Curative Factors in Dynamic Psychotherapy

Edited by

SAMUEL SLIPP, M.D.

JULES BEMPORAD

MORRIS EAGLE

EDRITA FRIED

MERTON M. GILL

ROBERT L. HATCHER

OTTO F. KERNBERG

HEINZ KOHUT

ROBERT J. LANGS

EDGAR LEVENSON

RUTH W. LIDZ

THEODORE LIDZ

JUDD MARMOR

STANLEY R. PALOMBO

LLOYD H. SILVERMAN

SAMUEL SLIPP

MICHAEL H. STONE

SAUL TUTTMAN

VAMIK D. VOLKAN

ERNST WOLF

DAVID L. WOLITZKY

Curative Factors in Dynamic Psychotherapy

Edited by SAMUEL SLIPP, M.D.

Jules Bemporad
Morris Eagle
Edrita Fried
Merton M. Gill
Robert L. Hatcher
Otto F. Kernberg
Heinz Kohut
Robert J. Langs
Edgar A. Levenson
Ruth W. Lidz
Theodore Lidz
Judd Marmor
Stanley R. Palombo
Lloyd H. Silverman
Samuel Slipp
Michael H. Stone
Saul Tuttman
Vamık D. Volkan
Ernst Wolf
David L. Wolitzky

McGRAW-HILL BOOK COMPANY

New York / St. Louis / San Francisco
London / Paris / Tokyo / Toronto

Lawrence B. Apple, Suzette H. Annin, Thomas H. Quinn, and Michael Hennelly were the editors of this book. Christopher Simon was the designer. Teresa F. Leaden supervised the production. It was set in Times Roman by University Graphics, Inc.

Printed and bound by R. R. Donnelley and Sons, Inc.

Library of Congress Cataloging in Publication Data

American Academy of Psychoanalysis.
Curative factors in dynamic psychotherapy.

Proceedings of the annual meeting of the American Academy of Psychoanalysis, 1978.
Bibliography: p.
1. Psychotherapy—Congresses. 2. Psychoanalysis—Congresses. 3. Personality change—Congresses.
I. Slipp, Samuel. [DNLM: 1. Psychoanalytic therapy.
WM 460.6 C974]
RC475.5.A48 1981 616.89'14 80-27133

1 2 3 4 5 6 7 8 9 RRDRRD 8 0 9 8 7 6 5 4 3 2 1

ISBN 0-07-058190-8

Contributors

Jules Bemporad, M.D., Director of Children's Services, Massachusetts Mental Health Center, Boston, Massachusetts; Associate Professor of Psychiatry, Harvard Medical School.

Morris Eagle, Ph.D., Director of Clinical Training Program, Professor of Psychology, York University, Toronto, Canada.

Edrita Fried, Ph.D., Training Analyst and Senior Supervisor, Training Department, Postgraduate Center for Mental Health, New York, New York; formerly Associate Professor of Psychiatry, Albert Einstein College of Medicine.

Merton M. Gill, M.D., Professor of Psychiatry, The Abraham Lincoln School of Medicine, University of Illinois, Chicago, Illinois; Supervisory Analyst, Chicago Psychoanalytic Institute.

Robert L. Hatcher, Ph.D., Clinical Assistant Professor, Department of Psychiatry, University of Michigan, Ann Arbor, Michigan.

Otto F. Kernberg, M.D., Medical Director, New York Hospital-Cornell Medical Center, Westchester Division, White Plains, New York; Professor of Psychiatry, Cornell University Medical College; Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research.

Heinz Kohut, M.D., Professorial Lecturer, Department of Psychiatry, University of Chicago School of Medicine, Chicago, Illinois; Visiting Professor of Psychoanalysis, Department of Psychiatry, University of Cincinnati; Faculty, Training, and Supervisory Analyst, Chicago Psychoanalytic Institute.

Robert J. Langs, M.D., Editor in Chief, *International Journal of Psychoanalytic Psychotherapy;* Director, Psychotherapy Training Program, Lenox Hill Hospital, New York, New York.

Edgar A. Levenson, M.D., Director of Clinical Services, William A. White Institute, New York, New York; Training and Supervisory Analyst, William A. White Institute; Clinical Professor of Psychology, Division of Graduate Studies, New York University.

Ruth W. Lidz, M.D., Clinical Professor of Psychiatry, Yale University, School of Medicine, New Haven, Connecticut.

Theodore Lidz, M.D., Sterling Professor of Psychiatry Emeritus, Yale University, School of Medicine, New Haven, Connecticut.

Judd Marmor, M.D., Franz Alexander Professor of Psychiatry Emeritus, University of Southern California, School of Medicine, Los Angeles, California.

Stanley R. Palombo, M.D., Associate Clinical Professor, George Washington University, Washington, D.C.; Faculty, Washington Psychoanalytic Institute; Faculty, Washington School of Psychiatry.

Lloyd H. Silverman, Ph.D., Research Psychologist, New York Veterans Administration, Regional Office, New York, New York; Adjunct Professor, Department of Psychology, New York University.

Samuel Slipp, M.D., Medical Director, Postgraduate Center for Mental Health, New York, New York; Clinical Professor, Department of Psychiatry, New York University, School of Medicine.

Michael H. Stone, M.D., Clinical Director, University of Connecticut Health Center, Farmington, Connecticut; Professor of Psychiatry, University of Connecticut, School of Medicine.

Saul Tuttman, M.D., Ph.D., Clinical Assistant Professor, Department of Psychiatry, New York University, School of Medicine, New York, New York; Instructor and Staff Lecturer, Training Department, Postgraduate Center for Mental Health.

Vamık D. Volkan, M.D., Medical Director, Blue Ridge Hospital, Charlottesville, Virginia; Professor of Psychiatry, University of Virginia, School of Medicine.

Ernest S. Wolf, M.D., Assistant Professor of Psychiatry, Northwestern University, School of Medicine, Chicago, Illinois; Faculty, Training, and Supervisory Analyst, Chicago Psychoanalytic Institute.

David L. Wolitzky, Ph.D., Director of Graduate Training in Clinical Psychology, Department of Psychology, New York University, New York, New York; Associate Professor of Psychology, New York University.

Acknowledgments

This book received special impetus through the leadership of the American Academy of Psychoanalysis whose Chairman of the Programs Committee, Ian Alger, appointed me Program Chairman of the National meeting of the American Academy of Psychoanalysis in Atlanta, Georgia, May, 1978. This privilege permitted me to bring together a panel of eminent clinicians who participated in a discussion of a topic of long-standing concern to me: "What Produces Change in Psychoanalytic Treatment." Their provocative and scholarly presentations served as the basis of the present volume. The rare friendship and professional support of Lloyd Silverman contributed significantly to the encouragement needed to pursue and elaborate these germinal ideas into a book.

A main source of my personal interest in this subject of curative aspects of the psychotherapeutic process came from Lewis Wolberg and his impact as a teacher during my psychoanalytic training. My interest further developed and broadened in the course of my research studies into the various aspects of psychotherapy at the Department of Psychiatry of New York University School of Medicine, under Morris Herman and subsequently Robert Cancro.

My three colleagues, Robert Langs, Saul Tuttman, and the late Benjamin Fielding, made valuable editorial suggestions for which I am extremely appreciative. I want to thank my editor, Larry Apple, for his kindness and important suggestions, Suzette Annin and Debra Weiss for the excellence of their copy-editing. I wish to express my appreciation to the contributors, all of whom were most cooperative in working closely with me on their respective chapters.

The extensive library research required for this book was most ably executed by Lee Mackler, Librarian for the Postgraduate Center for Mental Health. I

am especially grateful for my secretary Marie Smitelli for her efficient and enthusiastic assistance.

Most of all, I thank my wife Sandra and daughter Elena for their patience, ongoing support, and love extended continuously all through this time-consuming venture.

Contents

Introduction

Samuel Slipp

The most challenging issue in dynamic psychotherapy today is what actually produces change in the patient during treatment. What are these intangible yet powerful factors arising from the patient-therapist interaction that enable the patient to overcome symptoms, to give up maladaptive behavior, and to grow and develop as an individual? Recent advances in psychoanalytic knowledge have created a mounting wave of excitement and spurred the development of newer techniques that expand and enhance the usefulness of dynamic or psychoanalytic psychotherapy.[1]

Certain types of patients who formerly were considered unsuitable for psychoanalysis can now be treated by psychoanalytic psychotherapy. So often in the past, treatment with such patients was disrupted by negative therapeutic reactions, which occurred because of the defensive structure of these patients, their inability to develop a stable transference neurosis, their difficulty in establishing a therapeutic alliance, their intense rage, and their perceptual distortion of reality. The most important thrust of current psychoanalytic investigators is the work with narcissistic and borderline disorders as well as schizophrenic and depressive conditions. As we extend our analytic understanding and develop refinements in technique that enable us to engage and treat a much wider

[1]The terms dynamic and psychoanalytic will be used interchangeably.

group of patients, it becomes essential to evaluate the effectiveness of this treatment. The crucial question that confronts us is: what are the curative factors in dynamic psychotherapy that make it work? Are these the same as the curative factors emphasized in psychoanalysis? Yet, even in psychoanalysis, we are faced with diverse opinions about what is curative. This book will review the major factors considered to be curative and will suggest ways to evaluate them scientifically. One hopes this review will lead to better understanding of the therapeutic process and greater effectiveness in treatment, thus strengthening our common goal—to promote growth and change in our patients.

This book grew out of the Annual Meeting of the American Academy of Psychoanalysis in May, 1978. Having the opportunity to chair and organize that meeting, for three days I devoted an entire track to the important topic of what produces change in treatment. Most of the papers presented at that meeting were updated and included in this book. In order to present viewpoints representative of the entire psychoanalytic community, additional papers written by clinicians and researchers with diverse orientations were included in this volume. Most of these papers are published here for the first time. The contributors to the book were selected on the basis of the important and original work they have done in expanding our knowledge of how psychoanalysis or dynamic psychotherapy works. Each contributor was given the challenging task of writing a chapter on one aspect of the important question: what produces cure during dynamic psychotherapy?

We know that behavioral change or symptomatic improvement does indeed occur in patients as a result of suggestion, environmental manipulation, and a number of other nonspecific factors. There is a question, however, regarding the permanence of such change, which occurs without any alteration in the personality structure of the patient. Freud's original definition of cure rested on two pillars: the ability to love and the ability to work.* Cure involves not simply freedom from symptoms but also the patient's capacities to enter into intimate, loving relationships and to be productive at work. Repetitive, fixed patterns of thoughts, feelings, and behavior that may have been adaptive during childhood, but are self-defeating or limiting in the current reality, need to be relinquished to facilitate greater flexibility and better coping ability.

Freud believed that psychoanalytic cure came from insight, facilitated by the therapist's interpretations and reconstructions of associative material and dreams, and by the patient's reliving of old conflicts in the transference to the analyst. Insight served as a bridge between the past and the present. It was as if part of the patient were frozen (fixated) in the past and doomed repeatedly to act out the past through behaviors in the present. Cure was possible only

*It should be pointed out that this "definition" of cure may be what Freud meant by the term. No one has ever been able to find a written statement of it. Apparently Erikson, in *Childhood and Society*, 1950, p. 229, quotes Freud as having *said* something to this effect

after the patient remembered these conflicts and understood the unconscious wishes and fears underlying them. These memories contained ways of perceiving, thinking, and feeling from childhood, which, when brought to conscious awareness, could be reexamined in the light of adult functioning. The therapeutic alliance between the patient's observing ego and the therapist encourages self-observation of old conflicts as they are relived in the transference, resulting in restructuring, and expansion of the patient's ego.

Other factors that produce cure in psychoanalysis have also been suggested. These place less emphasis on insight and focus instead on the human relationship of patient and therapist, e.g., as providing a "corrective emotional experience," a "holding environment," or a second chance to relive and correct developmental arrests or deficits in the self (further to differentiate the self from the object) as well as an opportunity for the patient to identify with the analyst. These and other factors are further developed in the various chapters in the book.

Before proceeding it is important to define certain concepts that will be used and to provide a broad historical perspective for the chapters that follow. In this volume dynamic psychotherapy will be differentiated from psychoanalysis proper. Dynamic psychotherapy employs theoretical principles derived from psychoanalysis proper, but certain modifications in technique are made. Instead of the broad psychoanalytic goal of general personality change, dynamic psychotherapy as used here attempts to change specific aspects of the patient's behavior and character. The distinction between these two therapeutic approaches is not universally accepted, cannot always be clearly demarcated, and there is an area of overlap. In addition, the same patient, after sufficient ego growth in dynamic psychotherapy, may be able to benefit from psychoanalysis.

In 1954, controversy arose about whether Franz Alexander's therapeutic work could still be considered psychoanalysis, as well as about the core issue of whether the therapeutic relationship (a "corrective emotional experience") or the technical skill of the therapist was the most important factor in producing change in the patient. Taking the classical position, Rangell (1954) defined psychoanalysis in terms of technique and method of cure:

> Psychoanalysis is a method of therapy whereby conditions are brought about favorable for the development of a transference neurosis, in which the past is restored in the present, in order that, through a systematic interpretive attack on the resistances which oppose it, there occurs a resolution of that neurosis (transference and infantile) to the end of bringing about structural changes in the mental apparatus of the patient to make the latter capable of optimum adaptation to life. [pp. 739–740]

Gill's (1954) definition of psychoanalysis further narrowed the classical position by emphasizing the neutrality of the analyst and the resolution of the

regressive transference neurosis through the use of interpretation alone. Alexander (1954) and Fromm-Reichmann (1954) employed a broader definition of psychoanalysis, which encompassed the recognition of the importance of childhood conflict on personality development, the significance of the unconscious, and the use of transference and resistance in the treatment.

In a classic article, Bibring (1954) attempted to deal with this controversy by defining the procedures employed in all psychotherapies. He mentioned (1) suggestion, (2) abreaction, (3) manipulation, (4) clarification, and (5) interpretation. Bibring distinguishes between their use as a technique and their curative application in various treatments. He defined *suggestion* as an authority figure's inducing ideas, feelings, impluses, etc., in another person. Bibring considered that in hypnosis suggestion was curative. In psychoanalysis, suggestion is used as a technique to encourage the patient to produce dreams, memories, and fantasies, to tolerate anxiety and depression, and to face unpleasant situations. *Abreaction* concerns the therapist's acceptance or empathy with the expression of suppressed or repressed emotions. Although Freud originally considered catharsis to be curative, with the further development of psychoanalysis it became a technical tool for developing insight. In acute traumatic neurosis, however, abreaction may remain a curative factor. *Manipulation* involves giving advice and guidance, or changing the social milieu. The redirection of the patient's emotional attitudes through the therapist's words or attitudes is a subtler form of manipulation. Bibring believed that Alexander's handling of the transference to produce a "corrective emotional experience" was subsumed under this heading of manipulation. *Clarification* involves a more accurate differentiation of the self from the outside world. It increases self-awareness (feelings, thoughts, attitudes, behavior, etc.), and awareness of others and of objective reality. *Interpretation* involves the analyst's explanation of the unconscious motives and defenses that determine the patient's manifest behavior patterns.

Bibring contended that insight resulted from both clarification and interpretation, which increase self-awareness. Clarification involves little resistance, since it strengthens the patient's ego through fostering greater self-definition, more astute observation of others, and mastery over difficulties. Clarification is particularly significant in ego-psychological approaches, where the analyst's collaboration with the patient's observing ego is encouraged. Interpretation, on the other hand, arouses resistance because it brings into consciousness both repressed childhood memories that have been defended against and the release of painful affect. Bibring believed that, in psychoanalysis, all five therapeutic procedures are technically operative, but that insight through systematic interpretation is the primary curative factor. He believed that interpretations in dynamic psychotherapy tend to be less systematic and limited to partial uncovering of unconscious areas. In dynamic psychotherapy, the importance of the relationship between the patient and therapist assumes a greater significance.

Transference gratification is not always avoided, and identification with the therapist may be actively fostered through a more empathic and involved approach.

The controversy about the curative effect of relational factors versus insight was by no means resolved by Bibring. Its origins stem from an even earlier controversy between Freud and Ferenczi. Freud had carefully defined the analyst's position as one of technical *neutrality*. The transference was not to be gratified; only thus could fantasy be distinguished from reality in transference interpretations. *Interpretation* of transference and resistance was to be the main tool for change. However, Ferenczi, who worked with sicker patients, considered that maintaining this *neutral-interpretive* approach with patients who had suffered actual severe parental neglect would simply prevent engagement in treatment. Because of the patient's negative expectations, the abstinent approach would be experienced only as a repetition of parental indifference. Thus Ferenczi (1920) advocated his "active," caretaking approach, wherein the analyst was emotionally available, warm, and responsive. The patient was provided with an opportunity to regress to a symbiotic state of oneness. This provided a second chance to reexperience and grow out of the childhood neurosis, with the analyst serving as a good parental object.

This *nurturant-reconstructive* approach, as well as other aspects of Ferenczi's contributions, later found expression in the work of Alexander, Balint, Fromm-Reichmann, Guntrip, Khan, Kohut, Little, Marmor, Sechehaye, Sullivan, Thompson, and Winnicott.

Ferenczi is generally considered the father of object relations theory. He was the first to report on how patients used others to fulfill their needs by projecting their internal fantasies onto them. In addition, Ferenczi (1919) was the first to stress the importance of the analyst's being aware of both his persistent countertransferential feelings and the emotional interaction between patient and analyst. It remained for Melanie Klein, an analysand of Ferenczi's, to synthesize these insights into a systematic theory, and for the British school to develop them further into the object relations approach.

Guntrip (1968), one of the proponents of the British school, speculated on some of the differences between Ferenczi's and Freud's theory and technique. Freud placed greater emphasis on the part played by intellectual activity in analysis to produce change, an orientation that Guntrip considered masculine and phallic. The terms *in*sight and *in*terpretation themselves were indicative of active penetration. On the other hand, the analyst's stress on empathy, feelings, experiences, relationships, and interaction represented a feminine orientation. While Freud stressed the Oedipal period and sexuality, Ferenczi emphasized the pre-Oedipal period with its problems of dependency and aggression.

In this respect, Winnicott (1965) clearly believed the curative effect of therapy lay in *reexperiencing* a responsive, "good enough" mothering. The analyst provided the unconditional acceptance that served as a "facilitating" environ-

ment, comparable to the environment of infancy, which created a foundation of security and trust. In addition, the analyst created a "holding" environment which accepted and contained the patients' aggression without retaliation. Thus, patients were able to differentiate fantasy from reality through the therapeutic *relationship;* there they learned that their aggression did not destroy the object. Patients could relinquish their omnipotence and their need to control the object after they learned that the object had a separate and permanent existence. Winnicott believes that the analyst serves as a "transitional object" who enables patients to master their helplessness and distrust of the mother. Differentiation of the self and the object replaces the omnipotent fusion; thus the patient can individuate and develop a "true self" instead of a "false, compliant self."

In Freud's later work, he actively attempted to integrate the emotional and cognitive factors by concentrating his focus on the ego. Psychoanalysis changed from primarily an id psychology to an ego psychology, which encompassed drive theory but emphasized adaptation. In Freud's structural model (1923), the analysis of the ego and its defenses against the demands of the id, the superego, and the external world became paramount. In "Beyond the Pleasure Principle," Freud (1920) developed the concepts of the repetition compulsion and the ego's need to master instinctual drives as well as external forces. In Freud's new theory of anxiety (1926, 1933), a threat to the ego signaled anxiety, which in turn caused repression; previously, anxiety had been viewed simply as the result of repression of affect.

In Anna Freud's pioneering work (1936), she furthered the application of ego psychology to bring about change in psychoanalytic treatment and child analysis. Anna Freud disagreed with Melanie Klein's approach to child analysis—using early interpretations of deep unconscious fantasies revealed in the transference—since such interpretations could overwhelm the child's ego and lead to regression, uncontrolled acting out, and a negative therapeutic reaction. While Melanie Klein bypassed the ego to reach deep, instinctually generated anxieties, Anna Freud considered the ego an ally to the therapeutic process and believed that child analysis should begin on "the surface," by analyzing the ego's methods of defense. The patient was thus encouraged to participate actively in a therapeutic alliance, and the analysis of defense as well as the transference became important.

Kris (1950) elaborated this point in his concept of "regression in the service of the ego," wherein the ego participated in the analytic process of uncovering and synthesizing repressed instinctual material. Insight need not be the forced, rapid uncovering of unconscious material resulting from the analyst's dramatic interpretation, but rather, should come more slowly, with the appropriate involvement of the patient's ego. The importance of cognitive factors in adaptation to external reality was also further developed by Hartmann and his col-

leagues (Hartmann, 1939; Hartmann, Kris, and Loewenstein, 1951). They postulated the existence of a "conflict-free sphere" of the ego, which mediated the individual's drives and the demands of the environment for adaptive purposes. The conflict-free sphere determined what was expected and perceived, leading to a constancy of behavioral response. In addition, a model of external reality became internalized, like a cognitive map; it was termed the "inner world." Hartmann (1950) further defined the concept of the self as a separate structure within the ego, one that contained self- and object representations.

There have been further efforts to integrate the above-described theories and techniques. Kernberg (1977) considers Edith Jacobson's (1964) developmental model the most comprehensive psychoanalytic theory to date, integrating ego psychology, object relations, and drive theory. In addition, her close collaboration with Mahler (1968), whose work emphasizes the vicissitudes of early childhood development involved in separation-individuation, gave Jacobson important supportive material. Jacobson's work in turn served as a foundation for Kernberg's own important contributions to psychoanalytic theory and technique.

In his chapter in this book, Kernberg reviews theoretical issues and their applications to therapeutic work with borderline and narcissistic patients. Using the developmental schema based on Mahler's and Jacobson's work concerning stages of self- and object differentiation, Kernberg says the therapist's goal is to help these patients overcome their developmental arrest, to integrate part object relations into total object relations, to develop object constancy, and to achieve an integrated self-concept. To attain this objective, Kernberg suggests that the therapist maintain technical neutrality and interpret partial aspects of the transference. In addition, Kernberg recommends the systematic interpretation of splitting and other primitive defenses. In this way, patients can relinquish both the need to idealize and maintain omnipotent control over the analyst and the need to depreciate the analyst as an independent object to defend against the dread of empty aloneness. As patients learn that they can express their ambivalence without fear of retaliation from the analyst, their integration and differentiation improve. Kernberg's work with borderline patients (1975) has the advantage of a scientific foundation: his having been director of the Menninger Psychotherapy Research Project. This study found that borderline patients did poorly when treated by either classical psychoanalysis or supportive therapy. Those treated by expressive psychoanalytic psychotherapy did better. The degree of improvement depended on the ego strength of the patient as well as on the therapist's skill and empathy in establishing a working alliance and containing aggression.

The chapter by Kohut and Wolf elaborate another position based on extensive clinical data derived from the treatment of narcissistic disorders. Kohut (1977) has placed the self at the very center of the personality; he explains

pathology and symptoms in terms of a psychology of the self. Although he acknowledges the role of drive theory and ego psychology in understanding conflict, Kohut considers their importance secondary and their explanations insufficient for a thorough comprehension of the psychopathology in the narcissistic patient. Kohut sees a weakened or defective self, a self that has not been confirmed by the parents, as the core of the patient's psychopathology. An authentic and capable self can only be built when the "mirroring" (admiring responses) and "idealizing" needs of the child are satisfied by the self-objects (parents). The unresponded-to self of the child cannot individuate and thus retains its archaic grandiosity and the wish to merge with an omnipotent self-object. Kohut prefers the term self-object transference instead of narcissistic transference to describe the type of transference narcissistic patients develop. He recognizes the need these patients have to reexperience this self-object transference ("mirror" or "idealizing") in order to make up for their developmental arrest. In their chapter, Kohut and Wolf elaborate a comprehensive psychology of the self, including a characterology of disorders of the self. Kohut is aware that others have compared his work to that of a variety of other psychoanalysts—especially Aichhorn, Hartmann, and Winnicott (and even Ferenczi, as I mentioned earlier). Kohut emphasizes, however, that his theory and technique have arisen directly out of his own clinical work and the need to transcend the limitations of classical theory. In therapy, Kohut and Wolf emphasize the importance of the therapist's empathy rather than on the interpretation of drives, since the latter may be experienced as blame. The patient needs to become aware of, to express, and to accept the unfulfilled narcissistic needs from childhood, and thus to become more accepting of himself.

The chapter by Judd Marmor develops the viewpoint that the context of the treatment situation—the patient-therapist relationship—is of greatest importance to cure. This viewpoint stems from the scientific project undertaken by Franz Alexander in 1957, which involved the objective observation and recording of psychoanalytic sessions over a period of several years. In his report, Alexander (1963) challenged the neutrality of the analyst, claiming that the analyst's values are subtly learned by the patient through verbal and nonverbal cues. Thus the therapist as a real person is also significant—especially the attributes of genuineness, warmth, and respect. These qualities help develop a therapeutic alliance that permits working through past traumatic experiences. Alexander reported that a "corrective emotional experience" occurs when the analyst's response to the patient's maladaptive behavior differs from that of past parental figures. This experience is more important than verbal interpretation in bringing about cure. It is interesting that a recent controlled scientific study by Strupp (1979), in the Vanderbilt Psychotherapy Research Project, corroborated Alexander's position; i.e., technical skill did not seem to be as significant as the human relationship, at least in short-term treatment. A group