undo the repressed material of the patient and to overcome the patient's natural resistances to this endeavor. The therapist attempts to accomplish this by means of a slow and scrupulous unraveling of the largely historical meanings of mental events and the characteristic ways in which they may serve to ward off the underlying conflicts through defensive camouflage. Understandably, the analytic goal is thereby a long-range one, perhaps even interminable. At best this concept of cure means opting for total personality reorganization in the final resolution of neurotic conflicts. The most crucial manifestation of this is the resolution of the Oedipal conflict, which is traditionally regarded as requisite for a healthy personality. This ultimate integration of personality would translate itself into final mastery of ego over id impulses or, as classically stated by Freud, "where id was, there ego shall be."

There are believed to be four successive stages in attaining therapeutic insight: (1) preparation, which is characterized by frustration, anxiety, a feeling of ineptness, and despair. It may be accompanied by much trial-and-error activity relevant to the solution of a certain problem and the falling into habitual patterns or ways of thinking, foreseeing no apparent solution to the problem; (2) incubation or renunciation, in which one desires to hide or escape from the problem and is resistant or unmotivated in therapeutic or insightful efforts; (3) inspiration or illumination, in which the whole problem becomes illuminated, and a solution or solutions suggest themselves (often there is a flood of vivid ideas and a sense of finality accompanied by a conviction in the truth of the insight); and (4) elaboration and evaluation, in which the validity of the insight is checked against external reality.

Furthermore, insight is most therapeutic when it meets all of the following specifications: (1) consistency, whereby the deductions based on the original insight are stable and logically sound, regardless of the truth or falsity of the particular content of the insight; (2) continuity, whereby insights must take place within some existing theoretical framework or stream of tradition in which the insight can be tested; (3) personal consequences, whereby the insight must be judged by the fruit it bears in terms of the ultimate use to which the insight is put; and (4) social consequences, whereby the acquisition of insight should allow the person to interact with others in a more honest and meaningful manner.

1. Variations on the Analytical Theme

The prototypic embodiment of the psychoanalytic or psychodynamic theme is, of course, classical psychoanalysis. The variations on the dynamic theme reflect overt and covert modifications of theoretical conceptualizations as well as methodological and technical applications in practice. These include attempts to partially or completely transcend the biological focus of Freud with more interpersonal, social, ethical, and cultural considerations (e.g., Alfred Adler, Karen Horney, Harry Stack Sullivan, Erich Fromm, Frieda Fromm-Reichmann, and Alfred Meyer); to extend or enhance the ego with earlier or more adaptive endowments (e.g., Federn and Melanie Klein); to enlarge man's temporality with a time focus on his primordial past (e.g., Jung), his present and/or his future (e.g., Adler, William Stekel, Otto Rank, and Rado); to expand treatment procedures by altering the range and goals of treatment (e.g., Otto Rank, Franz Alexander, Helena Deutsch, and Albert Karpman); to shift from ego to self psychology (e.g., Heinz Kohut), to narcissism as a character disorder (e.g., Otto Kernberg) to develop guidelines for short-term psychotherapy with anxiety-provoking techniques (e.g., Peter Sifneos), and even brief treatment of serious illness within the context of a single interview (e.g., David Malan); to revise the role of the therapist's personality and relationship to the patient by making the therapist a more direct, flexible, and/or active participant (e.g., Adler, Sullivan, Rank, Alexander, Stekel, Sandor Ferenczi, and Victor Rosen); to emphasize the developmental approach to diagnosis and treatment (e.g., T. Byram Karasu, James Masterson) at perhaps the opposing end of the analytic spectrum, to restore the psychophysical balance of man by focusing equally on the physical half of the psychophysical split (e.g., Sandor Rado and Jules Masserman) and/or substituting an approach to therapeutic cure from the somatic side by trading the traditional change mode of insight for a reversal back to the earlier catharsis by means of the bodily release of conflictual tensions (e.g., Wilhelm Reich).

The fundamental goals of the interpersonal approach relate to the need to maintain good interpersonal relations and social adaptability; they include reconstruction of present maladaptive relationships and, where possible, restoration of past losses. This means both coping with immediate stressful interactions and forming better or new relationships by developing problem-solving strategies and mastery in social skills. In 1984 Gerald Klerman and Myrna Weissman formulated a short-term, manualized form of interpersonal therapy (IPT), specifically applicable, but not limited to, depression.

In practice, a seasoned dynamic therapist is more broadly defined. This refers to the integration of drive, ego, object relations, and self approaches, and to the more global synthesis of conflict and deficit models.

This integrative model of psychotherapeutic practice acknowledges the joint impact on psychic structure formation of unresolved conflictual urges and wishes interfaced with early environmental deficiencies and traumas in the real-object world of the patient. In terms of treatment, it recognizes the pivotal roles of both erotic and narcissistic transferences in the therapist–patient relationship and in the respective stances and strategies of the listening and empathic presence.

B. Behavioral Schools

For the behaviorist, all problems are construed as pedagogical in nature, and therefore alterable only through direct teaching and learning of new behavioral associations, that is, stimulus–response connections. The patient must be taught new alternatives that have to be repeated and practiced within as well as outside the therapy situation. These alternative modes of functioning do not occur simply as a concomitant of cognitive or emotional understanding of one's problems—the patient needs to rehearse the new alternatives directly. Thus, in direct contrast to the psychodynamic schools, the behavioral approaches have tended to sustain the view that insight is not only unnecessary but can hinder the treatment of deviant behavior.

One implication of the behavioral view of the mode of therapeutic action is that change can presumably occur within a short period of time. In contrast to the dynamic therapists, behaviorists generally believe that all treatment of neurotic disorders is concerned with habits existing in the present, and their historical development is largely irrelevant. Moreover, some behaviorists have even suggested that it is possible to have a situation in which symptoms have been removed, with no knowledge at all their etiology.

Although all behaviorists may be viewed as seeking change through direct conditioning, shaping, or training, the classical conditioning paradigm sees all therapeutic learning or change (not just behavior therapy) as occurring within the reciprocal inhibition framework, incorporating the substitution of relaxation for anxiety in the reduction or elimination of symptoms. However, more critically, the difference between behavior therapy and other therapeutic modalities is that in the latter, counterconditioning of relaxation over anxiety occurs indirectly unsystematically, whereas in behavior therapy this process is overt, systematic, and under the direct control of the therapist.

In Jan Ehrenwald's 1966 words, the behavioral schools of psychotherapy actively relinquish "the methods of the couch" and replace them with "the methods of the classroom and the pulpit." Behavior therapists have at their disposal a large variety of conditioning, training, and other directive techniques. This repertoire may include any or all of the following: the more classical conditioning techniques of systematic desensitization combined with deep muscle relaxation, implosion, or assertiveness training; the operant techniques of positive or negative reinforcement, such as aversiveness training; shaping or modeling; and/or the direct transmission of advice, guidance, persuasion, and exhortation. The latter methods more typically reflect the means by which behavior modification has been extended recently to the teaching or conditioning of attitudes underlying specific behaviors, methods of philosophical indoctrination, or cognitive programming.

The behavioral counterpart of the psychodynamic procedure of working through is behavioral rehearsal within the confines of therapy, as well as assignments to be worked on outside of therapy; these are important parts of the total regimen. For example, the patient might be directly trained in certain social skills that may first be role-played or rehearsed within the course of therapy, and then explicitly instructed and tested out in outside, real-life situations, and reviewed in subsequent sessions.

1. Variations on the Behavioral Theme

Three broad types of behavior therapies or behavior modification are considered under the umbrella of the behavioral theme: one, based on the early classical Pavlovian paradigm, primarily uses systematic desensitization or extinction of anxiety techniques (e.g., reciprocal inhibition therapy); a second type, based on an operant paradigm, uses direct reinforcement by means of reward/punishment procedures (e.g., token economy); and a third type, based on a human social learning paradigm, is contingent on direct modeling or shaping procedures (e.g., modeling therapy). The last type extends to a variety of new systems of directive psychotherapy that expressly aim at attitudinal or philosophical restructuring, albeit using methods of the behaviorist's laboratory. Such so-called integrity therapies share the fundamental learning or problem-solving stance, yet are usually more actively advisory and/or exhortative in their therapeutic techniques (e.g., Albert Ellis's rational therapy. William Glasser's reality therapy, and William Sahakian's philosophic psychotherapy).

Another way of viewing the scope of these behavioral variations is through the evolution of their targets of change, from external to internal alterations in man's learnings. The earlier behavior therapeutic systems

addressed overt behaviors and fears (e.g., Wolpe); the more recent systems are directed to more covert values and beliefs (e.g., Ellis). The most contemporary approaches even venture into the reaches of inaccessible and involuntary mental and physiological states and responses, such as heart rate, blood pressure, and brain waves (e.g., biofeedback).

Whereas in typical behavior modification, alterations in overt behavior are viewed as an end in themselves, with the cognitive approach they are considered a means to cognitive change. In 1979, Aaron Beck formulated a short-term, manualized form of cognitive-behavior therapy (CBT). The goals of this approach have been succinctly stated as: (1) to monitor negative, automatic thoughts (cognitions); (2) to recognize the connections between cognition, affect, and behavior; (3) to examine the evidence for and against the distorted automatic thoughts; (4) to substitute more reality oriented interpretations for these biased cognitions; and (5) to learn to identify and alter the dysfunctional beliefs that predispose the person to distort his or her experiences.

The major cognitive aims or processes of change have four successive components: recognition of faulty thinking through self-monitoring, modification of thinking patterns through systematic evaluation, empirical testing of the validity of automatic thoughts and silent assumptions, and self-mastery by means of homework and everyday practice on one's own. The initial phase of treatment, which aims at symptom reduction, emphasizes the recognition of self-destructive thoughts, whereas the subsequent phases, which aim at prophylaxis, concentrate on the modification of specific erroneous assumptions within and outside the treatment sessions. To isolate, control, and change illogical thinking—the cognitive concept of cure, treatment is organized to elicit and subject to rational examination the actual mental contents of conscious depressive ideation (current automatic thoughts, silent assumptions, attitudes, values, daydreams) and to trace their impact on dysphoric feelings and behaviors in current concrete situations. CBT has recently been applied to disorders other than depression. Its ultimate purpose is self-control and self-mastery—patients explicitly rehearse and train themselves to recognize and restructure their own faulty cognitions so that they can cope better in the future.

C. Experiential Schools

The experiential schools of psychotherapy trade intellectual cognition and insight for emotion and experience, forsaking the there and then of the distant past for the here and now of the immediate present. Experiencing is a process of feeling rather than knowing or verbalizing; occurs in the immediate present; is private and unobservable, but can be directly referred to by an individual as a felt datum in his own phenomenal field; acts as a guide to conceptualization; is implicitly meaningful, although it may not become explicitly so until later; and is a preconceptual organismic process. The many implicit meanings of a moment's experiencing are regarded not as already conceptual and then repressed; rather, they are considered in the awareness but as yet undifferentiated. Here therapeutic change occurs because of a process of experiencing in which implicit meanings are in awareness, and are intensely felt, directly referred to, and changed—without ever being put into words.

One variation of this thesis, especially applicable to Roger's client-centered therapy, reflects the underlying positive belief that every organism has an inborn tendency to develop its optimal capacities as long as it is placed in a optimal environment. The patient is offered an optimistic self-image and the understanding that the patient is basically good and full of potential. Therefore, the therapist does not need to challenge or shape the patient, only to offer a warm and understanding milieu that will enable the patient to unfold latent potentials.

Unlike transference, which is dependent on the revival of a former interpersonal relationship, experiential encounter works through the very fact of its novelty. Through encounter the therapist serves as a catalyst in whose presence the patient comes to realize his or her own latent and best abilities for shaping the self. In this behalf, there are schools of psychotherapy within the experiential theme that recoil at the idea of therapeutic technology. These schools, which are predominantly existential, renounce technique as part of their philosophy of understanding human existence. They feel that the chief block in the understanding of man in Western cultures has been an overemphasis on technique and a concomitant tendency to believe that understanding is a function of, or related to, technique. Rather, they feel that what distinguishes existential therapy is not what the therapist would specifically do, but rather, the context of the therapy. In other words, it is not so much what the therapist says or does, as what the therapist is. However, in this regard the existential schools of psychotherapy have been criticized for their vagueness about technical matters in the conduct of psychotherapy.

The experiential schools aspire to flexibility or innovation in their actual methods, as long as these methods

are useful in the therapist's attempt to experience and share the being of the patient. Here the aim of all techniques would be to enter the phenomenological world of the patient. In direct contrast to the view of the analytic therapist, the experiential therapist does not concern himself or herself with the patient's past, the matter of diagnosis, the aspiration of insight, the issue of interpretation, or the subtle vicissitudes of transference and countertransference. Unlike the behavioral therapist, the experiential therapist expressly does not set goals for the patient and does not direct, confront, or otherwise impose his or her personality on the patient with directives in the form of behavioral instructions or problem-solving preferences.

Although they share the same basic faith in the therapeutic encounter and an emphasis on feelings, schools under the experiential umbrella are often antiverbal in approach. Such schools (e.g., Gestalt therapy) view overintellectualization as part of the patient's problem, that is, a manifestation of defense against experiencing or feeling, and discourage it as part of the therapeutic endeavor. These therapies attempt to accentuate activity over reflection, emphasize doing rather than saying, or, at the minimum, aim to combine action with introspection. The goal of experiencing oneself includes developing the patient's awareness of bodily sensations, postures, tensions, and movements, with an emphasis on somatic processes. Awareness of oneself as manifested in one's body can be a highly mobilizing influence. The main thrust of therapy is therefore to actively arouse, agitate, or excite the patient's experience of self, not simply to let it happen.

Among the techniques for expressing one's self-experience in such schools is the combination of direct confrontation with dramatization, that is, role-playing and the living out of a fantasy in the therapeutic situation. This means that under the direction (and often the creation) of the therapist, the patient is encouraged to play out parts of the self, including physical parts, by inventing dialogues between them. Performing fantasies and dreams is typical and considered preferable to their mere verbal expression, interpretation, and cognitive comprehension. In variations of the somatic stance, body and sensory awareness may be fostered through methods of direct release of physical tension, and even manipulations of the body to expel and/or intensify feeling.

In yet other attempts to unify mind, body, and more especially, spirit, the immediate experience of oneself by focusing on one's spiritual dimension is sought. This is most often accomplished through the primary technique of meditation. The ultimate state of profound rest serves to transcend the world of the individual ego, forming a higher reality or state of consciousness that the individual ego subserves. Major methods of will training and attention focused on a special word sound or mantra, for example, serve to create an egoless transcendent state.

1. Variations on the Experiential Theme

The therapeutic systems that have evolved under the experiential theme represent various approaches, each propelled by the immediate moment and geared toward the ultimate unity of man. These include the following: (1) a philosophic type, which reflects existential tenets as a basis for the conduct of psychotherapy and pivots on the here-and-now mutual dialogue, or encounter, while retaining essentially verbal techniques (e.g., Carl Roger's client-centered therapy and Victor Frankl's logotherapy; (2) a somatic type, which reflects a subscription of nonverbal methods and aspiration to an integration of self by means of focusing attention on subjective body stimuli and sensory responses (e.g., Fritz Perls' Gestalt therapy) and/or physical motor modes of intense abreaction and emotional flooding in which the emphasis is on the bodily arousal and release of feeling (e.g., Alexander Lowen's bioenergetic analysis and Janov's primal scream therapy); and, finally, (3) a spiritual type, which emphasizes the final affirmation of self as a transcendental or transpersonal experience, extending one's experience of self to higher cosmic levels of consciousness that ultimately aim to unify one with the universe. This is primarily accomplished by means of the renunciation of the individual ego. The establishment of an egoless state can occur by meditation (i.e., relaxation plus focused attention) in which one reaches a state of profound rest (e.g., Transcendental Mediation). Such a spiritual synthesis may be amplified by various techniques of self-discipline and will training, for example, practice of disidentification (e.g., Assagioli's psychosynthesis).

A most recent "variation on a theme" crosses the boundaries of the above three schools. Dialectical Behavior Therapy (DBT), originated by Marsha Linehan, Ph.D., in 1993, empirically supported multimodal psychotherapy, initially developed for chronically parasuicidal women diagnosed with borderline personality disorder (BPD). DBT blends standard cognitive-behavioral interventions with Eastern philosophy and meditation practices, as well as shares elements with psychodynamic, client-centered, Gestalt, paradoxical, and strategic approaches. DBT structures the treatment hierarchically in stages. It is based on Linehan's biosocial theory, whereby

etiology of this dysfunction lies in the transaction between a biological emotional vulnerability and an invalidating environment.

IV. THE RELATIONSHIP AS THERAPEUTIC FACTOR

The patient's relationship to the therapist embodies one of the most powerful forces in the therapeutic enterprise. Psychotherapeutic changes always occur in the context of an interpersonal relationship and are to some extent inextricable from it. In the next section, these therapeutic relations are discussed under the three headings of transferential–therapeutic; teacher–pupil; and person–person. Again, they are far from being categorical distinctions. Rather, they simultaneously occur in different combinations and emphases.

A. Transferential Relations and Working Alliances

Deliberate, systematic attention to the vicissitudes of the special relationship between therapist and patient is crucial to the conduct of the psychoanalytic approach. It constitutes both the subject and the object of analysis. Historically, two stances—transferential versus nontransferential—have been described in portraying the psychodynamic psychotherapies: the primary stance with regard to the making of the transference relationship and, more recently, the secondary stance with regard to the making of a working or therapeutic alliance. Despite increasing acceptance of combining them in the therapeutic situation, these represent dual postures, even antithetical to each other, both in their essential purposes and in the actual requirements they make of the therapist.

The primary stance reflects Freud's original recommendations: (1) that the analyst be like a mirror to the patient, reflecting only what is reflected by the patient and not bringing personal feelings (attitudes, values, personal life) into play; and (2) that the analyst follow a posture of privation or rule of abstinence, that is, technical motives must unite with ethical ones in preventing the therapist from offering the patient the "love" that the patient will necessarily come to crave. These two basic requirements are traditionally made of the analyst, if the analyst must remain relatively removed and anonymous, a deliberately dispassionate observer and reflector of the patient's feelings. Such a therapeutic relationship is necessarily asymmetrical.

Conversely, the more recent concept of a working or therapeutic alliance reflects an alternatively nonregressive, rational relationship between patient and therapist. Although still in the service of analyzing transference and resistances, it means that the therapist aims at forming a real and mature alliance with the conscious adult ego of the patient and encourages him or her to be a scientific partner in the exploration of these difficulties. The real object need of the patient, deliberately frustrated by the transference relationship, is relatively satisfied by the therapeutic alliance. This therapeutic alliance has several variations and names, that is, working alliance, holding environment, corrective relationship, and empathic relationship. For example, self psychology introduced a new concept to psychology—the self, an experiential construction, the perceiver's own experience. Here the therapist provides an empathic atmosphere to foster development of a coherent self, and facilitates not so much insight as transmuting internalization, to crystallize the self. He or she is therapeutic through contemporary self-object functions for the self within an interpretive framework.

B. Teacher–Pupil Relations

The nature of the therapeutic relationship between therapist and patient in the behavioral therapies is an essentially educative, teacher–pupil relationship. It is a deliberately structured learning alliance in which, at its best, attention is drawn to the more current and presumably constructive aspects of the patient's personality in collaborating on the course of therapy. Here the behavior therapist has been depicted as a learning technician or social reinforcement machine. Although this rubric may apply to all therapies to greater or lesser degrees, usually the behavioral therapist openly regards him or herself as an instrument of direct behavioral influence or control, one who directly and systematically manipulates, shapes, and inserts individual values in the therapeutic encounter. In a comparable context, the therapist shapes personal behavior so as to be a social reinforcer for the patient. If the therapy does not proceed smoothly or effectively, the behavior therapist revises the behavioral plan or schedule to better fit the patient to treatment.

Behavior therapy deliberately does not dwell on the therapist–patient relationship; at most, it does so secondarily, only to the extent that this is seen to be important in securing the patient's cooperation with the therapist's treatment plan. The behavior therapist's use of warmth, acceptance, and any other relationship

skills is common but relegated to the realm of secondary "relationship skills" that are not crucial therapeutic requirements for desired change to occur in the patient.

The term *collaborative empiricism* has been coined to characterize the major therapeutic relationship in cognitive therapy—CBT, a specific form of behavior therapy for treatment of depression—in which the therapist is continually active and deliberately interacting with the patient. The two participants have been further depicted as an investigative team; the content of each depressed thought is posed as a hypothesis to be tested by two scientists, who collect all the evidence to support or refute that hypothesis. Under the collaborative empiricism model, the major role of the therapist is primarily educative—to instruct and advise the patient in rational thinking and to provide active guidance during systematic reality testing, which is considered intrinsic to the cognitive approach. The therapist actively points out automatic thoughts, helps to identify cognitions from the patient's report of recent experiences, reviews patient records, assigns homework, and provides concrete feedback. Often part of this tutorial approach is a direct problem-solving, question-and-answer format, with which the therapist and patient can jointly explore the patient's cognitions.

Interpersonal therapy (IPT) shares elements with both the psychodynamic and cognitive approaches as it addresses four major foci or problem areas: interpersonal role disputes, especially between family members; difficult role transitions in coping with developmental landmarks or significant life events, such as getting married or divorced, having a child, changing careers or retiring from work; interpersonal deficits, including inadequate social skills; and abnormal grief reactions. It emphasizes the solving of interpersonal problems and entails supportive and behavioral strategies as well as both directive and nondirective exploratory methods—information, guidance, reassurance, clarification, communication skills education, behavioral modification, and environmental management. Didactic education techniques and environmental interventions are largely used in initial efforts to ameliorate overt symptoms, whereas support, exploration, behavioral modification, and social skills training are subsequently applied to specific interpersonal issues.

C. Person-to-Person Relations

Although methods may vary, the real here-and-now therapeutic dialogue or mutual encounter, between therapist and patient is the *sine qua non* of many of the experiential schools. It is an emotionally arousing human relationship in which each person tries to communicate honestly, both verbally and nonverbally. These approaches to psychotherapy ideologically aspire to an egalitarian treatment model. The human alliance is not of analyst to patient or teacher to student but of human being to human being. Here the therapist is still presumably an expert; but, if he or she is not first of all a human being, the expertness will not only be irrelevant, but even possibly harmful. Rogers stated that if the patient is viewed as an object, the patient will tend to become an object. Therefore, this type of therapist says in effect: "I enter the relationship not as a scientist, nor as a physician who can accurately diagnose and cure, but as a person, entering into an interpersonal relationship." Naturally, what one construes to fall within the domain of personal or real in a therapeutic relationship is open to interpretation. The state of the art of therapeutic factors suggests that new paradigms are necessary to combine and transcend diverse perspectives of schools. As there are transcending nonspecific elements, there are also transcending dimensions to all specific therapeutic relations and techniques.

The psychotherapeutic relationship possesses certain qualities of other relationships, such as between parent–child, teacher–student, and friend–friend, but it is also quite different from them. It is not natural, induced, or intended. It seems spontaneous but is not random, in fact, calculated. It has an intuitive quality but is learned, in fact, cultivated. It seems informal, but is quite serious. There is a system to this relationship—psychotherapy requires the systematic use of the human relationship. Based on the degree of consolidation of the patient's psychic apparatus, the therapist may modulate his or her activities to establish and maintain the relationship with the patient, no matter what technique used; and he or she may use any technique. Yet all techniques are implemented interpersonally, even prescribing of a medication.

The relationship is potentially a healthy medium in and of itself. The cumulative aspect of the interpersonal relationship was an inspiration for the emergence of the Sullivanian school. For analytically oriented therapists, their schools' contributions of four patient–therapist relationships (transferential, therapeutic alliance, object relations, self-object) are diagnostic and formative. The analytical therapist's first task is to establish a relationship, but the second task is to explore what that relationship reveals. For the nonanalytical practitioner, there are the patient's relational predispositions. The therapist does not need to use the relationship as a

formative technique but must be aware that whatever technique used, these relationships will come to play.

V. AN INTEGRATION: THE PAST AND THE FUTURE

With shifting paradigms, every therapist must synchronize with the patient, not unlike meshed teeth of a cogwheel, and become a presence in the patient's psychic life. The technique evolves from such a presence. It has been said that the relationship is never sufficient. The technique alone is not feasible. The first task, the most fundamental technique, would be how to establish and maintain the therapeutic relationship. The second task is to apply any technique that is potentially useful and within the range of the therapist's competence and patient's receptivity.

Finally, we must not forget that there were "therapeutic factors" long before such a term was invented. Our professional ancestors used overarching teachings of their religions, the knowledge of their times, and their cultural myths in the service of the healing arts. Today, we can benefit from our professional ancestors by learning ways of the soul and the spirit, and by incorporating these into "spiritual psychotherapy," as recently described by T. Byram Karasu. Six tenets of transcendence incorporate the fundamental thesis that the way to soulfulness is through love—love of others, love of work, and love of belonging; and the way of spirituality is through believing—belief in the sacred (reverence for all life), belief in unity (i.e., oneness with nature and the universe), and belief in transformation (i.e., sense of the continuity and renewal of the life cycle)—the combination of which may turn out to be the superordinate therapeutic factors.

See Also the Following Articles

Behavior Therapy: Theoretical Bases ■ Cognitive Behavior Therapy ■ Existential Psychotherapy ■ Interpersonal Psychotherapy ■ Patient Variables: Anaclitic and Introjective Dimensions ■ Psychoanalysis and Psychoanalytic Psychotherapy: Technique ■ Working Alliance

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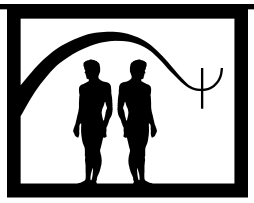

Therapeutic Storytelling with Children and Adolescents

Everett K. Spees

Devereux Cleo Wallace

GLOSSARY

arousal A heightened emotional or cognitive state in response to sensory input or internal neural stimuli.

attunement Alignment of the therapist and clients' emotional states so that each can experience the other's subjective world. This permits the sense of emotional communication and connection often described as "being together" and "feeling felt." The nonverbal signs of eye contact, body gestures, facial expressions, and tone of voice communicate the state of mind of each member of a dyad through the orbitofrontal cerebral cortex. Neurophysiological mechanisms use these stimuli to integrate several domains of the human experience, including emotional regulation, response flexibility, consciousness, social relationships, and the evaluation of meaning. Misattunements lead to emotional dysregulation, which require "interactive repair" through a sufficient number of beneficial interpersonal experiences for the child or adolescent to achieve or regain emotional regulation. Storytelling supports the "secure attachment" developmental state. This state tolerates arousal of excitement, interest, and enjoyment, and emotional resonance, which allows these pleasure effects to persist.

imagery The arousal of mental images through sensory neural stimuli.

resonance The mutual emotional alignment of the mental states of two individuals that persists within the mind of each individual after the direct interaction is no longer present. Secure developmental attachments allow children to tolerate the resonance of high-intensity emotional states without discomfort, while children with less secure attachments may experience affect blocking.

transitional phenomena Refers to a metaphorical dimension of living that does not belong to an external or internal reality, and a place that both connects and separates outer and inner. Donald Winnicott conceived of it as the area where cultural experience, creativity, playing, stories, and being occur. Contemporary developmental neurobiologists relate transitional phenomena to the complex neural interactions observed in attunement and resonance.

The stories that people tell are the container that holds their world together and gives meaning to their lives.

Andrew Ramer

I. DESCRIPTION OF TREATMENT

Stories within a psychotherapeutic setting can facilitate positive interpersonal interaction between therapist and client, and can provide emotional enrichment and inner cognitive resourcefulness. Either therapist or

client, in individual, family, or group therapy, may initiate the story. The setting can be a private office or an inpatient or outpatient institutional facility.

Both client and therapist often experience pleasure and camaraderie from following unwinding plots that stimulate mental images through curiosity, dilemma, suspense, delight, fear, and relief. Intimacy can occur because both therapist and client reveal much of themselves, their personal interests, values, attitudes, and playfulness. Clients may be able to speak of their issues more comfortably and indirectly in story or metaphor form than in explicit conversation. Developmental neurobiologists have suggested that metaphoric and story experiences help young people to organize emotions and integrate social experience through a process of "interpersonal neurobiology" of the developing mind.

Of particular value in therapy are young people's autogenic (spontaneous) stories, metaphors, and self-narratives, because these encode information about their developmental experiences, emotional maturity, and ability to achieve interpersonal synergy. The therapist who uses storytelling skillfully with these goals in mind can often build an alliance with young patients.

Early in the first encounter a well-chosen story may allay some of the child's natural anxiety, fear, and distrust, while energizing memory, emotion, and self-awareness. As psychotherapy progresses, stories can continue to serve treatment goals. Often the mutual exploration of an evolving spontaneous metaphor becomes the core of the helping enterprise.

One of the author's 7-year old clients enthusiastically referred to the stories in the therapy sessions as "word movies," thereby innocently naming the pleasant images he had experienced. At the start of each group session he would eagerly ask, "Will we have word movies today?"

Useful resources are increasingly available for the therapist interested in developing a storytelling approach, and customizing it to the specific client needs and clinical settings. Planning the therapist stories in advance, selecting an environment free of interruption, and orchestrating the necessary neurobiological dynamics that accompany effective storytelling, is necessary to optimize their therapeutic value. These necessary dynamic elements include attunement, resonance, imagery, modeling, transference, countertransference, social interaction, and interpretation, as shown in Table I.

TABLE I
Developmental, Neurobiological, and Dynamic Principles in Storytelling Sequence

Storytelling component	*Developmental/neurobiological correlate*
Private area	Allows focusing on group experience
Free of interruptions	Fosters attunement and resonance
Familiar staff members present	Provides comfort, safety, and trust
Drama, animation, stage props	Activates five senses, emotional arousal
Audience vocal participation	Activates interpersonal awareness
Vaguely mysterious storyteller persona	Excites curiosity, memories, images
Children gather around	Corporate experience is to be shared
Name recognition	Each child recognized, valued
Refocusing client's attention	Attunement gateway to rich experience
Storyteller's first story	Example of model structure to be realized
Children participate	Child plays role in enactment of model
Applause, discussion	Recognition, gratitude, challenging
Feedback from the children	Each child's peer input valued, used Opportunity for meaning making
Children volunteer their story	Permission to resonate and experiment New insights on personal self-narrative
"Storyteller hat," "storyteller seat"	Child earns status from staff and peers Social rewards for risk taking
Applause, discussion	Child's risk-taking is reinforced by peers Value of peer approval is learned
Staff attention to emotion and content	Can we decode child's emotional clues? What themes trigger arousal or anxiety?
Revealing autobiographical narratives	Child risks self-disclosure
"Oscar" calls	Narrative bridging object
Assessing the emotional experience	Transference, countertransference, synergy?

The mix of each of these elements varies with who is present at the storytelling session, who tells the stories, how interesting and well-told the stories are, how the group interacts socially, and many other factors. Because of the calls to memory and the unconscious, no two storytelling experiences are ever identical for an individual participant. Listening to children's after-story interpretations makes that phenomenon clear. Each child hears a unique story, and each storytelling is a unique never-to-be-repeated telling for the storyteller, because it is mysteriously nuanced by the presence and interaction of the listeners.

Knowledge of current literature and resources in storytelling presented in this article may facilitate selection, creation, and use of story techniques that can be shaped to specific client circumstances through the art of the therapist, and the use of client autogenic stories.

II. THEORETICAL BASIS

Storytelling and metaphors supplied by psychotherapists and clients are a universally recognized resource for developing rapport with children, and a technique that has a venerable reputation among psychotherapists since the early work of Helmut von Hug-Hellmuth, a Vienna psychiatrist, in 1913. He liked to make up disguised stories with young clients that might begin, "I used to know a little boy a lot like you who used to wet his bed, too, but he learned how to get over it." Over time the client would gradually begin to guess that he himself was the true protagonist, the "little boy" in the therapist's story.

Contemporary and later influential psychotherapists such as Sigmund Freud, Carl Jung, Anna Freud, Bruno Bettelheim, Milton Erickson, and Erik Erikson also advocated their own distinctive theories and treatment goals in the use of stories and metaphors, and commented on their relationship to play and dreams. David Gordon wrote in 1988, "Metaphors, in the form of fairytales, parables, and anecdotes, are consciously and unconsciously used by therapists in order to assist a client in making changes he wants to make."

Freud, through analysis of his own dreams, as well as those of his patients, gradually became aware of the resemblance of dreams to Greek tragedies and to mythology. Using the Sophocles *Tragedy of King Oedipus,* Freud made his interpretation of the Oedipus myth into one of the cornerstones of his scientific psychological system. He came to believe that the "Oedipus complex" was a critical key to the understanding of the history and evolution not only of social interaction, morality, and religion, but of normal and abnormal child development as well. As he put it, the Oedipus complex, with its unconscious guilt of imaginary patricide and incest, was "the kernel of neurosis." Carl Jung carried his teacher's ideas even further. He observed early in his psychoanalytic training that the powerful revelational emotional reactions and remembered experiences that occurred through the language of dreams, stories, metaphors, and childish play might relate to the presence of universal unconscious archetypes or archaic symbols that operated in the unconscious. Because of his theory that in the unconscious of modern man existed a vestige of the active mind of primitive man that was overtaken by later concessions to logic and written language, he later referred to archetypes as natural symbols or primordial images. The extensive findings of similar archetypal themes in his investigation of primitive cultures and myths from around the world, and in studies of medieval alchemy symbols, reinforced the validity of Jung's concept of archetype.

This wider cultural anthropological theme was further developed by Jung's friend Joseph Campbell, whose *The Hero with a Thousand Faces* in 1968 popularized Jung's concept of a universal subconscious archetype by showing the remarkable similarity of myths and legend themes from many unconnected cultures of the present and past. Not surprisingly Campbell's favorite lifelong venue was the New York Museum of Natural History.

Freud, Jung, and Campbell also called attention to important gender themes in human development. Myths and fairy stories frequently depict conflicts between maternal and paternal imperatives metaethically encoded in matriarchal and patriarchal social systems. These powerful archetypal images arouse both conscious and unconscious emotions. Homer's *Odyssey* provides us good examples in the protagonists Odysseus and Penelope. Penelope, the matriarch, embodies love, fidelity, care, and nurture and protection of children. She values ties to her (and Odysseus's) bloodline, ties to the earth (a live tree branch grows through the marital bed), universality, tolerance, acceptance of natural phenomena, longing for peace, and tender humanness. The woman's womb may produce many brothers and sisters to every human being, and all should have a chance to thrive. Meanwhile, Odysseus, the patriarch, embodies the archetype of adventurousness and risk-taking, obedience to divine authority, and a hierarchical order in society. In place of the feminine concept of equality of offspring and impartiality toward each, with Odysseus we encounter the concept of the favored son. Odysseus is as sexually promiscuous as his wife is

chaste. He is crafty and ruthless in combat and takes the lives of many mothers' sons in order to win honor and fame for himself. He pillages cities, takes his enemies' treasure and his enemies' wives and children as slaves or concubines, and desecrates nature by killing bulls, cutting down trees, making bonfires, and raising elaborate buildings. Through recklessness and offense to the gods he loses all his comrades, ships, and plunder, and returns home alone to desolated families, leaving a trail of corpses behind. He arrives home just in time to slaughter all of Penelope's suitors, thereby keeping his honor and winning more fame. Having no womb to make children, the patriarchal archetype makes words, fame, commerce, theology, waste, and war.

In the Judeo-Christian Scriptures God is envisioned as a patriarch and patron, whose preexistence and authority mysteriously emanated from "the Word." The Gospel of St. John begins with the patriarchal vision, "In the beginning was the Word, and the Word was with God, and the Word was God." These gender themes preserved since the dawn of the human record continue to be relevant to the world we now inhabit, and are alluded to in a recent genre of gender psychology books that began with John Gray's *Men Are from Mars, Women Are from Venus*.

David Hicks, Headmaster at Darlington School, in Rome, Georgia, commented in a homily in 2001 on the persistence of metaethical archetypal themes, "Now, the influence of the world and the mind runs both ways. The world ultimately reflects the minds of those who inhabit it. At the same time, our minds mirror the world we inhabit" (and, we might add, the stories that reinforce these archetypes).

Using storytelling and metaphor allows the therapist access to a domain of childhood usually off limits to adults because storytelling can bypass both client anxiety and emotional resistances.

Richard Kopp in 1995 classified these resistances as both those known to the client (secrets actively avoided) and not known to the client (unconsciously avoided), both of which can be a barrier to learning the issues that prevent "living a free and full life." Because it specifically avoids confronting resistances, storytelling to and by children is usually more successful than direct questioning in assessing a child's attitudes, emotional intelligence, moral intelligence, assumptions, inner drives and conflicts, and the child's developing self-narrative. With children in groups, important information about the social interaction with peers and caregivers can also be assessed. Storytelling is also compatible and used with every major discipline of psychotherapy, and many psychotherapists use stories routinely.

III. APPLICATIONS AND EXCLUSIONS

The author conducts a regular weekly storytelling group for children ages 5 to 12 at a 300-bed child and adolescent psychiatric facility in Westminster, Colorado. One group of clients is inpatient, one is a day hospital group, and another a public school day-hospital group. Group size varies from 5 to 15. In addition, the author regularly uses selected storytelling along with autogenic autobiographical poems and fairy tales in a weekly adolescent values group with 10 to 20 clients ages 12 to 18. Because the ability to fathom abstract ideas and to activate the imagination is a necessary part of understanding metaphor and stories, young clients who suffer from, for example, developmental disability, obsessive–compulsive disorder, psychosis, or profound sedation from psychotropic drugs may not be able to benefit from storytelling. These children may have such a limited vocabulary or a concrete or unimaginative perception that the point of proverbs and metaphors may be a complete mystery to them. In fact, in every storytelling group the ability of children to attune, resonate, focus, engage, and interact varies, depending on many factors, including their developmental level, their degree of anxiety, their psychoactive medication, their underlying behavior disorder, and their ability to be playful.

For these reasons advance consultation with unit staff in planning a group helps the storyteller therapist understand each child's handicaps as well as to avoid distractions and logistical missteps. Children who are oppositional, acting out, or completely somnolent due to medication are best excluded from the storytelling activity group until their behavior permits their ability to participate and not distract others. On the other hand even some children who speak slowly or have speech impediments, are shy, or have other difficulties, should be allowed and encouraged to tell their stories if possible, and the therapist leader should help the other group members to be patient and respectful of the handicapped individual. This models the social values of tolerance and compassion. The presence of familiar unit staff members to calm or redirect children who are inattentive or who "act out" during a group is essential, since the storyteller is engaged and cannot take time out to deal with unexpected individual behavior. Fortunately the enthusiasm carried over by children and staff from week to week often makes the storytelling group familiar, popular, eagerly awaited, and fun. Because children are aesthetically discriminating, quality stories may help children overlook distractions. Both

children and adolescents prize stories that are imaginative, dramatic, novel, subtle, intricate, and well told. Not infrequently children will request repetition of a story that they liked from the previous week.

IV. EMPIRICAL STUDIES

The quest for identifying the exact neurobiological pathway(s) by which storytelling and metaphor connects with development, consciousness, and unconscious goes back as far as Friederich Nietzsche, who coined the term "the third ear" in *Beyond Good and Evil* in 1886. Nietzsche proposed that with this imaginary extra ear we are able to hear and recognize the metaphorical language of our intuition.

J. L. Despert and H. W. Potter in 1936 reached the following conclusions from their clinical experience in therapeutic storytelling:

1. The story is a form of verbalized fantasy through which the child may reveal his or her inner drives and conflicts.
2. A recurring theme generally indicates the principal concern or conflict, which in turn may be corroborated with other clinical evidence (e.g., dream material).
3. Anxiety, guilt, wish fulfillment, and aggressiveness are the primary trends expressed.
4. The use of stories appears to be most valuable when the child determines the subject of the story.
5. The story can be used as both a therapeutic and an evaluation device. These observations are still valid.

Donald Winnicott wrote in 1971 of a "third area" of reality, as a dimension in which cultural experience is located between interior and exterior reality. He speculated that in this third area the young person experiences play, humor, metaphor, and stories as "transitional phenomena." Winnicott believed that the role of the child psychiatrist was to help the child who was unable to play attain the state of being able to play, and that "psychotherapy takes place in the overlap of two areas of playing, that of the patient, and that of the therapist."

Winnicott also described his experience with finding an unconscious meeting ground with children. He wrote of a "sacred moment" in the initial interaction of client and therapist when the child, aided by storytelling, believes that he or she is being understood in a common metaphorical language. He noted that the function of this sacred moment could either be to allow deep work during the first interview or serve as a "prelude to longer or more intensive psychotherapy."

Bettelheim, like Winnicott, was also highly aware of the "enchanted moment and place" phenomenon that stories could provide. He pointed out in 1975 an important subtlety of Grimms' and other traditional fairy tales: "The unrealistic nature of these tales … is an important device, because it makes obvious that the fairy tale's concern is not useful information about the external world, but about processes taking place in an individual." Milton Erickson, who was himself a gifted and creative storyteller and metaphor artist, theorized in 1979 on the basis of extensive hypnotherapy experience that the location of the "third ear" of Nietzsche or "third area" of Winnicott was a specialized neuroanatomical site in the right cerebral hemisphere containing the primary process locus for processing not only metaphorical language but psychosomatic symptomatology as well. Erickson believed that this anatomical localization could account for the more rapid improvement in psychosomatic complaints when metaphorical and hypnotherapy rather than standard psychoanalytical approaches were employed.

Neurobiological research with infants by Daniel Siegel in 1999 and by Alan Schor in 2001 and the earlier work of Daniel Stern has identified primary processing in human preverbal and verbal stages of development that correlates with the appearance of symbolic and metaphoric thought, often described as nonlinear, nonsequential, metaphorical, and nonlogical. This neurofunctional distinction was made to contrast it to cognitive thought, which is said to be linear, sequential, nonmetaphorical, and logical S. Engle in 1999 theorized that this primary processing helps explain the objective basis by which self-composed stories may serve as the "most essential symbolic process" for reflecting on and describing experiences. Siegel, a developmental neurobiologist, described findings that the mind encodes internal and external experiences represented in different forms and creates a sense of continuity across time by linking past, present, and future perceptions is within the narrative process. The autobiographical self-narrative is a key evolving integrative process that influences the nature of interpersonal relationships, and is central to secure attachment relationships, and to how one constructs reality. These and other developmental findings about childhood and adolescence suggest ways to use neurobiologically advantageous strategies for storytelling with young clients suffering from mental or behavior issues.

In case there has been any doubt about the significant role of storytelling, Siegel stated that from the developmental neurobiological standpoint, "Storytelling

becomes a proxy to the damaged or missing attachment relationships that are causing emotional despair and rebellion."

The hospital setting for a child away from family and among strangers and peers with behavioral problems may not seem so hospitable or safe. Consequently the therapeutic storyteller must make efforts to create a safe, comfortable, quiet environment so that each child can process as much sensory experience and emotion from the stories as possible, and feel free to contribute autogenic stories. The identification and timing of neurobiological factors, as well as psychodynamic concepts that can optimize the storytelling and autogenic narrative process, are summarized in Table I. The observation that adults outside the mental health setting also benefit from directed storytelling suggests that the effect is perennial and universal. Business leaders have recently written about the benefits of storytelling in the workplace to promote morale and teambuilding.

Theologians in recent years have reemphasized the narrative structure of the Scriptures and recommended narrative technique for homilies and teaching. More recently the U.S. Military Academies Academy Character and Leadership Divisions have adopted the practice of bringing in distinguished retired military officers to tell young cadet classes their personal stories of moral leadership struggles. For mentoring, small groups of cadets are given the opportunity to team with these elders.

The foregoing data support the author's belief that therapeutic storytelling facilitates the development of beneficial interpersonal relationships between client and therapist. Although each person experiencing a story has a unique psychic experience, stories activate important emotional and cognitive neural pathways that promote emotional enrichment and inner cognitive resourcefulness. Clarissa Pinkola Estes, the Jungian psychotherapist, poetic storyteller, and author of *Women Who Run With the Wolves,* once commented that we humans come not only from dust, but from stardust as well.

For children and adolescents whose brief life history has often been filled with grievous injustices such as parental neglect, physical and sexual abuse, violence, rejection, arrests, and pain, the redemptive personal attention, respect, ability to win peer approval, and the chance to develop a self-narrative through storytelling sessions may reopen an area of development and relationships that had been sealed. By approaching a side door rather than the main door, psychic resistance can often be bypassed so clients can willingly enter into a health-restoring personal psychotherapy program, the goal of which is to promote social and emotional maturation and healthy personal autonomy.

V. CASE ILLUSTRATIONS

Therapeutic storytelling preparation begins with finding and using or reworking story sources. Each therapist probably has at least a few and perhaps many favorite stories, and we encounter new stories daily in the various media. In general, little of the available children's story literature is immediately appropriate for psychotherapy storytelling. However, many of the following resources have been useful to the author in understanding, selecting, and working with a broad spectrum of storytelling options and psychotherapeutic approaches.

Jack Zipes' retranslation of classical folktales and his astute commentary on their archaic and modern cultural context, including feminist revisions, has enhanced their usefulness to psychotherapy. His books, such as *The Oxford Companion to Fairy Tales* in 2000, provide the therapist with a good background analysis of the genre. The Zipes references, taken in chronological order published from 1989 to 2000, make a thorough introduction to storytelling, as well as reviewing the state of academic "fairytale-ology." Bruno Bettelheim, who was intrigued by fairy tales and used them in therapy with adolescents, took off a year on sabbatical to write a book discussing his application of Freudian analysis to selected Grimms' (and other) fairy tales, and his 1975 publication *The Uses of Enchantment,* has been well received. Bettelheim's opinion was that fairy tales attract us because they permit our vicarious wish fulfillment in a seemingly perfect enchanted world. At the same time he said they help to affect sexual drives in a positive way, thus aiding resolution of oedipal tendencies and sibling rivalry.

Zipes, a nonpsychologist, disagreed with Bettelheim's analysis, writing that the appeal of the stories was more likely due to our desire to deal indirectly with repressed modern issues such as parental abuse, neglect, brutality, and our parental desire to abandon our children. Zipes wrote in 1995 that traditional fairy stories were originally written in raw detail for adults, and that the substitution of happy endings in order to dilute them for children was a travesty.

Ronald Murphy, a Jesuit priest and professor of German, pursued the religious themes in Grimm's fairy tales. Murphy journeyed to Germany for a detailed study of personal books, manuscripts, annotated personal Bibles, and other Grimm family items. In *The Owl, The Raven, and the Dove* in 2000, Murphy reconstructed from notations and background material in these original sources, the influences of Christian theology, oral culture, and German pagan mythology, choosing five selected fairy tales edited by Wilhelm Grimm.

William Bausch, another Catholic priest, published an extensive anthology of multicultural stories in several books (1996 to 1999), including *The Wizard of Oz,* with commentaries, which are potentially useful in psychotherapy, religious education, and homily composition. Recently other concerned educators have compiled story anthologies directed toward moral education of young people.

A recurrent dilemma in preparing traditional folktales or stories so that they are age appropriate and suitable for young mental health clients is how to maintain the charm and feel of the stories while making them more contemporary for young listeners. Ideally one should aim to preserve the authenticity, flavor, and meaning of the archaic story, as much as possible, although finding ways to deal with brutality, anti-Semitism, and sexual offenses may be a struggle.

John Stephens and Robyn McCallum in their 1998 *Retelling Stories, Framing Culture: Traditional Story and Metanarratives in Children's Literature,* showed how in traditional folktales and legends the encoded metaethics might impact the hearer on a deep moral or social level. They summarize the not-so-obvious cultural and ethnic baggage directed at the original audience, which they term the metanarrative in epics such as *The Arabian Nights*. In their opinion such ancient tales may transmit "implicit and usually invisible ideologies, systems, and assumptions that operate globally in a society to order knowledge and experience." Obviously the psychotherapist needs to consider these cultural and ethical overtones carefully for their positive or negative impact on today's clients.

Several resources have targeted specific children's behavioral health problems, such as kidney failure, bedwetting, and chronic illness, and the stresses from disruption of family life by divorce, useful for therapists who prefer modern stories. George Burns in his *101 Healing Stories: Using Metaphors in Therapy* in 2001 ranks high on the list of useful resources. Burns not only provides numerous engaging therapy stories, but he comprehensively discusses how to identify story resources from our own life experiences, from our patients, and from the secular world. He gives detailed, thought-provoking advice on how-to, and how-not-to develop and use stories with clients, and how to select and shape stories for specific client needs. Unlike other literary presentations, he comprehensively lists and discusses his interpretation of the psychodynamic themes in each of his healing stories from a psychoanalytic standpoint.

Lee Wallas in 1985 contributed 19 lively stories that she developed spontaneously in her Ericksonian hypnotherapy practice. She examines her personal experiences and insights about how she happened to hit upon these themes and develop the stories in the course of treating clients with various neuroses.

Richard Gardner in 1993 published his mutual storytelling techniques, *Storytelling in Psychotherapy with Children,* in which he relies upon autogenic (spontaneous undirected) stories told by the client, sometimes involving hypnotherapy. Gardner's therapeutic technique evolves from intense involvement with the client in therapy and, like Wallas, using reflections about the client's clinical problem as the kernel of a new story within the same metaphor and with the same characters used by the client. The therapist then tells the unique "new story" to the client in a way that suggests alternative methods for the client to deal with the problem issue(s). Gardner elaborates on further innovations including dramatized mutual storytelling, storytelling games, and bibliotherapy (the use of books in the therapeutic process).

Gardner's colleague, Jerrold Brandel in *Of Mice and Metaphors* in 2000, described his personal experience and his own modifications of Gardner's reciprocal storytelling technique. Brandel used the term "re-visioning" for his method of modifying struggling youngsters' own stories therapeutically and then "bouncing them back" to the client with the remedial editing and interpretation as part of a dynamic storytelling game. He might inquire of the client, for example, "How would you like this story to end?"

In 1997 Carlissa Pinkola Estes compiled a collection of deep and thought-provoking feminist fairy tales, *Women Who Run With The Wolves,* in both print and audiotape. She has used these in Jungian psychotherapy and hypnotherapy. Her tapes, published by the Sounds True Company in Boulder, Colorado, are a fascinating resource for grasping the immense possibilities of psychotherapeutic storytelling. Her audio performance of Hans Christian Anderson's *The Red Shoes* is an excellent example. She follows the story with a detailed and valuable interpretation of the Jungian insights of the fable. This author has found this story compelling in sessions with adolescent clients, who unerringly relate the theme of self-destructive obsession to their own life situation.

Ellen Wachtel in her 1994 *Treating Troubled Children and their Families,* wrote about helping parents compose and tell stories to their child at home as part of his or her therapeutic program, especially when there is poor clinical progress with conventional treatment methods. She reminds us of the immense pedagogical and spiritual value of parental life anecdotes that satisfy the child's developmental need to assimilate family

tradition and parental role modeling as part of a healthy attachment and evolving self-story.

Personal storytelling tutorials, for example Nancy Shimmel's 1992 *Just Enough to Make A Story,* offer useful guidelines and some prime examples. Her title story highlights human persistence and thrift, and the underlying purpose of stories. It is about a tailor who buys a bolt of cloth to make himself an overcoat. When the overcoat begins to wear out he cuts it into a jacket, after further wear he pares it down into a vest, then a hat, and finally there is only enough to make a button. When the button is worn out there is "only enough left to make a story."

Zipes, in *Creative Storytelling: Building Community, Changing Lives* in 1995, offers novel ideas and model tales for telling, although he shares his skepticism about using stories for psychotherapeutic goals. Several authors, including Gionni Ronardi in *The Grammar of Fantasy* in 1973 have given memorable advice on inventing stories for telling.

Internet resources are considerable, and include "The Storytelling Ring," a popular site with a variety of public domain story resources (e.g., the interesting Southern mystery stories at www.themoonlitroad.com or www.storyteller.net). Friends, relatives, and community members, and especially senior citizens, often have poignant or funny anecdotes that can be creatively reworked.

Therapists may wish to seek out community storytelling groups in order to observe presentation techniques and content. Even more useful is the easily obtained opportunity to volunteer as a storyteller at a local library or elementary school. Another resource is the Storytelling Magazine and the live storytelling festival audiotapes of the National Storytelling Network.

A. Immediate Preparation

Ideally, the therapist should review the story list prior to the session. Preparation includes memorizing newly adapted stories, rehearsing, and developing an agenda on the evening before a group. When only one story is to be used the author selects it to fit a specific topic and proverb for that day. For example, if the group topic is coping with adversity, a story of the "Rapunzel" genre might fit.

B. Running the Group

A comfortable and private office is favorable for individual client stories during a treatment session. Storytelling with a group in a mental health center is more logistically demanding. One needs to find a space free of interruptions and arrange for familiar staff to be present.

Drama, animation, stage props, and audience participation enhance the choreography of this activity, while activating sensory and emotional pathways in the participants. Token costume items like a Turkish hat or cowboy jacket, according to the therapist's taste and intentions, can help the drama effect. The children gather around in chairs or sit on the floor with name cards in front of them so that the storyteller can identify and address each child by name. The first action of the group session is to refocus the children's attention by various techniques such as group singing, or asking the children to quietly listen to and identify various white noise sounds such as a downpour in a rainforest or a faraway train. These sounds can come from an inexpensive electronic generator operated by the storyteller. Alternatives might include juggling or harmonica playing by the storyteller.

Once attention is refocused, the storyteller begins, choosing first a story in which the children participate by repeating phrases, assuming roles, or making sounds to accompany the narrative. For example, in a story about a train trip designated children provide the sound effects of the "All aboard!," others the train wheels sound, and still others the train whistle at the appropriate times.

When the first story and applause are through, the storyteller asks for feedback from the children. What were their impressions and feelings during the story? What did the story mean to them? How did they feel when they were hearing it? Were they surprised or puzzled by some story element? Each child usually interprets the story somewhat differently. If a child is reluctant to share a personal interpretation, asking the child to briefly repeat the story aloud may be useful.

Next three children are recruited sequentially to tell an autogenic story. Offering the child a special "storyteller hat," and allowing the child to occupy a special "storyteller seat" can enhance the honor of this selection. Following each child's story there comes applause and feedback comments from the peers about each story. The staff and the therapist pay attention to the body language, facial expressions, emotion, and content of each child's story and the social interactions of others in the group. When clients tell revealing autogenic stories, their body language tends to become busier than usual. Sometimes a "poorly functioning" child surprises everyone with dramatic and sensitive stories, or with the ability to repeat someone else's story verbatim even though he appeared not to be paying attention.

Occasionally between stories the therapist's cellular phone "rings," because "Oscar" is phoning. The therapist explains that Oscar (the mythical caller and narrative continuity object) is a wizened old storyteller with a gruff voice. He "calls" to ask about the children's stories and describes where he is located geographically, and what his activities are. Recently Oscar reported that he was riding on a porpoise's back in the Bahamas.

The children are charmed but skeptical about Oscar. In every group meeting, and even in the cafeteria or while crossing the campus, the more experienced children ask the therapist whether Oscar will call in that day.

After three rounds of therapist and children's stories the author concludes the group by asking each child one-by-one to step up directly in front of him, hand the storyteller his or her name card, look the storyteller in the eye, and state which "word movies" he or she enjoyed. In that final moment of eye contact the therapist attempts to assess the magnitude, richness, and meaning of the emotional experience that child and the storyteller have shared during the hour, and to look for any signs of emotional upset.

VI. SUMMARY

Therapeutic stories generated by both therapist and client are valuable tools in individual and group therapy with children and adolescents. When used as part of any psychotherapeutic approaches they enhance the ability of the clients' developing minds to make beneficial alliances with staff and therapists, and to further develop their personal self-narrative. Developmental neurobiologists believe that storytelling acts as a substitute for unhealthy attachment relationships that are at the root of many behavioral disorders in children and adolescents. Taking advantage of the neurobiological and social mechanisms that occur during storytelling helps the therapist optimize the setting and choreography of storytelling.

In an era of cost-cutting pressure on behavioral health care providers, and an increasing reliance on psychoactive drugs, therapeutic storytelling as described in this article may be one of the truest forms of psychotherapy still being practiced. An important bonus to the use of stories is that they are a lively and enjoyable activity. Stories encourage children to share their experience and redevelop its meaning in an environment of human warmth, safety, trust, and curiosity.

Acknowledgment

This article could not have been completed without the impeccable assistance of Ms. Pam Roth, research librarian at Presbyterian/St. Luke's Medical Center in Denver, Colorado, and the help of my family.

See Also the Following Articles

Animal-Assisted Therapy ■ Art Therapy ■ Biblical Behavior Modification ■ Bibliotherapy ■ Child and Adolescent Psychotherapy: Psychoanalytic Principles ■ Dreams, Use in Psychotherapy ■ Emotive Imagery ■ Parent–Child Interaction Therapy ■ Primary-Care Behavioral Pediatrics ■ Transitional Objects and Transitional Phenomena

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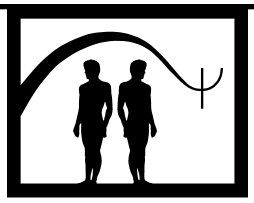

Thought Stopping

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GLOSSARY

counterconditioning A method to remove the original association between fear and the trigger for the fear and to replace it with a new trigger that is incompatible with fear.

covert sensitization A procedure in which an inappropriate response to a stimulus (e.g., a sexual response to children in an adult male) is broken by attempting to associate the stimulus with a new incompatible response (e.g., associating children with discomfort that may be produced by a puff of air in the eye).

escape conditioning A noxious stimulus is paired with anxiety/fear to terminate the fear and a more appropriate response is put in place (e.g., repeatedly pairing an intrusive thought with an electric shock. Over time the intrusive thought declines because of its association with the electric shock).

obsessive–compulsive disorder (OCD) An anxiety disorder that is characterized by the presence of obsessions and/or compulsions. Obsessions are defined as repetitive, unwanted, senseless thoughts, images, or impulses that may be repugnant or horrific. Compulsions are defined as overt behaviors or mental acts that are typically done in response to the obsession and function to decrease the anxiety. They are time consuming, excessive, and senseless. Persons are often aware that they are unnecessary but cannot stop themselves.

Thought stopping (TS) is a behavioral technique used to minimize the distress associated with unwanted intrusive thoughts. Clients are asked to sit with their eyes closed and verbalize a typical sequence of problematic thoughts. During this time the therapist suddenly shouts, "Stop!" The therapist then highlights that the thoughts did stop and proceeds to repeat the procedure several times until the client is able to subvocally disrupt the maladaptive thoughts.

I. OVERVIEW AND DESCRIPTION OF THOUGHT STOPPING

Joseph Wolpe describes TS as useful in the elimination of undesirable thoughts that are unrealistic, unproductive, and anxiety producing. Although used frequently by behavior therapists in the 1970s and early 1980s, TS has received relatively little rigorous empirical attention. Uncontrolled case studies and anecdotal reports of TS are generally favorable when used as both a stand-alone procedure or in conjunction with other cognitive and behavioral techniques. Our purpose is to summarize this work and draw conclusions about the usefulness of TS as a therapeutic technique.

Last, we will introduce a cognitive alternative to TS that has produced some initial success for clients with obsessive–compulsive disorder.

TS was introduced by James Alexander Bain and J. G. Taylor under the premise that thought control is important for positive mental health. Although TS is often viewed as an overly simplistic technique, it actually requires a thorough behavioral analysis. In 1977, Joseph Cautela and Patricia Wisocki suggest that the behavioral analysis should include a client's comprehensive list of disturbing and uncontrollable thoughts with particular importance placed on any overt or covert behaviors that have harmful societal implications (e.g., thoughts of seeking revenge).

Target thoughts are agreed on and the rationale for their elimination is discussed. Cautela recommends that clients be asked to close their eyes and raise their finger once deliberately thinking of the target thought(s). When the client raises a finger, the therapist loudly shouts "Stop!" that typically produces a startle response. The therapist explains that one is unable to think of two things at the same time (stop and the target thought[s]) and proceeds to teach the client the procedure for his or her own use by encouraging the the client to subvocally yell "Stop!" These rehearsals continue in-session for approximately 10 min or for 20 trials until the procedure is learned. Therapists emphasize that with the repeated and daily use of TS, the target thought(s) will gradually decrease in frequency until they disappear altogether. Subsequent sessions might allot 5 min for TS rehearsals including variations of the procedure (e.g., snapping a rubber band on the wrist instead of yelling "stop," substituting another word for "stop," visualizing a stop sign instead of yelling "stop").

II. THEORETICAL BASES

The theoretical underpinnings of TS are vague and sparse. Indeed, since the early 1970s, reservations concerning the adequacy of supporting theoretical arguments for TS have been expressed. Wolpe and Taylor did not discuss a conceptual basis for TS, however, Cautela and Wisocki suggested that the more likely interpretations include escape conditioning and counterconditioning.

Within the escape conditioning paradigm, TS functions to replace an inappropriate discomforting response with an appropriate alternative. In 1943, C. L. Hull contended that behaviors that reduce discomfort, such as anxiety, are associated with establishing a habit. Avoidance also strengthens a habit because it prevents clients from experiencing anxiety.

An anxiety-provoking thought is triggered by an internal or external cue. Counterconditioning is thought to function by replacing the old response with a new response in the face of the identical trigger. For example, once trained in progressive muscle relaxation, clients are instructed to think of the anxiety-provoking trigger while relaxed. The rationale behind this technique is that it is impossible to feel fear and relaxation at the same time. In 1958, Wolpe used a counterconditioning procedure and called it systematic desensitization. Cautela and Wisocki hypothesized that TS could be used to assist in the development of the new response.

III. EARLY EMPIRICAL STUDIES

Historically, TS was used in the treatment of obsessions, however, the technique has been used as an intervention for a variety of different disorders including smoking cessation, drug and alcohol dependence, psychosis, depression, panic, agoraphobia, generalized anxiety, and body dysmorphic disorder. Although numerous uncontrolled single case studies concluded that TS is a viable behavioral technique, there is little methodologically sound research with larger sample sizes to support the use of TS. After a thorough review of the literature in 1979, Georgiana Tryon concluded that the effectiveness of thought stopping had not been demonstrated. Another limitation preventing stronger conclusions about the efficacy of TS is the lack of a standard procedure when using TS. Many studies provide minimal detail regarding the procedure and use a variety of TS procedures in conjunction with various other techniques such as relaxation and self-monitoring.

TS is often used to treat obsessional difficulties. For example, in 1974 Raymond Rosen and Betty Schnapp reported that TS was helpful for a man who was ruminating about his wife's infidelities. In 1971, by instructing patients to snap a rubber band on their wrist in response to an obsessional thought, Michael J. Mahoney decreased the frequency of obsessive ruminations. In 1971, Toshiko Yamagami had success reducing color obsessions with four variations of TS. In 1982, Helen Likierman and Stanley Jack Rachman compared TS and habituation training for 12 individuals with obsessions and found little therapeutic benefit for both procedures. Of the six individuals in the TS group, four improved, one became worse, and, with one it was unclear.

TS has also been used in smoking cessation treatment. In 1974, Wisocki and Edward Rooney compared the effectiveness of TS, covert sensitization, and attention placebo in decreasing the number of cigarettes smoked. Initially, TS and covert sensitization significantly reduced smoking, however, this difference disappeared at 4-month follow-up. Another study conducted by Yves Lamontagne, Marc-Andre Gagnon, Gilles Trudel, and Jean-Marie Boisvert in 1978, compared four different treatments, including TS, group discussion, and wearing a badge, all with self-monitoring compared to self-monitoring alone. All treatments initially reduced the frequency of smoking; however, it was TS and self-monitoring that maintained a significant decrease at 6-month follow-up.

In another class of problems, Makram Samaan in 1975 reported that TS was successfully used to treat auditory and visual hallucinations in one client who did not experience a relapse 20 months after treatment. In 1979, John O'Brien applied TS to two cases of agoraphobia with no relapse at 1-year follow-up. However, the efficacy of TS is difficult to determine because the client received 1 year of treatment that included self-monitoring and some cognitive therapy. In 1978, John Teasdale and Valerie Rezin compared TS to placebo control for 18 individuals with symptoms of depression. TS had little effect in reducing the frequency of depressive thoughts or the intensity of depressed mood.

The previous paragraphs suggest that the efficacy of TS is based on single cases but its general usefulness is in question. Rachman and Padmal de Silva may have inadvertantly discovered one reason why TS is not helpful as a strategy. In a survey of people who lived in the general community, these researchers found that over 90% reported a multitude of intrusive thoughts, images, and impulses. The results of these and related studies suggest that experiencing unwanted intrusive thoughts is a completely natural, normal phenomenon. If so, the elimination of these thoughts through TS or other deliberate suppression attempts may be futile, at best, and harmful, at worst.

IV. THE IMPACT OF THOUGHT SUPPRESSION

Recent work in the area of thought suppression has confirmed that attempting to distract, ignore, or suppress thoughts may serve to increase their frequency. Dan Wegner's investigations on the effects of thought suppression have revolutionized the understanding of disorders characterized by persistent unwanted thoughts. In a series of two experiments, Wegner demonstrated that subjects who were asked to not think of a white bear during a 5-min time period actually thought of a white bear more frequently than another group of subjects who were told that it was okay to think of a white bear.

In a review of the literature in 1999, Christine Purdon indicated that thought suppression has now been identified as both a causal and/or maintaining factor in generalized anxiety disorder, specific phobia, posttraumatic stress disorder, obsessive–compulsive disorder (OCD), and depression. According to this line of research, purposely suppressing thoughts is associated with an unexpected and suprising increase in their frequency. For example, Paul Salkovskis and his colleagues in Great Britain have suggested that active and deliberate thought suppression in the form of neutralization is critical in the development of obsessions. Students who experienced frequent unwanted intrusive thoughts that they felt necessary to neutralize had their intrusive thoughts recorded and were asked to either neutralize the thought or distract themselves from it. Those students who neutralized the thought reported significantly more anxiety and a greater urge to neutralize when the thought was presented a second time.

V. A COGNITIVE ALTERNATIVE TO THOUGHT STOPPING

The work of Wegner, Salkovskis, and Purdon has demonstrated that thought suppression increases the frequency of the target thought(s). TS can be considered a form of thought suppression or control and will thus likely serve to increase the frequency of the thoughts. For example, if clients have a belief that they must be in control of their thoughts and emotions at all times, experiencing an unwanted thought (which we know from the work of Rachman and de Silva is a normal, natural phenomenon) will produce anxiety and the need to try to control the thought. Attempts at thought control often involve ignoring, distracting, or suppressing the thought. These strategies serve to increase attention to the thought process, likely making the thoughts more noticeable and seemingly more frequent. The apparent increase in the frequency of the unwanted thoughts likely serves to further heighten anxiety, attention to the thought process, and precipitate additional attempts at thought control. A vicious circle can quickly develop.

As part of recent developments in cognitive behavioral treatments for OCD, Maureen Whittal and Peter McLean have described a process coined "come and go." Clients are encouraged to experience the intrusive unwanted thought and not try to control it (i.e., do not try to ignore, suppress, distract or anything else that will serve to get rid of the thought). Rather, clients are instructed to let the thought leave naturally, typically when another thought logically takes its place. Clients are instructed to practice this "come-and-go" strategy and their usual style of thought control on alternate days and predict their anxiety and the frequency of intrusive unwanted thoughts on each of the days. Clients invariably predict that letting thoughts come and go will result in higher levels of anxiety and more frequent intrusive thoughts. They are often surprised that letting go of their efforts at thought control (i.e., letting thoughts come and go) lessens the anxiety and typically lowers the frequency of the target thought(s).

To date to the best of our knowledge, this "come-and-go" strategy has been tested only with clients with OCD. However, it is likely that it would also be helpful for other disorders that feature repetitive unwanted thoughts (e.g., eating disorders, impulse control disorders, and body dysmorphic disorder).

VI. SUMMARY

Thought stopping (TS) is a behavioral procedure used to minimize the distress and anxiety associated with unwanted intrusive thoughts. Clients are asked to sit with their eyes closed and verbalize a typical sequence of problematic thoughts. During this time the therapist suddenly shouts "Stop!" The therapist then highlights that the thoughts did stop and proceeds to repeat the procedure several times until the client is able to subvocally disrupt the maladaptive thoughts.

Although used frequently by behavior therapists in the 1970s, TS has received relatively little rigorous empirical attention. Uncontrolled cases studies and anecdotal reports of TS are generally favorable when used as both a stand-alone procedure or in conjunction with other cognitive and behavioral techniques. The few studies utilizing rigorous empirical methodology in their investigations of the efficacy of TS have been equivocal.

Recent empirical studies with thought suppression have demonstrated the paradoxical increase in thought frequency. TS can be considered a form of thought suppression or control and will, thus, likely serve to increase the frequency of the thoughts. With this in mind, Whittal and McLean developed a cognitive alternative to TS termed "come and go" that has shown success in treating individuals with OCD. The authors suggest that letting thoughts come and go will also be helpful with other problems that feature repetitive, unwanted thoughts (e.g., eating disorders, impulse control disorders, other anxiety disorders).

Acknowledgments

The authors wish to express their appreciation to S. Rachman, Ph.D. and Simon Rego, Psy. M. for providing comment on earlier versions of this manuscript.

See Also the Following Articles

Control-Mastery Theory ■ Coverant Control ■ Extinction ■ Orgasmic Reconditioning

Further Reading

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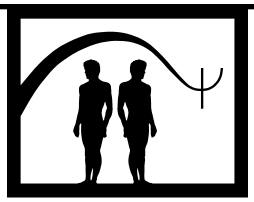

Time-Limited Dynamic Psychotherapy

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GLOSSARY

attachment theory Pertains to how children become comfortable or anxious in relationship to their caregivers' behavioral and emotional responses; such attachment patterns are presumed to carry over into adult relationships.

behavioral A therapeutic approach that emphasizes that behaviors are learned (according to learning principles such as reinforcement and extinction) and therefore can be modified using these same principles.

case formulation The process of diagnosing problems for psychotherapeutic intervention. Case formulation differs from diagnosing psychopathological categories. Rather than producing a diagnostic label, case formulation seeks to create a minitheory linking current presenting problems with recurrent problem patterns and underlying core-ordering processes.

cognitive A therapeutic approach that emphasizes that how one interprets events in the world determines an individual's behavior and feelings; interventions therefore focus on changing the way one thinks and evaluates.

manualized treatment A psychotherapy with principles and techniques that have been specified in a written manual developed to specify the treatment variable in research contexts. Manualized treatments usually include associated psychometric instruments for measuring therapist's adherence to the precepts of the manual.

metacommunication Refers to communications in which the process of communication or the relationship between the communicators becomes the topic of conversation. In psychotherapy, metacommunication functions as a form of interpretive intervention focused on clarifying the ongoing interpersonal process between the patient and the therapist.

psychodynamic A therapeutic approach that emphasizes unconscious processes, the influence of early experiences, conflict, transference/countertransference, and resistance.

schema Stable, enduring, often unconscious, cognitive structures for screening, coding, evaluating, and organizing stimuli into patterns.

transference The tendency to reenact experiences and relationship patterns from past relationships in the therapeutic relationship.

working models A mental framework of what can be expected from others derived from both observation and inner schemas.

Time-limited dynamic psychotherapy (TLDP) is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. This article will present TLDP theory, assumptions, goals, formulation, intervention strategies, a clinical illustration, and empirical findings. The goal of TLDP is to help patients change their dysfunctional, interpersonal patterns by fostering new experiences and

new understandings that emanate from the therapeutic relationships.

I. DESCRIPTION OF TREATMENT

A. Definition

Despite proponents dating to the 1920s, for decades the general response of the psychoanalytic establishment to short-term therapies was unreceptive. However, intense interest in brief dynamic therapy resurfaced in the 1970s and early 1980s, and by the 1990s brief intervention had become a treatment of choice for most patients. Confidence in the basic viability of brief therapy was buttressed by empirical research demonstrating that the majority of patients who benefit from psychotherapy do so within the first 6 months, and that success rates are not necessarily dependent on treatment duration.

Time-limited dynamic psychotherapy was developed with the intention of helping clinicians have more successful outcomes when treating patients with self-defeating interpersonal behaviors—the so-called difficult patient—seen in brief treatment. It was designed to target the specific subgroup of patients whose symptomatic problems (anxiety, depression, etc.) are embedded in underlying core patterns of recurrent dysfunctional interpersonal relationships and whose enactment of these dysfunctional patterns generalizes into the therapeutic relationship. When originally conceived, a liberal time limit of 25 to 30 hours was proposed. Currently the time frame is in the 15 to 20 session range, with the therapist maintaining a time-sensitive or focused approach rather than emphasizing a stipulated number of fixed sessions. The focus is not on symptom reduction per se, but rather on altering the way one relates to others and the self. More ambitious or perfectionistic goals, such as extensive personality reconstruction or plumbing the unconscious origins of experience, are generally inappropriate for TLDP.

Consistent with a general trend toward manualizing therapies for research purposes, the principles of TLDP were originally set forth in a manual published in 1984 under the title *Psychotherapy in a New Key,* authored by Hans Strupp and Jeffrey Binder with collaboration from Thomas Schacht. A subsequent volume produced a decade later by Hanna Levenson provides an updated perspective on TLDP. Levenson's approach places more emphasis on change through experiential learning, whereas the 1984 manual stresses insight through interpretation.

B. Assumptions Essential to TLDP Treatment

There are three core assumptions underlying the practice of TLDP.

1. Maladaptive interpersonal patterns acquired early in life underlie many presenting complaints of symptomatic distress and functional impairment.

Early experiences with parental figures inform the child as to what can be expected from others and what is necessary to maintain connectedness with them. These experiences from the building blocks in the mind of the child of what eventually become mental representations or working models of relationships in general.

2. Maladaptive interpersonal patterns acquired early in life persist and are maintained in current relationships, including reenactment in the therapeutic relationship.

Although one's dysfunctional style is learned early in life, according to the TLDP model, the individual's way of seeing the world must be supported in the person's present adult life for interpersonal difficulties to continue. For example, if one's parents were harsh and demanding, it would be understandable if such a child grew into a placating, deferential adult. Displaying such a subservient manner, such a person might inadvertently and unconsciously pull for others to respond in controlling ways—echoing the behavior of the parents.

This recursive focus is consistent with a systems-oriented approach, which holds that if you change one part of the system, other parts will shift as a result. In this manner, "pathology" does not exist solely within the individual, but rather resides in the totality of the interpersonal system that maintains the behavior. From a time-limited viewpoint, this emphasis on the present enables the therapy theoretically to be completed in a shorter amount of time, because the focus is on what is happening in the current interpersonal world of the individual rather than on an archeological dig into one's past.

The relationship that evolves between therapist and patient can be understood as a microcosm of the interpersonal world of the patient. The patient relates to the therapist in ways that are characteristic of interactions with significant others (i.e., transference), and hooks the therapist into responding in a complementary fashion (i.e., countertransference). Although this reenactment of interpersonal difficulties in the therapeutic relationship poses difficulties for the alliance, it is inevitable and also provides the opportunity to transform the therapeutic relationship into a specialized context for reflecting on and changing interpersonal patterns. In

such a manner, the therapist has the opportunity to see the maladaptive interactions evolve in the therapeutic relationship and to discern dysfunctional patterns. Because such patterns are presumed to be sustained through present interactional sequences, the therapist can concentrate on what is happening in the session to alter the patient's experience and understanding.

As pointed out earlier, the therapist in attempting to relate to the patient is unwittingly enlisted into a reenactment of the patient's dysfunctional pattern; in other words, in addition to observing, the therapist becomes a participant in the interaction or a participant observer. The therapist is pushed and pulled by the patient's style and responds accordingly. The therapist's transactional reciprocity and complementarity are not viewed as a "mistake," but rather as a form of interpersonal empathy or role responsiveness. Eventually, the therapist must realize how he or she is replicating this interpersonal dynamic with the patient, and use this information to change the nature of the interaction in a healthier direction.

3. TLDP focuses on one chief problematic relationship pattern.

The emphasis in TLDP is on the patient's most troublesome and pervasive interactive pattern. Although other relationship patterns of less magnitude and inflexibility are important, in a time-limited format pragmatics dictate focusing on the most central interpersonal schema.

C. Goals

1. New Experience

The first and major goal is for the patient to have a series of new experiences through which he or she develops a different appreciation of self, of therapist, and of their interaction. These new experiences provide a foundation of experiential learning through which old patterns may be relinquished and new patterns established. The formulation of each particular case (see later) determines what specific types of new experiences will be most helpful in disconfirming the patient's interpersonal schemata and thereby undermining his or her maladaptive style. The concept of a corrective emotional experience described more than 50 years ago by Alexander and French is relevant. They suggested that with experiential learning individuals could change even without insight into the etiology of their problems. It is our current thinking that experiential learning broadens the range of patients who can benefit from a brief therapy format, leads to greater generalization to the outside world, and permits therapists to use a variety of techniques and strategies in addition to traditional inisght-promoting clarification and interpretation. For example, with the placating individual mentioned earlier, the goal might be for him to experience himself as more assertive and the therapist as less punitive within the give and take of the therapeutic hours.

2. New Understanding

The second goal of providing a new understanding focuses on helping patients identify and comprehend the nature, etiology, and ramifications of their dysfunctional patterns. To facilitate such an understanding, the TLDP therapist can point out repetitive patterns as they have manifested with past significant others, with present significant others, and with the therapist in the here-and-now of the sessions. Metacommunication occurs when the ongoing process of interpersonal transaction between the patient and therapist becomes the content of the therapeutic dialogue. Therapists disclosing their own reactions (i.e., interactive countertransference) to the patients' behaviors can be of benefit in this regard. In this way, patients can begin to recognize relationship patterns and discern their role in perpetuating the very dysfunctional interaction they wish to change.

D. Patient Suitability

TLDP may be helpful to anyone for whom adequate descriptions of their interpersonal transactions can lead to a dynamic focus. It is designed, however, for people who have lifelong interpersonal difficulties. Table I contains the five major selection criteria and four major exclusionary criteria for ascertaining a patient's suitability for TLDP.

E. Formulation

1. The Cyclical Maladaptive Pattern

In long-term treatments, therapists may rely on the patient's spontaneous organizing abilities to bring coherence, over time, to the tacit themes and patterns of their difficulties. However, a time-limited therapy requires a more systematic approach, a core theme or dynamic focus, which acts as a guiding beacon to direct and organize therapeutic activity. In TLDP this core theme is the repetitive dysfunctional interactive sequence that is both historically significant and also a source of current difficulty. This cyclical maladaptive pattern (CMP) provides a framework for deriving a dynamic, interpersonal focus for TLDP. It forms an organizational structure for the various components that contribute to the idiosyncratic vicious cycle of reciprocal interactions. By creating

TABLE I
Selection Criteria for Time-Limited Dynamic Psychotherapy

Inclusionary
1. Patient is sufficiently uncomfortable with his or her feelings and/or behavior to seek help via psychotherapy.
2. Patient is willing and able to come regularly for appointments and talk about his or her life.
3. Patient is willing to consider the possibility that his or her problems reflect difficulties in relating to others.
4. Patient is open to considering the possibly important role that his or her emotional life plays in interpersonal difficulties.
5. Patient evidences sufficient capacity for relating to others as separate individuals so that identifiable relationship predispositions can be enacted in the therapeutic relationship and then collaboratively examined.

Exclusionary
1. Patient is not able to attend to the process of a verbal give-and-take with the therapist (e.g., patient has delirium, dementia, psychosis, or diminished intellectual status).
2. Patient's problems can be treated more effectively by other means (e.g., patient has specific phobia or manic-depressive illness).
3. Patient cannot tolerate the active, interpretative, interactive therapy process, which often heightens anxiety (e.g., patient has impulse control problems, abuses alcohol and/or substances, or has a history of repeated suicide attempts).
4. Patient's problems are primarily due to environmental factors (e.g., social oppression, imprisonment, proverty).

Adapted from Strupp & Binder (1984) and MacKenzie (1988).

a narrative that incorporates the elements of the CMP, the clinician is guided in developing a treatment plan. A successful CMP should describe the nature and extent of the interpersonal problem, lead to a delineation of the goals, serve as a blueprint for interventions, enable the therapist to anticipate reenactments, and provide a way to assess if the therapy is on track.

2. Constructing the CMP

To derive a TLDP formulation, the therapist uses four categories to gather, organize, and probe for relevant information.

1. Acts of the self. These acts include the thoughts, feelings, motives, perceptions, and behaviors of the patient of an interpersonal nature. "I enjoy social gatherings because I am the life of the party!"
2. Expectations of others' reactions. This category pertains to how the patient imagines others will react to him or her in response to some interpersonal behavior (Act of the Self). "I expect that if I go to the party, everyone will want to talk with me."
3. Acts of others toward the self. This third grouping consists of the actual behaviors of other people as observed (or assumed) and interpreted by the patient. "When I went to the party, people were so concerned with making a big impression on the host, that no one spoke to me."
4. Acts of the self toward the self. In this section belong the patient's behaviors or attitudes toward oneself. "When I left the party, I told myself that it was their loss and felt better."

By linking information in these categories together, a narrative is formed from which emerges themes and redundancies in the patient's transactional interactions. This narrative forms the CMP describing the patient's predominant dysfunctional interactive pattern. The therapist then sets the goals for the treatment by considering what specific types of experiential interactions and new understandings would help weaken the strength, rigidity, and repetitiveness of the patient's CMP.

F. TLDP Strategies

Implementation of TLDP does not rely on a fixed set of techniques. Rather it depends on therapeutic strategies that are seen as embedded in a therapeutic relationship. The Vanderbilt Therapeutic Strategies Scale (VTSS) was designed to measure therapists' adherence to TLDP principles. The 10 items that contain TLDP specific strategies are included in Table II.

In general these therapeutic strategies emphasize clarification and understanding of actions and experiences in the here-and-now rather than excavation of the patient's past. Although a search for historical antecedents may help to clarify current events, archeological exploration of the patient's life history is subordinate to a thorough reconnaissance of present experiences, behaviors, and circumstances. In TLDP the patient and therapist collaboratively "make" the patient's life story, as contrasted with the traditional unilateral "taking" of a life history.

II. THEORETICAL BASE

Historically, TLDP is based in an object-relations, interpersonal framework with roots in attachment theory.

TABLE II
Vanderbilt Therapeutic Strategies Scale

TLDP Specific Strategies:

1. Therapist specifically addresses transactions in the patient–therapist relationship.
2. Therapist encourages the patient to explore feelings and thoughts about the therapist or the therapeutic relationship.
3. Therapist encourages the patient to discuss how the therapist might feel or think about the patient.
4. Therapist discusses own reactions to some aspect of the patient's behavior in relation to the therapist.
5. Therapist attempts to explore patterns that might constitute a cyclical maladaptive pattern in the patient's interpersonal relationships.
6. Therapist asks about the patient's introject (how the patient feels about and treats himself or herself).
7. Therapist links a recurrent pattern of behavior or interpersonal conflict to transactions between the patient and therapist.
8. Therapist addresses obstacles (e.g., silences, coming late, avoidance of meaningful topics) that might influence the therapeutic process.
9. Therapist provides the opportunity for the patient to have a new experience of oneself and/or the therapist relevant to the patient's particular cyclical maladaptive pattern.[a]
10. Therapist discusses an aspect of the time-limited nature of TLDP or termination.

Reproduced with permission from Butler, S. F., & Center for Psychotherapy Research Team. (1995). Manual for the Vanderbilt Therapeutic Strategies Scale. In Levenson, H. *Time-limited dynamic psychotherapy: A guide to clinical practice.* pp. 243–254. New York: Basic Books.

[a] Item written by H. Levenson.

According to object relations theory, people are innately motivated to maintain human relatedness. Basic tenets of interpersonal theory hold that, all else being equal, people learn to treat themselves in a manner that is complementary to how they are treated by others. Therefore, images of the self and others are considered to be products of social interactions. This relational view contrasts with that of classical psychoanalysis, which holds that drives for sex and aggression and their derivatives take preeminence. From a relational perspective, psychopathology results when recurrent dysfunctional interactions cause the individual to engage in patterns of maladaptive behavior and negative self-appraisal. Although recent applications of TLDP are grounded in psychodynamic theory, they also incorporate cognitive, behavioral, and systems approaches.

III. EMPIRICAL STUDIES

A series of studies done at Vanderbilt University in the 1970s found that therapists have difficulty being therapeutically effective when their patients are negative and hostile; in fact, the therapists themselves can often become hooked into responding with negativity, hostility, and disrespect. These findings led Hans Strupp and colleagues to develop TLDP.

Time-limited dynamic psychotherapy does not belong to the new research paradigm of the so-called empirically validated therapies (EVTs). Rather, TLDP was created to support a long tradition of basic research into the elementary processes distinguishing effective psychotherapy from interventions that are less effective or even harmful. Whereas the EVT concept furthers the idea that it is the technique of treatment that is most important, TLDP, in contrast, stems from a research tradition that underscores the importance of so-called common factors such as the personal qualities of the therapist, the interpersonal nature of the therapeutic relationship, and the quality of the therapeutic alliance. Thus, rather than producing an empirically validated "treatment" per se, TLDP research has sought to validate underlying generic therapeutic principles. TLDP was constructed to provide a fertile arena for investigating these principles, but it is by no means the only therapeutic environment in which similar research could be or has been conducted.

Although the primary emphasis of research has not been to demonstrate that TLDP is effective for particular disorders, many patients in studies involving TLDP have improved. Research on TLDP outcomes found that a majority of patients at a Veterans Administration outpatient clinic achieved positive interpersonal or symptomatic benefit, with almost three-quarters feeling that their problems had lessened by termination. Long-term follow-up of these patients revealed that patient gains were maintained and slightly bolstered, with 80% feeling helped. Other analyses indicated that patients were more likely to value their therapies the more they perceived that the sessions focused on TLDP-congruent strategies such as trying to understand their typical patterns of relating to people. A study examining relational change found that following TLDP, patients significantly shifted in their attachment styles (from insecure to secure) and significantly increased in their secure attachment themes. Other empirical studies have found that patients' images and treatment of themselves are a reflection of the way they were treated by their therapists, and that these internalizations are associated with better outcomes.

With regard to case formulation, empirical research suggests that the TLDP-CMP is a reliable and valid procedure. CMPs from patients who had completed TLDP were read by five clinicians unfamiliar with the cases. Based only on these CMPs, the clinicians' independent ratings showed high levels of interrater agreement with regard to the patients' interpersonal difficulties. Further analyses indicated that there was considerable overlap in problems the raters said should have been discussed with those that actually were discussed. Also the therapies were found to have better outcomes the more they stayed focused on CMP relevant topics. Another study found that themes derived from CMPs corresponded to themes obtained from another psychodynamic formulation method.

With regard to training in TLDP, research has demonstrated that although a programatic effort to train experienced therapists in TLDP was successful in increasing therapists' use of TLDP strategies, many of the therapists did not reach an acceptable level of TLDP mastery within the training period. Further inquiry into the data also revealed some unintended and potentially untoward training effects. For example, after training the therapists were more willing to be active and as a consequence made more "mistakes," inadvertently becoming less supportive and delivering more complex communications to patients.

In another training study, psychiatry residents and psychology interns changed their attitudes and values about brief therapy in a more positive direction as a result of a 6-month seminar and group supervision in TLDP. In a multisite investigation, similar attitudinal shifts have been found with experienced clinicians who attended 1-day TLDP workshops.

IV. CASE ILLUSTRATION

Ms. R. was a professional woman in her early forties, married for 15 years with three children. She sought psychotherapy for chronic symptoms of depression and anxiety that had been present for several years. Exploration of the interpersonal context of the presenting complaints indicated that Ms. R. frequently experienced others as emotionally distant or uncaring. She responded with complementary interpersonal distancing. For example, she felt that her husband had been unsupportive with child rearing and during a past time of physical illness but rather than expressing her concerns and wishes to him, she concealed her resentment and withdrew from sexual relations without explanation. Ms. R.'s description of her family of origin mirrored her current marital relationship. She did not feel close to her siblings. Her relationship with her father was notable for unrequited wishes for greater closeness and involvement. In a prior attempt at psychotherapy, Ms. R. found herself wishing for more time with the therapist, but could not bring herself to reveal this, ultimately choosing instead to discontinue therapy.

From the opening moments of the first interview, her TLDP therapist focused on Ms. R.'s current problems, especially as they were reflected in relationships with others and in concerns and expectations regarding the therapist. The beginning of the therapeutic relationship was a primary source of clues for a focal theme. Ms. R. expressed concern about the cost of treatment and added that she had not felt able to discuss this with her husband. She indicated that she was having second thoughts about therapy, and wondered if treatment would be a mistake. The therapist invited associations that eventually linked Ms. R.'s descriptions of uncomfortable affective states to accompanying interpersonal contexts. A search for similarities in patterns across contexts clarified how Ms. R.'s ambivalence about therapy stemmed from a fear that participation in treatment would disturb her marriage. In response to a comment from the therapist inviting associations to her apparent anger and resentment, Ms. R. reported a fear that her husband would perceive her seeking therapy as a rejection of him. She then wondered if therapy might also represent an indirect act of aggression toward him. Such early clarifications and interpretations allowed the therapist to assess Ms. R.'s capacity to participate in collaborative inquiry and probed her response to the work of therapy.

In emphasizing the interpersonal context of Ms. R.'s presenting complaints, the therapist set the stage for identification of a focal theme. In Ms. R.'s case, a theme was identified the essence of which was: "If I ask for what I want, I will be disappointed and will feel useless and worthless. If I don't want to be hurt or abandoned, I must always be polite and must do what others want. I must avoid standing up for myself and must never express anger toward men and must always subordinate my wishes to theirs. If something goes wrong in my relationships, it must be my fault and I am responsible for correcting the situation." Consistent with this theme, Ms. R. often perceived others as withholding what she wanted or needed, and as unresponsive to issues of relationship fairness that were important to her. Although the superficial expression of this theme takes the form of a subdued and unemotional exterior, there is a subtextual theme of covert hostility that finds indirect expression in complementary withholding, in withdrawal, or in subtle or passive forms of aggression.

The therapist used this theme as a heuristic to guide construction of organizing questions and comments designed to stimulate the patient's curiosity and foster collaborative effort. Even as Ms. R. was discussing her husband, other comments, behavior, and perceptions suggested that she often felt similarly toward the therapist. For example, she expected that the therapist would criticize her for her reluctance to tell her husband about seeking psychotherapy. Ms. R. expressed a fear that she would run out of things to say, and that the therapist would respond judgmentally and would refrain from helping her, leaving her cruelly tongue-tied. Similarly, when the therapist agreed to accept her into a time-limited 25-session treatment immediately following the initial interview, she did not experience this as a helpful gesture, but rather perceived the offer of help as a form of coercive pressure, as if the therapist had said: "You can be my patient, but only on my terms and my schedule, and you must choose now." The potential for such transference enactment was continuously in the background of the therapist's awareness.

As treatment progressed, Ms. R. and the therapist reencountered examples of the enactment of this focal theme in narratives about primary childhood relationships, other current family relationships, romantic relationships including her current marriage, and her relationship with the therapist. Within a few sessions, this dynamic focus was sufficiently salient that the therapist proposed to Ms. R. that working on the manifestations of this theme become a primary goal for their continuing sessions.

In future sessions, Ms. R.'s primary task was to verbalize whatever came to her mind. However, she often began her sessions with an awkward silence and an aloof stare that most likely reflected the vigilance associated with ingrained expectations that others will be displeased with her. At the beginning of therapy, as expected according to the principles of interpersonal complementarity, the therapist alternately felt bored, irritated, or subtly dismissive in response to Ms. R.'s criticality and withdrawn stance. For example, in the third session, the therapist, annoyed with the patient's indirect criticism of him, began to think about a highly successful intervention he had made with a previous patient. As he was in the midst of this self-congratulatory reverie, he lost track of what Ms. R. was saying. His emotional distance echoed the behavior of Ms. R.'s husband (and others in her life) and in fact was a reenactment of the very CMP that had become the focus of the therapeutic work.

Ms. R., hurt by her therapist's inattention, started to berate him and then trailed into a series of self-denigrating statements with sullen affect. The therapist, reflecting on this transactional process in the moment, realized that he had been countertransferentially responding to Ms. R.'s behavior and attitude. Rather than defensively denying his inattentiveness, the therapist admitted his lapse, and helped Ms. R. to express directly her disappointment and anger toward him. Together they explored the interactional sequence leading up to their mutual disconnect. The therapist did not punish Ms. R. or excuse his own dismissive behavior, but rather welcomed hearing her feelings, thereby providing her with a reparative interpersonal experience. As other such reenactments were therapeutically addressed, they became fewer and farther between.

For much of the therapy the therapist was able to support, clarify, elaborate, and link Ms. R.'s concerns to the core theme. Connections between Ms. R.'s current experience and the past helped to clarify Ms. R.'s perception of her circumstances, while also highlighting their anachronistic character and underscoring elements of distortion associated with transferential experience. Exploration of the past was important, but clearly subordinate to the therapist's endeavors to stay close to the patient's emotional experience. To this end, the therapist used simple evocative language and avoided complex constructions or abstract interpretations that were likely to move the patient away from her affective experience. Redundant encounters with the focal theme provided repeated opportunities for discussion and corrective emotional experience derived from the contrast between Ms. R.'s transference expectations and what actually occurred with the therapist. In this portion of the work, both the process and the content of the therapeutic dialogue had a healing impact. Indeed, the therapist's behavior often spoke more loudly than his words. A verbal profession of support for Ms. R.'s autonomy would have been of little value if the therapist's conduct simultaneously expressed criticism or infringed on that same autonomy.

Numerous examples of such corrective emotional experiences occurred as the therapy progressed. The therapeutic dyad encountered numerous variations on the focal theme, each a different facet of the theme's pervasive presence in Ms. R.'s life. Around the 20th session, Ms. R.'s concerns turned urgently to the impending termination date. She pressed the therapist for reassurance that therapy would not really have to stop at the agreed time. In response, the therapist maintained the same exploratory stance that had carried the relationship forward from the beginning. Thus, the therapist expressed curiosity about the patient's emotional experience and

her wishes and fears associated with the anticipated end of the therapeutic relationship. The therapist did not attempt to reassure Ms. R. that everything would be OK or that the treatment had accomplished enough. Instead, he treated her responses to termination in the same manner as all other material that Ms. R. had brought to the therapy—as expressions of her central relationship issues.

As termination approached, Ms. R. initially pressed the therapist with rational arguments, protesting that while she had become much more aware of her automatic interpersonal predispositions, she needed much more therapeutic time to master alternative responses. When these arguments failed to elicit the desired amendment to the scheduled termination, Ms. R. then regressed temporarily, sarcastically stating that the therapist was putting her through hell and then withholding further disclosure by refusing to discuss her feelings. Despite Ms. R.'s provocative conduct, the therapist managed not to respond with complementary intensity or negative reaction, but instead maintained a gentle, receptive, and supportive curiosity. The therapist acknowledged Ms. R.'s experience of loss, empathized with her perception that she felt like a helpless child being summarily dismissed by an unfeeling parent, and clarified this fear of rejection and abandonment as a recapitulation of earlier traumas as expressed in the focal theme. The therapist also pointed out the realistic limitations of the therapy, emphasizing what Ms. R. had gained rather than what she imagined she may have foregone by terminating treatment at this time. In this way, the termination phase continued the primary work of the therapy, while also assisting the patient in a corrective emotional experience, namely experiencing the loss of the therapist via normal grief and mourning, rather than as a maladaptive resentment from perceived deprivation.

At their last session, Ms. R. indicated acceptance of the termination and reported that she felt "ready." She framed the termination positively via a metaphor of graduation, rather than negatively via analogy to divorce, abandonment, or ex-communication as would have been expected based on her focal theme. She verbalized comfort in the knowledge that further therapy was possible in the future if she encountered difficulties that she could not master on her own. She and the therapist parted with a sincere and warm good-bye.

V. SUMMARY

TLDP was developed to help therapists treat difficult patients within a brief therapy format. In TLDP, problems are defined in terms of a dynamic focus that formulates dysfunctional interpersonal patterns. The treatment process includes development and maintenance of a therapeutic alliance in the face of the patient's dysfunctional patterns and the therapist's own interpersonal proclivities. Therapeutic strategies include observing the inevitable reenactment of those patterns in the therapeutic relationship, metacommunicating about them, and providing opportunities for experiential learning.

See Also the Following Articles

Brief Therapy ■ Efficacy ■ Manualized Behavior Therapy ■ Minimal Therapist Contact Treatments ■ Outcome Measures ■ Single-Session Therapy ■ Solution-Focused Brief Therapy ■ Termination ■ Supportive-Expressive Dynamic Psychotherapy

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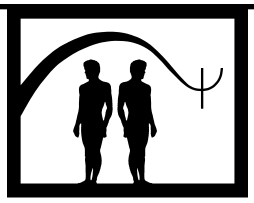

Timeout

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GLOSSARY

functional analysis Assessing a set of circumstances (e.g., through observation, interview, collection, and analysis of data) to identify and target variables that are influencing problematic behavior.

operational definition (of a behavior) A clear, specific description of a behavior so that it can be more easily targeted for change. For example, rather than targeting general "noncompliance," it is easier to target more specific "refusal to comply with direct instructions provided by an adult."

positive reinforcement (or reward) A situation or event, often pleasant in nature, which, when delivered contingent on the occurrence of a behavior, results in an increase in frequency of that behavior.

punishment An event following a behavior that thereby decreases the likelihood that the behavior will recur in the future.

Timeout is a punishment technique such that, following an act of negative behavior, a child spends a brief period of time in an environment less reinforcing than that in which the behavior originally occurred. This article will further define the concept of timeout, suggest typical methods for successful implementation of the timeout procedure, discuss the theoretical bases on which the technique relies, and identify several empirically supported variations of the technique.

I. DESCRIPTION OF TREATMENT

Timeout is a disciplinary technique that, when used correctly and consistently, can be quite effective in reducing maladaptive behavior patterns of children. Although several major principles of behavior modification may be involved with the use of timeout, the procedure is in its most basic form a punishment procedure, because it denies a child access to activities or situations that are sources of positive reinforcement. Thus, the term "timeout" suggests that a child is shifted from being in a reinforcing environment to being in an unpleasant or less reinforcing environment. It is important to note that timeout appears to be most effective when used in combination with other techniques, such as rewarding appropriate behaviors, and therefore encouraging greater frequency of positive behavior.

A. When to Use Timeout

The use of timeout can be effective for children from toddlerhood through adolescence, and in some cases even for adults, and can be used in many different

settings. Schoolteachers often find the technique quite useful in handling classroom disruptions. The procedure is also valuable in working with individuals with developmental delays, inpatient residents in psychiatric settings, children who are aggressive toward siblings or peers, or in families with children who are defiant or noncompliant. Timeout can reduce behaviors such as tantrums, aggression, inattention, refusal to follow directions, inappropriate social comments or actions, or self-injurious behavior.

B. Functional Analysis

Before considering the use of timeout on a consistent basis, a functional analysis should be conducted to identify typical patterns of problematic behavior. A functional analysis can be conducted through the use of both formal and informal methods. Formal methods might include a distinct written operational definition of the target behavior, noting when and where the behavior does and does not occur (e.g., percentage of the time, duration of incidents, number of occurrences per time period). The graphing or charting of trends might be helpful both before and after starting the timeout strategy so that changes in patterns of behavior are easily evident. More informal methods of functional analysis might involve making notes on a calendar or simply being more attentive to potential triggers of behavioral outbursts. Jill Taylor and Michelle Miller provide several classroom case examples illustrating how a thorough functional analysis can lead to successful timeout implementation, or can help identify why the procedure is not producing desired results.

Whether formal or informal methods are used, the goal of the functional analysis is to determine typical antecedents and consequences of the child's actions. Determining the contingencies that could be reinforcing the undesired behavior can help the adult anticipate under what circumstances the behavior is likely to occur. In addition, this information can be used in setting realistic goals for timeout. It is important to set a clear goal (e.g., decrease the behavior by a certain amount) and to recognize and reward the child as positive changes happen and when goals are met.

C. Type of Timeout

Jennie Brantner and Michael Doherty defined three major categories of timeouts: isolation, exclusion, and nonexclusion. Isolation timeout is one in which a child is taken to a solitary, non-reinforcing area, separate in location from where the inappropriate behavior occurred. At home or at school, this might be a hallway or other specified room (where the adult can monitor the child, but without reinforcers present). Alternately, exclusion timeout means that the child is not actually removed from the room where the behavior occurred, but is also not allowed to participate in or view ongoing activities. An example of this would be having the child sit in a chair facing the wall. Russell Barkley suggests a modification of these ideas for use in public places, such that the child can be placed in a quiet corner facing the wall or can be taken to the car for a timeout.

The third category of timeout is nonexclusion, meaning that that the child is able to view ongoing activities but the child's participation is restricted for a period of time following undesired behavior. Brantner and Doherty identified three further variations of non-exclusion timeout. The first variation, titled contingent observation, requires the child to sit on the periphery of activities and watch what is occurring, which might include observing others continue to receive reinforcement. Another variation is removing reinforcing materials, or giving a "timeout" to the television, toys, games, or stereo being used by the child. This seems particularly effective for older children or adolescents. A third variation of non-exclusion time-out is simply ignoring the child, so that reinforcement is not being provided for a period of time. This could include turning away from the child or refusing to interact for a period of time.

To choose which type of timeout will be most effective, one must consider the disruptiveness of the behavior itself, the age, and developmental level of the child (i.e., a very young child may be far less receptive to an isolation timeout), whether or not the behavior occurred in a group setting, and any potential reinforcers in the setting where the behavior occurred (e.g., peer attention). Charles Wolfgang offers several examples of charts useful for record keeping if timeout is to be implemented in a school or group setting, and emphasizes the importance of implementing timeouts without allowing ridicule or social reinforcement from peers. Russell Barkley offers suggestions for training parents to use the technique, such as modeling the procedure for parents and dealing with frustration commonly experienced when implementing a new timeout program. Barkley also offers several adaptations in the procedure, such as incorporating a token economy system and taking additional measures to deal with a child's noncompliance with timeout.

D. Duration of Timeout

There has been considerable debate among researchers and behavior modification experts regarding

the appropriate duration of timeout. The effectiveness of different lengths of time has been empirically tested and has produced varying results. Therefore, there is no absolute standard regarding how long a child should remain in a timeout. Some experts suggest a range of 1 to 5 min, whereas others suggest lengths of up to 20 min for older children. A typical rule of thumb is to require 1 min for each year of a child's age (e.g., a 5-year-old should receive a 5-min timeout). This rule seems logical, because a younger child will likely possess less patience than will an older child. However, this should not be an inflexible standard, because a child's developmental level should also be considered. For example, a 8-year-old who is developmentally delayed might receive beneficial effects from a timeout much shorter than 8 min in duration. For any child, use of a kitchen timer or buzzer can avert arguments or incessant questioning about when timeout has ended.

In determining appropriate timeout length, each child should be considered on an individual basis. The importance is to achieve the aversive and punishing nature of the timeout. That is, too short a timeout might not be perceived as aversive, whereas too long a timeout prevents opportunities to practice other behaviors. In either case, inappropriate duration of a timeout will ultimately be less effective in achieving the ultimate goal: reducing maladaptive behavior.

E. Providing Instructions

Before implementing timeout, the child must know ahead of time what the rules are and what consequences to expect when they are broken. R. Vance Hall and Marilyn C. Hall provide guidelines for explaining timeout to an individual. The adult must first explain to the child the specific target behaviors that will result in a timeout and convey that timeout will be enforced each and every time that behavior occurs. The length of timeout should be preestablished, and the child should know what indicates the end of a timeout. The adult should explain where the child is to spend timeout, and this designated area should be used consistently. If a "timeout chair" will be used, Russell Barkley suggests leaving the chair out for a few weeks to serve as a reminder of consequences. After explaining the entire procedure, younger children might benefit from practicing or role playing a pretend timeout, so they will know what to expect under real circumstances.

The child must also understand that certain behaviors can extend the duration of timeout. For example, screaming, arguing, leaving the timeout area, or other similar conduct should each extend the timeout (e.g., 1 minute for each infraction). The adult must enforce this rule, even if it initially leads to very long timeouts. Without enforcing this procedure, the child might manipulate his or her way out of the consequences and likely attempt that same tactic in later timeout sessions.

When a child's behavior actually warrants a timeout, the adult must deliver consequences in a calm, neutral manner. Russell Barkley suggests redirecting the behavior, waiting a 5 sec count, then warning the child that a timeout will occur if compliance with the request does not occur, waiting another 5-sec count, and if the child fails to respond appropriately, then direct the child to the timeout area. Many variations on this sequence can occur, depending on the child and the infraction. On the end of timeout, the child should be required to resolve the issue or behavior which necessitated timeout in the first place (e.g., if the timeout was for refusing to put away his toys, the child should put away his toys immediately following timeout). Otherwise, the child might begin using timeout as an escape from responsibilities. Consistent rewards, positive attention, and praise should be offered when the child demonstrates positive behavior following a timeout. In starting a new timeout program, the adult should initially expect resistance from the child, particularly if tantrums have been an effective ploy in the past. However, the adult must be willing to enforce timeouts in the same manner each time the behavior occurs. Without consistency, the technique will not be effective and will end up being more work for the adult than it is designed to be when used correctly.

F. When Timeout Does Not Work

If timeout seems ineffective, several factors could be the cause. Perhaps the target behavior is too vague, and the child is having difficulty understanding what behaviors are appropriate. On the other hand, perhaps the "timein" (time spent engaging in supposedly reinforcing activities) is not really rewarding. Thus, timeout might not seem so terrible an option. It could be that the child is using misbehavior and subsequent timeout as a way to gain attention or avoid being in particular environments. In addition, perhaps reinforcement is not being provided for positive displays of behavior. Adults who work to increase positive interactions with the child on a regular basis will be offering a more rewarding "timein," which builds a positive and supportive relationship and offers a little more leverage when disciplining the child.

Even if applied in a consistent and straightforward manner, some children react drastically to timeouts.

These reactions might include severe temper tantrums, physical aggression toward the adult, refusal to go to the timeout area, or leaving the timeout area before the required amount of time has been served. Adults must be prepared for these reactions so they can be dealt with accordingly. If a child is very young, he or she may be physically placed in the timeout area or restrained gently in the chair. If a child refuses to go to or repeatedly leaves the timeout area, extra time may be included or additional punishment (e.g., taking away other privileges) can be utilized.

II. THEORETICAL BASES

Timeout is based on the principle of punishment. Alan Bellack, Michel Hersen, and Alan Kazdin note that in his conceptualization of punishment, B. F. Skinner differentiated between two classes of punishment: one in which existing (often rewarding) stimuli are removed, and one in which new (often unpleasant) stimuli are introduced. A negative punishment (e.g., timeout) would fit into the first class, whereas a positive punishment (e.g., spanking) would fit into the second class. Barkley suggests that use of punishment should only be considered as an alternative after rewards or incentives fail to encourage positive behavior. He also notes that punishment usually fails to be effective when presented in a situation in which no regular positive interactions occur. Therefore, parents must accept some responsibility in finding ways to encourage positive behavior, as well as anticipating potential behavior problems. Simply reacting to negative behavior may encourage helplessness or guilt in a child, because few positive interactions are likely to occur on a consistent basis.

Karen Harris noted that the most important defining characteristic of an effective timeout is the discrepancy between "timein" and "timeout" environments. A timeout will not be perceived as a punishing event if the environment from which the child was removed was never rewarding to begin with. This idea also emphasizes the need for praise and positive social interactions between the adult and child, so that the child will value the "timein."

III. EMPIRICAL STUDIES

In considering length of timeout, Jennie Brantner and Michael Doherty reviewed timeout studies across different types of problem behaviors and in various settings. They were able to conclude that short intervals of timeouts (i.e., 5 min or less) can be quite effective with many populations and in many different settings. Successful use of the timeout technique has been documented with normal children in a family setting; with individuals in inpatient psychiatric settings; with defiant, assaultive, or delinquent adolescents; and in classroom settings at virtually all age and educational levels (to treat behaviors such as noncompliance with rules or inattentiveness). Timeout procedures can also be quite effective in working with autistic children and with children, who are mentally retarded particularly in dealing with aggressiveness or to shape new behaviors such as correct toileting habits. Timeout has been proven to be effective in dealing with a variety of undesirable behaviors, such as aggression, defiance, noncompliance with rules, temper tantrums, being argumentative, inappropriate social interactions, or engaging in self-injurious behavior. A timeout can also serve as a punisher during any type of training task, if the individual already understands and is capable of the desired response.

Robert Jones, Howard Sloane, and Mark Roberts targeted aggressive behavior, comparing the effectiveness of an immediate timeout versus a "don't" instructional command, which included "don't" directives, reinforcement for compliance, a warning for noncompliance, and finally a timeout for noncompliance with the warning. The immediate timeout proved more effective in reducing aggression, possibly because the "don't" procedure offered less immediate consequences and provided more social reinforcement and attention for misbehavior.

David Reitman and Ronald Drabman described an adjustment in implementing timeouts with children who typically become verbally noncompliant. The procedure is called "Read My Fingertips" and has the adult nonverbally adding additional minutes to the timeout, by touching each finger one by one, increasing the timeout one extra minute for each argumentative word spoken by the child. If the child understood the procedure ahead of time, the authors found the technique highly effective in reducing arguing that typically followed a directive to go to timeout.

R. M. Foxx and S. T. Shapiro implemented a nonexclusionary "timeout ribbon" procedure for use in a group setting with children with mental retardation. Following positive behavior, such children were given colored ribbons to wear and received edible reinforcers every few minutes for maintaining appropriate behavior. When misbehavior occurred, a timeout was issued,

meaning that the child's ribbon was removed, and the child received no reinforcement for a brief period. The procedure was found to be useful in reducing undesirable behavior, it did not noticeably disrupt the group as a whole, and the teacher was usually able to continue the procedure alone without extra staff on hand to assist.

There are countless studies and reviews (e.g., Karen Harris; Bellack, Hersen & Kazdin; Brantner and Doherty) examining specific cases and providing continued support for the effectiveness of timeout, particularly when compared with other behavior modification procedures. Although timeout may not work for every individual, there is abundant data to suggest that its use can be quite beneficial in many cases and across many settings.

IV. SUMMARY

When implemented consistently and in combination with reinforcement for positive actions, timeout can be a beneficial method for decreasing negative behavior. As a punishment technique following misbehavior, timeout prevents an individual's access to a more rewarding environment for a brief period of time. There are various subcategories of timeout, which can be adjusted depending on an individual's age, developmental level, and setting in which timeout will be used. A functional analysis can help clarify target behaviors and goals for change, as well as encourage recognition and reward for positive change. Alternate methods of discipline should be in place if timeout fails to be successful. Although timeout may not be successful for every possible situation, there is much evidence to suggest its efficacy across numerous settings and populations.

See Also the Following Articles

Applied Behavior Analysis ■ Conditioned Reinforcement ■ Contingency Management ■ Functional Analysis of Behavior ■ Good Behavior Game ■ Negative Reinforcement ■ Positive Reinforcement ■ Primary-Care Behavioral Pediatrics ■ Response Cost ■ Token Economy

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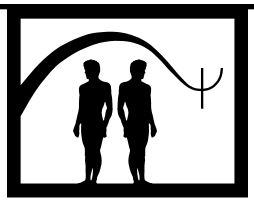

Token Economy

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GLOSSARY

backup reinforcers Goods and privileges purchased with tokens that provide the token with its reward value.

change agent Person who administers reinforcers to a client contingent on the performance of a behavior or set of behaviors according to a prescribed plan.

extinction A reduction in the frequency of a behavior upon the cessation of its reinforcement.

generalized reinforcers Secondary reinforcers that are associated with a wide variety of reinforcing stimuli. Money is an example.

law of association by contiguity A fundamental law of learning that states that two events will come to be associated, or mean the same thing, if they are contiguous or occur together.

law of effect A fundamental law of learning that states that the frequency of a behavior is dependent on its resulting effects or consequences.

level system A supplementary system to a token economy program that involves different stages through which clients progress according to their mastery of specific behavioral competencies. Each stage, or level, is associated with more demanding reinforcement contingencies. The goal of such level systems is often to remove the use of tokens entirely.

negative punishment (response cost) The removal of a desirable event following a behavior that serves to reduce the frequency of that behavior.

negative reinforcement Increasing the frequency of a behavior by removing aversive stimuli as a consequence of that behavior.

positive punishment (aversion) The application of an aversive event following a behavior that serves to reduce the frequency of that behavior.

positive reinforcement Increasing the frequency of a behavior by applying desirable stimuli as a consequence of that behavior.

primary reinforcers Stimuli that have an "unlearned" reinforcing value. These are things that are critical to our survival, such as water, food, and sleep.

prompts Events that initiate a behavior, which is subsequently reinforced. These include a specific instruction of the expected behavior and its associated consequence.

punishment Arranging consequences of a behavior to decrease the frequency of that behavior.

reinforcement Arranging consequences of a behavior to increase the frequency of that behavior.

secondary reinforcers Stimuli that gain reinforcing value after being associated with primary reinforcers.

social reinforcers Social stimuli, such as attention, facial expressions, and verbalizations, that come to have a reinforcement value after being associated with other reinforcers.

stimulus sampling Procedure whereby clients are permitted to try a variety of reinforcers at no cost to generate interest and increase the likelihood that they will purchase the reinforcer with tokens once the sampling period is over.

time-out from reinforcement Removal of the client from all sources of reinforcement for a specified period of time to reduce the frequency of a particular behavior. Usually takes place in an isolated room or quiet area.

token Any symbolic material that can be exchanged for backup reinforcers. Tokens often consist of coins, poker chips, or cardboard squares.

I. DESCRIPTION

A token economy program (TEP) is a system whereby clients earn tokens in exchange for engaging in designated target behaviors. In some TEPs, clients will also lose tokens or be "fined" in response to engaging in inappropriate behaviors.

Just as we use money to buy the things we want, clients in a TEP exchange their tokens for a variety of desirable backup reinforcers, including food, beverages, magazines, toiletries, CDs, potted plants, toys, crayons, school supplies, and other desirable goods. Clients in residential settings may be given the opportunity to purchase a private bedroom, room furnishings, or home passes. Persons in TEPs in correctional settings often spend tokens to buy the privilege to wear their own, rather than institutional, clothes.

Backup reinforcers are available to the clients at specified times during the day, often through a well-stocked "token store" that functions like a small convenience store. In addition, other things purchased with tokens include time to watch TV or play a video game, trips to town for movies or other leisure events, and other desirable privileges. Because most people engage in such behaviors at a high rate when given the opportunity, these high-frequency behaviors are often used as reinforcers in TEPs. Improving the selection of backup reinforcers available, instituting time-limited sales, and holding auctions of highly desirable items all enhance token spending and associated client performance.

Tokens are disbursed by a change agent (e.g., psychiatric aide, educator, or parent) contingent on the performance of desired behaviors by the client. Change agents play active roles in TEPs, including informing the client of the contingencies for earning, spending, and/or losing tokens, and providing prompts as needed. In addition, as the goal of token economy programs is often for a behavior or set of behaviors to take place and be reinforced in the "natural" environment, token reinforcement and prompts are often withdrawn once consistent rates of the desired behaviors have been achieved. Change agents therefore deliver social reinforcers in addition to tokens to help maintain behavior when tokens are withdrawn. In addition, the transfer from a token economy back to a natural environment may include a transition from tokens to more abstract credit vouchers and eventually to money. This transition may be facilitated by a level system, whereby clients demonstrating the acquisition of certain competencies are "promoted" to a higher level that has more demanding contingencies associated with the client's improved functioning. The highest level of such a program could include elimination of tokens.

II. THEORETICAL BASES

B. F. Skinner's pioneering work in operant conditioning is generally credited with providing the theoretical foundation for the development of token economies. It is assumed that basic laws of learning account for the occurrence of behaviors, whether adaptive or maladaptive, and these same laws can be extended to change these behaviors through the thoughtful engineering of environmental events.

Two major laws synthesize theories of learning and have been validated by a body of basic and applied research. The law of effect states that the frequency of a behavior is dependent on the resulting consequences, or effects. Thus, behavior is strengthened or weakened by what follows it in the environment. In fact, a consistent finding has been that the more immediately a consequence follows a behavior, the greater effect it will have. Reinforcement always has the effect of increasing the likelihood or recurrence of behavior. In positive reinforcement this is done by adding a positive or desirable event (e.g., tokens) to the environment when a behavior occurs. In negative reinforcement, it is accomplished by removing an unpleasant or aversive event from the environment after a behavior occurs. A patient who utters threatening comments in a therapy group that she dislikes will have this behavior negatively reinforced if she is subsequently asked to leave the group (removal of an aversive event) and can be expected to make such statements with greater frequency to avoid that group.

Decreasing the frequency of a behavior is accomplished by removing reinforcement, or extinction. For example, some research shows that self-injurious behavior (e.g., head banging, hair pulling) in children with disabilities generally results in attention from caregivers (e.g., verbalizations of concern, physical intervention). Often, this attention positively reinforcers

the self-injurious behavior. Brian Iwata and colleagues have repeatedly demonstrated that when such attention is withdrawn, a marked decrease in self-injury ensues.

Behavior can also be decreased by use of punishment. In positive punishment, this consists of applying an aversive event (e.g., spanking a child) following the target behavior, whereas in negative punishment the consequence involves removing a desirable event (e.g., removing a child's privileges). Punishment is most effective when used for brief periods and in combination with reinforcement for desirable behaviors. It is not recommended for use by itself.

The second law of learning is the law of association by contiguity. It states that two events will come to be associated if they are contiguous or occur together. Thus, things that are not reinforcing in and of themselves can become reinforcing by pairing them with things that are. By pairing tokens with a primary reinforcer such as food, the tokens become secondary reinforcers. Eventually, through association with a variety of primary and secondary reinforcers, tokens will become generalized reinforcers.

III. APPLICATIONS AND EXCLUSIONS

Because the operant conditioning principles on which TEPs are founded apply to all behavior, it is not surprising that TEPs have been developed to deal with a large variety of populations and target behaviors. They have been found to be effective in increasing exercise regimens in chronic pain patients; reducing cigarette smoking in psychiatric outpatients; improving outpatient therapy attendance and participation; reducing alcohol consumption and illicit drug usage in outpatient alcohol and substance abusers; increasing dietary compliance for individuals with diabetes or renal problems; promoting weight loss; improving word finding and decreasing misarticulations in aphasic patients; reducing temper tantrums, teasing, and other "acting out" by children in the home; eliminating thumb sucking; increasing self-care skills, social interaction, and exercise in geriatric patients; reducing stuttering; eliminating enuresis and encopresis; decreasing chronic nail biting; and improving marital satisfaction.

Token economy programs have also been applied to broader social issues, with successful implementations resulting in increased bus use at a major university, increased safety practices (and reduced injuries) at a pit mining operation, increased seat-beat use in youngsters, and increased litter control at a residential facility for individuals with mental retardation.

As should be apparent by now, participants for TEPs are not identified by focusing on psychological syndromes or diagnostic categories. Rather, the focus of the TEP is on the frequency and intensity of target behaviors. Thus, a TEP in a psychiatric hospital may focus on increasing grooming and hygiene, basic conversational skills, and vocational skills, and on decreasing assaultive and other maladaptive behaviors. It does not focus on treating "schizophrenia." Similarly, the social skills and academic skills of youth residing in correctional facilities may be addressed by a TEP. The TEP is not, however, used to treat "delinquency." In fact, although this article appears in the *Encyclopedia of Psychotherapy,* a TEP is not a "psychotherapy" or "treatment" per se. Rather, it is an extremely flexible organizational system used to deliver a wide range of plans for changing behavior. As Gordon Paul and Robert Lentz explained in 1977, the treatments delivered by two TEPs may be no more related to each other "than the action of heroin is related to that of penicillin, even though both are administered by injection."

IV. EMPIRICAL STUDIES

The bulk of the research on TEPs focuses on four populations: psychiatric patients, individuals with mental retardation, schoolchildren, and correctional populations. Although is certainly possible to apply diagnostic labels to these groups, it is important to reiterate that the focus of TEPs is on identifiable behaviors and not syndromes. Common targets across these populations include enhancing "motivation," increasing social and adaptive behaviors, and decreasing maladaptive and dangerous behaviors.

A. Psychiatric Patients

The first TEP for psychiatric inpatients with severe disabilities was implemented at Anna State Hospital in Illinois in the 1960s by Teodoro Ayllon and Nathan Azrin. Their research demonstrated that changes in the patients' off-ward job choices and increased performance of the non-preferred jobs resulted through use of token reinforcers. In another TEP at a VA hospital, John Atthowe and Leonard Krasner reported that previously catatonic, withdrawn, or isolated patients demonstrated a significant lessening of apathy indicated by requesting and receiving overnight passes with family,

going to the canteen, and engaging in a variety of social interactions on the ward such as playing pool or card games (where betting was done with tokens).

Other target behaviors addressed by early TEPs with psychiatric patients included grooming and hygiene, bedroom care, attendance and participation in group activities, general cooperativeness with ward rules, and social functioning. Scores of publications show patient improvements in all of these areas, as compared to either their own pre-TEP behaviors, or to behaviors of patients on non-TEP wards.

In addition to these increases in appropriate and adaptive behaviors, psychiatric patients in TEPs have shown decreases in inappropriate and maladaptive behaviors as well. Some of these reductions occurred without being directly targeted, apparently as side effects of improvements in adaptive areas of functioning. Other TEPs have directly targeted such behaviors, generally by withholding reinforcement or using token fines. Results over the years show reductions in screaming, ritualistic behaviors, mannerisms, responsiveness to hallucinations, and the frequency of delusional talk. In addition, TEPs have shown dramatic decreases in threatening and assaultive behaviors, with corresponding reductions in use of seclusion and restraint with patients. Research shows that decreases in PRN or "as needed" medication usage as well as reductions in dosage of routine medications is common for TEP patients. In fact, some studies show that behavioral interventions such as the TEP are effective with psychiatric patients even in the absence of medications. Gordon L. Paul and colleagues reported that patients diagnosed with schizophrenia in a social learning program, which included a TEP, were able to be withdrawn from all psychiatric medications without a deterioration in functioning.

Finally, although discharge from inpatient settings and subsequent community tenure are affected by a number of political, financial, and social factors, TEP patients have nevertheless demonstrated decreased lengths of inpatient stay, increased rates of discharge, and decreased numbers of readmissions in comparison to non-TEP patients.

B. Individuals with Mental Retardation

Token economy programs for individuals with mental retardation (MR) have had similar results to those for psychiatric inpatients. Bathing, grooming, toileting, bed making, feeding, tooth brushing, and washing/combing hair have all been shown to increase for individuals with MR in TEPs. Improvements are also seen in vocational skills (punctuality and attendance, production rates, task quality) and academic skills (test preparation, study behaviors). Some TEPs even permit banking of tokens and will teach check-writing skills to their clients with MR to access tokens saved in this manner. Social behavior has also been affected, from behaviors such as making eye contact and asking questions to more complex skills like proper noun-verb agreement, correct grammar, appropriate use of articles or pronouns, and even speech volume and dysfluencies. For younger individuals, increases have been shown in cooperative and competitive play in comparison to solitary or parallel play.

Inappropriate behaviors of individuals with MR have been targeted as well. Research has demonstrated that aggression, rocking behaviors, and self-injury are responsive to treatment programs using token reinforcement, time-out from reinforcement, extinction, and token fines.

C. School Children

Schools have been a popular setting for TEPs, with participants including "normal" children as well as children with a variety of problems including learning disabilities, attention deficit hyperactivity disorder, and emotional disturbances. Participants have spanned the age range from elementary through high school and beyond.

A large TEP undertaking reported by Howard Rollins and colleagues in 1974 included more than 700 inner-city students in Grades 1 through 8. Students in the 16 TEP classrooms demonstrated increased attentiveness and superior improvements in IQ and academic achievement measures than students in the 14 non-TEP control classrooms. Other researchers have obtained similar results, including improved completion of homework and increased basic academic skills as measured by task completion, accuracy, and grades. These improvements are reported in "normal" children as well as those who demonstrate learning disabilities, hyperactivity, and emotional difficulties. In addition, TEPs have been successfully used to improve articulation in children with speech disorders and have even been successful in enhancing writing skills as measured by use of different adjectives, verbs, and story beginnings, and as rated by outside blind reviewers.

A comparison of multiple methods for controlling disruptive behaviors in the classroom was reported by K. Daniel O'Leary and colleagues, who examined the effects of rearranging the structure of the class periods, posting and reviewing of behavior rules, using praise

and extinction, and finally adding a token economy. All methods were generally ineffective until the TEP component was added. Similarly, Marcia Broden and colleagues decreased disruptive behaviors as well as improved study behavior through use of a simple timer and a TEP. The timer went off at random intervals, at which time students who were quiet and in their seats received tokens. This and other research finds TEPs to be effective in reducing relatively minor disruptions (talking in class, being out of one's seat, interrupting, arguing), as well as more serious disruptive behaviors, such as threats and verbal or physical assaults.

As an alternative or supplement to individual contingencies, many classroom TEPs make use of group contingencies. In such an arrangement, it is the behavior of the entire group or class rather than the individual student that determines how much reinforcement each student receives. The "Good Behavior Game," developed by Harriet Barrish and colleagues, divides students into groups or teams, with each team earning or losing points depending on the behavior of the group's members. The team with the best score at the end of a specified time period receives reinforcement. Research using this game has successfully demonstrated its use to reduce disruptive behavior in the classroom. Variations on group contingencies in TEPs were examined by Ronald Drabman and colleagues. In different conditions, tokens were earned individually based on individual performance, or by the entire group based on the behavior of the best behaved child, the worse behaved child, or a randomly chosen child. Disruptive behavior decreased in all conditions, with no significant differences between them. Other research comparing individual versus group contingencies has reported similar results.

Although medications are often used to treat hyperactivity and disruptive behaviors in children, some researchers have found TEPs to be equally effective in controlling these behaviors. TEPs also have the added benefit of improving academic performance, a result not typically found with medication alone.

D. Correctional Populations

Token economy programs with youth engaging in criminal behaviors have also yielded favorable results, although these programs are generally conducted in institutional settings and not traditional classrooms. TEPs have resulted in improved self-care skills, conversational skills (including use of proper grammar), social functioning, classroom behaviors, academic skills, and vocational skills. Some programs, such as the Achievement Place program described by Elery Phillips and colleagues, involve using a client as a change agent to dispense tokens, levy fines, and assign jobs and other tasks. This innovative feature results in improved performance of target behaviors. In addition, decreases in aggressive and threatening behaviors have been reported, often through the adjunctive use of time-out from reinforcement and token fines.

Token economy programs in adult prisons have met with varying degrees of success. An effort in Missouri focused on the state's most problematic prisoners and involved a tiered token/point system. Prisoners initially earned tokens for lack of threatening or assaultive behaviors and for cooperating with the rules and could purchase privileges such as increased opportunities to shave and shower, exercise, and possess personal items. Improvement in behavior resulted in advancement through a level system and eventually a switch to points instead of tokens, with greater opportunities to access backup reinforcers such as visits to the commissary, outside phone call privileges, and paid "vacation" days from work. Plagued with legal problems throughout its existence, including charges of violating prisoners' rights, the program generally failed to meet its goals of returning its difficult prisoners to the general population and was closed after two years.

Less ambitious prison TEPs have been successful in improving compliance with basic prison routines (getting up on time, keeping cell neat, performing cellblock chores) and increasing academic skills in prisoners, including earning GEDs. Backup reinforcers in some innovative programs have included offering appointments with parole board officers, and even opportunities to go fishing or visit a women's prison.

E. Failures of TEPs

In spite of the success indicated here, research consistently shows that a small number of individuals fails to respond to TEPs. This may be due to individual differences in responsiveness to the contingencies arranged in a particular TEP. For example, providing cigarettes as a backup reinforcer to a non-smoking client is not likely to be very motivating. Similarly, offering reinforcers to a client who is unfamiliar with them may not generate much interest. Teodoro Ayllon and Nathan Azrin addressed this through the use of stimulus sampling. By permitting patients to "sample" new or unfamiliar backup reinforcers (e.g., attending a local fair or a concert) at no cost, they were able to increase interest in those reinforcers once token charges were reinstated.

Other TEP clients may not respond because they lack the skills necessary to perform the target behavior, or because they do not understand the relationship between the target behavior and the reinforcement. Devising individualized contingencies and personalized reinforcers can improve responsiveness in a TEP.

Finally, inadequate implementation of the TEP can attenuate client responsiveness. Some research shows that client change is related to the accuracy with which staff adhere to the planned contingencies. Inadequate training and/or oversight of the TEP can lead to poor results.

F. Generalization

Research indicates that gains made in TEPs do not always last after the token reinforcement has ended. Generalization of gains made in TEPs typically requires some advance planning and should not be expected to simply happen. Strategies for accomplishing this include a gradual rather than sudden cessation of token usage combined with a corresponding increase in naturally occurring reinforcers such as social praise. Other strategies include lengthening the delay between the behavior and the reinforcement, and providing reinforcement in a variety of settings so that the behavior is not limited to a narrow range of cues.

V. CASE ILLUSTRATION

Joe, 33, has spent most of his adult life in state psychiatric facilities. Periodically he gains discharge, only to be readmitted within a period of months. His current hospitalization has lasted over 3 years.

Joe typically spends his day in his bedroom. He rarely talks to anyone and only ventures out for coffee, cigarettes, and meals. He goes weeks without bathing, requiring strong staff encouragement or assistance on those occasions that he does bathe. Joe responds to auditory hallucinations and can frequently be heard talking and yelling at "Uncle Ed," his abusive and now-deceased uncle whom Joe believes is the source of his voices. At times, Joe assaults staff members and other patients in response to directives from "Uncle Ed."

On March 1, Joe is admitted to the hospital's TEP with identified goals of increasing socialization, improving self-care skills, decreasing responsiveness to hallucinations, and reducing/eliminating aggressive behaviors. Program staff orient Joe and explain the TEP to him, inducing a discussion of how to earn and spend tokens. Joe immediately begins a period of stimulus sampling, whereby all backup reinforcers are available to him free of charge so that he may be exposed to a wide variety of things that he may later wish to purchase with tokens. The free availability of backup reinforcers is gradually reduced over the next few days, and by March 5th Joe must have tokens to access his coffee and cigarettes. At first, Joe becomes angry when he does not receive a free cup of coffee and assaults a staff member. He receives a token fine for his behavior, which must be paid before he can purchase backup reinforcers for himself. Joe has similar incidents over the next few days but eventually realizes that assaulting others will not get him a cup of coffee, and by March 10th Joe is engaging in some simple behaviors to earn tokens. He starts attending a few scheduled treatment groups and begins to shower a couple of times a week. However, Joe doesn't use soap or shampoo while showering and only stands under the water for about 1 min. A decision is therefore made to individualize Joe's target behavior for showers. The next day, Joe earns a token for staying in the shower for 3 min. Eventually, he must use soap and then shampoo to earn his token. The change agents work closely with Joe to help him develop these skills. Slowly, over the course of about 2 weeks, Joe's showering skills advance to the point that he is taking full showers, with good use of soap and shampoo. His hygiene and grooming have improved immensely, and Joe smiles when staff compliment him on his appearance.

As Joe spends more time out of his room, he begins to notice other patients leaving the ward for vocational activities. He expresses an interest in this, but learns that he must be at Level 2 in the TEP to work, and he needs to participate in semistructured social activities to reach that level. Joe reluctantly begins showing up at a couple of the evening card games scheduled on the ward. When he discovers that he cannot earn tokens if he talks to his hallucinations, he angrily retreats to his room. Eventually, after this behavior costs him tokens in a number of activities, Joe begins to reduce the frequency of responding to hallucinations. By April 14th, Joe is promoted to Level 2 and starts attending work. Token payment for work activities is delayed at this Level, and patients are paid in a lump sum at the end of the week as the first step in gradually weaning them off the token economy.

While walking to and from work each day, Joe notices the Recreation Center on campus, as well as some of the gardens and nearby benches. His attendance and participation in other treatment groups starts to improve, as Joe tries to earn additional tokens to spend on grounds passes. An aggressive incident at work on May 10th results in a token fine and the loss of Level 2. Joe is frustrated and becomes sullen and withdrawn for a few days. Staff once again hear him speaking to "Uncle

Ed." However, after 3 days Joe shows up for the morning exercise group where he earns a token and receives a good bit of social praise from the staff. Joe focuses on regaining Level 2, and succeeds on May 22nd.

By late June, Joe rarely isolates himself in his bedroom. His aggressive behaviors are well under control, and he no longer talks to "Uncle Ed." Improvements in his group attendance and work performance result in a promotion to Level 3 on June 30th. Joe now receives a large weekly deposit of tokens into his "bank account," instead of receiving physical tokens at the time he performs each target behavior. He must learn to budget his token supply for an entire week, because no new token deposits will be received before the next week. Joe struggles with this for a few weeks, and often runs out of tokens after only 3 to 4 days, but with some teaching he learns to manage his funds for the entire week.

By late July, Joe is ready to make brief visits to local group homes in preparation for discharge. He continues to participate in treatment at the hospital during the day but starts engaging in evening and weekend leisure events at the group home where he wants to live. There are no tokens at the group home, and this is an additional step in helping Joe move from the token economy back to the community. When Joe is promoted to Level 4 on August 5th, he starts carrying money again and is taken off the token economy entirely. Staff continue to provide Joe with lots of social praise for engaging in positive and adaptive behaviors. By September 8th, Joe is ready for discharge.

VI. SUMMARY

Leonard Krasner once described TEPs as "the most advanced type of social engineering currently in use." Since their inception in the early 1960s, TEPs have been used to improve basic hygiene and grooming, social functioning, and vocational skills, and reduce agitation, assaultiveness, and other maladaptive behaviors. They have improved academic skills and have reduced classroom disruptions in schoolchildren. Individuals in correctional settings show improved social skills and rule compliance. Most participants respond favorably to TEPs, but poor implementation, including inadequate training or oversight, will reduce their effectiveness. In addition, people respond differently to reinforcement contingencies, and this will also affect the effectiveness of the TEP. Finally, planning for generalization can help ensure that client improvement continues after the token reinforcement has ended. Forty years after its inception, the token economy remains a powerful tool for changing an enormous array of behaviors with a wide range of populations in a variety of different settings.

See Also the Following Articles

Applied Behavior Analysis ■ Behavioral Contracting ■ Contingency Management ■ Good Behavior Game ■ Negative Punishment ■ Negative Reinforcement ■ Positive Punishment ■ Positive Reinforcement ■ Response Cost

Further Reading

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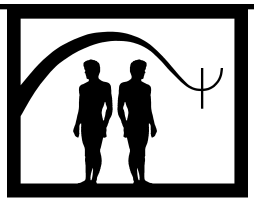

Token Economy: Guidelines for Operation

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GLOSSARY

backup reinforcer The positive reinforcers for which tokens are exchanged.

Premack principle The finding that the opportunity to engage in high-probability activities will serve as a reinforcer for engaging in lower probability activities.

radical behaviorism Based on the work of B. F. Skinner, it is the theoretical orientation that posits that behavioral principles provide an explanation and understanding of the full range of human behavior, thought, and emotion.

target behavior A desirable or undesirable behavior to be increased or decreased in the token economy program.

token The item earned or lost when desirable or undesirable target behavior occurs and which is exchanged for backup reinforcers.

I. HISTORICAL ANTECEDENTS OF THE TOKEN ECONOMY

Token economies have a long history. Perhaps the earliest description of what would now be considered a token economy was provided by Alexander Maconochie in the mid-1800s. While warden of the Norfolk Island, Australia prison, Maconochie concluded that the punitively oriented, torturous methods of inmate management common at that time did nothing to prepare offenders for a productive life in the community but instead increased the likelihood that they would return to their criminal ways when released. In an effort to bring humane management practices and meaningful rehabilitation programs to his prison, Maconochie developed a mark (token) system in which inmates earned marks for appropriate behavior and lost marks for inappropriate behavior. The inmates, in turn, used marks to purchase food, clothing, and privileges. Promotion through a levels system within the prison and even eventual release from prison were also determined by the number of marks accumulated.

It was not until the mid-20th century work of Ayllon and Azrin with severely disturbed psychiatric patients on one ward of a large state hospital and the work of Arthur Staats and his colleagues with children in a preschool setting that the token economy found acceptance and widescale use in modern psychology. Their work is a pioneering example of the extension of basic research conducted in the tradition of Skinner's radical behaviorism into applied settings.

II. OVERVIEW OF THE TOKEN ECONOMY

Stuve and Salinas provide a detailed description of the token economy in their contribution to this encyclopedia.

Our contribution therefore begins with only a brief overview of the token economy. We then offer a number of suggestions or guidelines for the operation of token economies that are based on both a consideration of published works in the area and our personal experience operating token economies in applied settings.

As Stuve and Salinas indicate, a token economy is a reinforcement-based motivational program that is used to encourage desirable, adaptive behaviors and to discourage undesirable, maladaptive behaviors. It differs from other reinforcement programs in that an artificial or contrived reinforcer (the token) is introduced to mediate the relationship and bridge the delay between behavior and more natural reinforcing consequences, such as extra recreational activities or special foods. Desirable behaviors are followed by the award of tokens, which are then exchanged for the natural reinforcers. Similarly, undesirable behavior is followed by the loss of tokens, which reduces or prevents access to the natural reinforcers. Token economies are typically employed with groups of individuals, such as all students in a classroom, all persons with developmental disabilities in a sheltered workshop, all psychiatric patients in a hospital ward, all delinquents in a group home, or all prisoners in a cell block. However, token reinforcement programs can also be used with individual children, adolescents, or adults. When this is done the program is usually referred to as a token or point system rather than as a token economy.

III. ESTABLISHING AND OPERATING A TOKEN ECONOMY

Token economies should be predominantly, if not exclusively, positive rather than punitive. That is, the target behaviors that lead to token award should far outnumber those that lead to token loss, and the participants should earn access to far more backup reinforcers than they are denied. Similarly, tokens should be awarded when earned by engaging in desirable target behaviors rather than given at the start of a day, for example, and taken away as punishment when desirable target behaviors are not exhibited. By emphasizing positive consequences for desirable behavior and for behavior that is incompatible with undesirable behavior, the token economy fosters cooperation and a sense of community among clients and staff while preventing the alienation and resistance that often is seen in punitively oriented programs. By so doing, the token economy fosters a positive attitude about the token economy, active participation in the token economy, and constructive relationships with those who carry it out on a day-to-day basis. Punitively oriented token economies tend to do just the opposite and explain much of the alienation and resistance commonly seen in such programs.

The major components of the token economy are the target behaviors, the tokens, and the backup reinforcers. In addition, the token economy includes the schedules relating target behaviors to the award or loss of tokens and the exchange of tokens for the acquisition of backup reinforcers. The token economy also includes provisions for the training and monitoring of staff, the use of behaviorally based methods for the development of the target behaviors to be reinforced, and procedures to ensure that behavior change is maintained as the client leaves the token economy. Finally, all aspects of the operation of the token economy and the progress of clients are monitored on a regular basis.

A. Target Behaviors

The token economy exists to increase and maintain desirable behaviors and to decrease and eliminate undesirable behaviors. In general, targeted desirable behaviors are those that contribute to or result in successful community adjustment and the living of a satisfying and productive life. Targeted undesirable behaviors are those that interfere with or prevent those outcomes. Quite often, the positive character of the token economy may be enhanced by targeting the desirable incompatible opposite behavior of an undesirable behavior for token award, rather than targeting the undesirable behavior for token loss.

The target behaviors should be in accord with the mission and goals those settings have established for themselves and their clients. A program for persons incompetent to stand trial that targets the signs and symptoms of mental illness, for example, is inadequate unless it also targets or even emphasizes the skills necessary to competently stand trial. Some behaviors may be targeted for all clients in the token economy. The target behaviors should also be based on an assessment of the strengths or abilities and the problems or deficiencies of the individual clients. As a result, clients may have several target behaviors in common, as well as several target behaviors that are unique to themselves or a small number of other clients.

The target behaviors or, in some instances, the products of the target behaviors should be described in unambiguous terms that make them observable and countable by a second party. This serves several

important functions that advance the treatment effort. First, the clients know exactly what is expected of them and act in a manner that will earn tokens or avoid their loss. The staff also know exactly what is expected of the clients and can accurately award or deduct tokens accordingly. In addition, the objective definition of target behaviors reduces conflict between clients and staff about the occurrence or nonoccurrence of target behaviors that typically occurs when more subjective criteria are employed. Similarly, the clear specification of target behaviors fosters consistency in the manner in which different staff, often on different shifts, work with clients. Finally, the more objectively defined the target behaviors, the less likely it is that clients will be effective in manipulating staff by arguing, for example, that a staff member is discriminating against them by treating them more harshly than other staff members.

B. Tokens

Tokens should be awarded as quickly as possible, if not immediately, following a desirable target behavior and taken away as quickly as possible, if not immediately, following an undesirable target behavior. The tokens themselves should be tangible, durable, portable, counterfeit-proof, and personalized in a manner that allows their accumulation by participants. In a very real sense, a country's financial economy is a token economy, and the characteristics of these tokens are a good model for the tokens in any token economy. In general, the nickels, dimes, and quarters of the United States' economy are tangible, durable, and portable. These coins can be accumulated in considerable numbers, and are virtually counterfeit-proof. They can also be easily carried by staff and can be awarded to clients immediately following a desirable behavior. Perhaps the greatest problem the currency in the United States' economic system poses is that it is not personalized and as a result individuals can and do acquire these tokens through theft and other means without engaging in appropriate and desirable target behaviors.

Rather than use "real" money, of course, token economies typically employ other items as tokens. What is used as a token in a token economy is limited only by the ingenuity of the staff of the program. One example is the poker chip or similar item, perhaps personalized with a number or letter to discourage illegitimate acquisition through theft or coercion. Another example is the daily punch card on which staff punch holes in circles as clients earn tokens and cross off punched-out circles as clients spend tokens. At the end of the day the cards are collected by staff who determine the number of unexpended tokens, punch that number into the next day's cards, and distribute the individualized cards at the start of the next day. Still another example is a checkbook banking system in which clients are told to add tokens to their account as they earn tokens and write checks as they spend tokens. At the end of the day staff balance each account and inform the clients of their balance at the start of the next day.

The tokens in the three representative examples range from concrete or tangible to abstract or intangible. Where along that continuum the token should fall is dependent on the characteristics of the client population. Young preschool children should be provided more concrete or tangible tokens, whereas older adult offenders would most probably function well with more abstract or intangible tokens. When making that decision, one should keep in mind that one cannot err in the direction of using tokens that are too concrete or tangible.

C. Backup Reinforcers

The backup reinforcers are the natural reinforcers that give value to the tokens. The token economy should not deprive any clients of anything to which they are entitled by the Constitution or by statute. The backup reinforcers therefore are additions to these legally mandated minimums. They may involve access to additional amounts or enhancements of entitlements, such as additional exercise time or special foods, as well as anything to which the client is not legally entitled. In general, backup reinforcers fall in several categories. These consist of edibles or consumables, such as special food or drink; activities, such as extra recreational or computer game time; material objects, such as special athletic shoes or posters; and independence, such as reduced supervision or movement through progressively less restrictive levels in a structured levels program. Each can be considered a to-be-earned privilege.

A number of strategies may be used to identify backup reinforcers. The most straightforward consists of asking the clients what they would like and would work for. Another is based on the Premack principle and involves observing clients during free or unstructured time to identify the things they are most likely to do. These may then be used as backup reinforcers for the typically lower probability target behaviors. Finally, the staff can be asked what they believe will serve as backup reinforcers for their clients. It is important to note, however, that the information gathered through these strategies results only in the identification of

potential backup reinforcers. The reinforcing properties of the potential backup reinforcers must be tested to determine whether they are true backup reinforcers. This is done by assessing whether clients will engage in target behavior to earn tokens and then exchange the tokens for the potential backup reinforcers.

What is reinforcing to one client may or may not be available to another client. The token economy must therefore offer a variety of backup reinforcers to ensure that there are sufficient reinforcers for all participants. Although some backup reinforcers may motivate most or all clients, additional backup reinforcers that function as such for only a few or, perhaps, only one client should also be made available to ensure that the unique interests of all clients are addressed. The backup reinforcers should be available to clients on a regular basis. Some should be available several times a day, others several times a week, and perhaps still others several times a month or only on a monthly basis. The schedule of availability of backup reinforcers is dictated, in part, by the characteristics of the clients, and a token economy cannot err in the direction of making backup reinforcers too frequently available to clients. Finally, the backup reinforcers must be available only through the token economy. The availability of "bootleg" backup reinforcers, that is, backup reinforcers that may be obtained through other means, will dilute or negate the reinforcing properties of backup reinforcers and should be prevented.

D. Additional Considerations

The token economy should be fair or balanced. That is, the backup reinforcers should be commensurate with the target behaviors. This is accomplished, in part, by ensuring there is a rich and variable array of backup reinforcers available to the clients, and by ensuring that the number of tokens earned is in accord with the nature of the to-be-rewarded target behaviors and the number of tokens expended are in accord with the nature of the to-be-purchased backup reinforcers. These ratios should be adjusted as participation in the token economy dictates. Clients should be included in the decision-making process to both better ensure fairness is maintained and to offer them the therapeutic benefit such involvement brings to the treatment setting. The token economy should also be as simple or straightforward as possible so that the relationship between target behaviors, point award or loss, and backup reinforcers is clear to all clients. Conditions, exceptions, and qualifications that obscure the direct relationship between target behavior, tokens, and backup reinforcers will work to dilute the effects of the token economy.

Although the token economy itself may provide experiences that foster a structure and an appreciation of the quid pro quo relationship between privileges and responsibilities that prepare individuals for life in the community, its greater power lies in its ability to motivate clients to participate in therapeutic and rehabilitative programs and activities. These should be identified while developing the target behaviors of each client's individualized treatment program. Staff require training to carry out the token economy and its treatment programs, or to support the staff that do. The general skills necessary to carry out a token economy include, among others, how to shape behavior, the use of prompting to increase desirable behavior and redirection to decrease undesirable behavior, how to use social reinforcement when awarding tokens and backup reinforcers, and the use of behavioral momentum, differential reinforcement, and chaining to further encourage appropriate behavior or discourage inappropriate behavior. Training in specific therapeutic skills is necessary to carry out the treatment programs called for by the characteristics and special needs of the client population. These should be in accord with the profession's movement toward the identification and adoption of empirically based treatments.

A monitoring system is an important part of the token economy. Not only should clients' progress be monitored and assessed on a regular basis, but the performance of the staff in carrying out the token economy should also be monitored and assessed on a regular basis. When the monitoring of clients indicates that their progress is not as is expected, changes in both the clients' individualized treatment plan and the design or implementation of the token economy should be considered and implemented as called for. When the monitoring of staff indicates that their performance is not as is called for, retraining and more intensive supervision should be considered and implemented as called for. More important, however, staff should participate in a positive organizational behavior management program to sustain high levels of work performance and morale.

Special procedures should be implemented to phase out the token economy when clients are eligible to move to another treatment setting or into the community. The general strategy to be followed is to give clients progressively more responsibility for the management of their own behavior. This may be done by moving clients through a structured levels program or by moving from the token economy to self-management in the absence of levels. One might begin, for example, by relaxing a requirement that staff evaluate clients' performance and award tokens as clients assume more responsibility for

evaluating their performance of their target behaviors and awarding or deducting their tokens accordingly. Similarly, the next phase might involve the clients assuming responsibility for exchanging tokens for backup reinforcers. Finally, the tokens might be eliminated and clients assume full responsibility for continuing to engage in their target behaviors and, in exchange, have full but reasonable access to backup reinforcers. Staff should continue to monitor clients throughout this process to ensure that performance is sustained. Transitional programs should ensure that improvements are maintained as clients leave the token economy setting. These programs range from training those who will work with the clients in the additional behavioral skills employed by the token economy staff to training them to continue token economy procedures, if such prosthetic arrangements are deemed necessary.

IV. EFFECTIVENESS OF THE TOKEN ECONOMY

Maconochie's anecdotal reports indicate that the recidivism rate for inmates released from his program on Norfolk Island was markedly lower than that for other prisons in the British colonies. More recent empirical research provides general confirmation of the effectiveness of properly designed and implemented token economies. Perhaps the most influential of the empirical studies is Paul and Lentz's thorough-going experimental comparison of milieu therapy and social learning therapy with a severely disturbed psychiatric population in a large state hospital. They defined the milieu approach as consisting of increased social interaction and group activities, expectancies and group pressure directed toward normal functioning, more informal patient status, goal-directed communication, freedom of movement, and treatment of patients as responsible people rather than custodial cases. The social learning approach was described as the systematic extension of principles and techniques derived from basic research on learning to clinical problems, specification of specific behaviors for change, emphasis on response-contingent consequences, and the use of token economy programs.

In general, Paul and Lentz found the token economy to be superior to the milieu program in terms of both in-hospital improvement and then postrelease adjustment during a year and a half follow-up period. It was also found to be the more cost effective of the two approaches. The milieu approach, in turn, was found to be superior to routine hospital care for both the in-hospital and postrelease indices of program effectiveness. Findings such as these ensured that the token economy would become an important component of many treatment programs for persons with mental illness as well as in educational settings, training schools, and prisons.

V. SUMMARY

The token economy employs a conditioned reinforcer to mediate between clients' behavior and its more natural positive reinforcement. It is an effective motivational system to encourage desirable behavior and discourage undesirable behavior. It is also effective in ensuring clients' participation in individually prescribed treatment programs. Although simple in concept, it requires sophistication in implementation as well as staff training and continued monitoring to ensure its effectiveness.

See Also the Following Articles

Behavioral Contracting ■ Contingency Management ■ Good Behavior Game ■ Job Club Method

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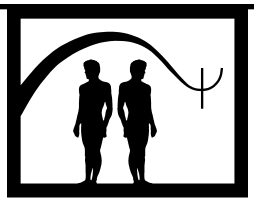

Topographic Theory

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GLOSSARY

defense The methods used by the ego to master and control id impulses or superego injunctions.

drives Another term for Freud's instincts. Two drives were postulated by Freud—sexual and aggressive. These were the major factors motivating the operation of the mind in his topographic model. They continue to be considered important but not the only motivating factors by modern psychoanalysts.

libidinal wishes Wishes infused with affectionate or sexual urges thought to be ubiquitous in human functioning.

libido The hypothetical psychic energy attached to the sexual instincts.

narcissism Love for the self. Modern-day psychoanalysts use the term primarily to refer to issues of self-esteem. Narcissistic defenses refer to defenses designed to protect or enhance self-esteem, for example.

object relations Refers to relationships to other people. In psychoanalysis, it is the internal representations of self and others that are important in motivating and mediating interpersonal interactions. A developmental distinction is often made between dyadic and triadic object relations. The former refer to relationships modeled on preoedipal experiences where the major goals of the child revolve around need satisfaction by the mother. Triadic relations are seen as more mature, implying oedipal engagement and the increasing mental complexity implicit in being aware of needs and wishes toward one parent vis-á-vis the other parent.

psychic determinism The tenet that all mental acts have meanings and causes. Psychoanalysis assumes that such causes have to do with mental phenomena that preceded the act in question.

resistance The manifestation of defense within the treatment process whereby the patient opposes the analyst's interventions.

transference The process by which the patient displaces onto the therapist or analyst feelings, impulses, attitudes, or defenses derived from important interactions in the past.

Topographic theory refers to Freud's second phase in developing his psychoanalytic model. It lasted from 1897 until he introduced his structural model in 1923. This phase was marked by rapid, significant evolution in psychoanalytic theory and technique. Many key concepts from it continued to inform psychoanalytic theory and practice including drives, unconscious mental functioning, defenses, unconscious conflict, object relations, and narcissism. Dream analysis, the importance of transference and resistance, and the importance of insight in bringing about psychoanalytic cure stem from Freud's interest in delineating the topography of the mind.

I. SEXUAL TRAUMAS

The most decisive clinical finding that led Freud to abandon his previous affect-trauma model and to develop his topographic one was his finding that the sexual traumas remembered by his hysterical patients thought to cause their symptoms had often not happened. He came to this startling conclusion when he realized that every patient blamed her problems on perverse actions of her father. The likelihood of such pervasive sexual abuse seemed too great to accept as Freud gained more experience with his new talking cure. Furthermore, he himself developed similar memories in his self-analysis. Yet he knew definitively that such actions had not truly happened. These realizations left Freud with the problem of how to account for the existence of such false memories as seemingly a part of the human condition. Puzzling over this problem, he realized that such memories were actually fantasies, fantasies from which he deduced the existence of sexual drives. The concept of defense was brought in to explain the patient's distortion of fantasies into memories. Thus was born the notion of intrapsychic conflict.

II. TOPOGRAPHIC THEORY

But Freud went far beyond the concepts of unconscious libidinal fantasies conflicting with defenses as he tried to understand a host of normal and pathological human characteristics during this stage of his thinking. In order to explain dreams, jokes, slips of the tongue, various types of psychopathology, and aspects of clinical technique he found it necessary to map out the terrain or topography of the mind. His topographic theory differentiated areas of the mind and mental characteristics according to their relationship to consciousness. A spatial metaphor of proceeding from the depths to the surface of the mind was used. Three regions or systems in the mind were delineated: (1) the system Unconscious; (2) the system Preconscious; and (3) the system Conscious. The mental contents of the system Unconscious, instinctual drives and wishes, were thought to be continually pushing to be discharged into the system Conscious. But the unpleasant affects anticipated were they allowed to emerge into consciousness gave rise to defenses that attempted to maintain them in the system Unconscious or to distort their expression so that only partial and disguised discharge was allowed into the system Conscious. This model of mental functioning, thought to give rise to the neurotic symptoms that Freud treated in his patients, led to the technical dictum of that era—make the unconscious conscious. Thus, Freud advocated that analysts impart insight of their patients' unconscious mental contents, and that this insight would lead to symptom relief.

The spatial metaphor that Freud relied on during this stage of his thinking was most clearly delineated in the seventh chapter of the *Interpretation of Dreams,* which he published in 1900. The model of the mind as composed of three systems or regions that he constructed was based on the concept of the reflex arc. This model held that mental contents had to proceed from the system Unconscious through the system Preconscious before becoming accessible to conscious awareness in the system Conscious. Each of these systems or regions of the mind had distinct characteristics, all of which combined to make mental functioning highly complex. Boundaries were thought to exist between each system, although the rigidity of the boundaries varied. When the mind was in a state of equilibrium or harmony, the boundaries between the regions were thought to be vague, but the dividing lines became quite defined during episodes of conflict.

III. SYSTEM UNCONSCIOUS

The system Unconscious was the most important system in this model. Indeed, the idea of unconscious mental functioning remains central to psychoanalytic understanding of normal and abnormal behavior to this day despite the concept of the system Unconscious having been eliminated. The idea that all behavior and psychological functioning have unconscious determinants remains central to psychoanalysis. Joseph Sandler and his colleagues have pointed out that this hypothesis assumes that the greatest portion of the mind operates outside conscious awareness. It follows from the assumption that most psychological adaptation occurs unconsciously. The principle of psychic determinism, so important in psychoanalytic theory, applies to unconscious mental functions and contents as well as conscious ones.

Perhaps the most noteworthy aspect of the system Unconscious are the contents that Freud thought it contained—the instinctual drives. The overall structure of the mind during this stage in his thinking was thought to occur so that instinctual drives from the system Unconscious could be controlled and expressed in a way that took into account both external reality and the need to allow drive gratification, albeit in disguised

and attenuated forms. These contents of the system Unconscious were emphasized to play a dominant role in the individual's development and ultimate psychological functioning. Freud described the concept of instinctual drives as "a concept on the frontier between the mental and the somatic" in his 1915 paper, *Instincts and Their Vicissitudes*. He seemed to see the concept as a mental representation of somatic stimuli. Initially he emphasized only libidinal drives although aggression in the form of the death instinct was eventually added to psychoanalytic theory later in his life. But the aggressive drive has never been formulated as clearly as the libidinal one despite the indisputable importance of aggressive impulses in mental functioning.

Four components of the libidinal drive were described by Freud. The first was the pressure of the drive, by which he meant the degree to which it pressed for discharge. Freud was struck by the peremptory quality of libidinal urges; they seemed to exert a degree of pressure to act far more compelling than most other human urges. The aim of the instinctual drive was satisfaction. Satisfaction could only be obtained at the source of the instinct. The source referred to the part of the body from which the instinct was thought to derive. Oral impulses, for example, derived from the oral cavity and so could only be satisfied at that source. Finally the object of the drive is that person or object through which satisfaction is obtained. These objects can be part of one's own body. The wide range of perversity known to the human condition demonstrates how variable this component of instinctual drives can be.

The system Unconscious was postulated by Freud to be characterized by a number of unique processes. Perhaps the most important was what he called the primary process in contradistinction to the secondary process, which he saw as characterizing the systems Preconscious and Conscious. Underlying this concept of the primary process was Freud's economic model wherein he believed that a special form of energy, psychic energy, contributed to all mental functioning. Freud believed that the energy in the system Unconscious was freely mobile so that instinctual energy could shift between separate ideas, parts of ideas, memories, and so on, without consideration of logic or time. Thus, ideas could be combined or shifted in ways that the conscious mind would be unable to understand or accept. As a result unconscious thinking is often characterized by displacement or condensation. The former allows one idea to stand for another in the system Unconscious whereas the latter involved a fusing of two ideas that might not be logically compatible. These two primary process mechanisms—displacement and condensation—are what made dream analysis so complicated and interesting a task for Freud. In order to make the unconscious conscious, the analyst needed to decipher the unconscious mental contents that were disguised by these two primary process mechanisms.

Other unique characteristics of the system Unconscious were also described by Freud. Thus, he described its timeless nature. Temporal considerations were thought to be irrelevant in this system. Furthermore, it operated on the basis of the pleasure principle with no regard for reality constraints or logic. No distinction between memories of real or imagined experiences occurred in the system Unconscious. Furthermore, contradiction did not exist nor did negation. In this way opposites could be experienced as identical in the system Unconscious. Finally words (symbols) and that which they symbolized were experienced as identical in this system according to Freud.

IV. SYSTEM PRECONSCIOUS

The second deepest system or region of the mind according to Freud was the system Preconscious. It was defined as lying between the systems Unconscious and Conscious with its major task being to protect the system Conscious from being inundated by the instinctual drives of the system Unconscious. Freud's topographic model hypothesized that the system Preconscious developed gradually from the influence of both unconscious instinctual wishes and external reality. Over the course of childhood it was thought to become increasingly differentiated from the systems Unconscious and Conscious. Helping in this differentiation was the development of defenses that Freud first called censorship and later repression in this stage of his model development. Thus, the system Preconscious formed a censorship at its boundary with the system Unconscious in order to prevent the instinctual wishes from gaining direct access to the system Conscious. It is important to note that this defensive or censoring function of the system Preconscious was thought to operate unconsciously. But this type of unconscious was descriptive in nature, in contrast to the dynamically unconscious contents of the system Unconscious. That is, functions and contents in the system Preconscious were said to be capable of becoming conscious were attention directed at them. In contrast, the contents and functions of the system Unconscious are actively maintained as unconscious by the energic force (counter

cathexis) that the preconscious censorship directs against them. This distinction between descriptively and dynamically unconscious content and functions remains relevant today.

Unlike the system Unconscious's operation according to the pleasure principle, the system Preconscious was postulated to adhere to the reality principle. Thus, the unconscious wishes that it allowed to pass through into the system Conscious were closely examined and modified to ensure that they would facilitate the individual's self-preservative needs and could be integrated with the individual's moral–ethical ideals. Secondary process thinking characterized the system Preconscious in order to ensure these adaptational needs also. Causality, logic, and temporality characterize the secondary process wherein language becomes the most important vehicle for harnessing the instinctual drives. The psychic energy assumed to characterize secondary process thinking was described as bound energy by Freud. Sandler and his colleagues have emphasized the multiple and complex functions the system Preconscious was thought to include: (1) unconscious scanning of thoughts and feeling states; (2) censoring of instinctual wishes and their derivatives; (3) formation of organized memory systems; (4) reality testing; (5) binding of psychic energy; (6) control of access to consciousness and motility; (7) affect modulation and development; (8) defensive functioning; (9) fantasy production; and (10) symptom formation.

V. SYSTEM CONSCIOUS

Freud described the system Conscious as being on the mind's surface. Unlike the two deeper regions, its contents were all conscious. Nonetheless the limitations of attention prevented all contents from being the focus of conscious attention at any one time. This system received input from both the system Preconscious and from stimuli of the external world. Thus, its contents were described as sliding back easily into the system Preconscious when conscious attention was completely removed from them. Accordingly, conscious contents are more fleeting than contents of the other systems. Self-preservation requires that the individual always be open to new perceptual experiences. Thus, attention cathexis was thought to be an important part of this system. It was described as based on psychic energy that had been neutralized of sexual or aggressive qualities. Otherwise the system Conscious was similar to the system Preconscious in its underlying structure. The reality principle dominated as did secondary process functioning.

VI. IMPORTANCE OF TOPOGRAPHIC MODEL

The topographic model remains important theoretically because all of Freud's papers on clinical technique were written during this stage in his thinking. Thus, it has continued to exert a prominent influence on psychoanalytic technique despite having been replaced with the structural model in 1923. Paying attention to transference and resistance, studying dreams as the royal road to the unconscious, and interpreting the unconscious content inherent in transference and resistance manifestations came to characterize the psychoanalytic process during this era. As mentioned above, the major curative factor was thought to involve making the unconscious conscious. These technical prescriptions are likely to still sound accurate to many today despite being based on an outdated theoretical model. In fact, Paul Gray has lamented what he calls a developmental lag in the psychoanalytic theory of technique wherein analysts have been slow to realize that the technical implications of the structural model call for a very different technique than that described earlier. Working in a typographic manner leads analysts to interpret unconscious mental content without analyzing the defenses that keep such content unconscious. This approach ignores the need to understand the motives for the defense. Failure to do so renders the patient vulnerable to maintaining these defenses. Also, interpretations that ignore defense can increase the patient's anxiety and, hence, resistance. Gray and his adherents have delineated the different technical implications of the structural model. Nonetheless, many contemporary analysts practice in a topographically informed manner without realizing that they are doing so or that such ways of working are outdated. Thus, it remains important to understand the topographic model as it may be some time before it becomes no longer used.

Furthermore, aspects of the topographic model remain important, even to those analysts whose theoretical understanding has been updated. Certainly the distinction between unconscious and conscious phenomena remains clinically relevant, as does the concept of psychic conflict. Unconscious, preconscious, and conscious are now used as adjectives describing mental processes and not as nouns depicting regions of the mind. The topographic concepts of instinctual drives also remain relevant. These concepts have been revised in an at-

tempt to make them more scientifically viable. Furthermore, psychoanalysts have expanded the number of motivational factors that impel human behavior beyond sexual and aggressive impulses. Nonetheless, sexual and aggressive wishes remain quite important clinically and need to be addressed and analyzed in psychoanalytic treatment.

A major contribution of the topographic model not discussed earlier, but one that is quite important on the modern-day psychoanalytic scene, is that of object relations. The idea that individuals build up a subjective world of mental representations of self and important others, and that this representational world is a crucial component of the psyche is explicit in almost every variant of psychoanalytic theory adhered to today. Recognition of this fact has led analysts to a new acceptance of the inevitability of countertransference enactments. Such enactments are now thought to provide useful understanding about the patient rather than indicating psychopathology in the analyst or therapist. Object relations models have led to new ideas about what is curative in psychoanalytic treatment and to new technical prescriptions including the judicious use of self-disclosure on the part of the treater.

Many fail to recognize that Freud's key papers, *On Narcissism* and *Mourning and Melancholia,* written at the height of his topographic thinking, contain the seeds of all subsequent object relations models. Both these papers involve his explicit delineation of the importance of object relations in understanding psychopathology and in deriving treatment strategies. In those papers he laid out the importance of developing representational boundaries between self and other as well as the role of internalization in giving rise to important emotional states. Thus, the topographic model continues to exert a modern influence.

Joseph Sandler, one of the most prominent psychoanalytic thinkers of the last four decades, has argued for a more direct viability of the topographic model, albeit in a modified form. He believed that the transition from the topographic to the structural model left gaps and inconsistencies in conceptual understanding and in clinical technique; he believed that these could be overcome by a modification of the topographic model—what he called the three box model. He used this three box model to highlight the necessity for conceptualizing a second censor between the second and the third box or system of the mind. This censor gives the second box or system depth, acknowledging the clinical reality that unconscious ego activities have a range of closeness to consciousness. Even more important, this second system or box is oriented to the present, not to the past. It creates current unconscious fantasies and thoughts as ways of maintaining psychic equilibrium and helping to defend against the infantile, peremptory, and potentially disruptive fantasies of the first box as they push toward actualization.

The second censorship occurring between the second and third systems attempts to avoid shame, embarrassment, and humiliation. In essence it is a narcissistic defense. The contents of the third box are surface or conscious expressions of second system thoughts, impulses, wishes, and fantasies. Sandler believed that the technical importance of this model is to distinguish between the past Unconscious of the first box and the present Unconscious of the second. It is the present Unconscious content that lies behind the second censorship and is closest to consciousness. Sandler believed that his model would help analysts to avoid the topographic era strategy of interpreting deep or past unconscious content before having dealt with less deep, present unconscious content. He advocated that the analyst listen for current unconscious content that was being censored. Thus, his modification of the topographic model is an attempt to deal with the same sort of technical problems as that of contemporary structural theorists such as Paul Gray or Fred Busch. Their approaches are currently gaining greater acceptance than Sandler's three box model. Nonetheless, his efforts do highlight the continued attraction of topographic theory to many contemporary psychoanalytic practitioners.

See Also the Following Articles

Intrapsychic Conflict ■ Object Relations Psychotherapy ■ Oedipus Complex ■ Structural Theory ■ Transference ■ Neurosis ■ Unconsious, The

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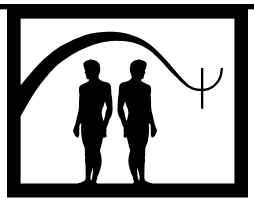

Transcultural Psychotherapy

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GLOSSARY

culture-bound-syndrome (CBS) Term coined by P.-M. Yap (1967/1974) as pertaining to only locally spread diseases in opposition to current psychiatric diagnoses. Today they are seen as strongly culturally influenced diseases, finding their explanatory roots in folk medical beliefs. Examples include koro/suoyang, paleng, amok, latah, susto, brain-fag, and ogba nje.

emic Culture-specific understanding; research by an insider; emphasized by the new cross-cultural psychiatry, comparing cultural aspects (e.g., A. Kleinman, B.J. Good, R. Littlewood, M. Lipsedge).

ethnopsychoanalysis Term, first used by G. Devereux in 1972, for a kind of work initiated by G. Róheim in 1932 and continued separately by P. Parin, G. Parin-Matthèy, and F. Morgenthaler in 1963. According to Devereux psychological and sociocultural explanations must be used separately. Modern interpretations of his ideas are controversial.

ethnopsychiatry Study of psychiatric diseases in other cultures. The term was first used by Devereux around 1950. He saw one of its tasks as being to create a culturally neutral psychotherapy.

etic Useful for global generalizations; a culture transcending view, as opposed to emic; research by an outsider.

immigrants first generation—5 phases Initially (1) the preparation for and (2) the act of migration. Communication barriers because of language problems are predominant. Overcoming many psychological problems by excessive effort, that is, (3) overcompensation occurs. However, this can have a negative impact, and (4) decompensation, occurs, especially on retirement. (5) Adaptation takes more than one generation.

immigrants second generation Mostly well-spoken new language, frequently hiding the problem of different meanings and losing their parents' language. Torn between traditional values of the family and place of origin and modern values of the new surrounding.

immigrants third and later generations On the surface mostly well adapted if belonging to a more educated social class, but—often unconsciously—still influenced by the family's cultural heritage. If belonging to a lower social class, they still might have difficulties in learning the new language sufficiently, while also not learning their original language well enough.

interpreters Should be neutral persons, not family members, trained in being translators without commentaries or cotherapeutic interventions.

qigong A therapeutic combination of movement, breathing, and hovering awareness as one example of therapeutic methods in traditional Chinese medicine (in addition to herbs, acupuncture, etc.). Many traditional medicines are used in diagnosis and treatment by their respective immigrants, often without mentioning it. Their traditional explanations of their disease might play an important role in Western psychotherapy.

shaman A traditional healer, found in most traditional cultures. He uses altered states of consciousness (ASC) if he is a real initiated healer.

transcultural psychotherapy (a) Using traditional methods from other cultures in Western psychotherapy. (b) Concerning all the sociocultural problems involved in the psychotherapeutic treatment of immigrants or refugees, deriving from the encounter of the two (or more) respective cultures. Often an interpreter is necessary.

I. INTRODUCTION

Mental health services rely not only on the physical body but also on the psyche, brain, mind, and soul. The body itself with its different physical afflictions, diagnoses, and treatments is viewed quite differently depending on the cultural context, according to Payer in 1996. Mental problems and sociocultural factors are so closely interrelated that they cannot be viewed separately, as discussed by Westen in 1996. With an ever-growing worldwide multiculturalism, it is imperative to integrate the results of international research. This concerns all theories of psychoanalytic, behavioral, humanistic, and other psychodynamic counseling and psychotherapy. To improve our understanding of transcultural psychotherapy I will introduce historical perspectives. Some of the main factors to be considered are aspects of migration and transcultural contexts. Short case studies, each emphasizing a particular facet, will illustrate this point.

II. THE HISTORICAL PERSPECTIVE

The foundation of transcultural psychotherapy is based on Middle European psychiatry. Known and unknown variations of familiar "mental illnesses" were discovered in distant and "exotic" countries. The scientific founders were Van Brero, who worked in the 1890s, and Emil Kraepelin in 1904. Their comparative psychiatric works dealt with mental disorders in Indonesia. Bronislaw Malinowski's work in 1924 on *Mother-Dominated Family and Oedipus Complex* represented a milestone in which he refuted Sigmund Freud's hypothesis on the general validity of the Oedipus complex by recording his observations on the Trobriand tribe in the Pacific. He was able to show that the complexes arising within the family core were a consequence of the social structure of the tribe or people. Nevertheless, he recognized the significance of Freud's attribution to the influence of the early childhood years. In 1957 Erik H. Erikson followed with his studies on *Childhood and Society,* a comparison between the North American Indian Yurok and Sioux tribes. Margaret Mead did her research with a scientific and objective point of view and described the customs and traditions of different races. In 1959 Mead introduced *Gender and Temperament in Primitive Societies* and was primarily interested in how children were raised within these societies. She was known as a representative of "Culture-Gestalt-Psychology," and her results are considered controversial.

Paul Parin, Golda Parin-Matthey, and Fritz Morgenthaler investigated African cultures according to psychoanalytical criteria. In the 1950s Georges Devereux coined the expression "ethnopsychiatry," and in 1972 he published the book *Ethnopsychoanalysis.* According to his ethnological studies, stress is traumatic when, within the respective culture, defense mechanisms are absent. He understood culture as a system of defense mechanisms. In 1982 he stated that shamans were mentally disturbed. The fact that in 1996, Asian shamans and African medicine men were invited to speak at the first World Congress of the "World Council for Psychotherapy," in Vienna, shows that today this situation is seen quite differently. Devereux's aim in 1970 was "the introduction of teaching and practice of cultural neutral psychotherapy," as described in 1982. This kind of psychotherapy should not be based on the attributes of any particular culture, but should be "comparable to affective neutral psychoanalytical therapy." Since this originated only in Devereux's culture, it is actually a contradiction in itself.

Jeanne Favret-Saada, a psychoanalyst and ethnologist like Devereux, introduced epochal standards to her field of research by participating in conversations and witchcraft ceremonials with the natives. These "natives" were not even "exotics" but a rural group of people from the western part of France. Favret-Saada allowed herself to become personally involved, and in doing so, pioneered a new scientific approach. Thus, in 1977, she added a third method of research. In 1966, R. Pike derived the already familiar "etic" approach, from linguistics, to be applied to ethnology. This meant gaining more culture-general information from scientific studies, in contrary to the rather culture-specific "emic" approach, which enabled a better understanding of the cultural aspects from the natives' point of view. Favret-Saada, as an insider among these "natives," was able to put herself into the position of examining the culture from both points of view, changing dialectically from inside to outside. These aspects were also considered by psychiatrists such as Christian Scharfetter, who, in 1987, published the book

Ethnopsychotherapy. His ideas were based on his own experiences with the Theravada-Buddhism method of meditation, and many discussions concerning altered states of consciousness (ASC). Thomas Heise used a similar method. He studied traditional Chinese medicine (TCM) for more than 2 years in China, and, in 1996, published the book *China's Medicine in Germany,* which also covered a broader view of "psychiatric-psychotherapeutic" aspects of TCM. Another book by Heise, published in 1999, dealt with *qigong* in the People's Republic of China, its historical development, theory, and practice. Michael Harner in 1972, 1973, and 1980 and Roger Walsh in 1990 also based their scientific books about shamanism and healing on their own experiences and participation. Similarly, Stanislaw Grof, in his works since the 1970s, investigated many traditional therapies in order to find common roots. He made the workings of the various subconscious layers and ASC more intelligible and understandable.

Eric Wittkower, Wolfgang Jilek, and Louisa Jilek-Aall influenced transcultural psychiatry in many ways. Wittkower in 1978 described its aim as the "identification of quantitative and qualitative differences when comparing mental illnesses in the various cultures, the investigation to determine these differences and the application of this knowledge for the treatment and prevention of mental illnesses." In 1980 he was concerned with the cultural and transcultural aspects of psychotherapy. On the one hand he placed emphasis on the introduction of foreign cultural methods to the West, such as yoga and Buddhist meditation, and on the other hand, on the use of Western psychotherapy outside the Western culture complex.

Based on his experiences in Taiwan in 1980, Arthur Kleinmann did research on the way in which cultural symbols and meaning influence the perception and expression of symptoms and therapeutic mechanisms. In 1985, he emphasized the theme in *Culture and Depression.* Wolfgang Pfeiffer concentrated on the analysis of dialogue and migration problems as well as on the contact between various medical systems. Having lived in Indonesia, he dealt in particular with those of Asia. His first work, *Transcultural Psychiatry,* published in 1971 and revised in 1994, is a phenomenological collection of culturally influenced expressions, corresponding to the various psychiatric groups of diagnoses. Erich Wulff, who worked in South Vietnam for 7 years, studied the methods of comparative psychiatry, and emphasized the social requirements for these methods, and thus their historical significance and subjectivity. Karl Peltzer, who spent many years researching in different parts of Africa, supported these ideas and coined the expression "postanalytical ethnopsychological research." In 1994 he published *Psychology and Health in African Cultures: Examples of Ethnopsychotherapeutic Practice.*

On the whole we can see in the historical development of transcultural understanding a start with a rather Eurocentric and limited approach. Scientists looked for the well known in foreign countries. The second step showed a deeper involvement into different cultures, but no change of scientific ideology, which only began with the third step. Here the dialectical switch between subjective involvement during field research and more objective scientific evaluation gave rise to new ideas. These are not limited to pure psychoanalytical or behavioral thinking and are more sincerely tolerant and humanistic, grounded on interdisciplinary cultural studies.

III. MIGRATION

Another pragmatically important topic concerns immigrants. They arrive for different reasons in historically varying waves, and experience specific stages of more or less successful adaptations to their problems. In Germany, for example, early research on the mentally related illnesses of foreign workers *(Gastarbeiter)* at the end of the 1970s was abandoned and thereafter temporarily forgotten. Other countries with a colonial or immigrant history were confronted with this problem to a greater degree. In the past two decades, in England and the United States, this has led to a growing literature on counseling. These perspectives on counseling apply to therapy as well. In past years the geriatric ailments of the "foreign workers" in Germany, the second and third generation of immigrants, and the increasing inflow of new immigrants and political refugees produced an escalation of problems in mental health and psychotherapy. It was found that for refugees suffering from posttraumatic stress disorder (PTSD) it is of utmost importance to assess the preflight personality, the circumstances that caused the flight, its conditions, and coping abilities. Around 20 years ago, *Counseling Across Cultures* was published by Paul. B. Pederson and colleagues. It deals not only with the specific ethnic groups in North America, but also with international students and refugees, gender conflicts, ethics, and cultural empathy. In 1989, Patricia D'Ardenne and Aruna Mahtani published the book *Transcultural Counselling in Action,* which demonstrated practical aspects of the transcultural therapist–patient relationship. That same year, Colleen Ward issued the volume *Altered States of Consciousness and Mental Health: A Cross-Cultural Perspective. Handbook of Multicultural Counseling* by Joseph G. Ponterotto

and co-workers discusses theoretical and practical statements. A book series on multicultural counseling covers themes such as *Preventing Prejudice* by Ponterotto, *Improving Intercultural Interaction* by Richard Brislin and Tomoko Yoshida, *Assessing and Treating Culturally Diverse Clients* by Freddy Paniagua, *Overcoming Unintentional Racism in Counseling and Therapy* by Charles Ridley, and *Multicultural Counseling with Teenage Fathers* by Mark Kiselica. Colin Lago and Joyce Thompson compiled the book *Race, Culture and Counseling* and Suman Fernando published *Mental Health in a Multi-Ethnic Society.* The latter two books deal particularly with the problems of biological and cultural racism and the different, often multiprofessional management of inpatient and outpatient institutions for the care of mentally disturbed foreign citizens.

One prominent French author, Tobie Nathan, published such works as *The Madness of Others: An Essay on Clinical Transcultural Psychiatry* in 1986, and *The Influence That Cures* in 1994. Initially, he held the opinion that the ethnopsychoanalytical background was of prime importance. Later, however, he changed his mind and stated that patients could also be healed using the therapeutic means of their respective cultures. In 1998, Marie Rose Moro, who worked especially with immigrant children emphasizing the aspect of family therapy, published a book on these topics. In the Netherlands, in 1996, Joop De Jong developed, among other things, a handbook on transcultural psychiatry and psychotherapy. A number of German books show, by their titles alone, that there are numerous problems in the search for better solutions: Heribert Kentenich, Peter Reeg, and Karl-Heinz Wehkamp, 1990, *Between Two Cultures: Why Does a Foreigner Become Ill?;* Horacio Riquelme, 1992, *Other Realities—Other Approaches;* Eckhardt Koch, Metin Özek, and Wolfgang M. Pfeiffer, 1995, *Psychology and Pathology of Immigration: German-Turkish Perspectives;* Peter Möhring and Roland Apsel, 1995, *Intercultural Psychoanalytical Therapy;* Jürgen Collatz, Ramazan Salman, Eckhardt Koch, and Wielant Machleidt, 1997, *The Medical Report with Special Emphasis on Transcultural Issues: Quality Safeguarding of Social-Legal and Social-Medical Reports for Working Immigrants in Germany;* Thomas Heise, 1998, *Transcultural Psychotherapy: Helping to Treat Foreign Citizens;* and Heise, 2000, *The Situation of Transcultural Counseling, Psychotherapy and Psychiatry in Germany.*

Traumatization can occur as a result of ethnic, religious, sexual, or economic pursuit, if the preflight personality cannot cope. These differences must be taken into account when determining therapy, which varies for immigrants in the various generations. Each subjective reality is based on the individual's identity, perceptions, and experiences. Neglecting its relation to culture, diagnosis may be inadequate, the patient does not feel accepted personally, and therapy is likely to fail. For evaluating the five phases of migration (see Glossary) important issues include reflecting on the cultural influence of one's own behavior; being able to investigate another person's cultural background, if necessary with interpreters; reflecting on one's own prejudices and the cultural and historical relativity of values; understanding each other sufficiently; and being able to find acceptable solutions in a multicultural teamwork. According to Sluzki in 1996, the therapist must help the migrant to prepare to accept times of feeling lonely, to encourage him or her to learn the new language and new customs as quickly as possible, to get as much new information as necessary, and in order not to lose continuity, to remain in contact with compatriots and enhance the personal environment with pictures from the past or other symbols.

IV. TRANSCULTURAL CONTEXTS

There are many cultural barriers to communication and we are only aware of some of them. Less evident are attitudes toward one another; nonverbal behavior; customs and traditions of greeting and meeting; personal theories of communication; political differences; fear, perception, and expectations of one another; systems of belief and ethics; view of personal and institutional power; notions of acceptable and unacceptable behavior; patterns of interpersonal relationships; ways of learning, working, and living; and views of illness and disease as well as of therapy regarding meaning for oneself and others. In 1980 Geert Hofstede determined some main criteria in 40 different nations and distinguished between small and large "power distance" (the acceptance of the distribution of power in society), weak and strong "uncertainty avoidance," collectivist and individualist, and feminine and masculine dimensions.

In approaching different philosophical assumptions, as Lago and Thompson showed in 1996, general views of the world will be compared.

The Western system emphasizes a material ontology, appropriating a high value to the acquisition of objects. External knowledge derived from counting and measuring is assumed to be the basis of all knowledge. The logic of this conceptual system is dichotomous (either–or), like the basis of computer technology and other technological processes that are repeatable and reproducible. In consequence, identity and self-worth tend to be based on external criteria, such as status symbols.

In the Asian conceptual system, the ontology of a cosmic unity, as taught in Buddhism, Taoism, Shintoism, and Hinduism, is of the highest value, emphasizing the cohesiveness of the group and traditionally the interplay with nature. Thus the Asian logic does not separate the body, mind, or spirit. Harmony is necessary to make the internal and external cosmos, in their interrelatedness, a balanced model of unity. In consequence identity and self-worth are based on being and an internal and external reality.

The African system emphasizes both a spiritual and a material ontology, valuing above all the interpersonal relationship between women and men. Self-knowledge is assumed to be the basis of all knowledge. One acquires knowledge through symbolic imagery and rhythm. The logic is based on co-unity, and through this process, everything in time and space is interrelated through human and spiritual networks. In consequence identity and self-worth are intrinsic.

For the sake of brevity, these views of the world indicating such tendencies may seem somewhat simplistic. Transcultural psychotherapy should try to be aware of these different processes, cosmologies, and values and their consequences.

V. APPLIED TRANSCULTURAL PSYCHOTHERAPY

According to findings by Fernando in 1996, ethnic minorities are more often diagnosed as schizophrenic, compulsorily detained under the Mental Health Act, given high doses of medication, and not referred to psychotherapy. A research survey conducted on behalf of the Royal College of Psychiatrists in 1991 and reported by Lago and Collins in 1996, showed that 85% of the 2000 respondents believed that depression was caused by life events and that psychotherapy, not antidepressants, was the most appropriate form of assistance. A study by Bebbington and colleagues of 297 randomly selected women demonstrated a significant excess of marked life events in acute cases of psychiatric disorders (50%) compared to chronic cases (16.7%) and noncases (27.9%). The effect of chronic social difficulties was even more pronounced (33.3%) than, and independent of, the effects of life events. Here psychotherapy would be helpful.

We should keep in mind that we must not be intimidated by this subject, since a good education in psychotherapy equips one with all the tools necessary and can be effectively applied here. One must simply be more eager, more neutral and tolerant, more open minded and more empathetic, and display these attitudes in various ways. Patients want our help and will give us every possible assistance, if asked for, in understanding them in their cultural background. Let us use their cultural expertise by asking "What does this mean to you?" If they do not speak our language fluently, a neutral interpreter is needed and not an emotionally involved family member. If after the translating job we ask the interpreter separately for some commentaries, most of them will recognize our interest and be glad to help us. In order to broaden this point of view I will provide additional important aspects followed by short case histories, in full reported by Heise in 1998.

The term transcultural psychotherapy contains two aspects that are expressed in the prefix "trans." The monocultural aspect of illness should be trans-cended with regard to the diagnosis and also to the manifestation of the illness itself as a dis-ease. This kind of mental illness may arise in certain individuals as a result of the encounter of two different cultures. This fact must be taken into account in an empathetic and unprejudiced manner. A neutral attitude toward affect and culture and feigned objectivity as shown in the classic psychoanalysis with its rules of abstinence is not adequate.

In medical reports and testimonies the pathogenetic and therapeutic differences between political refugees with either acute depressive decompensation or posttraumatic stress disorders are of great importance. The task of the physician, as sometimes opposed to that of official authorities, may be challenging in the case of foreigners.

Case History 1: Pathogenetic and Therapeutic Differences between Two Kurdish Refugees with Acute Depressive Decompensation

A young Kurdish patient, accompanied by his father and older brother, was brought for examination. He suffered persistent abdominal pain and had already undergone unsuccessful surgery. The dependence on his family, who after 3 years were still awaiting political asylum, due to predominantly economic reasons, resulted in a conflict with his wish to return to his relatives in Turkey. No inpatient treatment was required for this case. The doctor treating the patient sent a letter recommending that the boy return to Turkey. The second case concerned a Kurdish female from Iraq, an accepted political refugee. Her husband, who as a physician had treated Kurdish rebels, was therefore killed by the Iraq authorities. She, due to administrative and domestic problems, had attempted to kill herself along with her little son. This case required inpatient treatment with client-centered therapy with the help of an interpreter.

The patient received support regarding her social problems, and finally gained enough self-confidence to cope alone with her difficulties. The medical role had to be determined regarding contact between the patient and the authorities for foreign citizens.

Some patients feel bewildered because of the foreign land and people, and have even more problems discussing their difficulties and emotions. Here, the use of guided affective imagery therapy according to Hanscarl Leuner, art therapy, Gestalt-therapy, or bodily oriented methods are helpful to understand, for example, depressive disorders followed by psychosomatic complaints. In addition it helps to introduce the "talking cure."

Case History 2: Guided Affective Imagery Therapy as the Turning Point in the Psychotherapy of a Russian Female with Chronic Reactive Depression

A Russian immigrant came for psychiatric help with acute suicidal thoughts and admitted to suffering from headaches and depression for 2 years. With the help of an interpreter, she was able to build up a sufficient basis of trust during client-centered psychotherapy, according to Carl Rogers, to give an account of her rape incident. She was raped by an unknown person after her arrival in Germany and had not yet summoned the courage to inform her husband of this event. As she had great difficulty in coming to terms with negative feelings or even to speak of them, the guided affective imagery therapy was invoked twice to help her express her feelings and thoughts. Only two themes (flower and mountain) were necessary to give her access to her split feelings. Of particular interest were the specific transference relation, the recalling of the situation, the confrontation with her feelings, the catharsis, and the reaction toward the symbolic image. Talking about the two images helped her to visualize her partnership conflict. After painting them she tried to speak about solutions, first in therapy and later with him.

This procedure proved effective and the patient was then able to relate the whole story to her husband. Finally, she succeeded in improving her newly found verbal abilities so that she was able to carry out a constructive discussion with her husband concerning their relationship, and also to take part with him in partner discussions. She was seen in the outpatient clinic for 8 more months. In these partner discussions her resistance to "talk" started again. The therapist introduced breathing and relaxation exercises that the patient could manage with increasing ease. Three months later, she indicated she was ready to take up the discussions once more.

The topic "guilt" brought back the accusation of her husband that she was also guilty as she had not offered enough resistance to her rapist. It then became evident that for the Jewish family of the husband, the topic "guilt" with reference to "why didn't they kill us like the others?", played a major role in association with the persecution of the Jews in Russia.

Before this admission to the psychiatric department, the patient had already experienced three occasions when she had tried to talk about these same problems with Russian-speaking therapists without success. During the first phase of her illness, she was treated by a neurologist in Moscow in order to find the organic reasons for her symptoms. The diagnosis offered was a psycho-vegetative complaint with labile personality traits, while symptoms increased again on the way to Germany. She later consulted a Russian guest doctor (not a psychotherapist or a psychiatrist) and here misunderstandings arose in the communication between him and the doctor treating her for her psychiatric symptoms, most likely due to incorrect translation. Finally, she was treated as an outpatient by a Russian psychiatrist practicing in Germany who, on the one hand, showed a preference to administering medication and, on the other, forgot about the mutual influences of the involved cultures, and never spoke to her without her husband. Therefore, in this part of the therapy, the "trans" cultural element was disregarded. To avoid any similar retraumatizations, transcultural sensibility training should be introduced to medical and, in particular, psychotherapeutic and psychiatric education.

Problems of translation, interpreters, a mono- or bicultural approach, and a change in the therapeutic procedures (verbal – nonverbal) were discussed. This shows that language, ethnicity, and culture are not identical. All conscious or unconscious processes, interactions, and experiences are culture related, family related, and individual related. These can be clarified to make therapy successful.

The diversity of so-called schizophrenic manifestations is transculturally even more obvious. Therefore, diagnosis and therapy must take into account both the individual and the cultural diversity. Other cultures might even present a more adequate way to cope with psychotic experiences. In the delusion of being possessed the understanding of the patient's bio-socio-psycho-spiritual world view is paramount. This, in addition to the application of client-centered psychotherapy according to Carl

Rogers and the inspiration by transpersonal psychology, may prove more helpful in transcultural psychotherapy. An understanding of the cultural "differences" of the patient helps to build up the patient's self-esteem.

Case History 3: A Korean Patient's Delusion of Being Possessed

A Korean priest of a Christian sect was responsible for inflicting a patient of the same nationality with short-term exogenous psychosis by means of a syncretistic atmosphere and deprivation of sleep. This led to an attempted suicide. Mutual trust between patient and doctor was developed by therapeutic intervention according to Roger's client-centered therapy. Further anamnestic details were obtained, particularly in connection with the dead grandmother who was a *mudang* or shaman priestess. Knowledge of the patient's cultural background explained her reaction of feeling possessed by a bad spirit, and we, by showing a neutral respect for this particular culture, including the involved shamanism, presented the patient with a favorable prognosis for successful therapy. The conclusions resulted in a transcultural–transpersonal portrayal for diagnosis and treatment; it became obvious that there were syncretistic factors, but no real shamanistic transformation act or traditional healing process involved.

The second "trans" aspect concerns, on the one hand, the intracultural cooperation between the indigenous medical system of the immigrant and the Western medical system. On the other hand, it deals with intercultural cooperation. This may be in the form of influence or inclusion of aspects and methods from traditional medical systems together with our Western medical system. Some patients have better access to psychotherapeutic measures from other cultures. The use of foreign and archaic instruments in music therapy or therapeutic means from traditional Chinese medicine or Indian ayurvedic or Arab unani-tibb medicine may prove effective.

Case History 4: Treatment of Hallucinatory Psychosis with Complementary *qigong* Exercises

Taiji quan (T'ai Chi Ch'uan) "shadow boxing" and *qigong* (Ch'i Kung) meditative "breathing exercises" are therapeutic methods based on traditional Chinese medicine (TCM), like herbal medicine or acupuncture. There are several forms of exercises, some of which are becoming more popular in the Western sphere. At first glance only the movements bear a vague resemblance to our established forms of gymnastic exercises, but the exercises based on TCM are, in fact, far more advanced. By means of a balanced form of movement according to the *yinyang* concept, the meridians are harmonized and the activated subtle energy *qi* also contributes to balancing the associated functional organic system. According to TCM theory, certain emotions and mental conditions are associated with specific organs, and with the help of these exercises, a psychotherapeutic effect is obtained. It was shown in a recent study by Heise in 2002, that *qigong* reduces in psychosis significantly state anxiety after each session and trait anxiety on the long term (STAI) and depression and psychoticism (SCL-90-R), increases relaxation and ability for enjoyment, helps exhaustion and achievement, and diminishes cenesthesia (case histories).

The 40-year-old patient complained of hearing voices for 4 years. The physical problems in his arms and legs and his headaches had persisted for 3 years and were induced by voices with their lips on his body. He initially tried to block out the voices by "drowning" them with beer, then gave up drinking, and since one year, had only consumed limited amounts of alcohol. The patient could for the first time be convinced of the advantage of persistent high-potency neuroleptics while undergoing day clinic therapy. Organic causes were ruled out and analgesic medication reduced. During the group therapies he demonstrated an aggressive inhibition with withdrawal tendencies on confrontation with conflicts. In addition, he took part in 5 of the above mentioned *qigong* therapy group sessions, and then a further 11 sessions on an outpatient basis following discharge. During day clinic therapy, the patient appeared to be considerably more relaxed, more lively, and more socially active with increasing clarity of mind, and experienced reduced physical pain and fewer headaches with weaker and less aggressive auditory hallucinations. It was noted on *qigong* therapy that even at the beginning he was able to rapidly develop the special "*qi*-feeling." On discharge from the day clinic he reported that immediately after the *qigong,* the voices disappeared for an hour and the headaches became less frequent. He felt an inner calm. Up to the 6th session he admitted to changes in his condition with regard to the voices and the "headaches," showing a slight improvement. The physical pains disappeared completely. He executed these exercises independently twice a week, and continued to do them when followed-up for research purposes 1 month and then 4 months later, as he found they helped to combat the

more aggressive voices, which now appeared about two times each week. He then received his third kind of a typical neuroleptics, and although he was unable to differentiate between these medications, he was aware that they had a certain beneficial effect on his condition, but less so than the *qigong* exercises, which he would practice whenever needed.

In order to deal with ethnocentric feeling and thinking, new solutions are required for the basic points of transcultural psychotherapy. These are not yet statistically validated, but need further investigation in this rather new field of research. Special issues are the question of value and purpose ("honor") regarding self-responsibility and self-realization in different cultures together with its role in psychotherapy. For example, a supervisor of the same foreign culture in an analytically oriented self-experience group for social and medical professionals may help to combat hostility toward foreigners. He reduces defense mechanisms, because he has overcome these troubles himself.

Weekend seminars to discuss crisis intervention with youngsters of the same culture, using the group analytical method, may be effective in reducing violence. Thus underaged refugees may have the opportunity, during this session, to discuss, in an appropriate manner with their peers, their traumatic experiences of leaving their parents and their native culture. Different psychotherapeutic forms such as hypnotherapeutic and cognitive-behavioral therapeutic techniques may be effective, as well as ritual techniques and eye movement desensitization and reprocessing (EMDR) developed by Francine Shapiro and published in 1997, as discussed by Foa and colleagues in 2000 and Sack and co-workers in 2001.

For therapists treating in a foreign country, in their mother tongue, with deep psychological, systemic, and behavioral therapeutic elements, transference–countertransference and the risk of regression are important factors. Sociocultural circumstances influence drinking habits and drug consumption strongly and should not be disregarded in any therapy, according to Lala and Straussner in 2001.

Systemic individual and family therapy (mono- and bicultural) is resource- and solution-oriented by means of esteemed and engaged neutrality combined with respectful curiosity, as discussed by Krause in 1998. In addition to the routine service of psychotherapeutic-sensitive trained interpreters, the patient is also an expert in his culture. This induces a paradigmatic change.

Positive psychotherapy developed by Nossrat Peseschkian in the 1970s is derived from the narrative elements of Middle Eastern fables. This kind of therapy judges bodily feelings, senses, achievements, social contacts, and fantasy regarding future decisions. A comparison of giving life meaning in Eastern and in Western cultures is often added in this transcultural approach, similar to other humanistic psychotherapies.

All of these therapeutic methods concentrate on the way each individual interacts with his or her environment. The respective cultural background is responsible for influencing and molding the senses of perception and sensitivity of each human being. Culture is a term incorporating the material cultural relics and daily customs, everything that language makes "producible," "approachable," and "conceivable." This includes specific conditionable senses of perception (particularly apparent in the Yogis and Masters of the hard *qigong*) and metaphysical experiences, speakable and unspeakable expectations, and constructed models. All of these are attitudes that are more or less "culture-bound," without calling them a "culture-bound-syndrome." However varied the climate and the people they originate from may be, common denominators may remain with regard to the same generation, gender, spirituality, (un-) employment, wish for a better life of one's children, and so on.

All of these points need to be considered within the complete context of therapy—consciously or unconsciously. Certainly it would be more beneficial if this were to happen consciously and thus not uncontrolled. The rationalized, verbalized, and cognitive element has prevailed in the culture of the Western world over the past 2000 years; this is understandable when one reflects on its historical development. However, domination of this kind of thinking must not be accepted to such an overwhelming extent. Therapeutically, it is significant to attempt to discover the other elements in oneself, which one has either never or rarely recognized before, or which have not had the chance to develop properly. A feeling of amazement or astonishment must be produced, which leads to a realigning of the thoughts by thinking twice. This change of "sense(s)" cannot only be achieved by verbal tactics but also by other therapeutic techniques. This change of the senses may give another sense and meaning to living. This initiates a healing process that materializes into the human system and its culturally influenced relationships toward fellow humans and the cosmos, as a whole, in an intrapersonal, interpersonal, and transpersonal way. The therapist is the catalyst of this process, acting as a mediator to promote the self-curing efficacies of the patient.

It is interesting to note what effect this has on therapists, regarding their personal and professional development in relation to their feeling toward their own native culture, when one is constantly identifying with the patients and their foreign cultures, having to distance themselves in the next moment to assume the role of the catalyst once more.

VI. SUMMARY AND OUTLOOK

Many countries are faced with an increase in multiculturally based problems for which not only political but also specific psychotherapeutic solutions must be sought. On the basis of a bio-socio-psycho-spiritual view of humanity, there are two main tasks for "transcultural psychiatry and psychotherapy."

1. Adequate care that is suitably based on the individual and cultural background of mentally disturbed immigrants, along with their family and other close relations, is of prime importance. This should include a necessary and learnable sensitization of the therapist to cultural diversity, complemented by the use of professional interpreters when necessary.
2. With disregard for Americo- and Eurocentrism and school disputes, the vast area of transculturally comparative therapy research is concerned with offering the best forms of therapy to suit the requirements of the patients. Clarification for the culturally diverse self-understanding of mental illnesses in patients from other countries will ensue as a matter of course.

The experiences of many psychotherapeutic measures of other traditions are becoming of increasing interest in the Western world. For thousands of years these methods have demonstrated their value. These may not only be felt bodily but may be also related in language that uses subtle energetic–functional terms (not to be misinterpreted as purely symbolic). Consequently, methods taken from other cultures that influence the psyche are playing a more significant role in an increasingly globalized and multicultural society.

The future of psychotherapy will most likely be submitted to culturally reciprocal influences, which will not only affect the diagnostic criteria and the general attitude of life but also expectations regarding psychotherapy. Discussions in China have shown that Western forms of psychotherapy are gradually becoming better known and accepted; however, many Chinese emphatically believe that the use of Western methods in conjunction with their own methods and thinking will bring about some changes in Western psychotherapeutic procedures in China. In 1993, Louis Yang-ching Cheng, Fanny Cheung, and Char-Nie Chen described these mutual influences regarding practice in Hong Kong and for Chinese people in general. Sylvester Ntomchukwu Madu, Peter Baguma, and Alfred Pritz reported in 1996 the same relating to Africa. We must recognize that one culture can offer its therapeutic methods to other cultures, as discussed by Xudong in 2001 and Peseschkian in 2001. But it is up to each individual culture to decide what to accept, what to alter, and what to refuse.

See Also the Following Articles

Bioethics ■ Cultural Issues ■ Multicultural Therapy ■ Race and Human Diversity

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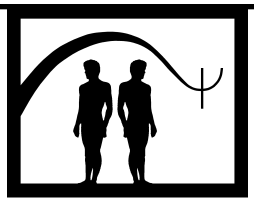

Transference

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GLOSSARY

personality Characteristic attitudes and behavioral reaction patterns based on temperament and experience.

resistance Unconscious defenses to psychoanalytic treatment or to the transference. Resistance is a term for defenses that are used against the treatment process or against the transference.

transference The transfer of feelings about childhood relationships onto the experience of the relationship with the analyst.

transference resistance Unconscious blocks to experiencing the development of the transference; defenses against the transference.

I. INTRODUCTION

Transference refers to feelings the patient has for the analyst. The term transference was first used by Freud to refer to the neurotic feelings that were displaced or transferred from formative relationships in the patient's childhood. Transference is of crucial importance to psychoanalytic treatment because transference reactions help bring into consciousness the content and organization of the patient's unconscious self and object representations, and can dramatically demonstrate the effect of constituent conflicts, defenses, and compromises. Transference is the patient's experience in the present that comes closest to those formative relationships from the past.

As psychoanalysis widened its purview beyond mental symptoms to include the analysis of personalty, the definition of transference was broadened to include all feelings the patient had for the psychoanalyst. This broadened definition included emotional reactions in the here and now that are basic to personality function.

II. HISTORY

The term transference was first used by Sigmund Freud, who discovered the phenomena in the course of his earliest treatments. He at first felt these transference reactions prevented easy and thorough reports of the emotional associations to symptoms connected to the patient's history. Seen perhaps most clearly in fears about a judgmental attitude in the analyst, Freud thought such transference anxieties could block the treatment by inhibiting a full report of symptoms and

associations. Therefore Freud at first felt that transferences were resistances to the treatment and were to be confronted by the psychoanalyst and consciously overridden by the patient. Later, Freud realized that these transference resistances were unconscious and were characteristic of the patient's personality defenses and adaptations. They displayed important aspects of the patient's symptoms. Freud further realized that the transference resistances often encoded and expressed the same themes as the patient's illness.

III. FUNCTION

Freud therefore began to focus on the transference and discovered that as the transference was allowed to intensify, the pathological attitudes and conflicts central to personality defenses rose to conscious intensity. This emotional intensity gave an experience of emotional validity to the treatment that was invaluable. Patients could see the emotional truth in their conflicts and compromise formations. Freud saw there was often little else that encoded so directly, so consistently, and so intensely these basic personality conflicts and compromise adaptations. When these compromise formations are part of personality attitude, the transference and personality disorder coincide. Analysis therefore more and more focused on transference, which became a hallmark of psychoanalytic treatment.

IV. TYPES

The emotional content of transference material may vary. The dominant theme of the content of the emotional transference is then used as a label to catagorize different types of transference reactions.

The maternal transference involves the emotional experience of the analyst as a mothering figure. Conflicts about dependancy needs and frustration, usually mobilizing intense conflicts between aggression and tender care, comprise the typical conflicts of this type of transference. Often associated with the personality features of the primary mothering figure, together with the child's reaction to the maternal personality, the two combine to form the projections onto the analyst, and the reactions to these projections, that form the maternal transference.

There is a similar transference possible to issues of authority and competition, often with fears of punishment. This type of material may be associated with the patient's early experiences of the father's personality. They condense together with the patient's personality reactions and the inevitable conflicts of growth and development. Together these form the projections onto the analyst, and the reactions to those projections, that are classically labeled the paternal transference.

Of course, sibling transferences (typically of competition and aggression), grandparent transferences (typically of tender care and an absence of competition), as well as transferences from other important figures during the patient's formative years are not only possible but probable.

Transferences may also be categorized according to the dominant emotional reaction. Erotic transferences involve sexual content irrespective of the formative figure involved. Aggressive transferences involve the emotional experience of anger. Idealizing transferences involve the projection of perfection. Denigrating transferences are the projection of feelings of devaluation.

Combinations of transferences are more the rule than the exception. The particular combinations are not just mixtures but highly specific condensations that reveal basic emotional compromise formations achieved in an attempt at emotional adaptation to constituent conflicts.

Because of these strong basic emotions and their combinations, containing the transference reaction both to the treatment setting and to the capacity of the patient to experience and describe rather than enact, the analyst must take great care in both the nurturing and containing of these reactions. The method of nurturing involves interpretation of resistances to the transference and the method of containing involves interpretation of the effects of the transference intensities. This is basic to psychoanalytic technique.

One of the most intense, most difficult to manage, and potentially destructive forms of transference and transference neurosis is the negative therapeutive reaction. In this form of transference, intense negative feelings are focused either on the analyst, the patient, or both as a result of the psychoanalytic treatment. Paradoxically, the reaction happens when things seem to be going well in the treatment. The negative therapeutive reaction is a reaction to accurate interpretation by the analyst, which then triggers an intense aggressive and guilt response. The danger is that the treatment may break off before the opportunity to thoroughly analyze the triggering factors, the constituents, and the destructive compromises inherent in the negative therapeutive reaction. The destructive nature of this reaction is often operating unconsciously at a lesser intensity throughout the patient's life and experience of themselves. It is one reason for life stalemate, life failure, chronic unhappiness, and self-destructive behavior.

V. TRANSFERENCE NEUROSIS

The focus on transference manifestations led Freud to the discovery of the transference neurosis. In the transference neurosis, the entire range of the patient's personality and neurosis is displayed in the psychoanalytic treatment relationship, and focused on the analyst and the treatment. This intense emotional involvement of the patient with the analyst and with the analytic treatment can reveal in great detail the emotional conflict elements and their psychopathological compromises. The analysis of the transference neurosis may take up the better part of the middle phase of psychoanalytic treatment.

Crucial to the use of the transference neurosis is the ability to catalyze its engagement, to manage its intensity, to analyze and interpret its meaning, to progressively unfold its developmental layers, and to show its relevance to the patient's symptoms and personality dysfunctions. It is for this reason especially that psychoanalytic training is long, arduous, and involves personal analysis for the practitioner.

Becuase transference is such a direct and felt experience, psychoanalytic technique attempts to bring it to an optimal level of intensity. This is why patients in analysis are seen many times per week and use the couch. Frequent sessions allow the intensity to build. Use of the couch helps because normal social interaction may dilute transference emotional reactions with reality representations or with reality experiences. Placing the patient out of sight of the analyst and reducing social interaction can increase the intensity, and therefore the consciousness of the transference.

Transference occurs as a part of all relationships but is not necessarily as consistently intense, nor verbalized, nor are its antecedents studied in an attempt to change. The transference neurosis can emerge in psychoanalytic treatment because the analyst is skilled at managing intensity. The analytic setting provides a safe setting because of the dependability, confidentiality, and lack of any agenda in the analyst other than the care of the patient.

VI. PHASES OF TRANSFERENCE

The different phases of psychoanalytic treatment can be defined in relationship to the transference. In the first phase, the transference is beginning to be catalyzed and engaged through the analysis of resistances to the transference. In the middle phase the transference neurosis forms, intensifies, progresses, and is analyzed. During the middle phase a deeper understanding of the transference and its origin occurs. During this phase, the insights from the analysis of the transference neurosis are applied to the patient's problems and pathological personality adaptations and these applications are worked through. The termination phase of analysis is the phase of resolution of the transference neurosis. During this phase, because of gains made in the analysis that resulted in psychological change, the neurotic transference reaches a kind of emotional conclusion. It then becomes less intense and disengages from the reality person of the analyst.

VII. USE IN PSYCHOTHERAPY

Transference is also triggered and used in psychodynamic psychotherapy. Although the focus may not be consistently on this level of the work with the patient, emotional reactions in and to treatment are used by the therapist to understand patients' reactions to people and problems that are the focus of treatment. The transference is thus a textbook of the patient's personality reactions to be read carefully by the analyst and analyzed thoroughly in psychoanalysis. Although not necessarily analyzed so thoroughly with the patient in psychodynamic psychotherapy, the transference is as crucial to the treating psychotherapist as it is to the psychoanalyst. The problem may be that because the psychotherapy is less intense, the exact nature of the transference is unclear. However, even in less intense or briefer treatments, the transference may be strong enough to reveal itself at least partially. Even this is useful to the treating analyst, who applies the information to understanding the patient's problems even if the transference is not usually the primary focus of psychodynamic psychotherapy.

VIII. APPLICATIONS OF TRANSFERENCE

Transference is important in all medical treatment. Emotional reactions may help or impede any form of helping relationship. In medical treatments, the most common cause of noncompliance to medication is an emotional problem in the doctor–patient relationship. In psychopharmacology treatments, patients may resist their medication because of emotional relationships they have either with the treating doctor or with the medication itself. The sophisticated psychopharmacologist understands these transference reactions and interprets especially the patient's attitudes toward medication.

Psychopharmacologists psychologically sophisticated in this way achieve better compliance with medication regimens and therefore better outcomes. Likewise, the sophisticated cognitive-behavioral therapist is attuned to even nascent transference reactions to the treatment or to themselves. This is especially so where either the reactions are negative resistances to the treatment or where the reactions are so idealizing that they imply the power of change is in the therapist rather than in the patient. Cognitive-behavioral therapists are adept at either sidestepping such transferences or including the attitudes as targets for their treatment. Their treatment aims at giving patients more conscious control over aspects of these attitudes that interfere with their treatment and support their symptoms.

The role of transference in all medical care is so powerful because illness tends to trigger emotional regression in patients, as does the setting of care in which trust and hope are to be vested in someone else, a dependency situation most like early childhood. Because of its application to medical care, to teaching, to social services, and even to institutions, the concept of transference is perhaps Freud's widest contribution.

IX. SUMMARY

All schools of psychoanalysis make use of transference. Ego psychology uses it to understand mental structure, its constituent conflicts, and compromises. Object relation theorists use it to understand the contents and functions of object relations. Self psychologists use it to understand the state of empathic attunement. Transference is basic to psychoanalysis.

See Also the Following Articles

Countertransference ■ Free Association ■ Intrapsychic Conflict ■ Resistance ■ Transference ■ Neurosis ■ Unconscious, The

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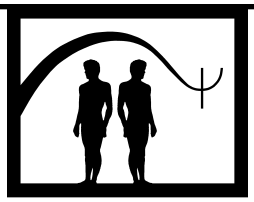

Transference Neurosis

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GLOSSARY

compromise formation Any mental phenomenon that is the product of internal conflict and expresses all components of the conflict.

conflict Opposition between mental forces. These forces can be instinctual or Freud's structures of the mind (id, ego, superego).

countertransference The analyst's feelings toward the patient. Some restrict the term to the analyst's emotional responses to the patient's transference.

defense The methods used by the ego to master and control id impulses or superego injunctions.

ego The hypothetical construct defined in Freud's structural model to enable the mind to organize its various components and to adapt to the external world.

libido The hypothetical psychic energy attached to the sexual instincts.

psychic energy Freud believed there was a quantifiable mental energy, similar to physical energy, that fueled the activity of the mind. Two major types of psychic energy were postulated-sexual energy (libido) and aggressive energy.

repression The particular defense mechanism of the ego by which a conflictual mental content or process is rendered unconscious.

resistance The manifestation of defense within the treatment process whereby the patient opposes the analyst's interventions.

structural model Freud's final model of the mind introduced in 1923 in *The Ego and the Id.* The mind was conceived of having three structures (the id, ego, and superego). Interaction between these three structures is thought to account for all mentally mediated behavior.

topographic Freud's earlier model of the mind in which its systems were defined in terms of their accessibility to consciousness. Despite the topographic model having to be discarded because of its theoretical inconsistencies and clinical failings the term *topographic* remains useful for describing mental contents and functions in regard to their degree of consciousness.

transference The process by which the patient displaces onto the therapist or analyst feelings, impulses, attitudes, or defense derived from important interactions in the past.

The phenomenon of transference neurosis is arguably the most important (and perhaps most controversial) concept in the psychoanalytic theory of technique. For almost 50 years its presence or absence has been used to determine whether a psychoanalytic treatment process is, in effect, true psychoanalysis or whether it is psychoanalytic psychotherapy. Merton Gill, in 1954, was one of the earliest psychoanalysts to differentiate psychoanalysis from psychotherapy based on whether or not the patient had developed a regressive transference neurosis in the treatment that could be resolved by interpretation. Leo

Stone, another prominent analyst of that era, concurred with Gill. But by the time of Gill's death, Gill, himself, as well as others had repudiated both his definition of transference neurosis and its centrality to the analytic process.

I. FREUD'S CONCEPT OF TRANSFERENCE

Understanding this reversal and arriving at an adequate modern-day understanding of both the concept and its role require that one study its origins in Freud's thinking. As with most of Freud's other technical concepts, the term transference neurosis predates the introduction of his structural model. Hence the concept was never reformulated or adequately integrated into Freud's new manner of thinking, leading to inconsistences and ambiguities that continued to affect how the concept is used today. Freud first introduced the concept of transference in *Studies in Hysteria* when he discussed the "false connection" between feelings arising outside the treatment situation and those directed toward the therapist. That is, he recognized that feelings and thoughts originally experienced in regard to significant figures in the patient's life, usually from childhood, were displaced onto the analyst. Soon transference was viewed as a displacement of libidinal ties into the treatment situation.

In his *Introductory Lectures,* Freud introduced the concept of transference neurosis as a diagnostic category that included both hysterical and obsessional neuroses. Such transference neuroses were thought to be the most amenable to a successful psychoanalytic treatment because patients suffering from them were able to form a relationship with the analyst and to be influenced by their transference to the treater. Patients suffering from transference neuroses were differentiated from those suffering from narcissistic neuroses (paranoids, melancholics, and schizophrenics). Freud thought that the latter group had no capacity for a transference relationship with the therapist and, therefore, was incapable of being helped by psychoanalytic treatment.

Earlier in his thinking Freud had first understood transference as a resistance to the remembering of the past. At that stage in the evolution of his theory and technique, such resistance was quite important given that psychoanalytic cure was thought to occur when the patient was made aware of previously unconscious mental contents, usually sexual fantasies from the past. By 1912, however, Freud raised the analysis of transference to the forefront of analytic technique. He described the transference neurosis as the replacement of the patient's clinical neurosis with an artificial neurosis "through which the patient could then be cured through the therapeutic work" in his 1914 paper, *Remembering, Repeating, and Working Through.*

The transference neurosis was described as the creation of an intermediate region between illness and real life. This newly created condition was said to contain all of the conflicts or elements of the clinical neurosis, making them amenable to therapeutic intervention. In essence, Freud came to understand the transference neurosis as a phenomenon in which the libido shifted from the original object(s) and associated internal conflicts into the transference where it became concentrated on the analyst. The original conflicts were then experienced with emotional immediacy in the relationship with the analyst. The analyst could then analyze these conflicts in a context of intense affectivity that allowed their historical or unconscious roots to become evident. Fresh repression was avoided, and the freed up psychic energy then became available to the patient's ego.

II. GREENSON'S CONCEPT OF TRANSFERENCE NEUROSIS

This understanding of the transference neurosis held sway in American psychoanalysis into the early 1970s. It was given the greatest legitimacy by Ralph Greenson, arguably the greatest clinical analyst of his era, in his tome, *The Technique and Practice of Psychoanalysis.* Greenson made it clear that he viewed the development of a transference neurosis to be a central dimension of the psychoanalytic process. He described its phenomenology as involving an increase in the intensity and duration of the patient's preoccupation with the analyst and the analytic process. This intensified interest in the analyst is usually experienced by the patient as a mixture of love and hate as well as defenses against these emotional reactions triggered by anxiety and guilt. Reactions to the analyst were described as varying. They could be intense, explosive, subtle, or chronic; such constellations of affects become omnipresent once the transference neurosis takes hold. As the patient's preoccupation intensifies, his or her symptoms and instinctual demands revolve around the analyst while simultaneously remobilizing all the old neurotic conflicts. The transference neurosis, therefore, was described by Greenson as a repetition of the patient's past neurosis.

Greenson argued that the classical psychoanalytic attitude toward the transference neurosis must be to foster its development. The analyst has to safeguard the analysis to allow the best opportunity for a transference

neurosis to develop. According to Greenson, contaminations or intrusions into the analytic space, such as the analyst's personal characteristics or values, can inhibit or limit the development of the transference neurosis. Thus, they must be avoided. He took pains to warn that the analyst's countertransference could impede the development of a transference neurosis. For example, undue warmth was thought to risk inhibiting the patient's hostile transference whereas incomplete transference interpretations could produce a treatment stalemate.

III. LEGITIMACY CONTROVERSY

By 1987, however, the phenomenon of transference neurosis was being called into question on a variety of grounds. An entire issue of the journal *Psychoanalytic Inquiry* was devoted to the question of its legitimacy—hence the title of that issue, "Transference Neurosis, Evolution or Obsolescence." Arnold Cooper was perhaps the harshest critic of the concept among the contributors to that volume. He argued that using the occurrence of a transference neurosis to differentiate psychoanalysis from other therapies left psychoanalysis in a difficult position because of the lack of precision in both the definition and the phenomenological recognition of the transference neurosis. Highlighting the term's conceptual ambiguity, he pointed out that those analysts who argued that the transference neurosis involved a heightened emotional experience of the analyst were at odds with Freud who had emphasized that the transference neurosis should be manifested more in memory than in enactment in the analytic situation. Cooper also quoted the writings of the early British analyst, Edward Glover, who had emphasized that transference neuroses developed only with regard to certain types of patients, generally those suffering from phobic, conversion, or obsessional symptoms. Thus, Glover did not see the occurrence of a transference neurosis as a differentiating factor for a psychoanalytic process.

Cooper also criticized the notion that the transference neurosis recapitulates the infantile neurosis. He pointed out the vagueness in defining the concept of the infantile neurosis. Some use the term to refer to the hypothetical childhood neurosis that presumably predated the adult one; others use the term to indicate oedipally based conflicts, while still others define it as concrete, observable, childhood, neurotic symptoms. To the extent that this concept is used in vague or inconsistent ways, it becomes impossible to describe the transference neurosis as a reactivation of it in any coherent fashion.

The connection between the concept of the transference neurosis and the infantile neurosis has also led to debate about the degree to which the transference neurosis is a regressive phenomenon. By the mid 1970s, some analysts, most notably Jacob Arlow, had argued that it was a fallacy to consider the analytic process and the activation of a transference neurosis as regressive. Rather than promoting regression, Arlow argued that the analytic situation created a context in which regressive aspects of the patient's mind could emerge in a clearly observable fashion. Merton Gill extended this view while pointing out that the transference neurosis did not involve the revival of the infantile neurosis. He challenged the entire thesis that an earlier developmental state could literally be reactivated. Rather, he believed that earlier developmental experiences that exert an active influence on present-day behavior did so because they remained active in the patient's personality. As such, he argued that such active influences would be manifested in patients' transferences to the analyst.

Such a position leads into another area of unclarity about the definition of transference neurosis. Traditionally, the concept of transference neurosis has been distinguished from the concept of transference. As mentioned earlier, the former concept has been used to distinguish a psychoanalytic process from a merely psychotherapeutic one in which many transferences develop. The latter are more fluctuating, less organized, and less intense than the sort of full-fledged transference neurosis described by Greenson. However by 1984, Gill was taking issue with this distinction. Thus, he argued that the reason for the more intense transference neurosis was not the difference in the type of treatment process involved. He believed, rather, that it was the analyst's failure to interpret earlier manifestations of transference in the treatment process that led to transferences intensifying to the point where they could not be ignored by the analyst. Thus, this sort of transference neurosis was thought by him to be a sign of poor technique, not of psychoanalytic process. For Gill there was no important clinical distinction between transference and transference neurosis. Instead he argued for early and consistent interpretation of the transference wherever it might be ferreted out in the patient's associations. Gill's technical strategy for transference interpretation has remained a minority view in psychoanalysis although his disinclination to distinguish transference from transference neurosis continues to be embraced by a number of psychoanalysts.

Charles Brenner is another prominent psychoanalyst who criticized the concept of transference neurosis. He argued, similarly to Gill, that there was nothing to be

gained theoretically or clinically by distinguishing transference neurosis from transference. Brenner argued that the term *transference* was sufficient, and that transference manifestations were compromise formations that needed to be analyzed in the same manner as any other compromise formation.

Despite these debates about the nature of the transference neurosis and its role in psychoanalytic technique, the concept continues to be valued by most theorists of analytic technique. Both editors of the *Psychoanalytic Inquiry* issue devoted to the topic concluded that transference neurosis remains a useful clinical concept and one that distinguishes psychoanalysis from psychotherapy. Nathaniel London was probably the most eloquent on the subject. He argued that the distinction between transference and transference neurosis is complex and significant, that the emergence of a transference neurosis does distinguish a psychoanalytic from a psychotherapeutic process, and that those analyses in which a full-fledged transference neurosis fails to emerge are more limited in their clinical results.

These conclusions leave psychoanalysts with the problem of defining the transference neurosis and accounting for successful clinical analyses in which one has not been manifested. A modern view is that the latter problem rests on the former. That is, many contemporary analysts believe that the apparent lack of a transference neurosis reflects a problematic definition rather than an actual failure to develop one. Too many psychoanalysts continue to think of a transference neurosis in the way that Freud did when he developed the concept. That is, it is defined as a displacement of childhood libidinal and aggressive wishes or fantasies from the parents onto the analyst in a particularly organized and emotionally intense fashion. But this definition arose from the topographic era of Freud's thinking when unconscious impulses were viewed as the explanation of most psychopathology and personality traits. The advent of the structural model in 1923 offered a more complex way of understanding transference (and, hence, transference neurosis). Freud, himself, never integrated his concepts of transference or transference neurosis with his structural model. Thus, many analysts continued to think of these concepts in a topographic manner without realizing it.

IV. STRUCTURAL BASIS

Anna Freud, in her 1936 volume, *The Ego and the Mechanisms of Defense,* offered a structurally based understanding of transference. She discussed three types of transference. It is her transference of defense that is most appropriate to a modern-day understanding. This type of transference involves the patient's projecting or externalizing significant aspects of his or her defensive structure into the analytic situation, particularly the relationship with the analyst. Thus, patients who are reported not to develop a full-fledged transference neurosis generally are found, with closer scrutiny, to be using a variation of transference of defense. Rather than displacing unconscious drive impulses onto the analyst, they externalize their defensive structure into the analytic situation and relationship with the analyst. In these instances, the defensive structure generally involves prominent defenses against feeling or becoming aware of strong emotions toward others. The apparent absence of a transference neurosis is, in actuality, an intense one whereby the analyst is treated with the same emotional detachment and/or fearfulness that characterize the patient's relationships with most important objects in his or her world, including internal representations of the parents. Thus, analysis of the transference neurosis with such patients involves the consistent confrontation, exploration, and interpretation of their distancing defenses and the reasons for them. Such work is generally quite productive but requires significant activity on the part of the analyst. Nonetheless, working in this fashion generally demonstrates the fallacy of assuming the absence of a transference neurosis and deepens the analytic work in the same way that analyzing the more obvious forms of transference neuroses do.

Those analysts who practice in this manner tend to agree that it is this work—the analysis of the transference neurosis—and all its complexity that allows for the important conflicts that cause the patient's symptoms or personality problems to be experienced and mastered by the patient in an emotionally vivid fashion. The intensity of feeling and firsthand quality of such work allows for conflict mastery far more than other nontransferential elements of the analytic process. Although not scientifically demonstrated, such work does not happen in psychotherapy because the reduced frequency of sessions prevents the emergence of the sort of transference neurosis just described, although certainly transference manifestations do occur and can be worked with in a fashion that is therapeutically useful.

V. SUMMARY

In summary, the concept of transference neurosis continues to be a valuable one in psychoanalysis. It

distinguishes psychoanalysis from other forms of psychotherapy, even psychoanalytic psychotherapy. Analysis of the transference neurosis remains a crucial aspect of the analytic process, one that many continue to view as the most important in promoting mastery of conflict. Thinking in terms of the transference neurosis serves as a useful guideline for the practicing analyst. After a certain point in analysis, most analysts begin to look for the emergence of one and to attempt to understand when one is not apparent. Utilizing a contemporary structural approach to analysis allows psychoanalysts in the latter situation to more carefully observe and listen to the patient's material for evidence of the defensive aspects against deeper feelings toward the analyst, defenses that the analyst brings to the patient's awareness to analyze the reasons that the patient feels it necessary to keep the analyst at such emotional distance.

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Countertransference ■ Intrapsychic Conflict ■ Oedipus Complex ■ Resistance ■ Structural Theory ■ Topographic Theory ■ Transference ■ Unconscious, The

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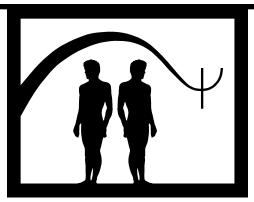

Transitional Objects and Transitional Phenomena

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GLOSSARY

illusion A belief or experience that is based on unconscious material and is experienced as real.

objective External reality, that which is outside the individual and separate from the individual.

subjective Unconscious material such as drives, impulses, wishes, and fears that is particular to the individual and cannot be objectively defined.

transitional object An object, typically a soft toy, chosen by an infant or child. Irreplaceable, the object is imbued with the child's feelings for and experience of his or her primary caretaker. The child uses the transitional object to aid the transition from primary dependence to independence.

transitional phenomena Individual experiences characterized by the interplay of unconscious material and objective reality in forming a novel emotional experience or state.

It is not unusual for parents or caretakers to intuitively allow children the use of some kind of object, oftentimes soft and furry, less frequently hard and with rough edges, that becomes a special kind of beloved possession of the child. Blankets, teddies, things that easily mold to the flesh, that keep a telltale smell, that survive the transition from toddlerhood into latency, ideally serve such a purpose. It is little short of miraculous how adults recognize the life-sustaining urgency of the need for the child to cling to these possessions. Such objects are often named "momma" or some such appellation that implies an understanding that the object is a stand-in for the mother, providing similar soothing and comforting, and herein lies a key paradox of childhood—the child's ability to separate from the mother begins in holding firmly to her, or at least a rendition of her. Thus, the necessary separation from primary caretaker takes place with the assistance of some symbolic object (the transitional object) that provides the continuity of closeness to the primary caretaker.

I. D. W. WINNICOTT

This paradox—that separation can come to exist only in the context of a symbolic continuity—is the sort of recognition D. W. Winnicott set about to explore in his career. A British pediatrician turned psychoanalyst, Winnicott saw thousands of infants and mothers in London during the World War II years, while developing a remarkable oeuvre that remains influential to this day. Never a systematic thinker, his uncoordinated insights into mother–child relations, the inner life of

infants and children, the relations between aggression, security, and creativity—remain the stuff to which many contemporary investigators turn for inspiration and guidance. In this article, the reader will recognize a certain allusive and poetic use of language. This is more Winnicott's than our style, for in order to grasp and communicate what Winnicott was trying to convey, one must remain true to his style of discourse.

II. TRANSITIONAL OBJECTS

In 1951, Winnicott published his classic paper "Transitional Objects and Transitional Phenomena," which investigated the relationship between symbol formation, maternal caregiving, and the development of creativity and, in fact, the mind itself. To Winnicott, the main function of a transitional object is to "start each human being off with what will always be important for them: a neutral area of experience which will not be challenged."

Winnicott provides sufficient material for a thorough understanding of transitional objects and transitional phenomena in his first paper on the topic. He presented these concepts with rich examples from infant observation and analytic work with adults. The topic appears in later articles but is only minimally refined or elaborated there. In the 1951 paper, Winnicott defines transitional objects and transitional phenomena, describes the key concepts, and identifies areas of further exploration, which have been taken up by theorists such as Paulina Kernberg, Arnold Modell, and Peter Giovacchini.

III. WINNICOTT AS THEORETICIAN

It is helpful here to say a bit about Winnicott the theoretician. Strictly speaking, Winnicott was less of a theoretician than he was a pragmatic yet intuitively driven observer. A member of the so-called middle school, his theoretical roots are both Freudian as well as Kleinian, especially in his uncanny understanding of the role of aggression in early mental life. His writings have contributed many fundamental concepts to the body of psychoanalytic thought (for example the good-enough mother, primary maternal preoccupation, the capacity for concern, and hate in the countertransference) which are not so much particular to a comprehensive theory as they are critical to what we might call the experience of being. Fogel explicates this in an article titled "Winnicott's Antitheory" wherein he explains that Winnicott was traditionally analytic in his theoretical beliefs but obviously singular and unique in terms of his distinctive application and elucidation of the concepts that stand alongside traditional theory. Transitional phenomena and objects are good examples of this. Truly grasping what Winnicott meant is crucial in order to undertake clinical work with children or psychoanalytic work with adults yet this knowledge does not necessarily alter in any way one's theoretical foundation. Thus, it is a challenge to fully describe Winnicott's concepts of transitional objects and transitional phenomena. On the one hand, understanding what he was trying to convey makes available an intellectual and, Winnicott would hope, experiential knowledge of self and other that deepens our contact with others. On the other hand, one will not find any particular alteration to one's structural understanding of the individual or technical view of the practice of psychotherapy on the basis of the knowledge.

IV. TRANSITIONAL OBJECTS

A transitional object is an object that is chosen, or, to be more explicit, Winnicott says "created," by the infant and that stands for the breast or object (bottle, caregiver's face) of the first relationship. It is developmentally appropriate, indeed a positive indicator of a healthy maternal–child bond, typically develops first between 6 and 9 months, and lasts often into the preschool years. It is the child's first possession and original "not-me" object. By this, Winnicott means that the child is sufficiently developed to have a growing sense of object permanence and constancy (see Piaget for discussion of object permanence.) Thus, the child is able to conceive of the transitional object's separateness from himself. Object use begins with an infant's use of fist-in-mouth, then thumb, then some mixture of fingers and thumb, and finally the infant moves to the use of an object. There is a gradual progression toward the use of objects that are part of neither the mother nor the infant but represent the shared experiences of both.

Certain features mark the relationship between the transitional object and infant. Perhaps most remarkable is the infant's assumption of possession of the object and the environmental cooperation with that. Caregivers hesitate to wash well-loved transitional objects and households are collectively turned inside out when a transitional object goes missing. The transitional object is "affectionately cuddled" and "excitedly loved

and mutilated." The transitional object possesses a reality and vitality of its own. It is cocreated by the infant's objective perception of the object and his or her subjective projections of relating (in this case, loving and being loved) onto the object.

Winnicott talks of the "fate" of the transitional object in further defining it as well as further illustrating the depth and a particularly unique feature of his theory. Winnicott proposes a "third area" of "existing" or human life, which is where transitional phenomena grow and live. For the purposes of this article, they shall be called the first and second areas, as Winnicott did not name them. The first area is the fundamental reality of individual experience. It is the inner life, intrapsychic world, or "personal psychic world" in Winnicott's words. Here we find the genesis of dreams, hallucinations, and the creative process. The first area of existence is our store of preferences, idiosyncrasies, and "neuroses." The second area is the external world of the individual composed of our relations with others, standards of conscience, and the various roles we fulfill (husband, wife, worker, friend, parent, sibling). Winnicott calls this the "expanding universe which man contracts out of."

Transitional phenomena illustrate the joining of the first and second areas of consciousness, which Winnicott calls the "cultural life of the individual." This third area is the meeting of the objective–subjective, personal–political, internal–external realms of individual experience. Using the example of the teddy bear as transitional object, we see that the teddy is an external object (second area) real to the infant and his extended external reality (parents, siblings, etc.). Yet, the teddy also represents the material of the infant's inner life (first area) to the extent that the teddy is a cuddling, nurturing, soothing, nonretaliatory object of his or her aggression, and a constant reliable feature of his or her existence. The infant has made the teddy with the imbuing of these unconscious features while also, for the first time, using an object outside himself to serve as a receptacle for internalized experiences. It is useful to note here Winnicott's famous phrase that "there is no such thing as a baby." Winnicott's view of infant and mother are as a union, the "nursing couple" and, according to the infant's perceptions, the mother does not exist without him or her; indeed, mother exists because of him or her. With the development of transitional objects, and by implication, the ability to live in the third area, the infant is demonstrating his or her ability to perceive the external world as separate while simultaneously giving away his or her reliance on the unconscious/first area. The use of transitional objects demonstrates the emergence of the baby as separate from his or her primary caretaker.

The transitional object sits in the middle of the continuum between the subjective and objective. It is slowly moved more and more toward the objective as the child grasps reality, develops reality testing, and is confronted with the inevitable frustrations of external reality. Thus, the fate of the transitional object is to "fade away" but never leave. The object loses its importance in the maintenance of and elaboration of unconscious material; other mechanisms such as play, language, and interpersonal interactions serve this function. But, Winnicott argues, we see the vestiges of transitional objects and the vibrancy of transitional phenomena in the human activities of art and the appreciation of creativity and religion.

Winnicott is especially concerned with the ability to symbolize that the use of transitional objects implies. Symbolization implies a broader human activity, interesting to Winnicott, which is the use of illusion. The transitional object simultaneously serves the infant's unconscious life of merger and union and external life of independence and self-reliance.

Here we arrive at another particular element of Winnicott's thought and the aspect of the theory of transitional phenomena that continues to be the focus of theorists and practitioners today.

> From birth and thereafter the human being is concerned with the problem of the relationship between what is objectively perceived and what is subjectively conceived of.… The intermediate area to which I am referring is the area that is allowed to the infant between primary creativity and objective perception based on reality testing. The transitional phenomena represent the early stages of the use of illusion, without which there is no meaning for the human being in the idea of relationship with an object that is perceived by others as external to that being.

V. ILLUSION

Winnicott's exploration of the use of illusion was not without precedent at the time. Freud in 1920 had described his grandson's ability to symbolize his own reality and existence through play when briefly separated from his mother. Muensterberger describes two theorists whose work predates Winnicott's and is clearly in the same vein. Geza Roheim described the activity of filling one's mind with thoughts of the people and relationships we are separated from as the "theory of an

intermediate object as stabilization between a trend that oscillates between clinging and going exploring." The reference here to the "intermediate object" is very similar to Winnicott's term the "intermediate area" and in fact, Roheim is clearly describing a transitional object (i.e., teddy bear) that helps the infant feel grounded enough to explore. Roheim later writes of the transitional phase "located somewhere halfway between the pure pleasure principle and the reality principle." Again, this description is very similar to Winnicott's description of the 1st, 2nd, and transitional areas of human experience. Here, Roheim is referring, in part, to an earlier work by Hermann, called seminal by Muensterberger, which is titled "To Cling—to go in Search." Hermann's view, very similar to Winnicott's, is that the infant requires a link between his or her inner experience and emerging external experience. When the link is concretized, it is a transitional object. The link may also be imaginal (the memory of a connection with a significant other) in which case, the memory lives and is sustained in the transitional area.

VI. THE FUTURE

Winnicott's concepts also provided the framework for generations of future papers. The most important aspect of his paper, in terms of the advancement of the field, is the explication of the transitional phenomena. Green states "It is easy to see that Winnicott has in fact described not so much an object as a space lending itself to the creation of objects." Indeed, after his death his wife Clare described how Winnicott considered this one of his most important achievements and it is evident that transitional phenomena, this area of the experiential field is the groundwork for much of his more important work including primary maternal preoccupation, playing in reality, and the facilitating environment. Describing transitional phenomena is a bit like describing a fog—we can only present the outline of it against the land and sky, note its thinner aspects, and watch its movement and effect. The transitional phenomenon is in fact an experience and one further complicated by its straddling of the objective and subjective experiences of the experiencer.

Winnicott described transitional phenomena as "an intermediate are of experience" and further stated "I am therefore studying the substance of illusion." This is a most remarkable statement for Winnicott to have made. The use of illusion is at the heart of the transitional phenomena. Here, Winnicott draws our attention to the activity of the early infant in perceiving the breast (or substitute) as created by and for him or her by virtue of the good-enough mother's repeated presentation of the breast at the moment the baby requires it—and early on, before the baby "knows" he or she requires. "The mother's adaption to the infant's needs, when good enough, gives the infant the *illusion* that there is an external reality that corresponds to the infant's own capacity to create." Our appreciation of and reliance on illusion is therefore with us from our earliest days. "From birth therefore the human being is concerned with the problem of the relationship between what is objectively perceived and what is subjectively conceived of." Gradually, reality seeps into the infant's sense of omnipotent control of the environment (still perceived as aspects of himself or herself) and the infant is confronted with the reality of the objective world. The good-enough mother allows the gradual impingement of reality, understanding the infant's need to be disappointed and thereby develop reparative capacities. The place where the objective and subjective meet, where our experience is created by the interaction between our subjective material and objective reality remains and is exercised in our appreciation of the arts, practice of religion, and ability to symbolize our daily experience lives. Winnicott called it the "neutral area of experience which will not be challenged." We do not argue with a person who cries during a soulful passage of a cello concerto or who believes in the sacrament of the Eucharist, nor do we argue with the poet who draws meaning from the curve of an arm. Only when an individual requires us to endorse the "objectivity of his subjective phenomena" do we "discern or diagnose madness." It is when a delusional patient asks us to believe a plot involving the FBI and CIA is the true source of his or her pervasive sense of danger, importance, and isolation that we see the bullying imposition of subjective experience in the intermediate/transitional realm of experiencing.

The nature of illusion and the transitional phenomena are important to current theorists for two general reasons. First, theorists who use clinical data to expand theory have advanced the importance of illusion; second, clinicians use theory to understand clinical material. While current theorists are typically psychoanalytic theorists, because Winnicott's theory is best applied to any two individuals conducting a relationship it is widely applicable. Clinically, researchers like Paulina Kernberg use the concept of transitional objects to identify her patients' abilities and frustrations of mediating internal impulses and fantasies while managing

an overwhelming and confusing experience of the external world. Kernberg's most ill patients develop no transitional object use or maintain a transitional object that is cruel, rejecting, and a poor receptacle for feelings of love, hope, and forgiveness. Kernberg uses the theory of transitional objects to further clarify her patients' functioning. Peter Giovachinni in 1987 explicates the use of transitional objects and of transitional phenomena in adult borderline states from a broad clinical, phenomenological perspective. He expands the theory of the transitional object in his consideration of the borderline patient's inability to regulate affect states and adaptively use projection, thereby making impossible the use of a transitional object. Arnold Modell in 1962 detailed the idea that the adult borderline patient lives in an inner world devoid of transitional phenomena, starkly reality bound, with all the attendant harshness and abrasions of the unmitigated reality of life. In all applications, the theory of transitional objects and transitional phenomena is useful in understanding the intra- and interpersonal functioning of an individual.

Theoretically, Green tells us that Winnicott's place is in guiding any analytic work that does not strictly adhere to the tenets of classical analysis. Green states "It seems to me that the only acceptable variations of classical analysis are those whose aim is to facilitate the creation of optimal condition for symbolization." Symbolization is a transitional phenomenon. It is Winnicott's explicit assumption that reality acceptance is a never-ending task and that the intermediate area of experience, illusion, or transitional phenomena (all different names for the same, unchallenged experience) provide relief from the ongoing tension of relating internal and external reality. This experience is what many good therapists attempt to create and sustain for their patients. More precisely, therapists and patients work to cocreate this experience. The intermediate realm of experience is activated in what Winnicott termed "the holding environment," is present in unconditional positive regard, and whatever the orientation, facilitates the therapist's ability to understand his or her patient in a meaningful and intimate, beyond-language way.

Winnicott left a legacy of literature that remains vital, challenging, and inspiring. Moreover, he left detailed insights about what it means to be human, to love, to mourn, to long for, and to hope. His concept of the transitional object is one of his better known contributions. Perhaps teddy bears and blankies appeal to all of us, regardless of age. It would be a underestimation of Winnicott's contribution to characterize his thoughts on transitional phenomena as primarily about soft cuddly toys. He described a realm of experience, never before or since captured with such elegance, wherein we have the capacity to be moved by art, find solace in religion, and use illusion in various ways to adapt and meaningfully mediate one's constant grappling with reality.

In this article, the theory of transitional objects and phenomena was presented. Additional considerations of more current applications of the theory were also presented. It is the authors' hope that the reader has been both awed and bemused by Winnicott.

See Also the Following Articles

Animal-Assisted Therapy ■ Child and Adolescent Psychotherapy: Psychoanalytic Principles ■ Dreams, Use in Psychotherapy ■ Parent–Child Interaction Therapy ■ Primary-Care Behavioral Pediatrics ■ Therapeutic Storytelling with Children and Adolescents

Further Reading

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Trauma Management Therapy

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GLOSSARY

exposure therapy A well-established behavioral treatment for anxiety disorders, it involves exposing individuals to feared thoughts, images, or other stimuli repeatedly and for prolonged periods in the absence of any actual threat until anxiety is reduced via habituation.

habituation A progressive decrease in the vigor of autonomic responses or behavior that may occur with repeated presentations of the eliciting stimulus.

posttraumatic stress disorder An anxiety disorder that may follow traumatic experiences (e.g., combat, physical and sexual assault), which is characterized by symptoms of re-experiencing the trauma (e.g., nightmares, "flashbacks"), emotional numbing and avoidance, and arousal (e.g., insomnia, hypervigilance, anger).

Trauma Management Therapy is a multicomponent behavioral treatment program for chronic combat-related posttraumatic stress disorder (PTSD). It is a comprehensive treatment designed to address all aspects of the clinical syndrome seen in veterans, via a combination of patient education, exposure therapy, social skills training, and relevant homework assignments.

I. DESCRIPTION OF TREATMENT

Trauma Management Therapy (TMT) is a multicomponent behavioral treatment program for chronic PTSD in veterans. It is a comprehensive treatment designed specifically to target various aspects of the clinical syndrome associated with chronic PTSD, particularly reducing emotional and physiological reactivity to traumatic cues, reducing intrusive symptoms and avoidance behavior, improving interpersonal skills and emotion modulation (e.g., anger control), and increasing the range of enjoyable social activities. The program is designed to incorporate exposure therapy, the PTSD psychosocial treatment approach with the most empirical support, with a social skills training component designed specifically for veterans with PTSD. It is a comprehensive treatment designed to address all aspects of the primary clinical syndrome seen in veterans, via a combination of patient education, exposure therapy, social skills training, and relevant homework assignments. It is important to note that this treatment is not merely a combination of exposure and traditional social skills training procedures. Rather, it includes strategies designed to remedy specific difficulties seen in veterans with chronic PTSD, and the particular sequencing and timing of the individual components are

thought to contribute to its overall effectiveness. The major components of TMT are described next.

A. Education

All patients are provided with a general overview of chronic PTSD, including common patterns of expression, issues of diagnosis, comorbidity of other anxiety and Axis I disorders, etiological pathways, and a review of current treatment strategies. This phase is important for ensuring that veterans not only develop a realistic understanding about treatment prognoses, but also an overall positive expectancy regarding the efficacy of behavioral treatment. Finally, this phase is used to educate veterans about the treatment they will be receiving and what will be expected from them regarding their participation in TMT.

B. Exposure Therapy

Individually administered intensive exposure therapy is included as the first active component of TMT, because it has been shown to effectively address the unique features of each patient's fear structure, allowing for a reduction in general anxiety, physiological reactivity, and intrusive symptoms. Patients are exposed imaginally to feared or anxiety-producing stimuli in a prolonged fashion until there is a decrease in fear and anxiety (i.e., until habituation is obtained) within session. Repeated contact with the feared stimulus hastens the habituation process and, with sufficient pairings, the stimulus loses its ability to elicit the fear response. Typically, most veterans with PTSD escape or avoid feared stimuli, which functions to increase the intensity of the fear response. The goal of exposure therapy is to provide prolonged contact with the feared stimuli of sufficient duration that within session habituation occurs. Repeated pairing across a number of days also is important and hastens the habituation process. Fourteen sessions of exposure therapy are administered early in the sequence so that veterans may experience relatively quick relief from acute symptoms of PTSD, enabling them to then concentrate on developing emotional control and improving their social functioning. All sessions are terminated following a 50% reduction in within session reactivity to the traumatic cues, with reactivity monitored physiologically (i.e., heart rate) and/or by patient ratings of subjective distress. Based on our experience with PTSD, and data on behavioral treatment of other anxiety disorders, exposure sessions usually average about 90 min in duration.

C. Programmed Practice

The programmed practice component of TMT is implemented in the final seven individual exposure sessions and is a form of exposure that does not require therapist accompaniment (i.e., it is "homework"), but requires careful planning on the part of the therapist and patient together. Examples of suitable exercises focusing on traumatic combat fears include self-directed imaginal sessions at home, which may serve as an initial step toward *in vivo* activities, such as watching movies (e.g., *Platoon* or *Hamburger Hill*), visiting war memorials or museums, speaking with other veterans or loved ones about war experiences, and visiting airfields or helicopter pads. Experiences should also be devised that require the veteran to engage in other feared activities, the avoidance of which may interfere with quality of life. Examples of suitable activities include social events, shopping, attending movies, eating in a restaurant, etc.

D. Social and Emotional Rehabilitation (SER)

A highly structured group (3–5 people) social skills training component (SER) was developed to target PTSD features that are not improved by exposure therapy only. In other words, interpersonal difficulties, commonly associated with chronic PTSD, such as social anxiety, social withdrawal, excessive anger and hostility, explosive episodes, marital and family conflict are targeted via a number of specific interventions. SER includes instruction, modeling, behavioral rehearsal, feedback, and reinforcement. Following each SER session, veterans are given homework assignments to allow further practice and consolidation of newly acquired skills. A series of symptom-specific strategies were sequenced to build on one another in a cumulative fashion and are designed to serve multiple functions. One purpose is to teach veterans the requisite skill foundation for effective and rewarding social interactions. Patients with PTSD vary widely with respect to basic social skill, but most have room for improvement. In addition to general social skill, the program is divided into four components that target specific areas of dysfunction.

1. Social Environment Awareness

Social environment awareness involves teaching the nuances of when, where, and why to initiate and terminate interpersonal interactions. Veterans are taught the

verbal and nonverbal mechanics of successful social encounters, including identification of appropriate conversation topics, attentional and listening skills, and effective topic transitions.

2. Interpersonal Skills Enhancement

Interpersonal skills enhancement is devoted to teaching how to establish and maintain friendships, appropriate telephone skills, and assertive communication. This component is designed to help patients learn those skills that are necessary to engage in new and diverse social activities to increase their social repertoires and the likelihood that social interactions will become intrinsically rewarding.

3. Anger Management

Anger Management involves teaching veterans how to better manage anger and other intense emotions. It is designed to reduce temper outbursts and the problematic expression of anger. This component is designed to give patients a range of strategies for expressing their anger, problem solving, improving their emotional modulation, communicating assertively with others, so that verbal and physical violence do not continue to disrupt their relationships with others.

4. Veteran's Issues Management

Veteran's Issues Management teaches how to improve communication regarding combat trauma and military issues with nonveterans, to increase the understanding of significant others. In addition, veterans are also taught to identify and challenge negative and dichotomous thinking patterns, which limit their quality of life by reducing their involvement with others.

E. Treatment Implementation

TMT consists of 29 treatment sessions ideally administered over a period of about 17 weeks. Sessions initially occur three times a week through the Exposure phase, then twice a week at the start of SER, and then once a week for the final 10 weeks of the program (see Table 1).

TABLE 1
TMT Session Overview

Week	*Session*	*Format*	*Treatment component*
1	1	Individual	Education
1	2–3	Individual	Exposure
2	4–6	Individual	Exposure
3	7–9	Individual	Exposure + Prog. Practice
4	10–12	Individual	Exposure + Prog. Practice
5	13–15	Individual	Exposure + Prog. Practice
6	16–17	Group	SER: Social Environment Awareness
7	18–19	Group	SER: Interpersonal Skills
8	20	Group	SER: Interpersonal Skills
9	21	Group	SER: Interpersonal Skills
10	22	Group	SER: Interpersonal Skills
11	23	Group	SER: Anger Management
12	24	Group	SER: Anger Management
13	25	Group	SER: Anger Management
14	26	Group	SER: Anger Management
15	27	Group	SER: Veterans' Issues Management
16	28	Group	SER: Veterans' Issues Management
17	29	Group	SER: Veterans' Issues Management

II. THEORETICAL BASES

A. The Clinical Syndrome

In 1980 the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* formally defined and recognized the cluster of acute symptoms often seen in victims of traumatic events (e.g., combat, sexual and physical assault), naming this condition posttraumatic stress disorder (PTSD). It is defined by six basic criteria: (1) the historical antecedent of a traumatic event that involves both actual or threatened death or serious injury, and an intense response of fear, helplessness, or horror; (2) persistently reexperiencing the traumatic event through intrusive memories, dissociative flashbacks, recurrent distressing dreams, and/or psychological or physiological reactivity on exposure to associated cues; (3) the avoidance of stimuli associated with the event, or a numbing of general responsiveness, including efforts to avoid thoughts and feelings related to the trauma, efforts to avoid activities or situations that arouse recollections of the trauma, loss of interest in significant activities, social detachment, and/or reduced affect; (4) the existence of persistent symptoms of increased arousal such as hypervigilance, sleep disturbance, irritability or outbursts of anger, impaired concentration, and/or exaggerated startle response; (5) duration of the disturbance for at least 1 month; and (6) the pervasive effects of the disturbance causing clinically significant

distress or impairment in social, occupational, or other important areas of functioning.

Posttraumatic Stress Disorder is frequently chronic, and many combat veterans still suffer severe symptoms from wars fought 30 (Vietnam) or 50 (WWII) years ago. Epidemiological estimates of PTSD put the current prevalence at as high as 15% and lifetime prevalence as high as 31% for veterans exposed to war zone trauma. Given that over 3 million American soldiers served in the Vietnam war alone, and many more have served in other foreign conflicts, the potential number of veterans currently with PTSD is well above the half-million mark.

Complicating the syndrome is the fact that PTSD is typically accompanied by multiple co-occurring mental disorders, including substance abuse (73–84%), major depression (26–68%), psychotic symptoms (15–40%), and panic attacks (21–34%), among others. Furthermore, chronic PTSD is also associated with a diverse set of symptoms associated with social maladjustment, poor quality of life, sleep disturbance, medical illnesses, and general symptom severity. This includes social avoidance, memory disruption, guilt, anger, social phobia, suicide attempts, and other debilitating behavioral features, such as unemployment, impulsive or violent behavior, and family discord. In fact, it is notable that a majority (69%) of veterans seeking treatment for PTSD within VA specialty clinics seek disability payments for the debilitating occupational impairment they experience. It recently has been documented that the costs associated with PTSD are extremely high and make PTSD one of the costliest mental disorders to society.

Although PTSD symptoms currently are grouped into three primary clusters, symptoms of reexperiencing (nightmares, intrusive memories, "flashbacks") and associated physiological reactivity, are what best distinguish PTSD from other affective or anxiety disorders. Supporting the prominence of autonomic symptoms are data from studies examining physiological responding in people with PTSD. Most notable is the finding of heightened reactivity. In these studies, combat veterans with PTSD have significantly larger blood pressure and heart rate responses during fear-relevant cue exposure than do combat veterans without PTSD.

B. Rationale for Exposure Therapy

Exposure therapy is a well-established behavioral treatment for a wide range of anxiety disorders (e.g., phobias, obsessive–compulsive disorder), which involves exposing individuals to feared thoughts, images, or other stimuli repeatedly and for prolonged periods of time. The rationale for this treatment is based on two-factor theory. As applied to the condition of PTSD, first, stimuli (e.g., combat images or sounds) that were once paired with actual danger and horror in combat now elicit a similar autonomic response (e.g., increased heart rate) and fear. Second, as a result of this fear response, those with PTSD tend to avoid or escape from such stimuli as much as possible. Thus, habituation to the stimuli never occurs, and the maladaptive condition is maintained. Exposure therapy involves exposing individuals to feared stimuli (e.g., combat images or sounds) repeatedly and for prolonged periods in the absence of any actual threat until habituation allows for a progressive decrease in the vigor of autonomic responses (e.g., heart rate). Therefore, anxiety and fear are reduced via habituation. In the case of individuals with PTSD, such exposure is usually accomplished, at least initially, via imaginal procedures, and is often then complimented later by *in vivo,* or "live," exposure experiences.

III. EMPIRICAL STUDIES

A. Treatment of PTSD

There are surprisingly few data available regarding treatment outcome for veterans or civilians with PTSD. To date only a relatively small number of randomized clinical trials of pharmacological and psychotherapeutic treatments have been published. Although a range of psychotherapeutic strategies for chronic PTSD have been suggested, cognitive-behavioral treatments, usually emphasizing various methods of exposure therapy, have been the most carefully studied and show the most promise.

1. Exposure Therapy for PTSD

Among civilians with PTSD, exposure has been found to be efficacious in a number of randomized, controlled trials. Exposure therapy has been found to be superior to stress inoculation training, progressive relaxation, supportive counseling, and wait-list control groups; and it is equally effective as cognitive therapy.

Among veteran samples, intensive exposure has proven partially efficacious for chronic PTSD, although the data are not as strong as for civilians. In an early trial, exposure therapy was compared to a wait-list control group using Vietnam veterans (N = 24). At posttreatment, the exposure group scored significantly lower than the control group on some clinical measures and received lower therapist ratings of startle responses,

memory disturbance, depression, anxiety, irritability, and legal problems. These improvements were maintained at 6-month follow-up. Significant differences were not found for emotional numbing, sleep disturbance, or any measure of social adjustment. In another study, veterans who received both "imaginal flooding" and "standard" treatment were compared to a group of yoked patients who received "standard" treatment only (N = 14). The exposure group showed superior outcome on patient ratings of sleep, nightmares, and intrusive thoughts, but no differences were found for heart rate, and only minimal differences were found for measures of trait anxiety, depression, and violent tendencies. Again, the treatment appears to have been only partially efficacious. Another study included the use of physiological recordings (e.g., heart rate) and self-report inventories to assess outcome in inpatient veterans treated with exposure or individual counseling. Participants receiving exposure showed modestly superior improvement across most psychological and behavioral rating measures, but no significant differences were found between the groups on physiological parameters. Further, regardless of treatment condition, those participants who showed decreased physiological responding were improved on psychological inventories at 3-month follow-up. This suggests that reductions in physiological responding was a critical element of efficacious therapy and might be a predictor of long-term treatment success. Finally, results from two uncontrolled studies support the partial efficacy of exposure for treating PTSD symptoms in veterans.

Data from these studies indicate that exposure therapy helps reduce the hallmark features of chronic PTSD and much of the general anxiety that accompanies it. In fact, according to the consensus statement on PTSD by the International Consensus Group on Depression and Anxiety exposure therapy is the psychotherapy of choice for the disorder. However, exposure does not have a significant effect on the "negative" symptoms of PTSD (e.g., avoidance, social withdrawal, interpersonal difficulties, occupational maladjustment, emotional numbing), nor on certain aspects of emotion management (e.g., anger control). This is because exposure is narrowly focused on anxiety and fear reduction and hence does not address other features of the disorder. Specifically, exposure does not address basic skill deficits, impaired social functioning, unemployment, or anger control problems. In essence, exposure therapy does not address the many problems often associated with any chronic mental disorder. Thus, many scientists have suggested that a behavioral treatment program, targeting specific areas of dysfunction via different behavioral strategies is necessary to address the complex symptoms associated with this condition—hence, the development of Trauma Management Therapy.

2. Trauma Management Therapy

The efficacy of TMT was examined in an open trial with 15 male Vietnam combat veterans with PTSD. The veterans participating in this study had a mean severity rating of 6.09 on the 7-point rating scale of the Clinical Global Impressions scale, indicating that the sample was severely ill. Demographics were as follows: six were African American (40%) and nine were Caucasian (60%). The mean age of the sample was 47.9 (SD = 2.1; range = 44 to 52 years), mean education level was 12.7 (SD = 1.2), 8 (53%) were married, 6 (40%) were employed full-time, 5 (33%) had a prior history of arrests, 7 (47%) had a prior history of psychiatric hospitalization, 7 (47%) received some level of VA disability payments for PTSD prior to treatment, and 11 (73%) currently were seeking disability payments or increases in existing disability payments. Acute psychiatric diagnoses other than PTSD included major depression, panic disorder, social phobia, and obsessive–compulsive disorder. Personality disorder diagnoses included borderline, avoidant, and schizoid. Overall, 15 (100%) were diagnosed with a co-occurring acute psychiatric disorder, and 11 (73%) with a co-occurring personality disorder. The combination of the multiple psychiatric disorders and extreme severity ratings indicate this was a severely ill sample.

Eleven patients were included in the analyses because 4 of the 15 (27%) dropped out during the course of treatment. One veteran discontinued after a few sessions of exposure treatment without giving a reason. The remaining three dropped out after successfully completing the exposure phase and all reported benefiting from the treatment; two of these veterans dropped out because their employment took them to another city, and the other cited transportation problems for not being able to participate in the SER phase.

To summarize the results, significant pre- to post-treatment improvement on most of the outcome variables was noted (see Table 2), suggesting that TMT is a promising treatment for the chronic and multifaceted symptoms associated with combat-related PTSD. Over the course of 4 months significant improvements were made on most critical features of PTSD. Symptom reductions occurred across problematic features of sleep disturbance, nightmares, flashbacks, social withdrawal, heart rate reactivity; significant improvements were

TABLE 2
Pre- and Posttreatment Data for Outcome Variables (*N* = 11)

	Pre-	*Post-*	*t*	*p*
Clinician ratings				
Hamilton Anxiety	33.91 (9.38)	23.26 (4.20)	4.88	.0003***
Clinical Global Impression	6.09 (.70)	4.00 (.78)	6.10	.0001***
Clinician PTSD scale	82.46 (19.23)	65.55 (8.51)	2.77	.0099**
Patient symptom ratings				
Sleep (hours/wk)	30.55 (8.64)	36.09 (8.85)	4.45	.0006***
Nightmares (freq./wk)	9.73 (5.12)	5.55 (3.14)	4.44	.0007***
Flashbacks (freq./wk)	9.00 (5.53)	6.27 (4.65)	2.95	.0073**
Social activities (freq./wk)	.55 (.69)	2.55 (.93)	8.56	.0001***
Physiological reactivity				
Heart rate	89.73 (9.81)	77.00 (8.65)	5.34	.0002***
Self-report inventories				
Social Phobia Difference	94.67 (21.62)	85.00 (20.28)	1.97	.0423*
Beck Depression	28.91 (9.66)	28.64 (8.70)	.14	.4441
Spielberger Anger Scale	34.82 (13.64)	35.82 (10.38)	.40	.3480

* $p < .05$; ** $p < .01$; *** $p < .001$.

noted on clinician ratings of general anxiety, PTSD symptoms, and overall level of functioning.

Because TMT significantly improved patients' social functioning across a number of dimensions, the outcome generally appears to be superior to findings reported for combat veterans in treatment studies using exposure therapy only or other nonexposure treatments. Furthermore, the patients' overall ratings of their treatment indicate that they considered it a credible and positive therapeutic experience, and all but one said that they would encourage other veterans with PTSD to participate in TMT. Although significant improvement was found on many measures, the clinical syndrome was not remediated entirely, which is usually the case even for most "successful" treatments of anxiety disorders and most other severe psychiatric conditions. Nevertheless, overall the new treatment strategy appears to have resulted in broad improvement across the wide symptom spectrum of PTSD in a sample of veterans typical of those in most VA settings.

For purposes of examining component efficacy, assessments were administered after completion of exposure therapy at midtreatment (Session 15), but prior to the commencement of SER. These data indicate that veterans responded with significant improvement after completion of the exposure therapy phase, but only on certain symptoms (e.g., nightmares, flashbacks, physiological reactivity, sleep, and general anxiety). Significant improvement in the frequency of social activities occurred only after the implementation of social skills training, suggesting that this deficiency improved only after specific intervention with the SER component. This validates the need for a broad-based intervention to address the entire PTSD syndrome. Research is pending to extend these results for TMT in randomized, controlled efficacy research.

IV. SUMMARY

Posttraumatic stress disorder (PTSD) is a severe and chronic anxiety disorder that may follow traumatic experiences (e.g., combat, physical and sexual assault). The clinical syndrome is characterized by symptoms of reexperiencing the trauma (e.g., nightmares, "flashbacks"), emotional numbing and avoidance, and arousal (e.g., insomnia, hypervigilance, anger), as well as severe impairment of social functioning. Research shows that intensive exposure therapy helps reduce the hallmark features of chronic PTSD (e.g., symptoms of intrusion, physiological reactivity) and much of the general anxiety that accompanies it and is considered to be the psychosocial treatment of choice. However, exposure therapy does not have a significant effect on the "negative" symptoms of PTSD (e.g., avoidance, social withdrawal, interpersonal difficulties), nor on certain aspects of emotion management (e.g., anger control). Although exposure may reduce maladaptive arousal and fear, it does not address basic skill deficits, impaired relationships, or anger control problems. Trauma Management Therapy

(TMT) is a multicomponent behavioral treatment program for chronic combat-related PTSD designed to address all aspects of the clinical syndrome in veterans. It utilizes a combination of patient education, exposure therapy, social skills training, and relevant homework assignments. Preliminary evidence from an open trial shows that overall TMT appears to result in broad improvement across the wide symptom spectrum of PTSD, including social functioning, in veterans treated within the VA. Research is pending to extend these results for TMT in randomized, controlled efficacy research.

See Also the Following Articles

Exposure *in Vivo* Therapy ■ Grief Therapy ■ Post-Traumatic Stress Disorder ■ Self-Control Therapy

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Unconscious, The

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GLOSSARY

cathexis Freud used this term to refer to changes in direction or quantity of psychic energy. Generally it means interest, attention, or emotional investment.

hermeneutic school This approach to psychoanalysis argues that the psychoanalytic process and theory should be understood as a humanities discipline, not a natural science. Thus, it disregards concepts such as causality to focus on the coherence theory of truth. Criteria such as internal consistency, coherence, comprehensiveness, and therapeutic efficacy are more important than empirical proof.

instinctual drives Freud's two drives, sexual and aggressive, were considered to be the major factors motivating the mind. They continue to be considered important but not the only motivating factors by modern psychoanalysts.

I. INTRODUCTION

The notion that most mental processes occur outside of consciousness and that these unconscious contents and functions exert tremendous influence on virtually all psychologically mediated behavior is perhaps the most central and long-standing of Sigmund Freud's many contributions. Although his definition and understanding of the role of unconscious phenomena have been revised and expanded, every practicing therapist who uses a psychoanalytic or psychodynamic orientation is always considering the role of unconscious psychodynamics in the symptoms and personality traits their patients want to change. Technical strategies for utilizing and working with these unconscious phenomena have evolved, but the basic idea that these phenomena are important and must receive therapeutic scrutiny has stood the test of time.

II. CONCEPT OF THE UNCONSCIOUS

The concept of the Unconscious was described in various sections of *The Interpretation of Dreams,* most notably Chapter 7, by Freud in 1900 as he delineated his topographic model wherein the regions of the mind were defined by their closeness to consciousness. But it was not until 1915 in his paper, "The Unconscious," that Freud elaborated on what he called the system Unconscious in detail. He began that paper by reviewing the justification for the inference of such a system. Thus, he pointed out what psychologists of most theoretical persuasions have come to acknowledge—that is, it is simply untenable to assume that everything that

occurs in mental life can occur in the conscious mind. Even recent cognitive and information processing models acknowledge that the conscious mind can only be aware of a fraction of the contents and processes occurring in mental life. One has only to reflect on daily phenomena such as arriving at one's destination while driving without remembering any details of stopping for traffic lights, making turns, and so on, to be struck by the evidence supporting the occurrence of unconscious mental processes.

Freud also argued that it was conceptually necessary to postulate the existence of an unconscious mind to explain the many gaps in the contents of consciousness (e.g., slips of the tongue, dreams). Such gaps were simply unintelligible using only the information provided by the conscious mind. In fact, many of the books and papers of Freud's topographic stage of thinking (1897–1923) were devoted to demonstrating the unconscious logic of these consciously illogical phenomena. Dreams, slips of the tongue, jokes, and neurotic symptoms were all studied and shown to be comprehensible once one grasped the role of the system Unconscious in their genesis and subsequent maintenance. In fact, Freud was able to argue for the legitimacy of assuming that others also had unconscious minds as he was able to make sense of their previously unintelligible behavior by illuminating its unconscious meanings.

The basic thesis of the topographic model was that the mind was organized into three systems or regions, the systems Unconscious, Preconscious, and Conscious, organized to prevent the contents of the system Unconscious from breaking into and overwhelming the system Conscious so that the individual could continue to attempt to adapt to the constraints of reality while allowing enough discharge of the contents of the Unconscious to avoid excessive frustration, unpleasure, or symptomatology. In essence, the mind's major function was one of maintaining some sort of homeostatic equilibrium between the contents of the Unconscious and the need to behave in the external world in a manner that enhanced the individual's self-preservation.

III. THE DRIVES

What made this task difficult was the nature of the contents of the system Unconscious. Most of its contents were understood by Freud to be instinctual drives—generally libidinal ones. Freud had been driven by clinical necessity to postulate the presence of unconscious sexual drives in 1897 when he realized that the sexual abuse reported by his patients generally involved fantasies and not the actual reality that he had assumed during his previous affect-trauma stage of thinking. These sexual fantasies were theorized to derive from libidinal instincts in the system Unconscious, instincts that had a powerful, peremptory quality, always pushing the individual to discharge his or her accumulated sexual tension in the real world.

But to blindly run amok, seeking gratification of the multiplicity of sexual urges available to humanity, would place the individual at great risk for not surviving. The same could be said for the aggressive instinctual urges that Freud described later in his life. Thus, the mind needed to function so as to keep these libidinal and aggressive contents repressed, that is, in the system Unconscious. Thus, Freud hypothesized the existence of a censor at the boundary between the systems Unconscious and Preconscious. Freud always believed that some form of special energy, what he called psychic energy, provided the means by which the system worked. Each system had its own psychic energy to serve its functions. Explaining how censorship worked in his 1915 paper, he said, "there is a withdrawal of the preconscious cathexis, retention of the unconscious cathexis, or replacement of the preconscious cathexis by an unconscious one." Another form of energic cathexis, what Freud called an anticathexis, was also used to buttress repression. In this way the mind could keep the potentially most self-destructive or unpleasurable instinctual impulses from moving into the system Preconscious, from where they could make their way into the system Conscious. Some discharge of instincts had to be allowed to prevent excessive internal tension from occurring. Discharge generally occurred through the system Preconscious disguising the contents of the Unconscious and depleting them of some intensity before allowing their derivatives to proceed into the system Conscious.

IV. THE ROLE OF PSYCHIC ENERGY

Freud also described the system Unconscious as being organized and functioning in very different ways than the other two systems. In large part these differences were due to the primary process that characterized the system Unconscious. Primary process referred to the earliest, developmentally most immature form of mental activity according to Freud. In many ways it corresponds to what cognitive psychologists call preoperational thinking. Such thinking seeks immediate and complete discharge of drive impulses by attaching psychic energy *(cathexis)* to the visual memory traces of

the object that gratified the drive in the past. Primary process mentation was characterized by the occurrence of both displacement and condensation. Displacement refers to immature thinking whereby one idea within a drive-connected associative network comes to symbolize another idea. Pars pro toto thinking is one example of displacement. For example, the color blond may come to symbolize the person toward whom the drive-wish was directed who had blond hair. Likewise, situations wherein the whole represents a part is another example of displacement. Condensation was the other primary process mechanism described by Freud. In condensation one mental content (idea, memory trace, etc.) can represent several others. For example, the occurrence of a church in someone's dreams might represent at the same time both wishes toward a particular figure who had been religious as well as memories of one's religious training. To account for the fluidity by which primary process thinking operated, Freud introduced the idea that the system Unconscious was characterized by mobile psychic energy that easily shifted from one mental content to another toward the goal of wish fulfillment.

V. CHARACTERISTICS OF THE UNCONSCIOUS

The system Unconscious was also said to operate according to the pleasure principle. Freud described the instinctual wishes that made up the contents of the system Unconscious as peremptory. They were so compelling that he believed they sought pleasurable discharge and the parallel reduction of unpleasurable tension at all costs. Drive stimulation was thought to arouse unpleasurable tension in what Freud called the psychic apparatus, and to push toward consciousness and motility so that satisfaction of the drive-wish could be achieved. As the wish proceeded through the other systems of the mind, its pressure for direct and immediate discharge often aroused conflict, leading the censorship between the systems Unconscious and Preconscious to transform it. If disguised sufficiently, such drive derivatives would pass into the system Conscious and provide instinctual gratification. Otherwise, they would be repressed and maintained in the system Unconscious by the censor. Thus, the contents of the system Unconscious included both the infantile sexual and aggressive drive wishes as well as their repressed derivatives that had originally been allowed into consciousness, but had subsequently aroused enough conflict that they were re-repressed.

As the individual developed, virtually all primitive sexual and aggressive wishes were said to be repressed and capable of conscious expression only after being disguised thoroughly by the system Preconscious. Repression of a drive derivative could occur at any time that it aroused unpleasure, generally in the form of anxiety, in an individual. In this way the system Unconscious was thought by Freud to be constantly changing as new repressions occurred. Strong repressions of drive wishes early on were said to serve as fixation points encouraging later repressions to regress to the fixation point.

The system Unconscious was also described by Freud as having other characteristics that differentiated it from the systems Preconscious and Conscious First it was timeless. Mental content and processes in this system were not affected by the passage of time or the concept of time. This characteristic was necessary to explain the clinical finding that childhood instinctual derivatives continued to play such vivid roles in the psyches of adult patients. Implicit in the concept of the pleasure principle was the notion that reality was disregarded in the Unconscious. This contributed to another special characteristic—the equating of psychic reality with external reality. That is, in the system Unconscious, memories of actual occurrences were treated as no different than imagined experiences. Thus, no reality–fantasy boundary existed. Contradiction was also said not to exist in the system Unconscious. Mutually incompatible ideas could be maintained simultaneously and without conflict because of this. Negation also did not exist in the system Unconscious. Finally words were treated as things in the system Unconscious so that the symbol of a concrete thing was treated as though it were the thing it symbolized.

It is impossible to overstate the importance of the system Unconscious during Freud's topographic era of model building. Treatment was guided by the dictum that the analyst needed to make the Unconscious conscious. Helping the patient to become aware of the unconscious drive wishes that were being repressed was believed to bring about cure, in part, by releasing the psychic energy that had been dammed up, and by alleviating the unpleasant sensation of drive frustration as well by insight. Dreams were described as the royal road to the Unconscious and psychoanalysts were taught to devote particular time and energy to unraveling the disguised unconscious wishes being expressed in the dream. The primary process mechanisms described earlier were of particular importance as knowledge of them became necessary in deciphering the symbolism of the dream.

VI. CONCEPTUAL PROBLEMS

Despite the many technical and theoretical contributions of this era, clinical findings and theoretical inconsistencies led Freud ultimately to replace the topographic model with the structural one and to give up the concept of the system Unconscious. As he gained greater appreciation for the complexity of defensive functioning, particularly the fact that it, too, operated unconsciously, he realized that organizing the mind in terms of its accessibility to consciousness was no longer clinically useful. In essence, he realized that his patients' symptoms and character traits were caused by conflicts between unconscious wishes and unconscious defenses. That is, the conflicting elements were both unconscious. At this point, consciousness or the lack of it ceased to serve a differentiating function. Furthermore, he became increasingly aware of the need to deal clinically with the phenomenon of unconscious guilt. Yet there was no easy way to explain this concept in terms of topography. He needed the construct of a superego, which he described when he replaced the topographic theory with his structural one in *The Ego and the Id* in 1923. From that point, to speak of the Unconscious as a noun became theoretically anachronistic. Today it should be used only as an adjective, describing mental contents or processes that are not conscious. Some analysts fail to grasp this point, however, and still talk of an Unconscious. Unfortunately adhering to an outdated concept often leads to outdated formulations about the process of psychoanalysis or psychotherapy and how it cures.

Nonetheless, unconsciousness remains an important concept. The contents of the system Unconscious—instinctual wishes—are now thought to reside in the id, a mental structure that retains most of the structural characteristics of the system Unconscious, in particular the pleasure principle and the mechanisms of the primary process. But psychoanalytic treatment no longer is geared toward making these contents conscious as a curative approach. The discovery of unconscious defensive functioning as well as unconscious superego prohibitions has led to a therapeutic strategy whereby psychoanalysts make their patients aware of the occurrence of mental conflict as it occurs in their thoughts during treatment sessions. The patient's attention is drawn to the evidence of such conflict and whichever aspect of it is most easily accessible to the patient at any particular time. This work leads to the exploration of unconscious defenses and their motives at one time, the analysis of unconscious superego injunctions or ideals at another time, and the elaboration of unconscious wishes at still another. But the point of the strategy is to expand the ego's awareness of such conflict, its elements, and the motives that cause it so that conscious ego mastery can occur. Drive satisfaction or tension reduction are no longer relevant to analytic cure, although the focus on unconscious features of mental functioning continue to remain important.

VII. THREE BOX MODEL

Joseph Sandler has also introduced what he calls the Three Box Model in which he tries to retain a place for the system Unconscious. In essence, he divides it into a Past Unconscious and a Present Unconscious in an attempt to argue the importance of interpreting the Present Unconscious content over ones from the Past Unconscious. Although most current-day analysts would support this technical dictum to interpret present before past, his theoretical modification has failed to receive widespread support. Other theoretical models, particularly the contemporary structural theories of Paul Gray and Fred Busch, offer similar technical emphases while not falling into the difficulties that describing the Unconscious as a system entail.

VIII. UNCONSCIOUS FANTASY

Another clinical arena in which the phenomenon of unconscious functioning remains salient today is the concept of unconscious fantasy. Freud first introduced the concept in *Formulations on the Two Principles of Mental Functioning* in 1911. He talked of an aspect of thinking that was split off and kept free of reality constraints. Fantasizing or daydreaming continued to operate according to the pleasure principle. Symptoms, dreams, moods, and character traits were all traced to derivatives of unconscious fantasies. Anna Freud, using the structural model, applied the concept of unconscious fantasy to explain defenses such as identification with the aggressor and denial in fantasy. Repressed masturbatory fantasies were shown to disrupt certain ego functions and to distort important object relations.

But it is Jacob Arlow who has brought this concept to current-day prominence while demonstrating its clinical utility. He pointed out that decisive conflicts during an individual's life become organized into a number of stable unconscious fantasies that provide constant stimulation to an individual's mind. In this sense they form a schema through which subjective experiences are perceived, interpreted, and reacted to. Such fantasies are organized hierarchically and group around

drive wishes, allowing for different versions of the fantasy. Arlow described such fantasies as developing early in life, but only with the resolution of the Oedipus complex. These fantasies provide what hermaneutically oriented psychoanalysts have called narratives, giving a plot to the individual's life that organizes his or her multiplicity of experiences into a few consistent and cohesive themes. Needless to say, they are important in maintaining ego identity.

Unconscious fantasies are usually the basis for neurotic symptoms and character traits. Generally the development of these clinical phenomena can be traced to an event that is reminiscent of a persistent unconscious fantasy built around a corresponding traumatic event. But equally as often unconscious fantasies lead to selective perception and responding. It is important to realize that unconscious fantasies involve the contribution of the ego and superego, and not just instinctual wishes from the id. Arlow has shown how fetishism can involve an unconscious fantasy that women have penises, which can fend off castration anxiety. Such a fantasy serves a defensive function.

Arlow has gone on to explain the technical importance of the concept of unconscious fantasy. He explained that the analyst needs to infer the presence of an unconscious fantasy from the patient's associations and to show the patient how its derivatives affect the patient's actions and mental life. An example described by Arlow was a patient who could only perform sexually if he fantasized spanking a woman. Analysis of this fantasy led the patient to realize his need to be in charge and not to see the female genital that made him anxious. Such realization allowed him to be more assertive with his wife and subsequently to have a successful sexual experience with her. Arlow has also said that the analyst's ability to empathize with and to understand the patient requires the ability to allow an unconscious fantasy to be evoked in the analyst that is similar to that of the patient's. Thus, the concept of unconscious fantasy remains another example of the continued importance of the concept of unconscious mental functioning in clinical practice.

It is impossible and technically unwise to ignore unconscious mental functioning when doing psychodynamic psychotherapy or psychoanalysis. Unconscious resistances are both inevitable and problematic if they are not analyzed. They lie at the core of patients described today as treatment resistant. Likewise, becoming aware of unconscious intrapsychic conflict is crucial in expanding the patient's consciousness and mastery of his or her own mind. Thus, unconscious phenomena remain as important as ever in psychodynamically oriented treatment as long as therapists are careful not to think of an Unconscious with the technical implications carried by that outdated concept.

See Also the Following Articles

Intrapsychic Conflict ■ Oedipus Complex ■ Structural Theory ■ Topographic Theory ■ Transference Neurosis

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Vicarious Conditioning

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GLOSSARY

classical conditioning Conditioning that is based on the association of one stimulus with another.

continuous reinforcement schedule A schedule in which reinforcements are given after every response.

coping model A model who initially performs the target behavior imperfectly or hesitantly but becomes better with repetition.

intermittent reinforcement schedule A schedule in which reinforcements are given fewer than once every response, according to a predetermined order. The schedules are fixed interval, variable interval, fixed ratio, and variable ratio.

mastery model A model who performs a target behavior perfectly and without hesitancy from the beginning.

model Someone who performs a target behavior and is reinforced or punished for it under observation.

operant conditioning Conditioning that is based on the reinforcing or punishing consequence of a behavior.

target behavior The behavior to be reinforced (increased in probability) or punished (decreased in probability).

vicarious conditioning Conditioning that occurs by an observer by watching a model perform the target behavior and being reinforced or punished for performing it. Also known as vicarious learning or vicarious reinforcement.

I. DESCRIPTION OF TREATMENT

In vicarious operant conditioning, the observer is exposed to a model who is reinforced or punished for performing a certain behavior. It is important that the model actually be observed being reinforced or punished for performing the behavior, not simply observed performing it, or vicarious conditioning will not occur. Usually it is important that the observer be repeatedly exposed to the model because conditioning may not occur after a single exposure. In addition, conditioning may not occur because the observer did not see the important features of the modeled behavior or may have no memory of it. It is helpful if the modeled behavior is symbolically represented by images or words or is mentally rehearsed. The observer, of course, must have the means to carry out the target modeled behavior.

In vicarious classical conditioning, the observer is exposed to a model who behaves fearfully when confronted with a feared object (such as a snake) or who has negative consequences occur when exposed to an object (such as being scared by a large animal or in association with that animal). As a result of making these observations, the observer may likewise learn to fear these objects or situations.

Whereas vicarious operant conditioning may require several trials and multiple models to become firmly established, vicarious classical conditioning may occur in a very few or even single trials or exposures. It is likely

that the majority of human anxiety responses are learned in this manner because most people have not had personal experiences with many of the events or people they fear.

II. THEORETICAL BASES

Vicarious conditioning is theoretically based on the modeling paradigm as developed by Albert Bandura. In modeling, individuals may show increases or decreases in various target behaviors by observing a model being reinforced (to increase target behavior) or punished (to decrease target behavior). It is not necessary that the observing individual be directly reinforced or punished for behavior change to occur. This process has been called vicarious learning, vicarious conditioning, or in some instances, vicarious reinforcement.

Vicarious conditioning is the analogous process to *in vivo* or directly experienced conditioning. According to the operant conditioning paradigm, the observing individual watches a model being reinforced for performing a certain behavior and the probability of the observer subsequently exhibiting that behavior increases as well. Observation of rewarding consequences occurring to a model for exhibiting a certain behavior, such as aggressiveness, may increase the probability of the observer performing that behavior in the future. By contrast, observation of a model being punished for exhibiting aggressive behavior may decrease the likelihood of, or inhibit the observer from performing, a similar aggressive act.

In vicarious classical conditioning, an observer watches a model becoming afraid of certain activities or animals as a result of seeing these stimuli paired with fear-producing situations. For example, the observer may see a model being bitten by a large furry dog, and subsequently fears large furry dogs without having been personally bitten. Indeed, the conditioning may generalize to a fear of large furry objects in general or to animals other than dogs.

Vicarious conditioning has been thought to be a major contributor to fear and anxiety disorders in people because people are commonly afraid of, or anxious about, situations or events that they have never experienced directly. It is also thought to account for a higher level of aggression in individuals who have not themselves been exposed to aggressive responses. Vicarious conditioning can develop through familial influences, subcultural influences, or symbolic modeling by the mass media because, for example, the latter provide ample models for violence and aggression.

Bandura has described several mechanisms or functions by which vicarious conditioning may occur. There is the informative function, in which the model's actions and response consequences provide information to observers about the probable consequences to them if they engage in similar actions. There is the motivational function, in which seeing others reinforced (or punished) can act as a motivator for the observer to perform similar actions. There is the valuation function, in which observers may come to value certain things if they see a model being reinforced for similar things. There is the influenceability function, in which observers may be influenced more by models' actions that respond positively to reinforcing consequences than by those who resist such consequences. In other words, observers tend to be more influenced by modeled responsiveness than by modeled resistance. Finally, there is the emotional learning function, in which an observer's emotional reactions are aroused by the model's emotional reactions while undergoing the rewarding or punishing consequences. This last function is essentially a form of classical conditioning in which an observer's fear responses may be enhanced or reduced by the model's fear responses or lack of them.

Observing the model gradually and perhaps hesitantly approach the feared situation or be reinforced for initially imperfect responses may be especially useful. Bandura found that a coping model, who performed the behavior gradually, imperfectly, or hesitantly was a more effective model than a mastery model, who performed the behavior perfectly, quickly, or without hesitation. People may respond better to a coping model because of perceived similarity to themselves. A coping model appears to be more like them whereas a mastery model may make them feel too inadequate and therefore not be imitated. Of course, it is important that the observers see the model as similar to themselves so that they may reasonably assume that the rewarding or punishing consequences would likely happen to them as well. For example, rewarded aggression occurring to a soldier model may not result in an increase in aggression in a civilian observer. The model and observer are not similar enough. Likewise, similarity of model and observer in such attributes as gender, age, and race may enhance the modeled vicarious conditioning effect whereas dissimilarities may reduce it. The use of multiple models may also enhance vicarious conditioning.

It should be noted that the standard laws of conditioning also apply to vicarious conditioning. For example it has been shown that conditioning that has been

established on an intermittent reinforcement schedule is acquired more quickly and established more firmly than that which has been established on a continuous reinforcement schedule. Whereas vicarious extinction may require many repeated trials, vicarious conditioning can often be accomplished in a few trials. In the case of highly intense or emotionally involving experiences, one-trial conditioning may occur.

III. EMPIRICAL STUDIES

There has been considerable research on the effectiveness of vicarious conditioning. Not only has it been found to be quite effective, it can be superior to direct reinforcement. This phenomenon is especially true if the tasks to be reinforced are more conceptual than manual. Vicarious conditioning is certainly more pervasive than direct conditioning, and likely accounts for the majority of human learning. In fact, a large number of behaviors exhibited in everyday life are probably conditioned vicariously by observing models being reinforced for performing these actions. The amount of vicarious classical conditioning has been found to be related positively to arousal level generated by psychological stress. It has been shown that the need for approval can increase the conditioning effect of vicarious reinforcement. Vicarious and instructional conditioning have been found to be major sources of childhood fears, more so than with adolescents, although they have often been combined with direct conditioning. Childhood fears have in fact been reduced or eliminated by this procedure. Vicarious conditioning has been found to be effective in eliminating maladaptive response patterns and increasing and maintaining new adaptive behaviors in children with mental retardation. It has been successfully implemented to train these children in more prosocial behaviors. It was found that children who were shown films in which a model showed either a fear response or a positive emotional response showed a lower rate of responding to the fear stimulus and a higher rate of responding to the positive stimulus. These effects were easily overridden by instructional and reinforcement conditions, however, and proved to be temporary. Only minimal cues from a model may be required for vicarious conditioning to occur as was demonstrated by one study that found that information about the model's heart rate was sufficient for it to occur. Thus, vicarious conditioning may account for a large part of human learning and be relatively easy to implement.

IV. SUMMARY

Vicarious conditioning is theoretically based on Albert Bandura's conditioning through modeling paradigm. It is analogous to direct trial conditioning, the difference being that it occurs when an observer learns by seeing a model performing a target behavior that is reinforced or punished. It is important that the observer actually see the model being reinforced for performing the behavior, not simply observed performing the behavior. Social behaviors, such as aggression and violence, are likely learned by this process. Vicarious conditioning can also occur through the classical conditioning paradigm whereby an observer sees a model learn to be afraid by being exposed to a noxious stimulus paired with an activity or event. Most human fears have likely been acquired by the latter process. Vicarious conditioning has been shown through research to be at least as effective as direct conditioning and possibly more so. It is a highly effective method for learning under a wide variety of situations and can be flexibly adapted to many conditions. Vicarious conditioning may be especially useful in learning conceptual material as opposed to manual skills. Mastery models may be less useful than coping models. Especially with vicarious classically conditioned fear, relatively few trials may be needed for conditioning to occur.

See Also the Following Articles

Classical Conditioning ■ Operant Conditioning ■ Response Cost ■ Self-Control Desensitization ■ Vicarious Extinction

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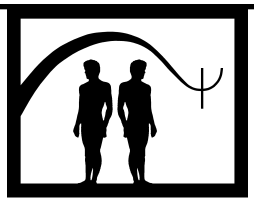

Vicarious Extinction

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GLOSSARY

classical conditioning Learning that is based on the association of one stimulus with another.

coping model A model who initially performs the target behavior imperfectly or hesitantly but becomes better with repetition.

extinction A change in behavior that occurs when it is no longer reinforced or punished.

intermittent reinforcement schedule A schedule in which reinforcements are delivered fewer than once for every response, according to a predetermined order. The schedules are fixed interval, variable interval, fixed ratio, and variable ratio.

mastery model An expert model who performs the target behavior perfectly and without hesitancy from the beginning.

model Someone who performs a target behavior and is reinforced or punished for it.

operant conditioning Learning that is based on the reinforcing or punishing consequence of a behavior.

thin reinforcement schedule A schedule in which few reinforcements are delivered for each response, for example, one reinforcement for every 50 responses.

vicarious extinction Extinction that occurs by watching a model perform a behavior that is no longer reinforced or punished.

vicarious learning Learning that occurs by an observer by watching a model perform the target behavior and being reinforced or punished for performing that behavior.

I. DESCRIPTION OF TREATMENT

In vicarious operant extinction, the observer is first exposed to a model who is reinforced or punished for performing a certain behavior. It is important that the model actually be observed being reinforced or punished for performing the behavior, not simply observed performing it, or vicarious learning will likely not occur. Then, the reinforcer or punisher is removed so that the observer simply sees the model performing the behavior. As a result, the observer is less likely to exhibit the behavior (if previously reinforced) or to suppress it (if previously punished).

In vicarious classical extinction, such as is commonly used to extinguish conditioned fearful avoidance behavior, the observer is first exposed to a model who behaves fearfully when confronted with an object, such as a snake, or who has negative consequences occur when exposed to an object, such as being knocked down by a large dog. As a result of seeing the model, the observer learns to fear the objects as well. Then the model is observed approaching the object (e.g., the snake) without fear or approaching the object (e.g., the dog) without adverse consequences. As a result, the observer is likely to feel less fear and to engage in less avoidance behavior in the future.

It is important that this extinction process be repeated a number of times, sometimes a large number of times, so that the previous learning will in fact extinguish. Overlearned or traumatic learning experiences may require many extinction trials. It may also be helpful for the model to exhibit gradual approach behavior to a feared object rather than approaching it too quickly. Finally, it may be helpful to use coping models for individuals who are fearful and avoidant themselves whereas mastery models may be more useful if precise skill development is desired in the relative absence of fear.

II. THEORETICAL BASES

Vicarious extinction is theoretically based on the modeling paradigm as developed by Albert Bandura. In modeling, individuals may show increases or decreases in various target behaviors by observing a model being reinforced (to increase target behavior) or punished (to decrease target behavior). It is not necessary that the individual be directly reinforced for behavior change to occur. This process has also been known as vicarious learning.

Vicarious extinction is the analogous process to *in vivo* or directly experienced extinction. According to the operant conditioning paradigm, the observing individual, after having vicariously learned a particular behavior by watching a model being reinforced for performing that behavior, now watches the model no longer being reinforced for exhibiting that behavior. Thus, the observer's target behavior likewise diminishes over time for lack of reinforcement.

In vicarious classical conditioning, an individual may have vicariously learned from a model to fear and therefore avoid certain activities or animals (such as avoiding members of the opposite sex or avoiding dogs) by watching a model learning to fear them (perhaps by being consistently rejected or by being knocked over by the dog). In vicarious extinction, the observer no longer sees the model performing fear-producing behaviors with adverse consequences (being rejected or knocked over); in fact the observer may see the model approach the dog without problems occurring. Thus, the fear that has become associated with either stimulus is gradually extinguished as the observer learns that the activities are safe.

Observing the model gradually and perhaps hesitantly approach the feared situation without problems occurring may be especially useful. Bandura found that a coping model, who performed the behavior gradually or imperfectly, was a more effective model than a mastery model, who performed the behavior perfectly or quickly. People may respond better to a coping model because of perceived similarity. It looks more like them whereas a mastery model may make them appear too inadequate and therefore not to be imitated.

It should be noted that the standard laws of learning also apply to vicarious learning. Therefore, the standard laws of extinction also apply to vicarious extinction. For example, it has been shown that learning that has been established on an intermittent reinforcement schedule is much more resistant to extinction than behavior acquired on a continuous schedule of reinforcement. Thus, vicarious learning that has been established on an intermittent reinforcement schedule would likewise be more resistant to vicarious extinction than that established on a continuous schedule. Likewise, a very thin vicarious reinforcement schedule would produce greater resistance to vicarious extinction than one involving a large number of reinforcers per response.

It is difficult to explain how fearful avoidance responses can be extinguished without ever being initially elicited. Bandura explains this by a dual-process theory of avoidance behavior. A conditioned aversive stimulus evokes emotional arousal that controls to some extent instrumental responding, and therefore if the arousal capacity of a fear-producing stimulus is extinguished, both the motivation and the avoidance stimulus are eliminated.

III. EMPIRICAL STUDIES

In the 1960s, there was substantial research conducted on vicarious extinction of fear and avoidance behavior, much of it conducted in Albert Bandura's laboratory. Vicarious classical extinction was found to be quite useful in extinguishing fear of certain animals in young children. Bandura and his colleagues also found that multiple models were more effective than single models in eliminating animal phobias in children, at least from posttest to follow-up. They also found that live modeling with participation (seeing an actual model perform the behavior with guided practice by the observer in performing the same behavior) was more effective than symbolic modeling (watching a film of the model performing the behavior) or systematic desensitization. Modeling appeared to account for about 60% of the behavior change and 80% of the attitude change. Guided participation accounted for the rest of the variance. Relaxation did not appear to

increase the effectiveness of symbolic modeling alone in reducing fear arousal.

Other research, including some doctoral dissertations dating from the 1970s, has been conducted on vicarious classical extinction designed to reduce fear arousal and avoidance behavior and has found it to be effective in reducing sex anxiety in women, reducing frigidity, reducing fear of dogs through films (symbolic modeling), and reducing fear of snakes. Multiple models were again found to be more effective than single models. One study comparing systematic desensitization and vicarious symbolic extinction found greater improvement for systematic desensitization. Another study comparing symbolic desensitization, symbolic modeling, and live modeling combined with guided participation (contact desensitization) found the latter to be the most effective.

IV. SUMMARY

Vicarious extinction is theoretically based on Albert Bandura's learning through modeling paradigm. It is an analogous process to *in vivo* extinction, the difference being that the former occurs when an observer sees a model performing a behavior that is no longer reinforced, rather than not being reinforced (extinguished) directly. It was shown through research conducted in the 1960s and early 1970s to be an effective technique for extinguishing fear and avoidance behavior. It is more flexible and adaptable than *in vivo* extinction because the observer does not have to experience the extinction directly. However, live modeling combined with guided participation, which is essentially a combination of vicarious and *in vivo* extinction, was found to be more effective than other forms of vicarious extinction alone.

See Also the Following Articles

Classical Conditioning ■ Operant Conditioning ■ Self-Control Desensitization ■ Vicarious Conditioning

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Virtual Reality Therapy

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GLOSSARY

virtual reality A technology that enables users to enter computer-generated worlds and interface with them through sight, sound, and touch.

Virtual reality therapy (VRT) is a new modality of therapy that enables clients to confront what troubles them and deal with irrational behavior using virtual reality technology. VRT is changing deeply held concepts about how human beings can overcome psychological disorders.

I. DESCRIPTION OF VIRTUAL REALITY THERAPY

VRT brings clients face-to-face with their deepest fears in a nonthreatening environment. That is the key. Entering a computer-generated world, clients know the situation is harmless, yet the re-creation of fearful scenes is lifelike, enabling them to deal with their fears in a realistic setting, confronting them through sight, sound, and touch.

VRT is similar to behavior therapy in its focus on exposing clients to fear-provoking stimuli. It differs from traditional behavior therapy modalities in that VRT computer graphics and various display and input technologies create real-life situations in the laboratory. These produce a sense of presence, so that the client feels immersed in the frightening scene. VRT can overcome some of the difficulties inherent in traditional treatment of psychological disorders. In traditional therapy, the therapist often has to imagine what is going on in the mind of the client. In VRT, the therapist can see how a phobic client reacts to fearful situations and is able to provide on-the-spot guidance. VRT generates stimuli of much greater magnitude than standard *in vivo* techniques can produce. It offers the added advantage of greater variety, efficiency, and economy in creating situations that might be either difficult or impossible with traditional techniques.

The centerpiece of VRT technology is a stereoscopic head-mounted video display with a head-tracking unit, along with a device that produces auditory and tactile stimuli (Figure 1). The effect can be startling, especially when the client is exposed to lifelike situations that have always produced fear. A set of VRT scenes is created before the therapy sessions begin. In the first laboratory session, which lasts approximately 20 minutes, the VRT client gets familiar with the virtual reality equipment. During this session, the client is asked to eliminate any virtual reality scenes that do not necessarily cause

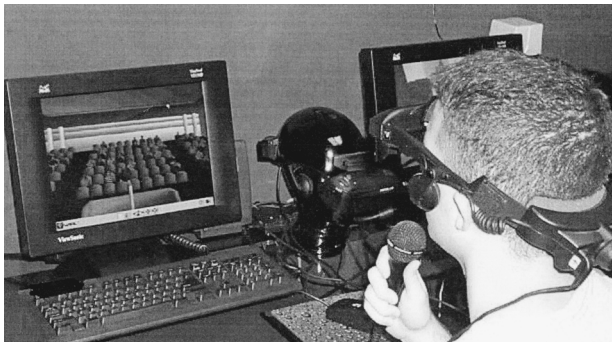

FIGURE 1 A typical virtual reality system with head-mounted display and head-tracking unit for use in VRT treatment.

anxiety. The client is asked to rank the remaining scenes from least to the most threatening. For the next eight weekly sessions, which last 15 to 20 minutes each, VRT is conducted in a standard format, tailored to individual needs.

The VRT session begins with the least fearful scene. Discomfort is measured every few minutes with the Subjective Units of Disturbance (SUD) scale. Clients rate their discomfort on a scale of 0 to 10. They progress systematically through each level of discomfort, and then are exposed to the next most threatening scene. Clients control their progress through the hierarchy of scenes. However, if the SUD score is 2 or less, the therapist may urge them to move up to the next level or next scene. Each new weekly session begins where the previous session ended. In addition to client-controlled subjective measurements, such as SUD, objective measurements of discomfort are also used. For instance, a heart-monitoring device, such as EEG/EMG, can be employed to monitor physical reactions.

II. THEORETICAL BASE OF VIRTUAL REALITY THERAPY

The principal aim of VRT is to help reduce or eliminate anxiety and fear. Phobias are nearly always linked to people's reactions to specific situations. VRT focuses on re-creating those situations in a controlled environment. When people encounter these disturbing situations under nonthreatening conditions they find ways to deal with them. In VRT, they learn new responses to old disturbing situations, thus gaining more control over psychological disturbances and their symptoms.

III. EMPIRICAL STUDIES

In testing military navigation software in a virtual reality setting in 1992, Dr. Max North and Dr. Sarah North discovered that it made some of the participants very fearful. They concluded that this technology could not only trigger phobias but could be used to combat these and other psychological disorders. Since then, they have successfully conducted numerous studies of VRT applied to specific phobias, such as fear of flying, heights, being inside a dark barn, crossing a river in an enclosed bridge, and being in the presence of various animals. Fear of public speaking; obsessive–compulsive behavior, and other psychological disorders were also found to be responsive to VRT treatment. These research activities have established a paradigm that is increasingly attracting scientists from the computer science, psychology, and medical fields.

As clients looking into the VRT head-mounted video display turn their heads, the scene changes appropriately. Visual, auditory, and tactile stimuli create a virtual world, with which the client can enter and interact. This controlled environment allows the client to reexperience events that have caused any psychological imbalance, and, most significantly, it takes place in the presence of the therapist. VRT, like current imaginal and *in vivo* modalities, generates stimuli that are unusually effective in therapy. Moreover, virtual reality generated stimuli are of greater magnitude than standard traditional techniques. VRT allows successful treatment of disorders that have often been difficult or impossible to treat with traditional techniques. A classic example is treatment of the fear of flying phobia. A virtual scene makes clients feel they are actually flying over cities. As VRT treatment progresses, these clients gradually become desensitized.

A substantial number of research activities have confirmed the success of VRT in treating psychological disorders. Table I shows a sampling of these innovative applications.

Mental and physical health risks associated with VRT can be greatly minimized by taking precautionary measures, as pointed out by Stanney in 1995. Clients at risk for psychological harm are primarily those who suffer from panic attacks, those with serious medical problems such as heart disease or epilepsy, and those who are (or have recently been) taking drugs with major physiological or psychological effects. A professional screening process will help identify these risks. Questions regarding physical and mental disabilities must be a standard part of the admissions process, and persons with these

TABLE 1
A Brief Report of Prior VRT Applications

Disorder to combat	*Experiment conducted*	*Researchers*
Fear of flying	Several case studies involving fear of flying were successfully conducted. After clients were exposed to virtual aerial views, they were given real world tests. A virtual helicopter and virtual commercial airplanes were used to fly the clients over realistic terrain. Afterwards, when clients flew long distances in real airplanes, they reported significant reduction in anxiety levels.	North et al., 1994 North et al., 1995 North et al., 1996 North et al., 1997a Hodges et al., 1996 Wiederhold et al., 1998
Fear of heights	Virtual scenes that were created for two major controlled studies and several case studies included belconies of various heights, an elevator, a canyon, bridges, and a series of balloons. The result: Clients comfortably accomplished real-life situations involving heights.	Rothbaum et al., 1995 North et al., 1996
Agoraphobia (fear of being in certain places or situations)	A major controlledstudy centered on helping clients who suffer from being in places from which escape might might have been either embarrassing to them or impossible. Several virtual scenes were created for this study. The scenes included a dark barn, a cat in the dark barn, a covered bridge over a river, empty room, and a few more related virtual scenes based on the request of the clients. In general, a subjective measurement showed that a majority of the clients' subjective measurements indicated their anxiety level was reduced and they became more comfortable in comparable real-life situations.	North et al., 1995, 1996
Autism	The challenge here was to create scenes of altered reality, of the kind clients were experiencing. Traditional treatments had often been ineffective for these clients. The virtual scenes closely tracked the distortion of environment that clients had personally perceived. This enabled them to gain new insight and to better understand the real situation.	Strickland, 1996
Body experience (eating disorders)	In this study, clients were exposed to a virtual environment that let them experience a modified body image. A partial reduction in negative feelings of body dissatisfaction was reported.	Riva, 1997a, 1997b
Fear of public speaking	Several case studies were conducted using a virtual auditorium with no audience initially. As treatmentprogressed, more audience and varieties of sound effects were introduced. Clients' symptoms reduced significantly, and they gained greater confidence in real-world speaking experiences after the therapy.	North et al., 1997b
Fear of closed spaces (claustrophobia)	Clients in several case studies were confronted with closed spaces in a virtual house. The spaces could be resized to suit the clients' progress, allowing them to gradually cope with their fear of closed spaces and significantly reduce their anxiety level.	Botella et al., 1998 Booth et al., 1992
Fear of driving	Volunteers tested the effectiveness of virtual reality technology in automobile driving situations. They were They were exposed to scenes that ordinary drivers might find themselves in, such as a series of stops, turns, heavy traffic, nearby buildings, and various hazards. Phobic participants significantly and consistently reported more anxiety than the nonphobic clients.	Schare et al., 1999
Posttraumatic stress disorder	In a case study, a Vietnam veteran was immersed in virtual jungle scenes, encountering thick foliage and armed combat, including machine guns and other weapons. The client reported significant decrease in symptoms as treatment progressed.	Hodges et al., 1999

(continues)

TABLE 1
(Continued)

Disorder to combat	*Experiment conducted*	*Researchers*
Obsessive–compulsive disorder	Another case study involved a young client who had trouble remembering to take supplies she needed for school each day. She was encouraged to prepare a virtual schoolbag with all the articles she would need on a particular day. After treatment she reported more confidence in remembering what to take to school each day.	North et al., 2000
Attention deficit disorder	A virtual classroom scene was created to help a client stay focused on studying. She was exposed to an increasing number of classroom distractions, as well as activities that could be seen outside the window. VRT was shown to be more effective than previous traditional treatments had been.	Rizzo, 2000

characteristics must be excluded from VRT experiences. Additionally, some otherwise healthy people experience symptoms ranging from headaches to epileptic seizures when exposed to certain visual stimuli. Clients must be closely observed by therapists at all times. Both the client and the therapist must agree beforehand to terminate quickly the virtual reality session if there is any evidence of significant physical or psychological distress. As a routine precaution, the therapist should ask clients to sit in a chair rather than stand during the VRT procedure. It is also recommended that the therapist use a modified head-mounted display so clients can partially see their physical body, choose the head-mounted display with a narrower field of view, and, most important, keep the sessions brief (between 15 and 20 minutes). This configuration reduces the degree of immersion while increasing the physical and psychological safety of the clients. There is a need for more research in this area. In the meantime, it is strongly recommended that researchers take appropriate steps to minimize client risks.

Therapists must keep in mind that symptoms of anxiety while under VRT are distinctly different from simulation sickness. Anxiety symptoms evoked under VRT are the same as real world experiences, including shortness of breath, heart palpitations (irregular or rapid heartbeat), trembling or shaking, choking, numbness, sweating, dizziness or loss of balance, feeling of detachment, being out of touch with self, hot flashes or chills, loss of control, abdominal distress, and nausea.

See Also the Following Articles

Cinema and Psychotherapy ■ Emotive Imagery ■ Online or E-Therapy ■ Post-Traumatic Stress Disorder

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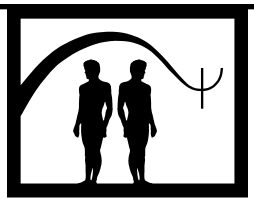

Vocational Rehabilitation

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GLOSSARY

akathisia A state of motor restlessness ranging from a feeling of inner disquiet to an inability to sit or lie quietly.

clubhouse A building run by clients and staff along egalitarian lines, where clients meet for social activity, mutual support and graded work experience.

expressed emotion Refers to a family environment characterized by hostility, criticism, or emotional overinvolvement.

individual placement and support model A type of supported employment approach.

prevocational training A form of vocational rehabilitation that advocates a period of preparation before placing clients into open paid employment.

rehabilitation Restoration of an optimal state of health and functioning by medical, psychological, social, and peer group support.

supported employment A form of vocational rehabilitation that emphasizes placing clients directly into open paid employment without any extended period of preparation.

transitional employment A form of vocational rehabilitation that involves the placement of clients in a series of paid but temporary jobs owned by a Clubhouse with the aim of helping them develop the skills and confidence required to cope with competitive employment.

vocational rehabilitation A range of interventions that aim to improve the quality of life and functional capacity of people who are subject to social exclusion by virtue of their disabilities, by providing them with the skills and attributes necessary for them to return to open paid employment.

The aim of vocational rehabilitation is to improve the quality of life and functional capacity of people who are subject to social exclusion by virtue of their disabilities. The main outcome is to reintegrate individuals back into open paid employment integrated into a community's economy. This article will present a psychosocial approach to this form of rehabilitation including the significance of work for people with mental health problems, the types of approaches offered, as well as the impact vocational rehabilitation has on psychopathology, self-esteem, and social relationships.

I. EMPLOYMENT AND MENTAL HEALTH

Work is central to human existence. It enables an individual to possess a valued social position and identity that has a significant influence on self-concept and relationships with others. As an important aspect of life

in today's society, work has a substantial effect on our fundamental aspects of personality and is a major contributing factor to our levels of self-esteem. In addition, work provides an opportunity for increasing social contact and improving skills while also providing income and financial security. Conversely, unemployment can produce high levels of stress, anxiety, and depression; low levels of self-worth; and decrease opportunities for self-development, autonomy, and social contact. The shift from being employed to unemployed is significantly associated with not only an increased risk of depression, alcohol dependence, anxiety states, and psychosomatic reactions, but also stigma, aimlessness, and poverty, which combine to trigger or amplify mental health problems. It appears that unemployment is associated with the conditions that substantially interfere with recovery from major psychopathology. This cycle of psychopathology, unemployment, and further distress, leading to further psychopathology, leading to further difficulty in adaptation and rehabilitation, is the vicious circle that spirals downwards in the lives of those with severe mental illness.

Unemployment is a major problem for all people regardless of their mental health status. However, for those people predisposed to mental health problems it makes sense that the effects of long-term unemployment could have a massive impact on their capacity to lead a happy fulfilled life. People who suffer from severe mental illness experience high levels of unemployment with rates estimated at 75 to 85%. Not only do these rates reflect the disability caused by severe mental illness, but also the discrimination experienced by this client group and the low priority given to employment by psychiatric services. Despite these high rates, surveys have consistently shown that psychiatric patients are strongly dissatisfied about not working and express a desire for competitive integrated employment.

II. THE ROLE OF VOCATIONAL REHABILITATION

Improving the course and management of severe mental illness involves not only the management of symptoms but also the social reintegration (or integration) of the psychiatric patient. Despite the recent advances in psychopharmacology for people with severe mental illness, medication is still unable to address the social impairment and skills deficits experienced by these groups that are a major contributing factor to high vulnerability for relapse. A comprehensive care package, therefore, would not only involve medication treatment and a psychotherapy approach, but also interventions that provide patients with the social and occupational skills necessary for them to function at their optimum capacity in the community. The provision of these skills requires a comprehensive infrastructure of community services, in particular housing and employment, and a means for ensuring continuity of care.

In response to this increasing awareness of skills deficit for psychiatric patients, vocational rehabilitation has assumed increasing importance in the treatment package for rehabilitating people with severe mental illness. In the mid-19th century, the moral treatment of insanity regarded work as an effective therapeutic task that distracted patients from their psychotic preoccupations. This school of thought has evolved over the last half century, which has been witness to the development of a range of approaches to vocational rehabilitation for psychiatric patients.

The emphasis within vocational rehabilitation programs is, in the first instance, to provide patients with a structured day, and provide skills training that will ultimately enable them to secure open paid employment at a level that they will be able to manage. It is important to note that all psychiatric patients will require differing levels of input and the rehabilitation they receive must be highly individualized to their needs and capacity to work. For some patients this may take as little as a few months, in others as many as a few years. The type of rehabilitation a patient receives is dependent on the level of their "work-readiness," and is usually provided in the form of one of the two ideologies described later.

III. TYPES OF VOCATIONAL REHABILITATION

Prevocational training (PVT) and supported employment (SE) are the two main ideologies that have developed to help people with severe mental illness return to work.

Prevocational training otherwise known as the "trained and placed model," assumes that people require a period of preparation before entering into competitive employment—that is, a job paid at the market rate, and for which anyone can apply. This includes sheltered workshops, transitional employment, work crews, skills training, and other preparatory activities.

Supported employment, otherwise known as the "placed and trained model," places people directly into competitive employment without an extended period of preparation, and provides time unlimited, on-the-job support from trained job coaches or specialists. Much

work has been done in this area that has led to the development of a carefully specified variant of supported employment known as the individual placement and support (IPS) model. The IPS model is distinguished by six key principles. According to Becker in 1994, these are (1) the goal is competitive employment in work settings integrated into a community's economy, (2) clients are expected to obtain jobs directly, rather than after a lengthy period of preemployment training, (3) rehabilitation is an integral component of treatment of mental health rather than a separate service, (4) services are based on client's preferences and choices, (5) assessment is continuous and based on real work experiences, and (6) follow-up support is continued indefinitely.

In addition to these approaches, cross-fertilization between the two ideologies has led to the development of a number of hybrid models (or stepwise-eclectic models), that offer either a combination of, or all of, the services offered by both PVT and SE.

Although much research has been done on the effectiveness of prevocational models in terms of returning people to the workplace, up until the past 10 years limited evaluations have been done on supported employment programs. However, the past decade has been witness to a growth in supported employment programs and along with it has come a number of reviews of their effectiveness. These reviews have shown that SE appears to be more effective than PVT in terms of helping people with SMI obtain competitive employment.

An underlying assumption that has been related to work since the early asylum system is that "work is therapy." Work of the right type has been assumed to benefit patients in other nonvocational domains such as better controlling of psychiatric symptoms, increased levels of self-esteem and self-worth, and improved capacity for social relationships, all of which contribute to an overall improved quality of life. The relationship between vocational rehabilitation and each of these domains is outlined later.

IV. VOCATIONAL REHABILITATION AND PSYCHOPATHOLOGY

The pioneers of the early asylum movement hypothesized a direct relationship between employment and symptom alleviation. In modern times, however, the conceptual models within which psychiatry operates have not tended to include constructive activity as anything more than a mediating factor, intervening between sociodemographic or psychopharmacological variables and outcome in terms of symptom relief. With the treatment of severe mental illness increasingly moving into the community, this attitude is beginning to change and the measurement of symptoms is often included among outcome measures as an indication of social adaptation and community living skills. Increasingly, these measures are being incorporated into evaluations of vocational rehabilitation services by measuring outcomes in terms of improvements to a person's psychopathology in addition to whether or not they have obtained employment.

Given that long-term mental health problems are commonly linked with chronic unemployment, it is not surprising that an improvement in socioeconomic status in the psychiatric patient improves psychopathology and prognosis. There are two likely explanations for this. First, the direct financial benefits of moving from an impoverished lifestyle will produce both mental and physical health gains, and second, the problem of chronic patienthood relates to social marginalization. The emphasis on employment or work, in "normalization" or "social valorization" rehabilitation theory, reflects a strategy to reverse this marginalization.

An additional latent clinical benefit of some work schemes is that they provide structured opportunities for supervision and treatment compliance. Support is often provided in the workplace for those who need it and in addition to an awareness of whether a person has taken medication or not, often an individual will not want to jeopardize their job by failing to take their medication and increasing the likelihood of relapse. A negative aspect of medication is that for many people the sedation effects and akathisia caused by medication make work tasks difficult. Therefore, until the medication regimen is stable, work would not be considered a feasible option.

Not only does employment appear to have a positive effect on psychopathology, but symptom alleviation could also be seen as a consequence of improvement in other facets of an individual's life, which again, are influenced by vocational rehabilitation. This type of rehabilitation is thought to have a significant impact on the level of self-esteem, which in turn can promote improvements in mental state.

V. VOCATIONAL REHABILITATION AND SELF-ESTEEM

Self-esteem is the evaluation people make and maintain about themselves and has been defined as evaluation of one's own worth, value, or importance. It is essential to our ability to function in a healthy way. Without the foundation of a solid sense of self-worth,

we are unable to take the risks and make the decisions necessary to lead a fulfilling, productive life. A low self-esteem has a negative effect on our relationships, careers, family bonds, and, most important, our internal sense of well-being. A high self-esteem, on the other hand, brings the high level of confidence, problem-solving abilities, and assertiveness needed to achieve what Maslow referred to as "self-actualization"—a continuous desire to fulfil potentials, to be all that you can be. Obviously this refers to everyone regardless of their mental health status; however, for psychiatric patients, this is a state that is particularly difficult to achieve. People who have positive self-esteem have healthier, stronger relationships with those with negative self-esteem. A strong sense of self-worth actually creates a type of self-fulfilling prophecy. The more people like themselves, the more they begin to act in likable ways, the more they believe they are able to achieve something, the more likely it is that they will.

The concept of self-esteem has been widely used as an outcome variable in studies of rehabilitation. This is based on the assumption that a higher level of functioning is coexistent with a higher level of self-esteem and feeling of self-worth. The sources of self-esteem are regarded as personality related and as a function of intrapersonal evaluation, individual roles, role accumulation, or early childhood experience. Self-esteem has two essential elements, social status and affirmative experience. Social status refers to an individual's position in society relative to others, and is most often measured in terms of household income, educational attainment, and occupation. As employment is a major source of social status, it may, therefore, be argued that employment in a respected occupation is a means of restoring the self-esteem of people with mental health problems that cannot be obtained in any other way. Affirmative experiences are experiences in which individuals receive positive reinforcement from others about their abilities and behavior. Affirmative experiences can usually be obtained through a variety of social encounters; however, people with mental health problems may have limited opportunities for social interaction. Hence, work in a nonstigmatized setting may enhance the self-esteem of people with mental health problems.

Goodman and colleagues in 1994 found that in psychiatric patients, low levels of self-esteem were found to be associated with higher levels of psychiatric disturbance and higher levels of external locus of control among African-American women. The potential of employment to influence self-esteem is shown by the Rosenfield model. Rosenfield's 1992 study of a Clubhouse took "mastery" as a pivotal concept, defined as "a personal resource that can moderate or help in coping with the effects of stress. … A low sense of mastery affects subjective quality of life because it results in feelings of hopelessness and passivity." Rosenfield points out that many psychotherapists have suggested increasing a sense of mastery as the first task in psychotherapy for people with chronic mental health problems. Leading on from this she set out to explore associations among vocational rehabilitation, mastery, and quality of life. She concluded that economic resources and empowerment increased a sense of mastery and hence a better quality of life. Controlling for perceptions of mastery, she also found that having a greater time structure as imposed by work, increased people's quality of life.

Studies comparing people with mental health problems who were either in competitive employment or unemployed, found that those in competitive employment had significantly higher self-esteem than those unemployed. In addition, studies have also shown that patients working in sheltered workshops had a high level of self-esteem associated with the opinion that their job held a "valued social position."

Given the obvious importance self-esteem has on both people's capacity to lead a fulfilling life, and the type of employment they consider themselves suitable for, and able to do, rehabilitation in conjunction with psychotherapeutic interventions need to implement techniques that focus specifically on increasing levels of self-esteem.

VI. VOCATIONAL REHABILITATION AND SOCIAL RELATIONSHIPS

Our levels of self-esteem also have a significant impact on our ability to maintain social relationships. This can be seen as a self-perpetuating circumstance in that a low level of self-esteem severely disables a person's ability to interact and build social relationships. Conversely, interaction and social relationships can help build a person's feeling of self-esteem and self-worth and make them feel wanted. Social support or interaction can be seen as part of our basic need for belongingness and love and is defined as the degree to which a person's basic social needs are gratified through interaction with others.

Psychiatric patients commonly suffer deterioration of social relationships, particularly in the case of schizophrenia. Evidence for the importance of social support

in schizophrenia is growing with research showing that psychiatric service users have smaller social circles than people without mental health problems. In addition, patients with schizophrenia also perceive themselves to have fewer people offering instrumental support, and fewer social companions than those suffering with depression.

Although an understimulating social environment has been shown to be associated with clinical poverty syndrome, or institutionalization, conversely, an overstimulating one can precipitate psychotic episodes. Given that patients with schizophrenia tend to react adversely to overstimulation it is unsurprising that they withdraw from social interaction and are reluctant to enter a work environment. The emphasis here is on both the level of stimulation and the level of communication required to operate within the workplace. Obviously both of these factors need to be at a level that is suitable for each individual, while acknowledging that thresholds will be different for each person.

It is important to note here that the quality of the relationships within work is of importance. Relationships are bidirectional in that they can be seen as reciprocal or dependent. Although psychiatric patients may consider themselves dependent on a relationship in terms of receiving support, they must possess a sufficient level of social skills to maintain that relationship. Therefore, diminished social interaction may be due to the breakdown of social skills, which then places the person at a disadvantage in terms of disabling his or her capacity for beneficial social interaction.

People with mental health problems who are entering a work environment are exposing themselves to an entirely new source of social supports. These supports can be seen as "natural" (e.g., from colleagues) or "constructed" (e.g., from supervisors or job coaches). These relationships can be then further built on in order to provide both emotional and instrumental support, in some cases becoming friendships that extend beyond the workplace. The Clubhouse movement advocates this ethos in its work intervention known as transitional employment. For psychiatric patients, constructed networks derived from therapeutic settings may serve as a substitute for poor social networks outside work.

Another important aspect of employment that may facilitate improvement is removal of psychiatric patients from the home environment where their social contacts may have a high level of expressed emotion (EE). Research in EE has clearly demonstrated that medication and removal from relatives who have high EE can protect the psychiatric patient from relapse. It therefore follows that a structured work environment to where the patient can "escape" on a regular, structured basis may serve as a protective factor. It is of obvious importance that the work setting does not replicate high levels of EE. This can be prevented by education of supervisory staff and colleagues about the concept and manifestations of EE.

VII. INTEGRATION OF VOCATIONAL REHABILITATION EFFORTS IN PSYCHOTHERAPY

Given the psychosocial aspects of vocational rehabilitation, there is a common link between this type of intervention and that of psychotherapy. Both interventions share the goal of increasing the functional capacity of the individual. The difference is that within psychotherapy, the improvement of psychopathology, self-esteem, and the capacity for social relationships are specific aims, whereas in vocational rehabilitation, they can be seen as by-products of improving an individual's capacity to work.

In terms of provision of these interventions it would be desirable to offer them within a framework where all aspects of the patient's care are provided collaboratively and communication between the services is common. Both interventions require the input of specialized individuals and it is unlikely that an individual or particular caregiver will be expert in both enough to integrate them into his or her practice. Therefore, it is often the case that both interventions will be carried out by separately trained practitioners who may not share the same views of the nature of psychopathology. They may have differing subtle and not so subtle goals and ideas about what is practical for an individual to achieve, and consequently the opportunity for conflict between the two may arise. Consequently if they are not organized out of the same agency providing care and leadership in treatment planning, they must commit themselves to a regular form of communication in which they share their ideas and assessments of individuals. Regular discussions need to take place concerning what the individual wants to achieve and whether it is feasible, what difficulties may be encountered, and perhaps most important any difficulties that may arise in their relationship with one another as they collaborate in the care of the individual. It is important to acknowledge here the existence of one such mechanism that aims to achieve treatment integration. This mechanism is known as case management, which involves a team of professionals

with a limited number of cases for each intervention, thus reducing the workload and enabling more time and commitment for patients' care. The emphasis within the team is on collaborative working, with regular meetings for discussion about patients.

Only by collaborative working between all services involved in a person's care will we be able to bring the management and rehabilitation of psychiatric patients together in an organized cohesive manner. This will enable us to ultimately provide a seamless service working closely together with the common goal of improving the overall functioning and capacity of the psychiatric patient, thus facilitating (re)integration back into the community.

Acknowledgments

The author would like to acknowledge the funding support from the National Health Service Research and Development North West.

See Also the Following Articles

Job Club Method ■ Schizophrenia and Other Disorders

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Women's Issues

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GLOSSARY

gender identity The perception of oneself as being either male or female, and the acquisition of social roles culturally appropriate for that person that are gender linked.

gender role A cultural construct referring to the expectations, attitudes, and behaviors that are considered to be appropriate for a particular gender in a particular culture.

sexual orientation The sexual preference of a person based on gender, i.e. homosexual, heterosexual, bisexual.

I. INTRODUCTION

Gender is an important variable in psychotherapy. Gender can influence a patient's choice of therapist, the "fit" between therapist and patient, and the sequence and content of the clinical material presented. It also affects the diagnosis, length of treatment, and sometimes outcome. Gender differences in experiences affect the perception and interpretation of patient material. Biologic aspects of gender must be considered from a perspective that reflects emerging data that unify brain and mind, biological, and psychosocial factors.

Evidence of gender differences in the nervous system beginning in fetal life suggests that, from birth, boys and girls may not perceive and experience the world in the same way. Gender differences in neural maturity and organization influence behavior and reactions in infants that can also affect caretakers' response, further reinforcing differences. These differences in reactions can alter the growth and development of neuronal pathways. Experience modifies the structure and function of neurons and neuronal networks, and can modify gene expression. Brain structure, metabolism, and function are also affected by psychotherapy. These findings reinforce our understanding of the plasticity of the brain and how it is affected by behavior and experience. The implications of these data underscore that the distinction between biological and psychosocial is both artificial and misleading.

In this article we focus on the relationship between gender and psychotherapy, considering psychosocial and biological variables. We will examine biological influences, developmental and life experiences, gender differences in personality styles, and the effects of stereotypes and values.

II. VALUES AND TREATMENT

Personal and social values affect standards of normality and influence the perception, diagnosis, and treatment of mental disorders and emotional problems. Although there have been changes in concepts of normality, mental illness, and the range of behaviors and attitudes that are thought to characterize each gender, evidence suggests that there continue to be differences in what is considered normal for men and women, even by therapists. Broverman and colleagues in their classic 1970s study found that when male and female psychotherapists were asked to describe a mentally healthy person, psychological health was more closely associated with descriptions of "healthy, mature, socially competent" men than with concepts of maturity or mental health of women. Although a 1990 report by Kaplan and co-workers noted that attitudes toward gender roles have changed to some extent, and that male and female psychiatrists' beliefs regarding gender-appropriate behavior had become more similar and less stereotyped, ratings derived from the Bem scale indicated that female and male psychiatrists were still more likely to choose stereotypical traits to define mental health.

Although concepts of normal masculine and feminine behavior and attitudes have shifted, these changes are not necessarily integrated into a cohesive view of normality for either men or women. Attitudinal changes may be consciously adopted by those treating a patient, but unconscious views about what is "normal" may be unchanged and can affect therapy.

Values are communicated to patients in both overt and subtle ways in the process of evaluation and referral as well as during treatment. In psychotherapy, therapists communicate values by their selection of material to respond to, by the timing of their interpretations, and by their affective reaction to the content of what is said by the patient. This subtle communication conveys the therapist's judgment. For example, the therapist may emphasize or ignore the patient's references to menstruation, to taking drugs, or to engaging in risky sexual behavior and women patients may be more reluctant to discuss these with male therapists. By responding, the therapist expresses a judgment of what is important and to whom, and consequently may misinterpret the importance of these issues for the patient.

Gender also affects treatment priorities and approaches. It has been suggested, for example, that concern about some more characteristically male behaviors, such as violence related to alcohol abuse, may lead to the development of treatment methods that are more suitable for men. These methods may also be used for women, although there is evidence that they are less effective for them. Likewise, more attention may be paid to treating the adolescent schizophrenic or substance-abusing man, because of the threat of violence, than to treating the seriously handicapped but less threatening women with posttraumatic stress disorder (PTSD) or depression.

III. GENDER INFLUENCES AND DIFFERENCES IN EARLY DEVELOPMENT

Early influences and endowments, both biological and psychosocial, are important in the shaping of personality. In childhood, the presence or absence of continued stable care, styles of child rearing, the responsiveness and nurturance of people in the environment, physical health and illness, loss, and trauma, as well as biological endowment, are all determinants of the ultimate configuration of personality.

Complex integrative functioning, such as conceptualization and learning of language and social skills, derives from both biological and psychosocial influences. These may differ between males and females. The effects of particular cultural practices, including gender differences in child rearing, and ideas about gender-appropriate roles are also manifested very early in life and affect development. Parental behavior affects male and female roles and is a powerful developmental force.

Ideas about the determinants of gender identity have changed from the early views that the major determinants of gender development were anatomical, to a view that development and gender concerns represent a complex interplay of anatomy, genetic endowment, and environment including developmental experiences and cultural context. These include the structure of the family, the presence and roles of other siblings, the mother's other pregnancies, and many aspects of the child's relationship with extended family and others.

There seems to be a connection between early trauma and the development of personality disorders, especially borderline personality disorder, which is more commonly diagnosed in women than in men. There is evidence that developmental disruptions occur when an individual is traumatized early in life.

Gender role is a cultural construct referring to the expectations, attitudes, and behaviors that are considered to be appropriate for each gender in a particular culture. There are enormous differences in the roles and expectations of men and women in different soci-

eties. Some societies dictate more rigid and fixed roles than others. Not all value the same traits or see certain traits as gender specific in the same ways. For example, physical strength is often considered a male characteristic, but despite their smaller size and lesser physical strength women in some cultures are assigned the heavy work. The role most consistently assumed by women across cultures is early child rearing.

During early development, in all cultures, the mother remains the primary caregiver of young children. The earliest attachment is more likely to be made with her. She becomes the primary identification figure in early childhood, for both boys and girls. Therefore, for girls, the first identification is with the parent of the same sex. For boys, the first identification is with the parent of the opposite sex. As girls grow up, this same-sex identification does not have to change in order for feminine gender identity to consolidate. Thus, girls learn about being women in identifying with their mothers. Boys, on the other hand, must shift their primary identification away from their mothers in order to develop a male gender identification. Thus, they move away from their early attachment.

For girls, the continuity of attachment to their mothers, and the fear of loss of love by manifesting aggression that is disapproved of, may make it more difficult to establish autonomy and independence. Aggression, competitiveness, and anger may be difficult to manage because these affects can threaten loss of relationships. It can be difficult for women to express themselves freely, especially when they experience anger and aggression, and, at the same time to preserve relationships. This may be seen later in life in a woman's conflict about aggression, manifested in her difficulty in being appropriately assertive and in her inhibited risk-taking or autonomous behavior. Cultural values such as independence, initiative, and competitiveness have been considered positive characteristics for males, but not for females.

Because of the primacy of relational ties, women also may be more vulnerable to loss throughout their lives. One of the syndromes that has been seen as related to the conflict about autonomy and independence and the sense of vulnerability to loss is agoraphobia, which is more commonly diagnosed in women than in men. Although this syndrome has multiple determinants, it may represent anxiety about moving out into the world and feeling alone. Depression is also more frequently diagnosed in women than in men. The reasons for this are complex and unclear, but multidetermined, including conflicts about aggression and mastery, social depreciation of feminine roles, identification with depressed mothers, early loss, and biological factors.

In contrast, disturbances involving violent, aggressive behavior, and problems with impulsiveness are more often diagnosed in men. Conflicts around intimacy and socialization toward aggression and action are consistent with this picture in men. These findings raise questions about the factors affecting the process of diagnosis itself, particularly with Axis II disorders. Because these disorders more generally reflect clusters of observed personality characteristics rather than specific symptoms, incidence figures may reflect biases and sex-role stereotypes.

At times, women may also fail to act in their own best interests because of their desire to preserve relationships, even if these are abusive. This can result in behavior that may continue to put them at risk for victimization. The threat of loss then, may motivate behavior that can be interpreted as masochistic. For women, the conflict experienced about aggression can result in turning aggression inward, with excessive self-criticism and diminished self-esteem. Culturally supported passivity with consequent feelings of helplessness can be risk factors for depression. Problems in the development of self-esteem, for girls, appear to be intensified in adolescence. Gilligan found that there are gender differences in self-concept and identity in adolescence. Males generally define themselves in terms of individual achievement and work, and females more often in relational terms. Gender differences in depression, except in bipolar illness, appear to have their onset in puberty, a time when girls begin to assume adult feminine identities and roles.

IV. BODY IMAGE AND REPRODUCTION

With the beginning of puberty, girls and boys experience their reproductive identities in different ways. For girls, menarche signals a capacity for pregnancy. This change also brings a potential vulnerability for girls that is not in boys' experience. It is both a positive experience and a source of risk and anxiety. Girls develop new organs, breasts, transforming their bodies. This has no parallel in boys. For a girl, menarche is an organizer of sexual identity. It is also an undeniable physical experience, and it can be a source of pleasure and conflict about growing up and about femininity. Adolescent girls in Western cultures are bombarded with media images of women who are loved because of their physical appearance. Self-esteem and self-confidence rest heavily on physical attributes and body image especially during adolescence, for both sexes.

Conflicts around self-image and body image become more prominent during adolescence and can be expressed differently for boys and girls. Discomfort with body image and fear and ambivalence about mastery, independence, separation from family, and adulthood including sexuality, are difficult issues that are thought to contribute to the dramatic incidence of eating disorders in adolescent girls. They may literally attempt to starve themselves back into childhood and diminish female body characteristics (e.g., curves and breasts).

V. THE ROLE OF REPRODUCTIVE LIFE EXPERIENCES

Women's life cycles are closely connected to their reproductive potential. The acknowledgment of a woman's reproductive capacity is an important component of her sense of identity and femininity, regardless of whether or not she actually bears children. The knowledge that there is a finite time period for reproduction also influences her concept of time. She must make different decisions about career and family than men do. This difference can affect her emotional state, her decision to seek therapy, and the issues that will be raised in the course of therapy. With delays in the time of childbearing for contemporary women, many come to treatment as they approach 40 or in their early 40s to deal with issues around childbearing. They have not confronted their biological clocks and must deal with the issues of reproduction before it is too late.

Reproductive events, decisions, and choices may have different significance for men and women, thus affecting the process of therapy. Because reproductive issues are more likely to be addressed for female patients, male patients may find that their reproductively related concerns are not dealt with. Therapists often share the patient's reluctance to explore these issues. This avoidance may result from the conscious or unconscious conviction that exploration of a man's infertility or sexual dysfunction would be too great a threat to his view of his "masculinity."

Pregnancy as a life event marks a transition to motherhood and raises many issues for a woman, including her relationship and identification with her mother. Although pregnancy is usually experienced positively it also increases a woman's vulnerability to specific psychiatric disorders, particularly postpartum depression.

Infertility is also a different experience for men and women, and there are different issues to consider in treatment. Historically, and in some cultures today, women have been seen as the sole responsible partner when there is infertility. A woman's pregnancy has been viewed as a confirmation of a man's masculinity and potency. Infertility can be a threatening and distressing problem for both men and woman, but in different ways, depending on how important it is to each partner and what the etiology is. Social norms have supported men's resistance to be involved in infertility workups and treatment.

Menopause is a unique marker of the life cycle for women. Stereotyped expectations about women's life cycle and the attribution of midlife symptoms to menopause have resulted in the confusion of the experiences of this time of life, including concerns about the physical and emotional aspects of aging, family changes, shifts in goals, and retirement, with the effects of the physiological event of cessation of menses. Menopause has been linked with depression and loss, but there is no evidence supporting that this is an inevitable connection. Those women who become depressed in midlife are generally those who have had depressions at other times in their lives. The peak incidence of depression in women, in fact, is in early adulthood. Responses to menopause are also strongly influenced by cultural expectations, and in many cultures, women regard the cessation of menses and childbearing with relief and sometimes with greater enjoyment of sexuality.

VI. GENDER AND CHOICE OF THERAPIST

Patients give many reasons for their choice of a therapist. These reasons have often been based on stereotyped views such as "men tend to perpetuate patriarchal values," or "women are more nurturant."

The search for a role model is often a determinant of the choice of a therapist. Women frequently feel that a woman therapist will be more responsive to their wishes for achievement, success, and self-actualization or that because she has faced similar conflicts she could empathize with them more easily. Although this idea may facilitate the development of an alliance, it does not by itself resolve the patient's difficulties.

Women may also request to see a woman because they seek permission to succeed in certain goals, particularly those involving career. Permission, explicit or implicit, can result in improvement and can enable the patient to compete and succeed, even if the issues are not taken up specifically and explicitly. Identification with a therapist is also important. Although the reasons for the choice may be based on stereotypes, without regard for the characteristics of the specific therapist, the patient's feel-

ing of greater comfort or empathy can facilitate the initial development of a positive therapeutic alliance.

A patient's gender-based choice can also derive from idealized fantasies about the characteristics and capacities of the clinician and what he or she can do for the patient. For example, if the clinician is a prominent person in the community, expectation based on this status can affect the therapeutic relationship. If the patient makes a choice because of particular political views, sexual orientation, or the cultural heritage of the therapist, treatment may begin with positive feelings, only to have these reversed if, in the course of treatment, the patient is disappointed. The recognition that the therapist is not omnipotent repeats past life experience. If there is a negative outcome it may be blamed on the therapist's gender. If the therapist is a woman who is not the fantasized omnipotent mother who can transform the patient, devalued ideas about women can be confirmed.

Choosing a therapist of a particular gender with the expectation that this will resolve the patient's problems can also be a resistance to therapy. A woman may want to see a woman for treatment because she feels unlovable and unattractive to men and can, in this way, avoid the experience of confronting her feelings or initially because she wants support, and later devalues the therapist or find herself in an angry competitive interaction, which can be a repetition of her relationship with her mother. She may be unaware of the origins of her feelings or the reasons for her choice of a therapist. Although there are conscious reasons for choices, unconscious factors or needs such as fear, anger, or a search for mothering may be important and should be considered in the initial encounter with a patient. For a woman, the choice to be treated by a woman can also represent a wish to restore the relationship with her mother or to have a better mother. A desire to see a male therapist can be based on the desire to avoid this maternal kind of relationship or the anxiety that these feelings arouse, or may reflect anxiety about the intense attachment that may be evoked by a woman.

Many support the view that women should be treated by women in order to avoid being misunderstood or treated from a male-oriented perspective. This oversimplifies the effects of gender and minimizes the necessary working through of ambivalence and conflict in the therapeutic relationship.

Concerns about sexualization and sexual relationships in treatment have become important factors in requests based on gender. For those patients who have actually been abused in previous treatment, trust can be severely damaged. It may be particularly difficult for such patients to see anyone who serves as a reminder of that previous experience. Women therapists are often asked to see women patients who have had sexual involvements with male therapists. Although it does occur, women are less likely to become sexually involved with their patients, either male or female, than are men.

Sexual orientation has also become a consideration for many gay individuals who request therapy with gay therapists. They feel that a gay therapist will better understand and empathize with them and will be less likely to judge their sexual object choice as pathological. Although there has been controversy about the appropriateness of disclosure of the therapist's sexual orientation, some therapists believe that this disclosure can be beneficial in therapy.

Stereotypes and expectations about women affect male patients as well. A man may seek treatment from a woman therapist in order to avoid a competitive or authoritarian relationship with a man, to avoid homosexual feelings, or because he has had poor relationships with women in the past and wants to work these out with a woman. His expectations may be that a woman will provide the cure for his problems with intimacy.

VII. THE THERAPEUTIC PROCESS

Understanding the concept of transference can clarify aspects of the therapeutic relationship that may otherwise be difficult to comprehend. The attitudes and feelings brought to a relationship from past experiences with important figures such as parents are components of future interpersonal interactions. The need to please or to gain love by acquiescence or seductive behavior can be brought into the therapist–patient relationship as if it were a response of the patient to the therapist as a real person in the present. The therapist can be seen as rejecting, authoritarian, giving, preferring other patients, and so on.

The classical conceptualization of transference assumed that both maternal and paternal transference could be developed toward both male and female therapists. Thus, the therapist's gender was not a particularly salient consideration. Freud came to believe that transference responses to a male analyst differed from those to a female analyst. Subsequently, however, Horney emphasized the importance of the competitive transference with the same-sex analyst, and Greenacre stated that strong gender preferences should be respected, but also carefully analyzed because prior wishes, expectations, and fantasies could affect not only the choice but also the course of the psychoanalytic process.

Gender can affect the initial relationship and the early evolving transference, as well as the sequence in which therapeutic issues emerge, and the pace at which therapy progresses. For example, working with a woman therapist can evoke maternal transference material earlier in therapy. Transference expectations may cause some patients to fail to reveal details of sexual abuse or other sexual experiences to a male or female therapist depending on the patient's view of how the therapist might hear or react to this information. This lack of disclosure may also be related to the patient's stereotypical ideas as well as the particular characteristics of both patient and therapist.

Assessment of the kinds of transference engendered may be complicated by the countertransference of the person doing the assessing. Although an erotic transference may occur in a man's transference to a woman therapist, it is more common for women patients to develop an erotic transference to either male or female therapists. This can create problems, particularly for the inexperienced therapist. The idea that a real romantic or sexual relationship can be therapeutic to a patient can be difficult to reject if the patient passionately pursues this or demands it, particularly if she is suicidal and it may be rationalized as life-saving. Sexual relationships with patients are ethical violations, boundary violations, and leave the therapist open to legal action as well as therapeutic failures. When these become an issue in therapy, a consultation and supervision is very important.

Transference can take many forms, including cross-gender manifestations. It is possible for a woman patient to develop a paternal transference to a woman therapist. It may be difficult for the therapist to imagine himself or herself as the cross-gender person or for a man to imagine himself as a mother or a woman as a father.

Current views of transference emphasize that the therapist or analyst plays a role in the creation of the transference, even if this is not consciously recognized. Thus, recognition of the effect of the gender of both participants is important.

Change or reassignment of a therapist on the basis of gender has been widely discussed and is often recommended. Some have suggested that a change of therapist might mobilize a stalemated situation. Transfers on the basis of the therapist's gender have also been made when there is a therapeutic impasse or failure.

Unless there has been a sexual interaction, however, it is rare that gender itself is the significant variable in the majority of cases that are not successful. A transfer based on gender may be a way of avoiding responsibility for failure or dealing with the embarrassment of a negative outcome. Person suggested that women therapists are often referred particularly difficult patients after these patients have failed a first therapeutic effort. Because gender affects trust and compliance in psychotherapy, change in the therapist based on gender might be helpful in some situations.

VIII. GENDER CHOICE IN COUPLES AND FAMILY THERAPY

As with all forms of therapy, gender is a consideration in the choice of a therapist for couples or families. In general, as with individual therapy, issues related to gender choice should be clarified and addressed. A couple with marital difficulties may request a female therapist because it is the wife who has made the call and it is her preference, perhaps because she feels intimidated by men or because she fears that she could be left out of the male dyad if the therapist were male. On the other hand, a husband may choose a woman or comply with his wife's choice of a female therapist because he is more comfortable and less threatened by women, because he does not take the therapy seriously, or because he has negative feelings about women. The choice of a male therapist for some couples may re-create, in the transference, a paternal or authoritarian relationship or even the fantasy of possible sexual abuse. This can be a special problem if abuse has actually occurred.

During the course of therapy, attention must be paid to bias regardless of whether the therapist is male or female. Transference issues in couples and family therapy are multiple and more complex because more people are directly involved in the therapy. For example, each partner and the couple as a unit will have different transference reactions to the therapist and to each other. If there are additional family members involved they too will add to the transference complexity.

Changes in family patterns have presented an increasing array of challenging issues for therapy. For example, the stress and demands of dual-career or commuting families, especially those with two achievement-oriented partners, can create enormous tension. This may be a greater source of conflict if the wife is earning more money, or if there is a job offer to either partner in another city. Because the husband's work has traditionally been the motivating factor in a relocation, a wife's job offer can create tensions, especially involving competition. A wife who achieves success later in life can be on a different timetable than her husband, who may wish to retire earlier.

Feminist critiques of family therapy express concern about the structural–hierarchical dominant role of

males in the family, mother blaming, assumptions about sharing power and responsibility embedded in systemic concepts, and assumptions about therapist neutrality. Family therapy has also been criticized for biased treatment of men, for example, for reinforcing the socialized limitations of male roles.

IX. GROUP THERAPY

As with couples and family therapy, there are gender issues in group therapy. When group therapy is sought or recommended, the gender of the group therapist is not frequently considered, although the gender composition of the group is often thought to be important. There are data suggesting that group behavior between group members and with the leader is affected by gender.

Women often seek women's groups because in groups of men or even in mixed groups they feel powerless, intimidated, and uncomfortable about speaking up. One need only look at classrooms, professional meetings, and business groups to recognize that women speak less often than men, and when they do speak, their comments are more often ignored or attributed to men. Women report the same experiences, regardless of professional status or income. They may feel supported and less anxious in same-sex groups, although mixed groups may be helpful in confronting these issues.

Most often single-sex groups have been used for support and consciousness-raising. Both male and female self-help groups often form around a specific focus (e.g., substance abuse, divorce, family violence) and use problem-solving approaches.

Therapy groups with both male and female leaders permit men and women to deal with transference issues, both as peers and as leaders. It is important, however, that the leaders' relationship with each other, just as with male and female therapists in family therapy, be a facilitating rather than inhibitory factor. Mistrust, competition, and anger that are not addressed in either leader or group members can be unproductive and inhibitory to group process.

X. SEXUAL ABUSE

When there is a history of early trauma, especially sexual abuse, which is more common in women, the impact of the trauma and the betrayal by parental figures or those in authority can result in psychopathology that can emerge later. It can be understood as an etiological factor in the increased likelihood that survivors of childhood abuse will be victimized as adults. Studies also report profoundly self-destructive behaviors emerging after victimization. Somatic symptoms can also develop later. The aftermath of abuse, particularly after repeated abuse, is often a residual sense of helplessness and loss of autonomy. This may intensify conflicts about dependency and stimulate self-criticism, shame, and guilt in many areas of life. Difficulty handling anger and aggression, and persistent feelings of vulnerability are also common repercussions.

For those who have been abused, the ability to form a trusting therapeutic alliance may be difficult. This is an example of a situation in which patients may not seek or continue therapy if they are not comfortable with the therapist, and in this way gender may be a variable.

Some of the responses and behaviors of those who have been victimized evoke profound countertransference reactions in those treating them. It may be difficult to work with battered and abused women, who often evoke frustration and anger because of their tendency to displace anger, their passivity and failure to follow through on suggestions, and the frequency with which they return to the abusive situation. Some therapists overidentify with these patients and may also project their own feelings, fantasies, or experiences onto their patients. These may include judgment about the appropriateness of the patient's response. Rescue fantasies may occur in both male and female therapists when they treat abuse victims and can lead to therapeutic problems such as boundary violations. The therapist may attempt to become the loving, nonabusive parent that he or she thinks the patient should have had instead of the real, abusive parent. These countertransference problems can compromise the therapeutic relationship.

XI. ALCOHOL AND SUBSTANCE ABUSE

There is less known about the epidemiology and treatment of alcoholism and substance abuse in women than in men. Pharmacological treatments have often paid little attention to the different presentations, physiology, and needs of men and women. For example, women's smaller body size, higher body fat content, and lower alcohol dehydrogenase levels contribute to higher blood alcohol concentrations in women with the same alcohol intake, and to the greater effect of smaller amounts of alcohol in women. Likewise, there are psychological and sociocultural factors affecting the behavior of those with alcohol and substance abuse. Currently, treatment approaches are similar for men and women, and do not ac-

count for gender differences. For example, treatment programs attempt to dissociate abusers from their alcohol- or drug-using peers, placing women drug and alcohol abusers at a disadvantage because they are more likely to live with partners who are also abusers and who discourage or prevent them from seeking help with threats or actual physical and/or sexual abuse.

Women respond better to relational involvement in treatment programs. They are more likely to attend and participate in women's groups. Because women's substance abuse often is less visible than it is for men, their abuse is often not recognized by family and friends so they are not encouraged to seek treatment.

XII. CONCLUSION

It is apparent that gender is an important treatment variable and that attention to the particular needs and experiences of women, together with better understanding of the complex interaction of gender and other variables, will shed light on the therapeutic process and contribute to greater therapeutic effectiveness. We have seen that gender can influence the patient's choice of therapist, the "fit" between therapist and patient, the sequence and content of the clinical material presented, the diagnosis, length of treatment, and the outcome of the treatment. Stereotyped views, expectations, and unconscious transference and countertransference fantasies about gender differences and what they will mean in the therapeutic process often persist and are influential, regardless of whether they have demonstrable validity. As more attention has been paid to the real attributes of the therapist, age, race, culture, gender, life experiences, and other variables have been understood to play an important role in the therapeutic process.

See Also the Following Articles

Couples Therapy ■ Cultural Issues ■ Eating Disorders ■ Family Therapy ■ Feminist Psychotherapy ■ Multicultural Therapy ■ Race and Human Diversity ■ Transcultural Psychotherapy ■ Sex Therapy

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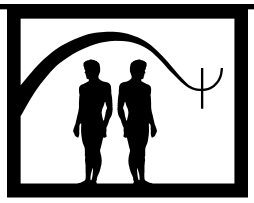

Working Alliance

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GLOSSARY

common factors Procedures and processes that occur in all types of therapies regardless of the theoretical orientation of the therapist.

effect size The statistical degree to which differences or relationships between groups exist.

meta-analysis A statistical analysis that combines the results of several empirical studies.

working alliance Client–therapist bond and agreement on the goals of therapy and tasks to be undertaken to achieve them.

Working Alliance Inventory (WAI) A scale that enables assessment of the common alliance factors of client–therapist bond and agreement on goals and tasks of therapy. Ratings may be done by clients, therapists, and outside observers.

The working alliance is a collaborative relationship between client and therapist that is common to all types of therapies and enables therapeutic success. This article presents an overview of the theoretical foundations of the alliance and a review of research on the quality of the alliance and its relationship to therapeutic outcome.

I. OVERVIEW OF THE WORKING ALLIANCE

For years, researchers conducted numerous studies to determine whether or not various psychotherapies were effective in relieving clients' problems, and if they were, which types of therapy were most effective. Large-scale reviews of these studies in 1994 by Michael Lambert and Allen Bergin, in 1986 by William Shapiro and colleagues, in 1980 by Mary Smith and colleagues, and in 1997 by Bruce Wampold and colleagues established that psychotherapy worked and that there was little difference in the effectiveness of different forms of psychotherapy. Since different types of therapy are virtually equally effective, some researchers have focused on the characteristics that all therapies have in common that contribute to client improvement. These characteristics are known as common factors, because they are procedures or processes that occur in all types of therapy regardless of the theoretical orientation of the therapist.

The working alliance refers to the collaborative relationship between therapist and client where the two establish a bond and agree on the goals of therapy and tasks to be undertaken to achieve them. It is a common factor that impacts outcome across a variety of therapies. Some theorists and researchers even believe that the working alliance is more important to outcome than the type of therapy that the therapist uses. In 1988, in an article on the integration of all forms of

therapy, Barry Wolfe and Marvin Goldfried called the working alliance the "quintessential integrative variable."

II. THEORETICAL BASES OF THE WORKING ALLIANCE

The concept of working alliance originated in psychoanalytic psychotherapy that is designed to make unconscious conflicts and feelings conscious. The analytic patient relates to the analyst in a distorted manner that mirrors these unconscious conflicts. In 1912, however, Sigmund Freud also posited a positive relationship between the analyst and patient that was based in the reality of their work together. This relationship later became known as the working alliance.

To humanistic therapists who believe that people are capable of helping themselves if they are provided with a facilitating relationship, the working alliance is both necessary and sufficient for client improvement. According to Carl Rogers in 1957, the therapist was responsible for creating this facilitating relationship by demonstrating empathy, genuineness, congruence, and unconditional positive regard toward the client. Within this accepting environment, the client was then able to achieve self-acceptance and self-actualization. This relationship would then generalize to other relationships outside of therapy. Thus, for Rogers, the working relationship was directly responsible for client improvement.

Behavioral and cognitive-behavioral therapy, which are based on learning principles, did not originally address the client–therapist relationship. In 1977, however, the Association for Advancement of Behavior Therapy (AABT) published ethical principles for behavior therapists. These principles emphasized client agreement with the goals and methods of treatments that are important components of the working alliance. Thus, most behaviorists and cognitive behaviorists stress the importance of the working alliance.

The working alliance is just one term for the collaborative relationship between client and therapist. Different theorists highlight different aspects of the alliance, and as a result, it is sometimes referred to as the helping alliance or therapeutic alliance. In 1979, Bordin put all the elements of the working alliance together into one conceptualization that applied to all types of theories and therapies. He defined working alliance as a bond between client and therapist and an agreement on the goals of therapy and the tasks necessary to achieve those goals.

III. EMPIRICAL STUDIES

Interest in the working alliance as a common factor in all types of therapies has spawned considerable research. This research is primarily, but not exclusively, concentrated in three areas: assessment of the alliance, the relationship of the alliance to outcome, and changes in the alliance across time.

A. Alliance Assessment

Because different researchers emphasize different aspects of the working alliance, they have developed scales to measure the alliance that reflect their theoretical interests. For instance, in the 1980s, Lester Luborsky and his colleagues at the University of Pennsylvania developed what are now known as the Penn Scales to assess client, therapist, and observer perspectives of the helping alliance. Also in the 1980s, Charles Marmar and Elsa Marziali and their colleagues developed the Therapeutic Alliance Rating Scale (TARS), and in 1989, Marmar and colleagues revised the TARS and named the new scale the California Psychotherapy Alliance Scales (CALPAS). In 1983, D. E. Hartley and Hans Strupp developed the Vanderbilt Therapeutic Alliance Scale (VTAS), and in 1989, Stephen Saunders and his colleagues developed the Therapeutic Bond Scales (TBS).

Each of these scales was based on the different theoretical conceptualizations of the working alliance, but most also incorporated Bordin's integrative formulations. One scale, however, was developed to specifically assess Bordin's conceptualizations. It is the Working Alliance Inventory (WAI) and was created in 1986 by Adam Horvath and Leslie Greenberg. It allows an overall alliance score and its three scales separately assess the therapeutic bond, agreement on goals, and agreement on tasks—the three dimensions of the working alliance identified by Bordin. The original WAI is 36 items long, with 12 items in each scale. In 1990, Terence Tracey and Anna Kokotovic developed a short form of the WAI that has 12 items.

Because they were designed to assess the same thing, the various working alliance instruments have been found by researchers, such as Victoria Tichenor and Clara Hill in 1989, to be highly positively correlated. In 2000 in a statistical analysis that combined the results of 79 empirical studies, using meta-analytic strategies. Daniel Martin and his colleagues found that each of these scales is associated with good reliability. With the exception of the TARS, each of the scales also related positively and significantly to therapy outcome. Thus,

researchers investigating the working alliance could use any of these scales, with the exception of the TARS, in their inquiries with confidence. Martin and colleagues suggest, however, that the WAI is an appropriate choice for most investigations because of its applicability to all theoretical perspectives.

B. Relationship of Working Alliance to Therapeutic Outcome

The numerous studies relating the working alliance to various types of outcome (i.e., ratings of patient improvement, type of termination) are summarized by two meta-analyses. The first was a meta-analysis of 24 studies done in 1991 by Adam Horvath and Dianne Symonds. They found that the working alliance was moderately positively related to therapy outcome. The effect size, or the statistical degree to which working alliance and therapy outcome were related, was .26. Their findings applied regardless of the length of the treatment, the number of clients in each sample, and whether or not the study was published.

The recent meta-analysis in 2000 by Daniel Martin, John Garske, and Katherine Davis also found a moderate positive relationship between working alliance ratings and treatment outcomes. The effect size was .22. This meta-analysis corrected for some factors that might reduce effect size in the studies reviewed, but it did not correct for other factors (such as test reliability and validity). As a result, the effect size is an underestimate. This means that the impact of the working alliance is greater than the meta-analysis reported.

This relationship between alliance and outcome was obtained regardless of who did the alliance ratings (therapist, client, or observer), who rated the outcome (therapist, client, or observer), what outcome measure was used, the time in therapy that the alliance was assessed (earlier or later in treatment), the publication status of the research (21 studies of the 79 studies in the analysis were unpublished, 58 were published), or the type of therapy provided. Thus, Martin and colleagues' meta-analysis provided support for the inference that the working alliance is a common factor associated with outcome for all types of therapies.

C. Changes in the Working Alliance across Time

In their 1985 article on the relationship in psychotherapy, Charles Gelso and Jean Carter emphasized the importance of establishing a positive working alliance early in treatment so that the alliance would sustain the relationships through the difficult periods in treatment. They believed that the alliance becomes disrupted in the middle phase of therapy when most intense work on behavior and attitude change is undertaken. The alliance was then assumed to recover to more positive levels later in therapy.

The 1991 meta-analysis by Horvath and Symonds provided some support for this perspective. They found a larger effect size between working alliance and outcome in studies where the assessment of the working alliance was done early in treatment session than for studies that assessed alliance in the middle phases of treatment.

The 2000 meta-analysis by Martin and colleagues did not support the formulation that successful treatment is associated with a better working alliance at the beginning and end than in the middle of treatment. The relationship between working alliance and outcome was not influenced by the time in treatment when the alliance was assessed, and, as stated earlier, the alliance–outcome relationship is also not influenced by type of therapy used. The findings of Martin and colleagues' meta-analysis support the perspective advanced by Carl Rogers that the working alliance is itself therapeutic. Thus, if a good working alliance is established, client, therapist, and external observers will perceive the client's problems as improved.

IV. SUMMARY

When clients come to therapy, they expect to find therapists with whom they can develop a close relationship. They expect that their therapists will want the same outcomes for them that they want for themselves, and they expect that therapists will suggest ways to attain these goals that they will find acceptable. These are the elements of the working alliance endorsed by most theorists and researchers—client and therapist bond and agreement on the tasks and goals of therapy. The strength of the working alliance may be assessed by giving clients and therapists any of several instruments, but the Working Alliance Inventory is recommended because it was specifically designed to assess client–therapist bond, agreement on tasks, and agreement on goals as well as the overall alliance.

Research results confirm that the working alliance is a common factor in all types of successful therapies. If the working alliance between client and therapist is positive, the outcome of therapy will be positive. If the

alliance is negative, the client will not improve and may even leave therapy before it is finished. Moreover, it could be said that the working alliance is itself a therapy. If they are part of a good working alliance, clients will improve regardless of what type of therapy is being conducted or when in therapy the alliance is assessed. These research results indicate that specific training in the establishment of positive working alliances should be done in all graduate programs regardless of the theoretical emphasis of the program.

See Also the Following Articles

Bioethics ■ Confidentiality ■ Engagement ■ Informed Consent ■ Integrative Approaches to Psychotherapy ■ Rational Emotive Behavior Therapy ■ Resistance ■ Termination ■ Working Through

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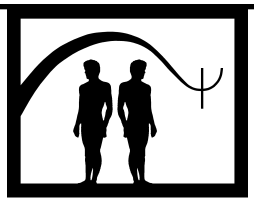

Working Through

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GLOSSARY

insight Understanding acquired in therapy that connects general themes with particular actions and emotions.

resistance Term that refers to a variety of intrapsychic forces that impede the progress of therapy.

working through A psychoanalytic concept that describes the effort by patient and therapist of overcoming resistance and effecting change.

I. DEFINITION

The psychotherapeutic concept of "working through" originated as a psychoanalytic construct that accounted for the failure of correct interpretive work to immediately result in symptom resolution and character change. It simultaneously invokes the fact that therapy takes time and that patience and persistence on the part of the therapist must be matched by active perseverance and effort on the part of the patient. If therapy is to produce genuine changes in patterns of thinking, feeling, and behavior then a process of transformation must take place, a process that achieves both self-understanding and that neutralizes the countervailing forces of inertia and defense. Although working through has at times seemed almost an afterthought for theorists, an epiphenomenon of the analytic work, others have viewed it as the quintessential activity that defines successful psychotherapy. Working through names the struggle to crystallize the insights gleaned from meticulous self-examination, to connect these insights not only to their putative origins, but to trace their consequences throughout one's subjective and interpersonal experience in an effort to establish a healthier, less fettered, character. This takes time and is often an elusive and arduous goal to reach. The tendency to reenact long-established patterns is not easily undone. In other words, therapy takes work and commitment if it is to result in something more profound than glib self-awareness, which is to say substantive change.

II. FREUD'S THEORY

Freud first makes reference to the notion of "working through" in his paper on technique "Remembering, Repeating, and Working Through" written in 1914. Troubled by the mounting recognition that often a patient's resistance persists in spite of the initial disclosures of a correct interpretation, Freud observed that the beginning analyst has

> merely forgotten that giving the resistance a name could not result in its immediate cessation. One must allow the patient time to become more conversant with

> this resistance with which he has now become acquainted, to work through it, to overcome it, by continuing in defiance of it, the analytic work according to the fundamental rule of analysis.

What the beginning analyst had forgotten was not always apparent even to Freud. In the early days of psychoanalysis, the work of therapy was admittedly "laborious and time-consuming for the physician" but the effort expended was directed toward bringing the pathogenic ideas to consciousness. The resistance of the patient was primarily a matter of repression; once the ideas were successfully retrieved and exposed to the light of conscious awareness symptom resolution followed in short order. Typically, this revelation was accompanied by an "abreaction" of affect associated with the offending idea. Where this failed, the affect was found to have been embedded in a series of affiliated memories and associations and only by a comprehensive "working over" of the pathogenic material could the symptoms be disposed of once and for all. This earlier term, "working over," was a prototype for the subsequent concept of working through and signified early on the fact that analytic progress is not always straightforward, even when it seems to be going well.

Clearly, resistance plays a key role in the analytic view of therapy and it is the antinomy of working through. In Freud's formulation working through engages the resistance once the patient has become acquainted with it. By its very nature resistance is an unconscious adversary that operates by subterfuge and stealth. It is protean in its manifestations and may appear as a failure to produce meaningful disclosures, as faulty remembering, by tenacious distortions and misconstructions, or through the distractions of a robust transference. This latter resistance was paradigmatic for Freud who was preoccupied with the dynamics of the transference throughout his papers on technique (1910–1919). Originally derived from techniques that employed suggestion, the psychoanalytic method first recognized in the transference a means of securing the cooperation of the patient and thus of facilitating the analytic work. Although there is no doubt that some degree of positive transference is indispensable to the progress of therapy, Freud learned from experience that transference is the "strongest weapon of the resistance." As a result of this discovery, the analysis of the transference proved to be a critical step in acquainting the patient with the fact of his resistance. Freud observed:

> Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses.

In this way the patient becomes aware of the resistances and their associated impulses. Becoming conversant with these manifestations constitutes the first phase of working through proper. This phase is time-consuming because recognizing resistances requires deep understanding and an appreciation for the common themes that run through what may appear on the surface to be totally unrelated attitudes and behaviors. It is this exercise that ultimately establishes insight.

Although the resistance exhibited in the transference may have been uppermost in Freud's thinking at the time he first wrote of working through, his subsequent deliberations on resistance called attention to the threat posed by the tendency to repeat. Freud had written variously of the "pertinacity of early impressions," of "psychical inertia," "fixation," and the "adhesiveness of the libido." All of these terms referred, in one way or another, to an obstinacy or lack of mobility on the part of the libido, its reluctance to give up its objects or to change its course. Writing of the general *modus operandi* of analytic treatment in the Introductory Lectures, Freud (1917) remarked:

> The more closely events in the treatment coincide with this ideal description, the greater will be the success. … It finds its limits in the lack of mobility of the libido, which may refuse to leave its objects…

Freud traced this obstinacy on the part of neurotic fixations to the "resistance from the id" and its manifestation he termed the "compulsion to repeat." Even after the ego resistance has been identified and the pathogenic material rendered visible, the tendency to repeat remains. Thus, Freud observed in his *Inhibitions, Symptoms and Anxiety* in 1926:

> For we find that even after the ego has decided to relinquish its resistances, it still has difficulty in undoing the repressions; and we have called the period of strenuous effort which follows after its praiseworthy decision, the phase of "working-through." The dynamic factor which makes a working-through of this kind necessary and comprehensive is not far to seek. It must be that after the ego-resistance has been removed the power of the compulsion to repeat—the attraction exerted by the unconscious prototypes upon the repressed instinctual process—has still to be overcome. There is nothing to be said against describing this factor as the *resistance of the unconscious*.

In other words, what Freud discovered was that even after the patient has gained an awareness of his resistances and the pathogenic impulses underlying them, the perennial therapeutic imperative—"let go and move on"—is far easier said than accomplished. The resistance from the unconscious manifested by the repetition–compulsion remains to be dealt with. Overcoming this deeply mired complex of resistances represents an aspect of working through that differs from that involved in the acquisition of insight. Faced with the inherently conservative nature of the drive derivatives motivating neurotic life, the ego engaged in working through must wrest itself free from these bonds in order to foster meaningful change. The contest would appear not to be a matter of insight or of understanding, but of brute force. Knowing that one is, by nature, subject to the law of gravity does not help one to escape its influence. Only by overcoming this force can one move out of its orbit.

It is not surprising, then, that Freud in 1940 concluded the chapter on technique in his posthumously published *Outline of PsychoAnalysis* by remarking that:

> We shall not be disappointed, but, on the contrary, we shall find it entirely intelligible, if we reach the conclusion that the final outcome of the struggle we have engaged in depends on *quantitative relations*—on the quota of energy we are able to mobilize in the patient to our advantage as compared with the sum of energy of the powers working against us.

This conclusion suggests that working through is nothing less than a heroic process, one that calls for overcoming, defiance, and perseverance. Indeed, the decision to continue the analytic work over and against all such forces to the contrary Freud deemed "praiseworthy." And, not inconsequentially so, for Freud conceded from the outset that working through names that "part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion."

III. PERSPECTIVES ON WORKING THROUGH

Given the obvious importance of working through to the outcome of psychotherapy it remains a curiosity that Freud devoted so little actual discussion to the problem. One explanation may be that working through is as pervasive in actual practice as it is intangible and that Freud could only invoke it as the ineffable ingredient that distinguished analysis terminable from analysis interminable. Any attempt to define it further immediately devolves into a discussion of technique, or of metapsychology.

Of course, subsequent theorists have intermittently elaborated on the concept and have generated a series of sometimes divergent positions. Not surprisingly, these elaborations typically reflect the differing approaches to technique or theory espoused by their authors. Classically, Otto Fenichel in 1945 viewed working through from the analyst's point of view, that is, as a problem in technique.

> Systematic and consistent interpretive work, both within and without the framework of the transference, can be described as educating the patient to produce continually less distorted derivatives until his fundamental instinctual conflicts are recognizable. Of course, this is not a single operation resulting in a single act of abreaction; it is, rather, a chronic process of working through, which shows the patient again and again the same conflicts and his usual way of reacting to them but from new angles and in new connections.

Others such as W. Stewart in 1963 and M. Sedler in 1983 emphasized the patient's contribution to the process. P. Greenacre in 1956 conceived of working through as a "working out" of residual infantile traumas and memories that could not be adequately reconstructed or resolved solely by an analysis of current defenses. In 1991 L. Aron proposed the term "working toward" in an effort to "capture the sense of the work of both patient and analyst as co-participants in the analytic process. Patient and analyst not only work toward a new and corrective relationship, but work toward making the nuances of that relationship explicit…" Transcending such positions, Charles Brenner presented a view of working through that underscored its ubiquity in the analytic process. He argued simply that "working through is not a regrettable delay in the process of analytic cure. It *is* analysis. … The analysis of psychic conflict in all of its aspects is what should properly be called working through."

Generally, there is agreement that working through is a concept made necessary in order to explain, "Why does psychoanalysis take so long?" Posing just this question, Charles Brenner in 1987 helped us perhaps to understand Freud's reticence on the subject by answering candidly, "we do not know." Brenner observed:

> that such analysis takes time, all analysts know. Why it takes as much time as it does is a question which remains

as yet unanswerable. However, we also know that when analytic work proceeds favorably—when working through is successful—it results in psychic changes which are of inestimable value to the patient and which no other form of psychotherapy can achieve.

III. SUMMARY

Many of the basic truths about character pathology, neurotic symptoms, and the possibilities for meaningful change discovered in the era of psychoanalysis have been obscured by the subsequent proliferation of derivative psychotherapies. Nevertheless, the promises and predictable results of "brief therapy" cannot negate the fundamental lessons about mental life learned from our experience of psychoanalysis. Serious conflicts rooted in the soil of constitutional factors and infantile residues are not easily brought to light, and are even less easily resolved. The method of psychoanalysis is a notoriously protracted one and its results are uncertain. For these reasons its popularity and its credibility have suffered. Nevertheless, the challenges defined by working through show why it must be so: Failures, uncertainty, struggle, and hope are facts of the human condition. Technical innovations in psychotherapy are not likely to fundamentally alter this reality. Insofar as the original meaning of "working through" has been assimilated by this psychotherapeutic pluralism, there may be a general understanding that successful therapy requires both time and hard work. At the same time, this assimilated meaning most likely designates the process only in its most generic sense, that is, as the struggle to replace one set of personal characteristics with another. In any context this is not an easy business.

See Also the Following Articles

Engagement ■ Outcome Measures ■ Relapse Prevention ■ Resistance ■ Termination

Further Reading

Brenner, C. (1987). Working through: 1914–1984. *Psychoanalytic Quarterly, LVI,* 88.

Cooper, A. (1989). Working through. *Contemporary Psychoanalysis, 25,* 34.

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Sedler, M. (1983). Freud's concept of working through. *Psychoanalytic Quarterly, LII,* 73.