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THE NEWER THERAPIES

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Table of Contents

- Rational Emotive Therapy
- Transactional Analysis
- Imagery Therapies
- Gestalt Therapy
- Primal Therapy
- Reevaluation Counseling
- Body Therapies
- Existential Psychotherapy
- Experiential Psychotherapy
- Reality Therapy
- Psychosynthesis
- Sex Therapy
- Fight Training
- Parent-effectiveness Training

Changing the Dyadic Pattern

- Groups
- Family Therapy

The Newer Therapies

Introduction

In addition to psychoanalysis and behavior therapy, a third type of psychotherapy has most recently developed and is widespread. Sometimes called "the third force," or the "humanistic"' or "existential" or "experiential" therapies, or simply the "newer therapies," they consist of many different methods with different names and procedures. A number of these will be discussed in detail. Although they have a great deal in common, there is not a universally accepted body of common principles. However, certain things are clearly stressed by most of them.

Attributes of the Newer Therapies

Direct Experience

Something happens during interviews that is other than words. These therapies emphasize one or more of the following: emotions, feelings, images, role playing, body tensions, choices and taking responsibility, hugging and touching, autonomously arising sentences and body-movement expressions. One or another of these kinds of direct experience is concretely worked with, and cognitive analyzing is explicitly downgraded. Something more than words and thoughts and externalized descriptions must occur. However,

these therapies, and the individual practitioners, vary in regard to this emphasis. Some of the newer methods are not so very different from psychoanalysis, although they use a different vocabulary; other therapies consist, very centrally, of quite concrete bodily, imaginative, or felt events so that a person can be in no doubt whatever that something more than thinking or just talking is occurring.

This emphasis during the interview on something other than words is in sharp contrast to psychoanalysis and operant-behavior therapy in which the interviews center on cognitively defining one's experience, or on analyzing one's external behavior and situations.

In psychoanalysis, the person's difficulties and experiences are translated into conceptual categories of dynamics and diagnostics. The therapy process is then guided by, and carried on in terms of, these conceptual definitions. The analyst moves from the patient's experience to conceptually understood categories, and then works with these. The person's experience is defined by them. The analysis is guided by them. In operant-behavior therapy the analysis of external behavior and situational circumstances has the guiding role. The person's experiences are related to externals, and these latter are then worked with. In contrast, most of the newer therapies work directly with concrete, experienced events during the interviews.

Change Now

Among other related principles held in common is the conviction that *concrete personality change can happen now.* There is a great rebellion against the psychoanalytic emphasis on the patient's past, and the psychoanalytic way of postponing change to a future that is thought to come only after years of talking sessions. Cognitive analyzing does not bring change or it brings very little, and only slowly. Instead, the emphasis is on what the person feels right now. The question is, how can we work with and move further with what the person feels right now? The content of the feelings may well concern events of infancy and childhood, but feeling them and crying is now, and the fresh release and new movement from these feelings into new experience can happen now.

Something more than words and ideas must happen right now, and this is always the main aim.

These methods have various procedures for moving off the level of mere talk and directly into concrete feelings. As will he seen, these procedures range all the way from simply condemning "head trips" (useless intellectualizing) to subtle methods for aiding a person to get directly in touch with a feeling process and having movement in it right now.

Responsibility

Concurrent with the emphasis on bringing about something more than ideas right now is an emphasis on the person's own responsibility. These therapies imply a *denial of determinism.* The past may have made one what one is, but changing now is possible now and it is one's own responsibility to choose and make a change. There is a flat denial of the psychoanalytic belief that natural-science forces keep one as one is.

Trust Your Own Body

Another emphasis held in common is *a reliance on the trustworthy and adaptive nature of the organism.* This emphasis opposes Freud who considered mental health a balance of forces that were in themselves pathological, lie held that repression was essential for civilized society, and viewed the body without socialization as a seething cauldron of savage, separate id drives. In the newer methods, the body is viewed as an adaptive self-balancing system. Integration and balance are not due to conscious ego control, as in Freud, but are natural in the body. Therefore, the solutions are already inherent in the organism, and must be allowed to emerge. Feelings can be trusted—their good reason will emerge. If any aspect of humans is mistrusted in some of these therapies, it is precisely the rationality and control in which Freud placed his faith. This mistrust of reason and thinking gives some of these newer methods a certain imbalance—as though reason and thinking were not also a proper part of the human organism. But this

mistrust is meant to counteract the widespread overemphasis on reason and control in our culture. For many people, therapy is a process of loosening overdeveloped controls and tensions so that a more natural process can be liberated.

Interaction

There is also an emphasis on *interaction.* Denying the psychoanalytic view of humans as intrapsychic mechanisms, most of these therapies imply that a person *is* an interaction with others and the environment. Instead of internal entities, drives, complexes, unconscious fantasies, and so on, the emphasis is on modes of living and relating to other people, the therapist, one's sexual partner, parents, friends, authorities, work, culture, and society.

Instead of internal psychic entities what one actually finds when one enters into one's feelings are interactions with others. For example, one finds no fear or hostility, one finds a fear of . . . something that might happen or might have happened or might have been done to one ... by certain people. One finds one's anger *at .. .* the people who did certain things and forced one to be in certain ways. What one finds are aspects of living done and left undone, not intrapsychic entities.

Therefore, those therapies that deal with directly had feeling, also emphasize interpersonal interaction. That is because when feelings are

directly explored, they turn out to involve interactional aspects. Only with theoretical concepts can one make purely internal entities, intrapsychic contents. An experiential approach leads to an understanding of human nature as interactional.

Arrested Growth, Arrested Living

The nature of psychosis and neurosis is arrested growth, or arrested living, not pathological contents. Therapists are not so interested in elaborating and understanding strange ways of being as in moving beyond them. From this new viewpoint the most interesting thing about a delusional system would not be its content or symbolic meaning but the living and relating, the absence of which it marks. The effort would not be to interpret it but to contact the person deeply and simply in spite of it. In the newer therapies there is, therefore, much less fear of seemingly pathological entities. Growth and inward richness are the heritage of any human being, and nothing that arises in a person is viewed as inherently sick or wrong or to be feared. The aim is not somehow to do away with seemingly insane content but to enable people to live and interact more fully and to get feelingly in touch with themselves. Therapy is personal growth, not a cure.

Not Adjustment

It follows also that these therapies, at least avowedly, are *not trying to adjust anyone to society as it is.* Rather, they are trying to overcome the stultifying and retarding effects of socialization. In these newer views, it is the dehumanizing, threatening, conventionalizing effects of society that are pathological, not inward contents of a person.

No Authorities

Along with these emphases it follows that *the therapist is not usually viewed as an authority* who knows what is sick or well. There is a revolt against what is called the "medical model," the view that the doctor's authoritative knowledge cures the patient. (The appropriate model would resemble a more ancient concept of medicine as ministering to a self-healing body, and as working with a knowing and self-directed patient whom one advises.) The therapist knows procedures that help get in touch with something and how to feel it through. The therapist is not an authority and cannot tell the person anything substantive, or do anything useful to the person that the person isn't doing.

Training Through Self-examination and Consultation

Accordingly, *the type of training* being advocated is not so much a university education or knowledge of concepts and experimental methods, as

it is one's own personal therapy and growth and the opportunity *to explore oneself with someone while one is doing therapy.* Supervision does not consist of an older therapist telling the trainee about the patient (consider—the supervisor hasn't even seen the patient, while the trainee has lived deep hours with the patient.) Rather, supervision resembles therapy except that the trainee's process takes its rise from the relationships with people being seen in therapy.

The more experienced therapist might sit in with the trainee in the session. Similarly, the experienced therapist might let a trainee participate as a cotherapist. The experienced therapist would be more likely to discuss difficult situations, would be more open about failures than perhaps the trainee at first dares to be. The traditional pattern is reversed, according to which the supervisor, almost in military fashion, could never be seen having difficulty.

Bringing Others into the Interview

The therapist-patient relationship *is more open to include others into the hour,* such as both partners of a marriage, all the members of a family, or someone to help the therapist express feelings or difficulties, or to move beyond a stuck situation. Because of the diminution of the authority structure, and because of the emphasis on real interaction and feeling what is

happening now, a therapist finds it much easier in these newer methods to own up to errors and conflicts (and to resolve them or process them right there) than used to be the case in the older methods. The therapist's consultant is, therefore, best made part of the ongoing interview, where more can be seen and processed, than in a later separate session consisting only of "talking-about." This emphasis on ongoing interaction makes it similarly desirable that the person and the important people in the person's life are here in ongoing interaction, instead of a lone person merely talking about these interactions.

Choices To Live

There is a strong *emphasis on choice.* Psychoanalytic determinism is viewed as a mere ploy to avoid feeling through what one can change. Behavioral methods of controlling others, as currently being used by jail administrators in many jails, seem patently designed to hide from people, or defeat in them, their own inherent capacity for choice and for assuming the direction of their lives. (On the other hand, behavioral methods for extending one's own control of one's own behavior are welcomed. Behaviorists are often unconcerned about the difference between these two kinds of uses of their work, a difference which seems so major.) Choice in these newer methods isn't viewed as arbitrary selection from among alternatives. Rather, it is taking on one's living, it is moving to a different mode of being alive,

harder perhaps than being controlled, but more exhilarating, more aware, and also safer. People can be controlled into doing almost anything. In contrast, becoming more sensitive and self-directed doesn't lead one to want to oppress others, or to need to hurt them. Rather, one wants others, to live with and interact with, who are also more broadly self-aware and in control of their lives.

Neither control by others, as in some behavior therapy, nor rational secondary process self-control as in psychoanalysis can achieve this manner of living. It makes use of a more holistic instinctual and more globally sensitive totaling in the body than habit or reason alone.

The Major New Methods

A number of therapies in this group will be discussed separately here. There are quite a lot of supposedly different therapies that are not sharply differentiated from each other. Even the chief ones overlap considerably. Therapists freely borrow procedures from each other. Many therapists hyphenate more than one orientation, calling themselves Client-centered-Existential for instance, or some other combination. In a chapter of this kind, only a few of the major and most representative methods can be discussed.

Most of the newer methods arc identified with a specific procedure.

The variety of procedures can best be understood if one bears in mind that something other than mere words or external actions is being worked with. What, other than words and actions, may be worked with? One may work with images or emotions, with directly sensed but unclear feelings, with body tensions, muscles, actual personal interaction, role playing, hugging and touching, music and painting, important words or sentences repeated or screamed, with body postures and expressive motions that come autonomously and can release powerful experiences in a person.

The following gives some notion of the variety, and, running through it, the constant aim for an impactful change or bit of experiential movement now, rather than staying with nothing but endless verbalizations.

Client-Centered Therapy

Carl Rogers (1961), who founded *Client-Centered Therapy,* eliminated all interpretation. Instead, *every* therapist response attempts to state exactly what the client is just now trying to communicate. Nothing is merely inferred. Only what is there for the client is said. Only what the clients themselves bring up is ever talked about by the therapist. However, the therapist responds to the personal edge of what the client says, or implies. If the client tells about an incident, the therapist will respond to what the incident seems to mean to the client, how it makes the client feel. The therapist attempts to

stay within the exact limits of what the client is trying to communicate. Any attempts to twist this, to add something, to reinterpret it, are viewed as getting in the way of the client's inward movement.

This method sounds simple, but it is quite demanding. One does not usually grasp another person's meaning and personal sense, because it is with one's own organism that one takes in what others say. Client-Centered Therapy requires that the therapist sense the client's concerns and personal ways of viewing and struggling with whatever is being said, just exactly as it is felt by the client. The therapist must respond to each bit the client expresses. Frequently, the therapist's response is such that the client has to "correct" it, "No, it isn't quite like that, it feels more like . . ." whereupon the therapist will restate it more correctly, until—perhaps after two or three corrections—the therapist grasps exactly how whatever is being worked on feels to the client. At this point, it is crucial that the therapist now keep quiet. The client will continue.

The client senses that what was just talked about has got across. There is now room in the client for some next thing to come up.

The interpersonal space and interaction with the therapist becomes an extension of the client's inner space, and there is a powerful uncramping and moving forward of feelings and perceptions, emotions, and implicitly sensed

inward experience. Rogers discovered that a very powerful and self-propelled process takes its rise and continues without being controlled or guided by either therapist or client. Once the process gets going, it is felt powerfully, and is frequently well ahead of what the client can rationally understand. During the week, between interviews as well as in the therapy hours, the client can feel much more going on, more feelings and unclear but important stirrings, than can possibly be kept track of. There is no doubt that a very large change is taking place.

Compared to tense, intellectual talking, and compared to the constant stops and starts of therapist-patient arguments and interpretations that get the patient off the felt track, client-centered therapy feels like being on an express train. It is nothing like "just letting someone talk." When people are not responded to, they tend to talk in circles and remain stuck in the same feeling sets. The Client-Centered therapist responds to each few sentences of the client. Another person sensing exactly where one is and "saying back each step" makes for movement. There is a relief that someone understands, but at the next moment something new arises within that would never have come up had one not been responded to. Therefore, quite often between therapy hours, clients think and talk to themselves, circling round and round their problems, and then find themselves moving swiftly again as soon as where they were stuck for several days has been expressed, heard, and responded to.

Rational Emotive Therapy

This therapy, devised by Albert Ellis (1962), may be viewed as the mirror opposite of Client-Centered Therapy. The emphasis is on beliefs rather than feelings. The therapist insistently moves the patient's attention away from any sentence that begins with "I feel," and focuses instead on "beliefs" and "ideas." The central notion is that people torment themselves internally on the basis of irrational beliefs. Examples of such beliefs are that one "should" do or feel something, or that one "must" feel bad if certain things have happened. Ellis distinguishes between "It would be nice if . . ."(for example, if I had someone to love) which he considers rational, and "Therefore I *should* feel bad" which he considers insane. The "RT" therapist exhorts the client to make that distinction, and to eschew all "shoulds." Similarly, the client is urged to distinguish between "It is too bad, that . . ." (for example, that he rejected me) and "It's *awful,* that . . ." or "I *must* feel bad, that . . ." The method assumes that bad feelings come from insane beliefs, mostly along the above lines. Many people experience considerable relief when they cut what seems like a logical tie between what is the case, on the one hand, and what they do to themselves inside about it on the other hand.

In a typical Rational-Emotive-Therapy interview, in contrast to Client-Centered Therapy, it is the therapist who does most of the talking. In a transcript, the long paragraphs begin with a "T." The client frequently says

only "Yes" or begins sentences with "You mean . . ." trying to understand the therapist's argument. The strongest possible words and forms of persuasion are used by the therapist who is not stopped by a client's tears or rage. On the other hand, the therapist has confidence in the client's capacity to improve.

As in the other therapies in this group, the emphasis is on the present and on stopping maladjustive patterns in the present. The past is no excuse for present behavior. It is in the present that the client is still maintaining and reinforcing his irrational beliefs, still "catastrophizing," still creating inward disturbance.

Even if the client vows to get rid of these beliefs, they are "underlying," and their removal requires practice. The beliefs are implicit and to root them out takes inward work that is not really as different from the other methods as the rational emphasis makes it sound.

Transactional Analysis

Eric Berne's transactional analysis (1961) might at first seem a simplified psychoanalysis. Its basic concepts are three: "PAC," which stands for parent, adult, child. Each person's behavior, both outward and inward, can be classified as being from one of these three sources. One may recognize a simplified superego-ego-id trio here, but all three are viewed as ego states. The therapist points out, and the patient soon learns, that it is "the parent" in

the patient's head who does all blaming, reprimanding, finger waving, both when patients blame themselves and when they blame others. Much progress can be made in a marriage, for example, if both people recognize when it is "the parent" in one of them who is berating or infantilizing the other. "The adult" is the rational realistic aspect. The child is both the needy aspect of a person, and the enjoying, consuming, and celebrating aspect. But the child can also be whiny, mischievous, or nasty and intent on getting even.

There is considerable power in the recognitions that one of these parts is originating a type of behavior, an attitude, or a repetitious pattern. The recognition can, in effect, cut the tie between the patient and the pattern or emotion. Recognizing that this way of acting or feeling is "that lousy, blaming parent of mine," removes the emotion and behavior sufficiently from the patient so that there comes to be some freedom of action against it.

Transactional Analysis shares the "now" aspect of the newer therapies. There is a downgrading of dynamics and understanding one's past. One is told that "You can stop behaving like that now, just by stopping." Exploring causes is discouraged.

Aside from "PAC" there are also humorous names for certain patterns people engage in, such as "brown-stamp collecting" (grievance collecting) and "Pay and don't go" (self-defeating patterns), "cop-out" (passive-aggressive "I

couldn't help it"). Again, these patterns are to be stopped by simple exhortation to stop on the part of the therapist, and a discovery that one can stop now by the patient.

Transactional Analysis is often conducted in small groups. In the group the therapist works with one person at a time. People do not relate much to each other.

Transactional analysts typically employ many procedures from Gestalt therapy and encounter groups, which will be discussed under the more proper headings. For example, "the empty-chair" technique (see Gestalt, page 276) is often used so that the patient confronts some particular aspect of the parent or the child.

The chief characteristic of Transactional Analysis is that it is interpretative and insight-based. In this sense it is old-fashioned. Once the insight is had, that a certain pattern obtains, or that a particular behavior is attributable to, for instance, the parent part, it is left to the patient to overcome it. Techniques borrowed from other methods do aid in making change occur. The method shares with other recent methods its emphasis on one's ability to change now.

Imagery Therapies

These therapies begin with Jung. They include Systematic Desensitization (despite its behavioristic vocabulary), and are currently mushrooming. Jung's "active-daydream" technique is, of course, not the whole of Jungian therapy. He emphasized that the images must be allowed to come autonomously (not made deliberately) and *then* the patient must react to the images actively. The patient must behave just as if the images were real. Seeing such and such a frightening figure, for instance, the patient might choose to hide or imagine having a weapon or feed the figure something to propitiate it, or the patient might talk to it, ask it what it has to say. Jungian imagery methods involve a rhythm of letting autonomous images come (a kind of regression) and of reacting quite actively in an alert and assertive way (not at all a regression).

Jung emphasizes that little is achieved if one just lets the images run on and watches them passively. Jung did not think that the images of themselves were therapeutic, but that they were a w ay by which a conscious person could interact with unconscious material and process it.

Current methods of imagery vary greatly. Some European methods (Autogenic Training [Luthe, 1969]) use very systematic steps to train a person to have vivid imagery, and then to use it in various ways. Sometimes these highly systematized methods seem more like research tools than therapies. Many current uses of imagery, in contrast, are rather like parlor

games without any systematic effort to pursue and work through what the images arouse. Between these extremes are effective methods.

One can easily engender imagery in a person simply by beginning with one of a number of common formulae: "Imagine the entrance to a cave. Enter it and go a long way." "Imagine a house. Go inside. See what happens." Strong emotions are often aroused and can be worked through in a therapeutic way. Again, this is a method for getting deeply into something quickly, rather than spending years with words only.

A dream the patient remembers can be continued. The patient is asked to recall and once more visualize the end. What would the patient now like to do in this visualization? After doing that, the patient is asked to see what autonomous reaction there now is in the image of the dream scene.

In Systematic Desensitization the person is first helped to relax (a feature also of Autogenic Training and some other imagery methods). Images come more vividly and easily when one is relaxed. The person is then asked to imagine scenes or situations that cause difficulty. The aim is to remain relaxed despite the (imagined) presence of something disturbing. Again therapy consists of not just having images but acting on them. In this instance there is the added aim of remaining relaxed.

Images can also be allowed to form *from* a troubled feeling that is not

clear to the person. They often provide a means by which the feeling can become distinct and change. It is important not to get so fascinated by images as to remain with them but to move from them to what is directly felt. What is the felt effect of the image? The *felt* impacts of imagery require pursuing so that therapeutic movement arises.

Gestalt Therapy

This therapy (1958; 1969), devised by Fritz Perls, features many "exercises." The basic aim is to integrate alienated parts of a person that are projected or in some way function separately. The person may have feelings about such an alienated aspect, or know about it, but it has not been integrated. To integrate that aspect or part, it is necessary that the person engage in a "dialogue" with it. Dialogue is an alternation in which a person spends some time having feelings and reactions toward that part, but also spends some time *being that part* (and feeling what that part says and feels).

One may find such an alienated "part" from talking about anything that causes difficulty, or in dreams—all of which are viewed as projections from alienated parts—or in some other way. The favored way is to sense one's body and find any place in it that is now tense, then to have a dialogue with that body part, beginning by being that part and feeling and saying what it feels and says.

The empty-chair exercise is one way of having a dialogue. One imagines that some aspect is sitting in a chair opposite. The patient then addresses this part. It might be the patient's father or mother, or a feeling or a part of the self that was talked about a moment before. It may be a feeling that criticizes and makes the patient feel bad. The patient then addresses this aspect. Done rightly, the patient waits until words and feelings well up toward what is in the opposite chair. After a few minutes the patient changes chairs and now *is* this aspect. What does the aspect feel and have to say to the patient? Again, quite powerful and surprising feelings and words well up of their own accord.

Similarly, a person can be asked to *be* any part or thing in a dream or fantasy (projections from alienated aspects of the person).

For example, if the person dreamed or imaged being crouched into a comer, the instruction might be, "Now *be* the corner." The person would first be asked to get up, describe the scene, and reenact the actual crouching. Then the person would be asked to step backward just a little and *be* the wall. What does the wall say? What does it feel? What would it like to do? Something will spontaneously come in answer.

Amazingly enough, in the above example, the person found himself kicking with his foot, kicking the imagined himself crouching before him. There was a flood of feeling along with the kicking. Yes, there was a lot of

anger at himself, here, suddenly. Then, on reversing and being himself again, he found a tearful, "Yes, I hide from out there, but it's furious at me in here, and there's no place to go."

The Gestalt therapist interacts rather uniquely, sometimes getting quite angry and insulting, and blatantly refusing to take responsibility for the patient. ("That's what I feel like saying. You don't like it, that's your problem. I don't feel like saying anything else.") Great value is placed on people standing on their own two feet, maximally able to bear it that the other person's feelings are other than one's own, and may be negative or critical of oneself. Of course patients may express their feelings toward the therapist whatever they may be, but must learn to do this without encouragement and approval for it. To have and express one's feelings regardless of others' reactions is to "own" them. In the Gestalt view each person stands alone and any togetherness is a fortunate accident on which one does not count.

Primal Therapy

This form of therapy, introduced by Arthur Janov (1970), stems from something like the same phenomenon that is basic to Gestalt therapy, namely the autonomous coming of something the person would not ever deliberately produce. However, Janov concentrates entirely on what seem to be early infantile experiences. He reports that he began from the observation (also had

by many other therapists) that some patients have an urge to let themselves go into crying and shouting certain sentences that are powerfully emotional for them. The patient might cry or say, "No, no, no" or cry, "Mama, Mama . . . come here," "Please don't hurt me," "Get away," nonverbal baby sobbing or other less typical things. Janov considered this a working through of infantile traumas and made a method of enabling every patient to experience these "primals." In his method the patient is encouraged to regress: Before therapy begins the patient may spend some days and nights alone, must not smoke or drink, and may be asked to go without sleep. As a result therapy begins with the condition most likely to engender infantile experiences.

The emphasis on regression is atypical for the newer therapies, which have rejected even the psychoanalytic couch. For the most part, these therapies emphasize that the person must now experience a *more* optimal living process and certainly not a more regressed one. The faith in the therapy process rests, in fact, on making the maximally best present process happen. Only because the patient is now living in a fuller and more open, more awake and more interactional manner can we expect that the bad experiences and emotions that arise will turn out for the best—if they are experienced within the present living. Primal therapy eliminates this advantage. Even in regard to the interpersonal relationship, the primal therapist is authoritarian and not very personal, preferring to invest everything into getting the primals and their living through.

The chief assumption of this method is that living through primals *releases* the traumas. But, what if people continue to run through these patterns, perhaps very many of them, again and again? Hart (1972), explaining his offshoot from Primal Therapy, says, "There is no emptying out of all that." The emphasis in this newer therapy is on "being able to feel what happened to you" and on "being able to integrate what you feel."

The integrating process that may be needed would be done in terms of procedures that can be common to other methods as well as this one.

Again here, no primal patient doubts that something more than just words and ideas is happening. In this sense Primal Therapy is very much part of the new trend. As much as any therapy in this group, Primal Therapy emphasizes the uselessness of the old-fashioned "just talking." A primal experience is an unmistakable event of considerable impact and power. One rolls on the floor, screams sentences that move with a will of their own, and certainly knows that one has gone through something.

Reevaluation Counseling

The approach of Harvey Jackins (1962) also employs the phenomenon of autonomous emergence (as I term it) common also to Gestalt and Primal Therapy. "RC" is a method capable of being practiced by ordinary people with a minimum of training, and by reference to a handbook by Jackins. The

training consists of several months of courses and practice together, with opportunities for further learning. Whereas Primal Therapy is a closely guarded secret, and costs between six and nine thousand dollars per patient, "RC" is given away nearly free. Therapy is mutual "cocounseling", each person is counselor in one hour and client in the other hour. Whereas the safeguards in Primal Therapy, if any, are not known, the safeguards in RC are taught and practiced with great care. The person now doing the counseling holds the person being counseled by both hands. They sit close, just far enough away so one's eye can focus. Throughout, the person is looked straight in the eye, and there isn't a moment when the interpersonal contact is not as strong as possible. Both regression and full awareness are practiced. That is to say, the person is encouraged to sense what unrealistic emotions are being "restimulated" now, and also to sense the difference between the present and the past. The counselor begins, perhaps, by saying, "Whom do I remind you of?" Having one's hands held is in itself likely to be "re-stimulating," one is likely to sense instantly "my mother" (or some important person). "How am I *like* your mother?" the counselor asks. Whatever comes now, will perhaps surprise the person. At any rate, within three minutes a powerful process has begun. But quite soon the counselor will ask: "How am I different from your mother?" Having got the person into childhood experiences, the person now differentiates that time from the present and fully returns to the present. (For these questions the counselor insists on getting some answer, always.) There

are other routine steps. "Tell me two or three new and good things that have happened to you in the last few days." Later: "Tell me two or three minor upsets that happened in the last few days."

The brief account of these things invariably gets the person into deep water. Either the counselor asks the person to repeat some sentence that seemed to have emotion in it or the counselor invents such a sentence and asks the person to repeat it. (For example, "I didn't like it." "I didn't like it." "I didn't *like* it.") Perhaps the person will be asked to scream the sentence. If this fails, another sentence will be tried. If it succeeds, a very powerful emotional process is engendered. The shouting of the sentence begins to happen as if of its own accord. There is usually also a lot of crying. This unmistakably powerful process is termed "discharge."

The purpose is genuine working through, as in most therapy, not only deep feeling as such. Thus, soon, the counselor will ask the person to say the very opposite of what was being shouted. ("It doesn't bother me at all. It makes me feel fine. It doesn't bother me *at all.* It makes me feel *just* fine, *just* fine. I'm not *at all* upset by it.") Both people might laugh, the person might be laughing and crying together, as these obviously false yet also powerful sentences are being said. Returning from the opposite to the original side, the person may again be asked to say the sentence "I didn't like it. . ."

Quite often, in working with emotional material in this way, further sentences come. There is an effect of gradual building. The counselor asks the person to repeat what seems to be the most powerfully *felt* sentence. If new and stronger ones come, these are concentrated on. For example: "I hated it." "Say that some more." "I hated it. I hated it. I didn't *like* it." The person begins to cry. "Say again I didn't *like* it." "I didn't *like* it. I didn't *like* it. It made me feel small, it made me feel small." The person may now be puckering his lower lip out like a small child and sounding like one. "Go away, stop that. *Stop* that. *Stop* that."

Very powerful, or not so powerful, experiences can be had with this method. Care is taken not to push anything against the person's will. "The client is in charge." After an hour the two people reverse roles. One or both may be experienced or novice, but in any one meeting each will be in each role half the time. Counseling and training are never separate.

Body Therapies

There are a large group of different therapies, as well as a great many individual practitioners with their own approaches (Selver, 1957). The best-known, current method is *Bio-Energetics,* in a direct line from Wilhelm Reich (1949). This method begins by making the body enormously tense. The person is put through contortions, of which only some people are fully

capable, until the body actually vibrates. People are pushed into distinctly painful physical experiences, postures, and exercises (stress positions). This can probably be interpreted as a kind of forcible regression (analogous to Primal Therapy.) One is on the verge of tears, and feels deeply invaded and imposed upon. Naturally enough, this enables infantile experiences of that sort to emerge. One is then encouraged to scream, "NO, NO" or "Leave me alone" or whatever words seem to come with great feeling.

Other body therapies employ opposite methods, many of them much more gentle and sensitive to the individual person. Brown (1973), by touching with his hands, senses tension, but encourages the very opposite of Bio-Energetics. Rather than *peripheral* muscle tension, Brown encourages *inward* body sensing. He holds that people have already abnormally high peripheral muscle tensions as it is, and need to focus on greater inward body awareness. The purpose is to relax peripherally and discover an inward center.

Most body therapies, including the two just mentioned, work with breathing. Some movements, perhaps hopping about, generate heavier breathing, the quality of which is indicative of quite a lot about the person. Most methods also work with specific places on an individual's body, for example, where there is pain in response to moderate pushing of the sort that doesn't generate pain elsewhere.

People's postures, ways of walking, standing, and sitting are also good starting points for therapeutic work. A person sitting tensely or with limbs close together or with legs wrapped around each other, tells a lot about that person. One becomes aware of many personal themes being manifested by how people stand and sit. The person can be asked to exaggerate such body positions and to sense what feelings they express.

Body therapists can see a great deal by looking at an individual's posture. *Rolfing* (1972) is a rather more violent body method than any other. It involves rearranging the person's body parts as they ought to be. However, this is no mere correction of posture. The pathological ways in which many years of poor posture has arranged one's body parts has become cemented in by cartilage. To put the parts of the body back into proper relationship involves breaking cartilage, and is extremely painful. Rolfing is undertaken by people who are willing to endure great pain for a few days, and then be, as it were, new people. The reports of those who have gone through this treatment continue to be so positive, however, that others are drawn to it.

The basic view held in common is that a person's body embodies the person's basic personality and ways of living. This is not a theoretical assumption, but something one can see on a person's body. To work directly with that seems much more powerful than merely talking about change while the person sits before one in the solid, vividly expressive posture embodying

the difficulty. One is therefore inclined to work directly with the body, and, indeed, a powerful process can begin almost immediately if one does so. Intense emotions are keyed off and lived through in sensing just what is involved, for instance, in the person's chronically raised shoulders. "Exaggerate that a little, pull the shoulders up even higher, sense what that is for you." The person may have an impulse to curve the shoulders forward altogether in an arching, closing gesture around the chest, as if to protect against some attack. Along with this there may be a very real sense of fear or a wish to withdraw. Conversely, when at last the person can let the shoulders drop to a new normal position, what is felt?

There may be some tension on one's face. Exaggerating it, it becomes a grimace. What emotion does it express? The emotion will come along with an acting out, perhaps with words and other gestures involving the whole body. Then, if that chronic tension can at last be relaxed—what feelings occur?

In these therapies, release experiences almost universally give the person at least some days of feeling freer, more open, and eager to live. The consensus is, also, that people's personalities, looks, and postures change, although as yet no research bears this out.

Body therapies often include massage, which is a serious and deep experience. Massage enables the therapist to sense where there is tension in

the body. Also, massage reveals what part of the person's body is alive and soft and full of energy, and what part is "dead," stiff, and closed. These metaphoric words describe quite palpable differences in how the various parts of the body feel to the massager's touch. It cannot fail to have a psychological meaning, for example, when the breasts and chest of a woman feel soft and responsive and have a kind of glow to the massage oil, and the lower part of her body feels to the touch like cement. (Roberta Miller, 1975). Equally significant, a stiff, tense upper part of the body is often combined with a tense, hunched posture and raised shoulders. Or more specific parts of a person may be tense, legs, feet only, jaw muscles, etc.

Body therapists differ in how much importance they attach to their psychological working through and personal integrating of the emotions and effects of body work. For some the entire aim is such working through, and the body work is only the take-off point, the most concrete and significant way to start and to make progress. Others believe that in working with muscles alone everything else is indirectly worked through (Alexander, 1969).

By beginning with the body, many of the procedures discussed up to now can be employed in a rather different and sometimes more impactful way.

Yoga

In this context, *yoga* has spread widely among people interested in therapy methods using the body. There is a very distinct effect on one's living generally from doing an hour of yoga stretching exercises every day. While the exercises look outlandish, at least the beginning ones are easy to do. Their purpose is not muscle building but muscle stretching and a general softening that makes the body supple. Tension is lowered, smoking and other nervous habits decrease of themselves. When yoga has been practiced for some time, there is a bodily longing for it when it is omitted.

Meditation

The relation between yoga and *meditation* is not accidental. Both are methods that lower tension. Many methods of meditation exist, some drawn from oriental sources, some developed here. They differ as to whether they are a deepening or a scattering of attention, but, at any rate, the person moves away from usual concerns, stops—or tries to stop—talking inwardly, and the body relaxes. Some meditation is religious or cosmic. There is a sense of a vast, positive universe within which one lives and breathes.

The relation of physical yoga and meditation is somewhat analogous to the relation of therapeutic body work, and psychological working through. Many people engage only in the physical side and are sure that the

psychological effects, while indirect, are nevertheless there. Others emphasize the need not only to engage in the physical exercises but also to quiet oneself inwardly and psychologically. They feel that the two aid each other. Similarly, the body therapies give rise to psychological experiences, so that psychotherapy processes arise from and are aided by body work.

Existential Psychotherapy

This therapy (May, 1958; Frankl, 1965; Binswanger, 1958; Binswanger, 1962) does not involve most of the procedures discussed so far. It is usually exclusively verbal. The emphases discussed at the outset are shared by Existential Psychotherapy. Many of them were first articulated by existential writers including Rollo May (Jaffe, 1971), Viktor Frankl (May, 1958) and Ludwig Binswanger (1958; 1962). The therapy centers on choice, responsibility, and genuine encounters between the two persons.

Anxiety is viewed as potentially helpful. Anxiety is indicative of unlived life, of opportunities for growth, encounter, and expansion of the person that are being missed. The person is encouraged to meet the challenges of living, the possibilities of radical change in living situations. People make themselves what they are and must continue to do so to stay as they are. There is an emphasis on the waste of life, that is, the avoidance of challenges.

Values and life meanings are focused upon, rather than following the

traditional view that in therapy they are ways of avoiding therapeutic material. Values and meanings are considered real, not epiphenomena of infantile conflicts. Social responsibility and an expanded life that expresses itself in social and cultural meanings is considered more truly being human than life without these. Most current neuroses are viewed as unlike those that Freud catalogued. Their etiology is thought to be not from natural-science forces in the person but from meaninglessness and atrophied living. Such narrowing of meaning results from avoiding challenges in life and from avoiding authenticity. A loss of meaning is also inherent in current social pressures to conform and in the downgrading of values.

Frankl, who says much of the above, has also devised the specific therapeutic technique called "paradoxical intention." People who struggle inwardly against certain impulses, or struggle to control them in some way, are asked to reverse this struggle. Instead of fighting against a particular impulse, these people are asked to tell themselves to do it more. From this some therapists have derived "symptom scheduling" and other related ways. The person is taken out of the circular struggle in which the very mode of trying only strengthens the difficulty. A more natural desire to stop the particular kind of behavior then emerges.

Existential psychotherapy varies from being quite like psychoanalysis with different words and concepts to being a genuine encounter in which

both persons are changed.

Experiential Psychotherapy

This therapy (Gendlin, 1962; Gendlin, 1964; Gendlin, 1973) consists of working with the concretely felt events to which the person can directly refer, and of living *further* from these felt events during the interview.

The interactional living in the relationship, and inward bodily sensing, are the chief sources of such concretely felt events. One or all of the already mentioned exercises may also be used, but these would be considered only as starting points for an experiential process of many steps in which what is aroused would be pursued, would shift and change, and would be lived further. Therapy is not only emotions and cathartic discharge.

Neither is therapy merely verbal behavior and response. Frequently, the person is asked to stop talking, (out loud and inside) and to sense inwardly. One must get into concrete touch with the bodily felt sense of what is being talked about. This might take only a minute of silence, or it might require a lot of work over many sessions. The person might then talk further, but soon again be asked to sense inwardly.

From a bodily felt sense of some difficulty, steps arise. When one gets in touch with a felt sense, and expresses it, there is a felt effect. The felt sense

becomes sharper, or shifts, or further felt aspects emerge. When one first gets the bodily felt sense of a difficulty, there is one global cognitively unclear feeling. From this, quite soon, a specific feeling emerges. As this is "focused" upon, it shifts or releases and gives rise to another step.

Experiential Therapy is possible because people have not only emotions, such as fear, anger, or guilt, but also always a mass of feeling that is implicitly rich and generates movement steps. This level of visceral sensing is, so to speak, "under" emotions. It is a sensing of the whole complexity that gives rise to the emotion. While an emotion as such tends to remain itself, a felt sense can move into a series of quite different emotions and felt aspects. By returning always to the bodily felt sense of each moment, a movement of steps results.

Anyone can have strong emotions, but many people cannot, at first, get in touch with a bodily felt *sense of* the difficulties and life problems they speak about. Their attention, so to speak, floats far above the concrete existence inside them of that of which they speak. When people lack this level of feeling, they are sometimes asked to choose the most meaningful sentence they can form and then to repeat it many times to themselves while trying to feel what felt sense is involved in these words. What feeling does the sentence arise from?

Getting the person in touch with the felt-sense level (under emotions) is the first order of business, if this is lacking. People are asked to note what they *do now feel.* Often they don't feel what they are talking about, but do feel, for example, confusion, or a sense of urgency, or a fear of being empty inside, or annoyance at the therapist's pushing, or a desire to do what is asked for. There may be feelings of unwillingness, restlessness, or trying terribly hard, running scared, doubt that anything in oneself can be of any use. What *is* there now, in the present living, constitutes good concretely felt starting points for experiential process.

There is also a specific procedure—"Focusing" (Gendlin, 1969)—consisting of instructions to be carried out in silent periods. The first instruction is to let oneself feel the whole of a problem as one global sense of it all, as if all of it together were newly coming home to one. A more specific feeling usually arises from this global feel of the problem. One is then asked to pursue that feeling, allowing attention simply to follow it. After another minute one asks oneself an open-ended question such as, "What is this feeling?" or "What is in the way of it's being all right?" But one doesn't answer the question oneself. Instead, one waits. The answer must come *from* the feeling. The person should let words go by. The only words the person is instructed to hold onto are words that have a distinctly felt effect in the feeling, either a sharpening of the feeling or a shift in it, an opening up, a release.

In some of the other newer therapies, strong emotions and autonomous discharges are viewed as therapy. People are often left with disconnected impactful events. Experiential therapy centers on the experiential working through process. The basic viewpoint of Experiential Psychotherapy is that real change takes place only through *a process* of bodily felt *steps.*

Procedures are not enough. People must be engaged as persons, by the therapist as a person—and this must occur in terms of the richness that is implicit in the ongoing experiencing of both of them.

An Experiential therapist may interpret or do many other things. The widest repertoire is available to the Experiential therapist. On the other hand, anything just done or said would be immediately discarded in favor of following whatever it roused in the patient or whatever the patient concretely feels and finds within. Words or actions or interactions are sought that will make touch with and will shift what the patient just now concretely feels.

The therapist's very honest interacting is a major avenue of getting people in touch with their feelings, and more importantly, an avenue of living them further and enabling them to shift. Most personal difficulties and stuck places also close off really personal interaction. If personal interaction can be carried further in spite of these difficulties, the difficulties resolve themselves. Most difficulties and repetitive patterns are quite general in the sense of

being always the same and leaving no room for the richness and specificity of this moment's actual experience. When what the Experiential therapist feels just now is explored, differentiated, and some of it is expressed in its unique detail, the patient's reaction tends to move beyond the usual pattern. The differentiated texture of actually feeling an interactional moment, is never exactly the same or exactly the opposite of a repetitive pattern. It is always different and much richer than the general repetitive pattern was.

The Experiential therapist welcomes the inevitable moments of interactional difficulties that occur during the interview because they afford opportunities to carry interaction beyond the stoppages by differentiating and expressing what both people just now feel.

The personalities of both people are likely to be involved simultaneously in any one difficulty. Both persons are likely to find themselves broadened if the interaction is carried further, with many steps of more differentiated feeling—expression beyond the point where it traditionally stops due to old patterns, defensiveness, politeness, or the role model of the imperturbable therapist.

On the other hand, the therapist's self-expression is not indiscriminate, but an attempt to open up and live more deeply *what is already happening between* the two people. Therapist expression also depends upon how far the

relationship has advanced.

Therapist self-expressions are self-owned and about oneself, they are steps into one's own inwardness. The form, "I feel that you . . ." is not a self-expression. When statements of that form are made, they are questions or invitations to the other person to look within. Self-expression does not mean attacks, or expressions the main point of which is something in the other person. In Experiential Therapy one works on a level of bodily visceral sensing that is neither just words nor just game-played routines and also *not just emotions.* There is a texture of specificities in each person that is *felt.* It can be gotten into only by *letting* a felt sense come and by *letting* it express itself. In such a process of steps, what is "next" is not a matter of choice. One may want something to be next, but one's direct inward sensing will meet exactly what it does meet, what is actually there, next. And that is not a matter of choice. The experiential process is not guided by the concepts or decisions of either person. The freeing and expansion of the person is a process that gives rise to *its own* next steps.

Other methods exist, which are certainly worthy of discussion.

Reality Therapy

This therapy (Glasser, 1965) combines an explicit emphasis on a caring and involved therapist with a focus on behavior. Planned steps of change in

behavior and situation are the stuff of therapy interviews. Decision, will power, commitment, responsibility, maturity, identity, confrontation are some of the concepts used. They mark the struggle to get past "excuses" and avoid explanations of failure. *Confrontation* is extensively used, "You said you would do it. When will you do it?". Confrontation is used when the therapist senses something irresponsible on the part of the patient.

Psychosynthesis

Under this name Assagioli (1971) draws together a great many elements that are found separately elsewhere, most of them discussed in this chapter. It is difficult to decide what the central notions or procedures are. Psychosynthesis emphasizes working with the will, and decision making. Self-awareness is considered as a distinct experience in its own right, a sense of self. Spiritual dimensions, music, specific training of intuitive sensing, are included.

Sex Therapy

Masters and Johnson (Brown, 1973; McCarthy, 1973) provide a step by step program lasting some months, and is undertaken by a married couple. For example, one step in the program requires husband and wife not to have intercourse for a period of time during which the focus is on touching,

foreplay, enjoying each other's bodies. With the anxiety about performance thus removed, this step in the program often frees sexual desires and feelings in the participants.

Fight Training

This therapy (Bach, 1968) emphasizes the helpful role in a relationship of being able to express anger, and accept its expression by the other person. Bach (1968) teaches joyous attacking by both partners in a marriage, which can re-enliven long-frozen relationships.

Parent-effectiveness Training

Client-centered ways of responding are used in a carefully thought-out system of responding to one's children. Detailed practice examples and regular classes are provided (Gordon, 1970). One seeks to grasp and verbalize the sense that the child's behavior and expressions make *to the child,* but, equally, one also expresses one's own parental and personal feelings and needs.

Changing the Dyadic Pattern

The methods to be discussed in this section center not on procedures of therapy but rather on changes in the one-to-one office pattern of therapy.

Groups

Groups (Sax, 1972; Schutz, 1967), while not new in themselves, have become a widespread social movement far exceeding the professional context. Encounter groups, Sensitivity groups, Growth groups, and many other names enable people who do not know each other to be almost immediately more intimate with each other than they can be with the people closest to them in their lives. Some think of this as an artificial and unreal intimacy. Certainly it seems easier to be intimate, self-revealing, and appreciative of another human being's inwardness when the other person isn't one's husband, wife, parent, daughter, or work associate. One can be appreciative of the other person's inward fears, angers, and peculiarities because one does not live in the situations where these feelings or traits of character are making things difficult. One can also risk being looked down upon, since one need never see these people again. But to emphasize this aspect is to understand only half. The other half of the phenomenon of encounter groups is the powerful way they aid one to come alive with others, to sense one's inward reactions and inward richness. Of course, many people have this already, but it seems that the mass of people do not. Encounter groups have, therefore, made a vast and growing subculture of people who have become aware of the richness of their inwardness, and that of others.

Coming, let us say, from a rather cold and defensive family, working in

some proper setting, a person may never have experienced interactions that went beyond the everyday routines of stereotyped relating. Even such a person's closest friends are not really close, but only partners in rounds of routine activities, drinking, socializing, small talk, sharing subjects such as baseball, the race question, sex, and TV. With one's marriage partner one is likely to maintain certain well-defended stances and engage in certain routinized ways of relating. These may be vital to a person, but that makes it all the more threatening to risk being more open.

In contrast to this, what happens in the first hours of a good encounter group can be deeper and more enlivening than anything that has happened in the person's life for many years. The person may never have known that people can talk on such a level, that people can differentiate unique reactions within themselves, reactions that have no routine names. No wonder the impact can be quite great.

For the ordinary person an encounter group can mark an utterly new world. If such a world exists, why be alone and stay silent and dumb inside? If people can talk and interact in this way, why stay in the empty routines? "How could I have so long been locked in, unformed and unheard, without even knowing it?"

The professional therapist has long known that therapy is not only a

cure for ills, but also a highly exciting and enriching process—after all, the professional spends his life that way, usually from choice. Can professionals wonder that others, too, experience the process that way? One need not be "sick" to want this process. In encounter groups the focus is less on therapy and more on growth.

Like all types of individual psychotherapy, groups are only successful sometimes. Perhaps half to two-thirds of groups are dull. They begin with haggling and a general unwillingness to open up. They involve a lot of complaining ("Why aren't we doing anything?") or mutual insulting ("You are phony. You aren't really feeling anything."). The wise participant leaves groups of this sort long before they are over. Increasingly, however, groups are not started in this way. Instead, they move directly into something more than words, in one or another of the ways already described. Many of the techniques outlined can occur in groups. The leader institutes them. In addition, groups provide a field of personal interaction. People develop strong feelings about each other. (Sometimes, of course, they only wish they did, and make much of small annoyances and a little warmth.) People can dare to try out ways of being more open, more spontaneous, more direct, expressive, courageous, self-revealing. Often they can take the first step toward some needed change.

Many patterns of groups exist. Some meet once a week for many

months, most meet one or two successive days (a weekend, for instance.) In *Marathon Groups,* the group continues throughout two days and nights with individuals sleeping when they want to. Intensity is said to be heightened.

Groups of various types are conducted at "Growth Centers" or "Human Potential Centers," which exist in every city.

Family Therapy

Family Therapy (Sorrells, 1969), *Couples Therapy, Marriage Counseling,* all are based on the widely shared view that "Not the individual but the relationship is sick." Therefore, the therapist seeks to work not with the individual woman or man but with the marriage. Wife and husband attend therapy together. The therapist may listen and interact, first with one for a while, then with the other. In this way, each is enabled to experience the other being very different, in the relation to the therapist, than at home. Or, the interaction between the two can be worked with.

Family therapy includes the children and the grandparents if they are living in the home. A family is considered a single "system" in which each individual has a certain role. A whole range of phenomena is revealed by family therapy that the individual therapist never sees. It is striking how some members of a family actively resist change in other members. The individual therapist does not see what happens to the patient at home when

some change is first tried out—and how quickly the patient is brought back into line by the pressures exerted on him or her by other members of the family. When all are in the office together, the moves each makes in regard to the others are apparent.

In a family or marriage the ways an individual is forced back into old patterns can vary from relatively subtle interaction modes to gross tantrums, goading, or threats. Behavior occurs that an observer would consider obvious, but that may be done without awareness. Even very well-intentioned family members are likely to anticipate the individual's disturbances, react as if the individual were upset again. They are likely to oppose new patterns, and may even become very disturbed and clinically ill themselves if the erstwhile patient remains outside of old patterns and continues strong and growing.

Furthermore, a good deal of psychological disturbance is really "at" someone. Suicide is often "at" someone (both someone past and someone present). Depression may be clinically diagnosed as defended-against anger, but it may be anger "at" the other person in the marriage, (and not, or at least not only, at a parent of long ago). Long-stuck interactions need to move before that changes. An individual patient can struggle alone in a therapist's office for years and be unable to change something because it is really interactive— geared in with the responses or lack of them in the other close person. But, then, why does that close person respond this way? That, in turn,

is partly due to how the first individual acts—and so it goes round and round. If the therapist can intervene to make a different process happen between them, this changes not only the relationship but also the personality of the individual. Many therapists have now observed this so often and constantly that they refuse to see one person singly—if the person is married or living with a parent.

If one member of a marriage is in traditional one-to-one psychotherapy and the other member isn't, divorce is very often the result, regardless of the original aims and wishes of the patient and the therapist. The patient develops and grows in therapy, the other marriage partner is left out of all this. What happens between them is less and less meaningful and relevant in comparison to what the patient is experiencing in the therapy. The marriage relation is not worked with and does not change. The patient develops new strengths alone without any new developments in the interaction patterns with the other marriage partner.

But the same lack exists if both members of a marriage are in therapy but with different therapists: they grow away from each other and leave their interaction patterns undeveloped.

To make clear how one-to-one therapy for marriage partners omits the work on their own interactions, let us consider the case of two traditional

analysts, one of whom is separately seeing the husband, the other the wife. The two analysts then consult with each other, but without husband and wife being present. Instead of husband and wife moving beyond their stuck-interaction patterns, it is the two analysts who are interacting! One analyst tells the other: "If *your* patient acted less castrating, my patient would be more assertive." The other analyst says: "If your patient were less whiny and grievance collecting, my patient would *love* to be more feminine." Looked at from the interactional perspective of the newer therapies, this means that the two analysts are getting all the personality growth inherent in working out interactions. The two patients never get past their stuck interactions and will eventually be divorced.

Family therapy is especially dramatic when an individual is in a psychotic state. Family therapists call the ostensive patient "the person in whom the illness manifests itself." The illness is an attribute of the family system, of the relationships, not of the person who has symptoms. Because this is so contrary to the obvious, it is quite dramatic when observed. Seeing the whole family, one realizes, for example, how psychotic withdrawal is the role enforced on one person by all the others. A psychosis can also remit as a result of one family interaction (Beebe. 1968).

Children especially—it is widely known— should not be treated in psychotherapy separately from their parents. To load the entire difficulty on

the child is an error that can have grievous consequences. It can turn the child into a psychological case. Neither should all the blame be placed on the parents. The basic idea of family therapy is that the interaction is sick, not any of the individuals. The patterns of interaction people get into with each other are only indirectly related to their individual dynamics. Also, the causal order may be in either direction. Instead of explaining interaction from individual personality, one can just as well argue that a certain type of interactional pattern rouses one of a great many possible, individual dynamics potentially in any person.

Therapeutic Communities

Many different kinds exist. Their principle is bringing people's real lives into interaction instead of merely the symbolic few hours of psychotherapy. Traditional psychotherapy assumes that psychological factors can change and be resolved, as it were, symbolically, in the therapy relationship. Then it will be possible for people to resolve their difficulties in their real lives. As the foregoing sections show, the newer therapies tend to question this. The therapy process itself should be "real life." The relation with the therapist tends toward perfect realism, honesty, and mutual involvement. Actual life relations (with others in groups or with family members) are physically brought into the therapy context, as in family therapy. It is a further step of this trend, to establish some form of living together.

A community may meet once a week, daily, or room and cook together. If meetings are only periodic, people see each other outside of such meetings. The basis of the community may be a closed group that wants to be together, or everyone from a given neighborhood may be invited, or everyone with a common problem, or it may be totally open to all. Its principles may be therapeutic in any of the many meanings of that word.

Examples of therapeutic communities are: Laing's community (Jaffe, 1971), Changes (Gendlin, 1973), Synanon (ex-addicts), A. A. Low's group of ex-patients of "mental hospitals," and many others.

In these communities people help each other to live. They help each other take the needed next steps of living rather than doing only symbolic therapy with each other, as in encounter groups. These communities are usually permanent, whereas encounter groups break up after a weekend. Communities are thus perfectly real, unlike groups where one becomes personally close to people who are not, and will not be, part of one's life. Groups that continue come to be a real life reference point and a place of belonging for each member.

Some few therapeutic communities are old and famous, but most are new and can be found most easily through the networks and connections of young people.

Community Psychology and Social Psychiatry

These therapies (Gendlin, 1968) work with a neighborhood or an inner city or rural community. Government-supported programs for mental-health centers, storefront clinics, and street workers attempt to bring psychological services to a population that cannot usually obtain such services.

Sometimes Community Psychology efforts are no more than new referral channels, sending to the usual services certain populations omitted until now.

More developed community efforts can include training local people to provide some of services usually done only by professionals. An increasing number of facilities and activities are largely staffed by "sub-professionals." Large numbers of such people can function well under the supervision of a few professionals who run periodic group meetings for them.

A therapist or other professional can take selected local persons in as co-therapists so that some of them can actually learn the skills required. Thus the community is helped to develop resources of its own.

Community Psychology includes efforts to restructure the basic conception of what a school, a hospital, a church, or a welfare agency is. There are experimental "schools without walls" in which the students go to many

places in the city for each of their "courses," and the "teachers" actually work at what they teach. For example one course may be in the zoo, another at the art museum, another in a factory. The zoo attendants, painters, and draftsmen are the teachers of these courses about animals, art, and drafting. Hospitals (or at least experimental wards) are being tried in which patients spend most of their time in foster homes or special workshops or jobs. Neighborhood organizations are also being tried that will enable people in a geographical neighborhood to become a community.

Social Structure

Concern with *social structure* further extends the trend of moving beyond one-to-one, individual therapy to groups, family, and community. Part of the trend is the belief that psychological difficulties are not separable from the structure of our society and its roles. The incidence of schizophrenia is much higher in poor communities than among the middle class. Changes in social structure have also changed the typical neurotic patterns. Hysteria, for example, is hardly ever encountered any more, yet it was very prevalent in Freud's time. Where can one still find hysteria today? In rural communities where the social structure hasn't changed as much. This means that the patterns and roles of society must be taken into account—and one may call *these* "sick" rather than the individual who cannot fit into them.

The most striking instance of this new outlook concerns women. For three generations women were told (usually by male analysts) that a dynamically based lack of femininity prevented them from finding fulfillment in the activities of marriage and child raising. Currently women en masse are rebelling against this structure, and claiming that they too (like men) need not only a family structure but also a work life in the world. It appears to have been an error to assume that a person necessarily should fit into an extant social pattern. Perhaps the pattern, not the person, needs changing.

Taking this line most broadly is *Radical Therapy* (Radical Therapist Collective, 1973). Along with many others it seeks to change the entire social structure or, at least, to free individuals from being blamed and blaming themselves for their difficulties in living in the social structure as it is.

Szasz (Reich, 1949) launched a famous critique in which he held that psychosis is really only a failure to "play the game." Patients called psychotic are simply not responding on cue in the "proper," social ways. That alone is the crime for which they are incarcerated. Cure would consist in teaching the proper responses—and teaching them for what they really are, not health, not morality but simply proper game moves.

Similarly, homosexuals are considered a subgroup of society that is oppressed or suppressed. Blacks, women, gay people, are forced into social

patterns that make it difficult to develop and assert one's own needs and nature. Increasingly, they see their struggle as one with social roles rather than with their own natures.

The therapist's reaction to these trends varies. Therapists may sense both pathology and social suppression. They may remain neutral, allowing whatever direction seems right to each individual. Or the therapist may propound the views mentioned above and encourage people to discover the freeing effect of these views. Once people see that they are up against a social pattern, they stop blaming themselves, they feel less inadequate and more able to act, and they come out from behind the false fronts instead of having to live a hidden existence. Individuals who felt personally too inadequate ever to speak up can assert themselves forcefully when they are conscious of belonging to a socially moving segment of the population. Much energy is released not only for social action but also for changing one's own life and going to new places and doing new things.

Women's Rap Groups (Brodsky, 1973) and other women's activities early adopted therapy-like ways (at a time when the radical movement considered therapy as nothing but a way to support the status quo). A personal and therapeutic process occurs when a woman grasps that she is not alone to blame for her inadequacies, that her lack of preparation in worldly things is a social pattern, that her lack of fulfillment from being locked in a

little house with a child is shared by millions of other women, that her lack of full sexuality in the current male-female routines is also shared by many. These topics are the same as the topics of therapy, but the social role context differs from the old purely intrapsychic context, and shifts the focus.

The Human Being in the Universe

Religious, spiritual, or cosmic sensitivity is the next logical extension of the movement branching out from the individual to groups, the family, and society. There is a dimension even greater than society—the universe or cosmos. In the current trends this is not a matter of belief. Rather, it is the bodily experience of sensing oneself in a vast cosmic context. It is an experience of breathing more deeply, of having a sense of vastness.

The third-force therapies are not, as a whole, religious. Nevertheless, sufficient numbers of people in them are concerned with meditation and spiritual attitudes toward growth so that these dimensions are generally

accepted. If one says today that therapeutic growth and spiritual growth are the same thing, most people nod. This assertion enlarges what therapeutic growth used to mean. There is little tendency to reduce the religious to the therapeutic. In the newer therapies, it is currently much more likely that people who are not religious will soon acquire some such sense, than that those who have that dimension would lose it. Some current

religious-therapeutic methods were discussed in the section on body therapies (see page 280). The religious dimension is most often found together with these, but is frequent throughout.

In addition, the current revival of interest in Jungian therapy must be mentioned. Jung is almost the only one of the therapists of the first half of our century who spoke of the spiritual dimension and its complexity, richness, and power in human nature. Psychosynthesis also emphasizes it. Many of the other newer therapies are at least open to this dimension in people.

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