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The symptom : a positive perspective.

Jeffrey L. Lukens
University of Massachusetts Amherst

THE SYMPTOM: A POSITIVE PERSPECTIVE

A Dissertation Presented

By

JEFFREY L. LUKENS

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Approved as to style and content by:

Howard Gadlin, Ph.D.
Chairperson of Committee

Elizabeth Aries, Ph.D., Member

Castellano Turner, Ph.D., Member

Alvin Winder, Ph.D., Member

Charles Clifton, Ph.D.
Department Head

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ABSTRACT

The Symptom: A Positive Perspective

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Jeffrey L. Lukens, B.A., Tufts College

M.A., University of Iowa, M.S., University of Massachusetts

Ph.D., University of Massachusetts

Directed by: Professor Howard Gadlin

The theory and practice of all psychotherapy is influenced in the most basic ways by the meta-theoretical underpinnings implicit in attitudes toward psychological deviance and its manifestation in symptomology. This dissertation is built around a comparison of positive and negative meta-theoretical perspectives in psychotherapy. The positive and negative perspectives do not establish another psychological theory. Rather, they form those crucial meta-theoretical poles which determine the adequacy of our theory to capture the essential human condition and the potency of our practice to facilitate psychotherapeutic change. The meta-theoretical notions that keep us at a distance, that induce blockages in our ability to empathize and get closer to the inner world of another, together with the consequences for the psychotherapeutic process, constitute the negative perspective.

Professional psychotherapists and society in general reduce psychological symptomology to an excessively negative and simplistic phenomenon. Language and theoretical constructs are permeated with these unexamined assumptions which would diminish symptomatic man to lifeless, mechanical objectification. Theoretical dehumanization of the deviant population evokes an attitude of distance and dominance. Consequently we fail to hear the language of the symptom, its artful reaching out in camouflaged symbology to establish that dialogue needed for psychological change.

There is another way of looking at psychological symptomology which facilitates empathy and psychotherapy: the positive perspective. This meta-theoretical perspective is more than a tidy collection of ideas and techniques which can be easily memorized and assimilated. The positive perspective is always an achievement and requires continual struggle. No one fully attains it or maintains it for very long. Its temporary achievement is always resisted by internal and external censors. These censorious forces arise out of the peculiar nature of consciousness itself, out of our need to distance from discomforting exposure to madness, out of the needs of an embryonic psychology to establish scientific legitimacy, and from societal pressures to keep the mirror of madness from reflecting our failures.

The positive and negative perspectives are elusive. To heighten awareness of them the philosophical premises are delimited and the broad meaning of symptomology is developed. Increasingly, this theme is concretized first by situating it within general psychotherapeutic constructs in a psychoanalytic base, then by tracing its history within mainstream psychoanalytic thought, and finally by exemplifying its reality and importance in psychotherapy, supervision and consulting. The psychoanalytic tradition has been chosen because of its seminal influence and current hegemony in the theory and practice of working with the psychologically deviant population. Within this tradition, the positive perspective has had a long and erratic course beginning with the truly radical and courageous breakthroughs of Freud.

Beginning in 1893 and ending with a loss of nerve in 1920, Freud almost single-handedly articulated the essential theoretical and practical qualities of the positive perspective. However, these qualities were never cohesively presented and are found scattered in isolated segments of his writings. Many of the major theorists/psychotherapists who followed extended one or more aspects of the positive perspective on symptomology, although the lineage is clearest in the object relational, self psychology pioneers. Those who worked with children and psychotics especially

learned the most about the positive perspective orientation. The attempt to understand the insistent but often incomprehensible ways of children and psychotics has also provided the experiential ground out of which this work has grown. Their message can facilitate psychotherapy, supervision and consultation with all symptomatic populations.

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INTRODUCTION

The way all of us look at psychological deviance and at its hopeful remedy in psychotherapeutic change is profoundly limited. We are caught up in a perspective which is inadequate, which overly simplifies, and which dulls our ability to understand madness and its communicative expression in symptomology. This dominant perspective insidiously colors our perceptions, our theory, and our mode of relating to those considered symptomatic. My intent is to unveil and delimit this covert perspective and to bring into focus another way of seeing.

There is a secretive, forbidden quality enshrouding this unpopular other way of seeing. I have always felt it necessary to keep this perspective to myself and even from myself. It is an uncomfortable way of seeing which demands a continually renewed willingness to live with discomfort. My method in what follows is to alternate from one perspective to the other, teasing out the theoretical parameters and practical consequences of each, while speculating on the sources of the discomfort. As I go along, my aim is to increase awareness of another orientation to the symptom in order to promote that healing dialogue needed by client and therapist as well.

This other way of seeing and the consequences for our notions of change and psychotherapeutic technique comprise the positive perspective. The positive perspective always starts with the symptom. By symptom I mean something broader in scope than simply those patterns of psychologically deviant thought and behavior classified in DSM-III (Spitzer, 1980). I mean all forms of clinically significant thought and behavior which may potentially alert trained therapists or the lay public that something is wrong. This may appear as transference, regression, hallucination, or an anti-social act. Experientially for the therapist, the positive perspective is always anchored in the therapist's relationship to the manifestation of deviance, to the symptom. As will be developed later, a symptom is a complex phenomenon. It is more than simply the apparent sign of pathology or deviance, although this is part of it. It is also an effort to communicate, an effort to induce a certain way of understanding and behaving in the environment, part of which may be a psychotherapist. To intellectually understand this is important, but to be able to sustain this sort of understanding and demonstrate it in the experience of being with another is extremely difficult and is of the essence of what is meant by psychotherapeutic. Further, as psychotherapists we must continually return to immersion in

the dialogue with symptomatic communication as a check on the correctness of our understanding and way of relating.

So the positive perspective must always start and end with the symptom. The symptom affords a way in, a way to facilitate our understanding of the other. This way of seeing in itself has consequences for our understanding of the therapeutic process. Although on the one hand I am positing much more value in the symptom than it is generally accorded, the focus of this paper is not on the nature of symptoms per se. I am most interested in reopening the dialogue between patients and therapists. It is the blockages in this dialogue, most of them out of our awareness and derived from implicit assumptions and unconscious attitudes toward the other, which impede the psychotherapeutic process. Clients want to change and seek those necessary environmental provisions which will allow them to do so. The scope of this paper, while expanding the notion of symptoms, will be limited to looking at those consequences of our implicit meta-theories which have practical bearing on achievement of the positive perspective, on that dialogue needed for change to occur.

The positive perspective is a broad and inclusive notion which, while being extremely abstract, is also extremely real. Its reality can be experienced and its consequences are of the utmost importance for the process of

psychotherapy. But the positive perspective does not exist as an independent entity the way a shoe does, for example. I claim no transcendent, ontological status for it. It can never be known in itself but only in contrast to the other way of seeing, to the negative perspective. It can only be known in our daily struggle with relating to ourselves and to others. The negative and positive perspectives do not constitute another psychological theory, such as Behaviorism. Rather, they form the meta-theoretical poles of the implicit assumptions governing our attitudes to ourselves and others.

The positive and negative perspectives form the defining poles along the dimension of objectification. To the extent we don't separate ourselves from all that is human, vital, and subjectively meaningful we are in the realm of the positive perspective. To the extent that we treat ourselves or the other as inanimate, as off the continuum with our inner self, as an object with little meaningfulness in itself, we are closer to the negative perspective. We all tend to vascillate between these two poles and no one achieves the positive perspective for very long. We might treat our dearest loved ones, for example, with the respect and empathy characteristic of the positive perspective. We might also, out of our fear of madness or out of the expediency a job might provoke, treat mental

patients as objects, as examples of pathology wholly different from ourselves, as requiring no more thought than it takes to medicate or to warehouse.

No one theory, or school of thought, or group of people has a monopoly on either of these perspectives. However, the relatively asymptomatic population always tends to objectify those labeled as mentally deviant or symptomatic. At least in the world of psychotherapy, especially in its theory, the negative perspective always tends to be dominant and in the majority and its consensual power makes the individual expression of the positive perspective seem radical. This is what I mean by the secret nature of this other way of seeing, of the positive perspective. My growth as a therapist has demanded that I find the courage to achieve greater clarity about the reality and character of this perspective which needs to express itself in subtle and camouflaged forms in symptomatic communication.

It is beyond the scope of this paper to examine in any depth the origins of the censorious forces which make the positive perspective such a difficult achievement. At first glimpse, it appears that society has developed a consensual contract which operates out of our awareness but into which we all readily buy. It is as though we have collectively conspired to legitimize turning into inconsequential objects those people who threaten our sense of stability, our sense

of power and effectance, who would dare confront us with the thinness and vulnerability of our comfortable sanity, or who would remind us of the failures and cost of our society. Or perhaps, as does Sartre in Being and Nothingness (1956), we must look within ourselves to the very nature of consciousness for this negation of the other and of ourselves which is the essence of objectification.

Sartre (1956) claims that negation arises logically and experientially in the same moment as our awareness of beingness. Awareness of our beingness-in-itself immediately confronts us with the dreadful awareness of non-being. To enjoy the fruits of that delicious sense of being fully alive is to live in the shadow of non-being, of death, of objectification. It takes great courage to sustain the intensity of awareness of beingness and of the concomitant sense of non-being. Consequently we project that negation onto others, or we deaden ourselves and the world around us by detaching from this awareness. Further, to be aware of our beingness is to apprehend that this possibility that is myself is only one of many possibilities. Being confronted with the recognition of my inherent freedom in choosing one of all these possibilities, and my awareness that I bet my life on the possibility I choose, is cause for great anxiety. Thus we tend to distract ourselves from this awareness, we negate ourselves, we lie to ourselves, we

indulge in "bad faith." This attitude of negation and denial mitigates the beingness of others for ourself and of ourself for others as we have negated ourselves. Therefore others are negated as well. Sartre would assert that given our tendency to hide in bad faith we all tend to objectify not just mental patients but everyone, including ourselves.

Whatever the source or sources of this objectification of our clients and their symptoms, this phenomenon is prevalent and impedes our ability to facilitate psychotherapeutic change. I cannot imagine a world without the continual dialectical play of objectification mixed with moments of compassion, empathy, and understanding. My position in this respect is more aligned with Foucault (1961/1973) than with Laing (1960, 1961, 1967) in that I am not advocating the overthrow of the consensual way of seeing and I don't view myself and mental deviance as being independent of, and superior to our social context. To Foucault I would add that none of us is independent of our mental context, of the nature of consciousness. The purpose of this paper, of explicating ramifications of the positive perspective, is to try to temporarily achieve a glimpse of both sides of that tension that exists between our often misguided efforts to understand our clients and our clients' efforts to communicate their reality to us. This tension is further situated within the client's artful production of a

symptom. In the course of this journey, I hope to sketch out some of the basic parameters of the positive and negative perspectives as they have existed in the psychoanalytic literature since the time of Freud and point out their consequences for therapy. Before I do that, it might prove helpful if I offer a concrete sense of my theme by relating two formative incidents which helped make me aware that there was the possibility of another way of seeing.

One of the first notable incidents took place while I was working for Dr. John Rosen as a live-in head of a house of psychotic patients at Twin Silos, a retreat geared to the therapy of refractory psychotics. No drugs of any sort were used, not even aspirin. One day I was sitting by myself, reading, when David (name changed), a chronically psychotic paranoid schizophrenic of forty-two, walked by. My relationship (if you can call it that) with David had always been extremely strained as he was totally uncooperative in any of the duties we all were to share in the upkeep of the house. David acted like a prima donna, was capable of great anger when pushed to do something, and our interactions were nothing but power struggles. I always felt that this is how it had to be as David was generally regarded as having reached his optimum level of functioning because of his past history with "maintenance shock." David had received ECT every day for approximately two years. He now could dress

and care for himself, but no one thought him capable of much meaningful interaction.

David was prone to talking to inanimate objects and on this cccasion he said something to the lamp I was using to read by. As he walked back and forth I sensed him craftily looking my way but then quickly acting preoccupied when I looked up. I felt in a playful mood and decided to play with his symptomatic behavior. I began to talk earnestly to the lamp as well. To make a long story short, David and I struck up a relationship initially based on great indirectness of communication, indirect in manner as well as in content. Eventually, David even became helpful with the household chores. To my astonishment, I discovered that David had been communicating all along but I had failed to adapt to his way of doing it. Further, there was something frightening for me about letting go of my accustomed ways of doing things. David's communication, far from being impoverished and meaningless, was rich in meaning, too rich for me to handle most of the time. He was highly attuned to the slightest whisper of interpersonal communication: a tone of voice, a look, a gesture. It was very unsettling to be with someone who remained in a state of hyper-awareness and who perceived things about myself and others which would pass without notice in the asymptomatic world.

A second influential incident took place several years later when I was engaged in a practicum at the outpatient unit of a Veterans Administration Mental Hospital. One of the senior staff psychiatrists who was much respected for his long experience, the books he had written, and especially for his supercillious ways, referred a patient to me. I was told, in essence, that I was being afforded the chance to further my education by getting to see a dyed-in-the-wool specimen of paranoid thinking. At our staff meeting I was further told that this man's acute disorder indicated very severe pathology. The only sensible course of action was medication and clearly therapy would be a waste of time as his prognosis was so poor. They decided that for the sake of an educational experience, however, it would do no harm for me to see him once per week on an hourly basis.

I began to see this man, let's call him Tom. True to his diagnosis, Tom related with great intensity his feeling that his wife, his co-workers in construction, and his friends were all acting aggressively toward him. I was intrigued by this uneducated man, by his survival ability in the face of a disasterous home situation as a child. He had worked his way out of poverty, abuse and neglect and was on the verge of making it as the construction boss. He had a home, a wife, and two children and was evidently skilled in his trade. Despite his limited vocabulary, in his

descriptions and telling of his story there was a kind of simple eloquence which class bias could easily obscure. I decided to listen carefully to Tom, not just to signs of his paranoia but to the content and context of what he was saying. I began to understand Tom's world a little and I began to understand that Tom, like David, wasn't just delusional and "decathected" from the real world. His symptoms contained his whole story and spoke forcefully of his attempts to work out past traumas and detours in his self. Tom also had been pushed into a state of hyper-sensitivity and awareness of his environment as became clear in his perceptions of me and of the staff. As I became able to appreciate his reality, the symbolic themes of his symptoms led to an understanding of how his past was being lived out in the present. Tom had, unawares, selected aspects of his current world, which few could see but were real nevertheless, to concretize traumatic interpersonal themes from the past. Some of this had been precipitated by his great guilt over impending success as a boss and over the unfaithfulness of his desire for women other than his wife. Tom came to some reconciliation with his past and with his great fear of loss of the internalized good, but weak object, his mother. Tom went back to work and got the job as boss.

The common denominator of these incidents was my recognition that there was a person behind and in the symptoms. I didn't start off with that idea and I am not sure what led me to listen in a different way. Perhaps it was the challenge provoked by those particular settings. Whatever the reasons, I was intrigued with my observations that the mental health deliverers seemed too distant, separated, and preoccupied with their theory and were deaf and blind to the communication of their clients. The therapists, institutional staff, and the lay public seemed to cling tenaciously to an implicit assumption that madness was qualitatively different from normality. There was an attitude of superiority toward those who were more symptomatic. This very attitude precluded communication and impeded any possibility of establishing a therapeutic environment. It seemed to me that our clients were always motivated for change but that our distant, unresponsive attitude consistently undermined their attempts to establish that environment they required. This is the crux of the problem. The theoretical and practical aspects of the positive perspective are intended to mitigate the unseen but forceful tug of the negative perspective.

In order to get a handle on these slippery, implicit assumptions which determine our attitude and practice I have arbitrarily separated theory from practice. The practice

had to come first in order for me to see the reality of these perspectives. But in this paper the theory comes first (the first three chapters). Szasz (1961), Laing (1960, 1961, 1967), Foucault (1954/1976, 1961/1973) and Sedgwick (1971) address some of the philosophical issues and the sociological determinants which help to define my two perspectives. My emphasis in the theoretical sections is quite different. I find that within the non-critical literature itself these perspectives have a tradition and development beginning with Freud which have not been sufficiently recognized. The scope of this paper is to remain within this tradition of the psychoanalytic literature. Once the parameters defining the contrast and tension of the two perspectives are drawn out in Chapters I through III, I will bring this theory and its implicatons for practice to bear on the clinical activities of therapy, supervision, and consultation in Chapter IV.

The chapters gradually develop the concept of the positive perspective. The way our implicit assumptions about, and attitudes toward, symptomology influence our notion of change and the psychotherapeutic process is the central theme within which the positive perspective unfolds. I start from the most general, abstract, and philosophical demarcating in Chapter I and become more particular, concrete, and experiential as the theme is carried toward

Chapter IV. Chapter I begins with the broadest of overviews, with my language, meta-theoretical intent, and definitions. Toward the end of the chapter, my notion of the psychological symptom is set out by contrast with its meaning and development within medicine by fixing its historical lineage and by defining its unique, positive perspective significance. Chapter II then separates the negative from the positive perspective. Important qualities of each are delineated, put in a psychoanalytic context, and applied to the major, structural components defining psychoanalytic psychotherapy.

In Chapter III, I move from more general theory to situate the positive perspective in specific, personal theories. I review the erratic course of the positive perspective in major, representative theorists within the psychoanalytic literature. Beginning with the initial and most important theorist, Sigmund Freud, I pursue in some detail his brilliant successes and understandable failures in capturing the positive perspective from 1893 through 1920. Freud's struggles to achieve the positive perspective serve to exemplify its major components, especially its consequences for psychotherapeutic change, as well as the inherent resistance it offers to those plummeting its enigmatic, illusive nature. Each of the cited theorists after Freud makes an important contribution and builds on

Freud's ground breaking innovations in theory and practice. However, after Freud, I am drawn most of all to D. W. Winnicott. He, like Freud, had the courage to allow enough closeness with the other to empathically discern the personal meaning of his story while allowing room for the other to come to be himself. Heinz Kohut is my last major theorist. He brings the positive perspective into the current era and into America. Many other significant contributors to the positive perspective have been left unacknowledged. These include Karen Horney, Margaret Mahler, Harry Stack Sullivan, Carl Rogers, Frederick Perls, Erik Erikson, Jacques Lacan, and Harold Searles, to name a few. All of these are important. But those selected are just as representative and influential and they especially furthered the conjunction of theory and practice.

Chapter IV grounds the theory in personal experience and practical application. First I discuss my own journey in coming to understand the significance of the positive perspective on symptomology. Then I discuss and exemplify the theme in the three principal settings in which I have been engaged as a clinical psychologist: therapy, supervision, and consultation. Abstract meta-theory is seen as more important, and more practical, than technique. The progression of the chapters has been intended to allow the crucial significance of the positive perspective to evolve.

It is primarily within these three settings that my own meta-theoretical conception of the positive perspective has evolved. I hope, after all, to pass on my client's insistence that their discomforting secret is real and worth disentangling.

CHAPTER I

THEORY AND BACKGROUND OF SYMPTOMS

> . . . factors in our experience are clear and distinct in proportion to their variability, provided they sustain themselves for that moderate period required for importance. The necessities are invariable, and for that reason remain in the background of thought, dimly and vaguely. (Whitehead, 1968, vii)

Theme

The history of psychoanalytic theory and practice up through the present has been dominated by a one-sided, negative perspective on psychologically deviant thought and behavior, that is, on symptomology. This negative perspective is a superordinate, meta-theoretical concept immanent in the very language, constructs, and assumptions of classical and modern psychoanalytic thought. It permeates all of the six metapsychological points of view (dynamic, topographic, economic, structural, genetic, adaptive) which are said to comprise all of the ways of looking at psychological phenomena. Consequently, the orientation of psychotherapists and the lay public alike toward symptomology and towards those who are symptomatic tends to be negative. By negative I mean all those characteristics which reduce people, their actions and thoughts, to impersonal, mechanistic constructs or objects. This reductionistic view of

our self-hood and its tormented expression in symptomology is characterized by a preoccupation with the biological, physicalistic, external world and a lack of recognition of the internal, dynamic world. The negative perspective in psychology objectifies the activity and personhood of those who are identified as deviant and establishes a qualitative gulf between "normality" and symptomatic conditions. This built-in distance and filtered discernment of symptomology in a broad sense precludes the growth of a more adequate psychodynamic theory, of a more realistic sense of the phenomenological experience of the other. For example, the many layered complexity and rich, communicative nature of a symptom becomes reduced to the simplistic, unbalanced view that symptoms express only pathology. The implicit and often not so implicit negative cast of our theory and general outlook bears directly on how we conceive of change, on our techniques in the psychotherapeutic process, and on the overall treatment and care of the symptomatic population.

Symptoms, however, have a positive aspect. The entire gamut of our thinking and behavior, and especially that which is symptomatic or deviant, contains a positive component which is developmental, dialogic, a present tense striving for growth and mastery and an expression of a creative core of selfhood. A symptom is the observable

communicative end product of both negative and positive forces. It is a complex symbol of deficit and adaptational compromise on the one hand, together with a camouflaged rebelliousness positing reproach and a current striving for development of the self on the other. The psychological literature is remarkably devoid of a clear and explicit account of this dual nature of symptomology and especially of the positive part of the overall perspective. All forms of symptomology, no matter whether fantasy, regression, resistance, transference, or anti-social acts, have a positive developmental and object relational component. The practice of psychotherapy, supervision, and consultation can all be enriched and facilitated by the attempt to achieve this neglected, positive perspective on symptomology.

Theoretical Orientation

The psychoanalytic framework is chosen as the basic theoretical orientation for several reasons. Perhaps the major reason is that the historical influence of psychoanalytic thinking currently influences the way we identify and characterize a symptom. Much of this influence operates out of our awareness. Further, the very historical and psychological reasons which caused early psychoanalytic thinking to lose sight of the positive aspect of symptoms continue to exert their blinding influence. It is hoped that by

examining the vicissitudes of the positive perspective within psychoanalytic theory we might come to a better understanding of our current difficulties facilitating psychotherapeutic change. Secondly, all other non-behavioral systems of psychological thought are primarily derived from, and make use of, psychoanalytic concepts. Even the behavioral approach when utilized with humans in real life situations in, for example, schools and half-way houses, perceives the problematic symptom much as a non-behaviorist would, no matter how quantified in form. What often passes for behaviorism in the field is little more than an attempt to provide security for the service provider by mechanizing a relationship. This objectification of a person and a relationship lies at the core of what is wrong with some of the meta-theory of psychoanalytic thought. Lastly, only the psychoanalytic framework provides the depth, the dynamic theory, to adequately comprehend and unify the apparent variety of symptoms to be found in the many settings in which a clinical psychologist might work.

Within the overall context of a psychoanalytic orientation, this paper will be limited to the object relational branch supported by the language of self psychology. This specific theoretical orientation provides both framework and content. The historical development and vicissitudes of object relational self psychology parallel the

developments and fixations in the positive nature of symptomology. The positive aspect of symptomology and its practical use are most explicit in this approach.

Meta-Theory and Metapsychology

Unquestionably the basic assumptions, the meta-theory of psychoanalytic thinking, influences all the rest of the theorizing and practice in ways both subtle and obvious. This might seem self-evident but this paper is precisely about the profound consequences of an unexamined meta-theory and of psychology's indifference and even hostility to examining first principles.

The present day psychoanalytic negative perspective is a consequence of insufficient attention to Freud's struggle with some basic meta-theoretical issues. Freud's major premises vacillated significantly. The fact that "Freud's metapsychological writings are neither complete nor systematic and are scattered throughout his writings" (Greenson, 1967, p. 20) has made detection difficult of one of these major vacillations.

Prior to 1920, Freud was working toward the position, though with great difficulty, that people have a fundamental striving toward mastery and "restoration." This was manifest in both the internal and external words in repetition. For example, a psychotic's hallucination repeats memories.

Freud attributes this repetition to the teleological speculation that the mental replaying is an attempt at recovery, an attempt to regain the lost object, an attempt "to restore a libidinal cathexis to the ideas of objects" (1915/1957b). This principle is seen in dreams, fantasy and hallucination, play, humor, and in neurotic and psychotic symptoms. Further, Freud makes the repetitive urge the essence of the psychoanalytic concepts of transference and resistance. This formulation represented a radical transformation of the medical-psychological thought of the time. What appeared as meaningless, pathological, and wholly negative was, for as long as Freud could sustain this revolutionary perspective, meaningful, a striving for health, and hopeful.

In 1920 (Beyond the Pleasure Principle) Freud (1920/1955) made a radical turnabout which altered the course of all the psychoanalytic thinking to follow. What was positive now became negative. Repetition was still meaningful but was reformulated as a principle of stasis and death. There was a corresponding change in his view on symptomology. The psychoanalytic community and the Western world became entrapped in one aspect of symptomology. This most significant event largely passed without notice and still remains in relative obscurity. Perhaps the boldness and drama of Freud's 1920 paper was blinding. Perhaps the paper filled a great need of the time for order and more

simplistic unifying principles. Certainly Freud's abandonment of a positive view of symptomology provided for psychotherapists and the lay public a reassuring distance from madmen, from those who might provoke in us unsettling questions about the nature of our sanity. In essence, this was scapegoating wrought from the power of an unquestioned meta-theoretical principle reified into psychoanalytic metapsychology.

Established (and establishment) psychoanalysts and psychoanalytic societies have little interest in questioning first principles. Elements of the neglected positive perspective on symptomology have been knocking on the door of American psychoanalysis for decades but few have dared to even greet the stranger. British school thinking (e.g., Fairbarin, Winnicott, Guntrip) and the French Lacanians have found the courage to radically confront established doctrine and pick up the threads of Freud's pre-1920 more truly psychodynamic thinking. In so doing they have been gradually changing the meta-theoretical base and correcting the long-standing theory and practice of an overly negative perspective. However, much of this has been resisted by the Americans as though it were a life and death struggle.

The major and representative American combatant is Roy Schafer (1976, 1978) who wants to dispense with the danger of a radically altered perspective (actually, only a more

balanced perspective) by sounding the death knell for metapsychology. In a surprising reformulation, Schafer shed his long history of influential texts on testing (Rappaport, Gill & Schafer, 1968; Schafer, 1948, 1954, 1967). He even abandoned his incisive, brilliant organization of the then still radical, qualitative and structural ego psychology approach (Schafer, 1968), radical despite Freud's construction of these principles almost twenty years before. Schafer's boldness and ability to critique metapsychological issues had long been in evidence. But it appears that Schafer has decided to take a shortcut and instead of disputing the new meta-theory and the altered metapsychology of the object relational and self psychology theorists, he claims to dispense with metapsychology altogether (Schafer, 1976, 1978). Schafer does not clarify exactly what he means by metapsychology. He does not distinguish metapsychology from meta-theory and he decides not to analyze those changes wrought in metapsychology on account of the positive perspective impact. Instead, he cloaks himself in a professed return to the starting point of the clinical data itself and introduces a "new language of action for the old one of metapsychology" (1978, p. xi). The "new language of action" eschews nouns and adjectives and is based on the use of verbs and adverbs.

Schafer's "new a-metapsychological" approach is neither new nor without metapsychology. There is a desperation in the sweeping boldness of instituting a new language and in the tedious detailing of its application. Schafer marshalls his considerable skills derived from life-long immersement in psychoanalytic theory to ward off the danger he senses is challenging the American establishment. His approach is old in the sense that it post-dates Gestalt therapeutic theory by thirty years. Perls, Hefferline, and Goodman (1951) were enunciating "techniques of awareness" and methods of more directly "contacting the environment" and were advocating the use of action language long before Schafer's new ideas found print. He does not even acknowledge them. Schafer's approach is not without metapsychology in the sense that he makes some of the same existential and psychoanalytic assumptions as do the Gestalt therapists. However, most damaging of all is the sad fact that Schafer's approach is neither new nor without metapsychology in its implicit, basic orientation. Behind the veneer of newness, its fundamental essence as Freudian post-1920 structural psychology is clearly discernible. Schafer's camouflaged premise laying slightly behind all the new language is Freud's famous dictum in The Ego and the Id (1923/1961) that the conscious ego ". . . is first and foremost a body-ego" (p. 27). The verbs, adverbs and nouns he still must use

presuppose the psychoanalytic concepts of warring instincts, of dynamic forces acting within a tripartite structure. First principles remain and their importance is underlined by Schafer's vehement attempt to deny them.

Assumptions and first principles can't be ignored but much of it in psychoanalytic thought has remained at an implicit level, perhaps because of Freud's unsystematic approach to it (Rappaport & Gill, 1959). There are other, just as compelling reasons for the peculiar lack of recognition of a whole set of assumptions which have, nevertheless, been formative in guiding psychology, theory and technique. These dimly and vaguely perceived assumptions have remained in a shadowy realm and few have dared to challenge them. These assumptions have remained in the "background of thought" because they were syntonic with the needs of the fledgling, peculiar enterprise of psychology. Psychology needed a scientific base to gain credibility and it needed a way of distancing from the unsettling, constant exposure to the unconscious and to madness. Sociologically it needed to align itself with the status quo and thus its metapsychology itself became a "symptom" of socio-economic-political realities of that time. This metapsychology, the unbalanced assumptions of the negative perspective, continue to haunt us. The abstractions of metapsychology are very real in

their all too human derivation, their immanence, and their down-to-earth consequences.

Meta-theory and metapsychology as used in this paper require further defining. Until 1915 Freud used metapsychology to mean only that which was beyond conscious apprehension (Rappaport & Gill, 1959, p. 153). In a footnote to A Metapsychological Supplement to the Theory of Dreams in 1915, Freud (1915/1957b) states that the intention of metapsychology ". . . is to clarify and carry deeper the theoretical assumptions on which a psycho-analytic system could be founded" (p. 222). It is the convergence of both these general, early Freudian meanings, that which lies behind our conscious thought and the notion of our fundamental theoretical assumptions, that is important for grasping the significance of the overall permeance of the positive and negative perspectives. This general, transcendent meaning of metapsychology, before metapsychology took on its specialized meaning in later psychoanalytic thought as consisting of six viewpoints, is synonymous with my use of meta-theory.

Psychoanalytic metapsychology is now based on six points of view although Freud used only three: the dynamic, the topographic and the economic (Rappaport & Gill, 1959, p. 153). Modern clinical psychoanalytic practice holds that, in the course of "working through," all six metapsychological

points of view (dynamic, topographic, economic, genetic, structural, adaptive) should be employed (Greenson, 1967, p. 21). When the term metapsychology is used in this paper it is only referring to this later development in which metapsychology took on a more specialized meaning.

It may be objected that the six points of view constitute the total meaning of the alleged superordinate concept of meta-theory. Isn't it true that no matter how we view basic assumptions one or more of the recognized points of view will more clearly, more explicitly convey the desired meaning? The answer is that all six points of view are themselves tainted by a transcendental point of view: the positive and negative perspectives. This requires further explanation.

In order to best highlight the effect which first order, implicit assumptions have had on the overall theory and practice of psychoanalysis and the derivative non-analytic psychotherapies, it is necessary to avoid identification with the tainted, metapsychological terms. For example, the topographic point of view posits a perspective which encompasses and speaks to the general characteristics of the unconscious-conscious dichotomy. This point of view might be utilized together with the motive forces of the dynamic points of view and the aetiological factors of the genetic point of view to explicate the phenomenon of the

fitful appearance of the positive perspective. The problem with using these points of view is that each of them contains assumptions of a reductionistic, mechanistic, objectifying nature which devalue and render meaningless the radical positive perspective at the outset.

The lack of consciousness of those unconscious elements in the dynamic point of view, for example, is said to be a product of the threatening instinctual nature of the unconscious elements. These unconscious elements are either instincts themselves or internalized representations associated with instincts. The true unconscious make-up of object relations, in a general sense, made up of social, political, economic and other interactional factors, could never get a fair hearing.

It might also be objected that the adaptational point of view contains the essence of what is meant by the positive perspective. In a way this is so, for the adaptational notion carries the seeds of the positive perspective. However, it is far from identical with it. Before explaining the differences, the adaptive point of view requires definition.

The adaptive point of view is now recognized by psychoanalytic theory as a legitimate and separate point of view although Freud never explicitly used it (Greenson, 1967, p. 25). Hartmann and Erikson are best known for

developing this point of view which they equated with an "inborn preparedness for an evolving series of average expectable environments" (Rappaport & Gill, 1959, pp. 159-160).

Rappaport and Gill (1959) summarize the four basic assumptions of the adaptive point of view as used by Freud, Erikson (1950, 1968), Hartmann (1939/1958), Fenichel (1954) and Spitz (1957):

> (a) There exist psychological states of adaptedness and processes of adaption at every point of life.
> (b) The processes of (autoplastic and/or alloplastic) adaptation maintain, restore, and improve the existing states of adaptedness and thereby ensure survival.
> (c) Man adapts to his society--both to the physical and human environments which are its products.
> (d) Adaptation relationships are mutual: man and environment adapt to each other. (pp. 159-160)

Further reference will be made to these assumptions of the adaptational point of view in Chapter III. Although the development of these assumptions is important for seeing positive aspects of the symptom, as will be developed later, it is now necessary to note the differences of this psychoanalytic concept compared with the positive perspective. All of these assumptions of the adaptive point of view remain tied to a mechanistic view of man. The inherent, positive, adaptive processes still treat man simply as the vector summation of impersonal forces. The inner forces are still ultimately derived from the id or from conflicting

instincts. Even the more advanced ego psychology notion of a conflict free ego sphere lacks the concept of an inherently vital self and is overly derived from impersonal, social forces. This criticism may especially seem unfair to Erikson because of his attempts to "socialize" the ego and to try to convey a more human sense of subjective reality through his concepts of identity and the life cycle (1950, 1968). However, despite these advances in ego psychology he remains tied to a devitalized ego. Thus, while the adaptive viewpoint may lead to the practical consequence of allowing the symptom to be seen in something less than a purely negative light, the fullness of its positive vitality, its developmental striving, its nature as a communicative, personal extension of the self remains unappreciated.

Definition of the Symptom

Symptom is used in this paper in its most commonplace and ordinary of meanings. However, a good part of the intent of this theme is to stress the uncommon view that symptoms are not just a sign or indication of something else. They are not just past history being repeated in the present. They are not just an aspect of anxiety or regression or anything else. Symptoms are creative expressions of the self and they exist in their own right. While they may "express" the past they fully "live" in the present. In the

psychoanalytic world the fullness of their present reality has received insufficient attention. Behaviorism has recognized and stressed the utility of taking the symptom seriously, but it treats the symptom only as something bad, something to be eradicated. Behaviorism fails to appreciate the reality and meaningfulness of the symptom while, ironically, claiming nothing but the symptom is important. In the end, behaviorism is no better than psychoanalysis in its depreciation of the symptom.

Symptom encompasses both thought and physical behavior. Its appearance is marked, first of all, by sufficient deviance which at any given period of history might attract our attention. The deviance of a symptomatic thought or behavior is necessary but far from sufficient for defining the symptom. Its deviant quality, in the sense of something being wrong, beyond the ken of normality, has been the orientation of the negative perspective. Deviance is often implicitly extended to mean a difference that is off the continuum of normality, a quantitative difference. This clearly was the belief of Kraeplin (Zilboorg, 1941/1967, p. 454) and we have inherited his legacy. The implication that symptomatic deviance indicates a quantitatively different state of affairs is rarely sanctioned in theoretical orientations today but it remains common in practice.

A symptom is almost always a composite, a complex of more than one thought or action. The composite nature of a symptom makes its precise, defining boundaries difficult to discern. In practice it is often impossible to tell where one symptom ends and another begins. Symptoms are far less discrete than we pretend they are. Any particular symptom is, in fact, nothing less than a glimpse of the total person. Its defining nature is ultimately inexhaustible, like a symbol or a dream. As Sarte so eloquently says:

> . . . man is a totality and not a collection. Consequently he expresses himself as a whole in even his most insignificant and his most superficial behavior. In other words there is not a taste, a mannerism, or an human act which is not revealing. (1956, p. 568).

Symptoms express this totality and so any given symptom can serve as a way in for understanding the client.

The complex of thought and action that make up a symptom is characterized by a coherent and unifying scheme to which we attribute meaning and cause. However, the scheme utilized in the negative perspective only takes the negative meaning into account. Symptoms become classified into relatively exclusive categories and usually there is more than one symptom per category. But again, the categories denote only negativity.

Symptoms tend to be repeated. This repetitive nature of a symptom is another important part of its definition, albeit a negative one in traditional psychological circles.

This repetitive quality is sometimes associated with inertia, or character armour (Reich, 1933/1945), or resistance, transference, inertia, and the death instinct (Freud). However, the very repetitiveness of a symptom may be seen in another, more positive light: attempted mastery and communication. This negative approach to symptomology originated in medicine. For a variety of reasons, psychology in its infancy found the medical model a fertile ground for the adoption of these aspects of the negative perspective.

Psychology and Medicine

Clinical psychological thought has tended to borrow the vocabulary and assumptions of medicine at the beginning of this century. At that time, the most essential aspect of a symptom was its descriptive power in being able to alert a trained observer to an underlying, pathological process. A symptom was always a sign of something else, even though the symptom itself might be quite serious and life threatening. Freud and psychoanalytic theory grew out of this medical legacy. The succession of assumptions from the pre-Freudian medical legacy to Freud is best seen in the monumental nosological system fathered by Kraeplin.

As Zilboorg (1941/1967) points out, Kraeplin (1855-1936) was a systematizer and his interest was only in the most general, descriptive qualities of those noteworthy

behaviors seen as deviant at that time. He wasn't interested in the particular, more personal content of thought but only in its most general form. Science would have none of the romantic folly of getting too personal. In his pursuit of facts he remained tied to an emphasis on abstract categorization of external phenomena. He essentially retained the physicalist base akin to the physics or chemistry of the eighteenth century as opposed to a more contemporary biology "which deals with the phenomena of life in a more comprehensive and much less impersonal fashion than it might at first appear" (Zilboorg, p. 454). One of the direct consequences of this was the view that disease exists as a separate entity from health and so mental illness is discontinuous with normality.

Kraeplin's impersonal and detached physicalist system might also be seen as a continuation of the medieval, theological tenet that "all illness, including mental illness, must be physical" (Zilboorg, p. 467). The theological fear that God's existence might be questioned if the God substance in man, his soul, is seen as imperfect, subtly reinforces the medical, physicalist base of the negative perspective.

Whatever the sources, Kraeplinian thinking identified symptoms with the separate entity of psychological disease

and reduced psychological reality further by assuming that behind the underlying psychological pathology was an even more basic, physical, organic pathology. For example, Kraeplin states:

> . . . dementia praecox on the whole represents a well characterized form of disease, and . . . we are justified in regarding the majority at least of the clinical pictures which are brought together here as the expression of a single morbid process, though outwardly they often diverge very far from one another. (Kraeplin, 1919/1971).

Freud, of course, also hoped and believed that some day a physical pathological process (chemical) would in fact be found as the root cause of symptoms appearing as psychological deviance (Breuer & Freud, 1893/1955, p. XXIV).

This notion of psychological symptoms being expressive of something else, of an underlying pathology and even of a physically based deviancy in the body's machinery, was considered enlightened thinking (Szasz, 1961). "Progressive scientific thinking" of the 19th and early 20th centuries looked disdainfully at the earlier "folly" of lumping together malingerers, criminals, and the insane (Foucault, 1961/1973; Rosen, 1968). Seeing psychological symptomology as real (not laziness or malingering) and as organically based as medical symptomology (not as possessed by the devil) legitimized psychology but at a very high price (Szasz, 1961).

As psychology uncritically adopted the medical model of symptomology, psychoanalytic thinking became burdened with the nominal fallacy. The assumptions of Emil Kraeplin's classification of mental illnesses in 1883 became part of all the clinical psychology which followed. Names were given to the unseen, inferred, underlying pathological processes which, in parallel to the medical model, had to exist because of the existence of symptoms. Symptoms existed because of the existence of the underlying pathology. These names for psychological pathology came to assume an unquestioned reality. Because the name existed therefore the referent must exist. These pathological ghosts lying behind symptoms made the symptoms themselves appear only in a negative light, an indication of insidious processes which were all the more frightening, grave and serious, precisely because they were unseen.

There is another major aspect to the high price psychology paid in finding credibility by adopting the early medical model's theory of symptomology. Psychology, by the inherent nature of its subject matter, by being burdened with a much more complex aetiological problem than medicine, was unable to keep up with medicine's rapidly increasing sophistication about the complexity of a symptom. Psychology was forced into a ceaseless exploration of one elusive causative factor after another precluding the opportunity

for sophisticated elaboration. Medicine, by the inherent nature of its subject matter, had a much easier time in finding simple, direct, physical and thus observable and testable aetiological factors. With a basic and relatively unchanging aetiological core medicine could afford to turn its attention to the complex composite of pathological and repairative processes which make up a symptom. Even though psychology came to assume field theories of multiple causation (Rosen, 1968, p. 245), the dual nature of any given symptom was obscured by the scant attention to any specific determinant of that symptom. Psychological "disease entities" could not be established with reference to indeterminate aetiological factors so the apparent coalescence of symptoms was reified into a psychological disease. Once again ghosts derived from a dubious source, however this time the net effect was an over-simplifying of symptoms and an over-emphasis on their most observable negative features.

During the Nineteenth century a symptom in medicine meant little more than an observable feature of an unseen pathological process. Medicine had a simplistic and one-sided notion of symptoms being wholly negative and a direct expression of the hidden illness. There was little appreciation for the many unseen bodily systems which converged into forming what an observer might detect as being noteworthy and deviant. As the body's immunological and

defensive systems were better understood a symptom came to be viewed as a complex phenomenon embodying the sum total, at any given time, of many mechanisms and forces from within and without.

While the medical profession has become considerably more sophisticated in its understanding of symptomology, psychological theory has remained fixated at a more simplistic level. The evidence of our diagnostics as exemplified by the one sided language and content of DSM-III (Spitzer, 1980) and by past and current psychoanalytic theory is that we have failed to achieve even the psychological equivalent of the medical model's view of symptomology. Specifically, we have missed the notion of an heuristically dynamic body which is alive with regenerative potential. Even accepting psychological structures correlative with that of medicine, ours in comparison are flat, lifeless, overly abstract and mechanical.

It is a curious irony that psychiatry and clinical psychology should actually be accused of fixation at a more primitive level than medicine regarding the narrowness in its understanding of symptoms. After all, it is said (Zilboorg, 1941/1967, p. 488) that one of Freud's major historical breakthroughs is his focusing on the total person rather than on Kraeplin's nosological categories or on specific anatomical structures. And to the layman, psychology

is supposed to deal with the person, with what is most alive about us. Perhaps in its flight from suspicion of spiritualism and vagueness and in its pursuit of a respectable positivistic base, psychoanalytic clinical psychological thought has wrung the life and autonomy from its subject matter. Frieda Fromm-Reichmann is one of the notable exceptions to the failure of the extended psychoanalytic community to understand the positive, vital aspect of physical symptoms in medicine and then see the possibility and importance of this notion for psychological symptomology:

> Every general practitioner knows that many physical symptoms are not only the expression of the patient's disease but also an expression of the tendency in the physical organism toward regaining health. (1959, p. 5)
>
> The same holds true for processes of mental illness. Its symptoms, too, both express the illness and show the mentally disturbed person's tendency toward mental health, that is, toward adjustive success in his relationships with other people. (1959, p. 6).

Symptom as Communication

Implicit in Frieda Fromm-Reichmann's view of the symptom's expression of a "tendency toward mental health" is the symptom's communicative nature. Symptoms can, of course, readily be seen as the expression of a problem but for those willing to make a radical change of perspective they also express their positive meaning. The language of

this meaning is far from discursive. Thomas Szasz (1961), taking his cue from Freud's observations in 1895 that hysterical symptoms could be seen as a pictorial form of non-verbal communication (Freud, 1895/1955), calls this language of symptoms "protolanguage." Protolanguage is relatively non-discursive, iconic or pictorial; it tends to be relatively idiosyncratic, and especially has an ". . . object-seeking and relationship-maintaining function . . ." (Szasz, 1961, p. 299). The word "relative" is frequently used because the language of symptoms is on a continuum with discursive language. It is only a matter of degree of difference within any dimension that "crazy talk" differs from "normal talk."

The iconic language of symptoms may be a "proto" or simpler and inferior language when it comes to efficiency at a purely cognitive level but in its symbolic nature it is more vivid, terse, dynamic and complex. Sechehaye (1951a,b) simply calls this language symbolic and sees it as having a unique power in being as close as possible to the actual, personal, historic coinage of the initial conflicts. The symbolic type of expression is more directly the equivalent of real experience, real affect, and tends to communicate this more poignantly. It can thus serve effectively as a conduit for empathy. The talent for psychotherapy rests on sensitivity to this mode of relating.

The language of psychological symptomology is a universal language which is naturally employed to both conceal and reveal. Its indirectness, as Szasz (1961) suggests, is part of the overall indirectness dictated by social reality. Our needs are expressed ever more indirectly as the social matrix becomes more sophisticated, complex, or close knit. Too much directness causes conflict and impedes the smooth functioning of the social group. Humor is a good example of a mode of highly symbolic communication which, like the symptom, utilizes indirectness to express ideas, needs and wishes so as to minimize open conflict. Freud, in his famous papers on humor (1905/1960, 1927/1961) held that humor essentially has its roots in aggression and is a relatively civilized way of expressing this aggression utilizing a variety of disguises. The symptom, like humor, has survival value in its indirectness and presents a slippery facade, a caginess which resists our probing (Lukens, 1977).

The concealment role of the symptomatic form of interpersonal communication is extremely important and must be respected by the inquiring therapist. Besides the potential richness and primitive directness of this form of relating, the need for this degree of concealment is a clear indication of the riskiness involved. Symptoms, as Freud repeatedly pointed out, are over-determined and it takes prolonged

suffering and many small blows, perceived by that individual as traumas, before a symptom becomes manifest. Concealment allows a relatively safe outlet for bruised parts of the self.

The concealment function of symptoms provides safety against possible further loss of love, responsiveness, and empathy while allowing the intrinsically active self to express its hurt to itself and others. The self requires a certain amount of responsiveness and empathy especially in its earlier stages of development. The self is active and expressive and cannot check its continual impingement on external and internalized reality. The external environment may experience this impingement and even this need for responsiveness as threatening, as anxiety provoking for a variety of reasons. Perhaps there is a misfit between mother (or father) and child in terms of innate dispositional factors such as activity level or the amount and forcefulness of stimulation required for each to experience adequate responsiveness in the other. Or perhaps, as is more often the case, the parents experience personal impingement as aggression or control or some other form of infringement threatening to over-tax their already diminished resources. The child learns to selectively attenuate his impingement to minimize this threat to his environment so as to maintain the greatest possible responsiveness under

the circumstances (externally and in the internalized world).

Over time, selective attenuation of impingement, a dissociation or false self (Winnicott) detour from normal development, leads to clearer symptomology as the appropriately successful disguises are tried out and incorporated. Every symptom thus derives from specific failures of the environment and bears the specific imprint of that failure. This is part of what the symptom reveals in a negative sense: the environmental failure and the deficit in the self. This negative revelation is irritating to the parents who have failed and may even serve to prompt some potentially positive action, such as bringing the youth in to see a therapist. But the aetiology of the failure is only hinted at, concealed by its expression in another language. Direct conflict and challenge remain hidden. The bruised self has safely spoken.

Symptomatic language thus provides relatively safe feedback about the pathology of parents, or even of the extended parental environment, the pathology of some part of society. Symptoms always occur in, and have their development in a social matrix. They are part of a never ending dialogue of alienation, of oppressors and the oppressed. Those who are less powerful must conceal their message of reproach. But they must also express it or give up their

naturally active self, their reality altogether. John Rosen (1968) based his radical therapy of psychotics in the 1940s on the revolutionary doctrine that no matter how dissociated and psychotic the patient, no matter how withdrawn and disguised his communication, he was always communicating. But in any age the idea of seeing meaning in the oppressed language of symptoms is never popular. Rosen found that "The idea of paying attention to psychotics--listening to them and trying to understand them psychologically--seemed to be considered ridiculous or even bizarre" (1968, p. 7).

The therapist, analyst, counsellor or teacher who would allow him (her)-self to see that symptoms have meaning, that they communicate, and that they are the disguised language of the oppressed has, upon that recognition, put himself in opposition to the status quo. This is extremely important to recognize especially for the practical application of the theory. "Seeing" the positive, communicative, object relational, and developmental aspect of symptomology requires a letting down of ordinary personal boundaries and immersement in a shared reality or dialogic experience with another. In short, it requires the activation of empathy without loss of self. The value of dwelling on the metapsychology of the positive perspective is hopefully a freeing of one's empathic capacity with consequent freeing of the need in those symptomatic for disguised expression of

their reproach and of their developing real self. This approach (as opposed to medication and objectification) requires boldness and courage and the willingness to confront opposition. This opposition is from society in general, from the specific setting in which one works, from the internalized societal injunctions in those symptomatic and in oneself, and from our individual and societal defenses against awareness of the consequences of being fully alive.

CHAPTER II

THE NEGATIVE AND POSITIVE PERSPECTIVES ON SYMPTOMOLOGY

The Negative Perspective

> The 'borderline' personality disorders . . . have in common: (i) symptomatic constellations, such as diffuse anxiety, special forms of polysymptomatic neuroses, and 'prepsychotic' and 'lower level' character pathology; (ii) certain defensive constellations of the ego, namely, a combination of nonspecific manifestations of ego weakness and a shift toward primary-process thinking on the one hand, and specific primitive defense mechanisms (splitting, primitive idealization, early forms of projection, denial, omnipotence), and on the other; (iii) a particular pathology of internalized object relations; and (iv) characteristic instinctual vicissitudes, namely, a particular pathological condensation of pregenital and genital aims under the overriding influence of pregenital aggressive needs. . . . (Kernberg, 1975, p. 44).

Delineation. The negative perspective is, first of all, that point of view in psychology and in society overall which sees only the negative aspects of symptomology or psychological deviance. The negative perspective is also that particular attitude and its consequences for the therapeutic process which reduce the totality of the symptomatic person and the totality of his personal expression to impersonal objectification. The negative perspective has been used so exclusively, so invariantly and for so long that we as a society, as a scientific community and as practitioners have lost sight of the negative,

reductionistic cast of our psychological language and premises and especially of the effect this has on those labeled symptomatic.

Negative in the first sense refers to almost all of the long accepted psychological terminology which denotes only a deficit, a loss, a more primitive stage than the rest of us enjoy, or more usually a "diseased" or "pathological" state. These deviant conditions (e.g., schizophrenia) frequently imply a qualitatively different state of affairs for those classifiable under DSM III (Spitzer, 1980) from those not classifiable. That is, instead of seeing psychological deviancy on a continuum from more to less deviant, instead of allowing that we all share the same human condition and our differences are only a matter of degree, the negative perspective tends toward the position that madness, no matter how slight, exists as a separate entity. This negative view of symptomology carries the connotation of badness, wrongness, and always is flavored by a pejorative quality.

The pejorative quality of the negative perspective also carries the implication of a lack of reality, of an emptiness, of something not important in its own right. Thus a symptom is never valued in itself but is only the unimportant appearance of a more fundamental process or condition. The symptom itself thus is of consequence only

insofar as it allows an interpretation or medication to eradicate it. The symptom thus tends to be ignored, not listened to, and the past and future eclipse the present.

Negative further denotes dehumanization and depersonalization. The essential human condition of dynamism, vitality, developmental object related striving and communication is reduced to impersonal forces driving an otherwise inert machine. Reduced as well is the breadth of reality. External reality becomes over-valued while internal reality is barely considered to be real.

As mentioned in Chapter I, a large part of this simplistic, one-sided view of symptomology is derived from an unsophisticated medical model formulated before the influence of immuniological systems were recognized. Richard Totman (1979) contends that even present day medicine has a myopic preoccupation with a reductionistic perspective. His analysis of psychosomatic phenomena from a medical standpoint captures some of the defining features of the negative perspective in psychology. He holds that there is a medical-social orientation which operates out of our awareness. This enshrouding background severely limits our understanding of the psychosomatic component in almost all disease. Totman starts with the explicit assumption that "While it used to be thought that there were just a few 'pure' psychosomatic conditions, now it is generally held

that most, if not all, diseases have a psychosomatic component" (1979, pp. 15-16). He then essentially argues that this seemingly obvious fact has been and remains obscured from medical theory because "scientific thinking about disease . . . betrays a fundamentally physicalistic, or mechanistic, orientation to the concept of illness. It treats the individual, the 'patient,' as a biological black box; a complicated piece of machinery inside which events are assumed to take place in a law-like way" (p. 29). Totman's conclusion is that this underlying mechanistic model of cause and effect in Western industrialized societies allows only a restricted view of health and illness. This has profound consequences both in terms of limiting the efficacy of treatment and in terms of the medical attitude which regards a person seeking treatment as a "piece of hardware" (p. 13).

As important as the reductionistic, physicalist base is in limiting medicine's ability to comprehend and treat illness, it is even more limiting and destructive in the psychotherapeutic world of psychology. The negative perspective has lost sight of the whole person and of the reality that symptoms are an expression of the self. The multi-faceted eloquence of symptoms has been ignored in favor of static, lifeless, unmotivated abstractions denoting only negativity. Reality itself has been shrunk to exclude

all that might challenge the power of the psychological status quo. That is, the internal world with its self-motivated, developmental striving for object relatedness, for community, is itself the locus and agent of change. To recognize that a therapist does not make change happen, is not the prime ingredient in change but only a facilitator of "good enough" (Winnicott, 1958/1975, 1971) conditions, directly challenges the therapeutic community's needs for effectance and control.

The negative perspective, when it accurately identifies and assesses a symptom, is useful in first receiving the communication that something is wrong. Unquestionably this is a necessary first step for everyone. This in itself, of course, is a skill capable of much refinement both in the formal setting of diagnostic interview or testing as well as in everyday therapy and consulting activities. The literature is filled with this aspect of hearing the symptom's communication. However, even this first step in the diagnostic process is intrinsically linked to the values and needs of a specific setting, of the current psychology establishment, and to society. This has been explicated quite thoroughly by R. D. Laing (1960, 1961, 1967), for example. This identification of symptoms, its merits and pitfalls, is closely tied to many of the problems

associated with the negative perspective but is beyond the scope of this paper.

The negative perspective especially becomes destructive for the process of therapy when it becomes the only mode of relating to the other. For the therapist, understanding is diminished, empathy is difficult if not impossible, interpretations are unfreeing and may be experienced as punitive, and a therapeutic alliance never gets started. The client gets bound to the therapist in a recapitulation of society's structure of power to powerlessness, of oppressor to oppressed. Further, the client becomes imprisoned either to his medication or to his heightened self-consciousness about all that is mentally wrong with him, about his madness (Foucault, 1961/1973). He is now labeled and shackled to the negative implications of that label. Unless the therapist can somehow transcend the convenience that accrues from labeling in the negative perspective the client is left without response to the hopeful cry of the symptom. A response to the deficit part of the symptom is better than none at all and is the first step in that dialogue needed for growth. But disillusionment, further interiorization, dissociation, "acting out," passivity and entrenchment of the symptom may occur if a positive perspective cannot be achieved long enough or consistently enough by the therapist. When the negative perspective holds sway

and unawares we treat the client as an object we are instrumental in distracting and discouraging the client from allowing creative, developmentally motivated and object seeking selfhood to risk change and action in the outer world.

Psychoanalytic concepts. Prior to 1920 (Beyond the Pleasure Principle), Freud (1920/1955) frequently toyed with the notion, derived from watching the play of his children, of there being an innate striving for mastery and relatedness in almost all forms of deviant phenomena. This important development of the positive perspective will be further elaborated in Chapter III. Suffice it to say that in 1920 Freud, in a curious piece of labored logic, did an about face and lost his radical nerve. After over twenty years of nurturing and teasing out the well hidden and quite subtle positive perspective he suddenly equated one of the mainstays of the positive perspective, the principle of repetition, with the principle of conservation and death. The main exponent of an independent selfhood striving for development and creatively expressing its need for a responsive environment both for normal growth and to overcome its dissociative retreats was effectively dead. Freud retreated to a structuralist position which brought clarity to his work but at great cost. The psychoanalytic establishment and psychological community inherited a legacy of

concepts crucial to an understanding of psychotherapy but missing the critical notion of the dual nature of symptomology.

Resistance. One of the major psychoanalytic terms now ubiquitously used in many forms of psychotherapy is resistance. Resistance occupies a central position in psychoanalytic theory and much of the psychoanalytic technique addresses the problem of analyzing resistance. Resistance is a large and complex concept which may be approached from all six psychoanalytic points of view (dynamic, topographic, economic, structural, genetic, adaptive). However, the types of resistance are often classified by their source within the structural point of view (id, ego, superego). Freud first gave a detailed account of resistance in 1912 (1912/1958), then in 1914 (1914/1958), but the structural analysis doesn't come until 1926 in Inhibitions, Symptoms and Anxiety (1926/1959) with his final elaboration in Analysis Terminable and Interminable (1937/1964) in 1937.

In Inhibitions, Symptoms and Anxiety (1926/1959) Freud developed five types of resistance: repression resistance, transference resistance, epinosic gain resistance, repetition compulsion resistance, and superego resistance. The first three derive from defensive functions of the ego, the fourth from the id and the fifth from the superego. Greenson (1967) believes all five types represent defensive

functions of the ego (conscious and unconscious) and certainly this has been the trend as seen in Fenichel (1945), Menninger (1958), and Blanck & Blanck (1974). Regardless of the source or the specifics of its hypothesized mechanisms, mainstream psychoanalytic theory sees resistance in negative terms as a type of defense (although Freud frequently used resistance and defense synonymously). Resistance tends to be seen only as something to eradicate. It exists only to defend some aspect of the ego when it is feeling threatened. Freud in his earlier two papers on resistance used images of battle and warfare to describe the analyst's task in removing resistances. Menninger's (1958) description of this attitudes still applies today:

> In a way the analysis of each patient is a kind of never-ending duel between the analyst and the patient's resistance. It is no wonder that resistance almost becomes personified for some analysts and that they tend to equate it with the disease process. Resistance is not something that crops up occasionally to 'impede' the course of treatment; it is omnipresent. (p. 102)

This one-sided view of resistance phenomena as bad or as a blockage (implied by the label "Resistance") frequently is inappropriately extended so that resistance is thought to be directed at the analyst. In practice, it is often the case that therapists self aggrandizingly think that they are being opposed. Wrongly sensing they are in a battle their own defenses become aroused. This counter-transference only serves to widen the client-therapist gap and intensify the

client's communication appearing to the therapist as resistance phenomena.

The meaning of resistance, no matter of what type, is in the best of definitions limited to those forces which resist therapeutic change within the patient. This is often equated with resistance to making the unconscious conscious, a broadened version of repression acting at various levels. But those phenomena labeled resistance in the negative perspective are almost always seen as the opposite of a tendency for positive change. This never helps to bring client and therapist closer together despite a professed interest in promoting a working alliance. When part of the client is treated as bad, and often this is seen as a major part, then to that extent he is demeaned, and treated as inferior. It's a small step in the real world from being seen as bad and oppositional to being labeled as willful, uncooperative, lazy, unmotivated, and unready for therapy or untreatable. The negative perspective in the concept of resistance breeds this sort of devaluing and name calling and limits the efforts of therapists to work at better understanding the positive communication in resistance.

Resistance, while recognized as one of the key psychoanalytic concepts, ironically means nothing more than that which only exists by virtue of its anti-nature. It is assigned to a shadowy and changeable realm, a temporary

force opposing other forces. It has no vitality or substance of its own though it may be almost reified and ossified as a sort of bodily character armor (Reich, 1933/1945). Rather than helping to alert the therapist to the reasons that the self has adopted a temporary refuge (for example, maintaining a sense of identity or autonomy or mastery when threatened with its loss) or even to the fact that the self is revealing itself as best it can, traditional resistance theory adds ever more technical labels to the forms of resistance. The totality of the client is missed as those operations developed over years of the self's struggle for survival and expression are dismissed with a quick interpretation based on the categorized form with which the phenomena are identified. Schafer (1976), leaving his early Freudian assumptions of drives and counter forces, surprisingly argues that there is a real, positive action behind the seeming negativity and anti-nature of resistance. He calls for a more "balanced understanding" (p. 263) which he hopes will be extended to the other major psychoanalytic concepts as well (p. 263).

Transference. Transference is certainly one of Freud's essential discoveries for the understanding of human behavior (the psychoanalytic establishment includes resistance, the unconscious, and regression as the other major

discoveries). Freud's attention was first drawn to the concept of transference during his early work with Charcot and then in his own experiments with and without the hypnotic technique (Menninger, 1958, p. 79). Freud was struck by his repeated observation of the exaggerated authority attributed to the hypnotist. In 1912, in his papers on technique, especially in The Dynamics of Transference (1912/1958), Freud was intrigued by the repetitive patterns of his patients and thereafter thought of repetition as a key element in transference. In 1920 (Beyond the Pleasure Principle, 1920/1955) Freud posited repetition to be the origin of transference.

Anna Freud (1937) defines transference as: "all those impulses experienced by the patient in his relation with the analyst which are not newly created by the objective analytic situation but have their source in early . . . object relations and are now merely revived under the influence of the repetition compulsion" (p. 18). Fenichel (1945) equates transference with resistance and Menninger (1958) sees it as an aspect of regression. All of these theories are somewhat too narrow for it is much too arbitrary to limit transference to therapy and it is certainly too restrictive to limit transference to resistance or regression. Greenson (1967) defines transference much as does Anna Freud but he gives it a broader and more useful scope: "Transference occurs in

analysis and outside of analysis, in neurotics, psychotics, and in healthy people. All human relations contain a mixture of realistic and transference reactions" (p. 152).

Transference, unlike resistance, is carefully cultivated in analytic psychotherapy. Its dual nature is much more clearly recognized although still limited because of its place in the overall negative perspective. Freud (1912/1958) first recognized and developed the dual nature of transference and the repetition compulsion. Transference on the positive side gives access to unconscious, repressed material much as does the dream. It allows insight into early object relations which otherwise, for the most part, are inaccessible. The established psychoanalytic view of the negative aspect of transference is its association with resistance. It is felt that transference phenomena can also be an obstacle to the work essentially by obscuring the observing ego and replacing the working alliance.

Despite Freud's clear recognition and that of the psychoanalytic community of the dual nature of transference, the positive aspect of the duality is incomplete. In fact, the recognized positive aspect is important not for itself but for the information it provides about the past. The communicative and object relational striving in the present, the present hopefulness of the self for a new dialogic experience, is missed. Missed is the chance for a genuine

encounter with the other. The client is still objectified, this time into an information machine. If the right keys are pressed, out comes the early traumas. Never is the self given credit for its fundamental, intrinsic striving for development and growth through its creative use of the other in transference phenomena. The analyst/therapist winds up taking the credit for a fancy piece of transference interpretation which in the final analysis is rooted in the therapist's need to be clever, to maintain control, to remain the healer.

The Positive Perspective

> It appals me to think how much deep change I have prevented or delayed in patients . . by my personal need to interpret. If only we can wait the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers. We may or may not enable him or her to encompass what is known or become aware of it with acceptance. (Winnicott, 1971, pp. 86-87)

Delineation. The positive perspective is more than the lack of a negative perspective. It is the relatively missing half of the full perspective needed to optimize the chance for understanding the other and for working successfully in a therapeutic modality. No one can fully grasp all of the positive perspective. Its appearance always signifies an

achievement. It doesn't come easily. It is forged in the crucible of training, experience, and work on oneself. After these three ingredients it takes, perhaps most of all, courage.

Courage isn't a popular word in the psychotherapy literature. Nevertheless, it is an apt description of that quality required to achieve the positive perspective for several reasons. Searles (1965, Chapters 10, 11, 13, and 15) frequently identifies the absolute requirement for successful therapy being the ability of the therapist to allow regression to occur. And even more, to allow oneself to enter the regressive sphere. This puts a great strain on anyone's sense of self and requires considerable fortitude.

The therapeutic situation in psychoanalysis, as in projective testing, has been defined as managing the environment so as to allow regression to occur (Menninger, 1958, Chapter III). Freud's second fundamental rule--abstinence--is directed toward this end (Freud, 1915/1958c, pp. 165-166). The positive perspective in psychotherapy requires not just the technical establishment of an abstinent environment but a venturing out into the regressive arena to maintain the needed responsiveness of a "holding environment" (Winnicott, 1958/1975, 1971). Excuses (rationales) are sometimes given for a commonly held position that there is some danger in a regression. But as Winnicott asserts:

"The danger does not lie in the regression but in the analyst's unreadiness to meet the regression and the dependence which belongs to it" (1958/1975, p. 261). There is a fear of dependence, of merging, and of sinking into a regressive atmosphere. The extent and intensity of this fear is indicated by the lack of press it receives, by the intensity of the resistance to looking at it. Rimbaud poetically captures the terrors attendant upon loss of conscious supports which besets anyone venturing into the uncharted paths of creativity or of the regressive experience:

> As I descended streams impassable and dark,
> I felt my haulers vanished as so many ghosts.
> Redskins, shrieking, had used them for an arrow mark,
> Nailing them, naked first, to many colored posts.
> (Rimbaud, 1960, p. 5)

As mentioned previously, the negative perspective always tends to remain dominant and in the majority as it serves the function of a relatively successful defense against madness. The chaos of madness is threatening at a personal level. Glimpsing the failures of our familial-social-economic system and the psychic consequences for the poor of our usurption of the limited riches is threatening at a societal level. Breaking through our personal and societal defenses is a courageous and radical act. There is the risk of isolation and professional censure. By definition, the positive perspective resists analysis, cloaks itself in various disguises, must always be in a minority,

always in the "background of thought," dim and vague. To read the disguise and behind the disguised communication of the symptom is to be a law breaker, is to step out of the status quo. No one can do this for long. The fifty minute hour, like many of the trappings of psychotherapy, are for the protection of the therapist.

So attaining the positive perspective takes courage in struggling with regressive phenomena, in risking proximity to madness, and in inviting isolation and censure when breaking societal and professional mores. To allow ourselves to see the positive perspective for awhile is akin to removing societal and psychological blinders. Unfettered seeing can be a radical act. It takes courage to fight off the unease precipitated by looking over the edge of our accustomed terrain. "Courage also slays dizziness at the edge of abysses: and where does man not stand at the edge of abysses? Is not seeing always-seeing abysses" (Neitzsche, 1954, p. 269)?

Achieving the positive perspective is not equivalent to just accepting a client nor to passively just letting things happen. It's not "unconditional positive regard" (Rogers, 1961). It requires a questioning of basic assumptions about the nature of man. One of the shortcuts to this alternative way of seeing, a procedure that can be effected in supervision and consulting activities to schools and half

way houses, for example, is by stressing the value of dwelling on those assumptions which make up the positive perspective.

The positive perspective assumes that man is a social and communicative animal always expressing his innate stirrings for object related development. Every psychological symptom is a complex, well fused amalgam of positive and negative elements. Ths positive perspective, while focusing on the positive elements, comprehends both of these. While it radically posits a hitherto unelaborated positive striving it further asserts that the negative elements of deficit and deviance are also communicative expressions of the self. The negative communication has been better recognized and well developed by Freud and others as repetition, transference and resistance, essentially as seeing the past in the present. This basic psychoanalytic proposition, insofar as it looks at symptomology as meaningful, is positive. But, to the extent that it stresses the past to the exclusion of the present, to the extent that it identifies the self only with the deficit aspect of the symptom, to the extent that it distances from engagement in dialogue with the self in the symptom, it is negative.

Psychoanalytic concepts.

Resistance. The consequences of the positive perspective are especially visible in the psychoanalytic concept of resistance. One of Freud's great achievements which has formed much of the bedrock of psychoanalytic technique is Freud's discovery of resistance. Freud, and most of the present day psychoanalytic community, aim their major weapon, interpretation, at the enemy of resistance. Freud wrote in 1910:

> It is a long superseded idea, and one derived from superficial appearances, that the patient suffers from a sort of ignorance, and that if one removes the ignorance by giving him information (about the causal connection of his illness with his life, about his experiences in childhood, and so on) he is bound to recover. The pathological factor is not his ignorance in itself, but the root of this ignorance in his inner resistances; it was they that first called this ignorance into being, and they still maintain it now. The task of the treatment lies in combating these resitances. (1910/1957, p. 225)

The positive perspective is diametrically opposed to this notion of resistance phenomena being "the root" of ignorance and of the overall assumption of resistance being located in the client. It is far from remarkable that clients don't give up their symptoms when the true facts are recited to them. What scientific hubris! What remarkable insensitivity to the aetiology of their problems. What is remarkable is the client's determined efforts to relate the story of his bruised self and the persistance in the attempt

to establish a reciprocal dialogue in spite of the failure of the therapist to understand his language.

The traditional Freudian techniques of resistance interpretation have undergone some modification because of the abject failure of this approach in the psychotherapy of children, adolescents, the more psychotic adults, and those less intellectualized. Chapter III will pursue the thread the positive perspective has taken as these populations demanded a different orientation. For now, it is notable that the negative perspective on resistance is still pervasive and remains the major orientation being taught in medical schools and in psychoanalytic institutes. Graduate training programs in clinical psychology are little better for although most have stated their objection to the extended medical model they have little with which to replace it.

The positive perspective offers the view that resistance is mainly an artifact of that encounter wherein the health provider has failed to achieve the positive perspective. It is not a matter of a client failing to appreciate an interpretation but of the failure of the therapist to understand the present reality and communication of the client. "The patient is always right." It's up to the therapist, to the environment (Winnicott) to adequately adapt to the client. As Winnicott puts it, ". . . it is the

patient and only the patient who has the answers" (1971, p. 87).

Further, patience is required in dealing with the necessary time it takes for trust to be established, for sufficient testing to take place, and then for the natural developmental, repairative sequence to occur. The delay in the process of the unconscious becoming conscious is not attributable to the inertia (a physicalist analogy) principle, to the death instinct, to a contrary force acting against reasonableness and our best efforts. The perceived "delay" is rather a product of our Western industrialized need for quick solutions and rapid progress.

Much of what is called resistance is only the increased communicative efforts of a client to let us know what the real state of affairs is with him when we persist in supplying the answers or when we doggedly maintain distance and power. This countertransferential issue, our need for power and effectance, along with the difficulty in maintaining patience, are the most stubborn problem for those learning the craft of psychotherapy. The difficulty is rooted in the negative perspective wherein the motive force for change is wrongly located within the therapist. It takes getting back to some basic assumptions to re-evaluate the change agent as the client himself. It is difficult for fledgling therapists, or even for the most

experienced, to first acknowledge and then sustain the perspective that therapy is nothing more than providing a facilitating, responsive, environment. The therapist must work at understanding, not at trying to make change happen.

Transference. The positive perspective was perhaps most developed by Freud in his concept of the repetition compulsion and transference, terms he used interchangeably. The positive value of transference as a form of communication will be developed in Chapter III as the starting point of the positive perspective in psychoanalytic theory. Freud's unfortunate loss of this radical position in his 1920 paper, Beyond the Pleasure Principle (1920/1955), left psychoanalytic theory burdened with a concept which now carried negative connotations. As with resistance, Freud came to associate the communicative richness of repetition with the non-psychodynamic, metabiological principle of inertia and Thanatos. Despite this negative association, Freud maintained that transferential phenomena were of great value (unlike resistance) in psychoanalytic therapy.

The positive perspective highlights the meaningfulness Freud attributed to transference in revealing unconscious aspects of the client's past. But as with resistance, the positive perspective would do more than merely use this communication as data to be interpreted. Transference is

simply another astonishing, creative activity of the self. Unquestionably it provides information. But it is also something positive in itself. In a way, it's the adult version of play.

Freud, and especially Melanie Klein (1932) and Anna Freud (1964, 1974) discovered this phenomenon that the play of a child is not meaningless, not simply a burning off of excess energy. Rather, in play a child creatively utilizes his environment to master past traumas and to exercise and master his stage appropriate developmental tasks (Piaget, 1967). The positive perspective sees the transferential activity of the adolescent and adult as another form of repairative effort. In transference the client seeks to use the therapeutic environment in some needed way. In general, the need is to master past object relational conflicts and, even more, to create these environmental provisions required for the establishment of the necessary "holding environment" (Winicott). The self uses transference to artfully shape the therapist and his environment so as to work through false self adaptions and re-initiate the proper development of the self.

Empathy. Empathy is the major tool of the positive perspective, as opposed to interpretation (traditional psychoanalysis), manipulation (behavior modification), or

the paradoxical manipulations and tag team interventions (family therapy) now in vogue. Kohut (1977, 1978) is one of the ground-breakers in postulating the radical notion that introspection and empathy alone are the major psychoanalytic tools of both research and therapy. Despite the passage of eighty years since Freud first started using introspection and empathy, these unique abilities remain largely devalued within Western culture. Kohut's efforts are directed at establishing the validity of these tools and the consequent and equally radical notion of the reality of the interior, psychic world.

Addressing the assumptions of the positive perspective can help facilitate empathy. This is done by establishing the continuity of client-therapist and viewing the deviancy of the client as understandable, communicative, and only quantitatively different from ourselves. By minimizing the distance between the two partners participating in the dialogue of change, empathy is encouraged. The negative perspective would merely look to theory and think of resistance when it is felt that the working alliance is disintegrating. The positive perspective would encourage introspection on the part of the therapist to look for blockages in one's empathy. Further, since the client is always right, working alliance difficulties should serve as an

incentive to the therapist for increased attention to the overall communication by the client.

Empathy can be developed not only by training and experience but also by continued review of the positive and negative perspective assumptions. All psychotherapy trainees, as well as teachers and others with a need for mental health understanding, come to their tasks with many implicit assumptions based on the negative perspective. Consequently, their empathy is curtailed. They often wind up in oppositional power struggles with their charges because of their limited empathy. Empathy is a useful, practical concept not just in psychotherapy but throughout the mental health field. The positive perspective can be instrumental in allowing greater use of empathy in a variety of settings to the benefit of everyone.

CHAPTER III

DEVELOPMENT AND VICISSITUDES OF THE POSITIVE PERSPECTIVE

> . . . (there is) a definite trend on the part of the lay and medical world to consider themselves as separate from and superior to the mentally sick, superior by virtue of this assumed, unproven, but generally accepted state of being normal. Consequently, the so-called insane, regardless of our scientific theories, are at a disadvantage in relation to the very world upon which they have become so dependent as a result of their illness. Psychologically the world considers them step-children of life. Perhaps it is this psychological factor which has been more responsible than any other for the sad lot of the mentally ill throughout the ages. Perhaps it is this factor, rather than the philosophical and theological errors of the Sprengers and the Kraemers, which throughout the demonological centuries brought down upon the mentally sick the full weight of human cruelty. Perhaps this psychological factor has survived in the human community as an atavistic but potent inheritance from those remote days when primitive peoples summarily killed the sick and the aged merely because they had become burdens to a community which refused to be discommoded by the dead weight of the inept. (Zilboorg, 1941/1967, p. 312)

Freud

Up to now, perhaps the passage of the negative perspective from Freud up through the present has been overstressed. It is unfair to attribute to Freud the present difficulties we have in struggling with the pervasive influence of elements of the negative perspective. Freud's great stature as the most influential psychological theorist can hardly be held against him. Like all of us, he is

partly the product of all the historical forces of his time. That aspects of the negative perspective, which by definition tend to oppose conscious thought, found their way into his theorizing is not unusual. What is remarkable is the extent to which he made these unconscious elements conscious and the extent to which he achieved the positive perspective.

Although elements of the positive perspective on psychological theory were in evidence long before Freud, it took Freud's genius and courage to begin to assemble them in a coherent point of view. As I have discussed, there is great difficulty today in "seeing" psychological symptomology from a more positive perspective. Freud's accomplishments are all the more remarkable given that his positive perspective achievements began eighty-six years ago and were carried out almost single handedly against great resistance from his medical profession and from society in general. In pursuing the meaning of all human thought and behavior, in trying to understand man in his totality, Freud greatly extended the meaning and scope of symptomology. Prior to Freud, symptoms had mainly been viewed only as a sign of an underlying pathology, as something to eradicate. Freud amplified the notion of symptoms from discrete, tell-tale signs of pathology into the more continuous revelation of the person's life history. It is this very broad notion of

symptomology, not the specific symptoms of a diagnostic category, that will be pursued. The interaction of Freud's bold new attitude toward symptomology with his radical method of listening rapidly led to meta-theoretical breakthroughs. With Freud, the positive perspective took a quantum leap forward until Freud lost much of his radical nerve.

Among Freud's significant positive perspective achievements, perhaps the greatest was the degree to which he took "normal man" out of his separate, ego-centric place in the world. To this extent, Freud is on a par with Copernicus and Darwin. It is not just that Freud challenged mankind's haughtiness in his exclusive identification with rationality and his denial of a bestial unconscious, although this would certainly in itself testify to his courage and radical insight. Even more, Freud defied the sacrosanct elevation and separation of one man from another, of the "normal" man from the "madman," of asymptomatic man from symptomatic man. As Foucault (1954/1976, 1961/1973) so beautifully elucidates, it has been considered "progress" that madmen have gradually been separated in houses of confinement and in our thinking from society in general as well as from criminals, malingerers, and debtors. Freud had the audacity to oppose this "progress" by theoretically putting madness and symptomology back into antisepticised society.

This achievement by Freud is especially noteworthy as he also had to question the elevated position and separateness of the doctor, of society's representative in keeping madness at bay. Through daily introspection Freud labored on lessening his personal separation from madness; through therapeutic activity (first hypnotism and suggestion with Charcot and then free association coupled with empathy) he, for the first time in western psychological history (Zilboorg, 1941/1967), cut through the scientific-medical-professional detachment from madness. This was a first for the psychological use of directed therapeutic effort serving as a research method as well and a first for putting all normality on a continuum with madness. All the rest of Freud's positive perspective achievements derive from this.

The positive perspective in Freud thus began with his earliest psychoanalytic work, On the Psychical Mechanism of Hysterical Phenomena: Preliminary Communication (Breuer & Freud, 1893/1955). Here Freud broke with the medical tradition and looked for the meaning and causality of hysterical symptomology not in the physical world (Charcot), not in the mere forms of the ideational world (Kraeplin), but in the specific content of the mental world. Eschewing three of Charcot's four descriptive, physicalist phases of hysteria (the epileptoid phase, the phase of large movements, the phase of terminal delirium), Freud says: "Our

attempted explanation (of hysteria) takes its start from the third of these phases, that of the 'attitudes passionnelles'" (p. 14). This is the hallucinatory phase. Freud continues:

> Where this is present in a well-marked form, it exhibits the hallucinatory reproduction of a memory which was of importance in bringing about the onset of hysteria--the memory either of a single major trauma (which we find *par excellence* in what is called traumatic hysteria) or a series of interconnected part-traumas (such as underlie common hysteria). Or, lastly, the attack may revive the events which have become emphasized owing to their *coinciding* with a moment of special disposition to trauma (Breuer & Freud, 1893/1955, pp. 13-14)

Freud was taking the internal world and its symptomatic expression seriously. He was also understanding that this world had meaning (his determinacy assumption) and even more, that the apparent madness of hallucination "reproduced," communicated memories of real past events (traumas). The qualitative gap between madness and sanity was closing and the special sort of seeing-listening this demanded contained the seeds of empathy. Further, Freud was using a therapeutic technique ("the cathartic method" in hypnosis) not just for therapy but as a tool for advancing theoretical understanding.

Two years later, in 1895, Freud opened the doors to a fuller development of the positive perspective by modifying his technique. In *The Psychotherapy of Hysteria* (1895/1955) Freud had broken with Breuer and established the technique

of free association. Advances in technique, like Descartes' construction of calculus, not only solve old problems but open new worlds. Freud was no longer manipulating or acting on his patients with a technique reminiscent of the operation of a machine. No longer was hypnosis "being applied." The need for effectance and control persisted in his interpretative technique but now he was just listening. Symptoms weren't just isolated phenomena to be eradicated but were coming to be seen as an irreducible part of the person's life history as narrated in free association. This technique could be applied to everyone, as well as to oneself. Empathy and introspection were becoming the therapeutic and research tools of the trade, though it took fifty years for them to be fully appreciated in Winnicott and Kohut.

Freud had begun to take the whole person into consideration by attentively listening to the story of his patient's life and to the contextual meaning of his symptoms. In 1900 Freud (1900/1953) added dreams to the significant activity of man and in 1905 (1905/1960) he added humor. Dreams and humor, like the symptoms of hysteria, were meaningful. Pathological conditions and the seemingly trivial activity of dreams, jokes, and even a child's play could communicate to him who valued the meaningfulness and present reality of another. The symptomatic expression of the self could take many forms.

The significance of repetition symptomology, of the repetition compulsion, was perhaps first observed in Breuer & Freud's work, Hysterical Phenomena: Preliminary Communication (1893/1955). Freud there spoke of ". . . the hallucinatory reproduction of a memory. . . ." (p. 14). In dreams, Freud then saw repetition symptomology in the dream work's replaying events of the past with the implication of an inner striving for mastery (1900/1953), a suggestion he then picked up in children's play and in the exercise of joking (1905/1960). However Freud soon was taken with the importance of resistance and repetition came to assume a mostly negative nature.

Repetition became mainly that activity which will be endlessly reproduced in acts if it is not abreacted and brought into awareness (1914/1958). At this stage transference is also seen in a more negative light, a source of resistance (1912/1958). The positive perspective is in danger of eclipse as Freud's narcissism blinds him to seeing that "the patient is always right," blinds him to seeing the positive meaning of symptomology. Images of warfare predominate in his work at this time for Freud wants to assert the correctness of his interpretations while the patient demands acceptance of his own way of testing and developing. Typically Freud says, "He (the therapist) is prepared for a perpetual struggle . . ." (1914/1958, p. 153).

Aspects of both the positive and negative perspectives on symptomology and on the therapist's attitude and methods are interwoven in Freud's ambivalence at this time. On the relatively positive side Freud says, for example, ". . . we must treat his illness, not as an event of the past, but as a present-day force" (1914/1958, p. 151), and "we admit it (repetition compulsion) into the transference as a playground in which it is allowed to expand in almost complete freedom. . . ." (p. 154). On the negative side Freud says, completing the last quote, ". . . and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient's mind" (p. 154). Freud continually warns of the dangers in repetition, both to the patient and to therapy. In the balance, Freud is leaning towards the negative perspective with clear emphasis on fighting resistance as opposed to "seeing" and aligning with the positive forces for change within the patient's symptomatic communication through repetition and transference.

One year later, in 1915, Freud dramatically regains some of that perspective on the total person he lost while embattled with resistance phenomena. Repetition symptomology can once again be seen in a more balanced way with its positive aspects recognized as an important ally in the process of therapeutic change. The inherent striving of the

self toward object related health even in the most "pathological" conditions gets its clearest expression in all of Freudian thought. In The Unconscious (1915/1957d), in his attempted explanation of the remarkable existence of dream-like "word-presentations" in the waking thought of schizophrenics, Freud asserts:

> It turns out that the cathexis of the word-presentation is not part of the act of repression, but represents the first of the attempts at recovery or cure which so conspicuously dominate the clinical picture of schizophrenia. These endeavors are directed toward regaining the lost object . . . (pp. 203-204)

Freud picks up this same theme in A Metapsychological Supplement to the Theory of Dreams (1915/1957b) and extends it to include even the most bizarre "word-presentations" in the schizophrenic's hallucinatory symptomology:

> The hallucinatory phase of schizophrenia has been thoroughly studied; it seems as a rule to be of a composite nature, but in its essence it might well correspond to a fresh attempt at restitution, designed to restore a libidinal cathexis to the ideas of objects. (p. 230).

At this point, Freud's individual achievement of the positive perspective is remarkable. He has brought almost all aspects of human activity and symptomology (dreams, play, psychotic thought and hallucinations, neurotic compulsions to repeat, especially as seen in the transference, and the mechanisms of regression, projection, condensation, displacement) into a cohesive, positive perspective. There is no form of human thought or behavior which can be considered

foreign or separate or qualitatively different. Even more, the very symptomatic expression of "pathology" or deviancy can now, quite astonishingly, be seen as having in its content an understandable striving towards "cure" or "health."

An ominous shadow falls on all this positive development in, fittingly, A Case of Paranoia Running Counter to the Psycho-Analytic Theory of the Disease (1915/1957a). While still strongly acknowledging the importance and reality of the inherent psychical tendency towards "cure," as expressed in symptomology, Freud's attention is captured by C. G. Jung's notion of inertia.

> These facts throw light on a statement by C. G. Jung to the effect that a peculiar 'psychical inertia,' which opposes change and progress, is the fundamental precondition of neurosis. This inertia is indeed most peculiar; it is not a general one, but is highly specialized; it is not even all-powerful within its own field, but fights against tendencies towards progress and recovery which remain active even after the formation of neurotic symptoms. (1915/1957a, p. 272)

Up to now, Freud had come to see the dual nature of repetition compulsion symptomology as expressive of both an indication of pathology as well as a striving for "progress and recovery." But now, as in 1914 when resistance was viewed as opposition situated within the patient, the negative denotations of repetition gain the ascendency. Freud had a brief flirtation with an object relational base for the positive, repetitive principle in The Unconscious

(1915/1957d) but now he finally consolidates all psychical symptomology in an instinctual base.

In The 'Uncanny' (1919/1955) instinct has clearly replaced the object seeking nature of the self, repetition has only a negative character and takes on a strange, eerie, threatening quality:

> For it is possible to recognize the dominance in the unconscious mind of a 'compulsion to repeat' proceeding from the instinctual impulses and probably inherent in the very nature of the instincts--a compulsion powerful enough to overrule the pleasure principle, lending to certain aspects of the mind their daemonic character, and still very clearly expressed in the impulses of small children; a compulsion, too, which is responsible for a part of the course taken by the analyses of neurotic patients. All these considerations prepare us for the discovery that whatever reminds us of this inner 'compulsion to repeat' is perceived as uncanny. (p. 238)

Freud had come the closest to articulating and achieving the positive perspective in The Unconscious (1957d) in 1915. It appears he was quickly losing his radical nerve, his courage was failing, and he was retreating to ever more abstractionistic, devitalized principles. The final blow for some of the most essential, comprehensive aspects of the positive perspective came the following year.

In Beyond the Pleasure Principle (1920/1955) Freud attempted to systematize some of his basic metaphysical assumptions (not his metapsychological points of view). The adequacy of the derivative Reality Principle to oppose the all powerful, instinctual core of the Pleasure Principle had

been questioned for years. Freud needed an equally strong and self-energized force to achieve a reasonable balance. He found the answer in the repetition compulsion. Freud's logic becomes awkward and forced as his need for a rigid dualistic scheme of opposing forces thrusts the repetition compulsion and the Pleasure Principle into unnatural opposition.

Freud first loosely associates psychical repetition with the meta-biological notion of ontogony recapitulating phylogony. Even the principle of the stability in genetic inheritance from one generation to another is linked to the principle of repetition. The logic becomes more abstract and stilted as Freud associates the repetition compulsion with a fundamental property of stasis and conservation in the physical and psychological worlds. The next step is to the Death Instinct, a force capable of opposing the activity and life of the Pleasure Principle.

There is irony in the metamorphosis of a principle which once was afforded the elevated, positive status of expressing man's inherent, unceasing, object relational striving towards mastery, "progress" and health, as expressed in concrete symptomology into an abstract principle of inertia and death. Resistance phenomena, regression, transference, dreams, play, and all symptomology were now tarred with the brush of negativity. As Freud himself says:

> Seen in this light, the theoretical importance of the instincts of self-preservation, of self-assertion and of mastery greatly diminishes. They are component instincts whose function it is to assure that the organism shall follow its own path to death, and to ward off any possible ways of returning to inorganic existence other than those which are imminent in the organism itself. We have no longer to reckon with the organism's puzzling determination (so hard to fit into any context) to maintain its own existence in the face of every obstacle. (1920/1955, p. 39)

After 1920 Freud does try to pick up the more human part of us. He places our selfhood in the ego and super ego, especially in the super ego. But these are lifeless constructs, mechanical, secondary and derivative without substance or energy in themselves. Instincts remain at the heart of us, Eros and Thanatos, impersonally and perpetually at war. Much of the psychoanalytic and clinical psychological establishment, along with lay society in general, remains caught, mostly unawares, in the resultant negative perspective. Symptoms can only be seen in a negative light. This resultant negative perspective on symptomology has significant and long lasting consequences for the theory of change and for the psychotherapeutic process.

Once Freud removed the vitality, the communicative striving and the impetus in all repetition symptomology toward restoration and health, the patient/client was left with no inner motivation for cure. Once change had been attributed to the natural tendency in the client to grow and develop, now the power for change can only be firmly located

in the therapist. It is now up to the therapist to make change happen, to intervene and manipulate and interpret. When resistance phenomena occur it is only the fault of the patient, of his basic inertia or Death Instinct. The therapist is off the hook.

Freud had the courage and perseverence to articulate more of the positive perspective than anyone previously. He left a mixed legacy, but there were others to cultivate the seeds he first planted.

Post-Freudians

Early Schizmatics--C. G. Jung and W. Reich. C. G. Jung and W. Reich were important spokesmen for some selected aspects of the positive perspective. However, both were relative deadends in the overall development of the positive perspective. Neither had a major impact on the established theory or practice of psychotherapy. Jung and Reich have always retained an intense and cult-like following, but their ardent supporters have remained in the minority. As theorists accepted by the establishment came to give voice to more of the positive perspective, and with the impact of Eastern culture and religions, these early Schizmatics have found greater acceptance.

C. G. Jung. It is well known that Jung broke with Freud partly on account of Jung's feeling that Freud

over-stressed man's sexual and secular nature and so despite his professed intent wound up treating symptoms in their superficial meaning rather than taking the whole person into account. Jung brought man's spiritual and religious nature into the therapy room. Jung, by virtue of his extensive work with psychotics, and given his adoption of Freud's positive perspective notion of the meaningfulness of all human thought, tried to find the meaning of psychotic thinking. Jung found associations between the highly symbolic (Freudian "word presentations") mode of religious expression in primitive and modern culture with the verbal and artistic productions (symptomology) of psychotics. Thus Jung, like Freud, put psychotic thinking (but also religous symbology) on a continuum with "normal thought" and helped close the gap separating creativity from madness from sanity from spiritual experience.

In his notions of archetypes and the collective unconscious, Jung came to a sort of teleological thinking. To E. Kant's a priori categories of understanding he added a kind of inherited memory with his concept of the collective unconscious. The collective unconscious is made up of archetypes which Jung defines as "unconscious regulators" (1960, p. 204). These unconscious regulators of "psychic energy" ". . . can be healing or destructive, but never indifferent . . ." (1960, p. 205). Jung thus hypothesized

that there was a potentially healing force in all of us if one's psychic energy could be property channelled. The consequences for therapy were that the patient himself had the answers to his problems, the curative agent was in the patient, not the therapist, and the motive force for change came directly from the patient's unconscious. Patients' dreams, artistic productions, and free associations all had a positive, communicative nature.

W. Reich. Wilhelm Reich's major break with Freud came in 1920 after Freud's publication of Beyond the Pleasure Principle (1920/1955). Reich felt that Freud had shied away from Freud's original theoretical basis for all psychological phenomena: sexual energy. Like Jung, Reich focused on the formative influence of the libido. But Reich would have none of Jung's (or Freud's) abstractness. Jung and Freud and the rest of the psychoanalytic community were essentially accused of being too fearful of sex and aggression, of "acting out" counter-transferential material. "At issue was the concrete releasing of aggression and sexuality in the patient. At issue was the personal structure of the therapist who had to deal with and handle this aggression and sexuality" (1942/1973, p. 121).

Reich's goal was to bring "man the animal" back into therapy. In this regard he also emphasized the positive perspective notion of accepting and engaging the whole

person. He emphasized that after 1920 "form eclipsed content . . ." (1942/1973, p. 125). He especially felt that the theory of the death instinct represented ". . . signs of disintegration within the psychoanalytic movement . . ." (1942/1973, p. 125). Further,

> The exponents of the death instinct, who appeared in greater and greater numbers and with increasing dignity, because now they could speak of 'Thantos' instead of sexuality, traced the neurotic self-injurious intent of the sick psychic organism to a primary biological instinct of the living substance. Psychoanalysis never recovered from this. (1942/1973, p. 128)

Reich wanted to bring the psychoanalytic patient back to life. He tried to restore the "rightness" of the patient's communication by stressing the unpopular issue of countertransference. He asserted that the so called "negative therapeutic reaction" was the therapist's fault, not the fault of the patient's Thanatos. Therapists are afraid not only of sex and aggression, but also of "pleasure anxiety." As for ego psychology, he said, "The atmosphere was becoming 'purified'" (1942/1973, p. 124). However, Reich's theory itself became purified and abstract as he went from sex to universal orgone energy and he also remained rooted in a physicalist, non psychodynamic orientation.

Early object relations and play therapy. Melanie Klein, Anna Freud and Heinz Hartmann stand out as significant contributors to the positive perspective. Anna Freud and

Melanie Klein, in particular, have been a seminal force in the development of the positive perspective. Jung had to modify psychoanalytic technique and learn the language of symbols and artistic creating because of his work with a new population, with the symptomology of psychotics. S. Freud had modified his hypnotic technique to work with those who couldn't easily be hypnotized and so opened up an entirely new view of man. Anna Freud and Melanie Klein also had the courage to extend psychoanalytic therapy to an entirely new population, to children. (Freud tried once, failed, and decided that unless the father were the therapist it would be impossible to enlist the support of the child in any of the psychoanalytic procedure, especially in following the basic rule--uncensored free association).

Melanie Klein. Melanie Klein was the intrepid innovator who first started the psychoanalytic therapy of children in 1919. She devised a new technique, play therapy, and followed and interpreted the free associations of children as acted out in play. Klein understood that children communicate symbolically in play. Her technique allowed her to work with children as young as two years old and even with them she utilized direct interpretation. Klein believed it was important to establish direct contact with the patient's unconscious anxiety and fantasy (Segal, 1967). She believed in by-passing the more cautious and circuitous route

established by Freud of interpreting defenses and resistance. In a way, this was a positive perspective technique in that she hoped to engage the deepest and "realest" parts of the self. However, these interpretations were made with little regard for the history of the defenses, were forced on patients, and implied that the curative power of therapy was situated in the interpretative ability of the therapist.

Melanie Klein pushed back the frontiers of theory to the months of earliest infancy. Perhaps her greatest contribution, besides the play therapy technique which allowed communication with children, was her development of the very early stirrings of object relations. "I have often expressed the view that object-relations exist from the begining of life . . ." (1975, p. 2). Klein's theory of very early development was based on the mechanisms of introjection and projection. Her thoughts on the two stages of the oral period, the paranoid-persecutory-schizoid and the depressive position were tied to an object relational vocabulary of whole objects (a person) or part objects (e.g., a breast). This had great influence on the rest of British School theory, especially Fairbairn, Winnicott, and Guntrip.

As great as these contributions were to a positive perspective, object relational, self psychology, Klein's thinking was imbued with much of the negative perspective.

While she used an object relational vocabulary and took the reality of the internal world very seriously, she tended to ignore the social and familial forces of the external world. Further, it was always very clear that behind the object relational, descriptive forms of the oral stage the real energic system was instinctual, not object relational:

> I hold that anxiety arises from the operation of the death instinct within the organism, is felt as fear of annihilation (death) and takes the form of fear of persecution. The fear of the destructive impulse seems to attach itself at once to an object--or rather it is experienced as the fear of an uncontrollable overpowering object. (Klein, 1975, p. 4)

Anna Freud. In 1926 Anna Freud modified Klein's play therapy. Anna Freud brought a new respect for the child to psychoanalytic theory and technique. Although perhaps best known for her elucidation of defenses which she developed in her work with children (they apply to adults just as well), it was her humanizing of the play therapeutic relationship which gives her a lasting place in the positive perspective.

Anna Freud eschewed direct and forced interpretations and stressed respecting the defenses of the child and the need to elicit trust and to build a working relationship. She maintained that the child was a person and contact had to be made with the quizzical, timorous self, not with unconscious anxiety. Unfortunately Anna Freud used a desicate, lifeless, structural ego psychology theory. But this didn't obscure her sensitivity to the person of the

child. Further, she was much more attuned to the external reality of children, to their plight as victims of insiduous social and familial forces, as seen in her collaboration in Beyond the Best Interests of the Child (Goldstein, Freud & Solnit, 1973).

Heinz Hartmann and Adaptation. In Chapter I, the relationship of the adaptive viewpoint in psychoanalytic metapsychology with the implications of adaptive processes in the positive perspective was briefly discussed. It was said that adaptation has relatively little to do with the positive perspective on symptomology, although there are similarities. The extent of overlap depends on how broadly we define the metapsychological concept of adaptation. Certainly the psychoanalytic concept of adaptation mainly developed by Erikson (1950, 1968) and Hartmann (1939/1958) has been helpful in advancing the positive perspective. The position of this thesis is that the positive perspective is a super-ordinate meta-theoretical assumption. The six metapsychological viewpoints partake to a greater or lesser degree in the assumptions of the positive and negative perspectives.

Greenson (1967) states the adaptive point of view comprehends "all propositions concerning the relationship to the environment (of) objects of love and hate, relations to society, etc." (p. 25). This definition excludes nothing.

Rappaport and Gill (1959) give a much fuller, detailed, bounded account. As a general statement it can safely be said that the adaptation viewpoint is based on biological principles first and only secondarily are these related to psychosocial processes. Even when we are out of the realm of biology altogether the psychosocial processes are based on biological and physicalist analogies and metaphors. The adaptive viewpoint never achieves a purely psychodynamic, object relational core. Never is the communicative aspect of symptomology or the striving for more than adaptation, for mastery and "curative" development, ever broached.

This general critique of the psychoanalytic metapsychological adaptive viewpoint applies to Hartmann's use of adaptation as well. However, in Ego Psychology and the Problem of Adaptation (1939/1958) Hartmann makes explicit, and develops much more fully, Freud's implicit notions of adaptation which have some import for the positive perspective. Hartmann's argument begins with the hypothesis that ". . . certain forms of conflict solution (defenses) may involve biological guarantees of an adaptation process to external reality" (1939/1958, p. 14). Hartmann then extends those adaptive processes to fantasy which ". . . in contrast to dream work . . attempts to solve problems in waking life" (p. 18). Adaptive processes may effect changes to the external environment (alloplastic), or to the internal

environment (autoplastic), or may even proceed by changing environments.

Although Hartmann remains tied to a biologically based ego psychology, he has been able to look favorably at his fellow humans. Basically he attributes a positive meaning to their actions, even to fantasies. He posits a self-motivated, self-energized force or structure within all of us. No matter what our label within DSM-III, we all share the same impetus towards getting along with and mastering the inner and outer worlds.

Later object relations and self psychology. The work of Fairbairn, Winnicott, and Guntrip, British school, object relations therapists and theorists, had a common development. They were contemporaries and although each was an independent and innovative thinker their theories grew out of one major, psychoanalytic branch. This was the positive perspective, object relational sequence started with Freud and greatly amplified by Melanie Klein. Klein had legitimized the object relational wafflings in Freud by rooting her theory in an object relational view of the neonate's mental structuring. This represented a major challenge to Freud's other base, the biological, and constituted "the real turning point in psychoanalytical theory and therapy within the Freudian movement itself" (Guntrip, 1971, p. 47).

Klein provided credibility to the realness of the internal world, Sullivan provided acceptance for the use of the term "self" with his "self-system" and "self-dynamism" (Sullivan, 1953, 1974), Balint (1968) began the notion of the formative significance of an early, object relational, "basic fault" (Balint, 1968), and Fairbairn synthesized all of this.

Fairbairn, Winnicott, Guntrip. Fairbairn was the first to truly achieve and maintain the view that object relations were the crucial, determining factor in the outcome of the personality. Even Guntrip, a theoretical rival of sorts, concedes this (Guntrip, 1971, p. 101). Adding the refinements and the special areas of development which Winnicott and Guntrip pursued, there was now, for the first time, at least in some isolated spots in the British Isles, a psychology of the person.

Fairbairn himself states that ". . it would appear as if the point had now been reached at which, in the interests of progress, the classic libido theory would have to be transformed into a theory of development based essentially upon object-relationships" (1952, p. 31). Man isn't just a chunk of floatsam pushed this way and that by dark, interior, animal forces. Rather, both the formative influence of the external social world of man and the reality of the internal social world of man is recognized, a radically

major event. Fairbairn also recognizes the positive aspects of regressive and other seemingly pathological symptomology and puts this in an object relational context.

D. W. Winnicott, while far less of a systematizer than Fairbairn, allowed his immersion in daily pediatric practice with children to inform and concretize the more speculative and abstract theory of Fairbairn. All of the positive perspective pioneers utilized the radical human tool of empathy, but Winnicott achieved the ability to utilize it best of all. Winnicott's writings demonstrate his closeness to, and dialogue with the psychic reality of another.

Winnicott created the major concepts of "the holding environment," of the "facilitating environment," and of "good enough mothering." These concepts, together with his consistent compositional attempts to convey the social reality of the inner world, give him a unique place in the achievement of the positive perspective. In addition, Winnicott extended and personalized Balint's notion of the basic fault in what Winnicott called the false self. Kahn pithily summarizes the false self concept of Winnicott: "The false self has as its main concern a search for conditions which will make it possible for the true self to come into its own" (1969, p. 393).

Winnicott's additions to the positive perspective, such as the concept of hope in the anti-social tendency, of

creativity, and his notions of play, are found in almost every page of his writings. All of this is of great practical significance for the practice of mental health delivery (Friedman, 1975). To read Winnicott is to risk having one's attitude permanently changed. This applies both in a theoretical reorientation to a new empathic understanding of man's striving to do the best he can in a difficult world as well as to an altered perspective on our professional therapeutic efforts:

> . . psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist. If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to enable the patient to become able to play, after which therapy may begin. The reason why playing is essential is that it is in playing that the patient is being creative (1971, p. 54).

Winicott continues:

> It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self. (1971, p. 54).

Harry Guntrip helped to bring Winnicott's and Fairbairn's work out of Britain, popularize it, summarize it, and put it in historical perspective. Guntrip made increasing use of Winnicott's work after a period of analysis with him (Sutherland, 1980, p. 849). Guntrip especially emphasized the positive nature of his extended view of defense, including splits in the self, the use of manic-depressive states, and the defensive use of object relations

in the internal world. Guntrip's work has served as a valuable link to Kohut.

Heinz Kohut. Winnicott had the ability to sustain empathic immersion in shared psychic reality. However, his use of this achievement remained at an implicit level. Heinz Kohut openly acknowledged the importance of these remarkable positive perspective abilities in man. Western man's stress on external reality, on a positivistic and physicalist obsession with external facts, has made the internal world generally thought of as unreal. Freud and the rest of the positive perspective theorists have had the courage to challenge this unbalanced perspective but the scientific community remains skeptical.

Heinz Kohut (1978) has brought the issue to a head in openly declaring not just the utility, but the necessity in using introspection and empathy as the basic tools of psychotherapy. Kohut has explicated the concepts, systematized them within his self psychology theory, and has used his elevated status within the Chicago psychoanalytic community to legitimize them. Kohut has helped to further the positive perspective's legitimization of the technique giving access to the internal world, of our ability to achieve this technique, and of the internal world. Kohut writes:

> The inner world cannot be observed with the aid of our sensory organs. Our thoughts, wishes, feelings, and fantasies cannot be seen, smelled, heard, or touched. They have no existence in physical space, and yet they are real, and we can observe them as they occur in time: through introspection in ourselves, and through empathy (i.e., vicarious introspection) in others. (1978, pp. 205-206).

Kohut, as legitimizer, has helped establish the reality in America of the notion of the self (1977). This has marked the end of the exclusive domain of the ego in American psychological thought. Freud's retreat in the 1920s to the structuralist position has finally been challenged in this country. With it, Kohut brings a new personalness and vitality especially with his stress on the value of psychic energy, of psychoeconomics as opposed to inert structure. American psychology now has the rudiments of a discipline equal to that of medicine.

CHAPTER IV

PRAXIS

> The behavior of the analyst represented by what I have called the setting, by being good enough in the matter of adaption to need, is gradually perceived by the patient as something that raises a hope that the true self may at last be able to take the risks involved in starting to experience living. (Winnicott, 1956, p. 387)

It is not without reason that most of the major, positive perspective developments have all proceeded from work with children or with the more psychotic end of the continuum of mental health. Freud first developed his notions of the striving for mastery significance of the repetition compulsion and of play in his observation of children. He saw the "curative," "restorative" function of regression, fantasy, and hallucinations in his therapy with schizophrenics, as did Carl Jung and Wilhelm Reich. Melanie Klein extended object relational theory and Anna Freud humanized technique in their work with children. Fairbairn, Winnicott and Guntrip solidified object relational theory out of their experiences with the schizoid and seemingly more psychotic phenomena. Winnicott also was guided by his daily contact with children and their mothers in his extensive pediatric practice.

It seems that children and those with more psychotic symptomology are most acutely sensitive to the personal

infringement and intrusiveness of negative perspective interventions. They have taught these major theorists the most about the human condition by their refusal to be reduced to non-personal mechanisms. In the unsocialized directness and insistent, unsettling communication of their symptomology, they force us to look more deeply at ourselves and at the consequences of the world we have constructed.

Children and psychotics have especially taught us about our mistaken notion of change in the psychotherapeutic process. Western industrialized man is especially fond of his ability to manipulate the environment. Psychology has not been immune to man's hubris in his ingenious capacity to effect change. But children and psychotics have been especially resistant to allowing psychotherapists to change them. New techniques have had to be developed to allow successful work with these populations in particular. Most of all, psychotherapists have been forced to either question their notion of change or to declare these resistant, symptomatic people untreatable. Psychotics and children have instructed those who could listen that it is unavailing to attempt forceful manipulation. Even more, they have demanded that therapists give up the comforting notion that they make changes happen. Rather, the impetus for change is situated within the client himself and is communicated in the symptom's reaching out for a dialogic encounter. All

the therapist must do, and this is a very difficult "all" to achieve, is symbolically adapt to the client's psychological needs.

I feel that children and psychotics have been most instrumental in "instructing" me in the significance and practical applicability of the positive perspective. My academic background had been in literature, especially poetry, and philosophy when I accepted a position as a live-in head of a residential house for psychotics. I wanted to sound the reality of my interest in psychology originally sparked by the power for literary critique of Jungian analytic theory. A year long immersion in daily living with adolescent and adult psychotics, under the guidance of Dr. John Rosen, convinced me that these residents were communicating. The communication, however, was in a form more reminiscent of highly symbolic, nondiscursive poetry than ordinary, linear conversation. In living together we were all forced to reach some understanding of one another, if only for the accomplishment of daily household tasks.

This very intense year at Twin Silos left me with the conviction that the actions and words of psychotics had meaning, no matter how seemingly bizarre or crazy. I was especially struck by the psychotics' use of humor, of irony, to cautiously make contact, test my capacity to understand, and yet still remain safely at a distance. I was frequently

vexed and impatient with this indirectness. I wanted to exercise a greater degree of control and immediate effectance both for the carrying out of daily chores and for "making" these patients "get better." Since they were crazy I felt I had to be the one to do something to make change happen. But whenever I became "pushy," direct and intrusive, no matter how good my intentions or how important the task, my efforts were resisted. This challenged my needs for power and effectance.

I also met with very frustrating resistance whenever I responded in literal ways to their symbolic language. I felt I had to get them to speak and act more "normally," like the relatively asymptomatic world. It was too difficult to stay with symbology. I felt it was my job to mitigate this indirectness. My attempts at getting them to talk more discursively were always resisted. I had to learn to give ". . . a bit of symbolic bread and a spoonful of symbolic tea . . ." (Sechehaye, 1951b, p. 138).

Seriousness was another major issue. I felt entirely justified in trying to promote greater seriousness and more discursive communication. Symbology and the seemingly unserious, play-like quality the residents demanded in our relating was OK for fun and for poetry, but not for the "real" world or the serious task of getting them un-crazy. Whenever I waxed self-righteous as the representative of

sanity and became too serious, too directive, unwilling to play, the residents would get angry and give up communicating for awhile. I am a product of the ethic in the western industrialized world that work is virtuous and needs to be separated from play (Russell, 1935/1960). Winicott's notion of therapy as a form of play (1971, pp. 40, 57), and of therapy as not doing (1958/1975, Chapter XXI), is very difficult to achieve.

After my year at Twin Silos, I concentrated on the therapy of the more psychotic population, with somewhat less emphasis on play therapy with children, in my graduate and residency clinical work. Reading, and the fortuitous supervision with Frank Summers, Ph.D., at our Sustaining Care satellite of The Psychiatric Institute of Northwestern University Medical School, allowed me to grasp the overall historical significance of my developing orientation and to further conceptualize and label two important concepts. The first is the necessity for the therapist to adapt to the needs of the client (Winnicott). The second concept is the reality of the client's true self and its inherent striving for object related maturation. The locus for the impetus of change lies not in the therapist but in the client. The arena for therapy is in the dialogic space between client and therapist.

From my experience, I began to more clearly see a fundamental divide in the clinical attitude and therapeutic approach to clients derived from implicit assumptions in society, in our profession, and internalized as needs within ourselves. I have come to label this divide simply the positive and negative perspectives. The positive perspective is always an achievement, both to recognize and to implement. In our culture the negative perspective always tends to dominate and is always associated with power and the status quo. The positive perspective is thus always radical, it takes courage to achieve it, and it can only be sustained for short periods of time through the radical techniques of empathy and introspection.

With this dichotomy in mind, I was able to see the possibility of a unified orientation which could inform all aspects of our existing techniques and theory. It has been a rewarding challenge to attempt to apply this orientation in the field to the three clinical roles I try to "play": therapist, supervisor, and consultant. I will give a brief sketch of some of the promise and the difficulties in my efforts to apply the positive perspective orientation.

Therapy

Therapy has been my basic research laboratory, medium, and teacher. It has been the setting where I have tried out

techniques in accord with the positive perspective, it has afforded an endless supply of material, and the unceasing feedback from my clients has been my major source of confirmation and criticism. Since the preceding chapters have been about therapy, I will limit this section to highlighting important positive perspective consequences for therapy and my struggles with them. In addition, I will provide one example, drawn from the literature, to exemplify these themes.

The positive perspective facilitates therapy with all client populations: children through the aged and the acutely psychotic through those with the mildest of adjustment disorders. The positive perspective is not a new theory but only a complement to existing theories. I feel it fits best with a basically psychoanalytic, object relational, self psychology base. That has been the orientation I have grown into. By "psychoanalytic" I don't mean psychoanalysis itself but, rather, a psychoanalytic orientation in psychotherapy. This essentially boils down to a belief in the determinacy of the unconscious, a recognition of the symbolic nature of thought and behavior even if the client isn't trying to follow the first cardinal principle of psychoanalysis, and a setting where transferential and regressive phenomena are emphasized.

The most important consequence of the positive perspective is the altered attitude of the therapist. Learning to do therapy is, most of all, a matter of achieving the proper attitude. All the technique and theory in the world is useless unless one can adopt a very special orientation toward the client, the therapeutic situation, and oneself.

The positive perspective, by situating the motive force for change within the client, helps create that attitude needed for a successful working alliance and helps one correct counter-transferential intrusions. The client is always trying to actively communicate and find that "facilitating environment" he needs. It is only necessary for the therapist to provide a "good enough holding environment." The client, after a period of testing, will work with and use the therapist (and continue to test) to give up false self adaptions and allow his true self to emerge. The positive perspective helps encourage this process by promoting greater warmth toward the client and appreciation of his creativity--his unique way of expressing his problem and of trying to solve it.

I have found that I have a tendency in therapy to want to do too much, to make things happen, to force change, to over-interpret. Winnicott's notion of working towards not interpreting is especially useful for me to keep in mind. I over-interpret and become anxious mainly when the flow of

material slows and I sense distancing by the client. The positive perspective philosophy helps me at the times to supervise myself. Rather than looking to the client when resistance phenomena appear, I am much quicker to look to gaps in the quality of my empathy. Invariably my own impatience, my need for control and effectance, has altered my attitude toward the client. With internalized positive perspective supervision, I am able to discern when my interpretations become premature and when they have the quality of forcing the client to see something about himself so he can get better faster. When therapy goes awry, the positive perspective reminds me that the agent promoting change is the client and that my job is to get back to the very difficult task of looking and understanding.

My favorite negative perspective way to exercise control and effectance is by allowing my ideas, my knowledge, to become my main focus. I may over-interpret or I may just pull into myself and lose contact with the client. Some alternation between empathic merging and discursive hypothesizing is necessary, but it's all too easy for me, and for most therapists I know, to value one's own cleverness above the creativity of the client. As Winicott nicely puts it:

> My description amounts to a plea to every therapist to allow for the patient's capacity to play, that is, to be creative in the analytic work. The patient's creativity

> can be only too easily stolen by a therapist who knows too much. It does not really matter, of course, how much the therapist knows, provided he can hide this knowledge, or refrain from advertising what he knows. (1971, p. 57)

I am far from having achieved the positive perspective and, by definition, it is always an ongoing struggle to catch it. It can never just become a part of one. It is never more than a momentary achievement and it is only in doing, in the struggle, that it can be approximated. But the ideas, the philosophy, can serve as something to hold on to in the unstructured potentiality of therapy. Like anything else, reliance on this crutch can become a disruptive defense, and sometimes it does. But for the most part, it serves me as a reliable supervisor and a self-correcting defense.

The disguise, the most visible aspect of the symptom, can be thought of as a form of test for the therapist. It is necessary for a client to establish a feeling of trust for the therapist. The symptom's disguise can be a way of testing to see if the therapist can be trusted enough not to be fooled. This theme of testing is presently being developed by Joseph Weiss (1971). Unfortunately, he is casting this valuable notion in ego psychology terms. In self psychology language, the client wants to know if the therapist can distinguish true from false self manifestations. Will the therapist be like everyone else and fail to look

for the vital, real self? Does the therapist have the courage and enough real self to tell one from the other? To not be content with compromise adaptions at the expense of the self?

The positive perspective cannot be maintained for long. All of us need our sessions to be well bounded in time, say fifty minutes, and our overall time of direct client contact to be limited. But even then we are often deaf to the communication of our clients. The quality of our empathy waxes and wanes. We are human. Too much chaos and even the hardiest among us feel the need for organization. We will make mistakes. It's amazing how much blindness and stupidity on our part the client's self will tolerate. As long as we can occasionally have the positive perspective remind us that there is a real, communicating person whose environment failed him we can even make use of these failures. Recognizing that we have failed, realizing the importance of this, and revealing it at the proper time is a positive perspective achievement.

One of my biggest struggles in applying the positive perspective was, and continues to be, difficulty in being clear about the way to express acceptance of the client's reality. I've talked of how I've tended to become too active out of my need for effectance. I've also been too active out of my need to show acceptance of the client by

working hard "with" him. Sometimes I've attempted to show my acceptance of the client's inherent creativity by being too passive. Establishing the proper space between the client and myself and finding my proper role in the dialogue is always difficult. It's very hard work. There is no simple formula. The positive perspective is helpful when I lose the way in telling me to look again at the client. He has the answers.

The following is an example of an abridged dialogue in therapy illustrative of several of these themes. It is drawn from Blanck & Blanck's Ego Psychology and is meant "To illustrate how the interpretation is made from the surface down to increasingly deeper levels . . ." (1974, p. 320). Blanck & Blanck capture an aspect of the positive perspective theme that Miss Keller's utterances have meaning, that they are attempting to symbolically communicate, and especially that to properly understand the communication it is necessary to situate it in a developmental context. However, because of their near-sighted preoccupation with their theory, they lose sight of their client and the negative perspective dominates. Blanck & Blanck purport to illustrate their theme by opposing their own more enlightened, modern, earlier developmental approach to the traditional psychoanalytic approach of interpreting at the tri-partite,

oedipal level. Miss Keller has been in therapy for two years and the therapist is a woman.

Miss Keller: Today I feel that I should see a dermatologist about my skin.

Therapist: You think constantly about your appearance because you are not sure that your body is always as it should be.

The therapist interprets too quickly. She never really finds out what Miss Keller is trying to say. The therapist is distant, preoccupied with her own preconceptions of the meaning of the material. The therapist is intrusive in the client's process and seems to feel that she must do something, must make a clever interpretation, must break through the client's indirectness to make changes happen. Further, the therapist interprets away from the object related component of this communication and misses the interpersonal message to the therapist.

Miss Keller: Sometimes I think I look better than at other times. (Passive compliance with the therapist)

Therapist: You are not always certain that your body is the same.

Miss Keller: I did not know much about my body when I was a child.

Therapist: Where was your curiosity?

Blanck & Blanck claim that "This comment is both to encourage curiosity and also to elicit historical material" (p. 320). They also see it only in terms of providing

genetic material: in this case, that there was no masturbation and therefore their hypothesis is correct that the phallic stage was never adequately attained. The positive perspective doesn't deny the importance of understanding communication in the context of a developmental perspective, far from it. The problem for this therapist is that this is her only focus and it seems to serve as an intellectualized defense against becoming involved in the broader, interpersonal communication. The therapist is evincing a demeaning, know-it-all attitude and continues to usurp her power and stay in charge.

Miss Keller: I always feel there is something wrong. (She's not just talking about her body!)

Therapist: Do you think you noticed your mother's body changing when she was pregnant?

Miss Keller: Well, I must have but I don't remember that.

Blanck & Blanck say that "Repression is operative" (p. 321). However, the therapist blindly barrels along with her enlightened Ego Psychology theory and is producing more material than the client.

Therapist: But you often worry about gaining weight. (The therapist is relentless. She clearly feels she knows better than the client.)

Miss Keller: I had a dream 1st night. I was going on a trip abroad. You were the tour director. You divided us up into two groups--experienced travelers and novices. You put all the men in the superior group.

Blanck & Blanck say: "A dream, presented following an intervention, confirms that the intervention is correct in content and timing" (p. 321). They go on to say again that their interpretive level is correct in being pre-phallic and that the patient's poor body image is a result of feeling damaged because of her lack of a penis when she compared herself to her brother. Further, "The therapist, here, wants to lead to the condensation in the primary process of the observation of the mother's enlarged, pregnant body with the brother's and possibly father's penis" (p. 321).

Rather than disputing the accuracy of these professed aetiological links, I think it is more fruitful only to observe that the theoretical and meta-theoretical assumptions of Blanck & Blanck and the therapist are obscuring their ability to see and to listen. Their attitude has been affected by the physicalistic nature of their orientation. They are heavy-handedly applying their theory the way a mechanic might apply grease to a wheel bearing. The poor client is relatively inert while they drive home one interpretation after another so as to give the client the benefit of their enlightened insights. It is the very nature of their theory, its implicit immanent quality that restricts their vision and makes empathy difficult.

The last communication by Miss Keller, the dream, is as clear a statement as one might wish of the method and

attitude of the therapist and the effect that this has had on her. Whatever her genetic experiences are that make her feel inferior to men, they are being reinforced, recapitulated, by the dominant and superior attitude of the therapist. It's amazing that Blanck & Blanck can only see the telling of the dream as a present, a confirmation of their approach. Dreams, like any other material, may be used by the self to communicate any kind of meaning. To rigidly see the presentation of a dream as always a gift is to have an overly simplistic view of communication. Ironically, the very communication used by Blanck & Blanck to prove the rightness of their interventions clearly indicts their theory and its application as promoting misalliance with the client. The dream is only taken as a superficial sign of something else, a present. In the end, this communication isn't taken seriously. The interpersonal meaning of the content is ignored and the form of the communication, a retreat to dream narration the better to directly disclose her feelings about therapy, is missed.

Supervision

Although I derived the elements of the positive perspective from therapeutic experience, supervision and consultation have required that I clearly explicate and synthesize these elements. My major focus in conveying the

positive perspective orientation in supervision is in getting the supervisee to question his implicit assumptions about therapy and the notion of change. At times this becomes didactic, and then no doubt I'm least effective. But this seemingly abstract, philosophical discussion about the premises of therapy has been surprisingly helpful to both new and experienced therapists.

This approach has been most successful when the personality of the supervisee allowed me to ground his difficulty in achieving the positive perspective in his counter-transferential issues. Every impediment to using the positive perspective can always be traced to internalized aspects of society's negative perspective. They operate out of the supervisee's awareness and he will always resist giving them up. He will often experience them as deep needs of his own.

I have found that alternating between philosophy and counter-transference kept supervision from becoming too much like therapy. The stress on theory provided the supervisee with an articulated perspective he could take with him into the therapy room. Without emphasizing theory, the supervisee comes to attribute too much power to the supervisor and is never afforded the security of knowing how his material will be reviewed.

I have found it important to model the positive perspective with the supervisee. The same benefits the positive perspective confers on the therapeutic relationship apply to the supervisory relationship. Of special significance is the opportunity for the supervisee to truly let his real self emerge and risk failure. To the extent that he remains armored in false self roles adopted to comply with his image of a "real" therapist he makes little progress in learning the craft and is guaranteed failure with his client. Adopting the proper attitude is one of the most difficult of the positive perspective achievements. The hovering attention, the personal warmth, maintaining the space required for play, all are much better demonstrated than described. Or better yet, the theory coupled with the experience provides both substance and structure enabling assimilation of the experience.

Another way to look at the supervisor's exemplifying what he wishes to convey is parallel process. Unquestionably this phenomenon is of great significance. Too often I have seen supervisors doing other than they say with their supervisees. The results are always destructive for therapy. Treating the supervisee as a person rather than a word processer pays great dividends. It is vitally important to be sensitive to the inner reality of the supervisee, his sensitivities and his needs. Without this, the supervisee

will either stay too distant and be unable to expend the effort it takes to appreciate the inner reality of his client or else he will rebel and get too close and enmeshed with the client.

The ability to merely see resistance phenomena rather than react to them is difficult to learn. And even more, to truly believe that the client is always right and to look to yourself for the therapeutic failure, your failure to adequately adapt and understand, takes considerable theoretic repetition and great confidence in the support of the supervisor. Again, it's important for the supervisor to model this interaction as well. Few supervisors can maintain the perspective that the supervisee is always doing the best he can and that the motive force for change within supervision must be attributed to the supervisee. Confidence in his growth if given sufficient empathic understanding is the sine qua non for facilitating the supervisee's achievement of the positive perspective.

Perhaps the main obstacle to successful therapy for the beginning therapist is his need to feel he is doing something. Therapeutic space creates great anxiety in fledgling therapists. They always seem to need to fill it. They are impatient for change and will exhaust themselves forcing it to happen. Of course, this only results in power struggles. Clients will fight back when they sense they're

being objectified, when there is intrusion into their personal reality. It is important to flush this issue out early and to reinforce the positive perspective view with much repetition. Powerless neophyte therapists will tend to assume what power they can in session with their clients and are loathe to give up the power.

The positive perspective view on diagnosis and the meaning of symptomology is of great value in helping the therapist alter his perspective. In traditional diagnostic labeling the deck is stacked against seeing the continuity of normality with madness. The negative perspective assumptions easily lead to a sense of separateness from, and superiority to, those with noticeable symptoms. This is, of course, out of the awareness of the supervisee and he will vehemently object that he doesn't at all think of himself as superior if the subject is broached in these terms. Nevertheless, as Zilboorg (1941/1967) points out, this attitude of superiority runs deep and has been with us for centuries. The positive perspective philosophy, when directed toward diagnosis and symptoms, allows recognition of this fact without directly confronting the supervisee with a challenge to his self image.

Langs' (1979) recent book, The Supervisory Experience, contains some of the most advanced psychodynamic thinking on supervision. Like many of his publications, however, the

text is taken from Langs's oral responses in a question and answer format. Consequently the book lacks a coherent, sustained and detailed explication of his position. His overall orientation does come through and the content of his answers illustrates many of the positive perspective themes and techniques for achieving them in supervision.

One of Langs's major techniques in helping the supervisee gain a therapeutic way of seeing is by stressing theory, especially the context of the therapeutic encounter. "I would offer the supervisee a rather detailed discussion of the function of the frame: its importance in creating a symbolic field and therapeutic regression . . " (p. 131). Langs also continually stresses the significance of countertransference as evoked by the client, by the setting of therapy, and by the supervisory relationship. Even more, Langs focuses on the meaning of the communication between client and therapist and emphasizes the importance to the supervisee of understanding that "the therapist's interventions are the immediate adaptive context for the patient's subsequent associations" (p. 122). Langs even stresses the importance of empathy for both therapist and supervisor.

However, Langs misses an important ingredient that I have found most useful in effectively conveying these themes. In terms of empathy, for example, Langs only refers to it in terms of its "validating" nature (p. 323), a kind

of supervisory check on the therapist's narration of therapy. Nowhere does Langs stress one of the most essential aspects of supervision: the modeling of empathic understanding with the supervisee. Langs frequently warns of the dangers of intellectualization by both supervisor and supervisee and yet his mode of relating to the supervisees is as distant and intellectualized as one can imagine. Langs does not do as he advises.

Consultation

I have tried to find ways to implement the positive perspective philosophy in schools and a halfway house. I believe in not supplying direct service to the students and residents of these settings. My orientation is to work with the teachers, parents, and counselors. I try to facilitate their work, help empower them to work more cooperatively and to utilize their own resources more effectively. I believe consultation means working yourself out of a job.

My consultation technique is similar to my methods in supervision. In these consultation settings, my "teaching" and my attempts to exemplify the positive perspective have met with more success than I anticipated.

The teachers, parents, and counselors with whom I work are psychologically naive. The basic problem for the consultant with this relatively untrained population is how

can one possibly inculcate therapeutic skills in an extremely limited period of time. These skills normally take years of training, study and supervision to acquire. What difference can a consultant possibly make in what often appears to be an impossible task?

I have found that a consultant can make a great deal of difference by using the same shortcut method utilized in supervision. Instead of focusing on one incident or even one type of situation with parents, teachers, and counselors, it is much more efficient in the long run to use the presenting incident as a way to discuss the philosophy of change in a broader context with that person or institution. For the consultant to understand that the most obvious form of the presenting symptom is less important than the total contextual message of the symptom is to approximate achievement of the positive perspective.

This may at first seem like the long way around to both consultant and consultee. The consultant wants to prove himself, demonstrate his cleverness, his understanding, and his ability to make something happen. The person or organization seeking help is looking for the answers, and perhaps especially looking for the consultant to provide the service directly. As with Freud's second cardinal rule of psychoanalysis, maintaining abstinence, the consultant must

abstain from directly responding to these explicit or implicit requests or to the insistence of his own needs.

It is tempting to encourage dependency in those to whom we consult and to establish a sinecure for ourselves in the process. It is difficult to put off the imagined, but no less insistent, need in ourselves and others for answers, control and effectance. To the extent that I have been able to ward off these pressures and get the help seekers to look to first principles and to themselves, the results have been quick in forthcoming.

Perhaps this process can be analogized to the notion in psychotherapy of the client's internalization of the therapist. In this case, the consultees internalize not the consultant but an orientation. The orientation of the positive perspective is best gleaned from being in the presence of a consultant exemplifying this orientation and from encouragement in looking at basic assumptions. This requires more explanation.

Looking at basic assumptions with teachers, parents, and counselors is similar to doing it with supervisees. Consultees have less initial theory than those we supervise so the transition to pure philosophical theory requires an extra emphasis on making this theory concrete. However, the problems and benefits that accrue from this basically didactic approach are the same as in supervision. This

direct "teaching" of theory has been well accepted by all the populations to whom I consult. But this sort of teaching, even when well grounded in the consultee's experience, isn't enough. It is necessary to couple this with the best teacher of all, exemplification.

When I say that it is necessary for a consultant to exemplify the positive perspective I mean several things. The example must be set in the relationship itself with parents, teachers, and counselors. There is a dialogue in the consultative relationship in which the consultee is seeking to have his self and his striving for mastery recognized, appreciated, and engaged. The consultant can further exemplify the positive perspective by the material he selects. He needs to show that within the seemingly negative situation both the ultimate recipient (the student or child or resident) and the consultee are trying to communicate and establish hopefulness. Also, the consultant exemplifies by his way of talking about the material. His timing, his attunedness to the receptivity of the consultee, his non-pejorative language, his lack of implying a superior attitude, his unwillingness to join the consultee in indulging the temptation for finding power in their alliance, all of this is essential.

The workings of exemplification are something of a mystery. I have discussed modeling and parallel process in

the supervisory process. Another important component is permission. Everyone seems to know at heart that the positive perspective is desirable. However, it is enormously difficult to achieve and to maintain. It has the quality of a taboo. It must always remain radical and seemingly risky to acknowledge. When a consultant, a representative of "sanity" and of a legitimized therapeutic technique, exemplifies the positive perspective, the internalized societal censors are temporarily neutralized. The negativity is transmogrified and where once there was only deficit and negativity, now there is communication, striving, and hope. What was obvious becomes possible, at least until the censors return.

One of the consultative settings in which I introduced the positive perspective was a half-way house for discharge patients from a state mental institution. These residents of the half-way house were all a more chronic population and all came from relatively financially poor families. None of the half-way house staff had training or experience in mental health and all tended to come from middle to upper middle class families. The staff was liberal, young, humanistically oriented, and looking for meaningful work. They were all underpaid. Politically, it has been expedient and good public relations for the state bureaucracy to dump the most difficult and symptomatic population on those least

trained to understand or care for them. It's cheap, the state saves money (or thinks it will), and the politicians wave the humanistic banner of "the least restrictive environment" in front of their applauding constituency. However, in this case, the very youth of the staff, their lack of training, their idealism and desire to find meaning where others avoided it, allowed them to be receptive to an alternative way of looking at these ex-patients and the system that had institutionalized them.

I was offered a consulting job on the only basis the half-way house could afford: two hours per week. Besides myself, there was no other training, supervision, or clinical guidance afforded. Given this extreme time limitation and the magnitude of the work to be done I felt that the most effective orientation I could take was to concentrate almost wholly upon the staff, its attitude, clinical expertise, and ability to use their own resources. No specific case material will be presented as my focus in the consultation always remained on the general, systemic application of the positive perspective.

When I arrived, my first impression was that these dedicated, well intentioned, hard working counsellors were serving as cannon fodder for the political war machine. They were overwhelmed with their task and had no guiding orientation. Burnout was threatening, morale was low, and

everyone jumped from crisis to crisis. If the positive perspective could be put to a test anywhere, this was surely it (although the school systems were no better). The negative perspective was here fully reified. The reality of madness: its suffering, its deep-rooted nature, its persistence, all were denied by this token gesture of the state of Massachusetts. No one had considered real improvement as a serious goal as there was no serious funding. I was concerned that my role was only intended to appease the workers, the staff, to let them vent their frustration, and that any other approach was foreclosed by design (unconscious) of the bureaucrats.

During the first several weeks of my consultation the staff entertained magical expectations. They wanted me to personally solve the unending crises and give them hard-nosed advice and procedures so they could better manage the crazy residents. I resisted the temptation to play an expedient god and tried to work towards the long term goal of understanding, of a radical change of attitude, and of better use of their own resources. I occasionally did intervene and become more directive when it seemed a "real" crisis threatened, or when I was persuaded that one did. Even in these cases, however, I found that I had made a mistake and that the crisis could easily have been handled just as well if I had stuck to my self-avowed approach.

We met in group sessions and either singly or as a team they would present the problems they were having with a particular resident. Little by little they began to get away from this crisis model and started to trust their ability, especially as a team, to confront the challenging problems. I focused on their basic assumptions about the residents. These always came down to attributions made about the most visible and superficial aspects of their symptoms: they were unmotivated, lazy, non-communicative, resistant, provocative, nonsensical, non-serious, and they stubbornly seemed to want things their own way. It was extremely difficult for the staff to see that there might be a symbolic, interpersonal meaning in the apparent symptomology. Even more, the staff implied that I must be soft-headed or just plain wrong to think that the residents had a striving for mastery and cure and that it was up to the staff to understand the form this took and adapt to it. I advocated allowing and encouraging the residents to come together more often and to feel freer in their use of the half-way house environment. Out of their need for separation from madness, the staff had unconsciously communicated to the residents that they should stay to themselves and to their own rooms.

At heart, it seemed that the staff had an unspoken fear of madness and loss of control. This issue was

manifested in their inability to empower the residents to use more of the half-way house on their own terms. The counsellors felt they were above reproach in their great sacrifice of time and effort in organizing activities for the residents. Letting go of some of their organizational control was very difficult. But most difficult of all was letting go of the control they maintained in interpersonal encounters. The staff always tended to approach the residents with their own preconceived agendas based on their class values and on the criteria by which the bureaucrats would judge them: maintaining a job, keeping their apartments clean, managing money appropriately, and interacting with "normal" social skills. These encounters always turned into power struggles, with the residents communicating that they weren't being heard in ever more dramatic ways and with the staff hiding their anger behind greater distance and self-righteous insistence on their middle class values.

I have now been working at the half-way house for over two years and I feel great progress has been made. All the "regular staff" has stayed. There is a much greater sense of professionalism and pride in their work. The half-way house, despite its clinical and bureaucratic dependence, is enjoying an atmosphere of self-reliance. The staff is much more aware of the political and clinical realities and are coming to appreciate the radical nature of their enterprise

and the level of their clinical insight. The work they must do is rarely facilitated by the rest of the de-institutionalizing system. More often, the nonchalance and the demeaning attitude (to say nothing of the ineptness) taken by the legions of psychiatrists, psychologists, social workers and bureaucrats makes their work even more difficult. None of the staff can individually maintain the positive perspective for very long in the face of all this outer and inner pressure. We have addressed this problem by spending considerable time working on the staff structure so as to promote closeness and cooperative reinforcement of this radical perspective. We have faced up to the task of clarifying the implicit power structure within the half-way house and in this respect and in others I have had to prove my lack of collusion with the bureaucrats, with the leadership of the half-way house, and with their own defenses. I have most often failed with the last of these challenges, with the collusive pull of their defenses.

The staff is now using their own resources for peer supervision. They are presenting case material with much greater depth, with attention to the interpersonal significance of the symptomatic behavior, and with far less of a crisis orientation. In some respects they have moved away from the anti-psychiatric, humanistic orientation of two years ago. This was exemplified by an outward show of

disdain for structure or money, an unwillingness to look at power issues, and a generally suspicious and resentful attitude toward clinical work. And yet, as they have become more structured, as they have come to take madness more seriously, they have been enabled to truly achieve a radical perspective.

Given the initial constraits of this consultation, my original goal of working towards staff adoption of the positive perspective has proven feasible. It's unclear to what extent the residents have benefited from this approach as there were no experimental controls. To the extent that the staff is more understanding of the residents, that the residents are interacting more and using more of their environment, the positive perspective has been useful. Further confirmation is their readiness to soon let go of their consultant.

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