NINTH EDITION

SYSTEMS OF PSYCHOTHERAPY

A TRANSTHEORETICAL ANALYSIS

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JOHN C. NORCROSS

Systems of Psychotherapy

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A Transtheoretical Analysis

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To Jan and Nancy

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Preface

Welcome to the ninth edition of *Systems of Psychotherapy: A Transtheoretical Analysis*. Our hope is that our book will inform and excite you: inform you about valuable psychotherapy theories and excite you to conduct powerful psychotherapy for the enrichment of fellow humans.

Our book provides a systematic, comprehensive, and balanced survey of the leading systems of psychotherapy. It is designed, however, to be more than just a survey, as we strive toward a synthesis both within each psychotherapy system and across the various systems. Within a particular system of therapy, this book follows the integrative steps that flow from the system's theory of personality to its theory of psychopathology and culminates in its therapeutic process and therapy relationship. Across the various systems of therapy, our book offers an integrative framework that highlights the many similarities of therapy systems without blurring their essential differences. The comparative analysis clearly demonstrates how much psychotherapy systems agree on the processes producing change while disagreeing on the content that needs to be changed.

Systems of Psychotherapy: A Transtheoretical Analysis is intended, primarily, for advanced undergraduate and graduate students enrolled in introductory courses in psychotherapy and counseling. This course is commonly titled Systems of Psychotherapy, Theories of Counseling, Psychological Interventions, or Introduction to Counseling and is offered to psychology, counseling, social work, psychiatry, nursing, human relations, and other students. Our volume is intended, secondarily, for psychotherapists of all professions and persuasions seeking a comparative overview of the burgeoning field of psychotherapy. We have been immensely gratified by the feedback from readers who have used this text in preparing for comprehensive exams, licensure tests, and board certification as well as from those who have found it instrumental in acquiring a more integrative perspective.

Our Objectives

The contents and goals of this ninth edition embody our objectives as psychotherapy practitioners, teachers, researchers, and theorists. As practitioners, we appreciate the vitality and meaning of different clinical approaches. We attempt to communicate the excitement and depth of these psychotherapy systems. Accordingly, we avoid simple descriptions of the systems as detached observers in favor of immersing ourselves in each system as advocates.

As practitioners, we are convinced that any treatise on such a vital field as psychotherapy must come alive to do the subject matter justice. To this end, we have included a wealth of case illustrations drawn from our combined 85 years of clinical practice. (When one of us is speaking from our own experience, we will identify ourselves by our initials—JOP for James O. Prochaska and JCN for John C. Norcross.) We demonstrate how the same complicated psychotherapy case—Mrs. C—is formulated and treated by each system of psychotherapy. This and all of the case examples counterbalance the theoretical considerations; in this way, theories become pragmatic and consequential—relevant to what transpires in the therapeutic hour. We have altered the details of individual clients, of course, to preserve their privacy and anonymity.

As psychotherapy teachers, we recognize the complexity and diversity of the leading theories

of psychotherapy. This book endeavors to present the essential concepts clearly and concisely but without resorting to oversimplification. Our students occasionally complain that theorists seem to have a knack for making things more complicated than they really are. We hope that as you move through these pages you will gain a deeper appreciation for the complexity of the human condition or, at least, the complexity of the minds of those articulating the human condition.

Our decades of teaching and supervising psychotherapy have also taught us that students desire an overarching structure to guide the acquisition, analysis, and comparison of information. Unlike edited psychotherapy texts with varying writing styles and chapter content, we use a consistent structure and voice throughout the book. Instead of illustrating one approach with Ms. Apple and another approach with Mr. Orange, we systematically present a detailed treatment of Mrs. C for each and every approach.

As psychotherapy researchers, the evidence has taught us that psychotherapy has enormous potential for impacting patients in a positive (and occasionally a negative) manner. In this view, therapy is more analogous to penicillin than to aspirin. With psychotherapy producing strong rather than weak effects, we should be able to demonstrate the effectiveness of psychotherapy even in the face of error caused by measurement and methodological problems. We thus include a summary of controlled outcome studies and meta-analytic reviews that have evaluated the effectiveness of each therapy system.

Research and practice have further taught us that each psychotherapy system has its respective limitations and contraindications. For this reason, we offer cogent criticisms of each approach from the vantage points of cognitive-behavioral, psychoanalytic, humanistic, cultural, and integrative perspectives. The net effect is a balanced coverage combining sympathetic presentation and critical analysis.

As psychotherapy theorists, we do *not* endorse the endless proliferation of psychotherapy systems, each purportedly unique and superior. What our amorphous discipline *does* need is a concerted effort to pull together the

essentials operating in effective therapies and to discard those features unrelated to effective practice. From our comparative analysis of the major systems of therapy, we hope to move toward a higher integration that will yield a transtheoretical approach to psychotherapy.

Changes in the Ninth Edition

Innovations appear and vanish with bewildering rapidity on the psychotherapeutic scene. One year's treatment fad—say, neurolinguistic programming—fades into oblivion in just a few years. The volatile nature of the psychotherapy discipline requires regular updates in order for practitioners and students to stay abreast of developments.

The evolution of this book closely reflects the changing landscape of psychotherapy. The first edition in 1979 was relatively brief and only hinted at the possibility of integration. The second edition added sections on object relations, cognitive, and systems therapies. The third edition brought new chapters on gender-sensitive therapies and integrative treatments, as well as John Norcross as a coauthor. The fourth, fifth, and sixth editions featured new chapters on constructivist therapies, interpersonal psychotherapy (IPT), and multicultural therapies (formerly combined with gender-sensitive therapies). The seventh and the eighth editions brought new chapters on third-wave therapies, including acceptance and mindfulness approaches, and enlarged consideration of the transtheoretical model.

This ninth edition, in turn, brings a host of changes that reflect recent trends. Among these are:

◆ new sections on Lacanian analysis in Chapter 2 and mentalization therapies in Chapter 3
◆ a lengthier section on the emerging evidence-based family therapies (Chapter 12)
◆ a new section on psychotherapy with gender-nonconforming people in the gender-sensitive chapter (13)
◆ a new section on integrative health in the future of psychotherapy chapter (18)
◆ updates of meta-analyses conducted on the effectiveness of each psychotherapy system

- a new appendix on meta-analytic research and how to interpret and apply the results to clinical work
- continued efforts to make the book student-friendly throughout (see the following section)
- a new book publisher (Oxford University Press)

  With these additions, the text now thoroughly analyzes 15 leading systems of psychotherapy and briefly surveys another 32, thus affording a broader scope than is available in most textbooks. Guiding all these modifications has been the unwavering goal of our book: to provide a comprehensive, rigorous, and balanced survey of the major theories of psychotherapy. Expanding the breadth of *Systems of Psychotherapy* has been accomplished only within the context of a comparative analysis that seeks to explicate both the fundamental similarities and the useful differences among the therapy schools.

Student- and Instructor-Friendly

The 35-plus years since the first edition of this book have repeatedly taught us to keep our eye on the ball: student learning. On the basis of feedback from readers and our students, we have introduced aids to enhance student learning. These include:

- a list of key terms at the end of each chapter to serve as a study and review guide
- a series of recommended readings and websites at the end of each chapter
- a set of PowerPoint slides for each chapter (coordinated by Rory A. Pfund, Nicole G. Plantier, and John C. Norcross, from Memphis University and the University of Scranton)
- an expanded test bank coauthored by three exceptional professors, Drs. Linda Campbell (University of Georgia), Anthony Giuliano (Harvard Medical School), and Jodi Prochaska (Stanford University). Available to qualified adopters, the test bank presents 2,000-plus original exam items (essay questions, multiple-choice items, and identifications/definitions).

- a revised instructor's resource manual featuring case materials and videotaped therapy demonstrations of the psychotherapy systems featured in the text, more than 400 activity/discussion ideas, and additional case illustrations for use in class
- an alternative table of contents as an appendix for those who wish to focus on the change processes cutting across theories rather than the psychotherapy theories themselves
- a book-companion website at www.oup.com/us/systemsofpsychotherapy that includes additional resources and free webinars

Acknowledgments

Our endeavors in completing previous editions and in preparing this edition have been aided immeasurably by colleagues and family members. In particular, special appreciation is extended to our good friends and close collaborators, Dr. Carlo DiClemente and Dr. Wayne Velicer, for their continuing development of the transtheoretical approach. We are indebted to Nicole Plantier and Donna Rupp for their tireless efforts in word processing the manuscript and in securing original sources. We are also grateful to the dozens of text reviewers over the years.

We are amused and strangely satisfied that reviewers occasionally find our book to be slanted toward a particular theoretical orientation—but then they cannot agree on which orientation that is! One reviewer surmised that we disliked psychoanalysis, whereas another thought we carried a psychoanalytic vision throughout the book. We take such conflicting observations as evidence that we are striking a theoretical balance.

Three groups of individuals deserve specific mention for their support over the years. First, we are grateful to the National Institutes of Health, the University of Rhode Island, and the University of Scranton for their financial support of our research. Second, we are indebted to our clients, who continue to be our ultimate teachers of psychotherapy. And third, we are appreciative of the good people at Oxford University Press, especially Sarah Harrington and Shelli Stevens, for seeing this new edition of *Systems of Psychotherapy: A Transtheoretical Analysis* to fruition.

Finally, we express our deepest appreciation to our spouses (Jan; Nancy) and to our children (Jason and Jodi; Rebecca and Jonathon), who were willing to sacrifice for the sake of our scholarship and who were available for support when we emerged from solitude. Their caring has freed us to contribute to the education of those who might one day use the powers of psychotherapy to make this a better world.

James O. Prochaska
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About the Authors
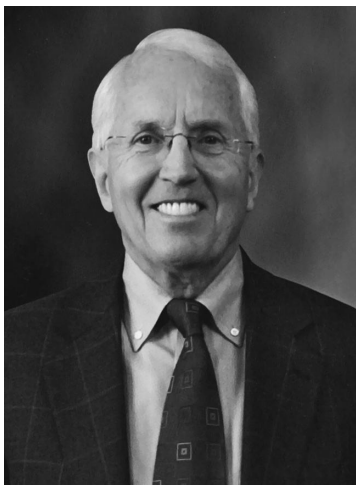
James O. Prochaska, PhD, earned his baccalaureate, master's, and doctorate in clinical psychology from Wayne State University and fulfilled his internship at the Lafayette Clinic in Detroit. At present, he is Professor of Psychology and Director of the Cancer Prevention Research Consortium at the University of Rhode Island. Dr. Prochaska has over 50 years of psychotherapy experience in a variety of settings and has been a consultant to a host of clinical and research organizations. He has been the principal investigator on grants from the National Institutes of Health totaling over $90 million and has been recognized by the Association of Psychological Science as one of the most cited authors in psychology. His 50 book chapters and over 300 scholarly articles focus on self-change, health promotion, and psychotherapy from a transtheoretical perspective, the subject of his professional book, *The Transtheoretical Approach* (with Carlo DiClemente), and his two popular self-help books, *Changing for Good* (with John Norcross and Carlo DiClemente) and

Changing to Thrive (with Janice Prochaska). An accomplished speaker, he has offered workshops and keynote addresses throughout the world and served on various task forces for the National Cancer Institute, National Institute of Mental Health, National Institute of Drug Abuse, and American Cancer Society. Among his numerous awards are the Rosalie Weiss Award from the American Psychological Association (APA), Innovators Award from the Robert Wood Johnson Foundation, Beckham Award for Excellence in Education and Inspirational Leadership from Columbia University, and the Fries Health Education Award from the Society for Public Health Education; he is the first psychologist to win a Medal of Honor for Clinical Research from the American Cancer Society. Jim makes his home in California with his wife, Jan, their two married children, and their five grandchildren.

John C. Norcross, PhD, ABPP, received his baccalaureate from Rutgers University, earned

his master's and doctorate in clinical psychology from the University of Rhode Island, and completed his internship at the Brown University School of Medicine. He is Distinguished Professor of Psychology at the University of Scranton, Adjunct Professor of Psychiatry at SUNY Upstate Medical University, and a board-certified clinical psychologist in part-time independent practice. Author of more than 400 scholarly publications, Dr. Norcross has co-written or edited 20 books, the most recent being *Psychotherapy Relationships That Work, Clinician's Guide to Evidence-Based Practices, Self-Help that Works, Leaving It at the Office: Psychotherapist Self-Care, Psychologists' Desk Reference, Handbook of Psychotherapy Integration,* and multiple editions of the *Insider's Guide to Graduate Programs in Clinical and Counseling Psychology*. He has also published two popular self-help books: *Changeology* and *Changing for Good* (the latter with Prochaska and DiClemente). He has been elected president of the APA Division of Psychotherapy, the APA Society of Clinical Psychology, and the Society for the Exploration of Psychotherapy Integration. He has also served on the editorial boards of a dozen journals and was the editor of the *Journal of Clinical Psychology: In Session* for a decade. Dr. Norcross has delivered workshops and keynotes in 30 countries. He has received numerous awards for his teaching and research, such as APA's Distinguished Contributions to Education & Training Award, Pennsylvania Professor of the Year from the Carnegie Foundation, the Rosalee Weiss Award from the American Psychological Foundation, and election to the National Academies of Practice. John lives, works, and plays in northeastern Pennsylvania with his wife, two grown children, and grandkids.

Defining and Comparing the Psychotherapies: An Integrative Framework

The field of psychotherapy has been fragmented by future shock and staggered by over-choice. We have witnessed the hyperinflation of brand-name therapies during the past sixty years. In 1959, Harper identified 36 distinct systems of psychotherapy; by 1976, Parloff discovered more than 130 therapies in the therapeutic marketplace or, perhaps more appropriately, the "jungle place." Recent estimates now put the number at over 500 and growing (Pearsall, 2011).

The proliferation of therapies has been accompanied by an avalanche of rival claims: Each system advertises itself as differentially effective and uniquely applicable. Developers of new systems usually claim 80% to 100% success, despite the absence of controlled outcome research. A healthy diversity has deteriorated into an unhealthy chaos. Students, practitioners, and patients are confronted with confusion, fragmentation, and discontent. With so many therapy systems claiming success, which theories should be studied, taught, or bought?

A book by a proponent of a particular therapy system can prove quite persuasive. We may even find ourselves using the new ideas and methods in practice while reading the book.

But when we turn to an advocate of a radically different approach, the confusion returns. Listening to proponents compare therapies does little for our confusion, except to confirm the rule that those who cannot agree on basic assumptions are often reduced to calling each other names.

We believe that fragmentation and confusion in psychotherapy can best be reduced by a comparative analysis of psychotherapy systems that highlights the many similarities across systems without blurring their essential difference.

A comparative analysis requires a firm understanding of each of the individual systems of therapy to be compared. In discussing each system, we first present a clinical example and introduce the developer(s) of the system. We trace the system's theory of personality as it leads to its theory of psychopathology and culminates in its therapeutic processes, therapeutic content, and therapy relationship. We then feature the practicalities of the psychotherapy. Following a summary of controlled research on the effectiveness of that system, we review central criticisms of that psychotherapy from diverse perspectives. Each chapter concludes with an analysis of the

same patient (Mrs. C) and a consideration of future directions.

In outline form, our examination of each psychotherapy system follows this format:

- A clinical example
- A sketch of the founder
- Theory of personality
- Theory of psychopathology
- Therapeutic processes
- Therapeutic content
- Therapeutic relationship
- Practicalities of the therapy
- Effectiveness of the therapy
- Criticisms of the therapy
- Analysis of Mrs. C
- Future directions
- Key terms
- Recommended readings
- Recommended websites

In comparing systems, we will use an integrative model to demonstrate their similarities and differences. An integrative model was selected in part because of its spirit of rapprochement, seeking what is useful and cordial in each therapy system rather than looking for what is most easily criticized. Integration also represents the mainstream of contemporary psychotherapy: Research consistently demonstrates that **integration** is the most popular orientation of mental health professionals (Norcross & Alexander, 2018).

Lacking in most integrative endeavors is a comprehensive model for thinking and working across systems. Later in this chapter, we present an integrative model that is sophisticated enough to do justice to the complexities of psychotherapy, yet simple enough to reduce confusion in the field. Rather than having to work with 500-plus theories, our integrative model assumes that a limited number of processes of change underlie contemporary systems of psychotherapy. The model further demonstrates how the content of therapy can be reduced to four different levels of personal functioning.

Psychotherapy systems are compared on the particular process, or combination of processes, used to produce change. The systems are also compared on how they conceptualize the most common problems that occur at each level of personal functioning, such as low self-esteem, lack of intimacy, and impulse dyscontrol. Because clinicians are concerned primarily with the real problems of actual patients, we do not limit our comparative analysis merely to concepts and data. Our analysis also includes a comparison of how each major system conceptualizes and treats the same complex client (Mrs. C).

We have limited our comparative analysis to 15 major systems of therapy. Systems have been omitted because they seem to be dying a natural death and are best left undisturbed, because they are so poorly developed that they have no identifiable theories of personality or psychopathology, or because they are primarily variations on themes already considered in the book. The final criterion for exclusion is empirical: No therapy system was excluded if at least 1% of American mental health professionals endorsed it as their primary theoretical orientation. Table 1.1 summarizes the self-identified theories of clinical psychologists, counseling psychologists, social workers, and counselors.

Defining Psychotherapy

An appropriate opening move in a psychotherapy textbook would be to define psychotherapy—the subject matter itself. However, no single definition of psychotherapy has won universal acceptance. Depending on one's theoretical orientation, psychotherapy can be conceptualized as interpersonal persuasion, health care, psychosocial education, professionally coached self-change, behavioral technology, a form of reparenting, the purchase of friendship, or a contemporary variant of shamanism, among others. It may be easier to practice psychotherapy than to explain or define it (London, 1986).

Our working definition of **psychotherapy** is as follows (Norcross, 1990):

Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable.

This admittedly broad definition is nonetheless a reasonably balanced one and a relatively

Table 1.1 Theoretical Orientations of Psychotherapists in the United States

Orientation	Clinical Psychologists	Counseling Psychologists	Social Workers	Counselors
Behavioral	15%	2%	11%	8%
Cognitive	31%	19%	19%	29%
Constructivist	1%	1%	2%	2%
Existential/Humanistic	1%	7%	4%	5%
Gestalt/Experiential	1%	1%	1%	2%
Integrative/Eclectic	22%	31%	26%	23%
Interpersonal	4%	8%	3%	3%
Multicultural	1%	2%	1%	1%
Psychoanalytic	3%	1%	5%	2%
Psychodynamic	15%	9%	9%	5%
Rogerian/Person-Centered	2%	3%	1%	10%
Systems	2%	4%	14%	7%
Other	2%	12%	4%	3%

Sources: Bechtoldt et al., 2001; Bike, Norcross, & Schatz, 2009; Goodyear et al., 2016; Norcross & Karpiak, 2012.

neutral one in terms of theory and method. We have, for example, not specified the number or composition of the participants, as different theories and clients call for different formats. Similarly, the training and qualifications of the psychotherapist have not been delineated. We recognize multiple processes of change and the multidimensional nature of change; no attempt is made here to delimit the methods or content of therapeutic change. The requirement that the methods be "derived from established psychological principles" is sufficiently broad to permit clinical and/or research validation.

Our definition also explicitly mentions both "clinical methods and interpersonal stances." In some therapy systems, the active change mechanism has been construed as a treatment method; in other systems, the therapy relationship has been regarded as the primary source of change. Here, the interpersonal stances and experiences of the therapist are placed on an equal footing with methods.

Finally, we firmly believe that any activity defined as psychotherapy should be conducted only for the "purpose of assisting people" toward mutually agreed-upon goals. Otherwise—though it may be labeled psychotherapy—it becomes a subtle form of coercion or punishment.

The Value of Theory

The term **theory** possesses multiple meanings. In popular usage, theory is contrasted with practice, empiricism, or certainty. In scientific circles, theory is generally defined as a set of statements used to explain the data in a given area (Marx & Goodson, 1976). In psychotherapy, a theory (or system) is a consistent perspective on human behavior, psychopathology, and the mechanisms of therapeutic change. These appear to be the necessary, but perhaps not sufficient, features of a psychotherapy theory. Explanations of personality and human development are frequently included, but, as we shall see in the behavioral, constructivist, and integrative therapies, are not characteristic of all theories.

When colleagues learn that we are revising our textbook on psychotherapy theories, they occasionally question the usefulness of theories. Why not, they ask, simply produce a text on the actual practice or accumulated facts of psychotherapy? Our response takes many forms, depending on our mood at the time, but goes something like this. One fruitful way to learn about psychotherapy is to learn what the best minds have had to say about it and to compare what they say. Further, "absolute truth" will

probably never be attained in psychotherapy, despite impressive advances in our knowledge and despite a large body of research. Instead, theory will always be with us to provide tentative approximations of "the truth."

Without a guiding theory or system of psychotherapy, clinicians would be vulnerable, directionless creatures bombarded with literally hundreds of impressions and pieces of information in a single session. Is it more urgent to ask about early memories, parent relationships, life's meaning, disturbing emotions, environmental reinforcers, recent cognitions, sexual conflicts, or something else in the first interview? At any given time, should we empathize, direct, teach, model, support, question, restructure, interpret, confront, or remain silent in a therapy session? A psychotherapy theory describes the clinical phenomena, delimits the amount of relevant information, organizes that information, and integrates it all into a coherent body of knowledge that prioritizes our conceptualization and directs our treatment.

The model of humanity embedded within a psychotherapy theory is not merely a philosophical issue for purists. It affects which human capacities will be studied and cultivated, and which will be ignored and underdeveloped. Treatments inevitably follow from the clinician's underlying conception of pathology, health, reality, and the therapeutic process (Kazdin, 1984). Systems of therapy embody different visions of life, which imply different possibilities of human existence (Messer & Winokur, 1980).

In this regard, we want to dispute the misconception that psychotherapists aligning themselves with a particular theory are unwilling to adapt their practices to the demands of the situation and the patient. A voluntary decision to label oneself an adherent of a theory does not constitute a lifetime commitment of strict adherence or dogmatic reverence (Norcross, 1985). Good clinicians are flexible, and good theories are widely applicable. Thus, we see theories being adapted for use in a variety of contexts and clinicians borrowing heavily from divergent theories. A preference for one orientation does not preclude the use of concepts or methods from another. Put another way, the primary problem is not with narrow-gauge therapists, but with

therapists who impose that narrowness onto their patients (Stricker, 1988).

Therapeutic Commonalities

Despite theoretical differences, there is a central and recognizable core of psychotherapy. This core distinguishes it from other activities—such as banking, farming, or physical therapy—and glues together variations of psychotherapy. This core is composed of **nonspecific** or **common factors** shared by all forms of psychotherapy and not specific to any one. More often than not, these therapeutic commonalities are not highlighted by theories as of central importance, but the research suggests exactly the opposite (Weinberger, 1995; Wampold & Imel, 2015).

Mental health professionals have long observed that disparate forms of psychotherapy share common elements or core features. As early as 1936, Rosenzweig, noting that all forms of psychotherapy have cures to their credit, invoked the Dodo bird verdict from *Alice in Wonderland,* "Everybody has won and all must have prizes," to characterize psychotherapy outcomes. He then proposed, as a possible explanation for roughly equivalent treatment outcomes, a number of therapeutic common factors, including psychological interpretation, catharsis, and the therapist's personality. In 1940, a meeting of prominent psychotherapists was held to ascertain areas of agreement among psychotherapy systems. The participants concurred that support, interpretation, insight, behavior change, a good relationship, and certain therapist characteristics were common features of successful psychotherapy (Watson, 1940).

If indeed the multitude of psychotherapy systems can all legitimately claim some success, then perhaps they are not as diverse as they appear at first glance. They probably share certain core features that may be the "curative" elements—those responsible for therapeutic success. To the extent that clinicians of different theories arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by their theoretical biases (Goldfried, 1980).

But, as one might expect, the common factors posited to date have been numerous and varied.

Different authors focus on different domains or levels of psychosocial treatment; as a result, diverse conceptualizations of these commonalities have emerged.

Our consideration of common factors will be guided by the results of a study (Grencavage & Norcross, 1990) that reviewed 50 publications to determine convergence among proposed therapeutic commonalities. A total of 89 commonalities were proposed. The analysis revealed the most consensual commonalities were clients' positive expectations and a facilitative relationship. In what follows, we review the therapeutic commonalities of positive expectations, the therapeutic relationship, the Hawthorne effect, and related factors.

Positive Expectations

Expectation is one of the most widely debated and heavily investigated of the common (or non-specific) variables. This commonality has been described as the "edifice complex"—the patient's faith in the institution itself, the door at the end of the pilgrimage, the confidence in the therapist and the treatment (Torrey, 1972).

A computer search yields more than 2,000 studies that have been conducted on patients' expectations of psychotherapy. The hypothesis of most of these studies is that the treatment is enhanced by the extent to which clients expect the treatment to be effective. Some critics hold that psychotherapy is not much more than a process of influence in which we induce an expectation in our clients that our treatment will cure them, and that any resulting improvement is a function of the client's expecting to improve. Surely many therapists wish on difficult days that the process were so simple!

The research evidence demonstrates that client expectations definitely contribute to therapy success, but is divided on how much (Clarkin & Levy, 2004; Constantino et al., 2011). Of the studies reporting expectation effects, most demonstrate that a high, positive expectation adds to the effectiveness of treatments. Up to one third of successful psychotherapy outcomes may be attributable to both the healer and the patient believing strongly in the effectiveness of the treatment (Roberts et al., 1993).

But psychotherapy can by no means be reduced to expectation effects alone. A sophisticated analysis of multiple outcome studies found that psychotherapy was more effective than common factors conditions, which in turn were more effective than no treatment at all (Barber, Funk, & Houston, 1988). The ranking for therapeutic success is psychotherapy, placebo, and control (do nothing or wait), respectively. In fact, psychotherapy is nearly twice as effective as **placebo** treatments, which seek to induce positive expectations in clients (Grissom, 1996).

On the basis of the research, then, we will assume that expectation is an active ingredient in all systems of therapy. Rather than the central process of change, however, a positive expectation is conceptualized as a critical precondition for therapy to continue. Most patients would not participate in a process that costs them dearly in time, money, and energy if they did not expect the process to help them. For clients to cooperate in being desensitized, hypnotized, or analyzed, it seems reasonable that they would expect some return on their investment. It is also our working assumption that therapists consciously strive to cultivate hope and enhance positive expectancies. Psychotherapy research need not demonstrate that treatment operates free from such common factors. Rather, the task is to demonstrate that specific treatments considered to carry the burden of client change go beyond the results that can be obtained by credibility alone.

Therapeutic Relationship

Psychotherapy is at root an interpersonal relationship. The single greatest area of convergence among psychotherapists, in their nominations of common factors (Grencavage & Norcross, 1990) and in their treatment recommendations (Norcross, Saltzman, & Guinta, 1990), is the development of a strong therapeutic alliance.

This most robust of common factors has consistently emerged as one of the major determinants of psychotherapy success. Across various types of psychotherapy, at least 15% of psychotherapy outcome—why patients improve in psychotherapy—is due to the therapeutic relationship (Norcross & Lambert, 2018). To summarize the conclusions of an exhaustive review of the psychotherapy outcome literature (Bergin

& Lambert, 1978): The largest variation in therapy outcome is accounted for by preexisting client factors, such as expectations for change and severity of the disorder. The therapeutic relationship accounted for the second largest proportion of change, with the particular treatment method coming in third.

Still, the relative power of the therapeutic relationship remains controversial. At one end of the continuum, some psychotherapy systems, such as the radical behavior therapies, view the relationship between client[1] and therapist as exerting little influence; the client change in therapy could just as readily occur with only an interactive computer program, without the therapist's presence. For these therapy systems, a human clinician is included for practical reasons only, because our technology in programming therapeutic processes is not developed fully enough to allow the therapist to be absent.

Toward the middle of the continuum, some therapy schools, such as cognitive therapies, view the relationship between clinician and client as one of the preconditions necessary for therapy to proceed. From this point of view, the client must trust and collaborate with the therapist before participating in the process of change.

At the other end of the continuum, Rogers' person-centered therapy considers the relationship as *the* essential process that produces change. Because Carl Rogers (1957) has been most articulate in describing what he believes are the necessary conditions for a therapeutic relationship, let us briefly outline his criteria so that we can use these for comparing systems on the nature of the therapeutic relationship.

1. The therapist must relate in a genuine manner.
2. The therapist must relate with unconditional positive regard.
3. The therapist must relate with accurate empathy.

These—and only these—conditions are necessary and sufficient for positive outcome, according to Rogers.

Then there are those psychotherapy systems, such as psychoanalysis, that see the relationship between therapist and patient primarily as the source of content to be examined in therapy. In this view, the relationship is important because it brings the content of therapy (the patient's interpersonal behavior) right into the consulting room. The content that needs to be changed thus occurs during therapy, rather than the person focusing on issues that occur outside of the consulting room.

In light of these various emphases on the role of the therapeutic relationship, it will be necessary to determine for each therapy system whether the relationship is conceived as (1) a precondition for change, (2) a process of change, and/or (3) a content to be changed. Moreover, in each chapter that follows, we will consider the relative contribution of the therapeutic relationship to treatment success, as well as the therapist behaviors designed to facilitate that relationship.

Hawthorne Effect

Psychologists have known for years that many people can improve in such behaviors as work output solely as a result of having special attention paid to them. In the classic Hawthorne studies (Roethilsberger & Dickson, 1939) on the effects of improved lighting on productivity in a factory, participants increased their output by being observed in a study and receiving extra attention. Usually such improvement is assumed to be due to increases in morale, novelty, and esteem that people experience from having others attend to them—a phenomenon that has come to be known as the **Hawthorne effect**.

One commonality among all psychosocial treatments is that the therapist pays special attention to the client. Consequently, attention has been assumed to be one of the common factors that impact the success of therapy. Anyone who has been in psychotherapy can appreciate the gratification that comes from having a competent professional's undivided attention for an hour. This special attention may indeed influence the course of therapy—including those occasional cases in which patients do not improve because they do not want to surrender such special attention.

Researchers have frequently found that attention does indeed lead to improvement, regardless of whether the attention is followed by any other therapeutic processes. In a classic study (Paul, 1967), 50% of public-speaking phobics demonstrated marked improvement in their

symptoms by virtue of receiving an attention placebo intended to control for nonspecific variables such as attention. (In psychotherapy studies, a placebo control group receives a "treatment" that mimics the amount of time and attention received by the psychotherapy group but that does not have a specific or intended effect.) Years of research demonstrate that attention can be a powerful common factor in therapy.

To conclude that any particular psychotherapy is more effective than an attention placebo, it is necessary that research include controls for attention effects or simply the passage of time. It is not enough to demonstrate a particular therapy is better than no treatment, because the improvement from that particular therapy may be due entirely to the attention given to the patients.

Several research designs are available to measure or control for the effects of attention in psychotherapy. The most popular design is to use placebo groups, as in Paul's study, in which control participants were given as much attention as clients in therapy but did not participate in processes designed to produce change. An alternative design is to compare the effectiveness of one treatment with that of another, such as psychodynamic therapy with cognitive therapy. If one therapeutic approach does better than the other, we can conclude that the differential improvement is due to more than just attention, because the less effective treatment included— and therefore controlled for—the effects of attention. However, we do not know whether the less effective therapy is anything other than a placebo effect, even if it leads to greater improvement than no treatment. Finally, in such comparative studies, if both therapies lead to significant improvement, but neither therapy does better than the other, we cannot conclude that the therapies are anything more than Hawthorne effects, unless an attention placebo control has also been included in the study. To be considered a controlled evaluation of a psychotherapy's efficacy, studies must include controls for the Hawthorne effect and related factors.

Other Commonalities

In his classic *Persuasion and Healing*, Jerome Frank (1961; Frank & Frank, 1991) posited that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing. The features that distinguish psychotherapies from each other, however, receive special emphasis in the pluralistic, competitive American society. Because the prestige and financial security of psychotherapists hinge on their showing that their particular system is more successful than that of their rivals, little glory has traditionally been accorded to the identification of shared or common components.

Frank argues that therapeutic change is predominantly a function of common factors: an emotionally charged, confiding relationship; a healing setting; a rationale or conceptual scheme; and a therapeutic ritual. Other consensual commonalities include an inspiring and socially sanctioned therapist; opportunity for catharsis; acquisition and practice of new behaviors; exploration of the "inner world" of the patient; suggestion; and interpersonal learning (Grencavage & Norcross, 1990). Most researchers now conclude that features shared by all therapies account for an appreciable amount of observed improvement in clients. So powerful are these therapeutic commonalities that some clinicians have proposed explicitly common factors or principles therapies (which we consider in our chapter on Integrative Therapies).

Specific Factors

At the same time, common-factors theorists recognize the value of unique—or specific— factors in disparate psychotherapies. A psychotherapist cannot practice nonspecifically; specific techniques and relationships fill the treatment hour. Indeed, research has demonstrated the differential effectiveness of a few therapies with specific disorders, such as exposure therapies for severe anxiety disorders, parent management training for conduct problems, and systemic therapy for couple conflicts. As a discipline, psychotherapy will advance by integrating the power of common factors with the pragmatics of **specific factors**. We now turn to the processes of change—the relatively specific or unique contributions of a therapy system.

Processes of Change

There exists, as we said earlier in this chapter, an expanding morass of psychotherapy theories and an endless proliferation of specific techniques. Consider the relatively simple case of smoking cessation: In one of our early studies, we identified more than 50 formal treatments employed by health professionals and 130 different techniques used by successful self-changers to stop smoking. Is there no smaller and more intelligible framework by which to examine and compare the psychotherapies?

The **transtheoretical**—across theories—model reduces the therapeutic morass to a manageable number of change processes. There are literally hundreds of global theories of psychotherapy, and we will probably never reach common ground in the theoretical or philosophical realm. There are thousands of specific techniques in psychotherapy, and we will rarely agree on the specific, moment-to-moment methods to use. By contrast, the **processes of change** represent a middle level of abstraction between global theories (such as psychoanalysis, cognitive, and humanistic) and specific techniques (such as dream analysis, progressive muscle relaxation, and family sculpting). Table 1.2 illustrates this intermediate level of abstraction represented by the processes of change.

It is at this intermediate level of analysis—processes or principles of change—that meaningful points of convergence and contention may be found among psychotherapy systems. It is also at this intermediate level that expert psychotherapists typically formulate their treatment plans—not in terms of global theories or specific techniques—but as change processes for their clients.

Processes of change are the covert and overt activities that people use to alter emotions, thoughts, behaviors, or relationships related to a particular problem or more general patterns of living. In fewer words, the processes are how people change, within psychotherapy and between therapy sessions. These processes were derived theoretically from a comparative analysis of the leading systems of psychotherapy (Prochaska, 1979) and were confirmed empirically by multiple studies (summarized in Chapter 17). In the following sections, we introduce these processes of change.

Consciousness Raising

Traditionally, increasing an individual's consciousness has been one of the prime change processes in psychotherapy. **Consciousness raising** sounds contemporary, yet therapists from a variety of persuasions have been working for decades to increase the consciousness of clients. Beginning with Freud's objective "to make the unconscious conscious," all so-called insight psychotherapies begin by working to raise the individual's level of awareness. It is fitting that the **insight** or **awareness therapies** work with consciousness, which is frequently viewed as a human characteristic that emerged with the evolution of language.

With language and consciousness, humans do not need to respond reflexively to every stimulus. For example, the mechanical energy from a hand hitting against our back does not cause us to react with movement. Instead, we respond thoughtfully to the information contained in that touch, such as whether the hand touching us is a friend patting us on the back, a thief grabbing us, or a partner hitting us. To respond effectively, we process information to guide us in making a response appropriate to the situation. Consciousness-raising therapies increase the information available to individuals so they can make the most effective responses to life.

For each of these processes, the psychotherapist's focus can be on producing change either in

Table 1.2 Levels of Abstraction

Level	Abstraction	Examples
High	Global theories	Psychodynamic, Gestalt, behavioral
Medium	Change processes	Consciousness raising, counterconditioning
Low	Clinical techniques	Interpretation, two-chair technique, self-monitoring

the individual's experience or in the individual's environment. When the information given a client concerns the individual's own actions and experiences, we call that **feedback**. An example of the feedback process occurred in the case of a stern and proper middle-aged woman who was unaware of just how angry she appeared to others. She could not connect her children's avoidance of her or her recent rash of automobile accidents with rage, because she kept insisting that she was not angry. After viewing videotapes of herself interacting with members of a psychotherapy group, however, she was stunned. All she could say was, "My God, how angry I seem to be!"[2]

When the information given a client concerns environmental events, we call this **education**. An example of therapeutic movement due to education happened in the case of an aging man who was distressed that his time to attain erections and reach orgasms had increased noticeably over the years. He was very relieved when he learned that such a delay was normal in older men.

Defenses ward off threatening information about ourselves in response to education and feedback. These defense mechanisms are like blinders or "rose-colored glasses" that selectively attend only to positive information and ignore negative input. Cognitive blinders prevent individuals from increasing their consciousness without feedback or education from an outside party.

For example, my (JOP's) wife, who is also a psychotherapist, confronted me with the following information that made me aware of my blinders: We were trying to anticipate who would be on each other's list of sexually attractive individuals. I was absolutely sure that my first three guesses would be high on my wife's list. When I said a friend's name, my wife laughed and said that she knew I always thought that, but she wasn't attracted to him. She also said that she was now certain that his wife was on my list. My next two guesses were also wrong, but my wife quickly and correctly guessed that I found their wives attractive. I was amazed to realize how much I had been projecting over the years and how my projection kept me from being aware of the qualities in men that my wife found appealing.

How can our awareness lead to behavior change? Think of our consciousness as a beam of light. The information unavailable to us is like a darkness in which we can be lost, held back, or directed without knowing the source of the influence. In the darkness, we are blind; we do not possess sufficient sight or light to guide us effectively in our lives. For example, without being aware of how aging normally affects sexual response, an aging man (or woman) would not know whether the best direction would be to admit he (or she) was over the hill and give up on sex, to eat two raw oysters a day as an aphrodisiac, to take Viagra, or to enjoy his or her present behavior without living up to some media stereotype of sexuality.

As we will see, many psychotherapy systems agree that people can change as a result of raised consciousness—increasing experiential or environmental information previously unavailable to them. The disagreement among these consciousness-raising psychotherapies lies in which concrete techniques are most effective in doing so.

Catharsis

Catharsis has one of the longest traditions as a change process and refers to the therapeutic release of pent-up feelings. The ancient Greeks believed that expressing emotions was a superb mechanism of providing personal relief and behavioral improvement. Human suffering was, quite literally, let out. In contemporary terms, it's "Let it go, let it go, can't hold it back anymore" as sung in in the Disney film *Frozen*.

Historically, catharsis used a hydraulic model of emotions, in which unacceptable emotions—such as anger, guilt, or anxiety—are blocked from direct expression. The damming off of such emotions results in their pressure seeking release, however indirect, as when anger is expressed somatically through headaches. If emotions can be released more directly in psychotherapy, then their reservoir of energy is discharged, and the person is freed from a source of symptoms.

In a different analogy, the patient with blocked emotions is seen as emotionally constipated. What these patients need to release is a good, emotional bowel movement. In this analogy, psychotherapy serves as a psychological

enema that enables patients to purge their emotional blockage. The therapeutic process is aimed at helping patients break through their emotional blocks. By expressing the dark side of themselves in the presence of another, clients can better accept such emotions as natural phenomena that need not be so severely controlled in the future.

Most often, this therapeutic process has been at the level of individual experience, in which the cathartic reactions occur directly within the person. We shall call this form of catharsis **corrective emotional experiences**. As the term suggests, an intense emotional experience produces a psychological correction.

A fellow clinician related a cathartic experience several years ago when she was fighting off a bout of depression. She was struggling to get in touch with the source of her depression, so she took a mental health day off from work. Alone at home, she put on music and expressed her feelings in a free form of dance that she could perform only when no one else was present. After some releasing movements, she experienced childhood rage toward her mother for always being on her back. She soon let herself express her intense anger by tearing her blouse to shreds. By the time her partner arrived home, she felt relieved and released, although her partner, looking at the destroyed blouse, wondered aloud whether she had flipped.

The belief that cathartic reactions can be evoked by observing emotional scenes in the environment dates back at least to Aristotle's writings on theater and music. In honor of this tradition, we will call this source of catharsis **dramatic relief**.

A patient suffering from headaches, insomnia, and other symptoms of depression found himself weeping heavily during Ingmar Bergman's movie *Scenes from a Marriage*. He began to experience how disappointed he was in himself for having traded a satisfying marriage for security. His depression began to lift because of the inspiration he felt from Bergman to leave his hopelessly devitalized marriage.

Choosing

The power of choice in producing behavior change has been in the background of many psychotherapy systems. The concept of **choosing** has lacked respectability in the highly deterministic worldview of most scientists. Many clinicians have not wanted to provide ammunition for their critics' accusations of tendermindedness by openly discussing freedom and choice. Consequently, we will see that many therapy systems implicitly assume that clients will choose to change as a result of psychological treatment but do not articulate the means by which clients use the process of choosing.

With so little open consideration of choosing as a change process (with the exception of existential and experiential therapists), it is predictably difficult to pinpoint how choice operates in psychotherapy. Some theorists argue choice is irreducible, because to reduce choice to other events is to advance the paradox that such events determine our choices. Human action is seen as freely chosen, and to say that anything else determines our choice is to show bad faith in ourselves as free beings. Few clinicians, however, accept such a radical view of freedom for their clients; they believe that many conditions limit choice.

From a behavioral perspective, choice would be a partial function of the number of alternative responses available. If only one response is available, there is no choice. From a humanistic perspective, the number of available responses can radically increase if we become more conscious of alternatives that we have not previously considered. For a variety of psychotherapy systems, then, an increase in choice is thought to result from an increase in consciousness.

The freedom to choose has traditionally been construed as a uniquely human behavior made possible by the acquisition of consciousness that accompanies the development of language. Responsibility is the burden that accompanies the awareness that we are the ones able to respond, to speak for ourselves. Insofar that choice and responsibility are possible through language and consciousness, it seems only natural that the therapeutic process of choosing is a verbal or awareness process.

The easiest choices follow from accurate information processing that entails an awareness of the consequences of particular alternatives. If a menopausal woman were informed, for example, that hormone replacement therapy

(HRT) eventually caused cancer in all women, then her best alternative would be to follow the information she has just processed. With HRT, however, as with so many life decisions, we are not aware of all the consequences of choice, and the consequences are rarely absolute. In these situations, there are no definitive external guidelines, and we are confronted with the possibility of choosing an alternative that might prove a serious mistake. Then our ability to choose is more clearly a function of our ability to accept the anxiety inherent in accepting responsibility for our future.

An example of so-called existential anxiety was seen in a college student who consulted me about the panic attacks she was experiencing since she informed her parents of her unplanned pregnancy. They insisted that she get an abortion, but she and her husband wanted to have the baby. They were both students, and entirely dependent on her wealthy parents for financial support. Her parents had informed her that the consequence of having a baby at this time would be disinheritance, because they believed she would not finish college once she had a baby. In 21 years she had never openly differed with her parents, and although she was controlled by them, she had felt protected by them as well. Now, after a few psychotherapy sessions, she became more aware that her panic attacks reflected her need to choose. Her basic choice was not whether she was going to sacrifice her fetus to her family's fortune, but whether she was going to continue to sacrifice herself.

At an experiential level, then, choosing involves becoming aware of new alternatives, including the deliberate creation of new alternatives for living. This process also involves experiencing the anxiety inherent in being responsible for the choice. We will call this experiential level of choosing a move toward **self-liberation**.

When changes in the environment make more alternatives available to individuals, such as more jobs being open to gays and lesbians, we will call this a move toward **social liberation**. Psychotherapists working for such social changes are usually called advocates.

With the exception of feminist and multicultural theories, systems of psychotherapy rarely embrace social liberation as a change process with clients in a formal way. Psychotherapy generally targets change in an individual, a couple, or a family, not an entire society. Nonetheless, most psychotherapists do in fact advocate personally for broader systemic changes in, for example, access to mental health care, improved social justice, and broader human rights (Kottler et al., 2013). We limit ourselves in this text to those psychotherapy systems that use social liberation as part of their change process and treatment contract directly with patients.

Conditional Stimuli

At the opposite extreme from changing through choosing is changing by modifying the conditional stimuli that control our responses. Alterations in conditional stimuli are indicated when the individual's behavior is elicited by classical (Pavlovian) conditioning. When troublesome responses are conditioned, then being conscious of the stimuli will rarely produce change, nor can conditioning be overcome just by choosing to change. We need, literally, to change the environment or the behavior.

Again, either we can modify the way we behave in response to particular stimuli, or we can modify the environment to minimize the probability of the stimuli occurring. Changing our behavior to the stimuli is known as **counterconditioning**, whereas changing the environment involves **stimulus control**.

Counterconditioning was used in the treatment of a woman with a penetration phobia who responded to intercourse with involuntary muscle spasms. This condition, known as vaginismus, prevented penetration. She did not want to modify her environment, but rather to change her response to her partner. As in most counterconditioning cases, the procedure involved a gradual approach to the conditioned stimulus of intercourse while learning an incompatible response. She learned relaxation, which was incompatible with the undesired anxiety and muscle spasms that had previously been elicited by intercourse. Counterconditioning is learning to do the healthy opposite—relaxation instead of anxiety, assertion instead of passivity, exposure instead of avoidance, for example.

Stimulus control entails restructuring the environment to reduce the probability that a particular conditional stimulus will occur.

A high-strung college student suffered from a host of anxiety symptoms, including considerable distress when driving his car. Whenever the car began to shake in the slightest, the student would also begin to shake. He attributed this problem to a frightening episode earlier in the year, when the universal joint on his car broke with a startling noise. Not once but three times it broke before a mechanic discovered that the real cause was a bent drive shaft. Because the problem proved a function of conditioning, counterconditioning was deemed the treatment of choice. Before the treatment was under way, however, the student traded in his car for a van. Because his anxiety response did not generalize to his van, he solved his problem through his own stimulus control procedure. Eliminating or avoiding environmental cues that provoke the problem behavior is the core of stimulus control.

Contingency Control

Axiomatic for many behavior therapists is that behavior is controlled by its consequences. As most of us have learned, if a response is reinforced, then the probability of that response is increased. If, on the other hand, a punishment follows a particular response, then we are less likely to emit that response. As B. F. Skinner demonstrated, changing the contingencies governing our behavior frequently leads to changed behavior. The extent to which a particular reinforcer or punisher controls behavior is a function of many variables, including the immediacy, saliency, and schedule of the consequences. From humanistic and cognitive points of view, an individual's valuing of the consequences is also important in contingency control.

If behavior changes are made by modifying the contingencies in the environment, we call this **contingency management**. Desirable, healthy behaviors are followed by reinforcement; in select cases, undesirable, pathological behaviors are followed by punishment.

For example, a graduate student with a bashful bladder wanted to increase his use of public restrooms; he also wanted more money to improve his style of living. Therefore, he made a contingency contract with me (JOP) that earned him two dollars for each time during the week

he urinated in a public restroom. I am pleased to say that I lost money on that case.

Seldom have behavior therapists considered the alternative, but there are effective means to modify our behavior without changing the consequences themselves. Modifying our internal responses to external consequences without changing those consequences will be called **reevaluation**.

A pathologically shy man desired a relationship with a woman but avoided asking anyone out because of his anticipation that he would be rejected. After several intensive discussions in psychotherapy, he began to accept that when a woman turns down a date, it is a statement about her and not about him. We do not know whether she is waiting for someone else to ask her out, whether she doesn't like mustaches, whether she is in a committed relationship, or whether she doesn't know him well enough—we simply don't know what her saying no says about *him*. After reevaluating how he would interpret being turned down for a date, the fellow began asking out women, even though he was rejected on his first request for a date. The external consequences of his behavior were the same, but he reevaluated their personal meaning. That's the hallmark of cognitive therapies: Change your thinking and thereby change your behavior.

Initial Integration of Processes of Change

A summary of these change processes is presented in Table 1.3. The processes of consciousness raising, catharsis, and choosing represent the heart of the traditional insight or **awareness psychotherapies**, including the psychoanalytic, existential, and humanistic traditions. These psychotherapy systems focus primarily on the subjective aspects of the individual—the processes occurring within the skin of the human. This perspective on the individual finds greater potential for inner-directed changes that can counteract the external pressures from the environment.

The processes of conditional stimuli and contingency control represent the core of **action therapies**, including those in the behavioral, cognitive, and systemic traditions. These psychotherapy systems focus primarily on the external and environmental forces that set limits

Table 1.3 Change Processes at Experiential and Environmental Levels

Awareness or Insight Therapies	Action or Behavioral Therapies
Consciousness raising	**Conditional stimuli**
Experiential level: feedback	Experiential level: counterconditioning
Environmental level: education	Environmental level: stimulus control
Catharsis	**Contingency control**
Experiential level: corrective emotional experiences	Experiential level: reevaluation
Environmental level: dramatic relief	Environmental level: contingency management
Choosing	
Experiential level: self-liberation	
Environmental level: social liberation	

on the individual's potential for inner-directed change. These processes are what the existentialists would call the more objective level of the person.

Our integrative, transtheoretical model suggests that to focus only on the awareness processes of consciousness, catharsis, and choice is to act as if inner-directedness is the whole picture and to ignore the genuine limits the environment places on individual change. On the other hand, the action emphasis on the more objective, environmental processes seriously ignores our potential for inner, subjective change.

An integrative model posits that a synthesis of both awareness and action processes provides more balanced and effective psychotherapy that moves along the continuous dimensions of inner to outer control, subjective to objective functioning, and self-initiated to environmental-induced changes. Integrating the change processes affords a more complete picture of humans by accepting our potential for inner change while recognizing the limits imposed by environments and contingencies. In Chapter 17, we will summarize the research evidence for these processes of change and our transtheoretical model.

Before completing our discussion of the processes of change, we offer two additional comments about them. First, please do not confuse the change processes with components of specific therapy systems. Consciousness raising, contingency control, and the other processes are not methods suggested by specific theories. Rather, they are generic change strategies that cut across many theories. Second, the names of many of the change processes are probably new to you. But rest assured that you will become familiar and comfortable with them as you move through the remainder of the book.

Therapeutic Content

The processes of change are the distinctive contributions of a system of psychotherapy. The content to be changed in a particular therapy system is largely a carryover from that system's theory of personality and psychopathology. Many books purportedly focusing on psychotherapy frequently confuse content and process. They wind up examining the content of therapy, with little explanation about the change processes. As a consequence, they are actually books on theories of personality rather than theories of psychotherapy.

The distinction between process and content in psychotherapy is fundamental. As we shall see, psychotherapy systems without theories of personality are primarily process theories and have few predetermined concepts about the content of therapy. Behavioral, integrative, systemic, and solution-focused theories attempt to capitalize on the unique aspects of each case by restricting the imposition of formal content (Held, 1991). Other systems, such as Adlerian, existential, and culture-sensitive therapies, which adopt change processes from other therapy systems, primarily address the content of therapy. Many systems of therapy differ primarily in their content, while agreeing on the change processes.

Put differently, theories of personality and psychopathology tell us *what* needs to be changed; theories of process tell us *how* change occurs.

Because psychotherapy systems espouse many more differences regarding the content of therapy, it proves more difficult to bring order and integration to this fragmented field. A refreshing guide is Maddi's (1996) comparative model for personality theories. We have adapted parts of Maddi's model in synthesizing and prioritizing the vast array of content—the what—in psychotherapy.

Most therapy systems assume a conflict view of personality and psychopathology. Some conflict-oriented systems believe psychopathology results from conflicts within the individual. For these, we shall use the term *intrapersonal conflicts*, indicating that the competing forces exist within the person, such as a conflict between desires to be independent and fears of leaving home. Other therapy systems focus on *interpersonal conflicts*, such as chronic disagreements between a woman who likes to save money and a man who likes to spend money. Another group of therapies focuses primarily on the conflicts that occur between an individual and society. We shall call these *individuo-social conflicts*; an example is the tension between living an openly gay life and the fear of ostracism that may result from homophobia. Finally, an increasing number of therapies are concerned with helping individuals go *beyond conflict to attain fulfillment*.

In our integrative model, we assume that patients' dysfunctions emanate from conflicts at different levels of personality functioning. Some patients express intrapersonal conflicts, others evidence interpersonal conflicts, and still others are in conflict with society. Some clients have resolved their principal conflicts and turn to psychotherapy with questions as to how they can best create a more fulfilling existence.

Because patients are troubled at different levels of functioning, we will compare the psychotherapy systems in how they conceptualize and treat typical problems at each level of conflict. At the intrapersonal level, we will examine how each therapy system addresses conflicts over anxiety and defenses, self-esteem, and personal responsibility. At the interpersonal level, we will consider problems with intimacy and sexuality,

communication, hostility, and interpersonal control. At the individuo-social level, we will compare their perspectives on adjustment versus transcendence and impulse control. At the level of transcending conflicts to fulfillment, we will examine the ultimate questions of meaning in life and the ideal person that would emerge from successful psychotherapy. Table 1.4 summarizes the **therapeutic content** occurring at different levels of personality.

Honest differences abound over whether particular problems—such as addictive, mood, and relationship disorders—are most profitably conceptualized as intra-or interpersonal conflicts. Thus, we expect disagreement over our assignment of problems to a particular level of personality functioning.

Any viable theory of personality can reduce all psychopathology to a single level of functioning that the theory assumes to be critical. For example, an intrapersonal theory can marshal a convincing case that sexual disorders are primarily due to conflicts within individuals, such as conflicts between sexual desires and performance anxieties. By contrast, an individuo-social theory could summon a coherent argument that sexual disorders are primarily due to the inevitable

Table 1.4 Therapeutic Content at Different Levels of Personality

1. Intrapersonal conflicts
    a. Anxieties and defenses
    b. Self-esteem problems
    c. Personal responsibility

2. Interpersonal conflicts
    a. Intimacy and sexuality
    b. Communication
    c. Hostility
    d. Control of others

3. Individuo-social conflicts
    a. Adjustment versus transcendence
    b. Impulse control

4. Beyond conflict to fulfillment
    a. Meaning in life
    b. The ideal person

tensions between an individual's sexual desires and society's sexual prohibitions. Our integrative assumption is that a comparative analysis of psychotherapies will demonstrate that particular systems have been especially effective in conceptualizing and treating problems related to their level of personality theory.

In comparing psychotherapy systems, we will discover that a theory's level of personality will largely dictate the number of people in the consulting room and the focus of the therapeutic transaction. If a theory focuses on intrapersonal functioning, then the therapy is much more likely to work solely with the individual, because the basic problem is assumed to lie within the individual. If, by contrast, a theory concentrates on interpersonal functioning, then it is more likely to involve two or more persons in conflict, such as a couple or family members.

Psychotherapies focusing on individuo-social conflicts will work to change the client, if the therapist's values are on the side of mainstream society. For example, in working with a pedophile who experiences no inner conflict over having sexual relations with children, a therapist will try to change the client, in that the therapist's values converge with society's values that such sexual behavior is unacceptable. However, if the therapist's values are on the side of the individual in a particular conflict, such as a Hispanic/Latino wanting to freely express his ethnicity in a White-dominated workplace, then a therapist is far more likely to work for the client and to support movements that are transforming society. In comparing psychotherapy systems, then, we will examine which level of personality functioning is emphasized and whether such an emphasis leads to working primarily with an individual, with two or more people together, or with groups seeking to alter society.

THE CASE OF MRS. C

Psychotherapy systems are not merely static combinations of change processes, theoretical contents, and research studies. The systems are, first and foremost, concerned with serious disorders afflicting fellow humans. In comparing systems, it is essential to picture how the psychotherapies conceptualize and treat the presenting problems of an actual client. The client selected for comparative purposes is Mrs. C.

Mrs. C is a 47-year-old mother of six children: Arlene, 17; Barry, 15; Charles, 13; Debra, 11; Ellen, 9; and Frederick, 7. Without reading further, an astute observer might discern Mrs. C's personality configuration. The orderliness of children named alphabetically and of childbirths every 2 years are consistent with obsessive-compulsive disorder (OCD).

For the past 10 years, Mrs. C has been plagued by compulsive washing. Her baseline charts, in which she recorded her behavior each day before treatment began, indicated that she washed her hands 25 to 30 times a day, 5 to 10 minutes at a time. Her daily morning shower lasted about 2 hours with rituals involving each part of her body, beginning with her rectum. If she lost track of where she was in her ritual, then she would have to start all over. A couple of times this had resulted in her husband, George, going off to work while his wife was in the shower only to return 8 hours later to find her still involved in the lengthy ritual.

To avoid extended showers, George had begun helping his wife keep track of her ritual, so that at times she would yell out, "Which arm, George?" and he would yell back, "Left arm, Martha." His participation in the shower ritual required George to rise at 5:00 A.M. in order to have his wife out of the shower before he left for work at 7:00 A.M. After 2 years of this schedule, George was ready to explode.

George was, understandably, becoming increasingly impatient with many of his wife's related symptoms. She would not let anyone wear a pair of underwear more than once and often wouldn't even let these underwear be washed. There were piles of dirty underwear in each bedroom corner. When we asked her husband to gather up the underwear for the laundry, we asked him to count them, but he quit counting after the thousandth pair. He was depressed

to realize that he had more than $2,000 invested in once-worn underwear.

Other objects were scattered around the house because a fork or a can of food dropped on the floor could not be retrieved in Mrs. C's presence. She felt it was contaminated. Mrs. C had been doing no housework—no cooking, cleaning, or washing—for years. One of her children described the house as a "state dump," and my (JOP) visit to the home confirmed this impression.

Mrs. C did work part-time. What would be a likely job for her? Something to do with washing, of course. In fact, she was a dental technician, which involved washing and sterilizing all of the dentist's equipment.

As if these were not sufficient concerns, Mrs. C had become unappealing in appearance. She had not purchased new clothes in 7 years, and her existing clothes were becoming ragged. Never in her life had she been to a beautician and now she seldom combed her own hair. Her incessant washing of her body and hair led to a presentation somewhere between a prune and a boiled lobster with the frizzies.

Mrs. C's washing ritual also entailed walking around the house nude from the waist up as she went from her bedroom bath to the downstairs bath to complete her washing. This was especially upsetting to Mr. C because of the embarrassment it was producing in their teenage sons. The children were also upset by Mrs. C's frequent nagging to wash their hands and change their underwear, and she would not allow them to entertain friends in the house.

Consistent with OCD features, Mrs. C was a hoarder: she had two closets filled with hundreds of towels and sheets, dozens of unused earrings, and her entire wardrobe from the past 20 years. She did not consider this hoarding a problem because it was a family characteristic, which she believed she inherited from her mother and from her mother's mother.

Mrs. C also suffered from a sexual arousal disorder; in common parlance, she was "frigid." She said she had never been sexually excited in her life, but at least for the first 13 years of her marriage she engaged in sexual relations to satisfy her husband. However, in the past 2 years they had had intercourse just twice, because sex had become increasingly unpleasant for her.

To complete the list, Mrs. C was clinically depressed. She had made a suicide gesture by swallowing a bottle of aspirin since she had an inkling that her psychotherapist was giving up on her and her husband was probably going to commit her to a psychiatric hospital.

Mrs. C's compulsive rituals revolved around an obsession with pinworms. Her oldest daughter had come home with pinworms 10 years earlier during a severe flu epidemic. Mrs. C had to care for a sick family while pregnant, sick with the flu herself, and caring for a demanding 1-year-old child. Her physician told her that, to avoid having the pinworms spread throughout the family, Mrs. C would need to be extremely careful about the children's underwear, clothes, and sheets and that she should boil all of these articles to kill any pinworm eggs. Mr. C confirmed that both she and her husband were rather anxious about a pinworm epidemic in the home and were both preoccupied with cleanliness during this time. However, Mrs. C's preoccupation with cleanliness and pinworms continued even after it was confirmed that her daughter's pinworms were eliminated.

The C couple acknowledged a relatively good marriage before the pinworm episode. They had both wanted a sizable family, and Mr. C's income as a business executive had allowed them to afford a large family and comfortable home without financial strain. During the first 13 years of their marriage, Mrs. C had demonstrated some of her obsessive-compulsive traits, but never to such a degree that Mr. C considered them a problem. Mr. C and the older children recalled many happy times with Mrs. C, and they kept alive the warmth and love

that they had once shared with this now preoccupied person.

Mrs. C hailed from a strict, authoritarian, and sexually repressed Catholic family. She was the middle of three girls, all of whom were dominated by a father who was 6 feet, 4 inches tall and weighed 250 pounds. When Mrs. C was a teenager, her father would wait up for her after dates to question her about what she had done; he once went so far as to follow her on a date. He tolerated absolutely no expression of anger, especially toward himself, and when she would try to explain her point of view politely, he would often tell her to shut up. Mrs. C's mother was a cold, compulsive woman who repeatedly regaled her daughters about her disgust with sex. She also frequently warned her daughters about diseases and the centrality of cleanliness.

In developing a psychotherapy plan for Mrs. C, one of the differential diagnostic questions was whether Mrs. C was plagued with a severe obsessive-compulsive disorder or whether her symptoms were masking a latent schizophrenic process. A full battery of psychological testing was completed, and the test results were consistent with those from previous evaluations that had found no evidence of a thought disorder or other signs of psychotic processes.

Mrs. C had previously undergone a total of 6 years of mental health treatment, and throughout that time the clinicians had uniformly considered her problems to be severe but nonpsychotic in nature. The only time schizophrenia was offered as a diagnosis was after some extensive individual psychotherapy failed to lead to any improvement. The consensus in our clinic was that Mrs. C was demonstrating severe OCD that was going to be extremely difficult to treat.

At the end of the following chapters, we will see how each of the psychotherapy systems might explain Mrs. C's problems and how their treatment might help her to overcome these devastating preoccupations.

Key Terms

action therapies
awareness (insight) therapies
catharsis
choosing
common (nonspecific) factors
consciousness raising
contingency management
corrective emotional experiences
counterconditioning
dramatic relief
education
expectations
feedback
Hawthorne effect
integration
placebo
processes of change
psychotherapy
reevaluation
self-liberation
social liberation
specific factors
stimulus control
therapeutic content
theory
transtheoretical

Notes

1. We will employ the terms *client* and *patient* interchangeably throughout this textbook because neither satisfactorily describes the therapy relationship and because we wish to remain theoretically neutral on this quarrelsome point.

2. In the case of this woman, as with so many clients, we cannot demonstrate that our conceptualization of the person's problems is, in fact, accurate or "real." We cannot, for example, demonstrate in an empirical manner that this woman's problems were due to angry feelings outside of her awareness. Nevertheless, it is still useful in psychotherapy to make provisional formulations about the origins of a client's problems. As case illustrations are presented throughout this book, they will be described in the manner that we found most helpful for the purposes of treatment, without assuming some ultimate validity of the clinical interpretations.

Recommended Readings

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Journals

American Journal of Orthopsychiatry; American Journal of Psychiatry; American Journal of Psychotherapy; Archives of General Psychiatry; Brief Treatment and Crisis Intervention; British Journal of Psychotherapy; Clinical Case Studies; Clinical Psychology and Psychotherapy; Clinical Social Work Journal; Counseling and Values; Counselling and Psychotherapy Research; International Journal for the Advancement of Counseling; Journal of Child and Adolescent Psychotherapy; Journal of Clinical Psychology: In Session; Journal of College Student Psychotherapy; Journal of Consulting and Clinical Psychology; Journal of Contemporary Psychotherapy; Journal of Counseling and Development; Journal of Counseling Psychology; Journal of Infant, Child, and Adolescent Psychotherapy; Journal of Mental Health Counseling; Pragmatic Case Studies in Psychotherapy; Journal of Psychosocial Nursing and Mental Health Services; Practice Innovations; Psychotherapy; Psychotherapy and Psychosomatics; Psychotherapy Research; Rehabilitation Counseling Bulletin; Voices: The Art and Science of Psychotherapy.

Recommended Websites

American Association for Marriage and Family Therapy: www.aamft.org

American Counseling Association: www.counseling.org

American Psychiatric Association: www.psych.org/

American Psychiatric Nurses Association: www.apna.org/

American Psychological Association: www.apa.org/

National Association of Social Workers: www.naswdc.org/

Society for Psychotherapy Research: www.psychotherapyresearch.org/

CHAPTER 2

Psychoanalytic Therapies
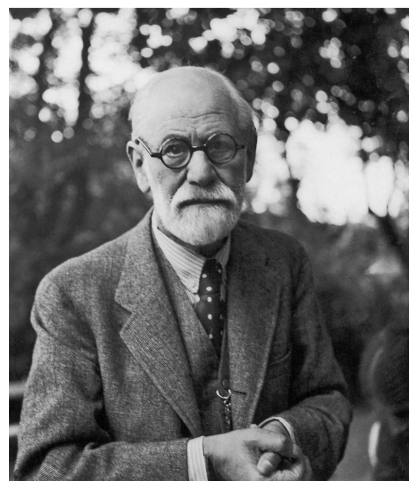
Sigmund Freud

Karen was to be terminated from her nursing program if her problems were not resolved. She had always been a competent student who seemed to get along well with peers and patients. Now, since beginning her rotation on 3 South, a surgical ward, she was plagued by headaches and dizzy spells.

Of more serious consequence were the two medical errors she had made when dispensing medications to patients. She realized that these errors could have proved fatal and was as concerned as her nursing faculty that she understand why such problems had begun in this final year of her education. Karen knew she had many negative feelings toward the head nurse on 3 South, but she did not believe these feelings could account for her current dilemma.

After a few weeks of psychotherapy, I (JOP) realized that one of Karen's central conflicts revolved around the death of her father when she was 12 years old. Karen had just gone to live with her father after being with her mother for 7 years. She remembered how upset she was when her father had a heart attack and had to be rushed to the hospital. For a while it looked as though her father was going to pull through, and Karen began enjoying her daily visits to see him. During one of these visits, her father clutched his chest in obvious pain and told Karen to get a nurse. She remembered how helpless she felt when she could not find a nurse, though she did not recall why this was so difficult. Her search seemed endless, and when she finally found a nurse, her father was dead.

I don't know why, but I asked Karen the name of the ward on which her father had died. She paused and thought, and then to our surprise, she blurted out, "3 South." She cried heavily as she expressed how confused she was and how angry she felt toward the nurses on that ward for not being more available, although she thought they had been involved with another emergency. After weeping, shaking, and expressing her rage, Karen felt calm and relaxed for the first time in months.

My psychoanalytic supervisor said her symptoms would disappear, and sure enough they did. He knew we would have to go much deeper into what earlier conflicts this adolescent experience represented, but for now, Karen's problems in the nursing program were relieved.

A Sketch of Sigmund Freud

Early in his career, Sigmund Freud (1856–1939) was quite impressed by the way some of his patients recovered following cathartic recollections of an early trauma. But he soon discovered that more profound, lasting changes required changes in his own approach. Over time, he switched from hypnosis, to catharsis, and finally to a dynamic analysis that radically increased not only the consciousness of his clients but also the consciousness of his culture.

Freud's genius has been widely admired, but he complained throughout his life about not having been given a bigger brain (Jones, 1955). Freud himself believed that his outstanding attribute was his courage. Certainly it took tremendous daring and inquisitiveness to descend into the uncharted depths of humanity and then to declare to a strict Victorian culture what he had discovered. Freud once observed that scientific inquisitiveness is a derivative of the child's sexual curiosity, the sublimation of anxiety-laden questions of "Where do I come from?" and "What did my parents do to produce me?" These questions exercised a particular fascination for Freud and later assumed a central position in his theory of personality because of his own intricate family constellation. His mother was half his father's age, his two half-brothers were as old as his mother, and he had a nephew older than he (Gay, 1990). He was the prized "golden child" born into a lower-class Jewish family.

For years he struggled for success. From his entry in 1873 into the University of Vienna at age 17, to his work as a research scholar in an institute of physiology, to earning his MD in 1891 and his residency in neurology, he expected that his hard work and commitment would result in public recognition and financial success. He had never intended to practice medicine, but he found the rewards of research to be quite restricted and the opportunities for academic advancement for a Jew to be limited. Finally, after marrying at age 30, he began to develop a rewarding private practice.

Yet Freud was willing to risk his hard-earned financial success to communicate to his colleagues what his work with patients had convinced him of: The basis of **neurosis** was sexual conflict—or, more specifically, the conflict between the id's instinctive desires and society's retribution for the direct expression of those desires.

Freud's profound insights were met with professional insults, and his private practice rapidly declined. For months he received no new referrals. For years he had to rely on his inner courage to continue his lonely intellectual pursuits without a colleague to share his insights. During this same period of the 1890s, he began his painful self-analysis, in part to overcome some neurotic symptoms and in part to serve as his own subject in his studies of the **unconscious**. Surprisingly, Freud was not particularly discouraged by his professional isolation. He interpreted the opposition he met as part of the natural resistance to taboo ideas.

Finally, in the early 1900s, Freud's risky work began to be recognized by scholars, such as the dying William James, as the system that would shape 20th-century psychology. Shape it he did, along with the incredibly brilliant group of colleagues who joined the Vienna Psychoanalytic Society. Most of these colleagues contributed to the development of psychoanalysis, although Freud insisted that as the founder he alone had the right to decide what should be called psychoanalysis. This led some of the best minds, including Alfred Adler and Carl Jung, to leave the Psychoanalytic Society to develop their own systems. Freud's insistence may also have set a precedent for a dogmatism that relied more on authority than on evidence in revising psychotherapy theories. Freud himself, however, continued throughout his lifetime to be critical of his own theories and would painfully discard selected ideas if experience contradicted them.

Success did not diminish Freud's commitment to his scholarly work or to his patients. He worked an 18-hour day that began with patients from 8:00 A.M. until 1:00 P.M., a break for lunch and a walk with his family, patients again from 3:00 P.M. until 9:00 or 10:00 P.M., dinner and a walk with his wife, followed by correspondence and books until 1:00 or 2:00 A.M. His dedication to his work was remarkable, although it is also striking that this man, dedicated to understanding sex and its vicissitudes, left little time or energy for his own sexuality.

Having emigrated from Vienna to London before World War II, Freud continued to work

despite suffering from the ravages of bone cancer. At age 85 he died of probable physician-assisted suicide (Gay, 1988), leaving the most comprehensive theory of personality, psychopathology, and psychotherapy ever developed.

Theory of Personality

Freud's theory of personality was as complex as he was. He viewed personality from six different perspectives:

- The topographic, which involves conscious versus unconscious modes of functioning
- The **dynamic**, which entails the interaction and conflict among psychic forces
- The **genetic**, which concerns the origin and development of psychic phenomena through the oral, anal, phallic, latency, and genital stages
- The economic, which involves the distribution, transformation, and expenditure of psychological energy
- The **structural**, which revolves around the persistent functional units of the id, ego, and superego
- The adaptive, implied by Freud and developed by Hartmann (1958), which involves the inborn preparedness of the individual to interact with an evolving series of environments

We will focus primarily on his dynamic, genetic, and structural perspectives because these are most directly related to his theories of psychopathology and psychotherapy.

From all these perspectives, psychoanalysis is a conflict model leading to **compromise formation**. The mind is embroiled in constant conflict between conscious and unconscious forces, between what the individual immediately desires and what the society deems acceptable. In the end, mature human behavior represents a compromise between these warring factions. The id will demand instant gratification of food, sex, bodily relief, and adoration, but the superego will deny these earthly and immediate pleasures. So we invariably compromise—we wait until the acceptable time and place to eat, defecate, have sex, and secure undivided attention. We mentally compromise all day long.

Freud believed that the basic dynamic forces motivating personality were Eros (life and sex) and Thanatos (death and aggression). These complementary forces are **instincts** that possess a somatic basis but are expressed in fantasies, desires, feelings, thoughts, and most directly, actions. The individual constantly desires immediate gratification of sexual and aggressive impulses. The demand for immediate gratification leads to inevitable conflicts with social rules that insist on some control over sex and aggression if social institutions, including families, are to remain stable and orderly.

The individual is forced to develop **defense mechanisms** or inner controls that restrain sexual and aggressive impulses from being expressed in uncontrollable outbursts. Without these defenses, civilization would be reduced to a jungle of raping, ravaging beasts.

Defense mechanisms keep individuals from becoming conscious of basic inner desires to rape and ravage. The assumption here is that if individuals are unaware of such desires, they cannot act on them, at least not directly. The defenses serve to keep the individual out of danger of punishment for breaking social rules. Defenses also keep us from experiencing the anxiety and guilt that would be elicited by desires to break parental and social rules. For defenses to work, the person must remain unconscious of the very mechanisms being used to keep sexual and aggressive impulses from coming into awareness. Otherwise, the individual is faced with a dilemma akin to keeping a secret from a 3-year-old child who knows you have a secret—the constant badgering to know what is being hidden can be overwhelming.

The core of the Freudian personality is the unconscious conflict among sexual and aggressive impulses, societal rules aimed at controlling those impulses, and the individual's defense mechanisms controlling the impulses in such a way as to keep guilt and anxiety to a minimum while allowing some safe, indirect gratification (Maddi, 1996). The difference between a normal personality and a neurotic one, of course, is simply a matter of degree. It is when the unconscious conflicts become too intense, too painful, and the resultant defense mechanisms too restrictive, that neurotic symptoms begin to emerge.

Although all personalities revolve around unconscious conflicts, people differ in the particular impulses, anxieties, and defenses in conflict. The differences depend on the particular stage of life at which an individual's conflicts occur. For Freud, the stages of life are determined primarily by the unfolding of sexuality in the oral, anal, phallic, and genital stages, as summarized in Table 2.1. Differences in experiences during each of these stages are critical in determining the prominent traits and personalities that ensue.

Oral Stage

During the first 18 months of life, the infant's sexual desires are centered in the oral region. The child's greatest pleasure is to suck on a satisfying object, such as a breast. The instinctual urges are to passively receive oral gratification during the oral-incorporative phase and to more actively take in oral pleasure during the oral-aggressive phase. Sucking on breasts or bottles, putting toys, fingers, or toes in the mouth, and even babbling are representative actions a child takes to receive oral gratification. As adults, we can appreciate oral sexuality through kissing, fellatio, cunnilingus, or oral caressing of breasts and other parts of the body.

The infant's oral sexual needs are intense and urgent, but the child is dependent on parental figures to provide the breasts or bottles necessary for adequate oral gratification. How the parents respond to such urgent needs can have a marked influence on the child's personality. Parents who are either too depriving or too indulgent can make it difficult for a child to mature from the **oral stage** to later stages of personality development.

With deprivation, the child can remain fixated at the oral stage: Energies are directed primarily toward finding the oral gratification that was in short supply during childhood. Deprivation likely leads to pessimism; the mental set from the start is that one's needs will not be met. Suspiciousness comes from a feeling that if parents cannot be trusted, there are few whom one can trust. Self-belittlement derives from an image of having been awful, if one's folks could not care less. Passivity follows from the repeated conclusion that no matter how hard one kicks or cries, parents will not care. Envy is an inner craving to have the traits that would make one lovable enough for people to provide special care.

With overindulgence, the child can also become fixated at the oral stage but energies are directed toward trying to repeat and maintain the gratifying conditions. Overindulgence

Table 2.1 Summary of Freudian Psychosexual Stages

Stage	Age	Libidinal Zone	Libidinal Object	Developmental Challenges
Oral	Birth to 1	Mouth, thumb	Mother's breast, own body	Passive incorporation of all good through mouth; autoerotic sensuality
Anal	2–3	Anus, bowels	Own body	Active self-soothing and self-mastery; passive submission
Phallic	3–6	Genitals	Mother for boy Father for girl	Oedipus and Electra conflicts; identification with same-sex parent; ambivalence of love relationships
Latency	6–11	None	Largely repressed	Repression of pregenital forms of libido; learning shame and disgust for inappropriate love objects
Genital	12+	Genital primacy	Sexual partner	Sexual intimacy and reproduction

Table content courtesy of Dr. Robert N. Sollod.

typically leads to preverbal images of the world and oneself that result in traits on the right side of each pair. Optimism comes from an image that things have always been great, so there is no reason to expect that they will not continue to be so. Gullibility derives from the experience of finding early in life that whatever one received from people was good, so why not swallow whatever people say now. Cockiness ensues from having been something super for parents to dote on. Manipulativeness relates to the mental set that comes from getting parents to do whatever one wants. Finally, admiration results from feelings that other people are as good as oneself and one's parents.

Fixation due to either deprivation or overgratification leads to the development of an oral personality that includes the following bipolar traits: pessimism/optimism, suspiciousness/gullibility, self-belittlement/cockiness, passivity/manipulativeness, and envy/admiration (Abraham, 1927; Glover, 1925).

Besides these traits, fixation at the oral stage brings a tendency to rely on more primitive defenses when threatened or frustrated. **Denial** derives from having to finally close one's eyes and go to sleep as a way of shutting out the unmet oral needs. On a cognitive level, this defense involves closing off one's attention to threatening aspects of the world or self. **Projection** has a bodily basis in the infant's spitting up anything bad that is taken in and making the bad things part of the environment. Cognitively, projection involves perceiving in the environment those aspects of oneself that are bad or threatening. **Incorporation** on a bodily level includes taking in food and liquids and making these objects an actual part of oneself. Cognitively, this defense involves making images of others part of one's own image.

The well-defended **oral personality** is not considered pathological but rather an immature person, like all of the pregenital personalities we shall discuss. There certainly are many people who are overly optimistic, gullible, and cocky without considering themselves or being considered by others as pathological. Likewise, there are many people who believe it is wise to be suspicious, expect too little from this world, and perceive selfishness in others. These people are also rarely judged to be pathological.

Anal Stage

In a society that assigned functions of the anus to the outhouse and gagged at the sight or smell of the products of the anus, it must have been ghastly to think that a physician like Freud believed that this dirty area could be the most intense source of pleasure for children between the ages of 18 months and 3 years. Even in our ultraclean society, many people still find it difficult to imagine that their anuses can be a source of sensuous satisfaction. In the privacy of their own bathrooms, however, many people admit to themselves that the releasing of the anus can be the "pause that refreshes." As one of our constipated patients said, it is his most pleasurable time of the week.

Children in the **anal stage** are apt to learn that urges to play with the anus or its products bring them into conflict with society's rules of cleanliness. Even the pleasure of letting go of the anus must come under the parental rules for bowel control. Before toilet training, the child was free to release the sphincter muscles immediately as soon as tension built up in the anus. But now society, as represented by the parents, demands that the child control the inherent desire for immediate tension reduction. In Erikson's (1950) terms, the child must now learn to hold on and then to let go. Not only that, but the child must also learn the proper timing of holding on and letting go. If the child lets go when it is time to hold on—trouble; and if the child holds on when it is time to let go—more trouble!

The anal stage involves all kinds of power struggles, not solely those associated with toilet training. What to eat, when to sleep, how to dress, whom to kiss—all of these struggles during the "terrible twos" represent the child's efforts to negotiate societal and parental rules and to assert themselves. The child is most likely to become conflicted and fixated at the anal stage if the caretakers again are either too demanding or overindulgent. The bipolar traits that develop from anal fixation are: stinginess/overgenerosity, constrictedness/expansiveness, stubbornness/acquiescence, orderliness/messiness,

punctuality/tardiness, precision/vagueness (Fenichel, 1945; Freud, 1925).

Freud was concerned with overdemanding or overcontrolling parents who forced toilet training too quickly or too harshly. The individual receiving this caretaking style was more likely to develop an **anal personality** dominated by holding-on tendencies. The child was frequently forced to let go when the child didn't want to let go. Then when the child did let go, what did the parents do with the gift to them? Just flushed it down the toilet. Now such individuals react as if they will be damned before they again let go against their will. So these personalities hold tightly to money (stinginess), their feelings (constrictedness), and their own way (stubbornness). Again, a well-defended anal character is considered immature, not pathological; anal people typically take pride in their neatness and punctuality and even may be admired by others for these traits.

Overindulgent parents who are lackadaisical about toilet training more likely encourage a child to just let go whenever any pressure is felt. This route to an anal personality results in people who easily let go of money (wasteful), let go of feelings (explosiveness), and let go of their wills (acquiescent). Lack of concern with such a basic social rule as proper toilet training is assumed to encourage a child to be generally messy, dirty, tardy, and vague.

For Freud, conflicts during the anal stage resulted in the development of particular defenses. **Reaction formation**, or behaving the opposite of what one truly desires, develops first as a reaction to being very clean and neat, as the parents demand, rather than expressing anal desires to be messy. **Undoing**, or atoning for unacceptable desires or actions, occurs when the child learns that it is safer to say, "I'm sorry I let go in my pants," rather than saying, "I like the warm feeling of poo in my pants." Isolation, or not experiencing the feelings that would go with the thoughts, emerges in part when the child has to think about an anal function as a mechanical act rather than an instinctual experience. **Intellectualization**, or the process of neutralizing affect-laden experiences by talking in intellectual or logical terms, is partly related to such experiences as talking about the regularity of bowel movement as being soothing to one's gastrointestinal system.

Phallic Stage

The name of this stage, which refers specifically to male genitalia, reflects Freud's problem of theorizing too much about men and then overgeneralizing to women. For both, the sexual desires during the **phallic stage** are thought to be focused on the genitalia. From ages 3 to 6, both sexes are fascinated by their own genitalia and increase their frequency of masturbation. They are also very interested in the opposite sex and engage in games of "doctor and patient" in which they examine each other to satisfy their sexual curiosity.

The conflict for youngsters is not with their genital desires, because theoretically they and other kids could satisfy these desires. The conflict is over the object of their sexual desires, which in this stage is the parent of the opposite sex.

The boy's desire for his mother is explained as a natural outgrowth of the mother's serving as the major source of gratification for his previous needs, especially the need for sucking. Therefore, the son will naturally direct his genital sexual desires initially toward his mother and would expect her to gratify him. The **oedipal conflict**, of course, is that the father already has the rights and privileges of enjoying the mother. The son's fear is that the father might punish his rival by removing the source of the problem—the son's penis. This **castration anxiety** eventually causes the son to repress his desire for his mother, repress his hostile rivalry toward his father, and identify with his father's rules, in the hope that if he acts as his father would have him act, he can avoid castration.

Why a girl ends up desiring her father rather than her mother is more difficult to explain, given that the mother is presumed to be the main source of instinctual gratification for daughters as well as sons. Freud asserted that girls become hostile toward their mothers when they discover that their mothers cheated them by not giving them a penis. Why Freud assumed that females would conclude that there was something wrong with them because they lacked a penis, rather than vice versa, has always been a mystery. For example, a non-Freudian colleague tells the story of his 5-year-old daughter's discovery of her 3-year-old brother's penis. Rather than envying his penis, she went yelling, "Mama, Mama, Andy's 'gina fell out."

Nevertheless, and in spite of understandable protest by enlightened women, many classical psychoanalysts still assume that girls initially envy penises, that they become enraged toward the mother, and that they turn their desires to the father in part to be able to at least share his phallus.

Again, the critical issue is how the parents respond to the genital desires of their children. Both overindulgence and overrejection can produce fixations at the phallic stage, resulting in formation of the following bipolar traits: vanity/ self-hatred, pride/humility, stylishness/plainness, flirtatiousness/shyness, gregariousness/ isolation, brashness/bashfulness.

Overrejection, in which parents give their opposite-sex children little affection, few hugs or kisses, and no appreciation of their attractiveness, is likely to lead to the following self-image: "I must be hateful if my parent wouldn't even hug or kiss me. Why flirt, dress stylishly, be outgoing or brash, or take pride in myself if the opposite sex is sure to find me undesirable?" On the other hand, people who had overindulgent parents, whether seductive or actually incestuous, can more readily develop feelings of vanity. They feel they must be really something if daddy preferred them over mommy, or vice versa. The flirting, stylishness, pride, and brashness would all be based on maintaining an image as the most desirable person in the world.

Conflicts over sexual desires toward a parent are not solely due to how the parent reacts, however. The child must also defend against society's basic incest taboo. These conflicts lead to **repression** as the major defense against incestuous desires. By becoming unaware even of fantasies about one's opposite-sex parent, the youngster feels safe from incest and the consequent castration or taboos that would accompany it. However, as with all conflicted desires, the impulse is omnipresent and can be kept at bay only by unconscious defenses.

Latency Stage

In classical psychoanalytic theory, this stage involved no new unfolding of sexuality, but rather was a stage in which the pregenital desires were largely repressed. Freud associated no new personality development with the latency stage, believing that all pregenital personality formation had been completed by age 6. Latency was seen primarily as a lull between the conflicted, pregenital time and the storm that was to reemerge with adolescence—the beginning of the genital stage.

In more recent psychoanalytic formulations, latency is a time for ego development and learning the social rules of being a citizen. These gains enable the child to psychologically enter adolescence and to navigate the genital stage when it hits.

Genital Stage

In the **genital stage**, the libido reemerges—this time in the genitals. Having largely completed the challenges of the phallic and latency stages, the adolescent must now find appropriate objects for sex (love) and aggression (work).

In Freudian theory, an individual does not progress to the genital stage without at least some conflict between instinctual desires and social restraints. Some individuals will be fixated at the oral, anal, or phallic stage and will demonstrate the related personality type. Others will experience conflicts at each of the stages and will demonstrate a mixed personality that combines traits and defenses of each stage. But no one becomes a fully mature, genital character without undergoing a successful psychoanalysis. Because such a personality is the ideal goal of analysis, we will delay discussion of it until the section on this theory's ideal individual.

Theory of Psychopathology

Because all personalities contain some immaturity due to inevitable conflicts and fixations at pregenital stages, all of us are vulnerable to regressing into psychopathology. We are more vulnerable if our conflicts and fixations occurred earlier in life since we would be dependent on more immature defenses for dealing with anxiety. In addition, the more intense our pregenital conflicts are, the more vulnerable we are, as more of our energy is bound up in defending against pregenital impulses, and less energy is available for coping with adult stresses. Well-defended oral, anal, phallic, or mixed personalities may never break down unless exposed to horrendous

stress, which would then lead to symptom formation and intensification of immature defense mechanisms.

Stressful events—such as the death of a loved one, an offer of an affair, or a medical illness—stimulate the impulse that individuals have been controlling all their lives. They react on an unconscious level to this current event as if it were a repetition of a childhood experience, such as rejection by a parent or a desire for taboo sex. Their infantile reactions lead to panic that their impulses may get out of control and that the punishment they have dreaded all their lives, such as separation or castration, will occur. These individuals feel that they are "falling apart"—their very personality is threatened with disintegration. Like children, they are terrified that their adult personality will break down and that they will become dominated by infantile instincts. These individuals reexperience at an unconscious level the same infantile conflicts that caused their personality development and now threaten to cause their personality disintegration.

In the face of such threats, the person is highly motivated to spend whatever energy is necessary to keep impulses from coming into consciousness. This may translate into an exacerbation of previous defenses to the point which they become pathological.

For example, a married woman who has been offered an affair and has an intense desire for taboo sex may rely more heavily on repressing such desires. Soon she is entirely fatigued and may show other symptoms of fatigue and depression, but at least she does not have the energy to engage in the affair even if she wanted to. Although she constantly complains about her fatigue, for her it is better to be tired than to be in terror of acting out her infantile desires. A woman who did not have such intense fixations and conflicts over taboo sex might simply decline the offer or might accept if she thought it was worth the risks.

When a person overreacts to life's events to such an extent that symptoms develop, Freudians believe the symptoms are defending against unacceptable impulses and childish anxieties. In many cases, the symptoms also serve as indirect expressions of the person's unacceptable wish. An example: Karen's symptoms of headaches, dizziness, and medical errors diverted her attention from emerging rage toward the nurses on 3 South and the accompanying anxiety. Her medical errors also provided some expression of her hostile wishes without her being conscious that she was even angry, to say nothing of being threatened by internal rage.

When symptoms serve both as defenses against unacceptable impulses and as indirect expressions of these wishes, then the symptoms are doubly resistant to change. Other benefits from symptoms, such as special attention from loved ones or doctors, are secondary gains and make symptoms even more resistant to change.

But why does a person like Karen overreact in the first place to an event like being assigned to 3 South? Why did she respond to the current 3 South as if she were 12 years old again? Why didn't she just make the logical discrimination between an old 3 South and the current 3 South? Obviously, Karen was unaware of responding to 3 South as if she were 12 years old. If her response to 3 South was primarily on a conscious level, then she could indeed have made such logical distinctions based on her conscious, **secondary process**. But unconscious responses like Karen's follow **primary-process thinking**, which is alogical and atemporal.

Logical thinking includes reasoning from the subjects of sentences, as in: (1) All men are mortals; (2) Socrates was a man; therefore, (3) Socrates was mortal. In primary process, reasoning frequently follows the predicates of statements, so that we think: (1) The Virgin Mary was a virgin; (2) I am a virgin; therefore, (3) I am the Virgin Mary. Or in Karen's case: (1) The ward where they let my father die was 3 South; (2) the ward where I am now is 3 South; therefore, (3) this 3 South is where they let my father die.

When Karen responds on an unconscious level, she does not systematically proceed through any reasoning process; rather, her primary-process reaction is automatically alogical. Primary-process responding is also atemporal, with no differentiation among past, present, and future. Therefore, on an unconscious level, Karen's response makes no distinction between the 3 South of 10 years ago and the 3 South of now. On an unconscious level, all is now, and so the same impulses and anxieties are elicited that were present 10 years ago.

Another characteristic of primary-process thinking is **displacement**, which involves placing the energies from highly charged emotional ideas onto more neutral ideas. In this case, Karen displaced the intense anger she felt toward her father for leaving onto her image of the more neutral people responsible for 3 South. Primary-process thinking is also symbolic, which means *pars pro toto*, that any part of an event represents the total event; thus, the name 3 South became a symbol for the many feelings stirred up over the death of Karen's father.

Finally, primary-process experiencing includes both **manifest** and **latent content:** The content that is conscious, or manifest, is only a minor portion of the hidden, or latent, meaning of events. Karen was thus originally aware of only the manifest event of becoming upset on her new ward; she was not even aware of the latent significance of the name 3 South until it was uncovered in psychotherapy.

With this understanding of primary-process responding, we can more fully appreciate why Karen's unconscious response to being placed on the present 3 South appeared to be irrational, or alogical. We can also appreciate why she was reacting like an angry child and why her response involved much more energy and meaning than could be understood from a relatively neutral situation like the name of the ward, 3 South.

If we went even deeper into the latent meaning of this event for Karen, we would probably find that her experience at age 12 represented her original loss of her father (through divorce) when she was 5. The rage that threatened to break out toward the nurses on 3 South may have been in part displaced from her original rage toward her mother, whom Karen imagined caused her father to leave at an age when she so desired him.

Working on 3 South may also have threatened to bring to awareness sexual desire for her father mixed with hostility for his leaving when she needed him so. Even the fantasy that she might wish his death could damage Karen's image of herself as the caring daughter who would have saved her father if she had been a nurse 10 years before. To protect her image of herself, to protect herself from acting out dangerous impulses, and to protect herself from all the anxiety and guilt such impulses would elicit could be the reasons for her symptoms as defenses of last resort.

In this sense, as William Faulkner wrote, "The past is never dead. It's not even past." The unconscious remains alive and present in our primary processes, apt to be reactivated at any time in our lives.

Psychoanalytic theory offers a diagnostic alternative to the static, symptom-based *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and *International Classification of Diseases* (ICD). Starting with childhood development and acknowledging unconscious motivation, psychoanalytic diagnosis provides a richer, multidimensional portrait of personality style, mental functioning, and relational capacities. It is a way of capturing the entire person, not only assessing a discrete disorder.

Multiple psychoanalytic organizations collaborated to publish the *Psychodynamic Diagnostic Manual* (PDM) to complement the DSM and ICD. The first edition proved so popular that a second edition, the PDM-2, recently appeared (Lingiardi & McWilliams, 2017). In this way, psychoanalysis and the PDM-2 provide a comprehensive profile of an individual's mental life for the purposes of case formulation and treatment planning.

Therapeutic Processes

If the essence of psychopathology lies at an unconscious level and if the person has no awareness of the psychological significance of precipitating events, the impulses being elicited, the anxieties threatening panic, and the defensive yet gratifying nature of symptoms, then how can individuals be helped to overcome their disorders?

For Freud, only one therapeutic process could succeed in making the unconscious conscious. Before we can respond to environmental events in a more realistic manner, we must first be conscious of how our pathological responses to the environment derive from our unconscious, primary-process associations. To remove symptoms, we must become conscious of our resistance to letting go of those symptoms because they both defend against and give partial release to unacceptable impulses. We must gradually recognize that our impulses are not as dangerous

as we thought as children and that we can use more constructive defenses to keep our impulses in control, in part by allowing more mature expressions of our instincts. Finally, to prevent future relapses, we must use our conscious processes to release our pregenital fixations so that we develop mature, genital levels of functioning. Such radical increases in consciousness require considerable work on the part of both patient and analyst.

Consciousness Raising

The Patient's Work

The work of **free association** sounds easy enough—to freely say whatever comes to mind, no matter how trivial or repulsive. If patients could let their minds go and associate without defending, then their associations would be dominated by instincts. Because the instincts are the source of energy and therefore the strongest forces in the individual, and because the instincts are pressing to emerge into consciousness, patients would immediately associate to thoughts, feelings, fantasies, and wishes that express instincts.

However, free association is anything but easy or simple. Our earliest lessons in life were that such direct, uncontrolled expressions of instincts are dangerous. Humans also learned at the time symptoms developed that a loosening of defenses can be terrifying and can lead to pathology. Now, just because the psychoanalyst has asked the patient to lie on the couch and say everything that comes to mind does not mean that the patient can do so without considerable resistance or defensiveness.

To help the patient work in the face of potential terror and resulting defensiveness, the analyst must form a **working alliance** with the part of the patient's ego that wants relief from suffering and is rational enough to believe that the analyst's directions can bring such relief. Through this alliance, patients also become willing to recall in detail dreams and childhood memories, even though such material brings them closer to threatening impulses.

The Therapist's Work

The therapist's work begins with evaluating the patient to determine whether he or she is indeed a suitable candidate for psychoanalysis. As Greenson (1967, p. 34) succinctly puts it, "People who do not dare regress from reality and those who cannot return readily to reality are poor risks for psychoanalysis." This generally means that patients diagnosed as schizophrenic, bipolar, schizoid, or borderline personalities are considered poor risks for classic psychoanalysis.

If psychoanalysis does proceed, the therapist uses four procedures—confrontation, clarification, **interpretation**, and **working through**—in analyzing the patient's resistance to free associating and the transference that emerges as the patient regresses and expresses instinctual desires toward the analyst (Bibring, 1954; Greenson, 1967).

Confrontation and Clarification

The first two are fundamentally feedback procedures. In analytic confrontation, the therapist makes sure patients are aware of the particular actions or experiences being analyzed. For example, in confronting a particular transference, the analyst might give the patient the following feedback: "You seem to be feeling angry toward me," or "You seem to have sexual feelings toward me."

Clarification, which frequently blends with confrontation, is sharper and more-detailed feedback regarding the particular phenomenon that the patient is experiencing. Greenson (1967, p. 304) gives an example of how, after confronting a patient with his hatred for the analyst, he helped the patient clarify the exact details of his hatred:

He would like to beat me to a pulp, literally grind me up and mash me into a jelly-like mass of bloody, slimy goo. Then he'd eat me up in one big "slurp" like the god damned oatmeal his mother made him eat as a kid. Then he'd shit me out as a foul-smelling poisonous shit. And when I asked him, "And what would you do with this foul-smelling shit?" he replied, "I'd grind you into the dirt so you could join my dear dead mother!"

Interpretation

Confronting and clarifying a patient's experiences prepare patients (or analysands) for the most important analytic procedure: interpretation. Greenson (1967, p. 39) defines

interpretation in such a way as to make it almost synonymous with analysis itself:

To interpret means to make an unconscious phenomenon conscious. More precisely, it means to make conscious the unconscious meaning, source, history, mode, or course of a given psychic event. The analyst uses his own unconscious, his empathy and intuition as well as his theoretical knowledge for arriving at an interpretation. By interpreting we go beyond what is readily observable and we assign meaning and causality to a psychological phenomenon.

Because interpretation goes beyond the experience of the patient, it is more than feedback to the patient. The meaning and causality assigned to psychological phenomena are determined, at least in part, by psychoanalytic theory. Therefore, the information patients are given regarding the meaning and causality of their responses is partly an education on how psychoanalysis makes sense of people and their problems.

This is not to say that interpretations are given in theoretical terms. They certainly are personalized for the individual, and in that respect represent feedback. Nevertheless, through interpretations patients are taught to view their conscious experiences as caused by unconscious processes, their adult behavior as determined by childhood experiences, their analysts as if they were parents or other significant figures from the past, and so on.

Psychoanalytic therapists assume that patients accept such teachings because the interpretations hold true for the patient. After all, it is the patient's response that verifies an interpretation. If patients gain **insight**—that is, if they have a cognitive and affective awakening about aspects of themselves that were previously hidden—then analysts have some evidence for the validity of their interpretations. The most critical response for verifying interpretations is whether the interpretations eventually lead to a change for the better in the patient.

The problem with patient improvement as the criterion for the verification of interpretations is that improvement in psychoanalysis is expected to be a slow, gradual process. First, the analyst and the patient must interpret the repeated **resistance** the client throws up against becoming conscious of threatening forces from within. The client misses appointments, comes

late, recovers dramatically and wants to leave therapy, wants to leave because of not recovering, represses dreams, and does a million other things to shore up defenses. Then, as blind resistance is gradually reduced through insightful interpretations, the client begins to release hidden instincts toward the therapist.

The patient satisfies frustrated sexual and aggressive impulses by displacing them onto the analyst, and gradually a neurotic transference develops in which the patient relives all of the significant human relationships from childhood. For weeks or months, the therapist may be experienced as the nongiving, miserly mother who does not care about the patient; then the analyst is the lecherous father who wants to seduce the patient; or the wonderful, wise parent who can do no wrong; or the stupid fool who is always wrong. Transference reactions serve as intense resistances: Why mature further when you feel so good beating on your therapist or feel so safe with such a wise, caring parent? Painfully, through repeated interpretations, the patient must realize that these intense feelings and impulses come from within and represent the patient's pregenital conflicts, not realistic feelings elicited by the relatively blank-screen analyst.

Working Through
The gradual process of working again and again with the insights that have come from interpretations of resistance and transference is called working through. In this last and longest step of psychotherapy, patients are acutely conscious of their many defensive maneuvers, including symptoms. They are undeniably aware of the impulses they have tried to defend against and the many ways in which they are still behaviorally expressed. They realize that they need not fear their impulses to the degree they once did as children, because in transference relationships they expressed impulses in intense words and were not castrated, rejected, or overwhelmed. Slowly the person becomes aware that there are indeed new and more mature ways of controlling instincts that allow some gratification without guilt or anxiety. Gradually the patient channels impulses through these new controls and gives up immature defenses and symptoms. The use of new defenses and the radical increase in consciousness are seen by Freudians as structural

changes in personality, in which energies once bound up in pregenital conflicts are now available to the more mature ego of the individual.

Other Processes

Most psychoanalysts accept that corrective emotional experiences can lead to temporary relief of symptoms, especially for traumatic neuroses. Catharsis, however, even if used by an analyst, is not considered part of the psychoanalytic process. There is only one fundamental change process in analysis, and that is to increase consciousness; all the steps in analysis are part of that process.

Therapeutic Content

Intrapersonal Conflicts

Psychoanalysis obviously focuses on intrapersonal (inside the person) conflicts in therapy. The patient's inner conflicts among impulses, anxiety, and defenses represent the core concern. Problems may be acted out at an interpersonal level, but the understanding and resolution of such problems are achieved only through an analysis of each person's intrapsychic conflicts.

Anxieties and Defenses

We have already discussed anxiety due to threats of separation and castration. The Freudians also postulate **primal anxiety**, which is due to the assumed birth trauma of being overwhelmed with stimulation. Primal anxiety is the bodily basis for panic, which is the adult threat of being overwhelmed with instinctual stimulation. Moral anxiety, or guilt, is the threat that comes with breaking internalized rules.

In psychotherapy, anxiety may drive a person to seek relief because of its aversive properties. Once in therapy, however, an analyst must be careful not to uncover impulses too quickly lest the person panic and either flee therapy or feel psychotically overwhelmed. Anxiety is one of the central reasons therapy moves slowly—partly because anxiety signals the person to shore up resistance when dangerous associations are being approached, and partly because analysts feel that immature egos cannot hold up under high anxiety.

Defenses or resistance, as defenses are called when they occur in psychotherapy, are half of the content of psychoanalysis. Almost any behavior in therapy can serve defensive functions—talking too fast or too slowly, too much or too little, feeling good toward the therapist or feeling hostile, focusing on details or avoiding details. So the analyst is never without material. It is just a matter of which defenses are most likely to be acknowledged by the client as resistance, such as missing appointments or not recalling dreams. The analytic goal is not to remove defenses, but rather to replace immature and distorting defenses with more mature, realistic, and gratifying defenses.

Self-Esteem

Self-esteem has not been a major content area for psychoanalysis. It seems to be taken for granted that patients will experience conflict over self-esteem. Some will hold unrealistically low self-esteem—deprived oral characters who engage in continual self-belittlement or rejected phallic characters who feel ugly and undesirable, to name but two. Other patients will hold unrealistically high self-esteem, such as overindulged oral characters who are cocky or overindulged phallic characters who are vain and brash. Pregenital personalities cannot feel fundamentally good about themselves as long as they are dominated by infantile desires to be selfishly taken care of, hostilely controlling, or seductively narcissistic.

Lack of genuine self-esteem results from personality problems, rather than causing such problems. As such, analysts do not treat esteem problems directly. Acceptance of infantile characteristics may bring temporary relief, but what the pregenital personality really needs is a personality transplant. The best that can be done is to help patients consciously restructure their personalities into a more genital level of functioning. Only then can individuals experience a stable sense of self-esteem.

Responsibility

In a deterministic system such as psychoanalysis, how can we talk about individual responsibility? In practice, the analyst expects the patient to be responsible for the bill, to keep appointments three to five times a week, and to free

associate. But theoretically, there is no freedom and no choice in psychoanalysis and, therefore, no responsibility. How can we hold a person responsible for any action, whether it be murder, rape, or just not paying a bill, if all pathological behavior is determined by unconscious conflicts and pregenital fixations? This difficulty in holding an individual responsible for his or her actions is one of the reasons why Mowrer (1961) said that Freud freed us from a generation of neurotics and gave us a generation of psychopaths.

Freud was a determinist, yet his theory is a psychology of freedom (Gay, 1990). His **psychic determinism** held that just as there is no event in the physical universe without its cause, so there is no mental event or mental state without its cause. Nothing is chance in the psychological world. Yet psychoanalysis is ultimately designed to make us more aware of our repressed conflicts and mental defenses, and thereby free us from the tyranny of the unconscious.

Interpersonal Conflicts

Intimacy and Sexuality

Intimacy, the authentic revealing and sharing between people, is fundamentally impossible for an immature personality. The problem of intimacy is basically a transference problem. The pregenital personality cannot relate to another person as the other person really is, but distorts the other according to childhood images of what people are like. In Piaget's terms, the person's earliest interpersonal experiences with parents result in internalized schemas that are primitive concepts of what people are like. Any new experience of a person is assimilated into this schema through selective attention to that person's actions.

Whereas Piaget (1952) suggests children's schemas of people change to accommodate new experiences, the Freudian concept of **fixation** suggests that pregenital personalities do not evolve in their schemas of people. Rather, immature individuals distort their perceptions of other people to fit internalized images. For example, a repeatedly abused child views people as untrustworthy and rejecting. That child becomes an adult who attends to the slightest reason for mistrust and the smallest sign of rejection as evidence that a new, potential intimate is the same as the abusers in childhood.

A thorough psychoanalysis is the premier method to mature to a level which people can perceive each other with the freshness and uniqueness each deserves. It is only by being fully aware of how we have distorted our relationships in the past that we can avoid destructive distortion in the present.

Sexual relationships for immature people also reflect transference relationships. Two immature people can only engage in object relationships in which the other is seen as perhaps finally being the one who will satisfy ungratified pregenital instincts. So the oral character may relate sexually with a clingy and demanding manner that smothers a spouse. The anal personality may relate sexually in a very routinized manner, such as every Wednesday night when the 11:00 television news is over rather than when sex is spontaneously desired. The phallic character may relate as the teasing, seductive person who promises so much in bed but has so little to give. The ability to relate to another as a mature, heterosexual partner results only after a satisfying working through of one's pregenital fixations. Otherwise we are reduced to two objects bumping in the night.

Communication

Most interpersonal communication between two immature people is interlocking monologue, not a genuine dialogue. Immature personalities are locked into their egocentric worlds, in which others are only objects for their gratification. They do not respond to what the other says, but rather to their own selfish desires. They do not talk to each other, but rather speak to their internal images of what the other is supposed to be. The messages they send have a manifest content that is also directed at hiding what the person really wants to say. If it takes an analyst years of "listening with the third ear" (Reik, 1948) to interpret what the person truly means, how can a spouse with two blocked ears be expected to hear? From a classical Freudian viewpoint, attempts at couples therapy between two immature personalities will only produce absurd dialogue best left to modern playwrights.

Hostility

The violence in our society, according to Freudians, reflects the hostility inherent in

humans. Just as the work of ethnologists such as Tinbergen (1951) and Lorenz (1963) demonstrated that animals instinctively release aggression, the work of Freud suggested that the human animal possesses aggressive instincts to strike out and destroy. But humans also desire to live in civilized societies, and the stability of social organizations—relationships, families, and communities, to name a few—is continually threatened by the hostile outbursts of poorly defended personalities. With paranoid personalities barely controlling their rage, defenses must be strengthened through supportive therapy or medication rather than uncovered by analysis. With overcontrolled neurotics, the best we can expect is to rechannel hostility into more socially acceptable outlets such as competition, assertiveness, or hunting. Otherwise, we will all be hunters and the hunted.

Control

Struggles over interpersonal control prove frequently struggles over whose defenses will dominate the relationship. The more rigid the defenses, the more likely it is that individuals will insist on others conforming to their view of the world and their ways of acting. The person who repeatedly projects hostility onto the world, for instance, is likely to put considerable pressure on others to see it as a hostile place. Conversely, if a person defends with repressive, rose-colored glasses, then interactions will be focused on only the cheery aspects of the world. If two people with incompatible defenses try to interact, there will be conflict. An insignificant matter, such as deciding which movie to see, can turn into a heated battle for control when it involves a spouse with rose-colored glasses who wants to see a light comedy and a hostility-projecting spouse who wants to see a war flick.

Individuals also expect to control relationships when they experience the other person as nothing more than an object that exists to gratify their infantile desires. Each pregenital type of personality has its unique style of controlling others: Oral characters control by clinging, anal characters control through sheer stubbornness, and phallic characters control through seductiveness. The most intensely controlling people seem to be anal personalities, who were once

forced to give in on the toilet and now act determined never to give in again.

An anal-restrictive woman was raised by a governess who seemed to enjoy giving her cold-water enemas to force her to let go when she was 2 years old. She married a man who was toilet trained at 10 months of age. He was complaining that his wife could never let go and enjoy their sexual relationship. She went along with his demands for sex but could not let go to have an orgasm. The trauma that brought them into psychotherapy followed the wife's decision to solve her problem. She read Masters and Johnson's sex therapy book and reserved a hotel room in New York so they could have a sexual holiday. Once in New York, she became very aroused as she approached her husband, but he was now unable to get an erection. He was so determined to control their sexual relationship that he shut off his penis to spite his wife.

In treatment, the analyst must be keenly aware of how a patient is trying to control. The analyst will recognize when controlling behavior is serving defensive purposes of resistance or gratifying purposes of transference. The analyst will confront and clarify the patient's attempts to control and then interpret the meaning and causality of controlling maneuvers. The analyst's most effective method of countercontrol is silence: No matter what response the patient insists on, the analyst can respond with silence. It is like trying to fight with a partner who clams up—it can be terribly frustrating because the quiet one remains in control.

Individuo-Social Conflicts

Adjustment versus Transcendence

Freud (1930) believed there was a fundamental and unresolvable conflict between an organized society's need for rules, on the one hand, and an individual's desires for immediate, selfish gratification, on the other. This represents, in a nutshell, the superego versus the id, the reality principle versus the pleasure principle. Freud argued that cultures did not need to be as oppressive about childhood sexuality as was his Victorian age; in fact, Freud, more than any other individual, was responsible for our modern sexual revolution. Nevertheless, Freud accepted the idea that culture must be repressive to some degree. Being

the civilized individual that he was, he threw his weight behind civilization and was willing to treat its discontents.

Some radical post-Freudians argue that individuals need not be repressed. All of the destructive expressions of the death instinct, such as violence, materialism, and pollution, result from repeated frustration of the life instinct. If we adopt more childlike, spontaneous lifestyles, in which we give free expression to playing in bed and in fields, then we would not be frustrated and so aggressive. Radical Freudians usually accept sexuality as an instinct but see aggression as the product of the repression of our desires for spontaneous sexuality. But Freud himself, as radical as he was in many ways, was convinced that even the most conscious individuals must compromise with the culture in which they live and leave fantasies of transcendence to the angels.

Impulse Control

Freud was convinced that human sexual and aggressive impulses must be controlled. We are animals covered with a thin veneer of civilization. For psychotherapists to encourage the removal of that veneer is ultimately to encourage raping and rioting in the streets. Some believe that Freud himself contributed to removing this thin veneer. They see sexuality and aggression as out of control in our post-Freudian society. Dependency on drugs, alcohol, and food is rampant; violence seems to dominate the streets. Freud, however, was one of the earliest to recognize it is much easier for therapists to loosen the controls of neurotics than to produce controls for impulse-ridden personalities. He did not preach removal of the thin veneer of controls; instead, he believed that the best hope for individuals and society was to replace the rigid but shaky infantile veneer with a more mature set of controls.

Beyond Conflict to Fulfillment

Meaning in Life

Freud once said that "The intention that Man should be happy is not in the plan of Creation." He believed we could not go beyond conflict, but he did suggest that we could find meaning in life in the midst of conflict. Meaning is found in love and work (*lieben und arbeiten*). Work is

one of society's best channels for sublimating our instincts; Freud himself could sublimate his sexual curiosity into his work of analyzing his patients' sexual desires. **Sublimation** is a mature ego defense that allows us to channel the id's energy into more acceptable substitute activities: Oral sucking can become cigar smoking, anal expression can become abstract art, and so on.

Freud's embrace of the value of work came mainly from his total involvement in his own work. His voluminous productivity could come only from a person with a passion for work. A clearer source of meaning is love—the atmosphere that allows two people to come together, the most civilized expression of sexuality, and therefore the safest and most satisfying. Obsessive ruminating about meaning in life can come only from someone too immature to love and to work.

Ideal Individual

The ideal individual for Freud, and the ultimate goal of psychoanalysis, is a person who has analyzed pregenital fixations and conflicts sufficiently to attain, and maintain, genital functioning. The genital personality is the ideal. The **genital personality** loves sex without the urgent dependency of the oral character, is fully potent in work without the compulsivity of the anal character, and is satisfied with self without the vanity of the phallic character. This ideal individual is altruistic and generous without the saintliness of the anal character, and is fully socialized and adjusted without immeasurable suffering from civilization (Maddi, 1996).

Therapeutic Relationship

There are two parts of the patient–analyst relationship, and they serve two different functions in treatment. The working alliance is based on the relatively nonneurotic, rational, realistic attitudes of the patient toward the analyst. This alliance is a precondition for successful analysis, because the rational attitudes allow the patient to trust and cooperate with the analyst even in the face of negative transference reactions.

Transference, by contrast, represents the patient's neurotic, unrealistic, and antiquated feelings toward the analyst. In transference

reactions, the patient experiences feelings toward the analyst that do not befit the analyst but actually apply to significant people in the patient's childhood. Feelings and defenses pertaining to people in the past are displaced onto the analyst. These transference reactions represent the conflicts between impulses and defenses that are the core of the person's pregenital personality.

Repeating these impulses and defenses in relation to the analyst provides the content of psychopathology for analysis. The person does not only talk about past conflicts, but also relives them in the current relationship with the analyst. Relationship expectations from there and then are reenacted in the here and now of the consulting room. Manifesting transference reactions is not a curative process per se, because the essence of the transference is unconscious. Patients know they are having intense reactions toward the analyst but are unaware of the true meaning of their reactions. It is the analysis, or making conscious the unconscious content of the transference reactions, that is the therapeutic process.

The analyst's own reaction to the patient constitutes a delicate balance between being warm and human enough to allow a working alliance to develop, yet neutral and depriving enough to stimulate the patient's transference reactions. The stereotype has emerged that an analyst is just a blank screen and therefore cool and aloof. Even such an orthodox analyst as Fenichel (1941), however, has written that above all the analyst should be human. Fenichel was appalled at how many of his patients were surprised by his own naturalness in therapy. In order for the patient to trust the analyst and believe the analyst cares, the analyst must communicate some warmth and genuine concern.

Freudians disagree with Carl Rogers's (1957) assumption that it is therapeutic to be genuine throughout therapy. If analysts become too real, they will interfere with the analysand's need to transfer reactions onto them from people in his or her past. Patients can transform a blank screen into almost any object they desire, but it would take a psychotic transference to distort a three-dimensional therapist into an object from the past.

Although psychoanalysts agree with Rogers that it is best to adopt a nonjudgmental attitude toward a patient's productions to allow for a freer flow of associations, they do not respond with unconditional positive regard. Frequently, neutral responses such as silence are more likely to stimulate transference reactions, and thus an analyst's reactions to the patient's productions are best described as unconditional neutral regard.

Analysts would agree with Rogers that accurate empathy is an important part of therapy. Empathy is a prime source of useful interpretations, after all. Psychoanalysts also agree that an analyst must be healthier or, in Rogers's terms, more congruent than patients.

Analysts must be aware of their own unconscious processes, as another source of accurate interpretations and as a guard against reacting toward their patients on the basis of **countertransference**—the analysts' desires to make clients objects of gratification of their own infantile impulses. For example, the analyst will analyze his or her hostile withholding or excessive warmth because a patient reminds the analyst of a sibling. Likewise, an analyst must recognize that giving too much of oneself to a client may represent encouragement to the patient to act out sexual desires with the analyst. In short, the analyst must be healthy enough to discriminate what is coming from the patient and what the analyst is providing, because a patient in the midst of transference reactions cannot be expected to make such crucial discriminations.

Practicalities of Psychoanalysis

In order for psychoanalysts to accurately analyze their own countertransference reactions, they must be psychoanalyzed by a training analyst and must have graduated from a psychoanalytic institute—a process that takes 4 to 6 years, depending on how much time is spent per week at the institute. Early on, most analysts in the United States were psychiatrists, because it proved very difficult for nonphysicians to be admitted to analytic institutes— even though Freud supported the practice of lay analysis, which is analysis by a nonphysician. In the past four decades, however, nonmedical mental health professionals have been routinely accepted into formal psychoanalytic training.

"But where and how is the poor wretch to acquire the ideal qualifications which he will need in this profession? The answer is in an analysis of himself, with which his preparation for his future activity begins." So asked and answered Freud (1937/1964, p. 246) in enjoining psychoanalysts to complete personal analysis themselves. Research has indeed found that 99% of psychoanalysts and approximately 90% of psychoanalytic psychotherapists have undergone personal therapy themselves and that their therapy experiences are typically lengthier than psychotherapists of other persuasions, averaging 400 to 500 hours (Norcross & Guy, 2005).

Although classical analysts prefer seeing patients three to five times per week, treatment can still be considered psychoanalysis if it occurs at least two times a week. Psychoanalysis currently costs between $120 and $200 per 50-minute session, with the cost varying according to the city and the reputation of the analyst. Theoretically, analysis has been considered interminable, in that there is always more in the unconscious that could be made conscious, but the actual work with an analyst is completed in an average of 3 to 5 years.

In orthodox analysis, patients agree, if possible, not to make any major changes—such as marriage or relocation—while in analysis. Above all, they should make no important decisions without thoroughly analyzing them. At times, patients are asked to give up psychotropic medications and chemicals such as alcohol or tobacco.

The psychoanalysis itself involves the patient (or **analysand**) and the analyst interacting alone in a private office. The patient lies on a couch with the analyst sitting in a chair at the head of the couch. The patient does most of the talking; the analyst is frequently silent for long periods of time when the patient is working well alone. Patients are subtly encouraged to associate primarily to their past, their dreams, or their feelings toward the analyst. The analyst keeps self-disclosures to a minimum and never socializes with patients. Needless to say, the analyst becomes a central figure in the patient's life, and during the neurotic transference, the analyst is *the* central figure. Following termination, the analyst remains one of the most significant persons in the patient's memory.

Major Alternatives: Psychoanalytic Psychotherapy, Lacanian Analysis, and Relational Psychoanalysis

Variations in the standard operating procedures of psychoanalysis have occurred throughout its history. At times, the innovations resulted in rejection of the unorthodox analyst by more classical colleagues, and the innovator has gone on to establish a new system of psychotherapy. A case in point is Carl Jung and his subsequent development of analytical psychology (considered in Chapter 3). At other times, variations in orthodox analysis have been seen as a practical necessity, because particular patients lacked the ego or financial resources to undergo the stress of long-term, intensive analysis. Cases in point are the development of psychoanalytic psychotherapy, Lacanian analysis, and relational psychoanalysis.

Psychoanalytic Psychotherapy

In practice, most contemporary followers of Freud lean more heavily on psychoanalytic psychotherapy than on classical psychoanalysis. Furthermore, many psychotherapists consider themselves Freudians although they have been trained in settings other than psychoanalytic institutes—including social work, clinical psychology, and counseling training programs.

Anna Freud (1895–1982), Sigmund's youngest child, devoted nearly 60 years to adapting psychoanalysis to children and adolescents. Her work tried to address the unfinished problems bequeathed by her father. She enlarged the boundaries of psychoanalysis with direct considerations of ego functioning without abandoning the bedrock of psychoanalytic instinct theory. Indeed, Anna is rightfully known as one of the "mothers" of ego psychology (which is also considered in Chapter 3). Anna systematized and expanded our understanding of defense mechanisms. Her classic monograph (1936), *The Ego and the Mechanisms of Defense*, legitimized interest in both the ego and defenses (Monte, 1991).

Establishing more flexible forms of **psychoanalytic psychotherapy** as acceptable alternatives within psychoanalysis has usually been credited to Franz Alexander (1891–1963)

and his colleagues at the Chicago Institute of Psychoanalysis. Alexander and French (1946) argued that orthodox analysis had been developed by Freud to serve as a scientific means of gathering knowledge about neuroses, as well as a means for treating neuroses. Once the fundamental explanations for the development of personality and psychopathology had been established, however, there was no justification to proceed with all patients as if each analyst was rediscovering the oedipal complex. With a thorough understanding of the psychoanalytic principles of psychopathology, therapists could design a form of psychoanalytic therapy that fit the particular patient's needs, rather than trying to fit the patient to standard analysis.

Some patients might profit from classical analysis—namely, those with personality/character disorders that do not respond to other forms of treatment. But these patients are in the tiny minority. Much more common are the milder chronic cases and the acute mental disorders resulting from a breakdown in ego defenses due to situational stresses. Clients with milder and acute disorders can be successfully treated in a much more economical manner than previously thought. Alexander and French (1946) reported 600 such patients who were treated with psychoanalytic therapy that lasted anywhere from 1 to 65 sessions. The therapeutic improvements they reported with their abbreviated therapy were earlier believed to be achievable only through long-term, standard psychoanalysis.

Following the principle of flexibility, psychoanalytic therapy becomes highly individualized. The couch may be used, or therapy may proceed face-to-face. Direct conversations may be substituted for free association. A **transference neurosis** may be allowed to develop, or it may be avoided. Drugs and environmental manipulations will be included when appropriate. Therapeutic advice and suggestions will be included along with dynamic interpretations.

Because daily sessions tend to encourage excessive dependency, psychotherapy sessions are usually spaced over time. Daily sessions can also lead to a sense of routine in which the client fails to work as intensely as possible because tomorrow's session is always available. As a rule, sessions are usually more frequent at the beginning of therapy to allow an intense emotional

relationship to develop between client and therapist, and then sessions are spaced out according to what seems optimal for the individual client. After therapy has progressed, it is usually desirable for the therapist to interrupt treatment to give clients a chance to test their new gains and to see how well they can function without therapy. These interruptions pave the way for more successful termination.

Transference is an inevitable part of any psychoanalytic therapy, although the nature of the transference relationships can be controlled. A full-blown transference neurosis is usually what accounts for the length of standard analysis, so briefer psychoanalytic therapy will frequently discourage a transference neurosis from developing. A negative transference can also complicate and extend therapy, and so may be discouraged with particular clients. When the transference relationship is controlled and directed, and when the therapist relies on a positive transference to influence clients, therapy can usually proceed more rapidly. A client with a positive father transference toward the therapist, for example, is much more likely to accept the therapist's suggestions to leave a destructive marriage or switch to a more constructive job than would a client involved in a negative transference.

The nature of the transference can be controlled through the proper use of interpretations. If it has been decided that a transference neurosis is unnecessary or perhaps even damaging, the interpretations will be restricted to the present situation, because interpretation of infantile conflicts encourages regression and dependency. Regression to early stages of functioning can also be interpreted as a means of avoiding dealing with present conflicts. Attention to disturbing events in the past would be used only to illuminate the motives for irrational reactions in the present.

The psychoanalytic psychotherapist can also control the transference by behaving less of a blank screen and more as a supportive figure that clients expect when they seek assistance for behavioral disorders. When the therapist is real and empathic, neurotic transference reactions will be more clearly seen as inappropriate to the present situation and will be less likely to develop.