A CRITIQUE OF THE PRESENT STATUS OF THE PSYCHOTHERAPIES*

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BEFORE ONE can write a meaningful critical evaluation of the psychotherapies of today, he must attempt to define the types of treatment methods which are commonly assumed to be distinguishable varieties of psychotherapy. This is no easy task, for there exists no such generally accepted classified listing of the psychotherapies. A motley array of adjectives is found to designate brands of psychotherapy which are supposedly different from each other but which actually overlap each other in manifold ways. It will be a necessary preliminary task for us to review the terms commonly used in psychiatric literature and in ordinary professional parlance to designate various types of psychotherapy.

In a survey of usages which probably falls short of being exhaustive, I have noted that the type of psychotherapy may be characterized from any one of a number of frames of reference:

1. With regard to the preponderant attitude taken or influence attempted by the therapist; e.g., suggestion, persuasion, exhortation, intimidation, counselling, interpretation, re-education, re-training, etc.

2. With regard to the general aim of the therapy; e.g., supportive, suppressive, expressive, cathartic, ventilative, etc.

3. With regard to the supposed "depth" of the therapy—superficial psychotherapy and deep psychotherapy.

4. With regard to the duration—brief psychotherapy and prolonged psychotherapy.

5. With regard to its supposed relationship to Freudian psychoanalysis, as, for example, orthodox, standard, classical, or regular psychoanalysis, modified psychoanalysis, wild analysis, direct psychoanalysis, psychoanalytic psychotherapy, psychoanalytically oriented psychotherapy, psychodynamic psychotherapy, psychotherapy using

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the dynamic approach, and psychotherapy based on psychoanalytic principles.

6. With regard to the ex-Freudian dissident who started a new school of psychotherapy. Thus we have Adler's individual psychology with its Adlerian "analysis," Jung's analytical psychology with its Jungian "analysis," the Rankian analysis, the Stekelian analysis, and the Horney modifications.

7. With regard to whether patients are treated singly or in groups—individual psychotherapy and group psychotherapy.

8. With regard to whether the psychotherapy is "directive" or "non-directive," an issue emphasized strongly by the Rogers group of psychologists.

9. With regard to the adjunctive technique which is coupled with psychotherapy; e.g., narcotherapy (narcoanalysis, narcosynthesis), and hypnotherapy (hypnoanalysis), the first using drugs and the second hypnosis for technical reasons to be discussed later.

It is not surprising that both physicians and the lay public regard this welter of terminology as something less than scientific, and that patients seeking help for emotional distress are often confused as to where to find that help and as to what type of psychotherapy to trust. In defense of the present confusion one can remind himself that although psychotherapy is said to be the oldest form of medical treatment, it is also one of the very latest to achieve a scientific, rational basis, i.e., to rest on a basic science of dynamic psychology. Because of its partial derivation from many unscientific and extra-scientific sources—primitive magical practices of tribal medicine men, religious rites, parental exhortations and commands, mysticism, common-sense advice and intuitive insights of friends, and downright quackery, to mention but a few—psychotherapy has among its practitioners today not only many lay fakirs but also a good many physicians whose training in dynamic psychology is grossly inadequate. Also, even among the best trained psychiatrists there exist some honest differences of opinion regarding principles and techniques of psychotherapy. However, research and experimentation continue to expand, and slowly the phenomena of artful and intuitive psychotherapeutic influence are translated into scientific principles and techniques.

It is impossible to overstate the importance of dynamic psychology as a basic science on which all competent psychotherapy must rest.

Without an underlying structure of psychodynamics and psychopathology, in which the psychotherapist must be well trained, all psychotherapy is at best empirical, at the worst the blind leading the blind. No valid critique of the psychotherapies is possible except in relation to the penetrating understanding of human personality and behavior provided by dynamic psychology, the chief contributions to which have been made by psychoanalysis.

It seems necessary, therefore, to review for an essentially non-psychiatric medical audience the theoretical essentials in modern dynamic psychology. The cornerstone of dynamic psychology is the concept of repression. As the psychic structure of the human personality develops in infancy and childhood, the primitive erotic and aggressive impulses come to be opposed by counter-impulses deriving from the child's training and adaptive experiences. The chief counter-impulse is repression, which banishes from consciousness—but not from continued active existence in the unconscious—those impulses, some native and some stimulated by specific experiences, which the child discovers are condemned and forbidden expression by its upbringers. Both the strength of the alien impulses and the child's capacity to oppose them are partially determined by his native constitution, partly by the nature of his early experiences, and partly by the character and upbringing methods of those adults who rear him. Some condemned impulses are simply repressed, along with their associated fantasies and affects; others are modified in partial expression and partial repression, assisted by other defense mechanisms. Topographically the unconscious is regarded as the repository of repressed impulses and forgotten memories, the preconscious as that part of the mind in which reside the rememberable but currently unattended to memories, and the conscious mind as the aware, focussing, thinking portion of the psychic structure. Viewed dynamically, the primitive impulses arise out of biological and psychological drives identified collectively as the Id, while the opposing, defensive forces arise from Ego, or organized part of the personality, and the Super-ego—roughly the conscience. The sum total of these dynamic internal and external interactions, plus constitution and native intellectual endowment, equals the developing personality in all of its individual uniqueness. While the major battle between opposing internal forces appears to be settled at about age five or six, thus forming the basic personality structure, there is a continuous internal interaction

and a constant external adaptive attempt throughout life, with special crises during adolescence and in reaction to the Protean forms that stressful life experiences can take. Also, each individual, however healthy his adaptation appears to be, has his own particular psychological areas of vulnerability to stress, and he may be precipitated into clinical neurotic or psychotic illness by experiences whose qualitative or quantitative nature exceed his capacity to master them through healthy adaptive methods.

This highly condensed exposition of dynamic psychology with its emphasis on the uniqueness of the individual will, I hope, be sufficient to serve as a background for the following proposition, namely, that competent treatment of a patient by psychotherapeutic means requires of the psychotherapist:

1. That he be thoroughly grounded in the basic science of dynamic psychology.

2. That he be well trained in clinical methods of evaluating the individual patient, not only in terms of general comparison with others presenting similar clinical pictures, but also in terms of the uniquely individual forces and factors in each individual patient.

3. That he then utilize, from among the available psychotherapeutic approaches and techniques, those particular ones which, according to his best clinical judgment, are most appropriate in a given case.

4. A fourth prerequisite does not follow logically from the previous argument but is of an importance at least equal to the other three, namely, that the psychotherapist be a person of integrity, objectivity, and sincere interest in people, and that he be relatively free from personal conflicts, anxieties, biases, emotional blind spots, rigidities of manner, and settled convictions as to how people should properly behave.

This last prerequisite for psychotherapeutic work requires some amplification. Unlike the situation in other fields of medical therapy, the man well grounded in the basic science underlying his therapy, well trained in diagnostic methods, and possessing technical competence to use the indicated therapy may still, in psychotherapy, be a poor practitioner if he is personally anxious, rigid, or full of moral convictions. Other therapies in medicine can be competently performed, with good results on patients, without these personal qualities, largely because a great deal of medical and surgical treatment consists of doing some-

thing *to* the patient. To be sure the personal qualities in a physician which cause his patients to love and trust him are exactly the ones which make him a real physician rather than a mechanical artisan; but far greater emotional demands are made on the psychotherapist. The nature of the subject material in psychotherapy, the intense personal give and take in the patient-therapist relationship, the enormously increased possibilities of anti-therapeutic personal involvement, the self knowledge in the therapist required both to understand his patients and to steer a sound therapeutic course with them, all require of the psychotherapist certain personal qualities not essential to other medical specialists. It is not particularly difficult for physicians to acquire protective attitudes of detachment in respect to those bodily elements and products—blood, pus, urine, diseased tissue, mucus, feces, guts—which so upset the squeamish layman, and this detachment serves the physician in good stead as he works coolly and efficiently at his therapeutic task. But this sort of detachment in a psychotherapist is not only no protection against the psychological products of his patients, it actually hampers and distorts his therapeutic work and, if extreme, even disqualifies him from undertaking to deal with psychopathology and psychotherapy. The counterphobic attitude may be sufficient for competent work in physiology, pathology, and surgery; it is a poor and brittle defense for work in psychiatry and psychotherapy.

Such personal considerations with regard to the psychotherapist raise important questions regarding selection of candidates for psychiatric training, and regarding the importance of personal psychoanalysis as a part of psychoanalytic and psychiatric training. Certainly every psychiatrist who wishes to do psychoanalytic therapy should have full psychoanalytic training, including, of course, the personal analysis. It might also be said that every psychiatrist who expects to practice major psychotherapy of any kind should have full psychoanalytic training, just as every physician who plans to do major surgery should have full surgical training.

I have so far attempted to show that the terminology designating supposed varieties of psychotherapy is very confusing because of the many frames of reference in which identifying adjectives were applied, and to indicate that a critique of these psychotherapies is not possible until a valid frame of reference is established. I then tried to show that familiarity with the basic science of dynamic psychology, and the

clinical techniques derived from it is necessary to provide a valid frame of reference for a critique. This led to the collateral but vital point of the psychotherapist's personal suitability. It is necessary to establish one more phase of this frame of reference. This has to do with the nature and vicissitudes of the patient-physician relationship in psychotherapy.

Most physicians are not much concerned about the attitudes, emotions, and fantasies their patients have about them as long as the patients are coöperative, don't go to other physicians, and pay their bills for professional services. Occasionally physicians are startled to encounter outbursts of unprovoked hostility or professions of love or jealousy, or suspicion from their patients. I suppose the usual result is that the patient is then discharged by that physician in the event the physician cannot "talk him out of his nonsense." Many psychiatrists of the past (and some in the present) have been more concerned about emotional reactions of patients to them, but have thought of them in terms of "good rapport" or the lack of it, without paying much attention to the exact nature of these reactions, whether friendly or hostile. Sigmund Freud, picking up a cue noted but abandoned by Josef Breuer, had the genius to follow through to a penetrating study of patients' emotional attitudes toward their doctors and to bring this group of phenomena into both the theoretical framework of dynamic psychology and the clinical framework of psychotherapy. He saw that whereas the various emotional reactions of the individual patient appeared at first to be irrational and unprovoked, actually these attitudes could be understood the same as other psychological phenomena in the patient could be understood, such as recovered memories, dreams, fantasies, and so on, and could, instead of being emotionally reacted to by the therapist, provide him with material for fresh insights into his patient. Freud called these reactions "transference" because of his understanding of them as emotions originally felt toward other significant persons in the patient's past experience, and now transferred to the doctor. He discovered that their nature could be interpreted to the patient, and that such interpretations, when correctly timed and accurately expressed, had significant therapeutic effect on the patient. Thus the theoretical understanding and clinical use of transference phenomena became one of the significant contributions of psychoanalysis to the field of psychiatry, and, indeed, to the practice of medicine in general, for trans-

ference reactions by patients are by no means limited to those being treated psychotherapeutically.

Freud also had the objectivity to observe and analyze his own reactions to patients, and concluded that all psychotherapists would have their own particular tendencies to react inappropriately (that is, inappropriately from the standpoint of correct therapeutic technique) to the material, or behavior, or persons of their patients. He called such reactions and reaction tendencies "counter-transference," and bade all analysts to be acutely observant of themselves in this regard so that they might analyze and dissipate these counter-transference reactions without letting themselves be unwittingly influenced by them to the detriment of their therapeutic efforts. Again, such counter-transference reactions are not confined to psychiatrists, psychoanalysts, or psychotherapists, but are present in all physicians toward their patients, albeit with considerably less significance, for the most part, in therapy other than psychotherapy. Once more, then, we see the importance for the psychotherapist of those personal qualities of integrity, objectivity, sincerity, and relative freedom from emotional blind spots.

I have now used almost half of my time to develop the background frame of reference in which any psychotherapy may properly be critically evaluated. The following elements have been emphasized:

1. The theoretical understanding of human personality provided by dynamic psychology.

2. The clinical evaluation of each individual patient—the nature and intensity of his internal and external conflicts, the genetic history of those conflicts, his particular defenses against anxiety, his strengths as shown by past adaptations and achievements, his vulnerabilities and weaknesses as shown by the extent of his decompensation, his way of relating initially to the therapist, his intelligence and its possible impairments, the intactness of his concept formation, his loyalty to reality, his capacity for introspection and self-confrontation, and so on.

3. The utilization of psychotherapeutic techniques based on sufficient knowledge of dynamic psychology and applied appropriately to the individual case in the light of the clinical evaluation.

4. The personal qualifications and suitability of the psychotherapist, and, we may now add, his capacity to recognize and deal with transference manifestations in his patients and counter-transference tendencies in himself.

If these four criteria provide a valid frame of reference in which to evaluate psychotherapy, it is readily seen that those psychotherapists who have a fixed system of treatment for all patients who come to them are practicing poor psychotherapy. This is true whether it refers to those therapists who treat all patients with such banal exhortations as "Buck up," "Go home and forget it," "Stop worrying about that," "Pull yourself together," "Don't cross bridges until you come to them," and so on; to therapists who treat all patients by assigning reading for subsequent interview discussions in prepared booklets on how to live; to psychoanalysts who put all patients on the couch and tell them to free-associate; or to therapists who keep the syringe loaded with sodium pentothal for each patient, or who routinely start their hypnotic maneuvers promptly. One may give insulin to every diabetic, or operate every acute appendix, with, of course, some judgment as to dosage, timing, and collateral measures, but psychotherapy is, or should be, a highly individual matter for each patient. Far too often in current practice the type of psychotherapy used with the patient is determined solely by the limited training and ability of the psychotherapist rather than by either the type of illness the patient has or the type of patient that has the illness.

Of the various possible ways of classifying psychotherapeutic attempts, most psychiatrists would agree that two large groups could be identified—those which aim primarily at support of the patient, with suppression of his symptoms and his erupting psychological material, and those which aim primarily at expression. It is actually more appropriate to speak of a group of techniques utilized to accomplish suppression or expression than to speak of sub-groups of psychotherapies under each major heading. Suppressive or supportive psychotherapy, also called superficial psychotherapy, utilizes such devices as inspiration, reassurance, suggestion, persuasion, counselling, re-education, and the like and avoids investigative and exploratory measures. Such measures may be indicated, even though the psychotherapist is well trained and experienced in expressive techniques, where the clinical evaluation of the patient leads to the conclusion that he is too fragile psychologically to be tampered with, or too inflexible to be capable of real personality alteration, or too defensive to be able to achieve insight. Certain recovering schizophrenics or agitated depressions or children might illustrate the fragility, rigid character disorders, certain manics and hypo-

manics, and elderly patients might illustrate the inflexibility, and some paranoid states might illustrate the defensiveness. The decision to use suppressive measures is made actually because of contraindications to using exploratory devices. One can say, then, that supportive or suppressive psychotherapy, with its variety of techniques and devices for accomplishing support and suppression, is a valid psychotherapy provided it is applied on the basis of sound indications and not indiscriminately to all or most patients simply because the particular psychotherapist does not know how to do anything else with the patient, and provided the psychotherapist realizes that transference and countertransference manifestations can and do occur, and need to be handled, even in such superficial psychotherapy. Supportive psychotherapy may be brief or prolonged, as indicated, and may be carried out with individuals or with groups.

It is in the group of psychotherapies intended to be expressive that one encounters the various schools of thought, the adjunctive devices, the more frequent conflicts in theory, and the more significant question of personal suitability of the therapist. Expressive psychotherapies utilize such devices as exploratory probing through questioning, free-association, abreaction, confession, relating of dreams, catharsis, interpretation and the like, all with the purpose of uncovering and ventilating preconscious and unconscious pathogenic psychological material. Elements of support, reassurance, suggestion, advice, and direction are not necessarily excluded, and may, in fact, be consciously utilized. Expressive psychotherapy may be brief and intensive or prolonged, depending on the aims of the therapist and the response of the patient. Expressive psychotherapy is major psychotherapy and should not be undertaken without thorough grounding in dynamic psychology, adequate experience in clinical evaluation, practice under supervision, and personal suitability. Lacking this background, the psychotherapist is extremely likely to get into difficulties. He introduces topics for the patient to discuss without being aware that they are irrelevant to the matters pressing for expression within the patient, or that the patient cannot tackle a given topic until certain defenses are first pointed out and removed. He gives long and sententious theoretical explanations which he regards as interpretations, but which are either then learned as intellectual defenses by the patient or their content ignored while the patient basks in this verbal bath at the hands of the therapist. He permits himself unwittingly

to be drawn into an active role as an ally in the patient's external interpersonal struggles, while remaining oblivious to the provocative shenanigans of the patient which keep these struggles going on. He pounces on dreams or slips of the tongue with ready and pat interpretations which miss the point. He focusses his attention on symptoms, and tries to treat them by interpretation, or special investigatory questioning. He becomes embroiled in transference-countertransference jams and does not know how to extricate himself except by discontinuing the interviews for a while. I cite these common errors as illustrations of what may happen if the inadequately trained psychotherapist undertakes expressive psychotherapy. Needless to say such mishandling complicates the patient's illness exceedingly and renders more difficult the task of the inevitable subsequent psychotherapist.

Competent expressive psychotherapy may have goals which vary considerably. In cases where there has been an acute onset of neurotic symptoms in reaction to a discoverable precipitating event, and the patient's history shows a comparatively healthy course, the therapy may properly consist of thorough ventilation of the reaction to the upsetting event, with the therapist pointing out connections, relationships, and hidden motivations in the limited life area of the setting prior to the event, of the event itself, and of the patient's immediate and later reactions to the event. In skillful hands this is a most rewarding type of expressive psychotherapy. Recovery may be achieved in a very few interviews and the patient is restored to his previous good functioning with insights he would not otherwise have achieved. In such instances there is no therapeutic aim of exhaustive investigation, recovery of infantile memories, or altered ego structure. In other cases which may at first seem similar, the early clinical evaluation uncovers more neurotic difficulties than were at first apparent, and it becomes clear that the patient's adjustment prior to the precipitating event was a precarious one at best. The therapeutic aim may now change to one of more thoroughgoing alteration of the neurotic personality structure, and the expressive techniques lead into psychoanalysis. If the psychotherapist is competent to conduct psychoanalysis as well as the shorter expressive therapies with limited aim, he will have so handled the early therapy that the analytic techniques are a logical continuation of his early therapeutic work. If he is not so trained, he should at this point refer the patient to a suitable analyst.

Freudian psychoanalysis—and psychoanalysis actually implies "Freudian"—is a major, time consuming, and therefore expensive, type of psychotherapy. It is by no means a panacea, and its most competent practitioners would readily concede that as a method of therapy it has limited application in the vast field of human psychological distress. (As a dynamic psychology and as a method of investigation it is, of course, invaluable, and possesses almost unlimited applicability.) Its limitations as a method of therapy do not depend merely on such factors as its duration (twelve to eighteen months as a minimum; four to five years as a maximum), its cost to the patient, and the availability of analysts (approximately 500 in the United States, with one-fourth of these in New York City). There is also a considerable list of special indications and contraindications, as, for example:

1. The patient should be of at least bright normal intelligence on the Bellevue-Wechsler scale (115 to 120 IQ).

2. The suitable age range for adults is about 20 to 50, with certain exceptions to be made at either end of this range.

3. There must be some capacity for introspection, and some awareness of nuances of feeling in himself and in others.

4. There must be sufficient motivation in terms of initial distress and strong desire to change.

5. The patient must possess sufficient intactness of personality so that this intact portion may become allied with the analyst in the analytic work.

6. In general, patients with unalterable physical handicaps are not suitable subjects for psychoanalysis.

7. The general field for psychoanalytic therapy includes the psychoneuroses, character disorders, some of the perversions, neurotic depressions, anxiety states, and some of the psychoses. Patients in the midst of acute external turmoil should not begin psychoanalysis as such until their life situations are more stable.

With all of its limitations, however, psychoanalytic therapy is, in well trained hands, a highly effective procedure for achieving in patients a profound alteration in their neurotic personality structure and developing otherwise latent potentialities for achievement and responsible living.

The Freudian school of psychoanalysis is the main stream of the psychoanalytic movement. There have, in the past, been several split-offs

from the main stream which resulted in transient and minor developments of non-Freudian schools. The school of the late Alfred Adler took one aspect of psychoanalysis, namely, the methods of the ego in dealing with external forces, and attempted to develop it into a system called individual psychology. The central theme of this psychology was that of inferiority feelings and the drive for power. This psychology and system of therapy died out with its leader. Carl Jung, also an early pupil and associate of Freud, split with him and developed a school of "analytical psychology" which emphasized symbolism and religious beliefs and which explained mental disorders, especially those of middle life and after, in terms of regressions to a collective unconscious, or racial heritage. His school still persists but his incorporation of Nazi racial ideology into his psychological theories has caused him to be severely criticized. The late Otto Rank, also an early pupil of Freud's, developed a system of therapy which emphasized the transference and the uncovering and working through of birth anxiety in a three months' period of treatment. There were many short Rankian analyses in the 1920's, but this system is now also extinct. The late Wilhelm Stekel, a remarkably intuitive man and a prolific writer, attracted a few followers to his technique of rapid and early deep interpretations of symbolic and unconscious meanings. His influence has now become almost nil. Karen Horney, originally a Freudian with many fine contributions to the literature, has led a movement in the last decade to eliminate a number of the fundamental concepts of psychoanalysis and to focus attention on current cultural conflicts as the main source of personality disorders. She rejects the libido theory, the significance of early psychosexual development, and in general takes a stand against genetic psychology in favor of culturalism.

There are other deviations from orthodox psychoanalytic techniques which are not represented by their practitioners nor regarded by others as separate dissident schools of psychoanalysis, but which are modifications of technique to meet the therapeutic problems in patients who are too ill to coöperate in the usual analytic procedure. These modifications are used chiefly with psychotics and involve approaches by the analyst which actively cultivate a treatment relationship, communication with the sick patient being established on whatever level is possible in the individual case. The success of such attempts depends on the resourcefulness of the analyst in coping with the patient's inaccessibility and his

capacity for empathy and intuition in understanding what is communicated by the patient's verbalizations, behavior, and attitudes. Long periods of careful therapeutic work are required but the results are often very rewarding. As the patient improves the treatment may merge into a more regular psychoanalytic procedure.

A special type of analytic psychotherapy developed by Rosen, for which the designation "direct psychoanalysis" has been made, deserves some comment. Rosen has reported a striking series of recoveries of severe and chronic schizophrenias. His method consists of repeated, prolonged sessions with the patient in which deep interpretative activity is carried out fearlessly and relentlessly. Interpretations are based on psychoanalytic theory, and sometimes on insights provided by other schizophrenics. The usual cautions and tentative approaches which have characterized others' work with psychotics are abandoned, and direct, deep interpretations are made promptly when the therapist believes he understands. The therapist also, when necessary to make contact, takes the roles of powerful figures in the patient's delusions and shouts denials, reassurances, and interpretations. Remarkable results are reported, and this work is now undergoing study under research conditions. It promises much but is at present difficult to evaluate.

The school of Adolf Meyer, identified as psychobiology, emphasized the sound concept of all-embracing study of man in his totality. He developed a new system of nomenclature which did not achieve significant acceptance, and termed his treatment "distributive analysis and synthesis." This psychotherapy aimed at exhaustive collecting of data regarding the patient's life, past and present, utilized diagrams to depict life influences, and assigned to the therapist the role of educator and explainer of the experiences and reactions in the patient's life. This procedure may be criticized as being far too theoretical and intellectual to influence many patients, and as having almost totally ignored the elements of transference and counter-transference in the relationship between therapist and patient. As a school of psychotherapy, it probably has a diminishing number of adherents.

All of the major psychotherapies—i.e., those which aim at significant alterations in personality structure rather than at symptomatic relief—have encountered the phenomenon discovered by Freud and termed by him "resistance." This refers to those partly conscious and partly unconscious tendencies in patients to resist self-knowledge and change,

as manifested in their inability to remember the past or to capture for therapeutic use the current unconscious content. Resistance produces a marked slowing down of progress, often approaching stalemate, while symptoms continue unaltered. Technical problems of resistance are among the most difficult to solve, and the long duration of major psychotherapy is attributable chiefly to this phenomenon.

In order to shorten the duration of therapy many attempts have been made to circumvent resistance. Chief among these techniques have been the use of hypnosis and certain sedative drugs. Under hypnosis or narcosis (also mild elation or light anesthesia) some patients are able to gain access to and to verbalize with affect otherwise unconscious memories, and to profit from the ventilation and abreaction and the interpretations of the therapist associated with this therapeutic experience. During World War II there was widespread use of intravenous sodium amytal and sodium pentothal as well as of hypnosis to produce dissolution of the resistance barriers against recalling overwhelming traumatic experiences. There often resulted clear recall and reliving of the traumatic experiences, with associated assimilation of the overstressful event and great diminution or relief of the symptoms. It was found that early treatment was essential, delay resulting in the building of stronger barriers against recall and fixing of the symptomatology, to which was then added the exploitation of secondary gains. These psychotherapeutic procedures had enormous significance in military psychiatry, but as sole treatment attempts, have proved to be disappointing in civilian psychiatry except with early traumatic neuroses in civil life. Such techniques of reducing resistance through hypnosis or narcosis do not constitute separate systems of psychotherapy, so that it is incorrect to speak of narcoanalysis, narcosynthesis, hypnotherapy, and hypnoanalysis as psychotherapies. They are adjuvant techniques to be used as a preliminary step in overcoming an initial impasse, or as devices to be introduced during psychotherapy when strong resistance blocks further progress.

The attempts to shorten the duration of psychotherapy have led to other techniques which make use of psychoanalytic principles but which try to achieve faster results especially through manipulation of the transference, role-taking by the therapist in order to provide a corrective emotional experience, and interruptions of treatment to avoid a difficult dependent transference. Alexander, French and others who report this work maintain that their therapy is entitled to be called psychoanalysis—

psychoanalysis with more flexible utilization of techniques. Many critics insist that the techniques as reported represent abandonment of fundamental analytic principles and that the goals of such therapy have become relief of symptoms and conventional social adaptation instead of the goals of structural personality alterations of psychoanalysis. Many other studies of short psychotherapy using psychoanalytic principles have been reported in the literature, and it seems well established that the whole field of psychotherapy has been greatly enriched by contributions from psychoanalysis.

In the last analysis there is only one psychotherapy, with many techniques. This one psychotherapy must rest on a basic science of dynamic psychology, and those techniques should be used which are clinically indicated for each individual patient—certain appropriate techniques for the initial stages and others later as the continuous clinical evaluation proceeds pari passu with therapy, and the goals and potentialities for the patient become more clearly delineated through his responses to therapy. And, finally, it is important to recognize that techniques as such are hardly separable from the individual who uses them. Psychotherapy is an enormously complex intercommunication and emotional interaction between two individuals, one of whom seeks help from the other. What is done and said by the one who tries to give help is inevitably his personal version of technique. Beyond all knowledge of dynamic psychology and training in techniques is his own individual personality, with its inevitable variables as to sex, physical appearance, depth of understanding, ability to communicate ideas, tone of voice, set of values, and all of the other highly individual elements which differentiate one therapist from another. The utmost impersonality and analytic incognito cannot exclude the effect of such individual elements. Hence we may say that in addition to a critique of psychotherapy one must also make a critique of the psychotherapist.