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A Review and Synthesis

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Morris Eagle and David L. Wolitzky

Our aim in this chapter is to extract from the preceding papers certain important themes and issues and to offer our comments on them. Our focus will be confined to the contributions in this volume, leaving aside the large extant literature on curative factors in psychotherapy. [1]

Before discussing these themes, a cautionary note must be sounded regarding the very use of the term "curative factors." It would be more accurate, although perhaps awkward, to say "presumably curative factors" or "purportedly curative factors." For the fact is that we do not know, with any degree of rigor and assurance, what the curative factors in dynamic psychotherapy—or any kind of psychotherapy—are. In this volume, seasoned clinicians have brought their experiences, impressions, intuitions, and understanding to bear on this issue. What this volume provides, among other things, is: (1) a set of hypotheses regarding curative factors—to be used by, and measured against the experience of, other clinicians as well as to be tested more rigorously, and (2) a kind of informal test of reliability regarding curative factors. That is to say, although each contributor has considered a

different aspect of dynamic psychotherapy, the emergence of a common set of overriding factors would give a degree of credibility to their importance and relevance to the process of psychotherapy. But again, the cautionary note must be introduced. As Kubie (1952) has pointed out, ordinarily psychotherapeutic sessions are rich sources for generating hypotheses rather than for testing them. The contributions to this volume likewise represent a rich source for our perusal.

Recapitulation of Contributions

Before commenting on the various themes and issues, it is necessary to summarize the views of each contributor. To a certain extent, the editor's Introduction has already provided such a summary, and we hope the reader will bear with the inevitable degree of repetition.

An orthodox and somewhat simplistic account of curative factors in psychoanalytic psychotherapy would be limited to two factors: (1) insight as a consequence of properly timed, effectively presented interpretations of resistance and conflict, and (2) the process of working through. While it would also be recognized that relationship factors (e.g., countertransference, positive and negative transference, therapeutic alliance) are important elements in the treatment process, their significance would be viewed as secondary in that they provide the context within which interpretation

leading to insight can best be accomplished.

Hatcher provides a historical review of the concept of emotional insight as a mutative factor in treatment, emphasizing the therapeutic "split," or oscillation, between experiencing and reflecting, as well as the role of analytic self-observation and awareness in facilitating conflict resolution and ego mastery.

Hatcher reminds us that, as Freud developed the concept of resistance, he began to focus on the patient's role in bringing to awareness previously unconscious contents. In introducing the basic role of free association, the therapist no longer lifted repressed memories directly by exercising "his will" against the resistance. Along with this change came a shift from an emphasis on abreaction to the ego's gradual assimilation and mastery of unconscious contents. Freud also recognized that patients must *experience* their resistance and insight via the transference neurosis. As Hatcher puts it, following Strachey and Bibring, "emotional insight demands a balanced integration of emotional contact and intellectual comprehension into a full-bodied experience of the meaningfulness of an unconscious conflict." The patient has to realize that his feelings toward the analyst are "real, but not *really* real." This attitude requires an oscillation between experiencing and reflecting on one's experience. In Sterba's (1934) words, it requires a "dissociation of the ego" in response to interpretations.

Hatcher describes insight as a "complex process that depends on the integrated, sequential operation of several different ego functions" (e.g., controlled ego regression, detached self-observation). In what Hatcher calls "reflective self-observation," the content is seen as part of a context, i.e., as "an organized cognitive system of meaningfully related contents." The sophisticated elaboration of such contexts presumably enhances ego mastery and is therefore curative.

It is not at all clear from Hatcher's account how this process occurs. For the most part, he simply asserts the value of acquiring a meaningful, coherent, organized account of one's personality and behavior. At one point, however, he suggests that this increased self-understanding (i.e., the development of new contexts) must take a specific form; he quotes Hartman, (1939, p. 63) who claimed that interpretations not only help uncover repressed material but "must also establish correct causal relations, that is, the causes, range of influence, and effectiveness of these experiences in relation to other elements." The idea that one can establish an accurate etiology of a neurosis by interpretation in adult analysis is, as we shall argue later, quite untenable.

While Hatcher does not consider the relative therapeutic efficacy of insight versus the therapeutic relationship, he does point out, citing Kris (1956) and Myerson (1965), that the motives for acquiring insight are complex and are often related to the state of the treatment relationship. For

example, identification, compliance, desire for praise, the wish to merge symbiotically with the analyst, as well as conflicts concerning these motives can determine the degree to which insight or resistance characterizes the therapeutic process. Hatcher seems to be suggesting implicitly what Gill argues explicitly, viz., that in dynamic psychotherapy, the acquisition of insight cannot easily be separated or disentangled from the therapeutic relationship.

As a concluding comment about insight, we find it remarkable that so few articles or books have been specifically devoted to this topic, considering the traditional emphasis on this factor as a curative—if not *the* curative—factor in psychoanalysis and dynamic psychotherapy. The present discussion suggests that the therapeutic relationship, insights about this relationship, and insights about matters outside the relationship are three potential curative factors whose relative therapeutic value remains to be established.

We turn now to Kohut and Wolf, who, in describing their experiences with narcissistic personality disorders and narcissistic behavior disorders, stress the importance of permitting narcissistic transferences (i.e., mirroring and idealizing transferences) to develop. According to them, emphatic understanding on the part of the therapist facilitates the patient's access to archaic narcissistic needs and serves as a partial gratification of these needs. The patient becomes aware of, expresses, and accepts the old narcissistic

needs, eventually transforming them into normal self-assertiveness and devotion to ideals. Elsewhere Kohut (1977) has written of the therapeutic role of small doses of frustration land of "transmuting internalization" in helping build psychic structures that have not developed adequately. Kohut and Wolf draw a parallel between the mother-child relationship and the therapist-patient relationship (a parallel drawn by other contributors to this volume). In short, Kohut and Wolf believe that when mothering is adequate with respect to empathy and mirroring, the small and optimal doses of frustration (what Winnicott [1958] calls "gradual failure of adaptation") experienced by the infant permit the building up of the infant's own psychic structures.

What is noteworthy is the clear implication that, for narcissistic disorders, understanding and insight are secondary to the emphatic quality of the relationship. In other words, the therapeutic value of accurate interpretation derives from the fact that it expresses the therapist's emphatic understanding of the patient. As Gedo (1980) observed in a recent paper, Kohut's emphasis on empathy as a direct agent of healing, rather than as a tool of observation, represents a radical departure from the traditional value system in which the "absolute quest for knowledge" is primary. Some clinicians believe that empathy is the primary healing agent mainly for more disturbed patients, who make only limited use of insight; others believe that such use of empathy should be universal. (This controversy is touched on by

other contributors.)

The mobilization of narcissistic transference discussed by Kohut and Wolf can be seen as a special case of the general issue of regressive phenomena in dynamic psychotherapy. (Of course, all transference phenomena are, in an important sense, regressive.) Tuttman's contribution addresses the role of regression in psychotherapy directly. Along with Kohut and Wolf, Tuttman believes that an important aspect of psychotherapy is the facilitation of infantile needs and other "fragmented regressive components" that the patient dreads reexperiencing. Tuttman, too, emphasizes the role of the therapist's acceptance and empathic understanding both in facilitating access to the infantile needs, and, via the therapeutic relationship, in partially meeting these needs. At Tuttman puts it, " ... the skillful acceptance of regression to the traumatic developmental phases where something needed for growth was missing, and then facilitating understanding and growth from that point forward via an analytic relationship … are necessary steps in treatment." The affinity between this statement and the views of Winnicott (1958, 1965) and Guntrip (1968) will be apparent to the reader.

Like many of the authors in this volume, Tuttman argues that a neutral interpretive stance does not work with more disturbed patients; instead, he believes that "treatment can offer, ideally, a parallel of the mother-child 'facilitating environment.'" That the parallel is not complete is indicated by

Tuttman's insistence that he does not advocate a "'milk-giving, hand-holding,' libidinally gratifying interaction" which, he believes, "often leads to more malignant pathology."

Another contributor for whom the curative aspects of the patient-therapist relationship are central is Volkan, who focuses primarily on more disturbed patients with defects in ego organization. Volkan's main proposition is that, for seriously disturbed patients, partial identification with the representation of the therapist is a primary curative factor. According to Volkan, this identification comes about through "introjective-projective relatedness." That is, the patient projects onto the therapist material from archaic self- and object representations. The therapist reacts in a positive, non-critical way, providing helpful interpretations of the patient's distortions. The patient then introjects the positive features of the therapist, a process which helps to "decontaminate," or rid, new representations of archaic ones and which strengthens "observing, integrating, and taming functions." Volkan reminds us that, as early as 1934, Strachey spoke of the patient's introjection of the analyst as an auxiliary superego, which helps to modify the patient's harsh, primitive superego. He also notes Rangell's (1979) point that, in the analysis of neurotic patients, there is "a constant series of microidentifications."

Levenson tells us that an interpretation is not a disembodied

phenomenon without a context. Communication, he reminds us, has its pragmatics as well as its semantics. That is, therapists communicate and interact with patients not only through the content of their interpretations but also through their style, tone of voice, timing, etc. And they also communicate by remaining silent. Given the necessity and inevitability of interaction with the patient, a primary responsibility of the therapist is to act *authentically*. An authentic response, while it cannot preclude the possibility of error, at least increases the likelihood that the patient will be "engaged, experienced, and responded to." And it is this response, Levenson maintains, that is likely to be therapeutic and to foster growth.

Despite Levenson's somewhat different vantage point, his view resembles both Kohut and Wolf's stress on empathic understanding and Volkan's concern with differentiating archaic and new representations. Levenson's reminder that communication (including interpretations) has its pragmatics as well as its semantics provides still another perspective on the insight and interpretation-therapeutic relationship distinction. If what is communicated to a patient is a function both of the content, style, tone, and context of the interpretation, and of the nature of the ongoing interaction between patient and therapist, then it follows that interpretation cannot be sharply differentiated from the therapeutic relationship. Further, if the effect of an interpretation (or any other therapeutic intervention) is, in part, a function of *how* one makes it and who is offering it to whom, it also follows

that the *personality* of the therapist and the match or fit between patient and therapist will be critical factors in therapeutic outcome. While one may learn a good deal about technique and dynamics, *who* one is and how one reacts to various people are likely to remain less subject to the effects of training and other forms of conscious control. But, as is implied in Levenson's chapter, these subtler and more "organic" features of the therapist are also communicated in the therapeutic interaction.

Silverman, Langs, and Gill articulate additional perspectives concerning the subtle personal influences, both general and specific, that are inevitable components of the therapist-patient interaction.

For Silverman, a frequent, though usually inadvertent, therapeutic agent is the activation of key unconscious fantasies. The activation is inadvertent in that it is unintended by the therapist; it is based on characteristics of the treatment situation, including aspects of the therapist's personality and behavior, of which he may be unaware. The two principal unconscious fantasies to which Silverman refers are symbiotic gratification and sanctioned Oedipal fantasies. Though insight is still assumed to be the principal agent of therapeutic change, according to Silverman these fantasies can facilitate the acquisition of insight if they are activated only occasionally and if they are analyzed at some point in the treatment. Silverman outlines certain conditions, however, in which these two fantasies can be allowed to operate

silently—that is, without interpretation—and still enhance adaptation and therapeutic effectiveness. In such instances, sanctioned Oedipal fantasies and symbiotic gratification fantasies do not appear to have maladaptive consequences that require interpretation and thus can serve as "noninsight agents of change." In Silverman's view, these fantasies were implicit in earlier concepts, such as the "holding environment" (Winnicott, 1965) and "identification with the analyst" (Sterba, 1934).

Silverman's thesis requires clinical investigations of the influence of these fantasies on treatment outcome when they are: (a) occasional versus frequent, (b) mild versus intense, (c) used for defense versus adaptation, (d) allowed to operate silently versus when they are interpreted, and (e) interpreted at earlier versus later points in the treatment. Of course, the above points also apply to the curative factors emphasized by other contributors to this volume (e.g., Kohut and Wolf's prescription concerning the timing of interpretations of idealizing transferences).

In Gill's view, the therapist's role, his therapeutic intent, and his unique personality characteristics are of central importance to the treatment process. Gill argues that analysts may see certain of their behaviors as expressions of technical neutrality, when in reality these behaviors are the stimuli that trigger transference reactions. If the analyst is aware of these stimuli and if his intervention includes a reference to the cues in the analytic

situation that may have prompted the transference reaction, he "will be respecting the patient's effort to be plausible and realistic rather than seeing him as manufacturing his transference attitudes out of whole cloth." Patients who are treated this way will "more readily consider their preexisting bias, that is, their transference."

Implicit in Gill's position is the feeling that analytic treatment often takes place in an atmosphere that the patient rightly regards as authoritarian, at least in the sense that the doctor is the repository and conveyor of truth. Thus, Gill makes it clear that he does not maintain an "absolute conception of reality" or see the patient as "distorting" that reality. We question this view, since every therapist, however tactful, presumably makes the final decision whether, and to what extent, the patient is displaying a "preexisting bias." Gill's states that different people (or the same person) can bring multiple perspectives to a situation. But, since Gill still emphasizes the value of insight, his "multiple perspective" approach seems to us to sidestep the issue of the significance of interpretive accuracy as a factor in treatment outcome.

In any case, Gill believes that the analyst should be more alert to transference allusions in material that is not manifestly about the therapist—what he calls "the here-and-now transference." If one interprets the here-and-now transference consistently, genetic material will tend to emerge spontaneously. Genetic transference interpretation, extratransference

interpretation, and working through are also regarded as essential but are accorded secondary importance.

With respect to the relative weight to be given to insight versus relationship factors, Gill writes that "in the very interpretation of the transference, patients have a new experience. They are being treated differently than they expected." Transference interpretation is "not a matter of experience in contrast to insight but a jointing of the two together." In other words, both are required; they are inseparable. This view is persuasive and makes it exceedingly difficult, if not impossible, to determine objectively the relative importance of each variable as a curative factor in psychoanalytic treatment.

Langs also places great emphasis on the therapist's responsibility for the outcome of treatment. He believes that both psychoanalysis and psychoanalytic psychotherapy aim at "symptom alleviation through insight into unconscious processes and constructive introjective identifications." The latter derives from object relational and interactional processes and tends to be "broadly ego enhancing," while the former, if it consists of "affectively meaningful and validated cognitive insights," leads to "specific forms of nonsymptomatic adaptive resolutions of specific unconscious, conflicted fantasy-memory constellations."

Within this overall framework, Langs focuses on the inevitable countertransferences which, if improperly managed, can result in negative outcomes, stalemated treatment, and a lack of genuine insight. At best, unrecognized and unmanaged countertransference will lead to what Langs terms a "misalliance cure"—that is, "uninsightful symptom relief."

Through the use of case examples, Langs articulates the subtle interactional and unconscious processes involved in countertransferences and their impact on the patient. To cite one example, Langs describes how the patient can react to the therapist's countertransference by attempting to cure him, an effort that Langs views as a reliving of childhood attempts to "cure" maternal and other primary objects. In such cases, the therapeutic outcome depends on the analyst's awareness and management of the countertransference. Langs makes the strong claim that "There is little doubt that unrecognized countertransferences are the single most critical basis for therapeutic failure." At the same time, countertransference is "an essential component" of a good therapeutic outcome.

In advancing this position, Langs is clearly placing the responsibility for therapeutic failure mainly on the therapist, giving lesser emphasis to patient characteristics (e.g., motivation, psychological-mindedness) typically associated with positive outcome. It will be necessary, though difficult, to test the many implicit and explicit assumptions and hypotheses inherent in

Langs's view. For example, Langs claims that: (1) every silence and intervention contains some element of countertransference, (2) nonvalidation of an interpretation (i.e., the absence of derivative, confirmatory material) is an indication of countertransference, and (3) countertransference influences "will override any other stated intentions or meanings of the therapist's interventions." To what extent and under what conditions these generalizations hold are vital issues in any theory of therapy.

Marmor also focuses on the personality of the therapist, but his concern is the curative potential of the therapist's interest, empathy, and warmth—qualities that Greenson and Wexler (1969) subsume under the notion of the nontransference or "real" relationship. Since interest, empathy, and warmth presumably cannot be simulated effectively, Marmor is referring here to the abilities and personality of the therapist as well as to the "fit" between therapist and patient. That is, particular patients may be more likely to call forth interest, empathy, and warmth from particular therapists.

Marmor also presents other factors that he believes produce change: the therapist's taking an active role in confronting defenses and resistances; the explicit and implicit approval and disapproval cues provided by the therapist; implicit suggestion and persuasion; catharsis and abreaction; and (along with Volkan) identification with the therapist. (This list is similar to those offered by Frank [1976] and Strupp [1976], among others.) As for the role of insight,

Marmor maintains that, while it may be useful in facilitating change, it is not essential: if an accurate or "correct" interpretation is a key factor in change, how does one explain patients' favorable therapeutic responses "to analysts with disparate theoretical views"? This same question has led many to argue that what is useful about interpretations is that they provide, to borrow Fingarette's (1963) term, a coherent "meaning scheme"; the clear implication is that many different "meaning schemes" will be equally effective and useful.[2]

Stone's chapter also reminds us of the variety of factors that can be influential in producing change. Stone deals with an interesting therapeutic phenomenon that is rarely discussed in the psychotherapy literature—what he calls "turning points." He is referring to rather sudden and dramatic positive changes, for example, the sudden experience of new alternatives beyond the rigid either/or choices a patient has set for himself; the patient's sudden emergence from mutism to communication; the sudden amelioration of a crippling symptom. Stone notes that such turning points are unlikely to occur in the treatment of essentially chronic and/or characterological conditions; they tend to appear only in cases of more acute pathological states.

Stone discusses the factors that appear to make these turning points possible. Some of the more traditional ones are: the role of awareness and

insight, including the cumulative effects of small insights which, at a particular point, can result in dramatic change; the experience and awareness of alternatives and choices (which, he points out, can be particularly important with suicidal patients); unpredictable extratherapeutic factors, such as a fortuitous environmental change; and abreaction, particularly when a major trauma is involved. Stone also discusses the patient-therapist relationship in an interesting and enlightening way, and considers the influence of both therapist and patient variables on the nature of that relationship. Thus, along with other contributors to this volume, Stone believes that the patient-therapist relationship is a curative factor and, indeed, says explicitly that the kind of parental, desexualized love toward the patient of which Nacht (1962) speaks may play a critical therapeutic role with more disturbed patients. To this extent. Stone's comment is a variation on a theme sounded by Kohut and Wolf, Tuttman, Volkan, and Marmor.

But Stone has some interesting additional things to say about what makes the patient-therapist relationship therapeutic. Among other things, the therapist must enjoy working with the patient and must genuinely believe that the patient has sufficient assets to make a lasting recovery. While such an attitude is partly dependent on the patient's characteristics (e.g., characterological type) and the "chemistry" between patient and therapist, it also is a product of the therapist's experiences and personality structure. Thus, a therapist's own experiences may strengthen his or her ability to instill

hope in a particular patient. (One is reminded here of Fromm-Reichmann's [1959] comment that one important consequence of the therapist's having experienced a successful analysis is that he or she is better able to sustain faith and hope in the therapeutic process, particularly when things are not going well.) Stone points out that therapists' insights into their own conflicts and countertransference reactions to patients may help them become more compassionate, accepting, and spontaneous in their therapeutic work.

Stone also speaks of therapy "as a tutorial program in which the patient is given individual lessons concerning hitherto problematic life situations." He notes that "obviously, the learning that occurs during psychotherapy, especially if it has centered on the transference, is of no utility unless the patient is able to apply it to analogous situations in his outside life." What Stone is referring to here is what Fried, in her contribution, discusses as working through.

Fried recognizes that the concept of working through has been variously defined, but the essential meaning she gives to it is the "self-innovative" learning of a new outlook toward oneself and the world. Along with Stone, Fried believes that an essential aspect of therapy, especially of the transference, is the exploration of new ways of thinking, feeling, and relating. It is here that transference interpretations can be most useful. But what is learned in therapy must be tried out outside of therapy in order for real

change to occur. Fried makes the compelling point that therapy involves overcoming not only the resistance to insight and awareness but also the resistance to change in modes of behaving and experiencing. She argues that "the ego does not unfold spontaneously when conflicts are understood and removed." (Here is another contributor to this volume who is implicitly saying that insight is not enough.) In addition, fresh images of the self must be mobilized by the therapist's evocation of new responses through interpretation and the establishment of a new object relationship, as well as by the patient's success in trying out these new responses in the outside world. (The idea that new behavior on the part of the therapist—as well as on the part of group members in a group therapy situation—helps both to extinguish old responses and perceptions and to facilitate new ones is, in important respects, similar to Alexander and French's [1946] concept of the "corrective emotional experience.")

In his discussion of change factors in depression, Bemporad is also concerned with modes of living—with "fundamental systems of beliefs, modes of relating, and ways of experiencing the world." Bemporad's basic thesis is that the depressed patient is characterized by a premorbid pathological mode of living that predisposes him to depression. These modes include: a life pattern in which much of one's behavior is directed toward an attempt "to wrest praise from some dominant other who has transferentially replaced the parent," and the "dominant goal" pattern in which the individual

"has precariously limited his avenues of esteem to one external source: that of fulfilling some great ambition." What is required in therapy with these patients, according to Bemporad, is first, the facilitation of awareness of these depression-predisposing modes of belief, of relating, and of experience; second, their alteration through the application of awareness and insights learned in therapy to everyday life. It is in the second phase that the need to change, the resistance to change, and working through occur. The third stage Bemporad refers to as "consolidations." He warns therapists not to assume a nurturing role or to permit depressed patients to idealize them. Bemporad believes such interactions will only perpetuate the patient's pathological mode. Instead, he urges that the patient's attempt "to distort the therapist into a needed transference figure" be subjected to "mutual analysis." Bemporad's view seems somewhat contrary both to Kohut and Wolf's interest in mobilizing narcissistic transference and to Tuttman's view of the therapeutic significance of regression. What may be involved here are different diagnostic categories (e.g., depression versus narcissistic disorders) as well as different degrees of pathology.

It would appear, however, that differences in conceptualization and preferred technique separate the contributors to this volume at least as much as do differences in the type and degree of pathology they encounter as therapists. For example, while Kohut and Kernberg presumably work with the same kind of patients, Kohut sees lack of self-cohesiveness as the central

issue, with aggression as secondary, whereas Kernberg focuses on oral rage and envy. They also differ in the technical implications of how the central problem is conceptualized.[3]

In Kernberg's view, the theory of psychoanalytic psychotherapy is not keeping pace with changes in theoretical views of personality and psychopathology. Specifically, patients with "severe character pathology and borderline personality organization" show "an intrapsychic structural organization that seems very different from the more usual transference developments in better-functioning patients." They show "contradictory ego states that reflect primitive internalized object relations, including primitive condensations of dissociated aggressive and sexual drives in the context of the relationship between part self- and part object representations that cannot be clearly located or differentiated in terms of ego, superego, and id structures." In arguing that the traditional psychoanalytic tripartite structural model and conceptualization of change do not fit these cases, Kernberg reviews the contributions of object relations theory that he believes are necessary to account for borderline pathology and develops the implications of his theoretical views for the conduct of psychoanalytic psychotherapy. Since his work, like Kohut's, has received considerable attention, we will limit our discussion to his view of the implications of object relations theory for a conception of curative factors in treatment.

Kernberg states that both psychoanalysis and psychoanalytic psychotherapy are appropriate treatments for mild disorders. By contrast, borderline patients respond poorly to both psychoanalysis and supportive psychotherapy. These and other findings from the Menninger Foundation Psychotherapy Research Project suggest that expressive, rather than supportive, psychotherapy is the treatment of choice for borderline patients. Stated succinctly, the central issues in borderline patients are envy and oral aggression, which lead to primitive splitting and ego weakness. The main therapeutic task is to help the patient become aware of and integrate split-off self- and object representations.

In cautioning against the traditional view that borderline patients should receive supportive therapy, Kernberg makes a crucial point. He argues against the idea that a very disturbed patient requires a warm therapist who can be internalized as a compensation for a poor infant-mother interaction, claiming that such a view results from a misreading of Winnicott (1958, 1965) and Loewald (1960, 1979). The key factor, according to Kernberg, is that the internalization of a benign dyadic interaction requires object constancy. Thus, with borderline patients, there is danger that an excess of support, warmth, and empathy will lead to "a primitive, pathological idealization of the ‘good’ therapist," and thereby prevent the patient’s expression of aggression toward the therapist.

According to Kernberg, cases of severe psychopathology require changes in the basic analytic paradigm of the systematic interpretation of transference by a neutral analyst. The following are some of his major technical prescriptions: (1) the immediate focus should be on the "here-and-now" primitive transferences that serve as resistances and genetic reconstruction should be postponed for later stages of the treatment; (2) analysis of the transference should not be systematic, but rather, should be codetermined by "the predominant conflict in immediate reality," the specific treatment goals, and "the immediately predominant transference paradigm"; (3) parameters can be introduced but should eventually be "reduced by interpretation"; and (4) interpretation and clarification should be used, but the therapist should remain neutral, using manipulation and suggestion only in instances of severe acting out.

In the context of the other contributions to this volume and the psychotherapy literature in general, Kernberg's chapter raises the question of the extent to which some of his theoretical and technical views are specific to borderline patients. For example. Gill seems to recommend an emphasis on the here-and-now transference in all cases, regardless of the nature of the psychopathology. With respect to the "systematic" interpretation of the transference, one wonders how systematic such interpretation really is, even in the case of the average neurotic. And the idea of introducing parameters when necessary and interpreting their significance later in treatment is

common in analytic work with mild disorders as well. Finally, the problem of distinguishing structural versus "merely behavioral" change is a difficult one in any treatment, and we shall comment on it later in this chapter. In our view, these issues are unresolved and need to be considered in formulating a general theory of dynamic psychotherapy.

In the course of a clinically sensible, humane, lucid account of the treatment of schizophrenic patients, Lidz and Lidz succinctly state their view of what is curative as follows: " … the essential curative aspect of therapy lies in releasing these patients from the bondage of completing a parent's life, or of bridging the schism between their parents, to invest their energies in their own development." The Lidzes thus view excessive and conflicted symbiotic relatedness as the core intrapsychic problem in schizophrenia. A principal task for the therapist is to encourage the "patient's latent desire for individuation." Their discussion of the therapeutic process focuses on the development of trust, the confirmation of the patient's worth as a person, the avoidance of an omniscient role on the part of the therapist, and the maintenance of an optimal distance between the therapist and patient.

In presenting their clinical views and technical recommendations for the conduct of treatment with schizophrenics, the Lidzes appear to emphasize relationship factors rather than insight. To cite a specific example, "the therapist does not analyze the patient's mechanisms of defense so much as

the distortions imposed by the parents' defenses of their own tenuous ego." As will be discussed in more detail later, the Lidzes are part of the general, though not complete, consensus that insight is less important than the therapeutic relationship in the treatment and cure of extremely disturbed patients.

Palombo focuses on the issue of the cognitive and experiential modes in which the patient presents his conflicts and fantasies. Basing his view on an information-processing model, Palombo argues that dreaming is essential to psychotherapeutic change. Central to his thesis is the proposition that "associative material that emerges during the analytic hour is worked through in the dreams of the following night and matched with related memories of past events that are already located in permanent storage." Failures in matching cause anxiety dreams, which, when recalled, are designated "index dreams." These are dreams in which the censorship does not allow for adequate matching. Material from the index dream appears in the dream of the following night as a day residue. When the "revised and expanded representation of the dream is rematched with the contents of the permanent memory," we have what Palombo calls a "correction dream." Apparently, in the correction dream there is an "active assimilation," integration, and working through of memories, fantasies, and conflicts in short-term storage so that they presumably become relatively quiescent elements in permanent memory. Or, as Palombo puts it, new understandings

do not remain isolated in short-term memory. He claims that "the correction dream is one of the principal agents of therapeutic change."

Palombo illustrates his thesis with a series of dream reports from a patient whose case is described at greater length in his recent book (1978). Since it is difficult to pinpoint exactly when material has been assimilated, worked through, or integrated, it seems to us that considerable inference is required to label a given dream as a correction dream rather than an index dream. Palombo maintains that "the success of the correction dream seems to be a more reliable measure for the effectiveness of the therapeutic work than any criteria based entirely on what happens in the hour during which the index dream is reported." He concludes that "dreaming is not only grist for the therapeutic mill, it is the mill itself."

In elevating the dream to a preeminent position in the conduct of psychoanalysis and psychoanalytic psychotherapy, Palombo joins other writers who feel that dreams deserve a special status in treatment. He believes that Freud's (1911) comment that the dream should be treated like any other association has been incorrectly interpreted to mean that Freud was deemphasizing the role of dreams. Whether dreams—or any other *particular* form of mentation (e.g., waking fantasies, childhood memories—will differentially facilitate conflict resolution and adaptive change, and whether they should be accorded special therapeutic attention are open,

empirical questions which are relevant to an explicit theory of therapy.

Having briefly described the nature of the various contributions to this volume, we turn to some of the general themes and issues that were raised.

Interpretation, Insight, and the Therapeutic Relationship

As would be expected in the context of psychodynamic psychotherapy, the three related therapeutic factors most frequently discussed in this volume are interpretation, insight, and the patient-therapist relationship. Although the three are interlocked, we believe it is possible, at least conceptually, to disentangle their relative roles. Of the three factors, the patient-therapist relationship is the most frequent overriding theme stressed by the various contributors to this volume.

Let us first consider the relationship between insight and the therapeutic relationship. As Slipp observes in his Introduction, the debate about insight versus the therapeutic relationship was already in full force in the Freud-Ferenczi controversy. In an important sense, that debate has continued among the heirs of Freud and Ferenczi, the former represented by traditional Freudian theorists, and the latter, through Klein and Balint, now represented by the so-called English object-relation theorists. For the former, insight remains the critical curative factor in psychoanalysis. It will be noted that Rangell's (1954) definition of psychoanalysis, cited by Slipp, places

primary importance on insight and, indeed, makes no explicit reference to the therapeutic relationship (see also Gill, 1954). Similarly, in Bibring's (1954) formulations, insight through interpretation is the primary curative factor in psychoanalysis.

It is widely accepted that therapeutically useful insight requires the context of an ongoing relationship. Both Hatcher and Gill remind us of the importance of dealing with active feelings that have emotional immediacy. And it is also widely observed that offering a clarifying and insight-facilitating interpretation itself contributes to a therapeutic relationship. A number of contributors, however, explicitly or implicitly take the position that the patient-therapist relationship can have therapeutic effects quite apart from that of generating insight. Indeed, at least one contributor, Marmor, tells us that the relationship factor is primary and that insight is not necessary for therapeutic progress. And other contributors—Volkan, for example—while not taking the explicit position taken by Marmor, stress the role of factors, such as identification with the therapist, which would appear to be at least somewhat independent of insight. In effect, what is being said is that while insight may depend on an ongoing therapeutic relationship, the patient-therapist relationship can be therapeutic quite apart from insight.

It is worth noting a recent paper by Bush (1978), who argues that Freud himself placed greater emphasis on the role of the therapeutic relationship

than on that of insight in effecting change and cure. He cites the following passage as evidence that Freud was not especially impressed with the therapeutic efficacy of insight:

> If the patient is to fight his way through the normal conflict with the resistances which we have uncovered for him in the analysis, he is in need of a powerful stimulus which will influence the decision in the sense which we desire, leading to recovery. Otherwise it might happen that he would choose in favor of repeating the earlier outcome and would allow what had been brought up into consciousness to slip back again into repression. At this point what turns the scale in his struggle is not his intellectual insight —which is neither strong enough nor free enough for such an achievement —but simply and solely his relation to the doctor. Insofar as his transference bears a "plus" sign, it clothes the doctor with authority and is transformed into belief in his communications and explanations. In the absence of such a transference, or if it is a negative one, the patient would never even give a hearing to the doctor and his arguments [Freud, 1917, p. 445].[4]

We turn next to the role of interpretation and its relation to the therapeutic relationship. While the importance of interpretation is discussed by most, if not all, of the contributors, it does not occupy the central place it has been given in more traditional accounts. Furthermore, interpretation is often viewed as important, not primarily because of the insight and understanding it provides, but because it gives the patient a *feeling of being understood*. That is, the major importance of the insight derived from interpretation is viewed, not in terms of cognitive restructuring, but in terms of such relationship factors as feeling understood, the provision of empathy and mirroring, facilitating identification with the therapist, etc.

Interestingly enough, interpretation is still seen as a primary tool, but its therapeutic role is linked to relationship factors rather than to insight. It is in the act of making accurate and helpful interpretations that the therapist expresses his empathic understanding and helps the patient differentiate archaic representations from current ones. In short, providing an accurate and helpful interpretation is therapeutically important because in so doing the therapist functions as a good object.

A somewhat different aspect of the relation between interpretation and the therapeutic relationship is involved in the oft-debated question whether interpretations should be almost exclusively concerned with the transference situation or should be concerned with a variety of extratransference concerns and experiences. In this volume, Gill's paper is a good example of the former position, while Bemporad's paper is a good example of the latter—insofar as he stresses the importance of offering interpretations of the patients' pathological life style, including their destructive belief systems, which are only indirectly related to transference reactions.

In this process of conceptual disentangling one can also look at the relationship between insight and interpretations. In traditional psychoanalytic theory, a most secure and unquestioned link is that between insight and interpretation. As noted above, however, that link is weakened in this volume. Feeling understood, rather than insight or understanding per se

(or cognitive clarity and restructuring), is viewed by most of the contributors as the critical therapeutic aspect of interpretation. That is, while insight facilitation is seen as a legitimate function of interpretation, the provision of empathy by the "good object" is seen as its primary role. It is interesting to note that this attitude toward interpretation parallels, in important respects, general developments in the field of psychotherapy research.

For example, Bergin and Lambert (1978), after reviewing a good deal of the psychotherapy literature, conclude that the "power [of techniques] for change pales when compared with that of personal influence. Technique is crucial to the extent that it provides a believable rationale and congenial modus operandi for the change agent and the client." They add that "these considerations imply that psychotherapy is laden with nonspecific or placebo factors … but these influences, when specified, may prove to be the essence of what provides the therapeutic benefit" (pp. 179-180).[5] They make clear that, in their view, those “placebo factors” center on “an interpersonal relationship” with the therapist that “is characterized by trust, warmth, acceptance, and human wisdom” (p. 180)—a point of view quite similar to the one enunciated by Marmor in this volume.

Although Bergin and Lambert view the value of interpretation primarily in terms of its importance for the relationship, what appears to remain intact is the assumption that if insight is to be achieved the primary means of

achieving it (however important or unimportant that may be) is through interpretation. But this link is also attenuated by recent findings from a group of psychoanalytic researchers (Weiss et al., 1980) who present evidence that patients can develop insight *without* interpretation as long as they experience "conditions of safety" in the therapeutic situation. This finding suggests that the emergence of warded-off contents, which is necessary to and part of the process of insight, can occur simply as a function of the patient's feeling safe in the therapeutic relationship (following "enactments" with the therapist which constitute test passing). If one accepts the view of Weiss, Sampson, and their colleagues (Weiss 1971; Sampson et al., 1972; Horowitz et al., 1975; Sampson, 1976; Sampson et al., 1977; Weiss et al., 1980) that patients primarily want to master infantile traumas, conflicts, and anxieties (as opposed to the view that they primarily want to gratify infantile impulses and wishes), have unconscious plans to do so, and make unconscious decisions about whether to lift defenses and express warded-off contents, then it is not surprising that under appropriate "conditions of safety" insight occurs without interpretation.

One can certainly conclude from this work that insight and the patient-therapist relationship are not opposing factors. But one might also make the more sweeping claim that the therapeutic relationship is the primary factor, not only as a direct curative agent (as is claimed by some of the contributors to this volume) but as the critical determinant of insight. In other words, what

is implied in this view is that the most profound, incisive, and well-timed interpretation will not lead to change if "conditions of safety" do not obtain and, in addition, that insight and change can occur as a direct consequence of the establishment of "conditions of safety."[6]

The concept of conditions of safety recalls Bush's (1978) suggestion that, at least in part, insight entails changes in one's perception of danger. For example, a patient may come to realize that criticizing the therapist will not destroy therapist or patient. If Bush is right, the patient's determination of whether a potential situation of danger had really changed would be influenced, not so much by the specific interpretation offered as by the general response of the therapist to criticism.

Degree of Pathology

Many of the contributors link their increased emphasis on the therapeutic relationship and their relative deemphasis of insight to the related facts that (1) they are dealing with more disturbed (rather than neurotic) patients and (2) they are describing dynamic or psychoanalytic psychotherapy rather than so-called classical psychoanalysis. As cited by Slipp, Bibring (1954) acknowledged that in dynamic psychotherapy the therapeutic relationship assumes greater importance than it does in psychoanalysis proper. There is, moreover, some evidence that among the

contributors to this volume, those who are not writing specifically about more disturbed patients (for example, Gill, Bemporad, and Langs) do place greater stress on the role of insight and less stress on other factors. With regard to the latter, we have already noted Bemporad's belief that, in working with neurotically depressed patients, idealization of the therapist—a transference development encouraged by Kohut and Wolf with narcissistic patients—is to be resisted.

But this general observation regarding the relation between the role of insight and the type of patient must be qualified. Marmor, for example, does not limit the lessened importance of insight to more disturbed patients. The context of his remarks regarding insight suggests that he means his comments to be general ones, applicable to all psychotherapy. Conversely, Kernberg, who deals with the more disturbed borderline and narcissistic categories, does not appear to minimize the role of insight.

The question thus is posed: what is the interaction between type and degree of pathology and the nature of curative factors? Are there specific therapeutic factors that are applicable to a particular type and degree of pathology, as well as general factors that are applicable across the board? Whether the changed conceptions of what is curative are applicable only to a limited range of more disturbed patients or to a wider patient population is one of the unresolved issues that emerges from this volume. (Ambiguity

about this question as well as the larger question of the range of applicability of his self psychology can also be found in the work of Kohut.) It is possible that the more disturbed patients—those with narcissistic disorders, borderline conditions, or schizoid states—may represent today's modal patient and that the classically neurotic patient—if he or she ever did exist in pure form—may be a disappearing breed. One recalls Erikson's (1963) observation, which was made well before the recent preoccupation with narcissistic and borderline phenomena: "the patient of today suffers most under the problem of what he should believe in and who he should—or, indeed, might—be or become; while the patient of early psychoanalysis suffered most under inhibitions which prevented him from being what and who he thought he knew he was" (p. 279).

In other words, problems of values, self, and identity—which are so prominent in, for example, Kohut's (1971, 1977) descriptions of narcissistic personality disorders—may well be widespread phenomena. If that is so, the modifications in theory and technique that were presumably relevant only for a certain limited class of patients may well be applicable to a much wider range of patients. Indeed, as Gedo (1980) observes, many patients who are diagnosed by Kohut's followers as "narcissistic disorders" are indistinguishable from other patients in whom more traditional analysts found "significant Oedipal problems" but "no other sources of psychopathology" (p. 372). In short, whether so-called "narcissistic

disorders" and certain classes of borderline conditions are distinguishable categories of psychopathology, qualitatively different from neurotic patients, or whether they mainly represent the predominant nature of today's neurosis, is an open question. [7] In any case, in the present context, the point to be stressed again is that the therapeutic factors—for example, the importance of the patient-therapist relationship—which some contributors suggest are mainly applicable to certain classes of pathology may be the critical elements in the general activity of all psychotherapy.

Warded-Off Contents and Therapeutic Attitude

While all of the contributors to this volume uphold the basic psychoanalytic emphasis on facilitating conscious access to warded-off contents (i.e., repressed and split-off material), they depart from traditional views in their conception of *what* is warded off and *how* one should facilitate access to this material. There is not a unanimous acceptance of the traditional assumption that warded-off contents are necessarily derivatives of sexual and aggressive drives. A number of contributors refer to various other contents. Thus, Kohut and Wolf discuss patients' lack of access to archaic narcissistic needs; Tuttman stresses their unmet dependency needs; Volkan emphasizes their archaic introjects; Bemporad focuses on patients' lack of awareness of their pathological program of living, including their pathological belief systems; Stone refers to lack of awareness of choices and alternatives; and so

on.

With regard to the issue of what constitutes an appropriate and facilitating therapeutic attitude, a number of contributors claim that analytic neutrality (what Kubie [1975, p. 100] referred to as "analytic incognito") is not therapeutic and needs to be replaced by such attitudes as empathy, interest, and warmth. Further, the altered conception of the kinds of unconscious contents that are warded off is linked to this conception of a proper therapeutic stance. Thus, one finds some contributors talking about the legitimacy (and even necessity) of partial gratification of the patient's needs (including archaic and infantile needs). Such a position is incompatible with the traditional view of the warded-off contents; namely, that they consist solely of sexual and aggressive wishes. But when one holds that the warded-off material includes wishes centering on, let us say, the need for mirroring or idealization, the strictures against any therapeutic gratification do not seem as self-evident.

There is a good deal of ambiguity about the meaning of "neutrality" and a "neutral stance." Neutrality may mean an aloof and impersonal manner, with as close an approximation as possible to "blank screen" status—an approach that led Ferenczi (1919) to wonder whether the therapist was fulfilling the patient's neurotic expectations regarding the "bad" and rejecting other. Or "technical neutrality" may include such behaviors as not taking

sides in the conflict; not being overinvolved, for one's own countertransference reasons, in one particular set of therapeutic goals; not being overinvolved in therapeutic outcome; not being seductive, manipulative, or sadistic; centering most of one's therapeutic gratification on the experience of professional competence. Interpreted in the latter way, neutrality need not be at all contrary to empathy, genuine interest, or warmth (see Kohut, and Wolf, this volume).

Weiss et al. (1975, 1977a 1977b) have done some interesting work relevant to the question of analytic neutrality as well as to the larger issues of insight and the patient-therapist relationship. They have presented empirical evidence that therapist neutrality is significantly associated with the emergence of unconscious, warded-off contents. When a patient tries to get the therapist to satisfy certain infantile wishes and the latter does not do so, the patient becomes more relaxed rather than more anxious. According to Weiss and Sampson, this response can be explained by the fact that most patients want to *master, rather than gratify*, unconscious infantile wishes; they hope to disconfirm the infantile beliefs and ideas that generated their conflicts and anxiety. However, in order to come forth with this distressing material, the patient must first determine whether "conditions of safety" prevail in the therapeutic situations—determinations that are made through tests unconsciously presented to the therapist.

In this context, one can see that it is not analytic neutrality per se that is important, but rather, the *degree to which it constitutes the conditions of safety developed in the therapeutic relationship*. It can be shown empirically that neutrality usually will constitute a condition of safety because, above all, patients need guarantees that the therapist will *not* be drawn into their infantile wishes. Rather than gratification of these wishes, they need assurances that the therapist will not be hurt and destroyed, will not be seduced or seductive, will not be "impinging" (Winnicott, 1958, 1965), etc.

Thus, to cite some of Weiss et al.'s examples: when a female patient learned that she was not actually hurting or destroying the therapist, she felt safer to express omnipotent wishes and fantasies; when a male patient felt assured that the therapist would not be seduced, he could then express his fear of homosexuality.[8]

Thus, a relationship is therapeutic to the degree that it constitutes a "condition of safety" for the patient. The condition of safety, in turn, will be a function of the individual dynamics and defenses of the patient, the "match" between patient and therapist, and the personality of the therapist, among other things.

Sharp distinctions between therapeutic neutrality and the "real" relationship are artificial (see Dewald, 1976). For one, the "real"

characteristics of the therapist will always be apparent, even in someone completely emulating the "blank screen" role (see Gill, this volume); and two, the "real" characteristics and personality of the therapist are the vehicle for any therapeutic work that is carried out. Such work is not done by disembodied interpreters, supporters, or whatever, but by particular persons with particular characteristics and styles. We need to remind ourselves constantly that this is so. For the position therapists take on issues such as neutrality versus warmth, etc., may bear a complex and uncertain relation to *what therapists actually do in therapy and to the personal and interactional feelings and attitudes they convey*. It is likely that some therapists who espouse an extreme "blank screen" position may convey a great deal of warmth and genuineness, whereas other therapists who advocate such qualities in theory may be personally remote and aloof.

Being accepting of someone, being genuinely interested in someone, and feeling warmly toward someone are *organic*, personal—or more accurately, interpersonal—qualities that cannot be meaningfully generated by the knowledge that they are therapeutic. Every therapist enjoys working with certain patients more than others; every therapist is more genuinely interested in and feels more warmly toward some patients than others (see Stone, this volume). Here Levenson's point concerning authenticity is quite relevant. It is unlikely that merely presenting an attitude of acceptance, interest, and warmth will be experienced in the same way or have the same

effects as the authentic behaviors and feelings. Even authentically expressed attitudes cannot be assumed to have the same meaning and the same effects for all patients.

While everyone would probably agree about the general applicability of certain ingredients in psychotherapy—for example, being nonjudgmental, accepting, showing genuine interest—the meaning and impact of other ingredients would depend on the particular patient and therapist involved. For example, for certain patients at particular times in therapy, obvious warmth might be experienced as a seduction or as generally "impinging," thereby creating anxiety, mobilizing defenses, and decreasing the likelihood of access to warded-off material. This point is quite relevant to parallels drawn by some of the contributors between the therapeutic relationship and the parent-child relationship.

Parallel between Psychotherapy and the Mother-Child Relationship

It seems to us that the claim that therapy meets unmet archaic needs, and a general uncritical parallel between therapy and good parenting, involve the risk of overlooking the above (and other) considerations. That is, in most cases of psychopathology, it is not simply a question of meeting unmet needs on the order of a deficiency-compensation model—analogous to having a vitamin deficiency and taking vitamins to correct the deficiency. Rather, it is

often more like having a deficiency and being conflicted about and/or allergic to the "substance" which could correct the deficiency. For example, someone deprived of love and nurturance is frequently precisely the person who experiences intense fear as well as need of intimacy and love. Hence, it is often the ability to resolve the conflict through clarification and mastery, rather than gratification, that is therapeutic.

The fact is, moreover, that an adult patient, however disturbed and regressed, is not a chronological infant. Hence, the parallel between the therapeutic relationship and the mother-child relationship cannot be complete. In discussing the role of regression in therapy, Tuttman tells us that offering empathic understanding and clarification are therapeutic, while milk-giving and hand-holding are inadvisable. But why are the latter inadvisable? Is it, as Tuttman suggests, because milk-giving and hand-holding are libidinally gratifying? Or is it because they are infantilizing, preclude mastery, and are, so to speak, age-inappropriate? Responding to someone with acceptance and understanding is age-appropriate for a adult, whereas milk-giving and hand-holding entail treating the patient regressively. Or, to put it somewhat differently, although an attitude of acceptance and understanding may facilitate the patient's access to regressive phenomena, it is not regression-inducing.

It must also be kept in mind that even when therapy involves gratifying

the patient's more primitive and archaic needs, the gratification is generally *indirect*, *disguised*, and *symbolic*. Thus, Silverman writes about *unconscious and symbolic* gratification of symbiotic fantasies. And, as will be recalled by those familiar with Sechehaye's (1951) account of Renee, her schizophrenic patient, therapeutic gratification of life-sustaining primitive needs such as eating initially had to be provided symbolically by Sechehaye. (Hence, the title of her book was *Symbolic Realization*. Such provision was necessary because Renee's mortal terrors and conflicts concerned those very areas in which she had been deprived.

One sees this same phenomenon at work, in less extreme form, with other patients. For many patients, being emphatically understood may have the symbolic and nonthreatening meaning of a good maternal environment, while more direct provision of a maternal (and paternal) environment and more direct gratification of regressive wishes are likely to prove threatening and destructive. In clinical work, one can observe that such direct gratification is likely to evoke, among other things, fear of being seduced and overwhelmed, frightening and insatiable greediness, and rage at past disappointments and deprivations. Above all, one must remember that, as Loewald (1979) puts it, "the analysis of adults, no matter how much given to regression or how immature they are in significant areas of their functioning, is a venture in which the analysand not only is, in fact, chronologically a grownup, but which makes sense only if his or her adult potential, as

manifested in certain significant areas of life, is in evidence" (pp. 163-164).

A more meaningful comparison between the parent-child relationship and the therapeutic one is, as Strupp (1976) points out, likely to center on the fact that the patient is in a dependent relationship, is subject to the influences that such a relationship entails, and is encouraged to substitute inner control and autonomy for such external influences—a process not unlike socialization.

Working Through

In describing each of the individual contributions, we have already spoken of the emphasis on working through as a therapeutic factor. Here we want to make the additional point that of the various meanings that can be given to the term working through, most of the contributors emphasize the process of trying out in one's outside life what one has learned in therapy, particularly about one's interactions with the therapist. As noted earlier, much of the discussion of working through is evocative of Alexander and French's (1946) concept of the "corrective emotional experience," as are other formulations in this volume. For example, Volkan's emphasis on the importance of helping the patient "decontaminate" archaic representations from new ones, in relation to the therapist, bears a resemblance to the concept of a "corrective emotional experience," notwithstanding differences

in terminology and in broader conceptualization. There is one important difference, however; Volkan and the other contributors to this volume would be likely to reject Alexander and French's manipulative strategy of carefully targeting the particular "corrective emotional experiences," including the therapists' deliberate selection of certain roles to play. In other words, they would expect the so-called "corrective emotional experience" to evolve spontaneously in the course of the therapeutic relationship.

Pre-Oedipal versus Oedipal Factors and Self versus Drive Theory

Although we cannot discuss it at length here, we want to note that running through some of the contributions are the related issues of the Oedipal versus pre-Oedipal basis of pathology, and self psychology versus drive theory as the basis for conceptualizing personality development and psychopathology. These issues appear in a number of contributions concerned with patients whose pathology is characterized by disturbances in self-cohesion, defective ego organization, and early developmental difficulties. Furthermore, the pre-Oedipal versus Oedipal and self versus drive theory disputes appear to parallel the therapeutic relationship versus insight debate. That is, those conceptualizing pathology mainly in pre-Oedipal and self theory terms are more likely to focus on the importance of the therapeutic relationship, whereas those stressing Oedipal factors and drive theory are likely to emphasize the role of insight.

Research on Therapeutic Outcome

In the present context, where the main concern is curative factors in psychotherapy, the critical question is whether different theoretical conceptions—pre-Oedipal versus Oedipal, self versus drive theory, or any other—are associated with differential effectiveness (see Silverman and Wolitzky, this volume). There is some evidence (Gedo, 1980) that more favorable therapeutic outcomes may be associated with "focusing on certain pregenital issues" that may include the developmental antecedents determining the Oedipal fixation. Issues of this kind need to be investigated more systematically. While it is extremely difficult to tease out the weights of different specific factors in therapeutic outcome, the effects of certain broad variables—such as different theoretical conceptions and their respective areas of concentration in therapy—*can* be more systematically investigated.

Gedo's (1980) observation that the analysts at the New York Psychoanalytic Institute involved in the Firestein report (1978) found predominantly Oedipal difficulties, whereas the analysts of the Chicago case book (Goldberg, 1978) found mainly pre-Oedipal material and self difficulties, raises important questions. Were the New York and Chicago therapists *interpreting* and formulating the patient's productions differently or were there differences in the actual content of the material elicited from the patients? If the latter is the case, did the personality as well as the theoretical

orientation of the therapist play a significant part in the kind of material elicited? For example, would a more aloof and authoritarian therapist be more likely to elicit Oedipal material? Here one must consider that the patients' very choice of therapist is likely to be influenced by their dynamic conflicts. These and other possibilities remind us once again of the importance of systematic therapeutic outcome studies in which the therapeutic effects of different variables are investigated.

Therapeutic Process

An important issue that needs to be pursued is *how* the various purported curative factors effect change. What specific psychological processes are involved? A careful microanalysis needs to be done in this area. Unfortunately, some of the concepts and functional relations posited by analysts and therapists are vague and need to be further sharpened and clarified. For example, what specifically is meant by "the building up of psychic structures"? And, as Gedo (1980) asks, how can the reliving of certain childhood experiences in the transference lead to the repair of developmental deficits? Are we, as Gedo suggests, really dealing with the acquisition of essential skills and the relative freeing of the learning process in the wake of such changes as increased trust and decreased grandiosity and anxiety? As a final example, how does one distinguish "structural" change from change that is "largely behavioral"? What is the measurable difference between "a partial

increase in ego strength," the presumed outcome of psychoanalytic psychotherapy, and "a reduction in the rigidity of the ego's defensive structures," the presumed outcome of classical psychoanalysis (Kernberg, this volume)? These are all thorny issues that, so far, are neither clearly defined nor adequately resolved.

An Autonomous Theory of Psychotherapy

We believe that one of the general conclusions to be drawn from this volume is that we need to develop a quasi-autonomous theory of therapy which, in good measure, stands apart from theories of personality development, especially those concerning the etiology of pathology. That is, we need to establish an independent and strong empirical base of knowledge and understanding of the therapeutic factors that produce change and the processes by which they produce change.

In this volume, Silverman and Wolitzky outline some research strategies that could be used to resolve controversial issues and to generate a body of reliable clinical knowledge. How this body of knowledge and theory will then fit into theories of the etiology of pathology and of personality development will undoubtedly be a complex matter. What we cannot assume—as is often implicitly assumed—is that effective treatment mirrors etiology. For example, if empathic understanding is therapeutically effective, it does not necessarily

follow that *lack* of empathic understanding was a significant etiological and historical factor in the patients' pathology. This possibly fallacious link between therapeutic effectiveness and etiology is particularly likely to be generated by the general analogizing between therapist-patient and mother-child interactions. Thus, if a particular therapeutic intervention or phenomenon (e.g., mobilizing a mirroring transference) is helpful, one conceptualizes it in terms analogous to "good" parenting that is therapeutic because it makes up for the etiologically significant "bad" parenting. Logically, this is equivalent to arguing that an undcrconcentration of aspirin in the blood is the etiologically significant factor in headaches.

Theories of etiology presented by clinicians are often built on adult patients' recollections of purported genetic *events*, such as mother's attitude and behavior toward the patient as a young child (even as an infant), with no corroboration other than the adult patients' free associations, dreams, and, on occasion, direct reports.[9]

As Gedo (1980) notes, in commenting on similar accounts, "the detection of a specific transference configuration was used, in a global way, to postulate the occurrence of an equally global, typical childhood emotional constellation" (p. 371). Furthermore, etiological theories regarding certain nosological categories (e.g., narcissistic personality disorders or borderline conditions) are developed on the basis of these data. It should not be

necessary to point out that an adult patient's free associations, dreams, etc., however useful they may be as a guide to the patient's perceptions, feelings, and intrapsychic life, are likely to bear uncertain and complex relation to actual early events. If one wants to relate early events to later pathology, at the very least one has to have some firm, independent, reliable evidence regarding these early events. The most elementary notions of what constitutes evidence would make this point apparent, even self-evident.

If one wants to study the relationship between, let us say, patterns of mother-child interactions and later pathology, one needs to study mother-child interactions directly in longitudinal studies. This is not the same as studying an adult patient's perceptions, feelings, and memories of his early years, nor is it the same as inferring what the mothering must have been like on the basis of interpretations and renderings of the adult patient's productions. This is not to say that the therapeutic situation may not be heuristically valuable in generating hypotheses regarding the etiology and vicissitudes of patterns observed in adults.

While the material generated in psychotherapy may not serve as solid evidence for a theory of etiology or a general theory of personality, it can and should provide basic data for an autonomous theory of psychotherapy—that is, a formulation of the necessary and sufficient conditions for therapeutic change. Quite apart from general theories of personality, it is important to

identify those factors that lead to specific therapeutic outcomes. In the course of specifying these factors, we will need to attend to issues such as independent criteria for the validity and effectiveness of interpretations, placebo effects, and patient and therapist variables, separately and in interaction with one another. Our task for the future is to subject the many intriguing ideas and important clinical insights presented in this volume to controlled, systematic investigation.

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Notes

1 The authors would like to express their appreciation to Dr. Rita Simon-Eagle for her helpful comments and suggestions.

2 This question is too complex to be dealt with fully and adequately here, but some points are worth noting. For one, so-called disparate theoretical views may only appear to be disparate. To a certain extent, different theorists may say very similar things in different ways. There are a limited number of themes in human development and in pathological disturbances, and different theorists may simply employ different theoretical language to refer to these themes. We must not lake theoretical controversies at face value and assume that they always reflect substantive differences.

A related point is that different theoretical systems may focus on a particular aspect of a larger truth and/or take a particular perspective on it. Unless the different theoretical systems are logically contradictory, one should not assume that their equal efficacy means that any explanatory account is as good as any other. The belief that one can have multiple perspectives and/or emphases on a complex truth does not mean that any perspective will do; nor does it mean that different perspectives are equally valid or

useful. With regard to this last point, we do not know whether a rigorous, systematic study would demonstrate that all theoretical perspectives are *equally* effective in therapy. It is possible that, while all might be somewhat useful, in given cases, one perspective would be more effective than others.

For example, on the basis of what is not known about multiple, complex phobias of which chronic agoraphobia is the core, it has become clear that a central dynamic issue in these cases is, to use Mahler's (1968) term, separation-individuation. Now, it seems to us that a perspective in which separation-individuation occupies a central role would be more effective than, let us say, a perspective that interprets agoraphobia primarily in terms of prostitution and street-walking impulses (Freud, 1933). If we are correct, the former perspective would be more effective because it is more accurate, more in accord with the case (for further discussion, see Eagle, 1979). The point is that one should not readily dismiss the importance of accurate interpretation—however complex and difficult it may be to formulate criteria for interpretive accuracy and however important other factors may be.

3 Of course, it is possible that Kernberg's patients are more disturbed than Kohut's.

4 Bush cites this passage as evidence of Freud's skepticism regarding the role of insight as a sufficient basis for change as well as of his emphasis on the curative primacy of the therapeutic relationship. However, a close reading of this statement indicates that, rather than downgrading insight, Freud is stressing the role of the relationship in maintaining insights already achieved and in facilitating the process of working through in achieving a cure.

5 A Grünbaum (1979) points out in an enlightening discussion of the concept of placebo, "nonspecific" and "placebo" cannot be equated. Placebo factors are no less specific than any other set of factors. Rather, it is only with respect to a particular theory specifying what is supposed to be effective (in relation to a particular outcome) that certain factors can be seen as placebos. For example, if one theorizes that interpretation and insight are the curative factors, and it turns out that the accepting way in which an interpretation is made is the curative factor, one would call the latter a placebo factor. But, (1) the placebo factor is no more and no less specific than interpretation and insight; and (2) it is a placebo factor only in relation to a particular theory. If one had theorized that authenticity of manner is a major curative agent, it would no longer constitute a placebo factor.

6 While this research demonstrates that interpretation is not a necessary precondition for insight, it does, of course, frequently generate insight.

7 That is, the form of current pathology may be particularly "narcissistic" and "borderline" in nature. As far as we know, no one has adequately explained the recent veritable preoccupation with narcissistic and borderline disorders and the relatively sudden popularity of these diagnoses. We strongly suspect that an explanatory framework which goes beyond an appeal to early mother-infant interactions and includes broad social factors will be necessary to shed light on this phenomenon.

8 Slipp (1981) has investigated direct family interaction and has suggested that the patient's developmental fixation occurred because the existing family dynamics corresponded to, and thus reinforced, the patient's unconscious fantasy; that is, aggression actually was considered as destructive in families of schizophrenics, whereas in families of hysterics and borderlines an Oedipal triumph seemed possible. Slipp believes that it is important for the therapist to resist the countertransference tendency to reinforce such conflicts. The therapist needs to contain the patient's projective identification and to respond differently than the patient's family did in order to permit the differentiation between omnipotent fantasies and reality.

9 Such accounts often begin with the caution that the patient's *perceptions* and experiences (of mother's attitudes, behavior, etc.) are being presented, but they soon lapse into talk about the mother's *actual* behavior and attitudes. It should be noted that it is only the patient's *current* perceptions and memories (in the context of the therapeutic situation) that are available