on the effectiveness of psychotherapeutic measures in specific situations and about the timing or sequence in which particular measures have produced the best results. Patients and society as a whole are making demands on us for the more precise application of specific procedures. These demands can be met by illuminating the still dark areas of psychotherapy with fresh knowledge.

3

Dealing with Aggressive Impulses

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In the life equation of every human being, the aggressive drive is an x force whose value is determined by what he does with it. Constructively released toward the outside world by a mature ego, the drive serves as a precious raw material for productive living; but if it is suppressed and repressed, the finished products are likely to be social maladjustment and emotional illness. What an individual does with the drive depends, in turn, on how his primary needs were met by his mother or other significant objects in his childhood experience. As Glover points out, aggressive impulses radically influence the mind from the very beginning of life and, besides contributing to normal development, "can be responsible for the most severe forms of mental breakdown" (1949, p. 40).

For example, the individual who was exposed early in life to extreme frustration of his basic needs habitually responds to frustration by mobilizing excessive aggressive impulses. Our present concern is with the patient who responds in this manner and, especially, with the development of healthy patterns for the release of his frustration-aggression.

A prodigious amount of psychotherapeutic effort is expended in undoing the evil consequences of suppression and repression. One of the reasons why play therapy and activity group therapy (Slavson, 1943) are commonly employed with children, and various educational, inspirational and counseling procedures with adults, is to secure the release of suppressed energy. These are among the generally recommended methods of stimulating emotional discharge and facilitating the formation of new release patterns.

But the patient who has developed stubborn infantile defenses against the release of aggressive impulses may require something more fundamentally

reconstructive than new opportunities and outlets for emotional release. Unless the actual *patterns* of his pathological behavior are resolved—that is, mastered and outgrown—the pressure to revert to them may prove irresistible. To be of permanent value, his treatment must be oriented to the resolution of these patterns. The psychic energy which has been so unprofitably invested in maintaining them can then be put at the ego's service for its own maturation and other desirable purposes.

That is why the preferred form of treatment for such a patient is intensive analytic psychotherapy, with consistent interpretation and working through of the infantile defenses. As a rule, this process serves to reawaken images and memories of the relationship and situations—usually preverbal ones—in which these patterns of response to frustration were originally formed and experienced. If catharsis takes place the resolution of the patterns becomes possible.

THERAPEUTIC IMPASSE

In a problem case or particular stage of treatment, however, a patient may fail to experience catharsis despite the accurate and well-timed interpretation and working through of his infantile defenses. The failure may be associated with too strong an attachment to the original object, which often militates against the development of a full negative transference toward the therapist.

Such a patient may remark, for example, that he is utterly worthless and that is why his therapist won't talk to him. Time and again it may be explained that he feels that way because he is attacking himself, and intellectually the patient may be able to grasp the validity of that interpretation. He does not feel any the better for it, though, unless the defense pattern it reactivates leads to a kindling of images and memories of the early experiences in which the defense was patterned. That, we repeat, is the *sine qua non* for resolving the pattern: the bringing to consciousness of the original experience and the discharge of aggressive impulses in new feelings, thoughts and language.

How is one to proceed when the ego attitudes of a patient who has been consistently receiving judicious interpretation block catharsis? Can the release of his hate tensions be instigated in some other way, or must treatment grind to a standstill?

We have found that such an impasse can generally be averted if the therapist psychologically reflects the infantile defense patterns as one aspect of treatment. We shall suggest certain theoretical concepts underlying this ego-strengthening approach,* and indicate how it has been employed by the

*For a fuller account of the therapeutic process, see Spotnitz and Nagelberg (1960).

authors and their colleagues for more than a decade in administering intensive analytic psychotherapy to several hundred patients who had proved refractory to consistent objective interpretation.

JOINING AND REFLECTING RESISTANCE

The long-range treatment goal, one to which the therapist needs to be constantly oriented, is the resolution of the patient's various resistances to telling the story of his life in a spontaneous and meaningful manner. As long as he has a strong need to maintain these resistances, no pressure is exerted on him to overcome them. Quite the reverse. The therapist supports and reinforces the resistance patterns—*joins* them. In a well-structured and favorably developing relationship, the psychological needs which gave rise to them gradually diminish. As the patient becomes more and more capable of functioning without these resistances, he tends to give them up voluntarily. Eventually they are mastered and outgrown—fully resolved.

How do the infantile defenses fit into this general plan? They are reactivated in frustrating treatment situations, and help the patient resist talking significantly about his life. They therefore fall into rank among the resistances which the therapist joins. One of the ways he does this is by psychologically reflecting their patterns.

Psychological reflection is a therapeutic approach which is not used exclusively to deal with the problem we are discussing. We shall not attempt to examine this approach, however, except as a specific means of facilitating the refractory patient's pathological response to frustration.

For this purpose, two forms of psychological reflection are often employed. We shall refer to one as an echoing procedure and the other as a devaluating procedure. Each is designed to resolve a different aspect of a defense pattern which is probably not too unfamiliar: the pattern of the worthless ego attacking its "low-down" self or worshiping a wonderful and distant object.

Echoing the Ego

The ego's pattern of self-attack is highlighted through the echoing procedure. The therapist uses it to repeat—at times with dramatic emphasis—the patient's expressions of low regard for himself. The unequivocal echoing of his ego in the process of "low rating" itself strengthens his attitude that he is not fit company for a wonderful object. And yet, however black the ego, the object never moves away. It dedicates itself to meeting the ego's constant need for psychological closeness to an object, the kind of object that will stick with the ego through thick and thin. That is the crucial factor.

Hypothetically, this procedure may be said to reverse the original process of ego formation, when the infantile mental apparatus failed to release

hostile feelings toward its earliest object since the latter was experienced as being too distant. Feelings of being neglected, and of being deprived of an object that could be depended on to receive the aggressive impulses which were mobilized, contributed to the formation of a pattern of directing these impulses back upon the mental apparatus. A similarly frustrating situation is created in treatment when the object echoes the ego's attacks upon itself, but with this vital difference: The once distant object has been replaced by one constantly within reach, one always close enough to serve as a target for the ego's aggressive impulses. Sooner or later the psychological twin image which faithfully stands by and joins in the ego's attack upon itself arouses sufficient resentment to reverse the flow of mobilized aggression from the ego to the object.

As it is repeatedly demonstrated that expressions of hostility do not drive the object away, the patient tends to discharge his aggression more and more freely in feelings and language. The feelings of hate and aggressive fantasies with which he characteristically responds to the echoing procedure often lead to the hoped-for recall and release. That is, the hateful situations in which the infantile defenses were structured and activated are recalled, and aggressive impulses are released in the form of emotionally crystallized and verbally discharged energy.

The Case of Mr. A.

To demonstrate how the echoing procedure may be used and what may result from it, we shall report some interaction which took place in the treatment of Mr. A. This prosperous and respected businessman regarded himself as a faker and could see little satisfaction in his life—past, present, or future. His attacks upon his own ego were psychologically reflected to help him resolve this pathological response pattern and develop a healthier pattern of attacking the object without fear of losing it. The four successive interviews drawn upon took place within a two-week period during the third year of treatment.

First interview. Dispiritedly, Mr. A complained that he was a rank failure. The therapist paraphrased the complaint and agreed that Mr. A could be regarded as a rank failure. Almost at once, the patient became more animated. He accused the therapist of looking for an excuse to drop the case. Then he added, "I resent your looking upon me as an inferior person. If I really was one, how could I solve my problems? But I have to admit that I really don't believe you when you say nice things about me. Words of approval don't give me the strength to fight. The first time something stirred inside me was when you criticized me."

Second interview. The patient began speaking about himself in very discouraging terms and the therapist echoed his remarks. This irritated Mr. A, and he declared, "My situation really is hopeless, but I don't want *you* to say so. Do you think I want to feel this way?" Battling against his feelings of hopelessness, the patient went on to say, "Instead of always attacking me, why can't you be helpful?" The therapist asked, "Why must I always be helpful? Why can't I attack you too?" After some consideration, the patient replied, "When you give me the idea you might not want to be helpful, you do seem more alive to me. That makes me feel more alive too; and I want to fight back. The trouble is I still feel I shouldn't attack you."

Third interview. Mr. A declared that no one loved him; probably this was so because he wasn't worth loving. He was asked, "Is there anything about you that makes you worth loving?" The patient quickly answered, "That's just your way of saying you have no love for me. I ought to quarrel with you for saying such things, but I know there are many things about me which people hate." He proceeded to recall occasions when he had felt resentful toward his associates.

Fourth interview. He hated most of the people he knew, Mr. A said, and he distrusted all of them, even the therapist. The latter asked, "Do you think that you yourself can be trusted?" The patient exclaimed, "Well, you really rang the bell that time. You should have asked me that a long time ago. I complain that people put pressure on me, and they really do; but I certainly put pressure on them. I don't give them any reason to trust me." As the session went on, the patient became more and more emotionally involved. He said to the therapist, "I'm beginning to get somewhere now, but you're no longer an easy mark for me. You make me feel like a baby beginning to walk." This led to the statement that the therapist was beginning to make Mr. A feel as he had once felt with his father. Early childhood experiences which had made the patient feel tense and numb were then recalled. He said that he had always bottled up his true feelings because he did not dare to give his father any reason to disapprove of him.

Devaluating the Object

There is more than one way of psychologically reflecting an ego in the process of "low rating" itself. Instead of echoing the ego's complaint about itself, the object may respond: I'm just as bad. In effect, that is what happens when the therapist employs the so-called devaluating procedure. He picks up the same cue as for the echoing process to resolve another aspect of the infantile defense pattern: the tendency toward object-worship. The lowly ego makes deep bows before the wonderful object perched way above it; such a superior object cannot be treated with hostility without risking the loss of its valuable services. Hence, the therapist acts upon an appropriate cue from time to time to make the object less wonderful, to move it down to the ego's

level. He suggests that instead of being an omnipotent therapist, he is just like the patient—equally inadequate or equally in need of help. Since they are really brothers under the skin, he deserves to be attacked and will welcome it.

The specific element in the process of ego formation which is being reversed through this maneuver, it is hypothesized, is closely related to that on which the echoing procedure is based. The greatly needed original object which was experienced as too rarely available also came to be regarded as too valuable to attack. Rather than risk damaging such a wonderful object or driving it even farther away, the infantile mental apparatus began to bottle up its aggressive impulses. The therapist's disillusioning attacks expose the ego to the frustrating experience of looking on while its cherished object is painfully devaluated. But it is transformed into an object that can be attacked with relief and with impunity, so that it eventually receives the verbal attack it has been inviting.

The two procedures described may be used singly or in combination at any phase of therapy. The one that we have generally employed first is the echoing procedure, with its focus on the patient. The process of object devaluation is usually set in train after the patient has acquired some feeling for the therapist as an external object. Interpretation, by the way, becomes an increasingly important aspect of the treatment process as the infantile defense patterns are gradually resolved. After the patient has become fully capable of expressing in the treatment relationship the aggression that objective interpretation may mobilize, the therapist shifts from psychological reflection to interpretation as his judgment dictates.

The Case of Betty

We shall now demonstrate the devaluating procedure—its use and characteristic effect. Betty, the patient, was an attractive single woman in her late twenties. Though advancing in her profession, she habitually complained that outside her office she felt like a robot or "lifeless shadow" who had to conform totally in order to survive. The therapist's interpretations of her behavior would help her for a while to assert herself more freely in her social relationships; but she could not be budged from the attitude that she herself was defective, and too dependent on the godlike creature who was deigning to treat her to express any hostility. Material is presented from a therapy session during which the devaluating procedure was employed to facilitate the resolution of this stubborn defense. The session took place after she had been in treatment for several years, with different therapists.

Betty complained that she didn't trust herself to go out socially; besides, no one ever asked her for a date. The therapist told her it was obvious that he hadn't helped her; had he done a better job, many men would have been taking her out. Betty responded that he couldn't be serious, and she apologized for painting such a gloomy picture. At any rate, if anyone had failed, it was herself, not the therapist. When he repeated that he had failed her and was responsible for her lonely evenings, Betty said that he was making her feel uncomfortable. She preferred to think that *she* was at fault. She added, "I tell you I'm a failure to annoy you, but I'm really not because I don't do or feel a thing."

Again the therapist shouldered the blame, and again she disagreed. He could show her how to walk, she said, but he couldn't do her walking for her. Betty went on, "What's the use of blaming you if I don't want to move? In a way, though, you are right. I ought to be wanting a husband instead of always sitting alone and doing nothing. Now you're making me feel terrible. Why must you get me so worked up about things? I hate to say it, but you really should have helped more than you have. No, that isn't true. I haven't cooperated. I should have talked more freely."

She *had* talked freely, she was told. Bewildered, Betty asked the therapist if he was certain of that. Then, after pausing briefly, she exclaimed, "You're right! I told you everything but it hasn't helped. What about all the time and money I've put into this treatment? If you get me to believe you, I'll be too mad to ever come again."

The therapist asked, "Why can't you be mad and still come? Even if I have failed, all this can change. I can begin to understand you if you'll help me."

"That would be a cheap way out for you," Betty shouted, "But if you haven't helped me by now you never will. Besides, since when is it *my* job to help *you*? If you need help, go and see an analyst yourself."

The therapist's next statement was that, although Betty had spoken freely, she had made no attempt to help him make her as popular as she wanted to be. They could work together to accomplish this if she would display more initiative about it.

Betty made no effort to conceal her anger as she shot back, "I could help you, and I'm smart enough to point out all the mistakes you've made, but I hate you too much to help you. My foot! I'll help you into the grave. If I let it sink in that you've botched up my treatment, I'd go crazy, scream and cut my throat. No. It's you who ought to go to prison for getting me in such a state. I was too nice to tell you what I thought of you before, but now I'm so mad I don't care. I ought to report you and sue you for my money. If I tore you to pieces I could plead insanity and get off scot-free."

After Betty's rage had somewhat subsided, she calmly—almost apologetically—told the therapist that he had gotten her into a mess, and would have to get her out of it.

"Why don't you get *me* out of it?" he asked her.

"I wouldn't lift my little finger to help you," Betty replied. Then she laughed. "You see how I hate you when you don't let me have my way. If you won't let me win, I won't let you either, even if my whole treatment goes up in smoke. Now you've seen how furious I can get when I let myself go. And there's still plenty of anger inside me."

Later in the session Betty remarked that she had never felt free to vent her anger until the therapist had told her he had failed her. The patient continued, "That made me want to fight because you wouldn't let me take the blame. Then I was able to feel my real feelings. I know that I can succeed: I really don't have to be so meek and apologetic. . . . But I still feel that you're on the defensive. I know it's absurd, but I also feel that you're still afraid of me and jealous, like the enemy I used to feel my mother was. I would try to convince her that I was good, so she wouldn't keep on being my enemy and attack me. But I was never as innocent as I tried to appear. I'd fight Mother tooth and nail, and I wanted her to die. All the time I was afraid she wouldn't go on taking what I was dishing out. I felt she was scared but would pay me back some day. I expected that would happen today when I hit at your feelings of importance. I was afraid you couldn't take it and would turn against me."

Betty stopped suddenly and appeared to be thinking over what she had just said. Then she told the therapist that she now realized she was taking the same attitude toward him that she had once had toward her mother. "I've been living all these years with my mother's image inside me," Betty declared. "I never dared to disobey her and show her my true colors. I was always against her but never felt it before. Now I'm going to begin thinking for myself."

In conclusion, brief presentations focusing on clinical practices often create a misleading impression. Inadvertently, we may have conveyed the notion that psychological reflection is a sort of gimmick, or a device that can be flicked on mechanically at any time in any treatment relationship. We therefore wish to make it clear that what we have been discussing is *not* an artificial technique. It is, rather, a general approach which the therapist has to develop in his own way and assimilate comfortably to his own personality. To be spontaneous and therapeutic, his responses must be motivated by genuine feeling for, and a sincere desire to help the patient. That is the key to the effective use of psychological reflection.

4

The Maturational Interpretation

Significant stages in the growth of understanding about the curative factors in analytic psychotherapy are reflected in changing emphases in interpretation. Half a century ago it was thought that what healed a patient was the recall of memories. Treatment was then regarded as incomplete unless "all the obscurities of the case are cleared up, the gaps in the patient's memory filled in, the precipitating causes of the repressions discovered" (Freud, 1917, pp. 452-453). When it became evident that the memories were less important than what prevented their recall, interpretations were made to overcome the repressive forces in the guise of resistance. Later resistance was recognized as an essential source of interpretive data because it told the story of the ego's development. The focus shifted to the constrictive influence that resistance, in order to create more favorable psychological conditions for ego functioning. Explanations were oriented toward the integration of the ego and the acquisition of insight.

More recently, widening appreciation of the communication function of resistance has stimulated other approaches to interpretation. As yet, these have not dispelled the misleading notion that therapeutic change issues primarily from objective understanding of one's behavior. In the professional literature, "interpretation" is still commonly laced together with such verbs as "convince," "point out," "demonstrate," "prove," "confront," and "unmask." But the use of interpretation primarily for veil-lifting purposes is waning, with the recognition that other aspects of the treatment relationship are often more significant than the development of self-under-