SAMUEL SLIPP M.D.

INTRODUCTION

Curative Factors in Dynamic Psychotherapy

Curative Factors in Dynamic Psychotherapy

Introduction

Curative Factors in Dynamic Psychotherapy

Samuel Slipp, M.D.

e-Book 2015 International Psychotherapy Institute

From *Curative Factors in Dynamic Psychotherapy* Edited by Samuel Slipp. M.D.

Copyright © 1982 by Samuel Slipp. M.D.

All Rights Reserved

Created in the United States of America

Contributors

Samuel Slipp, M.D., Medical Director, Postgraduate Center for Mental Health, New York, New York; Clinical Professor, Department of Psychiatry, New York University, School of Medicine.

Introduction

Samuel Slipp

The most challenging issue in dynamic psychotherapy today is what actually produces change in the patient during treatment. What are these intangible yet powerful factors arising from the patient-therapist interaction that enable the patient to overcome symptoms, to give up maladaptive behavior, and to grow and develop as an individual? Recent advances in psychoanalytic knowledge have created a mounting wave of excitement and spurred the development of newer techniques that expand and enhance the usefulness of dynamic or psychoanalytic psychotherapy.[1]

Certain types of patients who formerly were considered unsuitable for psychoanalysis can now be treated by psychoanalytic psychotherapy. So often in the past, treatment with such patients was disrupted by negative therapeutic reactions, which occurred because of the defensive structure of these patients, their inability to develop a stable transference neurosis, their difficulty in establishing a therapeutic alliance, their intense rage, and their perceptual distortion of reality. The most important thrust of current psychoanalytic investigators is the work with narcissistic and borderline disorders as well as schizophrenic and depressive conditions. As we extend our analytic understanding and develop refinements in technique that enable

us to engage and treat a much wider group of patients, it becomes essential to evaluate the effectiveness of this treatment. The crucial question that confronts us is: what are the curative factors in dynamic psychotherapy that make it work? Are these the same as the curative factors emphasized in psychoanalysis? Yet, even in psychoanalysis, we are faced with diverse opinions about what is curative. This book will review the major factors considered to be curative and will suggest ways to evaluate them scientifically. One hopes this review will lead to better understanding of the therapeutic process and greater effectiveness in treatment, thus strengthening our common goal—to promote growth and change in our patients.

This book grew out of the Annual Meeting of the American Academy of Psychoanalysis in May, 1978. Having the opportunity to chair and organize that meeting, for three days I devoted an entire track to the important topic of what produces change in treatment. Most of the papers presented at that meeting were updated and included in this book. In order to present viewpoints representative of the entire psychoanalytic community, additional papers written by clinicians and researchers with diverse orientations were included in this volume. Most of these papers are published here for the first time. The contributors to the book were selected on the basis of the important and original work they have done in expanding our knowledge of how psychoanalysis or dynamic psychotherapy works. Each contributor was given

the challenging task of writing a chapter on one aspect of the important question: what produces cure during dynamic psychotherapy?

We know that behavioral change or symptomatic improvement does indeed occur in patients as a result of suggestion, environmental manipulation, and a number of other nonspecific factors. There is a question, however, regarding the permanence of such change, which occurs without any alteration in the personality structure of the patient. Freud's original definition of cure rested on two pillars: the ability to love and the ability to work.[2] Cure involves not simply freedom from symptoms but also the patient's capacities to enter into intimate, loving relationships and to be productive at work. Repetitive, fixed patterns of thoughts, feelings, and behavior that may have been adaptive during childhood, but are self-defeating or limiting in the current reality, need to be relinquished to facilitate greater flexibility and better coping ability.

Freud believed that psychoanalytic cure came from insight, facilitated by the therapist's interpretations and reconstructions of associative material and dreams, and by the patient's reliving of old conflicts in the transference to the analyst. Insight served as a bridge between the past and the present. It was as if part of the patient were frozen (fixated) in the past and doomed repeatedly to act out the past through behaviors in the present. Cure was possible only after the patient remembered these conflicts and understood

the unconscious wishes and fears underlying them. These memories contained ways of perceiving, thinking, and feeling from childhood, which, when brought to conscious awareness, could be reexamined in the light of adult functioning. The therapeutic alliance between the patient's observing ego and the therapist encourages self-observation of old conflicts as they are relived in the transference, resulting in restructuring, and expansion of the patient's ego.

Other factors that produce cure in psychoanalysis have also been suggested. These place less emphasis on insight and focus instead on the human relationship of patient and therapist, e.g., as providing a "corrective emotional experience," a "holding environment," or a second chance to relive and correct developmental arrests or deficits in the self (further to differentiate the self from the object) as well as an opportunity for the patient to identify with the analyst. These and other factors are further developed in the various chapters in the book.

Before proceeding it is important to define certain concepts that will be used and to provide a broad historical perspective for the chapters that follow. In this volume dynamic psychotherapy will be differentiated from psychoanalysis proper. Dynamic psychotherapy employs theoretical principles derived from psychoanalysis proper, but certain modifications in technique are made. Instead of the broad psychoanalytic goal of general

personality change, dynamic psychotherapy as used here attempts to change specific aspects of the patient's behavior and character. The distinction between these two therapeutic approaches is not universally accepted, cannot always be clearly demarcated, and there is an area of overlap. In addition, the same patient, after sufficient ego growth in dynamic psychotherapy, may be able to benefit from psychoanalysis.

In 1954, controversy arose about whether Franz Alexander's therapeutic work could still be considered psychoanalysis, as well as about the core issue of whether the therapeutic relationship (a "corrective emotional experience") or the technical skill of the therapist was the most important factor in producing change in the patient. Taking the classical position, Rangell (1954) defined psychoanalysis in terms of technique and method of cure:

> Psychoanalysis is a method of therapy whereby conditions are brought about favorable for the development of a transference neurosis, in which the past is restored in the present, in order that, through a systematic interpretive attack on the resistances which oppose it, there occurs a resolution of that neurosis (transference and infantile) to the end of bringing about structural changes in the mental apparatus of the patient to make the latter capable of optimum adaptation to life. [pp. 739-740]

Gill's (1954) definition of psychoanalysis further narrowed the classical position by emphasizing the neutrality of the analyst and the resolution of the regressive transference neurosis through the use of interpretation alone.

Alexander (1954) and Fromm-Reichmann (1954) employed a broader definition of psychoanalysis, which encompassed the recognition of the importance of childhood conflict on personality development, the significance of the unconscious, and the use of transference and resistance in the treatment.

In a classic article, Bibring (1954) attempted to deal with this controversy by defining the procedures employed in all psychotherapies. He mentioned (1) suggestion, (2) abreaction, (3) manipulation, (4) clarification, and (5) interpretation. Bibring distinguishes between their use as a technique and their curative application in various treatments. He defined *suggestion* as an authority figure's inducing ideas, feelings, impulses, etc., in another person. Bibring considered that in hypnosis suggestion was curative. In psychoanalysis, suggestion is used as a technique to encourage the patient to produce dreams, memories, and fantasies, to tolerate anxiety and depression, and to face unpleasant situations. *Abreaction* concerns the therapist's acceptance or empathy with the expression of suppressed or repressed emotions. Although Freud originally considered catharsis to be curative, with the further development of psychoanalysis it became a technical tool for developing insight. In acute traumatic neurosis, however, abreaction may remain a curative factor. *Manipulation* involves giving advice and guidance, or changing the social milieu. The redirection of the patient's emotional attitudes through the therapist's words or attitudes is a subtler form of manipulation.

Bibring believed that Alexander’s handling of the transference to produce a "corrective emotional experience" was subsumed under this heading of manipulation. *Clarification* involves a more accurate differentiation of the self from the outside world. It increases self-awareness (feelings, thoughts, attitudes, behavior, etc.), and awareness of others and of objective reality. *Interpretation* involves the analyst’s explanation of the unconscious motives and defenses that determine the patient’s manifest behavior patterns.

Bibring contended that insight resulted from both clarification and interpretation, which increase self-awareness. Clarification involves little resistance, since it strengthens the patient’s ego through fostering greater self-definition, more astute observation of others, and mastery over difficulties. Clarification is particularly significant in ego-psychological approaches, where the analyst’s collaboration with the patient’s observing ego is encouraged. Interpretation, on the other hand, arouses resistance because it brings into consciousness both repressed childhood memories that have been defended against and the release of painful affect. Bibring believed that, in psychoanalysis, all five therapeutic procedures are technically operative, but that insight through systematic interpretation is the primary curative factor. He believed that interpretations in dynamic psychotherapy tend to be less systematic and limited to partial uncovering of unconscious areas. In dynamic psychotherapy, the importance of the relationship between the patient and therapist assumes a greater significance. Transference

gratification is not always avoided, and identification with the therapist may be actively fostered through a more empathic and involved approach.

The controversy about the curative effect of relational factors versus insight was by no means resolved by Bibring. Its origins stem from an even earlier controversy between Freud and Ferenczi. Freud had carefully defined the analyst's position as one of technical *neutrality*. The transference was not to be gratified; only thus could fantasy be distinguished from reality in transference interpretations. *Interpretation* of transference and resistance was to be the main tool for change. However, Ferenczi, who worked with sicker patients, considered that maintaining this *neutral-interpretive* approach with patients who had suffered actual severe parental neglect would simply prevent engagement in treatment. Because of the patient's negative expectations, the abstinent approach would be experienced only as a repetition of parental indifference. Thus Ferenczi (1920) advocated his "active," caretaking approach, wherein the analyst was emotionally available, warm, and responsive. The patient was provided with an opportunity to regress to a symbiotic state of oneness. This provided a second chance to reexperience and grow out of the childhood neurosis, with the analyst serving as a good parental object.

This *nurturant-reconstructive* approach, as well as other aspects of Ferenczi's contributions, later found expression in the work of Alexander.

Balint, Fromm-Reichmann, Guntrip, Khan, Kohut, Little, Marmor, Sechehaye, Sullivan, Thompson, and Winnicott.

Ferenczi is generally considered the father of object relations theory. He was the first to report on how patients used others to fulfill their needs by projecting their internal fantasies onto them. In addition, Ferenczi (1919) was the first to stress the importance of the analyst's being aware of both his persistent countertransferential feelings and the emotional interaction between patient and analyst. It remained for Melanie Klein, an analysand of Ferenczi's, to synthesize these insights into a systematic theory, and for the British school to develop them further into the object relations approach.

Guntrip (1968), one of the proponents of the British school, speculated on some of the differences between Ferenczi's and Freud's theory and technique. Freud placed greater emphasis on the part played by intellectual activity in analysis to produce change, an orientation that Guntrip considered masculine and phallic. The terms *in*sight and *in*terpretation themselves were indicative of active penetration. On the other hand, the analyst's stress on empathy, feelings, experiences, relationships, and interaction represented a feminine orientation. While Freud stressed the Oedipal period and sexuality, Ferenczi emphasized the pre-Oedipal period with its problems of dependency and aggression.

In this respect, Winnicott (1965) clearly believed the curative effect of therapy lay in *reexperiencing* a responsive, "good enough" mothering. The analyst provided the unconditional acceptance that served as a "facilitating" environment, comparable to the environment of infancy, which created a foundation of security and trust. In addition, the analyst created a "holding" environment which accepted and contained the patients' aggression without retaliation. Thus, patients were able to differentiate fantasy from reality through the therapeutic *relationship*; there they learned that their aggression did not destroy the object. Patients could relinquish their omnipotence and their need to control the object after they learned that the object had a separate and permanent existence. Winnicott believes that the analyst serves as a "transitional object" who enables patients to master their helplessness and distrust of the mother. Differentiation of the self and the object replaces the omnipotent fusion; thus the patient can individuate and develop a "true self' instead of a "false, compliant self."

In Freud's later work, he actively attempted to integrate the emotional and cognitive factors by concentrating his focus on the ego. Psychoanalysis changed from primarily an id psychology to an ego psychology, which encompassed drive theory but emphasized adaptation. In Freud's structural model (1923), the analysis of the ego and its defenses against the demands of the id, the superego, and the external world became paramount. In "Beyond the Pleasure Principle," Freud (1920) developed the concepts of the

repetition compulsion and the ego's need to master instinctual drives as well as external forces. In Freud's new theory of anxiety (1926, 1933), a threat to the ego signaled anxiety, which in turn caused repression; previously, anxiety had been viewed simply as the result of repression of affect.

In Anna Freud's pioneering work (1936), she furthered the application of ego psychology to bring about change in psychoanalytic treatment and child analysis. Anna Freud disagreed with Melanie Klein's approach to child analysis—using early interpretations of deep unconscious fantasies revealed in the transference—since such interpretations could overwhelm the child's ego and lead to regression, uncontrolled acting out, and a negative therapeutic reaction. While Melanie Klein bypassed the ego to reach deep, instinctually generated anxieties, Anna Freud considered the ego an ally to the therapeutic process and believed that child analysis should begin on "the surface," by analyzing the ego's methods of defense. The patient was thus encouraged to participate actively in a therapeutic alliance, and the analysis of defense as well as the transference became important.

Kris (1950) elaborated this point in his concept of "regression in the service of the ego," wherein the ego participated in the analytic process of uncovering and synthesizing repressed instinctual material. Insight need not be the forced, rapid uncovering of unconscious material resulting from the analyst's dramatic interpretation, but rather, should come more slowly, with

the appropriate involvement of the patient's ego. The importance of cognitive factors in adaptation to external reality was also further developed by Hartmann and his colleagues (Hartmann, 1939; Hartmann, Kris, and Loewenstein, 1951). They postulated the existence of a "conflict-free sphere" of the ego, which mediated the individual's drives and the demands of the environment for adaptive purposes. The conflict-free sphere determined what was expected and perceived, leading to a constancy of behavioral response. In addition, a model of external reality became internalized, like a cognitive map; it was termed the "inner world." Hartmann (1950) further defined the concept of the self as a separate structure within the ego, one that contained self- and object representations.

There have been further efforts to integrate the above-described theories and techniques. Kernberg (1977) considers Edith Jacobson's (1964) developmental model the most comprehensive psychoanalytic theory to date, integrating ego psychology, object relations, and drive theory. In addition, her close collaboration with Mahler (1968), whose work emphasizes the vicissitudes of early childhood development involved in separation-individuation, gave Jacobson important supportive material. Jacobson's work in turn served as a foundation for Kernberg's own important contributions to psychoanalytic theory and technique.

In his chapter in this book, Kernberg reviews theoretical issues and

their applications to therapeutic work with borderline and narcissistic patients. Using the developmental schema based on Mahler's and Jacobson's work concerning stages of self- and object differentiation, Kernberg says the therapist's goal is to help these patients overcome their developmental arrest, to integrate part object relations into total object relations, to develop object constancy, and to achieve an integrated self-concept. To attain this objective, Kernberg suggests that the therapist maintain technical neutrality and interpret partial aspects of the transference. In addition, Kernberg recommends the systematic interpretation of splitting and other primitive defenses. In this way, patients can relinquish both the need to idealize and maintain omnipotent control over the analyst and the need to depreciate the analyst as an independent object to defend against the dread of empty aloneness. As patients learn that they can express their ambivalence without fear of retaliation from the analyst, their integration and differentiation improve. Kernberg's work with borderline patients (1975) has the advantage of a scientific foundation: his having been director of the Menninger Psychotherapy Research Project. This study found that borderline patients did poorly when treated by either classical psychoanalysis or supportive therapy. Those treated by expressive psychoanalytic psychotherapy did better. The degree of improvement depended on the ego strength of the patient as well as on the therapist's skill and empathy in establishing a working alliance and containing aggression.

The chapter by Kohut and Wolf elaborates another position based on extensive clinical data derived from the treatment of narcissistic disorders. Kohut (1977) has placed the self at the very center of the personality; he explains pathology and symptoms in terms of a psychology of the self. Although he acknowledges the role of drive theory and ego psychology in understanding conflict, Kohut considers their importance secondary and their explanations insufficient for a thorough comprehension of the psychopathology in the narcissistic patient. Kohut sees a weakened or defective self, a self that has not been confirmed by the parents, as the core of the patient's psychopathology. An authentic and capable self can only be built when the "mirroring" (admiring responses) and "idealizing" needs of the child are satisfied by the self-objects (parents). The unresponded-to self of the child cannot individuate and thus retains its archaic grandiosity and the wish to merge with an omnipotent self-object. Kohut prefers the term self-object transference instead of narcissistic transference to describe the type of transference narcissistic patients develop. He recognizes the need these patients have to reexperience this selfobject transference ("mirror" or "idealizing") in order to make up for their developmental arrest. In their chapter, Kohut and Wolf elaborate a comprehensive psychology of the self, including a characterology of disorders of the self. Kohut is aware that others have compared his work to that of a variety of other psychoanalysts—especially Aichhorn, Hartmann, and Winnicott (and even Ferenczi, as I

mentioned earlier). Kohut emphasizes, however, that his theory and technique have arisen directly out of his own clinical work and the need to transcend the limitations of classical theory. In therapy, Kohut and Wolf emphasize the importance of the therapist's empathy rather than on the interpretation of drives, since the latter may be experienced as blame. The patient needs to become aware of, to express, and to accept the unfulfilled narcissistic needs from childhood, and thus to become more accepting of himself.

The chapter by Judd Marmor develops the viewpoint that the context of the treatment situation—the patient-therapist relationship—is of greatest importance to cure. This viewpoint stems from the scientific project undertaken by Franz Alexander in 1957, which involved the objective observation and recording of psychoanalytic sessions over a period of several years. In his report, Alexander (1963) challenged the neutrality of the analyst, claiming that the analyst's values are subtly learned by the patient through verbal and nonverbal cues. Thus the therapist as a real person is also significant—especially the attributes of genuineness, warmth, and respect. These qualities help develop a therapeutic alliance that permits working through past traumatic experiences. Alexander reported that a "corrective emotional experience" occurs when the analyst's response to the patient's maladaptive behavior differs from that of past parental figures. This experience is more important than verbal interpretation in bringing about

cure. It is interesting that a recent controlled scientific study by Strupp (1979), in the Vanderbilt Psychotherapy Research Project, corroborated Alexander's position; i.e., technical skill did not seem to be as significant as the human relationship, at least in short-term treatment. A group of empathic college professors were as effective as a group of highly trained psychotherapists in doing short-term treatment (25 sessions) with a homogeneous group of college students. These results were based on means or averages, however. Strupp (1980) further noted that failures by the professional therapists were caused by insufficient empathy and attention to the working alliance, an inflexible therapeutic framework, insufficient work with the negative transference, and acting out of countertransference. Thus, both empathic responsiveness *and* technical skill were important. In reviews of outcome studies before 1970 (Luborsky et al., 1971) and between 1954 and 1978 (Bachrach, 1978), these same deficiencies in the skill of therapists were understood to contribute to poor outcomes. All these studies, including Strupp's, noted that the best predictor for a positive outcome or cure is mainly the adequacy of the patient's previous personality functioning. Sicker patients did less well because of the severity of their pathology and the likelihood that they created more transference/countertransference difficulties in the treatment situation.

Robert Hatcher's chapter on insight traces the gradual evolution in psychoanalytic thinking concerning its functioning and its curative effects.

Originally psychoanalytic theory held that repressed material emerged in the transference because of two reasons—its own inherent press to seek discharge as well as the repetition compulsion. In current psychoanalytic writings, the ego has assumed the more significant role, with some considering that the very motive force for psychotherapy is the mastery-seeking role of the ego. On the other hand, resistance in treatment is believed to be due to the ego's fear of dangerous thoughts, feelings, and wishes. Strachey's (1934) landmark paper stressed that only when the ego allowed certain repressed material to emerge into consciousness could it be experienced, examined, mastered, and relinquished. For interpretations to be mutative, the timing of interpretations was crucial, i.e., when the patient's impulses were emotionally alive and actively experienced in the transference. This point is further developed in Gill's chapter. Interpretations could thus lead to insight and change. The patient's superego could then identify with the more adult and realistic point of view of the analyst. Hatcher points out that the context around which insight can become effective depends on the patient's ego capacity for controlled regression, tolerance for unpleasant affect, reflective self-observation, and integrative functioning. In addition, the patient-therapist relationship provides a safe or holding environment to facilitate the process. Reorganization of the ego can occur after causal relationships, based on adult understanding, replace old meanings founded on infantile drives, fantasies, and thoughts. The gradual cumulative effect of

interpretations allows the ego to expand into larger contexts for self-understanding and mastery of the environment, points that are also dealt with in the chapters by Fried, Palombo, and Stone.

In Levenson's chapter, he elaborates on the thesis advanced in his book, *The Fallacy of Understanding* (1972). Levenson believes that cure does not result simply from the correctness of an interpretation; instead, cure is effected by the dialectical interaction—what is said and done—in the patient-therapist dyad. Levenson focuses on the very tool of psychotherapy, namely, language. The content of a communication is clothed by the nonlexical contexts, kinesics (bodily and facial gestures), as well as by the immediate social and cultural context. Bateson's (1951) use of the term "metacommunication" implies that there is a message about the message in each communication. Speech can be viewed as a form of behavior. Words are considered deeds that determine how the receiver will hear, experience, and respond to a message.

Freud himself was aware of the fact that hidden unconscious meanings are communicated through tone of voice, posture, slips of the tongue, forgetting, and other parapraxes. Astute therapists invariably pick up inconsistencies or inappropriateness in the patient's communication, especially regarding its authenticity. With borderline and narcissistic patients, who attempt to induce the therapist into feeling and behaving in

certain ways, the nonverbal aspects of communication may be extremely significant as to how projective identification may operate. For example, Giovacchini (1975) and Green (1975) have commented on how narcissistic patients may try to make the analyst feel like an inanimate or nonexistent object. Others, such as Deutsch (1926), Heimann (1950), Little (1951), Racker(1953, 1957), Searles (1965), Kernberg (1975), and Langs (1976), have noted how borderline and narcissistic patients may attempt to induce countertransference responses of grandiosity, inferiority, depression, anger, or boredom in the analyst. These responses are evoked by projective identification and relate to the patient's internal objects. In turn, the therapist's own countertransference reaction (whether due to his own pathological transference or to induction by the patient) may be communicated to the patient through the context of the communication. Thus, language (paralinguistics and kinesics) may provide us with the necessary tools to study this phenomenon occurring in projective identification.

Merton Gill's chapter deals with the most critical and central issue of analytic technique: the analysis of the transference. Since the patient's neurosis finds expression in the transference to the analyst, analysis of the transference neurosis is tantamount to analysis of the neurosis. Gill's paper develops five recommendations for working with the transference in ways that enhance its curative potential. He recommends that (1) the transference be encouraged to expand, (2) interpretations of allusions to the transference

help this expansion, (3) all transferences have a connection to the analytic situation, (4) resistance to awareness of the transference be interpreted, and (5) resolution of the transference be in the here and now.

Since the patient-therapist interaction is such an emotionally loaded area, transference tends to be pursued less systematically than it should be. Gill points out that the therapist as well as the patient may resist awareness of the transference. Yet this very emotionality is the stuff that cures are made of: it allows for a genuine experiencing of the transference, so that emotional insight can develop.[3] Genetic interpretations may avoid the emotionally loaded area of the therapist-patient interaction, and may lead only to an intellectual understanding that can serve as a defense against change. Although Gill emphasizes the importance of insight, as do Kleinian analysts, he is at variance with the Kleinian emphasis on the interpretation of deep genetic material. Focusing on the here and now in the patient's transference maximizes the chance that emotional insight will develop, with a resultant loosening of constrictions, correction of ego distortions, and change in personality structure.

The issue of countertransference. which has received so much attention in recent years, is reviewed and developed in Robert Langs's chapter. In recent years, the meaning of countertransference was enlarged by Winnicott (1949) to include all the reactions of the therapist to the patient. Its

usefulness in treatment was further developed by Deutsch (1926), Sterba (1941), Heimann (1950), Little (1951), Racker (1953, 1957), and others. With sicker patients, the analyst does not serve simply as a screen for projections, but rather, as Bion (1970) pointed out, as a container for the patient's projective identifications. The patient projects aspects of himself into the analyst and attempts to provoke the analyst into thinking, feeling, and behaving like the patient's internalized object. The evoked behavior of the object is then reinternalized through identification. This process involves a certain fluidity of ego boundaries in the patient, and represents the patient's attempt to shape the external real world to fit his internal object world.

Langs discusses how these two forms of countertransference (pathological and inductive) operate continuously between the patient and the therapist in the "bipersonal field." When the analyst monitors his own reactions to the patient's material, the countertransference can serve as a useful therapeutic tool for understanding the patient's transference and internal objects, thereby actually contributing to the curative process. Langs further develops the concept of the "countertransference-cure." Here the patient forms a "misalliance" and complies with the therapist's countertransference needs for a cure.

In my own studies of families of schizophrenics (Slipp, 1973), depressives (Slipp, 1976), and hysterics (Slipp, 1977), the treatment

"misalliance" appears as a repetition of the process that originally produced the patient's pathology, e.g., the parents' need to complete themselves. The patient complies with the projective identification of the parent(s) by incorporating and acting out the parent's internal split objects.[4] In my opinion it is the convergence of the real world of the family with the intrapsychic world of the patient *throughout* development that contributes to the patient's continued fixation and use of primitive defenses. In therapy (as well as in other important human relations), these patients attempt to recreate this convergence of external reality with their internal objects; they use projective identification to provoke countertransference responses in the therapist. Essentially, they attempt to control the therapist's responses as they were controlled in the family. If the therapist acts out the countertransference, the pathology remains deeply fixated by external reality. Thus, Langs's contribution to the understanding and the appropriate use of countertransference is essential in helping patients to resolve their fixation in development, to differentiate fantasy from reality, to differentiate and integrate the self from the object, and to grow and change.

Vamik Volkan's chapter on identification and related psychic events explores a fascinating area of therapeutic change. Volkan reviews the literature on identification and differentiates the following terms: identification, introjection, introject, imitation, incorporation, internalization, projection, externalization, and projective identification. Ego identification

with the lost object as a step toward independence that follows normal mourning was first described by Freud in "Mourning and Melancholia" (1917). Since then, considerable interest has been evoked around the curative and pathological potentials of such identification. Strachey (1934) first described the internalization of the analyst by the patient's superego emphasizing the importance of identification with the analyst during the process of change. Identification by the patient's ego with the functional representation of the therapist can also enrich the patient's personality, just as repeated introjections of the analyst as an object may lessen the harshness of the patient's superego. Volkan points out that both these processes can serve as essential components of change and cure in psychotherapy.

An interesting point developed in this chapter is that certain patients with a defect in ego organization can almost serve as a clinical laboratory in which to observe the gradual structuralization occurring during psychoanalytic treatment. These patients have failed to achieve a cohesive self-representation and lack an integrated, internalized object world. They thus relate to the therapist through introjection-projection mechanisms until cohesive self- and object representations are developed. As is usual in Volkan's other work, this chapter contains excellent presentations of clinical data.

The topic of regression, developed in the chapter by Saul Tuttman, is

one that has been fraught with controversy from the beginning of psychoanalysis. Is regression necessary? If so, how much is optimal for cure? As mentioned earlier, Ferenczi (1919) believed it was necessary for patients to relive their childhood conflicts fully in the treatment situation if growth and change were to occur. Others have disagreed with the degree of regression that Ferenczi recommended; although some regression occurs in all psychoanalytic psychotherapy, it is usually more limited and more easily reversible. Such limited regression may best be subsumed under Kris's (1952) term "regression in the service of the ego." The therapeutic regression allows otherwise inaccessible material to come to conscious awareness, where it can be interpreted and worked through. Regression brings the past to life again; it is as if the past and present coalesce. This reliving adds a greater emotional impact to the transference. Stability is maintained by the working alliance, wherein the observing ego of the patient cooperates with the therapist. Thus the conditions for real emotional insight and the release from bondage to the past are created.

Tuttman deals with the problem of the therapist's distress about the patient's regression, which is accentuated in cases of intense regression. Should the therapist become more supportive and less probing? Should treatment be discontinued? My own clinical experience indicates that the serious regression that occurs as a result of the patient's life becoming more impoverished is of greater pathological significance than the regression that

occurs as a result of enrichment and change in the patient's life. The latter may also be pathological (reflecting an intolerance of success), but is more often a temporary regression connected with the restructuring of the ego.[5]

Edrita Fried's chapter on working through deals with a topic whose importance is well recognized but about which little has been published. How do patients utilize insight: how is it metabolized to bring about behavioral change? This is a puzzling issue that is also dealt with in the chapters by Palombo and Stone. First of all, Fried differentiates "spectator" insight from "experiential" insight. The former is characterized as passive, distant, and intellectualized. It usually does not produce change, but may itself be used as a defense against change. On the other hand, experiential insight is active, immediate, alive, and emotional. This form of insight combines both cognitive and emotional elements and is more likely to produce change. We know from laboratory experiments in the field of social psychology that changes in attitudes do not occur if people are simply given intellectual information. Change is more likely to occur if they are active, rather than passive, participants.

On a practical level, we know that simply reading about doing something that requires skill will not provide a person with the necessary ability; only doing it—experiencing the process—leads to real mastery. Insights need to be tried out repeatedly, in and out of the treatment situation,

in order for the patient gradually to learn new coping methods, new ways of behaving and relating. Change occurs gradually, as new structures in the ego, which allow for a greater flow of emotions and thoughts, are built up. Fried stresses the vital importance of expressing and processing aggression during the working-through period in order to fortify the patient's ego boundaries, promoting individuation and the development of a vital and authentic self.

Lloyd Silverman's chapter on the unconscious fantasy as a therapeutic agent presents us with fascinating information from the experimental laboratory that sheds light on some of the agents of change that operate during treatment. In the 1960s, Silverman developed a dramatically new use for the tachistoscope, through which he was able to study the effects on behavior of stimulating unconscious fantasies. Subliminal stimulation appears to bypass the conscious perceptual barrier and impinge on the unconscious directly. If the stimulus corresponds to an unconscious fantasy, the fantasy is activated and produces behavioral change, which can then be measured. Certain unconscious fantasies were found to have an adaptation-enhancing effect on thought processes and affect. Silverman suggests that these very same unconscious fantasies may be activated during psychoanalytic psychotherapy, and may account for some of the changes attributed to nonspecific factors.

The most potent subliminal message was one that stimulated

unconscious *symbiotic merging fantasies with mother*. This stimulus was found to be adaptation-enhancing for moderately differentiated schizophrenics, for a wide variety of other pathological conditions, as well as for a normal population. The stimulus seems to arouse memory traces of the good pre-Oedipal mother, providing a sense of security, and perhaps also inadvertently stimulating fantasies of Oedipal gratification. Thus the experimental data appear to support the importance of maternal factors in bringing about cure, as described in Ferenczi's "active" treatment, Alexander's "corrective emotional experience," Winnicott's "holding environment," Bion's "container," Kohut's emphasis on the idealizing transference, and Volkan's discussion of the introjection-projection process leading to identification in therapy.

Perhaps the most significant aspect of Silverman's findings is that both the context and the content of treatment (including the therapist's skill and technical competence) are important. They are not mutually exclusive, although, with certain types of patients, one aspect may be more important than the other. Silverman further suggests that there is now experimental evidence that stimulating the unconscious fantasy of merging with the good mother may also facilitate insight; indeed, it may be synergistic and enhancing. Thus the implications for treatment are significant.

The experimental study of dreams in the dream laboratory is presented

in the chapter by Stanley Palombo. Palombo’s findings indicate that the dream is not only the royal road to uncovering the unconscious but also the royal road traversed in the process of change. He believes that the integration of information generated in the analytic session takes place not in conscious cognitive awareness but during dreaming, by the convergence of associative pathways present in the patient’s permanent memory. Associative material and interpretations of dreams from the analytic hour become incorporated into the dream the following night. When matching of present and past experiences occurs, this link becomes part of the permanent memory structure, which then facilitates the normal adaptive mechanisms for evaluating and sorting new experiences. Palombo calls this kind of dream the "correction dream." The process is continuous, with the "correction dream" further evoking new sets of earlier memories, which then become accessible to be worked on. These new memories, in turn, therapeutically open up new associative pathways, which create further change in treatment. Palombo found that lack of matching of present and past experiences tended to create anxiety, which awakened the dreamer. Thus the dream is introduced into waking consciousness and is generally remembered the following day. This dream, in turn, forms the day residue for the dream the following night, which attempts to resolve the mismatch in a "correction dream."

Palombo recommends that, in order to enhance the development of the "correction dream," emphasis needed to be placed on expanding the patient’s

associations rather than the therapist’s interpretations. His work may be viewed as stressing the importance of the ego’s need for mastery: its ability to evaluate and derive meaning from experiences. We have long known of the human need to reduce helplessness, as reflected in the building of myths, legends, religion, and scientific theories. Piaget’s (1937) study of children’s need to develop schemata to explain their experiences and to make causal connections provides another example. Palombo’s discovery of how this process occurs unconsciously during dreaming may be the basis for understanding how interpretations and insight are worked through in the dream and how they are effective in bringing about change.

Michael Stone’s chapter deals with the sudden and dramatic improvements, or turning points, that sometimes occur in patients during treatment. Stone considers which types of patients are more likely to demonstrate this phenomenon and then attempts to understand its occurrence. He suggests that during treatment there is an accumulation of incremental knowledge which, at one point, results in a quantum leap forward in understanding that changes the patient’s life. This recalls Palombo’s description of a similar phenomenon in "correction dreams." Stone also mentions that a turning point is often heralded by a dream in the patient; this he terms the "mutative dream," but he does not give it the same causal significance that Palombo does. Stone considers the dream an epiphenomenon, the end result of a complex problem-solving operation going

on in the patient's mind outside of conscious awareness. Palombo, on the other hand, considers the turning-point dream to be a therapeutically active "correction dream." This dream, however, reaches the patient's conscious awareness because the unconscious solution of a major problem may in turn expose new problems that create sufficient anxiety to awaken the dreamer. Despite diverse explanations, both the astute clinician, Stone, and the careful researcher, Palombo, have highlighted this same phenomenon, the turning-point dream. Both believe this process of change occurs on an unconscious level, outside of the patient's awareness. Both view it as a continuous and gradual evolution that eventually results in the sudden resolution of a major personality problem. Both present a number of interesting clinical examples to enrich our understanding of the fascinating topic of sudden turning points in treatment.

Jules Bemporad focuses on curative factors in the treatment of depression. Depressed persons usually seek therapy after a major upheaval in their life creates a crisis in meaning around how they derive self-esteem and gratification in their existence. As a child, the depressed person was often used to complete a parent's life: the parent lived vicariously through the child's achievement. Drawing from Silvano Arieti's rich clinical experience as well as his own, Bemporad notes that the depressive's sense of worth and enrichment stems not from his or her own achievement but from parental approval. Autonomous gratification is forbidden. The depressive becomes

dependent on a transferential displacement of the parent, "the dominant other," who is empowered to provide self-esteem and meaning to life. These same dynamics that Bemporad derived from retrospective case studies were found to be operative in the direct study of depressives and their families (Slipp, 1976).

Bemporad outlines three phases of treatment and lists the potential pitfalls that may hinder cure. In the initial phase, the patient will try to induce the therapist to play the role of the omniscient "dominant other," which the therapist must resist; nor should the therapist be trapped into gratifying the patient’s demands. The therapist needs to encourage the patient’s introspection and assumption of responsibility for his own improvement. In the second stage, resistance to change—the fear of being abandoned as punishment for becoming autonomous—has to be worked through. In the final stage, the spouse may resist change in the patient and may thus require treatment. The spouse may enter individual therapy with another therapist or both spouses may be seen in conjoint treatment to establish a new and healthier relationship.

The chapter written by Theodore and Ruth Lidz reflects the wisdom of a lifetime spent working with schizophrenics as well as studying and understanding their families (Lidz, Fleck, and Cornelison, 1965). These families were found to be incapable of fulfilling the child’s needs for

nurturance, personality development, basic socialization, and enculturation; nor could they provide adequate models for identification. The child is caught in the symbiotic bondage of having to complete a parent's life, and the therapist's primary task is to release the patient from this bondage. How this is accomplished is the content of the chapter. The process of treatment is developed in a clear and comprehensive fashion, including such issues as establishing a therapeutic relationship, gaining trust, avoiding the omniscient role, the therapist as participant observer, clarification of schizophrenic communication, finding a working distance, and closure of the therapeutic relationship. In therapy, the patient develops ego boundaries and becomes a separate individual able to establish proper object relations and to direct his or her own life. Many of the problems and pitfalls that the therapist must cope with are carefully elaborated, including the possibility of disruption of treatment by the family. The latter frequently occurs with young adult schizophrenics who are improving and individuating because of treatment. As Bemporad mentioned in the previous chapter, other members of the patient's family may resist change in the patient. Thus the family may need to be involved in consultation, collaborative therapy with a social worker, or conjoint family treatment in order to consolidate the gains made in individual therapy.

In the chapter, "Toward the Resolution of Controversial Issues in Psychoanalytic Treatment," Lloyd Silverman and David Wolitzky, both

outstanding researchers, present some of the major controversial issues regarding what is curative in psychoanalytic psychotherapy. These issues are presented in earlier parts of the book and include (1) the problems of the self versus unconscious conflicts about sexual and aggressive drives, (2) Oedipal versus pre-Oedipal conflicts, (3) the importance of transference versus nontransference issues, and (4) the therapeutic context versus insight. Suggestions are made for the resolution of these controversies, including five research paradigms that range from naturalistic (approximating the treatment situation) to experimental (including controls and holding independent variables constant).

The final chapter by David Wolitzky and Morris Eagle reviews the important hypotheses presented by the clinicians and researchers contributing to this book regarding what is curative in psychoanalysis and dynamic psychotherapy. The current state of the field is thus presented to the reader. Each hypothesis is discussed in detail as well as in the light of the other chapters and outside literature. They address such issues as: What are the merits and problems of each of these hypotheses about what brings about change? How can these controversies be explored and possibly be resolved through further research? Indeed, some of the controversial issues may not be oppositional, but be complementary to one another. The general themes and issues raised by the contributors to the book are brought together to obtain a clearer picture of what is most effective and with whom to facilitate

change in psychotherapy.

From the inception of psychoanalysis, Freud stressed the importance of its being a discipline firmly rooted in science. His own theoretical formulations were based on direct empirical findings from his work with patients. He established a carefully controlled framework for both patient and analyst in the treatment situation. Freud considered that psychoanalytic research could only be done in the therapeutic session, that to introduce other methods of investigation would change the essential process. Thus the individual case study method became the primary one and, indeed, has proved to be the richest and most creative area for the development of clinical hypotheses and therapeutic techniques. With the expansion of psychotherapy into the treatment of a broader group of patients, it becomes increasingly important to assess our therapeutic effectiveness. Evaluative procedures for psychotherapy outcome studies have become more sophisticated. In addition, the newer applications of the tachistoscope, the dream laboratory, and other scientific methods bring Freud's hope for scientific validation of psychoanalytic theories clearly within our grasp. To this end, outstanding clinicians and researchers were brought together in this book to share their creative insights and scientific knowledge to further our understanding of the curative factors in dynamic psychotherapy.

REFERENCES

Alexander, F. (1954), Psychoanalysis and psychotherapy. *J. Amer. Psychoanal. Assn*., 2:722-733.

_____ (1963), The dynamics of psychotherapy in the light of learning theory. *Amer. J. Psychiat*., 120:440-448.

Bachrach, H. M., & LeafF, L. A. (1978), Analyzability. In: A systematic review of the clinical and quantitative literature. *J. Amer. Psychoanal. Assn*., 26:881-920.

Bateson, G. (1951) *Communication: The Social Matrix of Psychiatry*, New York: Norton.

Bibring, E. (1954), Psychoanalysis and the dynamic psychotherapies. *J. Amer. Psychoanal. Assn*., 2:745-770.

Bion, W. R. (1970), *Attention and Interpretation*. London: Tavistock.

Deutsch, H. (1926), Occult processes occurring during psychoanalysis. *Imago*, 12:418-433.

Ferenczi, S. (1919), On the technique of Psycho-analysis. In: *Further Contributions to the Theory and Technique of Psycho-Analysis*. London: Hogarth Press, 1926, pp. 177-180.

_____ (1920), The further development of an active therapy in psycho-analysis. In: *Further Contributions to the Theory and Technique of Psycho-Analysis*. London: Hogarth Press, 1926, pp. 198-217.

Freud, A. (1936), *The Ego and the Mechanisms of Defence*. New York: International Universities Press, 1946.

Freud, S. (1910), The future prospects for psycho-analytic therapy. *Standard Edition*, 11:139-151. London: Hogarth Press, 1957.

_____ (1917), Mourning and melancholia. *Standard Edition*, 14:237-258. London: Hogarth Press, 1957.

_____ (1920), Beyond the pleasure principle. *Standard Edition*, 18:3-66. London: Hogarth Press, 1955.

_____ (1923), The ego and the id. *Standard Edition*, 19:3-66. London: Hogarth Press, 1961.

_____ (1926), Inhibitions, symptoms and anxiety. *Standard Edition*, 20:75-174. London: Hogarth Press, 1957.

_____ (1933), New introductory lectures on psycho-analysis. *Standard Edition*, 22:1-182. London: Hogarth Press, 1964.

Fromm-Reichmann, F. (1954), Psychoanalytic and general dynamic conceptions of theory and of therapy: Differences and similarities. *J. Amer. Psychoanal. Assn*., 2:711-721.

Gill, M. (1954), Psychoanalysis and exploratory psychotherapy. *J. Amer. Psychoanal. Assn*., 2:771-797.

Giovacchini, P. L. (1975), Self projections in the narcissistic transference. *Internat. J. Psychoanal. Psychother*., 4:142-166.

Green, A. (1975), The analyst, symbolization and absence in the analytic setting (on changes in analytic practice and analytic experience). *Internat. J. Psycho-Anal*., 56:1-22.

Guntrip, H. (1968), *Schizoid Phenomena, Object Relations and the Self*. New York: International Universities Press.

Hartmann, H. (1939), *Ego Psychology and the Problem of Adaptation*. New York: International Universities Press, 1958.

_____ (1950), Comments on the psychoanalytic theory of the ego. In: *Essays on Ego Psychology*. New York: International Universities Press, 1964.

_____, Kris, E., & Loewenstein, R. M. (1951), Some psychoanalytic comments on "culture and personality." In: *Psychoanalysis and Culture*, ed. G. B. Wilbur & M. Muensterberger. New York: International Universities Press.

Heimann, P. (1950), On countertransference. *Internat. J. Psycho-Anal*., 31:81-84.

Jacobson, E. (1964), *The Self and the Object World*, New York: International Universities Press.

Kernberg, O. (1975), *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

_____ (1977), An ego-psychological object relations theory: The contributions of Edith Jacobson. Presented at the New York Psychoanalytic Society and Institute. (To be published in *Object and Self: A Developmental Approach*, a book in memory of Edith Jacobson, ed. S. Tuttman. New York: International Universities Press.)

Klein, M., (1948) *Contributions to Psychoanalysis*. 1921-45. London: Hogarth Press.

Kohut, H. (1977), *The Restoration of the Self*. New York: International Universities Press.

Kris, E. (1952), On preconscious mental processes. In: *Psychoanalytic Explorations in Art*. New York: International Universities Press, pp. 303-320.

Langs, R. (1976), *The Therapeutic Interaction*. New York: Jason Aronson.

Levenson, E. (1972), *The Fallacy of Understanding*. New York: Basic Books.

Lidz, T., Fleck, S., & Cornelison, A. R. (1965), *Schizophrenia and the Family*. New York: International Universities Press.

Little, M. (1951), Countertransference and the patient's response to it. *Internat. J. Psycho-Anal*., 32:32-40.

Luborsky, L., Auerbach, A. H., Chandler, M., Cohen, J., & Bachrach, H. M. (1971), Factors influencing the outcome of psychotherapy: A review of quantitative research. *Psycholog. Bull*., 75:145-185.

Mahler, M. S. (1968) *On Human Symbiosis and the Vicissitudes of Individuation*. Vol 1: Infanite Psychosis, New York: International Universities Press.

Peto, A. (1960), On the transient disintegrative effect of interpretations. *Internat. J. Psycho-Anal*.. 41:413-417.

Piaget, J. (1937), *The Construction of Reality in the Child*. New York: Basic Books, 1954.

Racker, H. (1953), A contribution to the problem of countertransference. *Internat. J. Psycho-Anal*. 34:313-324.

_____ (1957), The meanings and uses of countertransference. *Psychoanal. Quart*., 26:303-357.

Rangell, L. (1954), Similarities and differences between psychoanalysis and dynamic psychotherapy. *J. Amer. Psychoanal. Assn*., 2:734-744.

Searles, H. F. (1965), *Collected Papers on Schizophrenia and Related Subjects*. New York: International Universities Press.

Slipp, S. (1973), The symbiotic survival pattern: A relational theory of schizophrenia. *Family Process*, 12:377-398.

_____ (1976), An intrapsychic-interpersonal theory of depression. *J. Amer. Acad. Psychoanal*., 4:389-409.

_____ (1977), Interpersonal factors in hysteria: Freud's seduction theory and the case of Dora. *J. Amer. Acad. Psychoanal*., 5:359-376.

Sterba, R. (1941), The relaxation of the analyst. *Psychiatry*, 4:339-342.

Strachey, J. (1934), The nature of the therapeutic action of psychoanalysis. *Internat. J. Psycho-Anal*.15:127-159.

Strupp, H. H., (1980), The Vanderbilt Psychotherapy Research Project. Grand Rounds Presentation, New York University School of Medicine, Department of Psychiatry.

_____ & Hadley, S. W. (1979), Specific vs nonspecific factors in psychotherapy: A controlled study of outcome. *Arch. Gen. Psychiat*., 36:1125-1136.

Winnicott, D. W. (1949), Hate in the countertransference. *Internat. J. Psycho-Anal*., 30:69-74.

_____ (1965), *The Maturational Process and the Facilitating Environment*. New York: International Universities Press.

Notes

1 The terms dynamic and psychoanalytic will be used interchangeably.

2 It should be pointed out that this "definition” of cure may be what Freud meant by the term. No one has ever been able to find a written statement of it. Apparently Erikson, in *Childhood and Society*, 1950, p. 229, quotes Freud as having *said* something to this effect

3 This point is further developed in the paper by Edrita Fried.

4 In schizophrenia, the patient acts out the parent’s projected bad parental object, functioning as the family *scapegoat*. Thus the parents can displace their feared aggression onto the child and idealize their own relationship. In depression, projective-identification of the parent’s good self-image occurs; the patient feels compelled to meet the parental demands for achievement and serves as the family *savior*. In hysteria, the patient acts out the parent’s projected good parental object, entering into a seductive relationship with the parent of the opposite sex and serving as a go-between to preserve the marriage. In all these instances, the patient is bound into a symbiotic relationship that prevents individuation and results in the patient’s being exploited for the parents’ needs.

5 In this respect. Peto (1960) stresses the temporary fragmenting effect of successful interpretations, the result of which can be regression. A transitory disintegration within the ego occurs resulting in loosening of ego boundaries or even brief depersonalization. Split-off parts of the ego then reemerge and are reintegrated into more realistic images of self and object, so that more mature identifications and sublimations can then evolve. Peto also sees this transitory disintegration-integration effect operating in dream work and play to master traumatic experiences.