COMPANION WEBSITE NUMBER 1 -- PSYCHOANALYTIC THERAPY

Fundamental Tenets

HISTORY

Psychologists in the United States virtually ignored psychoanalysis from the 1890s to the 1920s and then vigorously opposed it from the 1920s until about the 1950s. By the middle of the twentieth century, psychologists were subjecting psychoanalytic concepts to rigorous experimental tests (Shakow & Rapaport, 1964), and subsequently many of the psychoanalytic principles were incorporated into mainstream psychology (Hornstein, 1992, p. 254). By the 1990s, psychoanalytic theory was considered a cornerstone of modern counseling and psychotherapy (Fine, 1990; Hornstein, 1992). Of the several hundred therapies in use from the 1970s to the 1990s, most derived some fundamental formulation, technique, or impetus from the psychoanalytic system (Fine, 1979; 1990; Goldman & Milman, 1978). Let's begin with a brief overview of psychoanalytic theory from its founder, Sigmund Freud, to current practitioners.

Freud was born in Freiberg, Czechoslovakia, in 1856, and died in London in 1939 (Jones, 1961, p. 3). He grew up in a time of great scientific progress, which influenced the development of his psychological theories. For example, one of the most important scientific works of that time was the Origin of the Species by Charles Darwin. Darwin's idea that a human was an animal among other animals and thus could be studied naturalistically was a foundation for Freud's study of the workings of the human mind. A second major influence came from the field of physics. Hermann von Helmholtz proposed that a human was an energy system that obeys the same physical laws as other matter. This conception of people led to Freud's idea that human motivation was influenced by unconscious sources of energy (Arlow, 1995, pp. 18--19; Fine, 1973, pp. 1--5).

At seventeen Freud entered medical school, where he was strongly influenced by Ernst Brucke, a prominent physiologist. Brucke's influence ultimately led Freud to create a dynamic psychology involving transformations and exchanges of energy within the personality (Jones, 1961, p. 9). After medical school Freud studied the nervous system and earned a reputation as a promising young neurologist. He began to specialize in the treatment of nervous disorders. He first studied in France with Jean Charcot, who used hypnosis to treat hysteria and other disorders. Hypnosis became a key component of Freud's practice as well. He then studied with Joseph Breuer, who had developed a cathartic method of therapy to treat hysteria (Arlow, 1979, pp. 5--9; Jones, 1961, pp. 38--65).

While scientifically exploring underlying causes of behavior, Freud formulated the idea of unconscious forces. In the 1890s he began analyzing his own unconscious forces, and during this time he wrote the Interpretation of Dreams. This work contained his views on the dynamics of the mind as well. In 1901 he published the Psychopathology of Everyday Life, which proposed that slips of the tongue, errors, accidents, and faulty memory are the results of unconscious motives. In 1905 he published three other important works: A Case of Hysteria, which described the treatment of hysterical disorders; Three Essays on Sexuality, which showed how sexual conflicts can produce neurosis; and Wit and Its Relation to the Unconscious, which proposed that much humor was a covert form of communicating hostility (Fancher, 1973).

All of these works led to the psychoanalytic system of psychology (Fine, 1973, p. 2). However, it was not Freud or his writings alone that made the psychoanalytic system so powerful and widespread. Equally important were the men...
who gravitated to him in what came to be known as the Vienna circle. Otto Rank, Alfred Adler, Carl Jung, Karl Abraham, Max Eitingon, Sandor Ferenczi, Hans Sachs, and Ernest Jones all started out as confederates and disciples of Freud but later developed, extended, and reformulated his theories, often in bitter disagreement with their mentor. In particular, Jung and Adler moved away from the "pure" psychoanalytics of Freud and developed their own theories and following. In 1909 Freud was invited to America by G. Stanley Hall to speak at Clark University. Following this initial visit, prominent psychologists in America such as Hall and William James became receptive to the components of psychoanalytics (Abeles, 1979, p. 136). While Freud's ideas were taking root, he continued to refine the psychoanalytic system, and from 1914 until his death in 1939 he extended his ideas into an ego psychology through which he attempted to understand the total personality (Fine, 1973, p. 4).

The Nazi rise to power prompted numerous adherents of Freud to leave continental Europe for America in the 1930s. America thereon became the world center for psychoanalysis (Arlow, 1995, p. 22). From the 1930s to the 1950s, theorists and therapists such as Karen Horney, Erik Erikson, Harry Stack Sullivan, and Erich Fromm broadened basic Freudian psychoanalytics. These theorists, characterized as Neo-Freudians, included cultural and social determiners and the development of interpersonal relationships as necessary extensions of the psychoanalytic view (Fine, 1962, pp. 257--259; Fine, 1973, pp. 4--6; Giovacchini, 1977, pp. 19--20).

A number of contemporary psychoanalytically oriented therapists have developed innovations to Freudian and Neo-Freudian formulations. Some of these newer approaches to psychoanalytic therapy are described in the section on strategies for helping clients.

**OVERVIEW OF FREUDIAN PSYCHOANALYTIC THERAPY**

Freudian psychology has been tagged with several names: psychoanalysis, psychoanalytic theory, psychodynamic theory, psychodynamic therapy, psychodynamics, psychoanalytic psychotherapy, dynamic psychiatry, dynamic psychology, and depth psychology. By whatever name, it is a psychology of the conflicting forces inherent in the dualistic nature of humankind. The conflicting dualism of the mind may be dichotomized into conscious and unconscious. The dualism of humans in society may be dichotomized into the person as a biological animal and the person as a social being (Arlow, 1979, p. 1). It is through conflicts between the conscious and the unconscious and between the biological motivating forces in people and the social tempering forces in the environment that the personality develops, acculturation occurs, and values are acquired. Freud described this human motivation as being governed by the tendency to seek pleasure (a biological drive) and to avoid pain. He called this tension-reducing force the pleasure principle (Arlow, 1995, p. 16; Freud, 1958, pp. 213--227).

Freud's conception of the development of neurosis grew from his studies of hysteria and hypnosis. In these studies he found that certain unacceptable events and thoughts people had consciously experienced were sometimes repressed into an area of the mind he called the unconscious. These experiences, which were of a sexual nature, directly influenced the person's behavior and caused hysterical symptoms. These ideas were the basis of Freud's theory of the development of neurosis (Fancher, 1973). Thus, the hysterical neurotic became the accepted prototype for the early Freudians' understanding, diagnosis, and treatment of maladjusted patients.

The methods of psychoanalysis grew from the early studies of hysteria and hypnosis. Hypnosis was found to be useful for relieving hysterical symptoms in some cases, but not all of Freud's clients responded equally well to this
method. Freud thereupon began to use an open-ended, gently guided discovery technique to bring to light childhood sexual fantasies. This technique evolved into the free association method, one of the cornerstones of classic psychoanalysis. The primary goal of this method is to make unconscious material conscious and thereby promote insight and understanding. Interpretation is then applied to the unconscious material, as it is applied to dreams, facilitating the client's understanding of the influence of unconscious motives on present behavior. Finally, the client uses transference, an emotional response to the therapist that represents a repetition of the individual's fantasies about a past relationship (such as with a parent), to gain insight and eventually to resolve the neurotic conflict (Arlow, 1995, p. 32; Goldman & Milman, 1978, pp. 2--19).

Auld and Hyman (1991, p. 17), citing Rapaport (1967), identified seven postulates or assumptions that have driven psychoanalytic therapy from the middle of the twentieth century to the 1990s:

1. Access to unconscious functioning comes through the associative process.
2. Later mental structures have to be explained by earlier experiences, by turning back to the past.
3. Psychic continuity is a lifelong process.
4. Mental life has meaning.
5. Determinism, the conviction that nothing that happens is accidental, is an accepted principle.
6. Instinct, that is, as the source of motivation in bodily processes, is an accepted concept.
7. The assumption of the concept of the unconscious is necessary because conscious experiences leave gaps in mental life that unconscious processes bridge.

Auld and Hyman hold that postulate one (which they added to the other six assumptions developed by Rapaport), is the guiding rationale for psychoanalytic technique. Thus, their view of psychoanalytic therapy is built on the premise that insofar as the psychodynamics of the patient “can be elucidated by pursuing his or her associations, the therapist and the patient, working together, can understand the patient and have a constructive effect on the patient’s life.” Therapists use all of the powerful tools that the psychoanalytic system has to offer. But in modern practice therapists do not simply instruct clients to talk at length about their childhood experiences and fantasies. Rather, psychoanalytic therapists are committed to discovering what clients are experiencing and discovering in the moment—collaboratively with their therapists in the therapy room. Auld and Hyman (1991, p. 6) contend that “more than any other kind of therapy, psychoanalytic therapy deals with the here-and-now.”

According to Arlow (1989, 1995), effective psychoanalytic treatment can best be understood by examining empathy, intuition, and introspection (1989, pp. 39--40). Arlow explains that empathy is a form of “emotional knowing,” central to the psychotherapeutic process, whereby a therapist exercises the ability to identify with and share the client's experiences both affectively and cognitively. He describes intuition as the organization, in the therapist's mind, of the myriad of data communicated by the client “into meaningful configurations outside the scope of consciousness” of the therapist (1989, p. 40), yet made conscious through unconscious mental operations. The therapist
becomes aware of such unconscious material through introspection, a process using mental free association, whereby the therapist consciously synthesizes the client's accumulated communications. These introspections are not communicated to the client but rather are used to understand and help the client finally to attain the insight and ego strength needed to cope with whatever emotional traumas or dilemmas brought him or her to therapy in the first place. The communication of empathy directly to the client has been recognized and recommended by many modern psychoanalysts as a prerequisite to effective psychotherapy (Bacal, 1995; Feiner & Klersky, 1994; Josephs, 1994; Kohut, 1995; Warren, 1994).

**THEORY OF PERSONALITY**

According to Arlow (1995), personality "evolves out of the interaction between inherent biological factors and the vicissitudes of experience." Psychoanalytic personality theory is based on several fundamental principles cited by Arlow (pp. 23--24):

1. **Determinism.** Mental events are not random, haphazard, accidental, unrelated phenomena. They are causally related chains of events.

2. **Topography.** All mental elements are judged according to accessibility to consciousness.

3. **Dynamic viewpoint.** The interaction of libidinal and aggressive impulses is biologically based and is more correctly defined by the term *drives* than by the more common but acceptable term *instincts*.

4. **Genetic viewpoint.** Psychoanalysts have empirically linked later conflicts, character traits, neurotic symptoms, and psychological structures to childhood events, wishes, and fantasies.

Freud proposed that the personality consists of three major parts—the id, the ego, and the superego (Hall, 1954).

**THE ID**

The id exists at birth and is the source of psychic energy and the instincts, the most important of which are sex and aggression. Energy in the id is mobile and can be readily discharged through action and wish fulfillment. One function of the id is to fulfill the pleasure principle, which, as we have seen, is a basic motivating force that serves to reduce tension by seeking pleasure and avoiding pain (Arlow, 1995, pp. 21--22; Fine, 1973, p. 14).

The id is the newborn's reservoir of emotional energy. A basic function of the id is to maintain the organism in a state of tension-free comfort. When the infant is hungry, the id seeks immediate gratification to restore the infant to a state of comfort (Hansen, Stevic, & Warner, 1982, pp. 28--29). Frustration occurs when the infant's oral erotic wishes are not immediately satisfied. The experience of overcoming early frustration initiates learning and development. The sucking instinct serves some important purposes. It satisfies the oral erotic need for stimulation and satisfaction. Because of this a *cathexis*—the concentration of one's psychic energy on some person, thing, idea, or aspect of self—develops between the infant's need for protection and satisfaction and the mother, the mother's breasts, or the bottle. The infant's early experience of locking the mouth onto the nipple may serve as the first "click" of insight and thereby the root of all later learning (Belkin, 1980, pp. 56--57). Thus the id is the energizer and the starting point of the organism's personality.

**THE EGO**
The ego is a complex psychological organization that acts as an intermediary between the id and the external world. It has both defensive and autonomous functions. It is not present at birth but is developed as the person interacts with the environment. To function as this intermediary, the ego operates by the reality principle. The reality principle postpones the discharge of energy until an object that will satisfy the need, or reduce tension, is found. Unlike the id, the ego is able to tolerate tension and thus delay gratification. The reality principle is served by the secondary process, which consists of discovering or producing reality through a plan developed by thought and reason. The secondary process interacts with the environment and develops the ego. These lines of development are also influenced by heredity and maturational processes. The ego has been called the executive of the personality because it controls and governs the id and the superego and maintains interaction with the external world (Fine, 1973, p. 15; Giovacchini, 1977, p.21; Hansen, Stevic & Warner, 1982, p.29).

THE SUPEREGO

The superego is the moral, social, and judicial branch of the personality; it represents the ideal rather than the real. The superego strives for perfection rather than pleasure or reality. It develops as a result of the need to control the aggression that results when needs are not immediately satisfied. The superego develops from the ego by assimilating parental standards and eventually substitutes parental authority with its own inner authority. It takes over the governance of the psyche and mediates between the person and the environment. It acts as the moral and social gatekeeper and keeps the person’s baser instincts from running rampant (Fine, 1973, pp. 15--16; Giovacchini, 1977, p. 21).

The superego has two subsystems—the ego ideal and the conscience. The ego ideal is composed of the child’s conceptions of what the parents consider to be perfection, or the perfect person. These conceptions are established through experiencing parental acceptance. The conscience is composed of the child's conceptions of what is considered to be morally bad and is established through experiencing admonitions, punishment, or lack of acceptance (Giovacchini, 1977, p. 21).

In summary, the id is the reservoir of the psychic energy that operates the three systems of personality. Since the id can receive gratification only through reflex and wish fulfillment, the ego rationally satisfies the impulses of the id by selecting objects in the environment that will reduce tension and bring pleasure. The ego eventually obtains control of most of the id’s psychic energy. The superego serves as the moral arm of this personality structure, using the prohibitions of conscience to block discharge of energy or directing the discharge of energy through the ego ideal. A person who is dominated by the id will tend to be impulsive; one who is dominated by the superego will be overly moralistic and perfectionist. The ego functions to keep the individual from these two extremes (Hansen, Stevic, & Warner, 1982, pp. 28--30). Where the ego is working well, the personality is a unified blend of the three systems (Giovacchini, 1977, p. 21).

THE DEVELOPMENT OF PERSONALITY

Childhood sexuality plays an important role in the development of the personality (Freud, 1961a, pp. 141--149). The infant is capable of receiving sexual gratification from rhythmic stimulation of any part of the body; Freud termed this polymorphous perversity. As the infant matures, the generalized ability to receive sexual gratification decreases as certain parts of the body become preferred sites for gratification. In other words, the possibilities for gratification of the sexual instinct narrow as the infant develops. Freud
postulated a series of developmental stages that describe this narrowing process of sexual gratification. These stages, now referred to as the stages of psychosexual development, are as follows.

ORAL STAGE

This stage occurs during the first year of life and develops from the act of feeding in which the mouth and lips naturally come to receive more stimulation than other parts of the body. Because oral responses had been demonstrated to have strong sexual connotations in perversions, neuroses, and latent dream content, Freud thought that the nonnutritive components of an infant's oral behavior were sexual. Conscious and unconscious memories of oral experiences have a central position in the psychological life of the infant, and new experiences are organized around these memories (Arlow, 1995, p. 25; Wolman, 1968, pp. 67--69).

Freud proposed that the mouth has five functions: (1) taking in, (2) holding on, (3) biting, (4) spitting out, and (5) closing. Each is a prototype for certain personality traits. These functions take on symbolic meaning in the adaptations the individual makes in coping with the anxieties and stresses of life. For example, taking in through the mouth is the prototype for acquisitiveness, holding for tenacity, and spitting out for rejection. Whether these traits become part of one's personality depends on the amount of anxiety and frustration experienced in the oral stage. For example, an infant who was weaned too soon or too abruptly may develop a strong tendency to be possessive in order to avoid repetition of the anxiety and frustration of the weaning experience (Fine, 1979, pp. 150--171; Hall, 1954).

ANAL STAGE

The anal stage develops during the second and third years of life as the anal area begins to assume a central position in the child's sexual development. This area becomes more strongly associated with sexual gratification than the mouth. As children become capable of voluntary muscle control and eventual bowel control, they discover that sexual stimulation occurs from voluntarily retaining and expelling feces. Anal ideas and memories involve such activities as elimination, retention, smearing, or cleaning. Just as with the oral stage, the prototypes of later personality characteristics develop during the anal stage. Expulsive elimination is the prototype for emotional outbursts and temper tantrums in later life. Toilet training, which usually occurs during this time, can have the effect of establishing prototypes for later conflicts with authority figures, meticulous cleanliness and orderliness, or even generosity and philanthropy (Arlow, 1995, p. 25; Fine, 1979, pp. 177--188).

PHALLIC STAGE

This stage occurs after mastery of the tasks of toilet training. At approximately age three or four the child discovers the pleasures of genital manipulation and another shift of the zone of sexual stimulation occurs. Because of increased dexterity, the child can now have regular and intense pleasure by stimulating the genitals. It is during this stage that the Oedipus complex develops. Freud named this stage for its parallels with the Greek play Oedipus Rex, in which Oedipus kills his father and marries his mother. The Oedipus complex develops when the child has intense sexual feelings for the parent of the opposite sex. The male child fears castration by the powerful father and subsequently represses his desires for the mother and identifies with the father. The female child thinks she has already been castrated and thus suffers from penis envy and is not as fearful of her mother as the male is of his father. Difficulties in the resolution of the Oedipus complex may lead to problems of sexual identity (Arlow, 1995, pp. 25--27; Wolman, 1968, pp. 71--72).
LATENCY PERIOD

The first stages constitute the pregenital stages. Fixation at any one of these stages may produce oral, anal, or phallic character types in later life. These stages are precursors to the fourth stage of psychosexual development, the latency period, which extends from age five or six to puberty. At about age six, the sexual instinct diminishes and the child enters a stage of sexual quiescence. During this stage, children enter school and apply themselves to the tasks of learning. Although the sexual instinct is repressed, the sexually charged memories of the previous stages are still intact and will influence personality development (Arlow, 1995, pp. 27--28; Freud, 1961a, pp. 141--149).

GENITAL STAGE

This fifth stage of psychosexual development occurs at puberty and is characterized by nonnarcissistic behavior that develops in the direction of biological reproduction. Characteristics of this stage are an attraction for the opposite sex, socialization and group activities, marriage and the establishment of a family, and vocational development. The genital stage becomes fused with the pregenital stages as kissing, caressing, and sexual intercourse satisfy pregenital impulses. This stage lasts from puberty to death or senility, whichever comes first (Babcock, 1983, pp. 37--44; Wolman, 1968, pp. 81--82).

In summary, Freud emphasized the role of sexuality in the development of personality. The narrowing manifestations of sexuality proceed through five psychosexual stages of development. As the person proceeds through these stages, propelled by inherent forces and molded by the environment, he or she acquires various components of personality. Fixation at any of the first three stages may produce certain personality types, such as the oral, anal, or phallic character. Although there are two further stages of psychosexual development, the basis for the individual's personality in later life is determined during the first three stages.

NATURE OF MALADJUSTMENT

A basic theme of Freudian psychology is that human development requires the suppression of “impure” childish impulses. Adults continue to fight these antisocial and disruptive impulses. In Freud's time a common manifestation of the attempt to repress these “loathsome” childhood wishes was hysteria. It was through Freud's work with hysterical clients that he discovered the relationship between sexual fantasies and impulses and hysterical symptoms. He first thought that childhood seduction and sexual trauma were the cause of hysterical symptoms, but he eventually proposed that his client's “memories” were the products of wish fulfillment rather than actual traumatic events. He found traces of childhood sexuality in himself, and from these observations concluded that the unsuccessful resolution of the Oedipus complex was responsible for neurotic symptoms (Freud, 1961b, pp. 173--183).

Basically, what precipitates the neurosis is that the impulses of the Oedipus complex have a strong need for satisfaction. Most people can satisfactorily resolve these impulses. The most common and significant conflicts arise from wishes during the Oedipal phase. Childhood neuroses are usually manifested through nightmares, phobias, tics, mannerisms, ritualistic behaviors, and general apprehensiveness. Childhood behavior disorders are generally related to repressed neuroses. Adult neurosis is generally interpreted as a resurfacing of childhood neurosis (Arlow, 1995, pp. 29--30).

Freud proposed that the psychic processes in neurosis and psychosis had a fundamental unity. The symptoms of the psychotic are explainable by the same unconscious mental processes that give rise to the symptoms of the neurotic client and the dreams of a normal person. The principal difference between
psychosis and neurosis is the change in the psychotic's relationships with people and the environment: the psychotic withdraws from the world and people, often thinking that the world has changed and that people are unreal. Thus the psychotic, unlike the neurotic and the normal person, has a break with reality (Arlow & Brenner, 1964).

**MAJOR CONCEPTS**

Psychoanalytic theory embodies a host of formulations, assumptions, and concepts. The major Freudian concepts that we will mention are the unconscious, instincts, identification, displacement, the Freudian symbol, defense mechanisms, transference, and free association.

**THE UNCONSCIOUS**

The unconscious is an actual entity of the mind, the lowest of its three layers. The preconscious is the middle layer and the conscious is the upper layer (Wolman, 1968, pp. 6--11). The contents of these three layers of the mind vary in their degree of availability to conscious awareness. Some are readily accessible, because resistance to their expression is weak; others are not available except through psychoanalysis. What seems most important about unconscious content is the influence it exerts on the behavior of the consciously unaware individual. Its effects range from forgetfulness, slips of the tongue, and accidents to neurosis manifested in hysterical symptoms. Freud explained that the unconscious stores material that is unavailable to awareness because of incompatibility. The incompatibility is between certain unacceptable ideas and the ego, which represses those ideas (Wollheim, 1971).

Wolman (1989) introduced the concept of the protoconscious rather than the preconscious. The protoconscious is described as a bridge between conscious and unconscious phenomena. For example, many altered states of consciousness such as lucid dreams, posthypnotic states, meditation, and parapsychological phenomena are observed on the protoconscious level when individuals are neither totally conscious nor totally unconscious. Fluctuating modes and shifts from the unconscious to protoconscious states of mind, and vice versa, may be observed in schizophrenics and autistic children.

**INSTINCTS**

Instincts are organic motivational forces, or drives (Wolman, 1968, pp. 39--40). Freud recognized two classes of instincts---the life instincts, which he labeled libido, and the death instincts, or thanatos. The seat of the instincts is the id. Instincts direct psychological processes and function as the motivational forces in people. Each instinct has a source (energy), an aim (removal of a need), an object (such as food), and an impetus (strength) (Hall, 1954).

**IDENTIFICATION**

Identification is an ego mechanism that is important in personality development (Wolman, 1968, p. 68). One form of identification is the incorporation of the qualities of another person into one's personality. According to Hall (1954), there are four types of identification:

1. **Narcissistic identification** is identification with others who possess the same trait as the identifier, such as athletic ability.
2. **Goal-oriented identification** is identification with someone who has a trait the identifier hopes to acquire. A male child wanting to be strong like his father is an example.

3. **Object-loss identification** occurs when someone attempts to regain a lost object by identifying with it. The child who tries to regain parental love through attempts to please his or her parents by adopting their values and standards is an example.

4. **Authority identification** is identification with the prohibitions set down by parents and other authority figures. This type of identification leads to the development of the conscience.

**DISPLACEMENT**

This is the process by which psychic energy from the instincts can be rechanneled from one object to another. Only the object of the instinct varies; the source and the aim of the instinct remain the same. Through this process a major portion of the personality is formed. The development of the personality through displacement is a complex process by which multiple tensions can be reduced, and the object chosen may be far removed from the drive that started the process. For example, the original drive for oral gratification, which is first satisfied by sucking the nipple, will undergo several displacements—thumb sucking, candy sucking, cigarette smoking, beer drinking, eating, talking, oratory, and so forth (Hall, 1954; Wolman, 1968, pp. 147--152).

**THE FREUDIAN SYMBOL**

The Freudian symbol is a socially acceptable representation, usually in dreams, of an unconscious and objectionable thought, wish, or object. For example, the penis may appear in dreams as an elongated object or an object capable of penetration, such as a knife, gun, snake, statue, spire, or cigar. The vagina is represented by objects capable of being receptacles, such as a cave, box, tunnel, or pocket. In psychoanalytic treatment, the symbols in dreams, which may represent a wide range of unconscious thoughts, are analyzed as a means to make unconscious material conscious (Hall, 1954).

**DEFENSE MECHANISMS**

Defense mechanisms are used by the ego to reduce anxiety associated with threatening situations and feelings. Anxiety is generated by the instinctual demands of the id and the pressures of the superego. In contrast with realistic measures for dealing directly with the source of the threat, defense mechanisms distort, deny, or falsify the reality of the anxiety-producing situation. These protective mechanisms are used by most people, and at times, particularly when the ego is developing, may prevent the person from being overwhelmed by parental and societal demands. Such demands may become so excessive that the defense mechanisms employed thwart the natural development of the person and thereby become unhealthy. Some of the more important defense mechanisms are as follows (Wolman, 1968).

1. **Repression.** Repression forces a threatening memory, thought, or perception out of consciousness and prevents it from returning. Repression may prevent a person from seeing an object that is actually in view, or it may allow distortion of objective reality in order to protect the ego from the danger associated with the perception. Freud attributed hysterical disorders to repression. Repression may contribute to a conversion reaction resulting in so-called psychosomatic disorders such as asthma, arthritis, and ulcers (Wolman, 1968).
2. Projection. When forces from the id or the superego threaten a person, the ego sometimes attributes those forces to an external source. The ego is attempting to convert internal anxiety into an objective external anxiety that is easier to handle. Thus, projection is the attribution of one's feelings or characteristics to people in general. One who is unhappily married may reduce the anxiety associated with that condition by concluding that all marriages are unhappy (Wolman, 1968, p. 146).

3. Reaction formation. Reaction formation occurs when the ego sidetracks the expression of a threatening impulse by prompting the person to behave in the opposite way. A person who crusades against vice and corruption may be doing so (unconsciously) to deny an urge to participate in these same activities. The principal features of reaction formation are an exaggerated demonstration of the opposite feeling and an inflexibility of expression of that feeling. Reaction formations are also employed against external threats, as in the case of exaggerated friendliness toward or obedience to someone or something that is feared (Wolman, 1968, p. 146).

4. Fixation. Fixation is a psychological stunting whereby the person fails to proceed from one developmental stage to another. People generally experience anxiety when faced with the prospect of engaging in a new behavior; they worry about performing adequately, are afraid of being ridiculed for failure, or fear punishment. Most people will take the risk in order to grow. However, some people feel such great anxiety at the thought of the anticipated situation that they refuse to engage in the new behavior and thus remain fixated at an earlier developmental level. This fixation, a fear of leaving the old for the new, is also called separation anxiety (Wolman, 1968, pp. 140--141).

5. Regression. Regression is a retreat to a previous stage of development. Some forms of regressive behavior are so common they are viewed as childish. The college freshman regresses when he or she returns to the security of the parental home every weekend or drops out of school rather than face the anxiety of confronting the world “alone.” A more severe expression of regressive behavior is withdrawal into a world of daydreams and fantasies to the exclusion of independent functioning in society (Hall, 1954).

TRANSFERENCE

Transference is a key concept in psychoanalytic therapy. It occurs when the client's feelings are directed toward the therapist as though the therapist were the source of the feelings. The therapist's analysis helps the client distinguish between the fantasy and the reality of the feelings transferred from some previous significant person to the therapist (Arlow, 1995). Also, the client is helped to gain an understanding of how he or she “misperceives, misinterprets, and relates to the present in terms of the past” (p. 32). Since most transferee's feelings are unconscious, the skill of the therapist is needed to help the client realign these distorted relationships.

FREE ASSOCIATION

Free association is a technique that encourages the client to report to the therapist without bias or criticism whatever enters his or her mind. Such reports enable the therapist to uncover repressed material. The analysis of hidden conflicts helps the client gain the insight that is the core of growth (Fine, 1973, p. 21). According to Auld and Hyman (1991, p. 243), “free association is the primary method (perhaps the only one) by which the therapist and the patient gain access to unconscious conflict [emphasis added]. Thus, free association becomes the defining element of psychoanalytic therapy.”
The Counseling Process

CENTRAL FOCCI

According to Arlow (1995) the principles and techniques of psychoanalysis are based on the psychoanalytic theory of neurosis. Those techniques and principles that evolved through Freud's study of clients' nervous disorders are employed to make the contents of the unconscious conscious. Two basic focuses for bringing unconscious material into awareness are free association and transference. The standard technique for studying the functioning of the mind is called the psychoanalytic situation (Arlow, 1995). The client lies on a couch looking away from the therapist and expresses whatever comes to mind. The client looks away from the therapist so that the latter's nonverbal behavior will not influence the production of whatever comes to the client's mind. The therapist's role is to observe and occasionally interpret the content of the client's free associations; the client, in turn, reflects and comments on the interpretation. The purpose of this situation is to allow repressed material to come to conscious, verbal awareness so that the psychic conflict can be examined, interpreted, and eventually resolved (pp. 28--31).

THERAPY

According to Arlow (1995, pp. 31--33) treatment is composed of four phases: the opening phase and the development, working through, and resolution of the transference.

THE OPENING PHASE

This phase has two parts. The first consists of a set of interviews during which the client's problem is determined and a decision is made as to the appropriateness of analysis. The structure of the analytic situation is explained, particularly the delineation of the responsibilities of the therapist and the client. If the therapy proceeds after the first few sessions, then the second part of the opening phase begins. The client continues to assume the position on the couch, and everything he or she says and does is observed and recorded (Arlow, 1995, pp. 31--32). The therapist thereby compiles a comprehensive file of conscious and unconscious material. The therapist uses these dreams, fantasies, projections, free associations, and early memories, as well as emergent life themes, to facilitate client insight during subsequent phases of therapy.

THE DEVELOPMENT OF TRANSFERENCE

The development and analysis of transference constitute an important therapeutic phase. The client's feelings for the therapist, who has become a significant figure in the client's life, are used to demonstrate how the client perceives, interprets, and responds to the present in the same ways he or she responded to significant persons in the past. By understanding how this past behavior influences and determines present behavior, the client can learn to make more appropriate decisions. Concomitant to the analysis of transference, the therapist must be aware of the possibility of countertransference: the therapist's unresolved feelings for significant others may be transferred to the client. Any countertransferences must be analyzed and worked through. This step in the analysis is necessary so that the therapist's unresolved feelings will not interfere with the analysis of the client's transference (Arlow, 1995, p. 32). The analytic process is enhanced by both the therapist and the client gaining a conscious awareness into the emergent transference and countertransference aspects of their ongoing relationship.

WORKING THROUGH TRANSFERENCE
This phase overlaps with the previous phase. The working through of one transference usually precipitates the recall of a significant event that in turn leads to further insights. Working through the transference is an evolving process, and with each working through there is further clarification and understanding (Arlow, 1995, pp. 32–33). Many clients manifest resistance during therapy. Resistance is either the active or the passive opposition of the client to the therapist's attainment of the therapeutic objectives. Even though at the conscious level the client wants help, he or she uses defense mechanisms to avoid bringing to the surface unconscious, usually repressed, material such as painful memories or guilt feelings. Working through client resistance is an important aspect of the therapist's role in the psychoanalytic process.

THE RESOLUTION OF TRANSFERENCE

When the client and the therapist believe that the client's major conflicts have been worked through, a date is set for termination of the therapy. The purpose of this phase is to resolve the client's neurotic attachment to the therapist. Several aspects of this phase are common. One is that the client may be reluctant to give up the relationship and may maintain dependency on the therapist. The resolution of this aspect of therapy represents the finishing touches to the client's therapy. Sometimes further memories, related to the interpretations made earlier in the treatment, emerge. It is important to work through any grandiose fantasies or wishes the client may have regarding his or her condition after therapy is terminated (Arlow, 1995, p. 33).

Finally, psychoanalytic therapy focuses exclusively on how the client's mind works (Giovacchini, 1977). The therapist's views are not imposed on the client. The therapy is centered in interpretation within the context of transference (p. 19). A unique and powerful characteristic of psychoanalysis is the therapist's ability and willingness to allow transference to develop with the objective of increasing the client's autonomy by extending his or her control over inner, primitive forces (p. 39).

Strategies for Helping Clients

Psychoanalysis focuses on the workings of the client's mind. The attainment of the Socratic motto "Know thyself" is the essential goal of the therapy (Giovacchini, 1977, p. 36). The therapist may use a variety of strategies to enhance the analysis of transference. Assessment of the client's emotional, situational, and medical readiness to participate in and profit from therapy is essential. Not all clients or problem situations lend themselves to the psychoanalytic approach. The early sessions are typically devoted to free association, dream interpretation, fantasizing, hypnotic techniques, or other ways of gaining access to the client's unconscious.

CONTEMPORARY PSYCHOANALYTIC STRATEGIES

Modern psychoanalytic therapists have developed a variety of treatment strategies. Based on Freudian formulations, these strategies have broadened the client population served and represent innovative refinements of classical psychoanalytic practice (Belkin, 1980, pp. 23-24). Other innovations depart from traditional psychoanalysis. Several of the latter are identified here.

UNIQUE EPISODES OF SELF-CHANGE

The phenomenon of the client as active change agent is a critically important, but a new and understudied one. The active episode of self-change on the part of the client is identified as a psychoanalytic strategy that promotes positive and therapeutic outcomes in clients who are engaged in therapy. An active episode is
an emotionally charged or psychological event that occurs in a client during therapy that, though complete within itself, forms a part of a larger event or episode. Such active episodes, catalyzing rapid client recognition of prior unconscious psychic material, are similar to and roughly correspond with the nurturing and positive use of chaotic episodes described by J. S. and D. E. Scharff (1998). Chaotic episodes (internal psychic occurrences that are emotionally charged but totally confusing) can be turned into therapeutically positive events whenever, within the client’s unconscious mind, the “chaos” bifurcates (divides) into recognizable images, one of which is an image of stability and equilibrium. Active episodes or chaotic episodes, that occur within the supportive framework of psychoanalytic therapy, are believed to empower clients in rapidly attaining substantive psychologically forward leaps or mental gestalts (“ah ha experiences”) toward self understanding and self-change.

INTROSPECTION AND SELF-UNDERSTANDING

Kohut and Adroer (1998) have strongly suggested that the entire domain of psychoanalytic inquiry is that of subjective experience. They argue that the only data for psychoanalytic understanding are those that are accessible by introspection (i.e., “vicarious introspection”) and empathy.

PSYCHOANALYTIC RESPONSES TO THE HIV/AIDS EPIDEMIC

Blechner (1997) contends that the HIV/AIDS epidemic has changed basic views about psychoanalytic therapy with all patients. The shifting of psychological attitudes regarding HIV/AIDS among clients and all of society in the past few decades has compelled psychoanalysts to find ways to understand and assist clients, friends, and families who often manifest irrational reactions toward the HIV/AIDS crisis. Blechner concludes that psychoanalysis has much to offer to all levels of practitioners of counseling, psychotherapy, and related disciplines that are involved in helping people living with AIDS and those individuals who care for them.

EFFECTS OF PLAY IN PSYCHOANALYTIC THERAPY

Sanville (1999) explored Freud’s idea of transference as a playground, and Winnicott’s assertion that psychotherapy is a subspecies of play. In the context of what those authors called “intermediate” space, a client discovers ways of interpreting or attributing meanings to inner feelings, thoughts, and being as he or she engages in dialogue with others. Whether with children or adults, psychoanalytic therapies have developed a specialized form of playing in the service of this necessary communicating and relating with other people. It would appear that Sanville’s strategy brings to the psychoanalytic repertoire some innovative eclectic elements from cognitive and gestalt therapies as well as a smattering of psychodrama.

VALIDATION OF THE PSYCHOANALYTIC PROCESS

Gunderson and Gabbard (1999) assert that a variety of political, economic, and scientific forces have caused psychoanalytic therapies to become marginalized in psychiatry and society. They aver that psychoanalytic therapies are given short shrift in recently developed treatment guidelines, which are based largely on notions of empirical validation narrowly construed. Gunderson and Gabbard advise that the efficacy of psychoanalytic therapy can be meaningfully addressed by systematic assessment of available knowledge and potential data bases and through explicit efforts to locate the role of psychoanalytic therapies alongside other modalities. They list four steps that might be taken to lend greater credibility to psychoanalytic therapies: (1) define the distinguishing features, (2) identify clear indications and contradictions, (3) systematically collect case histories of successfully treated mentally ill (diagnosable
clients), and, (4) increase vigilance (together with clients) toward assessing progress in treatment.

WRITTEN FACILITATION OF FREE ASSOCIATION

Keeping a diary is another way for the client to facilitate free association (Pearsons, 1965). The case of Mary in Chapter 13 (eclectic counseling and psychotherapy) is an example of the use of a written diary to encourage a resistant client to engage in free association and self-examination (Proff, 1977).

Brief Psychotherapies

The advent of managed care and the work of psychotherapy outcome researchers such as Strupp (1986, 1992, 1993), Strupp and Binder (1984), Ellis (1995), and Small (1972) have brought credibility and widespread application of different forms of brief psychotherapy. In terms of brief psychotherapy's impact on psychoanalytic therapy, a number of studies have consistently shown that the clients' length of stay has far less influence on outcome scores than does the quality of the therapist-client relationship (Alpher, Henry, & Strupp, 1990; Binder, 1993; Demos & Prout, 1993; Harrist, Quintana, Strupp, & Henry, 1994; Henry, Butler, Strupp, & Schacht, 1993; Henry, Schacht, Strupp, & Butler, 1993; Najavits & Strupp, 1994; Strupp, 1992, 1993). The gist of all these studies is that although severe cases of mental disturbance may require long-term treatment, many individuals with situational problems can be served effectively in one to ten sessions (Ellis, 1995, pp. 187--189; Strupp & Binder, 1984).

PSYCHOANALYTIC THERAPY

Small and Bellak developed a six-step model for brief psychotherapies (Small, 1972, pp. 27--35). First, the problem is identified. Second, a detailed history is taken to secure data that will reveal the client's personal experiences and lead to a diagnosis. Third, causal relationships are established. Fourth, methods of intervention are chosen. The fifth step incorporates the working-through phase. The sixth and final step is to leave the client with a positive transference. In step four Small and Bellak recommend environmental manipulation strategies, similar, to those suggested by Ellis's (1995) rational-emotive behavior therapy (REBT), which depart from and greatly augment the procedures used in traditional psychoanalytic therapy. Examples might include the therapist telephoning family members or friends; job placement referrals for the client; teaching clients cognitive skills to use when problems beset them; and even providing clients with audiotaped cassettes of therapy sessions to listen to in their homes, cars, or offices to enhance their ego coping strength during periods of crisis or stressful situations.

AUTONOMOUS PSYCHOTHERAPY

Auld and Hyman (1991, p. 3) brought Freudian psychotherapy into contemporary usage through what Szasz (1974) termed autonomous psychotherapy. They employ some of the basic formulations of both Szasz and Freud and apply modern psychodynamic techniques based on empirical research findings of the past fifty years.

In autonomous psychotherapy the therapist and client develop a working alliance, built on mutual trust and a supportive and empathic relationship, that facilitates both parties in bringing the client's unconscious conflicts to light. The supportive, caring, and empathic relationship, similar to what we would construe to be a person-centered modality, operates to elicit free association to uncover unconscious material needed for the therapy to move
forward. Unlike the person-centered approach, which uses basic facilitative conditions to help clients become more self-actualized, autonomous psychotherapy practitioners use these basic facilitative techniques to effect therapy while providing optimum client autonomy. Thus the autonomous psychotherapist uses fewer artificial means, such as hypnosis or word association, than do traditional psychoanalytically oriented therapists in assisting their clients to uncover therapeutically important material from the unconscious.

The therapist must be knowledgeable and skilled in facilitating the associative process, working through transference issues, dealing with the client’s repression, handling resistance, and performing other psychoanalytic techniques. But the curative factors lie in the associative process, the therapist's ability to make appropriate interpretations within the working alliance, and the capability and motivation of the client and therapist to experience autonomy, work through defenses, and deal with issues of transference and other impediments to resolving unconscious conflicts.

TIME-LIMITED DYNAMIC PSYCHOTHERAPY

Strupp and Binder's (1984) time-limited dynamic psychotherapy integrates important elements of both traditional and modern psychoanalytic therapy. Although the time limitation of the therapy is not as clear-cut as in transactional analysis or REBT, it is an important dynamic because it motivates both client and therapist to work toward attainment of some degree of clarity or progress during each session. Time is of greater essence than in more traditional forms of psychoanalytic therapy.

THEORETICAL TENETS

Time-limited dynamic psychotherapy is an interpersonal model in that the source of the client's disturbance is viewed as being rooted in difficulties in interpersonal relationships. The major purpose of psychotherapy is to assist the client to form new, healthy relationships. The therapist-client relationship plays an important part in enabling the client to gain insight as well as to develop and strengthen relationship skills. Conceptually, the therapist may focus on the past, present, or future, thus helping the client to understand and root out damaging attitudes of the past, mitigate against emotional deficits of the present, and prepare for improved relationships in the future (Strupp, 1986).

Three major tasks of therapy are: (1) to identify cyclical maladaptive patterns; (2) to bring to the client's attention those patterns; and (3) to help the client explore how those patterns affect behavior and relationships (Strupp, 1986). The therapist has an opportunity to be both a participant and an observer and is able to step aside as an objective mentor and point out patterns to the client. The therapist is also observant of his or her own reactions and uses these reactions to help clients discover their own thoughts, emotions, and relationship needs. Thus, time-limited dynamic psychotherapy may be conceptualized as having balance among emotional, cognitive, and experiential components and typically focusing on past, present, and future factors that affect clients (Strupp, 1986).

TECHNIQUES AND STRATEGIES IN TIME-LIMITED DYNAMIC PSYCHOTHERAPY

Time-limited dynamic psychotherapy strategies and techniques operate on a personal and trustful level. Yet the element of connecting present dilemmas to past traumas and patterns is pervasive in time-limited therapy. Objective interpretation, action-oriented problem solving, and effective mentoring are continually evident. Both the client and the therapist remain aware of the need to make therapeutic progress within the constraints of time, which is a limited and valued therapeutic
commodity.

EGO PSYCHOLOGY

Ego psychology, founded on Erikson's (1963; 1968; 1982) principles of psychosocial development throughout the life span and promoted by theorists such as A. Freud (1936) and Hartmann (1939), sought to broaden and extend S. Freud's earlier formulations into a more complete theory of human behavior. The main thrust was the study of the ego and its functions. Hartmann (1939) viewed the ego as the guiding factor in an individual's adaptation to an "average expectable environment." Later, Beres (1956) and Blanck and Blanck (1968; 1974; 1986) redirected ego psychology away from psychic conflict and focused instead on the deficiencies and arrests accrued during development of the person's ego functions. Thus, in therapeutic application, ego psychotherapy becomes a task of promoting undeveloped or underdeveloped ego strengths and skills.

Typically, the ego therapist serves as a model or a sort of auxiliary ego for the client while the client is in the process of developing a stronger ego. Caper (1995) emphasizes that current ego analysts are concerned mainly with real and contemporary events affecting the client, whereas Britton (1995) describes the ego as a creature of the frontier between the internal and external worlds of the client. Britton suggests that belief is to psychic reality what perception is to material reality. Belief gives the force of reality to that which is psychic, just as perception does to that which is physical. Consequently, compared with a traditional psychoanalytic practitioner, the ego therapist pays less attention to uncovering unconscious conflict and analysis of transference and more attention to here-and-now reality testing. The therapist is quite active in assessing the client's ego status, guiding the client toward goal attainment, asking open questions, directing the client to focus on the realities of life such as deficits in psychosocial functioning, praising the client for achieving successes, and tending to take the client's presenting problems or conflicts at face value and emphasizing the integration of his or her current interpersonal and sociocultural adjustment into the ego or self-concept (Altman, 1995; Levine, Jakubowski, & Cote, 1992).

The therapist's role is similar to that of a mentor or coach and represents a model or pattern that the patient may emulate to form a psychic attachment or object identification that is realistic and appropriate. Because a major goal of ego therapy is strengthening the ego so the client may develop healthy psychosocial functioning, therapeutic strategy deals more with remediation and correction than with unconscious conflict resolution.

OBJECT-RELATIONS PSYCHOLOGY

Object-relations therapy, similar to ego psychotherapy, emphasizes the importance of the client's intrapsychic relationships with others more than do the traditional psychoanalytic therapies. According to Hamilton (1988) and St. Clair (1986), Freud used the term object with reference to that external person, target, or thing that satisfies the individual's needs. The word other, used synonymously with object, might typically denote the intrapsychic relationship with a significant other person with whom the client forms a psychic attachment. That other person might also be the therapist.

Object-relations therapists may focus on any number of "object" relationship conflicts: experiences of attachment and separation, boundaries between self and others, interpersonal relations as dominant elements in personality development, and identity diffusion and identity coherence (Auld & Hyman, 1991, p. 245). In the therapeutic setting the client's stories may be taken at face value, not to be considered as either verifiable or refutable but rather to be regarded as
associations. Auld and Hyman contend that “one should focus on what these associations of the patient tell us about the patient's unconscious conflicts: They are representations of this latent material” (p. 246).

Object-relations therapists seek to establish personal, empathic, trusting relationships with clients. Transference and countertransference are handled as object relations in the therapeutic setting. Analysis and interpretation are oriented less on uncovering unconscious conflicts and more on the client and therapist collaboratively examining the nature of the client's interpersonal and psychosocial relationships (Stricker & Healey, 1990). The therapist typically focuses on those “object” relationships that drive the patient's current interactions with people. McCarthy (1995) underscores the analytic task of facilitating individuation from internal objects and recommends that analysts form an alliance with the client's development process. Object-relations theorists emphasize relatedness, dissociative processes, and disruptive anxieties in self-object dialogues. Warren (1994) emphasizes the importance of the appropriate use of empathy in conducting object-relations therapy as one psychoanalytic approach. The primary goals of object-relations therapy are to make clients aware of relationship deficits and to help them discover ways to improve interpersonal functioning.

FUNDAMENTAL TENETS OF OBJECT RELATIONS THERAPY

We emphasize here and in the text upon which this Companion Website is based that object relations therapy is among the foremost modern psychoanalytic subsystems. Therefore, here, in our treatment of the fundamental tenets of the object relations modality we include a brief review of its history, major concepts, the counseling process, and strategies for helping clients.

HISTORY OF OBJECT RELATIONS THEORY

Drive versus Relational Theories. Over the course of several decades, Freud’s formulations provided the impetus and conceptual basis for several competing analytical philosophies and clinical approaches. Concomitant with the current disarray among the psychoanalytical approaches are two broad, competing perspectives, Freud’s drive theory and a cluster of relational models that include object relations theory, interpersonal psychoanalysis, and self psychology. Although drive or instinct (sometimes simply called biology) theory is systematic, unified, and comprehensive, it is also obsolete because it does not account for major aspects of human motivation that modern theorists attribute to environmental factors (Mitchell, 1988, p. viii; Scharff & Scharff, 1998). Relational theories are proliferating and more consistent with applied psychoanalytic practice today, and a number of relations oriented analytical clinicians (including many in North America) are working toward developing the newer theories (especially object relations therapy) into a more coherent, comprehensive, and systematic framework (Blanck & Blanck, 1986; Corrigan & Gordon, 1995; Ganzarian, 1989; Gomez, 1997; Klein, 1990; Kumin, 1996; Mitchell, 1988; Rogers, 1991; J. S. Scharff, 1997; J. S. & D. E. Scharff, 1998; Skolnick & D. E. Scharff, 1998; St. Clair, 1996; Summers, 1999).

Object relations therapy is one of several different psychoanalytically oriented schools that cluster around the concept of “relational” theory rather than Freudian “biological” or “drive” theory. Even so, all of the relational models are grounded in Freud and are derivations of the basic formulations that were laid down by Freud. Mitchell (1988, pp. 8-9) regards the family of relational models as valuable correctives (checks and balances) for each other. He considers the cluster of emergent relational psychodynamic approaches to be a multifaceted relational matrix which takes into account self-organization, attachments to others (objects), interpersonal transactions, and the active role of the client in the continual re-creation of her or his subjective world. For our purposes in this Website, we believe that an appropriate and useful way for
entry-level learners to view psychological reality is by operating within the relational or interpersonal realm of object relations psychology.

**The Attachment Theory Connection.** The research and clinical work of a large group of attachment theorists are similar, related to, and complimentary of the studies of object relations theorists. The work of attachment theory figures such as Bowlby and Ainsworth lend credence to and support many of the theoretical underpinnings and clinical practices of object relational work. As an interesting example, one major conclusion of Bowlby’s studies, grounded in rigorous empirical evidence, was that to grow up mentally healthy, the infant and young child should experience a warm, consistent, caring intimate, and continuous relationship with her or his mother (or permanent mother substitute) in which both find satisfaction, security, and enjoyment (Bretherton, 1992, p. 6).

Ainsworth’s research supports the connection between attachment theory and object relations. Two of her core emphases are that (1) the mother-infant relationship is the start of personality development, and (2) substantial elements of that early personality development carry forward through all stages of life. An example of special note, derived from Ainsworth’s studies, involved the evaluation of maternal sensitivity to infant signals. Securely attached infants had mothers who were rated as highly sensitive and spontaneous. In contrast, insecurely attached infants had mothers who were rated as inattentive and/or imperceptive of the nuances of infant behavior. The latter babies were significantly less content. The securely attached babies cried little and seemed content to explore in the presence of mother. But insecurely attached babies of inattentive and/or imperceptive mothers cried much more frequently, even when being held by their mothers, and explored little or none. Not-yet attached infants manifested no differential behavior toward the mother (Ainsworth & Bowlby, 1991, p. 7; Bretherton, 1992, pp. 10-11).

**MAJOR CONCEPTS OF OBJECT RELATIONS THEORY**

**Description of “Objects.”** According to St. Clair (1996, pp. 5-6), the object in object relations is a technical term that refers not so much to some inhuman entity but identifies or symbolizes something that provides a specific gratification. Essentially, an object is that with which the person relates. Feelings and affects may have objects. For example, I love my children, I fear furry animals, I am angry with my sibling. Human drives may have their objects too. The object of the hunger drive is food; the object of the sex drive may be a sexually attractive person or thing (object representation of a person). An infant’s objects might be first the mother’s breast, then, the mother herself, and later other people or things that might gratify the baby.

It should be noted that the term representation is used to define how the individual internalizes and represents an object. An example of representation might be the case of a famous tycoon who marries and divorces several beautiful women. An object relations theorist might view this man’s inner world as being filled with distorted, idealized representations of nurturing women, which in turn creates a fantasy world that disturbs his actual relationships with actual women. In his distorted representations of both himself and women, he may feel quite needy and have cravings or yearnings to be cared for by these temporarily idealized women. In his fantasies he projects that each woman, in turn, will fulfill his unmet yearnings or needs. But alas, the painful discrepancy between his inner world and his actual wives results in disappointments, more divorces, and the need for new relationships (St. Clair, 1996, p. 4).

**The Meaning of Being Human.** At its most fundamental level, object relations theory is based on the assumption that the human being is essentially social and that the need for relationships is at the central core of the definition of self. Our innate need for contact with others is primary and cannot be
adequately explained in terms of drives, other needs, nor can it be reduced to something more basic (Gomez, 1997, pp. 1-2).

External/Internal Dichotomy. Ganzarain (1989, p. 10) reminds us that the concept of object relations theory presents a confounding observation that humans exist “simultaneously in an external world, and that the relationship between the two ranges from the most fluid intermingling to the most rigid separation.” The object relations theory is concerned with studying the “relationship between real, external people, and internal images and residues of relations with them, as well as the possible significance of these residues for psychic functioning” (p. 10).

Motivation and the Role of Objects. According to Fairbairn (1954) and discussed in St. Clair (1996, p. 56), people have an inherently basic drive toward relating with other humans. Libido is a highly directional object-seeking mechanism. The “object” that libido is constantly seeking is another human. Motivation is understood in terms of striving for a relationship with a human (object), not merely seeking drive reduction through satisfaction.

The Structure and Influence of Objects. An object relations theory view of the ego’s inner structure can best be understood in terms of the way a child must handle various unpleasant or cruel situations that life presents. For instance, a child who is abused or who receives harsh parental treatment believes that the only option for changing or improving the situation is to change him or herself. The child may seek to solve the object-related dilemma by mentally splitting the object into good and bad components and then mentally internalizing the bad aspect (Gomez, 1997, pp. 37, 65; St. Clair, 1996, pp. 56-57). The likely result is that the child mentally constructs the object as “good” and him or herself as “bad” and deserving of abuse or punishment. Because objects internalized within the psyche become dynamic structures, the ego becomes intertwined with the objects. Consequently, ego and object become inseparable. For example, following a commonplace childhood error or accident, the child is unfairly punished and arbitrarily demeaned by a powerful and domineering parent or caregiver. The child, striving to please the perceived omnipotent powerful caregiving figure, internalizes the belief that he or she is evil and not only deserves to be treated harshly but also is so wicked that he or she can never be worthy of love or affection.

Internalization of Object Representations. For substantive or affective meaning to be incorporated into the ego, the thing, event, or person represented through the object must become merged with the ego. Internalized objects are fluid and are capable of acting as independent entities within the mind. Therefore, in object relations theory, objects are more than merely internal figures or representations. They are agencies that produce dynamic psychological activity. For example, an abused child may love and cling to the abuser but hate him or herself, and, may, later in life make choices that result in becoming re-victimized (St. Clair, 1996, pp. 56-57). Gomez (1997) refers to such love-hate phenomena in terms of the infant’s splitting off his or her unbearable neediness in a withdrawal from external object relationships. This neediness implies that the original object of the child’s need—the person who excited the child beyond what he or she could endure—becomes repressed and emerges from the repression in intense dependency cravings. As an adult, “at a more conscious level, it merges into the central ego/ideal object, as painful yearning in situations such as waiting endlessly by the phone for the lover who had promised to ring, but who we know from experience will not” (p. 62). This example underscores a primary issue in object relations theory that the concepts of splitting and yearning, referred to by St. Clair (1996, pp. 3-4) center on the discrepancy between the person’s inner world representations and the situations of the actual environment.
Influence of Attachment Theory. Commenting on the positive attributes of Bolby’s theories and their applicability and adaptability to object relations therapy, Lopez and Brennan (2000, p. 283) stated that “Attachment theory effectively juxtaposes personality and developmental themes within a broad lifespan framework. In particular, we contend that the literature in adult attachment is contributing to an increasingly comprehensive understanding of the healthy and effective self.”

Lopez and Brennan further state that persons possessing the healthy and effective self, which is derived through positive object attachments, are “resilient in adapting to the vicissitudes of life, and they have a remarkable capacity to develop, maintain, and enlarge their networks of supportive, intimate relationships” (p. 283). Other attachment theory studies have also supported the interplay of object attachment and care giving behavior in infancy and early childhood and attachment functions in adult relationships (Bolen, 2000; La Guardia, Ryan, Couchman, & Deci, 2000; Pietromonaco & Barrett, 2000). Individuals who, as infants, experienced overall attachment security may be predicted to positively experience the basic needs of autonomy, competence, and relatedness during adulthood.

THE COUNSELING PROCESS IN OBJECT RELATIONS THERAPY

Definition and Meaning of “Object.” St Clair (1996, p. 219) defines “object” as “The ‘other’ involved in a relationship or, from an instinctual point of view, that from which the instinct gets gratification.” The term “object” can denote other relationships, memorable events, or impressionable things. Object relations is largely based upon the individual’s relational need of important “others” from infancy to the present. How people obtain their need fulfillment through others speaks to the essence of adaptive (healthy) or maladaptive (pathological) functioning. Thus, object relations therapy serves as a process of providing for clients the psychological nurturing, at least a part of it, that they did not receive in early infancy and childhood (J. S. Scharff, 1997). To provide such nurturing, J. S. Scharff and D. E. Scharff (1998, pp. 10-13) describe the theory as more of an art than a science. In object relations therapy, we try to assess the client’s internal perceptions of other groups or individuals as objects to seek to determine what effect the client’s perceptions have on ourselves as counselors in the immediate setting of the therapeutic encounter. It is more than simply monitoring the client-counselor relationship to maintain a healthy alliance. We do not avoid confrontation or empathic failures. We provide a safe space for thinking, feeling, and making ourselves available for clients to use as current, realistic, and therapeutic object attachments, the goal being to transport or transfer that therapeutic experience to relationships outside the therapy setting. We view the counseling session as an evolving and ongoing laboratory for sharing experiences, examining motivations, and exploring viable options. In summary, the therapeutic relationship is at the core of clinical practice.

Crucial Role of the Client-Therapist Relationship. Regarding the primacy of relationships over impulse, Fairbairn believed that the single most important factor in facilitating therapeutic movement in clients is not the transference relationship but the person-to-person relationship with the therapist (Gomez, 1997, p. 74). That does not mean that the transference relationship is ignored or is considered obsolete. It means that the quality of the therapist relationship takes precedence over transference as the primary emphasis in object relations clinical practice. Melanie Klein and other object relations clinicians also suggest that counselors and therapists seek to help clients understand the relationships between their unconscious or forgotten infant and childhood object relations and to assess the impact of those objects on present emotions and motivations (Gomez, 1997, p. 49).
Focus on the Client. According to Scharff (1997) the therapeutic process in the object relations approach entails the therapist’s genuine acceptance of all clients who present themselves for help. Every client is different, even if they happen to look similar or have similar backgrounds. The therapist must create psychological space by allowing his or her own internal object representations to reverberate with the client’s. Initially, it may help if the therapist keeps an impartial or neutral position and allows the client to affect the therapist. The therapy is managed in such a way that the deep empathy and focus is on the client, especially on the client’s internal world. Such a focus will usually allow the client and the therapist to affect each other. This is highly desirable. The therapist follows the client’s affective lead. Client affect may be a signal of a deeper conflict, perhaps stemming from an earlier experience that the therapist will want to explore. The therapist will be especially sensitive to an expressed wish, dream, or fantasy that may shed light on an inner need or that may constitute a representation of an important internal object relational issue.

STRATEGIES FOR HELPING CLIENTS IN OBJECT RELATIONS THERAPY

Objectives of the Therapist. The casual observer of an object relations therapist at work would notice little difference between the therapist’s strategies and those of other psychoanalytical, dynamic, or even humanistic therapies. The main distinction is in the object relations therapist’s thinking or attitude; in how the therapist is conceptualizing what is transpiring in the therapeutic relationship. In interviews with the client the therapist conducts a subjective assessment to gain a sense of the client’s inner being and to get a feel for being in the room with that client. The therapist wants to know something about the client’s family background, career goals, current living conditions, perceptions of the past and present, fears, hopes, dreams, and fantasies. Initially object relations therapy tries not to be too directive of the therapist’s self or of the patient or client, but attempts to let things develop and to tolerate chaos. The therapist is highly interested in the positive value of chaos, of allowing meaning to emerge from the relational experience in its own time (Scharff, 1997). During the get acquainted phases of therapy, the therapist operates with empathic listening, concern, and acceptance, doing lots and lots of listening for meaning in the client’s inner world.

The Therapeutic Climate. Object relations therapy is really a way of being with a person. It is not a precise, scientific, intellectual process. It is an intensely personal, in-the-moment, you-and-me kind of relationship. The therapist strives to do whatever must be done to create a space for the client to truly be him or herself—to be as natural as possible. It is very important that the therapist facilitate the conditions whereby the client gains and maintains autonomy. In the initial interviews, the therapist purposefully avoids being intrusive or assaulting the client’s ego in a way that impedes the development of trust. The relational aspects of the object relations therapy depend upon a high level of mutual trust (Scharff, 1997).

Once a bond of trust has developed and the client’s tolerance level has been established, the therapist will operate with more directness and authority, moving into matters that may be more sensitive, painful, and defended by the client. The therapist will assertively go after guarded and sensitive material because it must be confronted by the client if progress toward self-understanding is to be attained by the client. After all, the client is coming to therapy for help. Whenever sufficient rapport and trust levels have been attained, the therapist welcomes the opportunity to deal with chaos. It is as if during therapy the therapist is covertly saying to him or herself and to the client, “I can better understand your pain whenever you openly disclose to me your prior chaotic episodes. That disclosure and mutual understanding will enhance our ongoing relationship and therefore strengthen our therapeutic...
Such a trustful and constructive alliance increases the chance of enabling the therapist and the client to reach a clearer understanding of the client’s unconscious and conscious material and examining alternative choices that the client may wish to pursue (Scharff, 1997).

**Therapeutic Technique.** As the therapy unfolds, usually during interviews succeeding the initial interview, the therapist carefully attends to the client’s dreams, fantasies, wishes, and needs. Following up on these kinds of inner-world dimensions gives the therapist opportunities to explore in depth the kinds of object relational and representational issues that are likely to be bothering the client. The therapist does not go off on intrusive tangents or into fishing expeditions and information gathering just to make conversation. All of the follow-up questions, insightful confrontations, and information sharing are geared to what the client says, how the client reacts, what the client omits, how the client relates to the therapist, how the therapist is feeling about the client, and the mutual object relations and transference issues that are arising in the moment of the therapeutic laboratory. The interview is considered to be a microcosm of the client’s and the therapist’s lives. What we learn about each other, how we feel about each other, and how we respond to each other in the interview becomes grist for our examination of the meaning of life and the meaning of relations outside the therapy session (Scharff, 1997).

Object relations techniques, as practiced by Fairbairn and others, essentially established the primacy of relationship over impulse as the central psychoanalytic rationale (Gomez, 1997, p. 74). That rationale holds that the single most important factor in facilitating change in clients is the real relationship—not the transference relationship—with the therapist. If clients are going to become empowered to release their attachments to their internalized bad objects, there must be a genuine relationship with the therapist to replace such bad objects. Also, the relationship with the therapist is far more important than the accuracy and correctness of any interpretation offered by the therapist.

Object relations technique abandons the conventional analytic interview setting. The client sits in a comfortable chair facing the therapist and the therapist also sits in a comfortable chair—not behind a desk or seated or standing above the client. Removal of all barriers to the development of a trusting and therapeutic relationship is an important conceptual change. To have the client lying down, with the therapist located behind or out of sight, is perceived to replicate the client’s early traumas of abandonment, deprivation, and bad object images. The purpose of these conceptual changes is to enable the client and the therapist to experience each other more fully and more truthfully (Gomez, 1997, pp. 74-75; Scharff, 1997).

Another fundamental rationale in object relations therapy is that the client’s internalized objects or attachments are important and must not be summarily expunged by the therapist. The most powerful resistance to change is the client’s loyalty to and need for these internal objects or attachments. Humans have a propensity for holding on to our inner world of unsatisfying relationships. That tendency leads us to view the external world in the same terms. Gomez (1997, p. 74) states that “the risk of disregarding our normal way of being, with its familiar judgments and predictions, feels extraordinarily dangerous because of our absolute need as children to reserve our external relationships through the only means available to us.” Therefore, if the therapist opens up the client’s closed systems, the client is at risk of an acute fear of falling into a spinning vacuum of emptiness, disorientation, or humiliation in a resurgence of early trauma. That is why a real, trusting, secure, client-therapist relationship is absolutely essential. Without such a trust in the therapist, clients cannot risk abandoning their internal objects or attachments to turn more fully to the therapist. Both Gomez (1997, pp. 74-75)
and Scharff (1997) support Fairbairn’s basic purpose of therapy: to help clients, through genuine concern, understanding, and challenge, to re-own their split-off capacities for anger and need and to integrate them into their central ego/ideal object. Clients will then be able to relate to others with more richness and their inner world will be less divided and conflicted. Clients can then experience themselves, the therapist, and other people more fully and more truly. Broadly speaking, the primary outcome goals of object relations therapy are to make clients aware of relationship deficits and to help them discover ways to improve their interpersonal functioning.

**SELF PSYCHOLOGY**

Self psychology (Kohut, 1971, 1977; Wolf, 1988) is the study of that aspect of mental functioning in which the person as self is the central focus. Therapy deals with the deficits and pathologies of the client's mental life. Self psychology is closely aligned with object-relations psychology. The development of the self is conceptualized as initially (during infancy) requiring a “self” object outside of oneself to provide life-sustaining functions. As a person normally matures he or she develops the “self” object through a process that Kohut (1977, 1984) termed *transmuting internalizations*. That process facilitates the person's growth and enhancement of the self (Pires & Pedro, 1994). The ideal self is empathic. If the developing “self” object is missing, stunted, or distorted, an ideal self is not attained and the person develops deficits in mental and relationship functioning that may lead to debilitating disorders (Lachmann, 1993).

Therapy is based on providing empathic experiences wherein the client confronts—through transference relationships with the therapist, who the client has idealized—failures that replicate his or her original failure to develop an ideal, cohesive self (Bacal, 1995; Butz, 1992; Lachmann & Beebe, 1995; Wolf, 1994). By working through such failures of empathy in the safety of the therapeutic situation, the client overcomes the crippling lack of development of an earlier ideal self and achieves a transmuting internalization (Kohut, 1977, 1984; Leach, 1995; Stolorow, 1995; Wallerstein, 1995). The most important aspect of self psychology therapy is for the client to experience the utmost empathy from the therapist, which in turn helps the client to discover who he or she really is (Pauchant & Dumas, 1991; Tobin, 1991; Warren, 1994). Such transmuting internalization or self-discovery diminishes the need for the interpretation of unconscious conflict (Auld & Hyman, 1991, p. 247).

**Sample Case**

The case of Carla illustrates some of the contemporary psychoanalytic techniques used with an adolescent female client.

**DREAM WORK**

Carla, sixteen years old, was given up by her biological parents at age four. She was adopted at age seven. Her adoptive home was stable and religious. At fourteen she began having dreams that her adoptive father was making sexual advances toward her. Carla's ability to distinguish between fantasy and reality was uncertain, and she developed a love-fear attitude toward her adoptive father. At age fifteen she exhibited chronic delinquent behavior, which included running away from home on numerous occasions, experimenting with drugs, and engaging in sex with a wide variety of males. Carla's behavior produced a great deal of guilt, anxiety, helplessness, and fear that she was losing her mind. Initial therapy focused on her dream. She reported that in one of her dreams her adoptive father fondled her and attempted to engage in intercourse with her, whereupon she awakened in terror. A brief segment of a therapy session about that dream follows:
TH: How did you react to the dream?

CL: I know it was a dream, but I've had funny feelings about it. I guess I'm a little afraid of him now. I find myself avoiding him.

TH: So now you're not sure about how much of your imagery and fears of sexual relations with your father comes from your dream or how much is projected from your conscious thoughts.

The main dilemma, from a psychoanalytic viewpoint, was the confusion between the dream content and Carla's conscious thoughts. With the help of her therapist, after a period of striving to do so, Carla learned to fantasize having normal, healthy daughter-father relations.

TH: Carla, can you free-associate this idea of a healthy relationship with your father?

CL: (thoughtful silence) Okay, what I want to see is myself being in the room with him, without having any sexual thoughts---to just be normal---to enjoy being with him and to trust him. I want to be able to embrace him or be embraced---to have him kiss me on the cheek, without my pulling back and thinking awful things. I guess I'm still having trouble getting away from all the stuff in the dreams.

TH: It sounds like you're trying to separate all the images in your dreams and fantasies from your conscious experiences and desires, but there's a blockage. Can you free-associate around that blockage?

CL: (thoughtful silence) I'm feeling kind of torn...between two feelings. I have an image of a desire to be this little girl again---to be touched and caressed and hugged and loved. Another picture---the one that bothers me most---is of a more mature love relationship with him. It's like...he's not really my father, but he's someone like my father. Like he's my boyfriend with all the qualities of my father. I guess what I want is to have a boyfriend like my father.

In this segment Carla verbalized the desire to have a love relationship with someone with her father's qualities. In the interviews that followed she was able to work through her fantasies and clarify her distinctions between father-child and father-adolescent daughter relationships. She was also able to fantasize having appropriate heterosexual relationships.

OBJECT-RELATIONS THERAPY IN THE CASE OF CARLA

Object-relations theory had a substantive influence on the therapist's early conceptualization and case management with Carla. Carla's impaired psychosocial development was manifested in several areas, such as attachment and separation, identity diffusion, and maintenance of boundaries between self and others---none of which she seemed to be consciously aware. During therapy sessions at the beginning of Carla's treatment she disclosed a number of her life events, memories, fantasies, and judgments that provided significant information about her personality and unconscious conflicts.

CL: Guess it didn't take my real mother long to get tired of me!

The therapist considered such material not in terms of narrative or verifiable truth but as associations revealing Carla's object-relations distortions and unconscious conflicts (Auld & Hyman, 1991, pp. 245--246). These important associations, judged to be representations of latent material, provided valuable
and powerful background knowledge. No "techniques" were immediately employed with Carla to attempt to remediate her unconscious distortions and conflicts or to "rush" her into gaining insight. Much of the value of object-relations psychology rests in the education of the therapist early in the therapeutic relationship (Hamilton, 1988; Scharff, 1997). Without such "education" the therapist cannot make helpful responses later on.

PSYCHOIMAGINATION TECHNIQUES

When Carla was seventeen, the therapist employed psychoimagination techniques (Shorr, 1972) to help Carla rehearse steps she could take to establish normal relations with her father.

TH: You've said you wish to be able to openly be with your father, carry on both serious and casual conversations, and feel no threat at all. Can you get in touch with your fantasies, project yourself into your desired encounter, and describe your actions and feelings?

CL: (moment of thoughtfulness) I'm at home with my mother. We're talking and enjoying each other. I'm helping prepare dinner. I see Dad drive into the carport. He comes in the kitchen door and kisses my mom...then he kisses me...I feel faint for a moment, then I remember exactly what I planned to do...I planned to put my mind on enjoying being with my parents instead of thinking about what had happened in my dreams.

TH: Can you project yourself into the emotions you want to experience while, at the same time, holding to that view of the family situation as vividly and realistically as possible?

CL: (moment of thoughtfulness) I'm surprised at how comfortable I'm feeling compared to a few months ago. I'm relaxed. I'm thinking how different it is now. I see me talking, laughing, and listening to both parents...not putting ulterior motives into his voice and actions...I'm seeing him as the dad he really is, and always has been...and I guess I'm pleased with me too...pleased that I can see myself as valuable and lovable. Even with my faults, I'm still a good daughter.

TH: You seem to be fully owning your dreams and fantasies. You're also painting a very positive picture. What are the words you're saying to your dad, mom, and yourself? And what emotions do you want to feel and project for them to receive?

CL: Okay, I'm talking about things that interest them...asking Mom about her day at the office...asking Dad about his visit to the ETV studio. I'm feeling good about having such interesting parents. I'm feeling comfortable with Dad, but I'm also aware of my desire to enjoy and pay attention to both parents equally (thoughtful silence).

TH: It sounds to me that you're rehearsing a “perfect” situation. I wonder if we can check out whether you are retreating to a previous stage in your earlier childhood or substituting a “hoped for” family scene to keep from dealing with problems and anxieties that are too painful to face.

CL: I've thought about that too. I don't want to be defensive. But I really think I've progressed beyond that point. I do have some concerns...that I may wake up and discover that I'm back like I was before...and that frightens me. What I want to do is maintain what I've got and go on from there. I don't see myself as going backwards or deluding myself.

SUPPORTIVE AND CATHARTIC TECHNIQUES

Langs (1973), Small (1972), and Stricker (1978) have described modern applications of psychoanalytic therapy, such as supportive and cathartic
techniques. Supportive techniques are used when the client's anxiety level is assessed as ego-threatening to the client.

CL: My life seems to be crumbling all around me. My parents have been out of town for a week. Our dog, Ginger, got killed, and last night I kept having visions of seeing my wrists cut and bleeding, like when I slashed them when I was fourteen.

TH: Carla, I hear your desperation, and I'm concerned right now about your physical and emotional safety. I want us to talk about your suicidal fantasies. I cannot ignore these fantasies, and I want to tell you that there may be direct relationships among your background experiences, your present loneliness, your parents being out of town, your grief and loss of Ginger, and your regressing to thoughts of slashing your wrists. I want you to know that we're going to work on these together, and that I'll continue to work with you, be with you, and be available to you until this crisis situation is over. I can assure you that the crisis will pass! Now, let's go back and start by your telling me about all those events that led to your feeling like your life is crumbling.

The therapist was attending to Carla's need for support while considering her unique background and present circumstances. The therapist continued to take a very directive and active stance in the session, as recommended by Stricker (1978). The therapist kept three considerations in mind: (1) the support and safety of Carla were paramount; (2) even in this crisis, Carla's age and need for independence and responsibility were important; and (3) it was primarily Carla's ego that was being supported.

Cathartic techniques help clients recognize and express emotions verbally without having to act on them impulsively. A segment from a later session with Carla illustrates a cathartic technique.

TH: Carla, I want you to know it is safe for you to talk about your vulnerable feelings here.

CL: Like I said, last night I suddenly felt like I really wanted a hit, some ecstasy or crack, but I knew I'd end up back out on the streets again and I didn't want that! I'm scared I'm not strong enough to resist it forever. I feel so stupid and weak and helpless when I'm feeling like this. I nearly blew it.

TH: It's okay to feel like that. But it's not okay to act on it impulsively. One reason we're meeting together is to look at and help you strengthen your inner resources and choices. The first step is to talk about it right here. This is where you're going to begin to overcome your fears and to be able to do whatever you choose to do. Carla, I'm really glad you're here today.

The therapist was setting the stage for the cathartic opportunity for Carla to express her feelings verbally and bring them under ego control. Stricker (1978) stresses the modern cathartic strategy of immediacy of client expression of fears in a safe, protected, and supportive therapeutic atmosphere (p. 143). Carla's therapist used cathartic techniques to show her that she could gain insight and ego control over her negative emotions such as fear.

SHORT-TERM COUNSELING TECHNIQUES

Tilley (1984) has demonstrated how a great number of psychoanalytically oriented approaches can be used with efficiency and immediacy in short-term counseling. Carla's therapist used many such techniques during their work together, one of which is illustrated here.

RECEPTIONIST: (speaking to the therapist) Carla is on the phone. She wishes to speak directly with you. Shall I take a number?
TH: No, thank you. I'll take it now. Please transfer it to the phone next door.
Thank you. (goes to adjoining room) Hello, Carla, Dr. G. here. How may I help you?

CL: I'm sorry about calling you while you're busy, but I have an emergency. It's about my mother being in the hospital and my needing to go stay with her this afternoon until my daddy can get there, and I'll probably be twenty minutes late getting to your office for my appointment. My mother's got cancer and I wanted to talk to you before I leave for the hospital, so I can decide what I want to say to her when I see her.

TH: Carla, I'm very glad you called. I'm in the middle of something right now. Are you at a number where I can reach you eight or ten minutes from now?

CL: Yes.

TH: Good! Give me the number and I'll call you right back just as soon as I'm free. This is very important. Please keep your line free so I can get right back with you. Thank you.

Whether or not to accept phone calls from specific clients is a controversial issue among traditional psychoanalytically oriented therapists. According to Tilley (1984, p. 191), there are compelling reasons that therapists should do so. Depressed clients may need to hear the therapist's voice; the therapist may want to hear and assess the client's level of stress; and usually a therapist, not a receptionist, should make judgments about cancellations or reschedulings.

DIRECT-DECISION TECHNIQUES

The psychoanalytic applications of direct-decision therapy (Greenwald, 1973) are many. They draw on several other systems of therapy, such as Adler's individual psychology, rational-emotive behavior therapy, behavior modification, and trait-factor counseling.

TH: Carla, you say that you are disappointed because your commitment to the religious group is losing its meaning to you.

CL: That's right. I thought it would be a lasting cure for my previous sinful life. Now, I don't want to go back to the street life, but I'm beginning to believe the religious life, like that of this group, is not the way I want to live either.

TH: Let's examine the circumstances and the time in which you originally chose to join the group---that is, what your goals were at the time.

Here the therapist makes a typical response based on the direct-decision tenet that all decisions have validity to the person at the time they were made. The therapist senses that even though Carla's original decision may have been vital to her psychic economy at that time, the payoffs she is currently receiving from the group affiliation may not be providing sufficient ego supports for her. Having explored in depth the original context of Carla's joining the group, the therapist asks a direct-decision question.

TH: Carla, what goal do you have right now? In terms of your needs today?

CL: Well, what I want most right now is to start getting my education in order. I want to go to the university and prepare for a career.

Carla's answer to that question provided the direction needed for the therapist to pursue a variety of options available to her.
SUMMARY OF THE CASE OF CARLA

Carla's therapist used traditional Freudian methods plus several innovative techniques, all within a modern psychoanalytic context, to help Carla open up action alternatives. These techniques included Hamilton's (1988) and Scharff's (1997) object-relations psychology; Shorr's (1972, 1980) psychoimagination; Greenwald's (1973) direct-decision techniques; and short-term counseling and psychotherapy strategies (Demos & Prout, 1993; Sifneos, 1987; Strupp, 1993; Tilley, 1984). Many modern psychoanalytic procedures (Alexander & French, 1980; Auld & Hyman, 1991; Goldman & Milman, 1978; Greenberg & Mitchell, 1983; Hamilton, 1988; Kohut, 1977; Scharff & Scharff, 1998; Sifneos, 1987; Strupp, 1993; Strupp & Binder, 1984; Tilley, 1984; Wolf, 1988) enable the contemporary therapist to extend Freudian formulations far beyond classical psychoanalysis. Even so, Carla's therapist worked through the traditional transference, resistance, and countertransference stages of therapy with her. Contemporary analytic therapists allow the client to "experiment with and integrate fantasy and reality, reality and potentiality, self and not self, and choices of action all within the context of a cooperative therapeutic alliance and encounter" (Shorr, 1980, p. 522). Carla's case was fairly typical. To gain control of her life, her ego had to gain control of her psychic energy by mediating the struggle between her id and her superego. Her id impulsively demanded immediate gratification and attention by impelling her to act out her instincts. Her superego demanded perfection in her behavior by imposing parental, societal, and religious standards and heaped large doses of guilt on her for her failure to attain perfection. Through therapy, she was finally able to integrate fantasy and reality and bring her id and her superego into a rational balance.

For the reader who seeks a diversity of case studies by both classical and modern psychoanalytic practitioners, Goldman and Milman (1978) have provided a rich array of cases. Belkin (1980) has supplied several excellent case histories depicting both classical and modern psychoanalytic procedures with clients of several different types and from several age groups. Scharff and Scharff (1998), Sifneos (1987), Tilley (1984), Strupp and Binder (1984), and St. Clair (1996) have demonstrated how psychoanalytic techniques can be used effectively with many different kinds of clients in both object relations therapy and short-term dynamic psychotherapy and counseling.

Contributions of the Psychoanalytic System

Freud (1958) is considered one of the founders of psychotherapy and psychiatry. His ideas influenced literature, art, religion, social science, and education during his time and continue to do so to some extent. It is difficult to be aware of Freudian psychology and not see some of his concepts manifested in human behavior—unconscious motivation, the symbolism in dreams, defense mechanisms, and the sexual origins of conflicts, to mention a few. The practice of "talking therapy" has been carried forth in every major model of psychotherapy. Anxiety, resistance, transference, and interpretation are familiar terms to therapists. Therapy models directly influenced by Freudian and psychoanalytic thought include ego counseling, Adlerian therapy, Gestalt therapy, object relations therapy, and transactional analysis. The most unique and valuable feature of the psychoanalytic approach is the nurturance, within the transference relationship, of client autonomy and self-control (Alpher, Henry, & Strupp, 1990; Arlow, 1995; Auld & Human, 1991, pp. 5–22; Giovacchini, 1977, p. 40; Scharff, 1997; Scharff & Scharff, 1998; Warren, 1994).

Among the most notable contributions of the psychoanalytic movement has been the ascendancy of the postmodern relational theories. A primary example is the widespread acceptance and use of object relations therapy, as described in this chapter.
Shortcomings of the Psychoanalytic System

Traditional psychoanalysis has several limitations. This is not surprising when we consider that the method was first developed a century ago in a Victorian society whose values were much different from those of today. Analysts in Freud's day could not possibly have envisioned a therapeutic environment that is now so inextricably intertwined with the managed care milieu. One of the major drawbacks of the Freudian approach is that the completion of analysis may require several years. This inordinate time requirement seems ill suited to today's fast lifestyle. Lengthy analysis also costs more, which may make it prohibitive to almost everyone except the affluent. Another limitation is that there are simply not enough trained analysts to provide therapy and counseling for the many people who seek it. Finally, some problems are not ideally suited to psychoanalytic therapy because of the time required for analysis. People go to therapy with many kinds of problems. Although Freudian analysis has long been known for its applicability to marital, vocational, parenting, sexual, assertiveness, shyness, divorce, grief, and loneliness problems, many of these contemporary areas are now viewed as being much more suited to therapeutic approaches that can provide brief or short-term help more efficiently than traditional psychoanalysis can.

Auld and Hyman (1991) list several types of client situations that they believe are not appropriate for psychoanalytic therapy. Among these are distresses that arise from other than psychological causes, such as biologically based disorders (p. 4). They are unenthusiastic about using psychoanalytic techniques with clients who are addicted to alcohol or other drugs or who have committed sexual offenses or other crimes (p. 5). They also raise questions and cite controversies and criticisms regarding the use of psychoanalytic therapy with women (pp. 219--238). The role of women in today's society is dramatically different from what it was during the nineteenth and most of the twentieth centuries. That fact alone would render completely obsolete most of the therapeutic approaches that were developed in earlier times.

Psychoanalytic Therapy with Diverse Populations

Several psychoanalytic therapies are appropriate for use with diverse populations. Arlow (1995) characterizes psychoanalysis as the most inclusive and most comprehensive system of psychology. It extends to clients with diverse cultures, ages, life styles, races, ethnicities, and physical abilities.

Object relations therapy (Scharff & Scharff, 1998) and Self psychology (Feiner & Kiersky, 1994; Josephs, 1994; Kohut, 1971, 1995; Wolf, 1988) are particularly appropriate for use with diverse populations because their primary strategies are to establish and maintain optimally empathic relationships with clients. Though the self psychology practitioner and the object relations therapist may deal with many different types of clients and presenting disturbances, their strong and pervasive empathic case handling nurtures positive psychotherapeutic movement. Attention is given to the development of the client's self-esteem, which, in turn, enables the therapist to focus on the client's disturbance (Auld & Hyman, 1991, p. 247; Scharff, 1997). The condition of optimal empathy enables both client and therapist to focus on the client's current inner core of concerns, rendering any differences (cultural or other) tangential to the therapeutic condition (Feiner & Kiersky, 1994; Josephs, 1994; Kohut, 1995; Scharff & Scharff, 1998).

Many clients from backgrounds “different” from the prevailing majority population suffer from identity and/or developmental deficits, and object-relations therapy (Greenberg & Mitchell, 1983; Hamilton, 1988; McCathy, 1995; Scharff, 1997; Scharff & Scharff, 1998; Stricker & Healey, 1990) can be
appropriate for such clients. For example, borderline clients from ethnic minorities who have a diffused sense of identity may be assisted in working through their identity diffusion by exploring the meaning of their ethnicity as an emergent part of their therapy (Comas-Diaz & Minrath, 1985). Because object-relations therapy focuses strongly on the client's interpersonal relationships, attachments, and boundaries between self and others (Auld & Hyman, 1991, p. 245; Scharff, 1997), object-relations therapists may address clients' strengths and assets and emphasize a psychosocial approach in facilitating the development of a sense of identity and self-esteem. According to Auld and Hyman (1991, p. 230), citing Grier and Cobbs (1968, pp. 157--160), in addition to receiving culturally sensitive training, the therapist must also combine an understanding of the unique conditions that shape minority clients' lives and provide a framework wherein clients can resolve their inner conflicts as well as respond appropriately to prejudices in the environment.

Training for psychoanalytic therapy has long included intensive self-analysis and introspection to promote a full understanding of self on the part of the therapist and how one's selfhood affects the therapeutic relationship. Contemporary psychoanalytic approaches have broadened the perspective of therapist self-analysis to include environmental and cultural factors to sensitize the practitioner to diverse clientele (Riskin, 1993).

The past thirty years have been a time of exponential growth, expansion, and change in therapist training and philosophy (Hornstein, 1992, p. 261). The development of a keen awareness of cultural, gender, and other diversities is now considered an essential component of training and practice (Auld & Hyman, 1991, pp. 221--238). Self-perception (Hornstein, 1992, p. 261) and the ability to handle the wide array of reciprocal impact issues (Kell & Mueller, 1966) that arise in working with diverse clientele are major assets of the psychoanalytic therapist.

Object-relations, self, and ego psychologies are not the only subsystems in the psychoanalytic family equipped by education and philosophy to work effectively with diversity. Time-limited dynamic therapists (Strupp, 1993; Strupp & Binder, 1984), autonomous psychotherapists (Auld & Hyman, 1991), short-term or brief therapists (Sifneos, 1987; Tilley, 1984), and many other modern psychoanalytically oriented therapists understand and work empathically and successfully with people of various colors, cultures, genders, sexual orientations, and other lifestyles and backgrounds (Feiner & Kiersky, 1994; Josephs, 1994; Kohut, 1995).

Livneh and Sherwood (1991, pp. 526--527) have documented several psychoanalytic constructs that are applicable to counseling clients with physical disabilities. Among those relevant to understanding the psychosocial implications of physical disability are the ego's defense mechanisms, body image and self-concept, mourning and grief, and the centrality of early developmental stages.

Livneh and Sherwood (1991) consider the psychoanalytic approach appropriate for counseling clients with disabilities because of its dynamic and developmental aspects. Because physical disability is never a static condition, psychoanalysis accommodates the differential and developmental strategies needed to facilitate client movement and fluctuation through the usually progressive adaptational phases such as shock, anxiety, denial, depression, internalized anger, externalized hostility, acknowledgment, and adjustment (p. 525).

Psychoanalytic therapy has several deficits to working with diverse populations. One is cost-effectiveness: many clients do not wish to expend the money, time, motivation, effort, or commitment required to make efficient use of therapy. For others, the psychoanalytic approach is simply out of sync with their sociocultural and/or socioeconomic backgrounds. Clearly, it is out of step with the fast pace of many people's lives.
A second and related deficit of psychoanalytic therapy is its time-datedness. Modern health-care systems are largely driven by funding from government, insurance-related, and health maintenance organization (HMO) sources unknown in the past. Though many proponents of the psychoanalytic approach have turned to brief, time-limited therapies as a remedy, the perception persists that psychoanalytic therapy may go on and on for unspecified lengths of time. Funding agencies are not prone to support time-unlimited treatment systems.

An age of elitism is a third problem for the psychoanalytic approach. The context in which it was founded and practiced for many years led to charges and the widely held belief that it is elitist and not pertinent to most people. This has spawned many alternative therapies. Its elitist image leads people to believe that psychoanalytic therapy is not applicable to those in lower socioeconomic classes and that the therapeutic system is bound to a narrow, nineteenth-century culture. We have concerns about applying the psychoanalytic approach to peoples whose origins and cultures differ significantly from those of the founding European analysts and patients. As previously noted, we have particular concerns related to the use of traditional psychoanalytic methods with women.

A fourth deficit of the psychoanalytic approach is its relevancy to modern family systems. The patriarchal families in existence during the early development of psychoanalytic therapy are all but extinct. Treatment concepts that were appropriate for an 1890s patriarchal family do not apply to family structures at the turn of the twenty-first century (such as blended, commuter, single parent, and so on). The unique and complex problems inherent in the cultures of modern family systems require approaches that are far different from treatments that were appropriate for the nuclear families of a former era.

Summary

Freud grew up in a time of scientific progress that influenced the development of psychotherapy and set the stage for the scientific study of human behavior. In his study of human behavior, Freud postulated a basic biological force that motivates people to seek pleasure and avoid pain. He called this motivating force the pleasure principle. He also postulated the theory that much individual behavior is influenced by experiences, thoughts, and feelings that are not in conscious awareness. It was through the idea of material repressed into the unconscious that Freud's theory of neurosis was developed. For example, hysteria grew from repression of unacceptable impulses and wishes.

Freud viewed the human personality as an interworking energy system composed of the id, the ego, and the superego. The id is the original source of psychic energy, the ego is the executive of the personality, and the superego is the conscience and ego ideal. The development of the personality is influenced by childhood sexuality and follows a sequence known as the stages of psychosexual development.

The techniques of psychoanalysis developed from Freud's work with hysterical clients. The purpose of these techniques was to make the contents of the unconscious conscious so that the client could understand the reasons for his or her neurotic behavior and thus behave differently. To this end, Freud developed the free-association method, in which the client tells the therapist, without any superego censorship of thoughts, whatever comes to mind. The therapist interprets the client's free associations to foster client understanding and uncover additional unconscious material. The final phase of therapy involves the working through of the client's transference to the therapist of conflicts and wishes with significant others in the client's life.
During the latter years of Freud's life and immediately after his death, the
work of Neo-Freudians such as Horney, Erikson, Sullivan, and Fromm broadened
psychoanalysis. Many contemporary theorists and therapists have developed and
extended psychoanalytic techniques that are appropriate and effective with the
complex problems of clients in modern, fast-paced society (Arlow, 1995; Auld &
Hyman, 1991; Goldman & Milman, 1978; Scharff & Scharff, 1998; Strupp, 1993;
Strupp & Binder, 1984).

Over the course of several decades, Freud's formulations provided the impetus
and conceptual basis for several competing analytical philosophies and clinical
approaches. Concomitant with the current conceptual disarray among the
psychoanalytical approaches are two broad, competing perspectives: Freud's drive
theory and a cluster of relational models that include object relations theory,
interpersonal psychoanalysis, and self psychology. Although drive or instinctual
(sometimes simply called biology) theory is systematic, unified, and
comprehensive, it is also obsolete because it does not account for major aspects
of human motivation that modern theorists attribute to environmental factors
(Mitchell, 1988, p. viii; Scharff & Scharff, 1998). Relational theories are
proliferating and more consistent with applied psychoanalytic practice today,
and a number of object relations oriented analytical clinicians (including many
in North America) are working toward developing the newer theories (especially
object relations) into a more coherent, comprehensive, and systematic framework
(Blanck & Blanck, 1986; Corrigan & Gordon, 1995; Ganzarian, 1989; Gomez, 1997;
Klein, 1990; Kumin, 1996; Mitchell, 1998; Rogers, 1991; J. S. Scharff, 1997; J.
S. & D. E. Scharff, 1998; Skolnick & D. E. Scharff, 1998; St. Clair, 1996;
Summers, 1999).

Object relations therapy is one of several different psychoanalytically oriented
schools that cluster around the concept of "relational," as opposed to Freudian
"biological" or "drive" theory. Even so, all of the relational models were
originally grounded in and grew from the basic foundations that were laid down
by Freud. Mitchell (1988, pp. 8-9) regards the family of relational models as
valuable correctives (checks and balances) for each other. He considers the
cluster of emergent relational psychodynamic approaches to be a multifaceted
relational matrix that takes into account self-organization, attachments to
others (objects), interpersonal transactions, and the active role of the client
in the continual re-creation of his or her subjective world. We believe that,
for entry-level learners, an appropriate and useful way to view psychological
reality is through operating within the relational or interpersonal realm of
object relations.

Suggestions for Further Reading

Principles and applications. Lincoln: University of Nebraska Press,

(Eds.), Current psychotherapies (5th ed., pp. 15--50). Itasca, IL: F. E.
Peacock.

introduction to psychoanalytic therapy. Washington, DC: American
Psychological Association.

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**References**


