

Psychotherapy and Growth

By Leon Hammer M.D.

Published in Contemporary Psychoanalysis, Vol. 10 NO. 3, 1974

I

During 1971 I spent four months at the Community, which is a continuation of Kingsley Halt I learned then, among other things about myself and others, that so-called "blow-out" centers, such as this one, correctly recognize the need people have to disorganize. I also came to recognize the incomplete truth in this idea, since it is incorrectly assumed by some that disorganization is an act of growth in itself. My belief is that disorganization leads to endless chaos unless other conditions for growth exist simultaneously. It is toward an exploration of these conditions within the framework of psychotherapies that this paper is directed. In this paper I will initiate a clinical discussion around three constants: experience, dependency, and contact.

Experience, roughly defined by Buber's "relationship," is the irreducible absolute of human growth essential to human physical and psychological survival. Contact is the facilitator and journeyman of experience. Whereas experience is that which is undergone, contact is the living act, the concrete involvement, the labor and craft of experience. The primacy of contact and experience as constants of human growth renders man almost infinitely dependent on his own kind. These three primary constants are the matrix around which are woven all basic human needs.

The first opportunity for "new experience" in therapy is contact with the patient's so-called "resistance." Resistance is understood here to be the expression of the patient's defensive self-system in the therapeutic situation. The patient's defensive system is essentially a mode of relating designed to maintain life-giving contact with people without risking pain, hurt, or annihilation. At best it is a tenuous and unstable contact full of the fear of isolation at one end and the fear of invasion and destruction at the other. I have substituted the concept "restitution" for "resistance".

This is, of course, hardly the condition in which most of us could begin to take the initiative in revealing our real selves. In this state, the patient is barely in a position to accept a stranger's invitation to trust. He is in no state of mind or emotion to embrace alien techniques which threaten to sweep away what he regards as safety and survival. Whatever school of thought therapists embrace, they have been one in regarding the patient's reluctance to go their way as a form of perversity which must be either overcome (Freud, 1916) or "- analyzed (Wolstein, 1964). Glover (1958) mentions this as a major problem of psychoanalytic practice and states in short, the general impression given is that the patient is personally resisting instead of becoming the tool of his unconscious mechanisms and conflicts; . . . these ego-resistances are apt to create an impression of perversity.

It is true that most people who come for therapy hope simply to be helped to make what they are already doing work better. It is, of course, part of our work to inform the patient in a meaningful way that he needs to find another way. But the fact is that at this point in time and space, the person has no other way of relating to us.

I begin with the patient's tenuous and often self-defeating gestures; whereas, most of the gesture may seem to wave me away, as it does most other people, I make some safe return sign saying that I see it's more basic intent.

I do not approach the contact as a negative force, though I may make some comment on its limitation. I recognize my responsibility to take the initiative to provide alternative and more productive forms of contact, forms which the patient is afraid to make first. I make them as tentative as necessary to

make the patient feel safe. Yet he is encouraged to see the importance of risking new contact in his search for real security. I respect his form of contact, and I demonstrate other possibilities by my own behavior. There is no contest to have the patient give up his style for my own conception of a therapeutic "relationship." For example, a young lady came to see me and talked about her past life in a monotonous monologue for over an hour. When she was finished I asked her in a friendly way why she chose to bore me for an hour when we both knew she was on the verge of suicide, conveying to her my acute awareness of her underlying despair and desperation. Coming from a finishing school background, she was "bucking up" in public while quietly slipping into madness and despair. No one had seemed to recognize her desperation. Previous therapists had analyzed the details of her boring "rap" in- stead of recognizing the "rap" as a camouflaged way of saying "if you feel the deadliness of this you will know how close to death I am".

a

When turning to an analyst the patient complains; he is negative; he is too nice; he is irrelevant or autistic; he is hostile or obsessive; he is superficial or silent; he is demanding or self-effacing. He is a total bungler at direct productive contact.

The analyst may notice only one aspect of this complicated but natural movement of the patient towards him and lose sight of the fundamental principle of life which motivates the direction. He may watch only the way in which he is approached and lose sight of a larger picture, the necessity for the approach. Analysts frequently brand the entire maneuver "pathological."

The patient's resistance is his natural, though impotent, repudiation of what he knows is wrong in his life. The patient is easy prey, a perfect victim. Feeling defective to begin with, he can only assume that he himself is wrong, and once again he is required to label that part of himself sick which is fundamentally healthy.

For the neurotic who is well prepared for defensive pseudo mutual behavior, this model provides the ideal diversion. The therapist's preoccupation with resistance is the neurotic's best defense. The psychotic's obvious defenses of denial and dissociation offer little challenge to a therapy which is so heavily designed to deal with resistance. Important issues are almost immediately available in the therapeutic situation but are frequently frightening to a therapist who is trained to deal with pseudo problems. He may be at a loss with the direct confrontation of a real need laid bare in its primal, chaotic state. For the psychotic, the dissociated material, which is rooted in terror, is easily tapped as grist for the mill. Conventional therapies are not prepared for the dissociated. They are more comfortable with the less disturbing repressed material. They tend to welcome feelings on the level of castration, but reject, with appropriate horror, feelings associated with annihilation, murder, and death, those dissociated insane feelings which seem so profoundly and elusively hidden in the well-defended neurotic. Unless the therapist is prepared to engage the patient at this level, meaningful growth and development does not take place.

Change begins exactly at the point of initial contact. Growth begins because the patient has had a new experience in areas of basic human needs that he is too frightened to initiate. The therapist has taken the responsibility and is demonstrating new models of relating in the following ways:

- (a) The patient is not expected to do the impossible. Contact with the patient is guided by the patient's style and capacity. There is no contest to have the patient conform to the therapist's pattern.
- (b) There is an advantage in identifying the patient's pseudo contacts, his restitutive "games," and in giving some early indication about what is missing from his contact with the therapist - and how this is interfering with the patient's security and/or pleasure in the contact. The therapist attempts to identify the patient's defects in contact and make up for it immediately (as with people who cannot talk).
- (c) The positive side of maladaptation is recognized. The need to keep the therapist at a distance is accepted. The negative is dealt with only as it interferes with the patient's need to

make contact. The overwhelming thrust towards the life-giving aspects of the patient's personality brings the patient a new self-esteem.

(d) Inherent in every defensive system is an enormous amount of talent and energy which needs to be separated and identified. The patient does not wish to recognize these talents. He rarely cares at this point to give of himself to his fellow man. His hidden talent for life may have been initially exploited or ignored. However, the therapist's recognition of the "good in the bad" gives the patient the building blocks for future positive contact with self and the world.

The need for respect or, often, for anything from another human being is difficult for an injured person to express directly. The initially expressed reasons for coming are often far from the real reasons, though the therapist may be able to spot the latter in the former. The patient is prepared for the worst, even though at some deeper level he may long for the best. The respect he needs is a dissociated need. He cannot express it directly. The new experience, I believe, is unexpected and must be handled, therefore, with great sensitivity in terms of approach and avoidance.

The trust engendered by these real experiences is a solid foundation for the difficult and painful road ahead. This trust is in sharp contrast to the "trust" often associated with "positive transference," which can only be a hopeful fantasy of an unknown authority whom we fear. It is a way of allaying fear so that we may get help. No one with genuine trust requires an analyst. The beginning of therapy requires a new, good experience with a stranger willing to take the initiative to build such an experience.

II

The medium for new experience and for human growth is the heat, light, and energy of a searing and powerful direct involvement between two members of the human species. In a profound way, each person knows that the experience of being himself can change only when his most hidden selves live again in this intense way with another person, one who will relate to these selves differently from those who bore the original responsibility for labeling his psyche.

By meeting, in this encounter, the basic human need for respect, the therapist is allowed by the patient to become more and more engaged in a relationship involving those dissociated basic needs whose evolution are fundamental to his development and self-actualization. Meeting the need as it was once meant to be met and the therapist's grasping the significance of the fact that the integration of experience occurs in different modes in different developmental eras are the conditions which obtain for growth to take place in adulthood. The new experience, and the fantasies and distortions which are built around them, are in the context of a real relationship. It is of value to the patient when he can see how his distortion of a relationship interferes with his achievement of real satisfaction. He must see this over the broadest spectrum of human contact. Meaningful fantasy and distortion come quickly and powerfully at the appropriate moment only in the heat of a broadly based relationship. This is the natural way for it to happen. Powerful feelings such as love and intimacy with which most patients cannot cope are not evoked or resolved in isolation.

Many therapists confuse reserve with neutrality. Yet there is nothing neutral about reserve. Ironically, reserve is a most powerful activity. Indeed, psychoanalysis has always been active. It has, however, tended to allow itself too often, only limited activities, reserve and intellectualization for the therapist and talk for the patient.

I believe that the endless fantasies stimulated by hours of relative isolation in a chair or on a couch are artificially induced and significant of almost nothing except the terror of isolation. However, periods of time to oneself, the moment alone, the exhilaration of a separate self in meditation or in some kind of internal intellectual or emotional dialogue or contact is necessary to life. Change occurs through new experience with one's hidden self, not through the revolving door of the established circuits of one's inner mind. An outer experience was indispensable for the original inner experience,

and a new outer experience is necessary to bring about a new inner experience. There is a dynamic field of action in which the natural quality of the exchange between analyst and patient creates a new experience before, during, and after uncovering. Isolation of therapist from the patient or from his uncovered feelings usually perpetuates the deadness of the patient's life.

In the context of therapy, the therapist is, by definition, a necessary active partner. The therapist has no choice but to be actively and powerfully involved. He cannot relegate his involvement to an activity outside of therapy. The fact is that however much we encourage patients to gather experiences outside of therapy, many cannot. Furthermore, in the areas of dissociated needs and feelings, the involvement required for growth is often a "descent into hell." The commitment, knowledge, and courage necessary for this is rarely found in daily life. However, the patient can ultimately use the therapist's sensitive activity as a model for his own reality.

For example, a female patient had an accident after she left my house - about six miles away. She called immediately and asked my wife to come. Later that day she stayed at our home because she had no way of being cared for properly. In the evening she began to feel "paranoid" that she was not doing enough to earn her keep, that we resented her presence, that her bandages offended us, and so on. These were almost overpowering feelings and were exact ' - replicas of what she had been talking about in her sessions. I told her to respect her senses. She had perceived that I am a person who likes my privacy and she probably sensed my reserve. Also, my wife, who was quite worn by this time and somewhat over- talkative, was annoying me, and I was sure the patient sensed that. This was the valid part of her "paranoia."

The invalid part was her feeling that we were not accepting her as she was that we were expecting a major performance on her part so that she could be accepted. She was indeed fearful that she would be asked to relate to us in a way in which she felt inadequate. She believed that we would resent her for being unable to care as much for us, as we could for her.

This was a critical issue in her life up to that time. This girl's distortions and valid feelings were evoked, clarified, and realized in a natural life situation with her therapist. People who need help are avoiding these real situations in their lives so as to avoid the unhappy associations they make with everyday contacts. Deeper feelings do not come to light in a relative vacuum. Patients are experts at creating and maintaining vacuums such as is often provided in conventional therapy. Activity limited to silence revokes only a tiny fraction of these deeper feelings. Activity directed to reality and to people's real needs evokes a broad range of inner feelings which in itself is a new experience. Once evoked, the therapist may engage the patient and his earlier dissociated feelings in an original growth-producing encounter.

The evoking of the significant distortions in a patient's life is often minimized by the almost totally unnatural environment of an analyst's office and of the traditional analytic situation. A broadened range of interaction can create more realistic situations between people to which they can respond in their characteristic fashion and provide more meaningful data for the therapist. People transfer real feelings, distorted and otherwise, in real situations. It is our obligation to provide that reality. We must become active, reactive, and interactive on a widened scale with people and accept the added emotional burden of being responsibly aware of ourselves. There is an enormous temptation facing the therapist to become endlessly involved with these negative feelings aroused by his own reserve, because this involvement with pseudo feelings touches nothing of what all patients, and many therapists unwittingly fear-closeness and intimacy.

While the patient's way of handling negative feelings is a problem to him, his negativism is frequently legitimate. Let the therapist look to himself when a negative transference persists. Some years ago I had an experience with a patient who had been given LSD for therapeutic purposes. The first part of her "trip" had been a quiet, joyful experience, a significant departure from her usual

feelings of depression and paralysis. The "trip" was taken on a day during which I became progressively more ill from incipient influenza so that by the end of the day I was barely able to go on, but was unaware of my deteriorating physical and mental condition. In the post-"trip" dinner we discussed what happened, and because of my fatigue I regressed losing sight of the significance of this important event-the warmth, peace, and joy-and concentrated on analyzing the negative aspects of the "trip" experience. During the next few weeks the patient was markedly negativistic until she was finally able to vent her feelings of resentment about my destructive response to her experience for which I apologized.

Risk-taking and mistake-making by the therapist are vital to the patient's growth. Also basic to this growth is new experience in a structured but realistic, no rigid atmosphere that takes a broader and less academic view of man than psychiatry has taken to date. Even more central is the extreme consideration the therapist must give to nurturing, sustaining, and encouraging the smallest sign of the patient's caring for anything or anyone, especially the doctor. The patient's life may depend upon this consideration.

III

As the patient's real needs emerge-especially those never realized in childhood the therapist reacts and meets them as best he can in the therapy if they cannot be met outside. The therapist takes the initiative to make the contact necessary to satisfy these needs when the patient cannot do this. The engagement takes place on all levels of need including physical care, physical contact and nonverbal communication, caring, respect, initiative and response, responsibility and commitment, structure, socialization, and symbolic communication.

The following is a discussion of the most basic human needs 'which are necessary to human life. These needs cannot be ignored or abused without creating some emotional strain on a developing personality. The pain associated with a disjunctive early experience' leads to dissociation of the need and the loss of its energy and content in the final weave of consciousness. These needs must re-emerge, and if they are to join the fabric of personality, they must be realized in a new real experience.

Physical Care

Physical care, in the developmental sense, is probably the area of contact between doctor and patient which is most neglected in the traditional rationale of psychotherapy. Physical care is both the attention to individual needs for physical survival and the overall feeling of belonging to a family and a home or some secure place.

In the area of physical development this caring will include: feeding, temperature control, clothing, shelter, protection, and respiration. These needs cannot be easily met outside of an institution. Unfortunately the meeting of the need in an institutional setting rarely involves "new experience" around the need itself. In my practice these needs have been met primarily in my home by my family and myself. However, it is not the simple gratification of the need, but the gratification with a meaningful interpersonal experience that makes for change.

Physical Contact and Nonverbal Communication

Next to physical care, physical contact is most basic to life and is the area of need out of which the most personality difficulties arise if unmet or distorted. It is also the area in which the greatest sense of security may develop when these needs are met.

Physical contact includes: touch, tenderness, pain, erogeny, holding, breathing, and the entire spectrum of energy transfer from one person to another. The quality of the contact is the determining factor. The concept of empathy and the quality of the contact are, of course, intimately related.

A developmental model of therapy that concerns itself with the deepest level of dissociated material

does, of necessity, concern it- self with the earliest and certainly the prelogical stages of development. If we postulate that needs which were significantly unmet or misused in childhood must be relived with the therapist as a prerequisite for growth, then physical contact, physical care, and nonverbal communication must occupy central roles. A rational therapy is based on species inherent characteristics of growth. Whatever the stage of development or the appropriate learning mechanism at that age (introjection, association, imitation), it must take place in a context of other people and in interaction with other people. The therapist who succeeds in reaching the patient has to comfortably touch, hold, cuddle, caress, fondle, and talk with his hands and his body.

My practice of therapy is heavily in this central area of the spectrum of contact. It is difficult to isolate one example from the thousands that characterize the need and the value of physical warmth in growth and change, though this need is most obvious for those who cannot communicate verbally. Touch is that experiential area where the most profound failures of development occur. Touch is basic to and is the basic form of communication. It is basic to life. One brilliant young lady was referred by her college instructor. Like many, she was essentially cut off from feeling. Her talk about herself was so abstract, when it came at all, that it was meaningless. She was lost. I moved next to her; I held her. She sank into my arms and stayed. Gradually some verbal communication took place, but for the most it was just holding. She cried. She had had no father and her mother was a detached, possessive, alcoholic school principal. She had been the housemaid for herself, her two older brothers, her mother, and her mother's lovers who came for the night. What was there to say? Later she formed a close homosexual relationship with the wife of a college instructor that was enormously important in the same way. Her course was not simple, but there was a course-one that led to basic human satisfaction and security with this one woman and later with men on all levels of communication.

Another young woman (age 29) is typical of many whose "holes" in their personality are related to feeling defective as warm, giving women. She saw herself, and played to the hilt, the role of the hard woman, constantly angry, nagging, and complaining about all of my inadequacies. As she left one day I took her hand and cautiously offered to hold her. She came and took hold of me. For the first time in her life she broke down. She sobbed my name for a long time with a primitive pleading wail, like a young animal hurt and lost in the forest. She could not believe that I could stand to touch her. Over a period of time she began to experience herself as I did-a soft, warm, satisfying woman.

That the physician may enjoy experience does not make it inherently bad, immoral, or unethical. In fact, his genuine enjoyment of the patient in some situations may be the experience that the patient needs. The patient may try to deny subsequently that either they or the doctor enjoyed each other. Because it was a mutually experienced event, the facts are more difficult to deny.

Many believe that physical pain inflicted by one person upon "another is invariably a humiliating and destructive experience. There are times when hitting another person is an inescapably productive act. For many children the gravity or seriousness of the effect of their behavior on another person cannot be conveyed in any other fashion. At times, any less response would convey an inferior feeling on the part of the parent. This is equally true for patients in therapy. It is often so much easier to walk away and mutter "to hell with you" than to stay, strike back, and become engaged.

The feeling that no one really cared, as expressed by the fear of parents to punish, to react violently, is one of the most common themes in my practice, especially with youth. The parent's fear becomes the child's feeling of weakness with a pervasive sense of alienation. "Who will show me that they do not fear death? Who will show me that I will not break if I am really hurt? Who will take the trouble to break through my detachment and depersonalization? Who cares?"

Caring is the basic form of adult contact with other people, work, nature, and ourselves. It is the ineffable empathetic message that tells all of us that our existence is significant. The patient's need to care can be expressed and develop only in an atmosphere of caring. This includes being cared for and

being allowed to care for another. "Not caring" is man's most common defense against the pain of his vulnerability. In therapy the therapist cares and allows himself to be cared for sensitively, openly, and appropriately enthusiastically.

Caring is the vital spark of life and the central issue in therapy. For most patients caring means death, and not caring is a living death. Tillich (1952) wrote that "neurosis" is the way of avoiding nonbeing by avoiding "being." Caring is central to being. I endeavor to do nothing in my work with a patient which will discourage the growth of caring, most especially if that caring is for me. I carry this consideration as a sacred trust. The doctor must be the first to care. Yet caring (and knowing) in a paradoxical way is also the most catastrophic threat to the autonomy of a vulnerable person. To care for oneself especially may be the final surrender of one's greatest defense - to not exist.

No human animal is capable of caring for himself more than he is initially cared about. For our existence to be joyful, someone somewhere has to experience us as joyful and show it. Young people say over and over about their parents, "I want to just look into their eyes and see that I made them happy." To feel worth saving ourselves someone somewhere has to accept the responsibility for us, a basic human commitment to transcend our loneliness by "seeing things through" together. Especially in crises, the therapist must stand firmly with the patient through the terror and disorganization which can accompany growth in the most hidden areas of personality.

Respect

All the qualities of contact mentioned here must be characterized by the most profound respect for a dependent person. These needs are for objectivity (out of the win-lose game), autonomy (individuation), encouragement (for new experience), validation (especially of perception and individual temperament), realization, authenticity, directness, trust and faith, understanding, sympathy, pity, forgiveness, separation, flexibility, tolerance of imperfection, failure. The development of a sense of identity depends ultimately on the reverence another significant sustaining person has for that separate unique quality which is "me." One's self-respect depends on the ability of those whom he depends to be relatively free of the need to exploit as a price for the dependency.

Initiative and Response

The response to a call for meeting a need and the initiative in meeting those needs, which a developing person is not ready to call for or do himself, are prerequisites for survival. In therapy the patient is dependent on the therapist to take the initiative in making the appropriate contacts necessary to sustain the relationship and work. This initiative will be made only in those areas outside of the patient's ability to act for himself. It will, however, be taken actively as often and in as many ways as necessary and possible. The patient will be encouraged to assume the initiative; however, this cannot become a contest of wills.

The therapist will engage the patient actively in those areas of basic need in which the patient is unable to provide experience out- side of therapy. The therapist will provide a model of risk and activity for the patient. The therapy will be a natural sequence of movement, energy, activity, silence, and stillness. Real trust on which people can grow has to be mutual. The therapist may need to reveal himself before the patient is willing to take the risk.

Commitment and Responsibility

For optimal development one needs the relatively unencumbered involvement, support, love, affection, discipline, touch, loyalty, and acceptance of a other stronger person who is unafraid of the truth. Although growth, development, and movement are our measure, they do not always make the patient or others in his environment happy. As one woman who had made a serious suicide at- tempt earlier said to her husband recently, in my presence, "As I see it now, I have a choice between killing myself or getting a divorce, and I think that I have decided that I would prefer to get a divorce." In this instance her growth and this expression of it made her husband unhappy. A measure of constructive effort is movement in the individual towards "responsible human growth." When it

comes out of a destructive way of life someone, perhaps every- one, is bound to be hurt. The resolution of a bad situation cannot be totally good, and the patient needs our commitment to see him through.

Structure and Adaptional Functions

The basic needs for orientation in time and space, for limits and expectations, and for frustration, pain control, and the need for organization and logic are of necessity within our purview of interaction. It is in this area, which includes the issues of cognition and learning that the therapist must draw from other disciplines.

A young woman has lost the use of her senses to experience feeling and her mind to integrate. As a child there was no place for experience or expression of strong feeling. From the start there was incredible preparation for "high-society" and severe discipline. Authority was obsessive (father), intimidating (governess), and exploitive (mother). Strong feelings became for her the "unknown" and a source of terror. She coped with any approach by another person, or movement to another person, with instant inner deadness - nothingness.

Therapy became, at first, a long period of respectful gestures involving tender physical contact and physical care. My taking the initiative for clarifying and establishing communications gave her the feeling that I cared. Then I began to exist for her by my response to objects around us with increasingly powerful expressions of sensation and thought until she would scream in sympathetic vibration. She experienced intense feeling. She then deadened herself and accused me of attacking her. When I accepted her need to retreat to this level of contact we could start again with the goal of having her express feeling and risk her worst fears of being intimidated, exploited, or analyzed. She was able to have a new experience with me in which she positively realized her hidden self, her passion and her energy.

Symbolic Communication

Authentic therapeutic encounters include the clarification of 4- content and form dealing with some or all of the following: silence (blocking and autism), circumstantiality, evasiveness, flight of :. ideas and double binds. Obsessive-defensive manipulative communication inherent in the power struggle is another way of guarding oneself. The terribly abstract schizoid and concrete hysterical personalities are two ends of another spectrum of defensive symbolic communication.

The verbal expression of all feeling is necessary to growth. It is necessary for a person to know as well as to feel. Labeling and relabeling the psyche is essential to a total integration of the avoided hidden aspects of personality. Values and principles are indispensable to maturity. These values and principles are tyrants rather than liberators unless they are rooted in a flexible humanistic acceptance of others.

Socialization

The patient often may need a guide to a code of acceptable behavior among people. Whenever the patient "cannot" find such a code on his own the therapist teaches. However, again we can call upon outside resources even though the therapist is the principal resource the patient requires for new experiences in socialization. Problems in socialization are generally rooted at earlier levels of development. The therapist is indispensable to the working- through of these needs at these levels.

"The Descent Into Hell"

Gradually the most dissociated selves are engaged in what would be the high points of crises in therapy (peak experiences) leading to the greatest growth. The most profoundly concealed feelings which the patient eludes in daily life, and which would not enter the real world without the therapist's activity and initiative, emerge in response to intense contact.

As these feelings enter the mutual awareness of patient and doctor, the doctor constantly responds.

The patient expresses feelings or he acts. The therapist reacts. The patient expects a catastrophe, nothingness, or destruction; the therapist provides a new experience for the patient. He validates in motion, his words are emotional, and his actions are a new and different reality from the old reality. Longings that have caused pain and fear for many years become pleasurable and exciting and, in some situations, behavior that had never been set into realistic limits is structured and disciplined. One young man whose parents had never been able to punish him felt he needed some kind of limiting by some- one who cared. One day, when he was finally convinced that I did care, he hit me and we fought. Though he was half my age, I put everything I could into it and held my own. His grandiosity was reduced and manic-depressive states disappeared, and later he experienced an intense desire to simply be an infant in a womb, a role he had previously acted out, unbeknown to himself, for a long time.

A profoundly depersonalized and extremely talented young lady "could not exist" because, in her own eyes, she was despicable for not having murdered a mother who had severely debilitated her. She could not bear herself in any form. She played little part in her own life because she felt she was too contemptible to exist. She had also failed to make her parents care for her. This was further proof of her incompetence and absolute worthlessness. Since she could ~ not exist until she satisfied these two conditions of her worthiness, I hurt her so that she could, for a moment, stop punishing herself, and she came to life-existed-and at first, tried to kill me. Her existence was suddenly accompanied by passion, and she was aroused, she had aroused me, for the moment. The feelings were good, her power was realized; she felt good and made me feel good without killing. Subsequently she tried to return to her nonexistent state but could not completely do so. She was still unable to risk a more complete existence. The process of appropriate intense interaction can be repeated many times until she realizes her strength. She can then risk getting involved in life in a self- sustaining and satisfying fashion.

IV

The purpose of this paper has been to focus on the need for psychotherapists to regard the growth process occurring in nature as a separate and distinct phenomenon from psychopathology. To succeed growth therapies must adhere to the laws of this process independent of technical innovation or personality theory. We require above all a theory of human adult growth based on a study of the natural phenomena and its constants using clinical experience. The work I propose is potentially exhausting, requiring at times an extraordinary amount of time and energy and intimate contact. I believe that it is the only way in which people grow. We must create a situation in society which makes it possible for a therapist to meet these needs without severely penalizing him and, his family. Fundamental changes in social values, including the prevalence of ecology over economy, humanity over profit, and pleasure over power, are part of the challenge to meet these real needs for growth and change.

The 50-minute hour was designed for therapy as it is conventionally conceived; its very limit is its philosophy. The usual way of working is a self-fulfilling rationalization for why we do it. With patients we tend to create a frustrated "monster," whose monstrous feelings are proof of his "illness" and proof of our obligation and right to avoid and isolate him. Time is the analyst's first dimension of alienation. Space is the second, decorator-designed space, in which no one may urinate, defecate, or fornicate. Psychoanalysis was designed for this society as we know it to be. The natural process of growth requires a world that values its own nature. It has not yet come to be.

The theory of change and growth, and the therapy rooted in the theory presented in this paper, rests on the precept that the inner life of one man depends forever on the outer life of another. Men are, thereby, defined by the nature of this dependency both for initial growth and for an ultimate attempt at change. Our tragic association with weakness and danger renders us blind to our real needs. Our acceptance or rejection of these constants in our nature will determine the fate of real growth for one man and for all, growth into a rational family of man.

Despite our wildest and most desperate thrusts for power, we are destined to remain ontologically

insecure. This is our fate absolute and yet ever changing. All we have is each other and the possibility of accepting, rather than fighting, this endless interdependency of men on one another, and on all of nature.

REFERENCES

Freud, S. (1916), Introductory lectures on psychoanalysis. Standard Edition, 7: Chapter 27, London: Hogarth Press.

Glover, E. (1958), The Technique of Psychoanalysis. New York: International Universities Press.

Wolstein, B. (1964), Transference. New York: Grune & Stratton.

112 Old Fireplace Road

East Hampton, N.Y. 11937

405