Albert Rothenberg

The Mutual Creative Process and Therapeutic Action

The Creative Process of Psychotherapy

The Mutual Creative Process and Therapeutic Action

Albert Rothenberg, M.D.

e-Book 2015 International Psychotherapy Institute

From *The Creative Process of Psychotherapy* by Albert Rothenberg M.D.
Copyright © 1988 by Albert Rothenberg M.D.

All Rights Reserved

Created in the United States of America

www.freepsychotherapybooks.org
ebooks@theipi.org

By the Same Author

The Emerging Goddess:
The Creative Process in Art, Science and Other Fields (1979)

The Creativity Question (with Carl R. Hausman) (1976)

The Index to Scientific Writings on Creativity:
General, 1566-1974 (with Bette Greenberg) (1976)

The Index to Scientific Writings on Creativity:
Creative Men and Women (with Bette Greenberg) (1974)

Table of Contents

The Mutual Creative Process and Therapeutic Action

As a creative process, psychotherapy emphasizes worth, innovation, and volition for both therapist and patient. Both are engaged in enhancing the patient's self and social worth, ego growth and development. While growth is required in treatment to reverse developmental stasis, fixation, and impairment, the course of growth is never simply reparative or smooth. The patient goes beyond the correction of deficiency to develop new and better ways of understanding, behaving, and interacting with others. To facilitate these effects, highly developed and actively applied skills are required on the therapist's part and, for the patient, an active making of choices. Only through active participation and decision-making can creative effects take place. In this creative process of psychotherapy, the patient feels that he has had a major share in producing the results. He chooses new patterns of behavior just as the creative artist actively chooses to produce newly structured content and the creative scientist actively chooses new theoretical formulations.

I shall not discuss supportive or directive orientations in relation to the creative process because these have little to do with the model I have been presenting. All types of psychotherapy involve some degree of supportiveness and directiveness which, although potentially suppressive of active choice,

may not in practice interfere. Overall goals, effects, and operations may stimulate active patient choice in a way that is not clearly stipulated in general descriptions of particular therapeutic techniques.

The therapeutic process begins, as we know, before the patient and therapist actually meet and before the initial appointment is made. It begins when, in the course of a patient's illness, a particular shift in a balance of forces occurs. At this point, illness has either become overbearing, or treatment of some type has become attractive and feasible, or both factors operate, and the patient makes a decision to seek help. Again, I will not go into instances of manifestly directed or forced therapy such as those resulting from psychotic breakdown and institutionalization, suicide attempt, antisocial acts and the like, because any of these may represent indirect requests or decisions for treatment. Although available evidence is, to some degree, retrospective, it seems highly likely that no therapy of psychiatric illness can succeed unless some shift by the patient toward actively overcoming the illness takes place.

At the point of shifting, however, a decision to enter into a creative process has not been made. Although some patients may be aware of the growth-enhancing effects of psychotherapy and know or believe that such growth is necessary to overcome their discomfort, most initially prefer not to change. Unlike other creative activities, where an artist or scientist is highly

motivated to create something out of particular materials, a patient seeking help has selected the materials but not the process of creation. He has, at that point, only decided that the subject of therapy is primarily himself. Nevertheless, this shift does constitute a step toward entering into a creative process, and it is a palpable and risky one.

After the patient meets with the therapist, the conditions for improvement are set. Different therapists may offer interventions ranging from medication, hypnosis, and advice on the one end of the spectrum to formal psychoanalysis at the other. Or they may offer a number of types of combinations from throughout the range. Regardless of particular treatment content offered, instigation to enter into a creative process occurs when a structure involving a trial domain is presented as well. As described in Chapter II, if the therapist tells the patient that the treatment will involve meetings with definite time limits and regularity, offers confidentiality, and indicates that improvement will result from the sessions themselves rather than a change in the patient's environment, a potential trial domain of interpersonal interaction is set up. If, in subsequent behavior, the therapist continues to avoid interfering in the patient's (including family or group as the patient unit) environment, he will further extend the instigation to engage in a creative process, even if also giving medication or being directive.

This is not to say that such instigation is sufficient to motivate the

patient toward a creative effect. Indicating to him that his problems derive from patterns of living, unconscious conflict, or life history experiences also enters in. Most patients resist such formulations, and although many psychiatrists today believe they are less pertinent than biological ones, they must be accepted to some degree by both patient and therapist in order for the creative process to begin. A specific agreement or verbal "therapeutic contract" about the nature and structure of the treatment can then be established. I must point out here, as I did earlier, that even if psychiatric illness were caused by biological factors alone there would still be psychological sequelae of having experienced the illness. New structures and attributes are needed both to overcome the experience of the illness and to cope with future stresses.

The early preparation for active engagement in a therapeutic creative process consists of helping a patient to see or experience connections between conflicts and maladaptive patterns and the symptoms and suffering for which he sought help. Much of the initial phase of psychotherapy is concerned with establishing this. Continuing on, sometimes over considerable periods of time, and requiring reinforcement at later phases as well, the understanding of connections is at no point a purely intellectual matter. The patient must find that talking with the therapist about factors in his life is itself relieving and beneficial.

Without this preparation, without what for the creative artist would be respect for and interest in the materials he uses, little creative activity on the patient's part would be possible. The motivation still, however, does not arise automatically after this preparation occurs. The stage is set, the trial domain is structured, and the patient as major participant is ready. However, it is the therapist's creative activity that effectively instigates the mutual creative process.

The therapist's absorption in and love for the material of psychotherapy, of which I spoke earlier (Chapter IV), antedate the patient's interest. This love and absorbed regard for what the patient brings pervade the entire therapeutic transaction and are major instigating factors. Through his interest in the patient's presentation —including the form and structure of the symptoms, the intricate workings of recurrent behavior patterns, factors of symbolization in both the illness and verbal and nonverbal productions in sessions, the give and take of the verbal interaction —the therapist also conveys interest in and respect for the patient himself. The therapist experiences the doing of therapy with another human being as an especially worthy endeavor, and the patient, partly as a result, feels himself a worthy participant. Therapists do not often speak or write about their love for and gratification in the material the patient brings; they more often talk only of feelings about the patient as a person. Although these feelings are distinctly interrelated, the creative therapist's love for the human materials of his work

is the same as the artist's love and fascination for the words, pigments, and sounds that are used to produce literature, visual art, and music, and the creative scientist's fascination with the puzzles and mechanisms of his field. Without such involvement and absorption, the creative process could not take place. No one, I have found, creates without this.

Other motivations for creating, such as drives for mastery, growth, and understanding, operate for both therapist and patient. However, the patient's motivation to participate in therapeutic creation is primarily facilitated by the treatment interaction. Out of a developing sense of worth comes a feeling of ability to make changes and —although not explicitly formulated in these terms—to produce creative effects. Once the patient feels the possibility of inducing change and making active choices, the therapist's creative skill facilitates the process and helps determine the nature of the creative outcome. At that point, all the faculties and processes I have discussed in this book play a role in activating the mutual creative process. Focus on form and structure, use of homospatial and janusian processes, articulating error, and guiding the overall process of articulation all have a part in inducing and maintaining the creative engagement. All of these factors contribute to the ongoing production of new and valuable effects. The therapist's application of these creative functions is critically responsible for the course of the creative process and also serves as a model of creative action for the patient.

UNDERSTANDING IN THE THERAPEUTIC CREATIVE PROCESS

Enhancement of the therapist's understanding is a generative function of the focus on form and use of the homospatial and janusian processes. This understanding is a core facilitator of the creative process. Transmitted through the therapist's particular interventions, interpretations, and overall approach, it provides the springboard from which the patient develops insight, resolves conflict, makes choices, and develops new attributes and structures. Only if the patient feels understood in a meaningful way can he undertake the risk of engaging in a creative therapeutic process. Having risked a shift in the direction of overcoming illness at the start, he cannot and will not undertake the further risk of change and creation unless he feels it will be for his own sake. The therapist's transmitted understanding assures the patient that there are reasons to change and he, not the therapist or another person, will be the primary beneficiary. In particular, the therapist's transmitted understanding helps the patient to overcome, in each case, the self-defeating factors and resistances that interfere with his engaging in the therapeutic process.

Although there are numerous other means besides the homospatial and janusian processes for achieving understanding, these are creative ones. In the creation of empathy in the course of treatment, the homospatial process provides a specially important type of knowledge. Freud made a strong claim

for empathic understanding when he stated that empathy was "the mechanism by means of which we are enabled to take up any attitude at all toward another mental life."[1] Because empathy in treatment provides presentational or presented validity and other types of knowledge described in Chapter IV, it does, at a minimum, provide a special access to another's mental life that is probably not available by other means. So much reasonably successful psychotherapy is carried out without any particular creative functioning on the therapist's part that I would be subject to the charge of extravagance were I to make a stronger claim. In order to improve therapeutic practice above the reasonably successful, however, and attain more meaningful and useful understanding of a patient's mental life, creative modes of thought are necessary.

Interventions derived from empathic understanding bear the marks of their creative origins. Because these interventions develop from mental superimposition and a "feeling into" by the therapist, they are accompanied by warmth and genuineness. Creative thinking and activity in any field always involve giving to others, whether that effort results in gratifying artworks, useful scientific theories, or other products. Indeed, creative work cannot derive exclusively from narcissism because of the necessity for a highly developed giving factor. Especially operative in the achievement of empathic understanding, giving over of oneself and warmth emerge from the highly focused concentration on another person. Because only a genuine self

representation is functional in this process, genuineness pervades the understanding and interventions derived. Emotional warmth also is generated by the therapist's experiencing his self representation together with the other person in a complicated way that I cannot explain or dwell on here. Suffice it to say that the genuineness and warmth connected with the therapist's empathic understanding and resulting interventions often provide the patient with support and stimulation to continue to pursue the challenging creative therapeutic process.

Understanding derived from the janusian process consists of flashes of insight or discovery and solutions to therapeutic dilemmas. Immediate and comprehensive grasp of a patient's conflicts is a particular feature of such understanding. There may be early rapid formulations of conflicts or later realizations and breakthroughs. In both cases, the constructed simultaneous antitheses pertaining to the conflict are developed and transformed into extensive dynamic understanding. They then become the bases for interpretations and other interventions.

Such understanding is often described by a therapist as intuitive without recognition of its generative function in an ongoing therapeutic creative process. Janusian "intuitions" may serve to initiate the process, as in the case described in Chapter V, or may facilitate creative movement at different points along the way. In the latter instances, janusian formulations

often serve as factors in a process of creative problem-solving. A therapeutic impasse is present, or a countertransference issue blocks the therapist's recognition, or both, and the formulation of the simultaneous antithesis provides a new approach or breakthrough. As in any creative process, this understanding produces continued shifts, new elements and directions, and further elaboration.

Interventions derived from understanding achieved through the janusian process may also bear creative earmarks. Rapid achievement of comprehension may at times produce rapid interventions that speed up and facilitate the treatment process. Creative therapists have, in other ways, designed briefer therapy approaches in recent years, based on better understanding and concise use of psychodynamics. Judicious application of the comprehensive grasp provided by the janusian process may facilitate the patient's development of insight and also help to shorten therapy. Paradoxical interventions and irony are often used with just this purpose in mind.

Use of the janusian process by the therapist requires both flexibility of thinking and a willingness to take both mental and emotional risks. Such features of a creative orientation are often conveyed to a patient by the nature of the therapist's understanding and interventions. They provide a model for the patient's own creative work. However, directly indicating the sudden or immediate nature of a particular illumination would not usually be

beneficial. Doubt and competition may be instilled rather than emulation or insight. Doubt would result both from the implicit indication that the therapist has been a good deal in the dark and stymied and from a seeming emphasis on his own thinking. Competition would be induced by the sense of his showing off proficiency and skill.

Understanding is the primary creative effect resulting from the use of the homospatial and janusian processes. Although not the usual tangible effect found in other creative fields, it is appropriate to the task and goals of therapy. While it is not a final created product, understanding is a facilitator and waystation in the ongoing creative process. Thus, the homospatial and janusian processes function overall as they do in other fields; they are responsible for interim effects that are transformed, modified, and otherwise developed into final created products.

One reason that these processes are the same within different types of creative activities, with overlapping types of functions and similar sequences, is that they relate to universal features of cognitive and affective function. The same processes that provide understanding of intrapsychic and interpersonal phenomena in psychotherapy also lead to gratifying effects in artistic fields where these phenomena are developed and explored as well. Metaphor and conflict, for example, are of abiding interest in all the arts and their construction and display provoke understanding and enjoyment. In scientific

fields, focus on opposites or metaphorical constructions and models derives from particular proclivities in human cognition. That these foci lead to successful creative results in the latter might be, on the one hand, because the natural world that is the subject of scientific contemplation is organized in terms of oppositional factors. Or else it might be based on related principles such as symmetry.[2] Also, the structure of metaphorical interactions might be the structure of nature. On the other hand, scientists might have primarily come to know the oppositional, symmetrical, and metaphorically describable aspects of an enormous variety of substances, organizations, and structures. Historian of science Andrew Pickering has stated, "it would be useful to replace the idea that scientists are passive *discoverers* of the . . . facts of nature with the alternate view that they *actively* construct their world"[3] The reason that these cognitive proclivities produce their effects is not known and possibly not know- able. That intrapsychic conflict pervades all human activities is known, however, and conflict of that type may play a role in promoting cognitive construction and manipulation of opposites.

Understanding derived from these processes in psychotherapy is transmitted to the patient in various ways. In psychoanalysis and psychodynamic psychotherapy, these interventions are frequently in the form of verbal interpretations; depending on the type of understanding achieved, other types of interventions, such as clarification, reconstruction, silence or non-intervention, and confrontation, may be used. The early grasp of conflict

derived from the janusian process may, as suggested in Chapter V, be a basis for the use and development of interpretations throughout therapy. With respect to the homospatial process, empathic understanding achieved may be especially linked, as suggested by the writings of Kohut and his followers on empathy, to interventions leading to "transmuting internalizations."[4] In other types of psychotherapy, directive types of interventions may be derived from both processes. Regardless of type of intervention or of psychotherapy, however, the therapist's creative understanding helps to focus on critical issues and open up new areas for exploration. It facilitates the articulation process and the development of both insight and new personality attributes and structure.

Particular types of interventions are developed directly from the homospatial and janusian processes in conjunction with the therapist's understanding (from both creative and noncreative sources). These types-metaphorical, paradoxical, and ironic —also serve as interpretations or identifiers of conflicts. However, usually they do not involve literal propositional statements about conflict but consist of dramatic or enacted types of interpretations. Tending to be more affectively charged than literal interpretations, these interventions all stimulate patient response and engagement. Because they are products of creative homospatial and janusian processes, they initiate a particular course of innovative development that is taken up and continued by the patient. A metaphorical intervention, for instance,

provides both affective acceptance and a new direction, and the patient begins to explore some of the embedded conceptual and affective implications. With paradoxical interventions and irony, compressed formulations are presented that instigate shifts and changes. The conflicts focused upon by all the interventions mentioned may be directly acted on or may become separated and clarified in a dialectical therapeutic process and resolved.

CREATION OF INSIGHT AND PERSONALITY ATTRIBUTES AND STRUCTURE

Two endpoints of the creative process in psychotherapy are the production of insight and of personality attributes and structure. Usually, and especially in what is called the expressive type of psychotherapy,[5] insight precedes the development of personality structure. This may not necessarily be the case in all types of psychotherapy, particularly if insight is narrowly defined as involving conceptual or intellectual comprehension. Patients frequently experience a largely affective, or at least nonconceptual, type of insight that instigates choice and positive change.

As I suggested in the previous two chapters, creation of both insight and personality attributes and structure results from an articulation function that operates throughout the course of therapy. In addition to this continuing articulation, with its separating and connecting in general, it is important to remember that both homospatial and janusian processes provide particular

types of articulation. The homospatial process involves bringing together along with separation of multiple sensory images. Superimposition of mentally represented spatial entities maintains the separate identities of these entities while they come together and interact. Both particular elements and whole mental representations may interact while specific features continue to be discrete and identifiable. Following the formulation of a homospatial conception, continued articulation occurs and a new identity is produced.

In the janusian process, contradictory, mutually exclusive, opposite and antithetical propositions are brought together and also retain their separate identities. Whereas the homospatial process involves articulation of spatial entities, the janusian articulation is a temporal one. Multiple opposites or antitheses are conceived as operating separately while simultaneous in time; they are neither compromised nor absorbed into one another. Following the formulation of a janusian conception, continued articulation usually occurs. Often, the homospatial process articulates a janusian conception further. In the creation of metaphors, a janusian process may be modified and further articulated by a homospatial one. In this way, metaphors having simultaneously antithetical or paradoxical structures are produced.

Particular articulations constructed by the homospatial and janusian processes, whether in the form of understanding or interventions or both, are

subjected to further articulation either by the therapist alone, by patient and therapist together, or by the patient alone. When the therapist continues on his own to articulate the understanding developed from the two processes, he achieves fuller and more integrated insight into the patient and sometimes into himself as well. Similarly, the patient on his own articulates his reactions and responses into integrated insights and new patterns of behavior. The primary mode of articulation in the therapeutic process involves both therapist and patient working together. In this way it goes beyond both homospatial and janusian processes and incorporates their effects.

Jointly, the therapist and patient develop the connections together with separations that constitute insight. In the overall articulation process, they connect experiences in the trial domain of therapy with behavior and experiences in the patient's current and past life and concomitantly clarify the separations. Resulting insights consist of affective and cognitive apprehension, precisely, of the relationships both between the world of current reality and the trial domain of therapy, and between past and present experiences and patterns of behavior. These relationships invariably involve concurrent connections and separations.

I must emphasize that, in this view of the matter, insight is created in the interaction between the therapist and patient. It does not consist of an exact replication in memory of actual events of childhood or even thoughts

and feelings connected with them. On the basis of recent research on memory and development, there is reason to believe that all childhood events are construed in adulthood in accordance with the child's level of cognitive and affective development at the time they occurred.[6] At certain levels of development, for instance, only sensory and motor aspects of an event will be apprehended and experienced. This plays a role in the substance and structure of memories about infantile masturbation or primal scene experiences, for example, and the range of experiences involving love or loss as well. Reconstructions in adulthood of the relationships between childhood experiences and the present are further affected by the context in which they are developed. In therapy, they are necessarily influenced by factors and experiences in the interpersonal relationship. Reconstructions and other insights regarding the past are articulated by the patient and therapist working together and have new and created aspects.

Articulation of insight leads, in an intrinsic way, to articulation of personality attributes and structure. Also, the former in some measure requires the accompaniment of the latter. As the therapist asks the patient about connections and separations among different experiences, feelings, and actions, the patient begins to develop a similar orientation, both in therapy sessions and in everyday life. Whereas previously the patient acted on impulses without consideration, he begins to ask himself questions about how his impulses are connected with and separated from other feelings and

experiences. Articulation of insight and of personality attributes and structure occurs concomitantly, each serving, to some degree, as a function of the other. Further action also is required. Based on insight, the patient actively tries out and adopts new outlooks and patterns.

Creation of insight, making of active choices, and creation of new personality attributes and structure are all necessary, because psychopathology cannot be simply removed or eradicated. The conflicts and maladaptive patterns that produce symptoms and psychological suffering have, almost invariably, been operating for a long enough period to affect growth and development as well as overall personality organization. These conflicts and patterns have therefore assumed functional importance in the patient's life and makeup. Both including and extending beyond the secondary gain of particular symptoms, conflicts and maladaptive patterns influence current adjustment as well as further growth and development. They help determine what and how a person learns, choice of friends and other affectionate ties, and the nature of skills. Defensive patterns of reaction formation and ego splitting, for instance, may play a role in the development of certain types of executive skills; defensive projection may enhance artistic interest and appreciation, and so on. In more extensive ways, schizoid patterns may dictate solitary work and recreational pursuits and hysterical ones facilitate development of role-playing skills. On the side of non- adaptive function, conflicts about one area may help to avoid or protect another difficulty.

Conflicts and concerns about homosexuality, for example, may function as protection against psychotic decompensation. Conflicts about eating may justify serious social inadequacies or result in the poor development of social skills.

Alteration of maladaptive patterns and resolution of conflict, therefore, cannot alone result in improvement. New patterns and structures are needed that the patient never before experienced or used. These patterns must serve some of the functions of maladaptive ones and also be adaptive and reduce suffering. They are articulated from both the particular understanding developed in the therapeutic interaction and the direct experience of the interaction itself.

CREATIVITY IN PSYCHOTHERAPY

As I cautioned at the beginning of this book, all psychotherapeutic activity is not directly creative and creative therapists are not the only satisfactory ones. Use of ordinary logic, problem-solving, and trial and error learning characterizes a good deal of psychotherapeutic interaction. Even compliance and acceptance of the status quo are sometimes quite important. For the therapist, broad understanding of human motivation and behavior, as well as qualities ranging from complex abilities to postpone gratification to simple practicality, are necessary to carry treatment forward. Although these

qualities may often be involved in creative actions, they are not creative in themselves.

As in any creative activity, much of psychotherapy is not directly oriented to creative effects. Composition of artworks involves a good deal of imitation and reproduction of past successful effects. Plots, designs, and musical forms need not be original; they may be reproduced, polished, and perfected to produce an aesthetic effect. One of the most creative figures in literary history, Shakespeare, took many of the plots of his plays from previous sources. Much of scientific activity involves reproduction, rigorous testing, and trial and error assessment. In psychotherapy, a large proportion of the interaction is designed to be supportive, reduce anxiety, facilitate an alliance, educate, solve concrete problems, apply general principles to particular cases, and allow for the development of understanding. Although these activities are often the background, or foundation, for creative work, they are not specifically creative. For many patients and for many types of problems, such activities are, however, often sufficient to promote improvement.

As I have suggested throughout, creative activity is necessary to move the practice of psychotherapy into more efficient and effective directions. Moreover, the capacity to engage in such creative activity does not appear to be inborn, for either therapists or patients. The processes I have discussed

have all already been employed and further learning is feasible. Although all have operated in outstanding and often dazzling accomplishments in other creative fields, their increased application to psychotherapy will produce less tangible but no less important individual results.

It would, furthermore, be a mistake to assume that creativity in the therapist or in therapeutic activity is incompatible at any time with competent health care or with therapeutic effect. Stereotypes about creativity abound. Nonetheless, solidity, reliability, means-end thinking, and good reality-testing are all compatible with creativity and creative thinking, despite some popular and professional conceptions to the contrary. Creative therapists can, and routinely do, carry out the entire range of activities connected with effective treatment.

FORM AND CONTENT OF PSYCHOTHERAPY

The therapist's focus on form and structure and his use of the homospatial, janusian, and overall articulation processes are interrelated. Both the homospatial and janusian processes are form and structure oriented in that they primarily concern relationships among potentially unlimited components and types of content. The homospatial process concerns formal factors of spatial configuration and discreteness; in the janusian process, temporal configuration and the relationships of opposition or antithesis are

formal matters. Also, articulation processes concern formal relationships of connection and separation, similarly among potentially unlimited content. Creative thinking and creative processes, then, are highly involved with considerations of form and structure.

Is content then a secondary matter in psychotherapeutic treatment? Such a rhetorical question must now be turned on its head because there is a sense in which content is all-important in therapy. I have not really ignored that point before this despite my emphasis on form because, as I said earlier, form and content are inextricably related and any formal process must both derive from and influence content. The janusian process, for instance, begins with the identification of salient opposites within the content of the patient's thoughts and productions. Also, this process pertains to psychological conflict, tendencies to conceptualize in opposites, and other factors in the makeup of human beings. The homospatial process pertains to psychological fusion and tendencies toward unification. Articulation involves form together with all psychological content, conscious and unconscious; it involves all sociological and biological substance as well.

One reason content is all-important in therapy is that the content of a human being's experience constitutes a good deal of what makes him a unique individual. Uniqueness in turn is a quintessential aspect of what constitutes a creation, because to be one of a kind is to be truly new with

respect to the world of events and objects. One can be new in relation to a particular context, or in relation to what one was before, but something unique is new in relation to the known universe. Consequently, content of therapy and of a particular human being's experience is inextricably involved in the creative process.

Content of psychotherapy consists of all the narratives regarding the patient's current life and past experience that are woven by the patient together with the therapist. It ranges from the substance of his mental and emotional life to social and biologically instigated experiences. As the patient speaks of fantasies, feelings, thoughts, and dreams, the therapist may consider psychodynamic content, as well as symptoms, information processing, systems content, learned patterns of behavior, or cognitive and affective functions.

For the patient seeking therapy, the content at the beginning is quite concrete. Some of the frequent types of difficulties patients bring to therapy are as follows: inability to cope with loss and rejection, difficulties in marriage and intimate relationships, problems in choosing a life's commitment, extreme impulsiveness and rebelliousness as manifestations of personality disorder, inability to learn in school or perform well on the job, sexual problems, suicidal preoccupations, criminal and violent behavior, psycho-somatic problems, eating disorders, addiction to alcohol and drugs, mood

swings and depression, symptoms of anxiety disorders and psychosis.

Narratives that patient and therapist construct regarding the background, current condition, and potential future of these types of difficulties become part of the ongoing content of therapy. These narratives are not literary ones that unfold with beginning, middle, and end. They are articulated throughout the therapy in disorganized bits and pieces. Unlike literary narratives, they do not emerge from the interaction with built-in elements of suspense along the way. But suspense is engendered and felt by both patient and therapist; it is the suspense of discovery. This arises from a mutual conviction that more underlies the surface of a story than may be immediately revealed. When true narratives of the entire psychotherapy process are written or told, they must be told as narratives of discovery rather than as unfolding literary tales.

From the point of view of the creative process of psychotherapy, two factors of content are particularly related to the therapeutic effect. These are transference and dependency. With regard to transference content, I have already described the creative articulation of transference (Chapter VIII) and its therapeutic effect. Transference distortions are both separated and connected and thereby incorporated rather than being obliterated. By means of this articulation process, the patient is able to separate the therapist from parents and other influential individuals; at the same time, he actively accepts

or chooses attributes of both past and present persons. The patient is able to separate past from present motives and experiences and also accept a continuity.

Excessive dependency is a feature of all the concrete content of initial patient difficulties I have listed. Intense reaction to loss and criticism is based on a person's strong need to have the support, recognition, and care of others rather than relying on oneself. Difficulties in marriage and other intimate relationships often derive from excessive dependency of one partner on another. Sexual problems involving inability to satisfy oneself or one's partner frequently result from enslavement to internalized prohibitions instilled by parents and others, or from attempting to conform to oversimplified and restrictive images about masculinity or femininity dictated by parents or society. There is excessive dependency in depressive illness with its catastrophic reaction to loss; also, compulsive rituals and phobias involve unconscious fears of experiencing drives, affects, or the implications of ideas that might alienate an internalized parent or a real spouse or friend. In such a ubiquitous feature of personality disorder as passive-aggressive obstructionism, the pouting resistant state is directly reminiscent of the resentful dependence of the three- or four-year-old on his parents. In addiction and alcoholism, the obvious dependency on a chemical always seems clearly derived from excessive dependency on people. And, running through all of the difficulties, poor self-images or low self-esteem

ultimately seem to derive from feelings of being at the mercy of others, inability to be the master of oneself and one's fate, and troubles both in coping with one's environment and being effective in social relationships. Again, excessive dependency is an important enemy. Spoken of another way, regression and fixation are factors in symptom formation and illness.

Excessive dependency also is a feature of schizophrenic disorder. Although considered a thought disorder, one of the cardinal behavioral features of schizophrenia is a withdrawn demeanor and flat or inappropriate expression of affect or emotion. These patients appear to feel "dead" inside and sometimes say that. Although there are many reasons for this condition, it amounts functionally to being unable to experience or express one's feelings. One explanation is that schizophrenia involves a physiological interference with experiencing and expressing feelings or thinking connected with feelings. Or, there is another physiological mediating factor such as intensely high levels of anxiety that interferes with feeling expression. Other explanations have been that it results from double binding experiences,[7] attention disturbance, input disfunction,[8] or transmission of irrationality in upbringing and intercategorical fixation.[9] Although all of these factors may be critically involved, an essential and potentially remediable ingredient of the condition is the connection between fear of expressing or experiencing feelings and excessive dependency on others. If the schizophrenic individual were to express feelings of anger or love, he would take the risk of alienating

or losing a person, or the internalized representation of a person, on whom he desperately depends. In referring to dependency in this condition, I mean to indicate the construction of the entire ego and self around the internalized representation of a parent or parents. If the representation is lost, the ego becomes obliterated.

ARTICULATION AND THE CREATION OF INDEPENDENCE AND INTEGRATION

One of the primary effects of the articulation process, including both janusian and homospatial processes and others yet undetermined, is the independence and integration of a final created product. In human beings, independence consists of being both separated and connected to other persons at once. No one stands completely isolated and alone; all must recognize responsibilities and connections with others in order to function independently within a social context. Independence from family does not involve total renunciation, at least not on a psychological level. In order to feel independent, one must accept and be comfortable with one's own attributes, many of which are shared with parents and other family members. One cannot renounce these shared connections without renouncing features of oneself. Similarly, independence within human history involves acceptance of both connection and separation with past social and cultural experience.

A criterial feature of artistic creation is that a completed artwork is an

independent entity. It has both connections and separations with previous artworks produced throughout the course of history as well as with other artworks produced by the same artist. Because of the latter it bears the stamp of the artist's individuality, but stands as a separate entity in the corpus of his works. Also, artworks accorded high degrees of value or approval are usually integrated —in the sense I have discussed above—with coordination and interaction among their parts and a distinct identity to the whole. Neither lacking in discreteness nor submerged within the whole, these parts interact and contribute to overall function and organization. This integration is often likened to the living biological organism, and valued artworks are said to have organic unity. In the biological organism, discrete identifiable body parts, on a molar and molecular level, interact and contribute to the function of the body as a whole. In this way, an organism is a fully self-sufficient and independent entity.

In the other field of our interest, scientific creations may not always have the same degree of integration as valued artworks. However, they clearly are articulated and independent. For a scientific discovery or theory to be acknowledged and accepted it must connect, to some degree, with previous canons of knowledge, and to be recognized as a creation it must be clearly separated from those canons at the same time. Scientific creations are often designated with the name of the individual or group who developed them because of this factor of independence. Einstein's theory of relativity,

Bohr's complementarity, Darwin's evolution, Fermi's slow neutrons, and Mendelian heredity are examples of creative work that is recognized as singular and independent despite the tendency in science for individual work to be absorbed, changed, and superseded.

In the creative process of psychotherapy, the patient's achievement of independence and integration is the final creative outcome. Although excessive dependency, as well as related factors of regression and fixation, may not be a sole or even major causative factor in all mental and emotional illness, it is invariably involved. The articulation process, which develops separation from the past together with continuity, and separateness from other individuals together with connectedness, counters excessive dependency and produces independence. With the achievement of valid independence, many, if not all, psychological symptoms are reduced in intensity or they disappear. Whether residual symptomatology and disability are due either to incompleteness of independence gained or to fixation of learned patterns of functioning, or whether there is persistence of other types of causes, cannot be determined with the present state of our knowledge.

The creative process of psychotherapy involves ego development and growth. Unlike other living organisms—although this difference cannot be ascertained with certainty—human beings do not seem to grow psychologically without active volition coming into play at some point.

Perhaps difficulties with both growth and dependency in humans derive from the fact that we sustain and require a longer period of dependency on progenitors and others than most other organisms. Knowledge about this matter again is lacking, but not about the *course* of growth. Human mental and emotional growth does not occur in a smooth unfolding way. Spurts and deficits, pits and valleys appear throughout its course. Some of this erratic course is connected with and caused by psychological stress and difficulty. As a creative process involving choice and articulation that leads to independence and integration, psychotherapy does not smooth the course but produces spurts of growth and durable variations. While reversing some of the noxious effects of past interferences with growth, it reaches beyond itself into the future.

Notes

1. Freud, *op. cit.,* 1921, p. 110. Also see above, Chapter IV.

2. See Zee, *op. cit.,* for presentation of extensive data and a theory of symmetry as fundamental in the laws of nature and the structure of the Universe.

3. Quoted in Holton, *op. cit.,* 1986, p. 2 36.

4. Heinz Kohut, *op. cit.,* 1971, pp. 49ff.; Robert D. Stolorow, "Self Psychology —A Structural Psychology," in Joseph D. Lichtenberg and Samuel Kaplan (eds), *Reflections on Self Psychology,* Hillsdale, N.J.: The Analytic Press, 1983, pp. 281-296.

5. Roben S. Wallerstein, *Forty-Two Lives in Treatment,* New York: The Guilford Press, 1986, pp. 373-388.

6. Jean G. Schimek, "A Critical Re-examination of Freud's Concept of Unconscious Mental Representation," *International Review of Psycho-Analysis,* 2(1975): 171-187.

7. Bateson, *et al., op. cit.*

8. P. H. Venables, "Input Dysfunction in Schizophrenia," in Brendan A. Maher (ed.), *Progress in Experimental Personality Research. Vol. 1,* New York: Academic Press, 1964, pp. 1-47.

9. Theodore Lidz, *The Origin and Treatment of Schizophrenic Disorders,* New York: Basic Books, 1973.