that he or she knew. Instead of evading the parental role thrust on the therapist, as in conventional analysis, the "direct psychoanalyst" accepts it, functioning as "a loving, omnipotent protector and provider" for the patient. With a psychotic person, the analyst acts like an idealized patent who has the responsibility of bringing up the child again. With a neurotic person, the therapist guides him or her parentally to maturity. Observing Rosen working with patients, a number of therapists have followed his methods and have attempted to detail in their writings the techniques of direct analysis (Brody, 1959; Scheflen, 1961; English, et al, 1961). While Rosen's technique in the hands of skilled, trained therapists establishes rapid communication with regressed patients, its advantage as a form of reconstructive therapy has been challenged. For example, a controlled follow-up study at the Psychiatric Reception Center of the Philadelphia General Hospital showed that the percentage of improved patients treated by direct analysis was approximately the same as the control groups (Bookhammer, et al., 1966).

Criticism of Transactional Therapies

The greater activity inherent in transactional methods, as in other psychoanalytically oriented approaches, is believed by some observers to sponsor reparative and hence goal-limited tendencies that are more reeducative than reconstructive. A more passive approach, on the other hand, is said to permit the patient more readily, from his or her own growing resources, to appreciate transferential distortions and develop different ways of relating to others as a product of personal experience. Censured, also, is the minimization of insight as a constructive therapeutic force. Social insights acquired through manipulatory procedures rarely effectuate permanent change. The strongest criticism has been directed toward those transactional therapies that advocate a free, spontaneous interaction between therapist and patient, characterized by unrestrained physical and symbolic communication (aggression, physical contact, long periods of silence, joint fantasy), verbal and nonverbal. The emerging irrational experience, which may reach a psychotic level, is presumed to get at the core of problems. Since both the patient and therapist are encouraged to regress, there is said to issue out of this interaction mutual growth and maturity.

It is the "letting oneself go" and acting in an unrestrained way in the therapeutic relationship that have brought forth the greatest cries of disapprobation. This is because some transactional therapists have interpreted freedom in the relationship as an invitation to play the kind of role with patients that they need transferentially to project onto them. Thus, they assume the identity of the father, mother, sibling, God, devil, lover, persecutor, or whatever other figure is dredged up from their own or their patient's imagination. The more inventive and histrionic-minded the therapist, the keener the fantasy life of the patient, the more the eventuating drama takes on the aspect of a folie-a-deux. While the patient may register benefits from such tactics, as one can from any other kind of relatedness, and though better rapport may be established, particularly with psychotic individuals (such as occurs in Rosen's direct psychoanalysis), one should not be deceived regarding the depth and permanence of changes effectuated by such play acting.

Freedom of participation without control can give the therapist with neurotic problems a license for personal emotional catharsis and acting-out. This release has positive values for detached therapists who otherwise may find it difficult to relate and who therefore respond more genuinely and spontaneously if they are able to express themselves verbally or to act with few or no restraints. Some patients are willing to accept the unconventional behavior of therapists on the basis that they are now dealing with new, easier, more genuine kinds of authority who can admit to certain weaknesses: some patients tolerate a therapist's unconventional acts because they feel sorry for or protective toward the therapist. They may even assume the role of "helper," considering the therapist as as patient, fulfilling in this way their own neurotic needs for control and dominant status. As long as a working relationship exists, patients seem to be able to adjust to an astonishing variety of provocations. In their eagerness to get well, they will make capital out of almost any kind of relationship. This criticism, of course, is not directed at all transactional therapists, but only at those whose personal problems are such that they interpret behaving naturally as meaning undisciplined expression of their feelings and impulses.

ANALYTIC GROUP THERAPY

The spectacular growth of group psychotherapy throughout the world attests to its general acceptance as an effective treatment method. Where its proposed objectives are toward reconstructive changes in the personality structure, methods are introduced that purportedly release growth potentials.

Among the earliest dynamic formulations was a paper by Lazell (1921), which described group work among schizophrenics in terms of psychoanalytic theory, and the studies by Burrow. In the early 1930s Trigant Burrow (1926a, b, c, & d, 1927) organized a group of "participant observers" as part of a research project to investigate human basic motivations, particularly destructive and pathogenic impulses. Observing his own and the reactions of his colleagues, Burrow (1924) evolved ideas about the "social neurosis" or "mass neurosis" (1926b), and he concluded that human beings were faced with phylic defect that fostered autistic self-reference (Burrow, 1933, Syz, 1957). The study of this ubiquitous defect he called "phyloanalysis" (Burrow, 1930). Since emotional prejudices prevented the individual from fully scrutinizing his or her own processes, Burrow believed that these could best be approached through mutual interaction and self-disclosure in a group ("consensual observation"). A group, he found, helped to orient and resolve "man's unacknowledged self-centered and socially disruptive trend" (Syz, 1963). This was rooted in a preconscious primary identification with the mother, the basis for later stages in the child's development. Obsessive libidinal strivings were the product of an intrusion on this primary identification by objectification and cognition. Awareness of psychosomatic accompaniments of emotional blocking, in the form of oculofacial tensions, sometimes produced unexpected behavior changes, with a resolution of affect images (Burrow, 1941a & b). "The drive for self-justification and social approval gave way to an inclusive feeling attitude, to enhanced communication and a more direct application to immediate tasks, which outlasted the consciously induced attentional shift" (Syz, 1963). The focus on how attentional behavioral shifts could influence endo-organismic tension patterns differentiated Burrow's organismic from other group therapeutic approaches (Syz, 1936, 1957).

An integration of psychoanalytic theory into group process was to be expected as soon as psychoanalytically oriented psychotherapists became interested in groups. Among the earliest group analysts was Paul Schilder (1936, 1939, 1940), who, in working with criminals, described a method that combined autobiographical material with free association and dream interpretation. Wender (1940) employed a group analytic procedure in a hospital setting, and Sarlin and Berezin (1946) also reported an uncovering approach in group therapy.

Among the pioneer efforts to amalgamate psychoanalytic and sociological concepts were those of Moreno (1957), who very early in his career used the group method, and Wender (1940, 1963) and Slavson (1943), who outlined an analytic group process that they considered equivalent in every respect

to psychoanalytically oriented psychotherapy. Slavson brought out that transference in the group was multiple, being directed toward various persons at the same and at different times. It could be positive or negative, but if progress was to occur, positive transference toward therapist and group members had to develop after analyzing and disposing of negative feelings. The group, essentially patterned after the original family, fostered transference that was of parental, sibling, and "identification" types; in the latter case the therapist and certain group members served as identification models. The effect of the group was to dilute the transference, although the total consequence to the individual was a heightening of emotional feeling.

Shortly before the end of World War II Alexander Wolf (1950), applying himself to the "psychoanalysis of groups," endorsed the use of free association, dream analysis, exploration of transference and resistance, and the search for those early memories and experiences that were the forerunners of current characterological and symptomatic disturbances. Countertransference was also to be considered. Wolf advocated hetergenous groups of approximately the same age with a balancing of males and females. He believed this facilitated resolution of problems on the heterosexual gregarious plane. Excluded were psychopaths, alcoholics, stutterers, mental defectives, hallucinating psychotics, and hypermanic patients. The groups, which had eight to ten members, met two to three times weekly for 90 minutes. So-called "alternate sessions" were also introduced by Wolf; i.e., scheduled meetings of a therapeutic group without the therapist present were alternated with regular sessions held with the therapist. A number of individual interviews might be required before the patient was ready to enter the group. This, the first stage of therapy, was diagnostic. The patient was also prepared for group analysis by explanations regarding its theory and practice.

The second stage of therapy, conducted in the group setting, consisted of free associations organized around the dreams of the group members. Once good rapport developed, the third stage of therapy began. This consisted of each patient spontaneously free associating about the next, which resulted in a bombardment of the patient's defenses and exposure of conflicts. The patient learned which of the characteristics pleased the group and which disturbed them. In the fourth stage of treatment, resistances mobilized by the free associations of the group members came up for analysis. The fifth stage of treatment was concerned with analysis of transference—its identification and resolution. Recreating his or her original family in the group, each patient learned how he or she projected parental and sibling

images toward members and therapist. Wolf claimed that identification and resolution of transference proceeded more thoroughly and rapidly in a group setting. The sixth and final stage of treatment was characterized by planned conscious responses in the interests of the group and the individual. These replaced strivings of an irrational or compulsive nature engendered by the person's habitual character structure. More penetrating analytic explorations were possible in groups than in individual analysis because the "group ego," with which each member identified, supported an impoverished ego and heightened tolerance of anxiety.

In his later contributions Wolf, in conjunction with E. K. Schwartz, expanded the advantages of group over individual analysis (Schwartz & Wolf, 1960; Wolf & Schwartz, 1962). An important feature of group, they wrote, was the replacement of the omniscient ego ideal of the single therapist by the group ego ideal with which the patient could align. In this way the group enabled the patient to face social reality and "to become aware that his fulfillment can only be realized in a social or interpersonal setting." At the same time the authors depreciated the impact on the individual of group dynamics, considered by some other therapists to be a potent force in a therapeutic group. They considered group analysis essentially the psychoanalysis of the individual within a group rather than the analysis of the group.

Other psychoanalysts also experimented with methods that drew on psychoanalytic theory. Sutherland (1952), for example, stressed that psychoneurotics could be helped adequately in group therapy only if a change was brought about in them through the resolution of their unconscious conflicts. He contended that group therapy could be conducted along strictly analytic lines in order to achieve this purpose. Somewhat similar points of view were emphasized by S. H. Foulkes (1948) and Ackerman (1950). Ezriel (1950, 1952) listed three hypotheses related to a method of applying psychoanalytic theory to group therapy. The first was that unconscious feelings toward past authoritative personages were projected onto figures in the social environment. The group provided an opportunity for such multiple transferences. The second was that a common group tension developed that involved all group members and elicited in each person unconscious fantasies that had a common denominator. Each member assumed a role in a "drama," enacted in the session by the group. This brought out the individual's particular defense mechanisms. The third hypothesis dealt with interpretations that were made to the group members. These were given in relation to the unconscious content of the area of common tension and to the specific defenses the patient employed. Spotnitz (1952b) discussed the

enhancing of ego functioning of the individual in the group setting. Where selection of group members included a scattering of problems and personality types, an opportunity was afforded patients to experience and to observe a variety of reactions that helped them scrutinize their own reactions more objectively. Individual resistances were handled rapidly by the group, and this resulted in symptomatic improvement. Spotnitz believed that the instinctual forces at work in group could be understood in terms of the life and death instincts as outlined by Freud.

In England, as in the United States, fruitful investigations of analytic group therapy have been ongoing. Bion and Rickman, around 1943, instituted group discussions among army personnel in an atmosphere stripped of the traditional authoritarianism. Bion's work at the Northfield Military Hospital was particularly outstanding and was adopted as a model for psychoanalytic group practice in various parts of England. All groups, Bion (1948—1951, 1961) claimed, operated on the basis of certain cultural assumptions that gave rise to heightened emotional states. Contributions to the group were in accordance with whether individuals resisted or accepted the existing cultural standards. Valences of pairing, dependency, or "fight-flight" developed with shifts in the emotional culture of the group. Operating in a relatively nondirective way and purposefully avoiding structure, Bion utilized the initial resentment or confusion of the group members as material for analytic exploration. Throughout the group process interpretation was focused on the total group rather than on individual behavior.

Expounding on the importance of group factors as distinctive from individual phenomena. Foulkes (1948; Foulkes & Anthony, 1957) considered the group matrix the essential element. The group analyst, he insisted, had to deal, as a participant observer, with all communicative and relationship processes as aspects of the total interactional field. Substantive regressive, infantile manifestations were, according to Foulkes, minimized by the presence of the group. Maintaining some Freudian concepts, Foulkes felt his approach drew largely from Gestalt and field theory, particularly from the ideas of Kurt Lewin (1945). Analytic group therapy, he insisted, must concern itself with the "deep aspects of social interaction," which is "preeminent in the uncovering of the deep unconscious group phenomena." Though transference occurred in a group, it was not of paramount importance for the therapeutic trend of the group. "The group is not the most suitable place to analyze a transference neurosis... . Psychoanalysis provides the ideal solution for this.... It is not that group-analysis does less; it does something different.... It is consequently unprofitable to confuse the scope and field of the two therapies."

Due to the present-day rapid growth of group psychotherapy, methodologies, as M. Rosenbaum (1965) has pointed out, have moved far ahead of theoretical explications. Conceptual clarity of the process operative in groups is particularly lacking. In this void it was to be expected that each school of analysis would project postulates regarding group phenomena, attempting to delineate in its own terms what happens to people in groups and how they best may be helped to achieve personality growth. Thus, Freudian analysts conceive of the group as a family in which the individual acts out repetitively and compulsively infantile neurotic tendencies. Catharsis and regression are accordingly considered to be significant therapeutic agencies, although Scheidlinger (1968) has emphasized that therapeutic usefulness rests in how well ego functions can overcome resistance to face warded-off infantile drives and accept and master them. Psychoanalysts with an inclination toward "ego analysis" regard the group as a medium that supports mutual exploration of defensive characterological factors and healthy adaptive functions. Horney analysts believe that a group helps to modify exaggerated self-idealization and other distorted concepts of the self and world. In an atmosphere of mutual cooperation a healthy feeling of belongingness may be restored. Sullivanian analysts look upon the group as a laboratory in which neurotic interpersonal patterns may be detected and constructive models elaborated.

Superimposed on adumbrations of unconscious mechanisms are group dynamics, held by some (such as Bach, 1954; Thelen, 1954; Thelen, et al, 1954: Whitaker & Lieberman, 1964) to be, not an accessory, but a primary factor responsible for change. Postulates from field theory and role theory are borrowed liberally by analysts who subscribe to group rather than patient-oriented methods (Bales, 1950, 1958; Bavelas, 1952; Cameron, N. & Margaret, 1951;Cartwright, 1950, Deutsch, M, 1949a, 1951; Festinger, 1942, 1947; French, J, 1941, 1944; Gough, 1948; Homans, 1950; Lewin, K, 1947, 1948, 1951; Lippitt, 1948, 1952; Mead, G, 1934; Parsons & Schils, 1951).

These concepts, some of which were discussed in the last chapter in the exposition on reeducational group therapy, are combined with psychoanalytic formulations and make for a confounding diffuseness in ideas. Accordingly, group dynamically oriented analysts have been subject to virulent attack. Indeed, the most vocal antagonists consider group processes to be obstructive rather than helpful during analytic group treatment. In another direction are group analytic activities that are wedded to existential concepts, exploiting the "feeling" and "experential" components of the group process (Mullan & Sangiuliano, 1958; Hora, 1959a & b; De Rosis, 1964). A total involvement by the

therapist in the group is a primary aim with communication of all of his or her authentically perceived experiences and reflections.

Innovations introduced into the field of analytic group therapy include the use of multiple therapists (Spitz & Kopp, 1957; Rosenbaum, M. 1963), of family members in groups (Ackerman, 1958b; Grotjahn, 1959; Bell, J. 1962), of marital couples (Whitaker, C. 1958; Perelman, 1960; Leichter, 1962; Grinker, 1966; Sager, 1966a) and of videotaping (Berger, 1970, 1971; Alger, 1972; Melnick & Tims, 1974).

The literature in group therapy reflects a paucity of substantial contributions in research and follow-up and a diffuseness of regard for the boundaries of group psychotherapy per se in relation to other types of group experience, such as group counseling, small-group interactions, family therapy, marital therapy, and the therapeutic community. There is particularly a tendency to amalgamate reeducational with analytic groups. This is understandable in that group dynamics operate in all group interactions; however, it tends to confuse issues relating to group theories and techniques. Excellent reviews of the yearly literature are found in annual issues of the *International Journal of Group Psychotherapy,* the official publication of the American Group Psychotherapy Association, under the title "The Group Psychotherapy Literature." Overviews of the literature in group psychotherapy for a ten-year period are included in the books *Group Therapy* (Wolberg and Schwartz, 1973-1975; Wolberg and Aronson 1974-1979, 1980—1983). An excellent historical account may be found in the paper by Durkin (1974). The books by Yalom (1975, 1980, 1983), Sager and Kaplan (1972), Grotjahn and Freedman (1983), and Kaplan and Sadock (1983) continue to enjoy deserved popularity. Among the important past articles and publications are the reviews written by Taylor (1958), M. Rosenbaum (1965), and Durkin (1974). A coordinated bibliography has been compiled by R. Thorne (1966) and Strachstein (1965). As may be expected, the writings reflect many cause controversial issues, not only in relation to theory, but also in regard to the organization and direction of the group, including the participation and role of the therapist, the therapist's relative activity or passivity, the value of alternate sessions, pre-sessions and post-sessions, the management of acting-out, and the handling of resistance and transference.

The most important older general readings include the following: Ackerman (1957), Bach (1954),

Berne (1961, 1963), T. Bieber (1957, 1959), Bion (1961), Brock-bank (1966), Cartwright & Lippitt (1951), Cartwright and Zander (1960), Corsini (1957), Durkin (1954, 1957, 1964), Foulkes (1948, 1957, 1964), Foulkes and Anthony (1957), Glatzer (1964), Hinckley (1951), Hobbs and Rogers (1951), Hulse (1960), J. Johnson (1963), Kadis (1963), Klapman (1946), Locke (1961), Moreno (1957), Mullan (1962), Powdermaker (1951, 1953), Rosenbaum and Berger, (1963), Scheidlinger (1952, 1960), E. Schwartz and A. Wolf (1957, 1960, 1961), Slavson (1943, 1947, 1956a & b, 1960, 1964), Spotnitz (1952a & b, 1961), Wender (1963), D. Whitaker and Lieberman (1964) and A. Wolf and E. Schwartz (1962). Recommended literature on topical problems subsume the following references:

1. *Special technical management*—M. Berger (1958), Hulse (1950) Markowitz and Kadis (1964), Munzer (1964), Scheflen (1964), Winick and Holt (1961)

2. *The alternate meeting*—Kadis (1956, 1958, 1960), A. Wolf and E. Schwartz (1959, 1960)

3. *Selection of patients for groups*—M. Freedman and Sweet (1954), Furst (1950), Glatzer (1956), Leopold (1957), Slavson (1955), Stein (1963)

4. *Combined and joint therapy*—Aronson (1964), Lipschutz (1957), H. Papanek (1956), Sager (1959)

5. *The use of co-therapists*—A. Gans (1962), L. Lundin and Aranov (1952), Solomon et al. (1953)

6. *Transference*—Bach (1957), Belinkoff (1964), Beukenkamp (1956), Chance (1952), Demarest and Teicher (1954), Ezriel (1959), Farrell (1962), S. Foulkes (1961), Fried (1965), Glatzer (1952, 1965), Grotjahn (1953), Hadden (1953), Horowitz (1964), Loeser and Bry (1953), Mullan (1955), Slavson (1950), Spangaard (1959), A. Wolf (1950)

7. *Countertransference*—R. Cohen (1961), Flescher (1953), G. Frank (1953), Grotjahn (1950, 1953), Hadden (1953), Hora (1956), Mullan (1953b), L. Rosenthal (1953), Schindler (1953), E. Schwartz and A. Wolf (1964), Shaton et al. (1962), Slavson (1953), Stroh (1958)

8. *Resistance*—Arsenian et al. (1962), Belinkoff et al. (1962), Bry (1951), Durkin (1951), Flescher (1957), Gadpaille (1959), Geller (1962), Glatzer (1953, 1959a & b, 1962), Goodman and Marks (1963), M. Goodman et al. (1964), Greenbaum (1957), Heckel et al. (1962), G. Hill and Armitage (1954), Hulse (1950), J. Jackson and Grotjahn (1958), Kotkov (1957, 1958), Krause (1961), E. McDonald (1951), R. Menninger (1949),

Morse et al. (1955), Mullan (1953a), Ormont (1962, 1964), Redl (1948), J. Rosen and Chasen (1949), L. Rosenthal (1963), Spotnitz (1952b, 1958), Spotnitz and Gabriel (1950), A. Stein (1952), Stock (1962), J. White (1964), Wolman (1964)

9. *Acting-out*—Abt (1965), Aronson (1964), Bry (1953), Burke and Lee (1964), Drukin (1955), Durkin et al. (1948), Eaton (1962), Slavson (1956), Vass (1965), A. Wolf et al. (1954), Ziferstein and Grotjahn (1957)

10. *Dreams, fantasies, and early recollections*—Chalfen (1964), Kadis (1957), Klein-Lipshutz (1953), Locke (1957)

11. *Special clinical issues*—Abrahams (1953), S. Brody (1961), Durkin (1954), Ginott (1961), Godenne (1964), Grotjahn (1959), J. Krasner (1959), L. Kubie (1958a & b), S. Kubie and Landau (1953), L. Rosenthal and Nagelberg (1956), Slavson (1945, 1950), C. Whitaker (1958), A. Wolberg (1960), Wolman (1964)

Criticism of Analytic Group Therapy

There are those who insist that individual therapy is doomed. Some analytic group therapists have become so completely involved with their specialty that they forecast a bleak future for the dyadic model. Because no person is an "island" and each individual is propelled by a feedback of stimuli from others, some predict that psychotherapy of the future will be experiential and concern itself exclusively with the "here and now," with clusters and not single entities, with the "what" and "how" and not the "why." History taking and ransacking childhood memories in search of "significant traumas" will be relegated to "the archives of psychological history" (Kempler, 1969).

This dire augury probably reflects the sentiment of therapists whose working styles are more attuned to groups than to individuals, and in all likelihood it refers to those patients whose learning patterns and cognitive modes synchronize with group interactions. There are patients, however, who are inflexibly unmotivated to resolve their problems in groups, and there are some whose defenses operate against benefits accruing from therapeutic group experiences. Such persons do very much better in individual therapy. Moreover, the verdict of many therapists who do both group and individual therapy points to the fact that if the patient has a desire and capacity for reconstructive change, there is no substitute for intensive individual treatment. Intrapsychic alterations, reflected in depth transformations of the character structure, may occur in patients in group therapy who possess a readiness for change. In

my opinion, however, there is a greater likelihood that this will happen with properly administered individual therapy or with combined therapy.

Individual therapy is here to stay despite the adaptations that undoubtedly will need to take place with massive programs for the delivery of mental health services.

Criticisms of analytic group therapy are not so much levied at the concept of working with a group but rather at the theories of the different group therapists and the global claims that they make for their methods. The controversy in group therapy between adherents of the regressive-re-constructive and the experiential-affect approaches (which interpret analytic group therapy as a blend of psychoanalytic and group dynamic processes) is as heated as the Freudian-neo-Freudian polemic in individual psychoanalysis. Controversial also is the tendency on the part of some group analysts to consider the analytic group by itself an adequate substitute for individual analysis. Indeed, in the opinion of a dedicated few, group analysis *is* psychoanalysis. This idea has been disputed by other group analysts who differentiate analytic group process, irrespective of theoretical direction, from psychoanalysis; rather it is classified as a form of psychoanalytically oriented psychotherapy.

The group process, nonetheless, stimulates powerful projective and identification mechanisms in both patients and therapists that operate in the interests of cure as well as of resistance. In a group setting, say the critics, it is more difficult to detect the resistance manifestations, since patients are capable of concealing themselves better behind vocalizations of more active members. It is particularly inconvenient to unmask transference as it assumes the regressive form of claiming the right to a symbiotic tie with the mother. In groups transference is often displaced from the therapist to the group members, undergoing such sharp splitting, "dilution," and distortion that it loses its therapeutic potential. Defenses against transference are more easily elaborated in the group than in individual analysis. The resolution of the regressive transference resistance, one of the most important elements in therapeutic change, may, as a consequence, be completely blocked. This failure is abetted by the propensity of the group to sponsor the acting out of members with each other, particularly in alternate or post-therapy meetings, where pairings drain off transferential tensions and leave the neurosis exactly where it was. The therapist is put in an anomalous role here since to forbid interaction outside of the formal group places the therapist unhappily in the position of a punitive and nonneutral authority; to sanction it invites further acting-out.

Moreover, the nature of the group situation makes it arduous for the therapist to identify with each patient and then to objectify the identification in the form of appropriate interpretations. Some therapists try to overcome this by seeing patients in combined individual and group therapy or by avoiding placing patients into groups until they are well into the middle phases of therapy.

Reconstructive change presupposes intrapsychic restructuring. This is often impeded in the group, it is claimed, by alliances that members make with each other, by encouragement of hostile verbal exchanges, and by interpersonal interlacings through which neurotic regressive gratifications are derived at the expense of mature growth. Analysis of interpersonal operations, continue the critics, is important but often done on the sacrificial altar of true intrapsychic exploration. The engaging of members in verbal combat as an outlet for "sibling-rivalry" hostility serves too readily as defensive resistance. Complicating matters also are the reassuring, advice-giving directives that the reincarnated "family-members" extend to those undergoing stress who are seemingly in need of support. Such tactics, critics allege, water down the reconstructive potentials of treatment. Analytic group therapy also poses a strain on the therapist, since the multiple impact of the group members will exaggerate the therapist's countertransference and interfere with objective interpretations.

A great deal of criticism is extended toward experiential therapists who abdicate their role as therapists and become themselves patients in the group. This is said to play into their patients' defensive needs for omnipotence and control.

These criticisms, while authentic, do not really negate the value of analytic group therapy. They merely accent the need for great experience and maturity on the part of the analytic group therapist. If therapists are able to manage the resistances of their patients, they will have in analytic group therapy a most important, even indispensable, therapeutic instrument. Most therapists endorse a combination of group and individual therapy (combined therapy) during which the benefits of both forms of treatment are used to advantage (Caligor, Fieldsteel & Brok, 1984).

Notes

1 The existence of a portion of mental activity at the periphery of awareness or permanently blockaded from awareness was known to scientists and philosophers before Freud. Freud's contribution was to demonstrate the dynamic operation of the unconscious in the daily life of the individual and its role in psychological illness. He devised ways of examining and exploring unconscious

ideation, and he formulated a theory organized around the workings of this hidden portion of mental activity. Though some of his hypotheses have been altered and new terms for the unconscious have been elaborated (such as Rado's "nonreporting brain activity"), Freud's basic contentions about the unconscious and his methods of decoding it continue to be accepted as a most fundamental contribution.

2 Freud (1934) regarded the original libidinal charge or "cathexis" of the ego, as "primary narcissism." Part of the libidinal cathexis of the ego was later yielded to outside objects. This enabled the individual to participate in relationships with others. The original libidinal cathexis of the ego persisted and was related to the object cathexis, like the body of an amoeba is related to the pseudopods that it puts out. And like pseudopods that could be withdrawn into the body of the ego, so object libido might, in times of stress, be withdrawn with return of narcissism ("secondary narcissism"). Infantile conflicts and patterns were also revivified in this process. Sexual perversions constituted the positive expression of pregenital libidinal fixations, while neurotic symptoms were a negative or converted expression (Freud, 1938a).