UNDOING THE EFFECTS OF INJURY TO THE SELF

Treating, healing, restoring, and curing are all terms that have found favor at some time or other for the process of undoing the effects that past psychological traumas can have in the present. No one, of course, can change the past. No substitute experience can undo now what happened in the past, nor can it remove the emotional scars left behind. Strengthening the self in the therapeutic situation by empathic resonance with the therapist, however, allows the self to re-experience the same old trauma now in a changed context. That changed context is provided by a self strengthened through experiencing the therapist as a selfobject. Changing the experiential context also changes the meaning of an experience and thus may make it possible to gradually loosen and discard the defensive armor acquired earlier in life to protect a modicum of self structure and functioning. The therapeutic regression of the self, which is engendered by the treatment situation, makes the self's structure more fluid and thus makes the self again more adaptable to changing experiences. Distorted aspects of the self's experience of itself and of others come into renewed contact with a different reality, which it may experience as benign, learn to understand, and to which it may then gradually readapt itself.

The therapeutic process just outlined is predicated, among other factors, on the self being sufficiently strong to withstand the process. The self must be strong enough to withstand, especially, the therapeutic regression and the painful disruptions of the transference, without further uncontrolled and undue regression or total and perhaps irreversible fragmentation of the self. Patients who never achieved a cohesive self, therefore, are not suitable for psychoanalytic treatment. This eliminates most of the functional psychoses—in particular, schizophrenia and the severe dysthymic disorders—from psychoanalysis as a treatment method. Though the lack of a cohesive
self is covered over by defenses in the borderline states, these patients are also disposed to regress severely with loss of structure. As a rule, they are not analyzable, though this is difficult to predict; the final diagnosis should not be based on any kind of theoretical definition or brief clinical assessment, but only on a sufficient trial and failure of psychoanalytic treatment.

Weak Self at Center of Pathology

Certain principles should be restated. A weakened self stands at the center of all selfobject relations disorders. Therefore, the treatment process should aim at strengthening the self. Strengthening the self takes precedence over all other possible aims, for example, making the unconscious conscious, remembering, reconstructing, resolving conflicts, and the like. These latter aims are important also, but they usually become possible to the strengthened self without the need for specific measures.

A weak self is the result of faulty selfobject experiences. The vulnerability of a weak self disposes it to certain self-defeating defenses that lead to difficulties with potential sources of enhancing selfobject experiences. As a consequence of these difficult and frustrating experiences with the available selfobjects, the vulnerable self's needs are not adequately met and lead to further weakening of the self. A vignette will illustrate:

A forty-five-year-old professional man came into treatment because of chronic depression. As the only child of elderly parents, he was doted on by an overprotective mother who effectively prevented him from participating in the rough-and-tumble of playing with his peers. Instead, he was given much encouragement and profuse approbation for intellectual activities of all kinds in which he, indeed, excelled. From the point of view of the parents, this was not only reasonable—after all, why should he risk getting hurt playing with those roughnecks when he could spend that time enjoying good reading and good music?—but also suited the aged parents' low tolerance for the confusing noisiness of children and adolescents. The youngster thus grew up in compliance with his parents' needs, while his own needs for gratifying selfobject experiences evoked by pleasure in the effectiveness of his body and by self-enhancing selfobject experiences with his peer group were greatly curtailed. No one admired him, only certain
parts of him were acceptable to others, and consequently his self lacked cohesion and was prone to fragmentation. A resulting sense of both physical and social inadequacy were symptomatic of this vulnerability. To keep from regressing further, he engaged in certain sexualized rituals and obsessive preoccupations that distracted him from the ever-present sense of inadequacy. He yearned for the selfobject experiences, particularly with his peer group, that were so needed for the strengthening of his self. But the very defenses of intellectualization and a certain haughtiness that protected his self-esteem simultaneously interfered with peer relations and thus led to further deprivation. He became a loner—talented, moody, living in fantasy, deprived of the self-sustaining selfobject experiences of an active social life.

At the extreme, a weakened self is in danger of regressing to total fragmentation, that is, to dissolution and death. Persons with weakened selves are, more or less, aware of their weakness and sense some of the dangers to which they are exposed as a consequence. Symptoms such as anxiety or excessive irritability warn of the impending threat to the self. People with weak selves suffer unpleasant symptoms in great discomfort or act out unacceptable behaviors. They come into treatment with the hope of being helped.

A weakened self may be weak for one or more of three reasons:

1. because faulty selfobject experiences during crucial developmental periods interfered with the normally unfolding developmental processes and development became arrested in one or more particular sectors of the developing self; 
2. because of injury sustained as a result of faulty selfobject relations during the developmental phases, mostly in childhood, but also during certain developmental crises such as adolescence, midlife, and aging; and 
3. because the fragility of a vulnerable self forces it into defensive postures that interfere with current selfobject relationships and thus effectively hinder the establishment of self-sustaining and self-healing selfobject experiences in the here-and-now.

**Strengthening the Weak Self**

Rational treatment, therefore, should address itself to strengthening the weak self, if possible. This strengthening of the self comes about via the psychoanalytic process, which in a step-wise fashion replaces the archaic (and thus pathological) needs for selfobject responses with age-appropriate needs for selfobject responses—that
is, replaces the archaic needs with a selfobject response that we might label reciprocal empathic resonance. Without at this time going into the technical details for activating the psychoanalytic process, let me outline the steps as follows.

By providing a proper ambience of noninterference, the therapist is enabled to interpret resistances to treatment—that is, fears—allowing and facilitating the emergence of the archaic selfobject needs in the treatment situation (cf. Shane, 1985). The emerging selfobject needs will spontaneously focus on the therapist; that is, a selfobject transference develops. This transference will be disrupted, often very painfully, when inevitably the therapist somehow fails to respond in precisely the manner required by the patient. The therapist then explains and interprets this disruption in all its dimensions, but particularly with reference to analogous early and presumably etiological situations with significant persons of the past. These explanations and interpretations restore the previous harmonious selfobject transference, but the mutual understanding achieved and experienced thereby serves to replace the previously frustrated archaic selfobject need with a reciprocal empathic resonance with the therapist, which strengthens the self. The selfobject experience with the therapist strengthens the self, and it becomes better able to integrate into a social selfobject matrix, that is, to successfully find responsive selfobject experiences in the social surround unhampered by defenses.

NEUTRALITY AND ABSTINENCE

Abstinence is one of the rules of psychoanalytic technique, though, as Rycroft (1968, p. 1) tells us, it is not clear what the patient should be made to abstain from. Freud stressed that the analyst not gratify the patient’s demands for love, but he did not hesitate to feed the Wolf Man when needed, and the reports from Freud’s analyses testify to his being anything but formal, cold, and stiffly detached.

A rational approach would prescribe that the patient abstain from whatever interferes with the therapeutic process. This means that both patient and therapist should abstain from turning the professional relationship into an ordinary social relationship.

Clearly, the pleasures of social intimacy of all degrees will distract from the analytic work and tempt both patient and therapist to avoid
the pain of re-experiencing traumatic memories. Social intimacy, therefore, must be avoided. However, that does not mean a rigid adherence to rules of analytic etiquette, but a flexible freedom to respond to each other as friendly and interested human beings. Such freedom would include expressing one’s condolences at afflictions or bereavement, and expressing one’s congratulations on appropriately happy occasions. Abstaining from the ordinary courtesies of friendly human discourse creates an impression of artificiality and lack of honesty that may well be destructive to the conduct of the therapeutic enterprise. It not only misleads the patient into thinking the therapist coldly detached and uninterested in the patient’s affective experiences, but also sees to it that the patient experiences the therapist as unresponsive and uncaring. Such abstinence destroys the therapeutic ambience.

Traditionally, abstaining from any kind of gratification—as part of the technical neutrality of the analyst in the analytic situation—has been made into a technical prescription for doing analysis. According to Leider (1983, p. 665) neutrality is both an attitude and a technical stance most frequently recommended for the analyst, and many consider it essential to the definition of analytic treatment. These clinicians recommend that the analyst’s proper function is to understand and to convey that understanding to the patient. In this view, neutrality requires adherence to the rule of abstinence, and a perspective equidistant from the demands of the id, ego, and super-ego. Such a neutrality insists on the exclusion of values other than the search for knowledge, of attitudes other than professional commitment, and of interventions other than interpretations.

From a self-psychological point of view, the proper attitude is more complex. The self psychologist emphasizes the importance of the re-experience in the transference of the archaic selfobject needs. Thus, the proper criteria for neutrality—or for abstinence or ambience—are determined by the optimal facilitation of this therapeutically useful re-experience. The patient will not give up his resistances because the analyst tells him to or because the analyst interprets them to him. The patient gives up his resistances slowly and gradually and cautiously when he has learned to trust the analyst a little bit. Some patients are never able to develop this degree of trusting and therefore they are the most difficult to treat. Those that learn to trust do so because they have gained the conviction that the therapist’s neutrality is a friendly one, that is, that the therapist is affectively on the side of the patient’s self without, however, necessarily joining the
patient in all his judgments. It is one of the paradoxes of analytic therapy that once the patient has learned to trust the therapist and himself enough to really follow the basic rule of speaking without much censoring himself (it usually takes years of analytic work to reach this freedom from defensiveness), the analytic process has reached the point where the therapist is needed less and the analysis of the self by the self can proceed unaided much of the time.

INTERVENTIONS

Understanding is a good term for the process that is often referred to by a variety of synonyms, for example, being in tune with, attunement, or empathy. As stated earlier, Freud used the term Einfühlung, which means to feel oneself into the subjective experience of another. The process of understanding is more than trying to figure out what another person is experiencing, because it is more than just a conscious, logical, cognitive process. To understand means to sense one- self into another’s experience, that is, it includes preconscious and unconscious perceptions, particularly of affects. The term affect attunement used by infant researchers (Stern, 1985, pp. 138-161) seems to designate a process that is similar to what analysts call empathy. Analysts do not seem able to agree on a precise definition of empathy or to say much about the nature of what is involved; therefore, I will avoid trying to define with scientific precision a concept that is known well enough operationally. Clinically, I think, we all know what we mean when we say that somebody is empathic or in tune. This may be why Freud could state that without empathy there cannot be any real understanding of another, yet never bothered to define empathy within his metapsychology. I will adhere to Kohut’s usage, which distinguishes an initial affective understanding from a supplementary and more cognitively logical explanation. An empathic grasp, then, encompasses both understanding and explaining.

To explain is to provide a logical and verbal expression that will make intelligible a meaning for the observed phenomena.

1. “A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude at all towards another mental life” (Freud, 1921, Standard Edition 18:110, note 2).
To interpret is to bring out the meaning, that is, to explain within the frame of a specific theory. For example, an interpretation may be an explanation in terms of a psychoanalytic theory.

To enact is to express in an interpersonal context the meaning of an unconscious or preconscious communication by way of a more or less dramatized interaction.

Not Content, but the Experience

It is not the content of the information conveyed to the patient, not the substance of the interpretations and interventions made, nor the correctness of the therapist’s conjectures, nor even the therapist’s compliance with demands to “mirror” the patient or to be his or her ideal that is pivotal: It is decisive for the progress of the therapeutic endeavor that the patient experience an ambience in which he or she feels respected, accepted, and at least a little understood.

This does not mean that the messages or information contained in communications and interpretations are unimportant. On the contrary, the correctness of interpretation is second only to the proper ambience in moving the analytic process forward. The informational content of an interpretation, however, will not be heard in depth unless given in an ambience that allows the patient to listen. More important than the ability to conceptualize his or her insights is the therapist’s ability to sense the patient’s need for the particular kind of ambience in which this therapy can proceed. The person who is the therapist thus becomes as crucial a variable as the person who is the patient.

Evocation of Mutative Experience

Clinical experience demonstrates that the knowledge gained by a patient about himself or herself has a certain usefulness to the patient, but does not effect any deep-going changes. Such new knowledge may have some influence on the patient’s consciously controlled thinking and behavior, but it has no effect on unconscious experience. Reading self-improvement literature accomplishes few psychological changes even when the material convinces the reader. Similarly, the information conveyed by a therapist to a patient, let us say, has meant the archetypal experience of the patient. The patient has no way of knowing that the information was conveyed by the therapist. The therapist must understand the patient’s experience in a way that is not conscious.
say in an interpretation, has little significant impact. In order for an interpretation to be effective in causing change—to be mutative—it has to evoke an experience in the patient. What aspects of a therapeutic experience make it mutative?

First, the experience must involve the transference, that is, it must be an experience that involves intense feelings about the therapist, and these feelings must be related to the feelings associated with some traumatic events involving significant persons of the patient’s early life. Second, to make the re-experience of the archaic affects in the here-and-now therapeutically effective and mutative, they must occur in a context where the patient understands and fully accepts both the actions and the affects of the therapist as well as his or her own. In other words—and this is the decisive difference when compared with the archaic situation—in the therapeutic situation, no blame is attached to either patient or therapist for the painful interactions that are taking place. They are accepted because they can be understood as occurring naturally, perhaps even inevitably. It is in this sense that knowledge of self and other—perhaps provided by an explanation or interpretation—can facilitate the experiential acceptance of painful interactions. The skillful interpreter establishes a link between the experience-near events in the here-and-now, the more distant events of the experienced archaic past, and the experience-distant explanations derived from general knowledge, history, and psychological theory. But sealing a mutative experience into a context by interpretation must be preceded by the evocation of the experience.
THE THERAPEUTIC PROCESS

In this section, I will elaborate the process by which an analysand (or a patient or a client) may achieve an improved state of mental health from the point of view of self psychology. In Kohut’s view (1984, p. 7), the psychological health of the core of the personality is always best defined in terms of structural completeness, that is, in terms of an energetic continuum in the center of the personality having been established such that the unfolding of a productive life has become a realizable possibility. Clearly, health is not merely a static condition. Implied in Kohut’s definition is a view of the person embedded in a net of ever-changing relationships, the selfobject experience of which has evoked and maintained a structurally complete, vigorous, balanced and ever-changing self. In short, a healthy self is strong and creatively acting in community with others.

AIMS

Strengthening the Self

The ultimate aim of the therapeutic process should be to strengthen the self so that the person is willing and able to actively plunge into the rough-and-tumble of everyday life, not without fear, but nevertheless undeterred. The intermediate aim is to initiate an analytic process, and a long-term aim is to keep the analytic process active—optimally even beyond the termination of the formal therapeutic relationship—with the expected concomitant benefit of a strengthened self. Other aims are secondary to the primary aim of strengthening the self. Depending on one’s theoretical conceptualization of health and pathology, the definition of the aims of treatment varies. Among the goals proposed at various times in the history of psychoanalytic practice have been: making the unconscious conscious, resolving unconscious conflicts, recovering a complete and
THE THERAPEUTIC PROCESS

truthful personal history, removing disturbing symptoms, controlling undesirable behavior, integrating into a social matrix, freeing potential creativity, reaching higher levels of maturity in development, improving the quality and depth of interpersonal relationships, improving the capacity to love and to work, and many more. All these goals are still laudable, but from the point of view of self psychology, what is not entailed in the aim of strengthening the self must be regarded as secondary to it.

The Goal of Treatment

The goal of treatment in self psychology has been described in structural terms as increasing the cohesion and wholeness of the self through transmuting internalization. As growing knowledge of the self disorders has enhanced our understanding, we have placed greater emphasis on the crucial vicissitudes of the self-object experience. Empathic resonance with a responsive self-object matrix is now seen as the guarantor of psychological structure and well-being. But whether the goal of treatment is defined in terms of self-structure (i.e., restoration of the structural deficit or the establishment of an uninterrupted tension arc from basic ambitions, via basic talents and skills, toward basic ideals) or in terms of the self-object milieu (i.e., the ability to allow free and nonanxious closeness to a needed self-object milieu), the result sought is a strengthening of the self’s structure concomitant with a greater latitude in tolerating less than optimal self-object experiences without a significant loss of self cohesion. No longer is it legitimate to demand that patients change. Instead, we can hold out the hope that the transmuting experiences of self-psychologically oriented treatment will enhance the strength of their self, and that in consequence of the incremental accretion of structure they will be able to integrate previously unintegrated affects.

A patient’s self is strengthened by re-experiencing the archaic trauma, with its associated affects, in the here-and-now of a therapeutic situation that allows an integrating and self-enhancing re-structuring of the self. This is not a corrective emotional re-experience as Alexander (1958, pp. 326-331) described it, because

2. Stolarow, Brandchaft, and Atwood, 1987, pp. 74-86.
the therapist is just as imperfect in his or her responsiveness as the parent was in childhood. Therefore, the therapist does not attempt to play a role that makes him or her different from the parent of childhood, as Alexander suggested. Indeed, the therapist’s imperfection, that is, his or her faulty responsiveness is as inevitable as the patient’s experience of a painful disappointment and subsequent disruption in the empathic tie to the therapist. This is how there comes about a repetition of the traumatic experience of childhood in the here-and-now of the analytic situation. But the restoration of the disrupted tie through empathic understanding and explanation confers enough extra strength to the self to enable it to integrate the contents and affects of the traumatic disruption into the structure of the self. The self thus emerges from the disruption—restoration incrementally strengthened by having integrated into the organization of its self-experience the contents and affects of the disruption—restoration experience.

What distinguishes these wholesome therapeutic experiences from the disintegrating (disposing toward fragmentation) pathogenic experiences of the past? A number of factors can be mentioned here. There is the greater age and resilience of the more mature self. There is also, in analysis, the memory of many such previous disruption—restoration incidents that were repaired with gradually increasing trust in the therapist. But more importantly, there is the therapist’s acceptance of the patient’s reactions, including the demands and symptoms secondary to the fragmentation of the patient’s self. The therapist knows that these behaviors are inevitable, given the patient’s history and therefore subsequent weaknesses of the self that were brought into the therapeutic situation. The therapist does not ask the patient to change, as a parent might, but explains to the patient what is going on, with the hope that gradually the patient will continue to become stronger and therefore less reactive, that is, less disrupted.

In other words, the reason that the patient grows stronger in the therapeutic situation is that the therapist’s rational equanimity signals an affective ambience of acceptance to the patient. In this ambience the patient’s affects are able to calm down rather than being further exacerbated as they would be if the therapist responded with affectively colored nonacceptance of what the patient was experiencing. To put this into more technical language, the proper therapeutic ambience, by virtue of providing a selfobject matrix in which
the patient's self can become embedded, is experienced as an empathic resonance that is sufficiently strengthening to the cohesiveness of the self. The self's capacity for integrating the evoked unpleasant affects are enhanced without trauma to the self’s structure and cohesion and with an incremental accretion of structure.

Wish to Change?

It is often thought that successful treatment requires that the patient have a strong wish to change. In the face of the difficulties and obstacles attending psychoanalytic treatment, it seems only reasonable to expect that strong motivation is needed to overcome the emotional discomfort of facing the unpleasant truths about oneself with which an analysis confronts the analysand. In addition, there are the burdens of frequent and inconvenient sessions, the expense of time, effort, and money, and the embarrassment of being a “mental patient.” Some therapists judge a patient’s motivation for treatment to be insufficient for psychoanalysis if the prospective patient does not manifest a wish to change. The more a therapist conceptualizes pathology in terms of holding on to instinctual pleasures, and the more, therefore, treatment is understood to help the patient to tame and renounce his infantile aims, the more treatment will be conducted in an ambience devoid of those conventional aspects of an ordinary social situation that could be interpreted as yearnings for derivatives of these infantile strivings. Commonly, such concepts of treatment generate an adversarial posture and require from the patient a willingness to suffer uncommon frustration. It is thought that only a painful dissatisfaction and concomitant wish to change oneself will yield the requisite motivation to undergo and to work through the displeasures attending analytic treatment.

The ambience becomes friendlier and more relaxed when the therapist conceptualizes the treatment process less in terms of the patient’s having to effect a renunciation of neurotic pleasures and more as providing an experience for the accretion of needed structure and strength. In a properly conducted therapy, the reigning ambience allows the process of gaining strength to come about without any conscious effort on the part of the patient. In this respect, it resembles the processes of growth during development that also proceed automatically in accord with the epigenetic pro-
gram if the proper conditions exist. It is therefore improper to demand a desire to "change" from a prospective patient. Individuals who have undergone analyses that are regarded as successful (by them and by their therapists) feel better and act better, but in some basic fundamentals they have not changed. They are the same people, with the same characteristic personalities, the same idiosyncratic constellation of likes and dislikes; the same basic ambitions, talents, and values; the same configuration of anxieties and depressions, though quantitatively ameliorated. The continuity of the self guarantees the continuity of basic patterns.

A patient's promise to change has no more meaning than a child's promise to grow an inch. Under the appropriate conditions it will happen, otherwise it will not. Extracting a promise to change implies a power that the patient does not have and knows he or she does not have. Such a demand to change is likely to make the patient feel either guilty or ashamed or both because of his or her presumed deficiency and inability. It is obvious that the prospective patient wants to change something and came in spite of inconvenience or shame about consulting a mental health professional. The desired change is most likely an unpleasant affect—a psychic pain, for example, anxiety, depression, shame, fear, guilt, disgust, horror, or the like. In a nutshell, the patient wants to feel better. No other motivation is needed for good analytic work.

Does this mean that patients do not achieve any real changes in psychotherapy?

A professional man in his mid-thirties came into analysis because he felt chronically anxious. In his dealings with colleagues and superiors he was timid to the point of feeling painfully shy at times. He experienced his marriage to a woman he had known since childhood as lacking joy and draining his energies because his wife had settled into a complaining passivity where she was unable to contribute much to their common family goals. During the analysis, his yearning for confirmation of his self—a mirror transference—was frequently disrupted, leading to transient depressed regressions when he experienced some unempathic comment by me as lacking the proper concern for his welfare. Associations led to memories of having been left alone to play with a younger sibling, for hours it seemed, and he recalled how he thought they had been forgotten. Working through his fear of abandonment as it manifested in the transference in innumerable
forms led gradually to a significant reduction in his discomfort with himself: He became more cheerful, more self-confident, more assertive with his wife, friends, and professional contacts. The defenses that had protected him against the dangers of rejection, by keeping him isolated and uninvolved, faded into the background and no longer kept him from enthusiastically engaging in social intercourse. His wife also began an analysis and as a result, in conjunction with his greater availability to her, both finished her professional training and had a child.

This brief vignette does not touch on the many issues that were analyzed. But even this barest outline provides an overview that would make it difficult to argue that the analyses of these two people were not successful. Yet both people remained essentially and recognizably the same. No one would have thought that they had become different sorts of people, and only the most intimate of their friends would have noticed any changes at all. Still, the small changes that had occurred were of the greatest importance and account for turning depressed sterile lives into satisfyingly productive ones.

SUCCESS OR FAILURE?

Whether the patient and the therapist together will succeed in reaching the patient’s goal depends on many factors and usually cannot be predicted with certainty. With luck, that is, barring any unforeseen and unforeseeable difficulties, and given a reasonably intact patient and a reasonably competent therapist, they should succeed, maybe, three out of four times: not such a bad percentage at all when compared with the results of the treatment of other serious chronic impairments that human beings fall heir to.

Why do some treatments fail? Assuming a well-analyzed and well-trained therapist, we often do not know the reasons for therapeutic failures. A number of explanations have been suggested.

Lack of Empathy

Among these explanations are the therapist’s inability to be sufficiently empathic with the particular patient in question though
he or she may be quite capable of good empathic contact with other patients.

**Idiosyncratic Incompatibilities**

Individuals—therapists as well as patients—have their own idiosyncratic qualities, and in the analytic situation these may clash rather than yield a therapeutic fit. Sometimes therapist and patient not only remind each other of their respective parents—the expected transferences and countertransferences—but sometimes, in actuality, the other person in the room does resemble very closely the remembered and dreaded archaic imago. In either case, the two parties may evoke in each other unacceptable affects associated with traumatic memories. Usually these transferences and countertransferences can be worked through. However, if the therapist does in fact closely resemble the early caregiver, working through becomes much more difficult and sometimes even problematic. The undogmatic analyst will usually recognize such an actual resemblance and, being alert to this danger, he or she avoids making an erroneous transference interpretation. Because so much depends on the fitting together of two individuals, the patient and the therapist, it is a good rule of thumb not to label a patient as unanalyzable unless there has been a trial of treatment with at least two and preferably three different therapists.

**Excessive Damage**

Finally, the patient may be too severely damaged psychologically, his or her self too fragile for the stresses and strains of a rigorous therapeutic process, and his or her ability to mobilize a minimum of basic trust too compromised.

**TREATMENT PROCESS**

Conceptually, one can distinguish two paths to strengthening the self. In actual clinical practice, both types of process often operate simultaneously on the arrested as well as on the distorted structures.
Via the Ambience

No self is totally free of areas where its development was arrested. Potentials of the self that are capable of being reactivated remain even when the ambience during development was by and large stimulating and facilitating. For a small number of patients, however, the accepting ambience of being in the presence of a respected person who is seriously, nonjudgmentally, and empathically interested in the patient's inner world may be the first such experience in their life. Treatment becomes the first occasion to be in a milieu that facilitates the healing of the self by allowing those aspects of the self which had been arrested in their development to resume developing. Thus, the selves of such patients may finally recover somewhat from the early trauma resulting from faulty selfobject experiences. Still, there will remain scars and at least part of the pathologically heightened needs for distorted selfobject experiences.

Via the Disruption-Restoration Process

Frequently, the vulnerable self has been injured through faulty selfobject experiences, and the self has undergone traumatically induced distortions, leaving it crippled and malfunctioning in certain aspects. Such distortions of the self secondary to injury appear to be more than arrested development, but they manifest as serious and deeper-going weakening of the self in conjunction with defensive structures. Archaic selfobject needs dominate in a weakened self and demand the experience of a total response. In contrast, mature selfobject needs can be satisfied by partial and measured responsiveness. Such injuries to the self are not repaired by a therapeutic ambience alone. Fortunately, there is a second and extremely important avenue for strengthening in psychotherapy the self weakened by structural malformation. This restoration of a strengthened self comes about via the disruption-restoration process that I spoke about earlier. The needs for fixed and defensively distorted archaic and primitive (and thus pathological) selfobject responses are re-

placed with age-appropriate needs for selfobject responses. I described this in overview as the step-wise replacement of archaic pathology with a selfobject response that one might label reciprocal empathic resonance. I will discuss this process now in some detail.

THE DISRUPTION-RESTORATION PROCESS

Resistance Analysis

The individual's always-present needs for selfobject responses emanate both from (1) residues of archaic needs modified by defenses, and (2) contemporaneous configurations. In the therapeutic situation, these ever-present selfobject needs tend to mobilize and manifest as more or less unconscious hopes or demands on the therapist. An accepting-ambience will facilitate this mobilization, but even under the most propitious circumstances the fears carried forward from the past will interfere with the open expression of the mobilized needs. In other words, the patient resists the expression and even the awareness of these needs. An analytic interpretation of these resistances against the spontaneous emergence of these selfobject demands on the therapist facilitates mobilization of the selfobject transferences. Then the mobilized transferences will structure the relationship with the therapist in such a way that the therapist will be experienced as either performing or as refusing to perform the needed selfobject functions. Resistances protect against new injuries. Overcoming these resistances means that the injured self dares open itself up to a potential experience of being injured again.

In other words, the self entrusts itself to the therapist's capacity and willingness to perform the selfobject function. It is not easy to trust a stranger when past experience with the significant figures in one's life has usually been full of misunderstandings and ill-considered moralistic judgments. Will the therapist be competent and fair-minded? Will he or she really understand? The patient's self suspects that new disappointments and new injuries will occur again, as has happened before on numerous other occasions before coming into treatment.

In fact, the therapist inevitably will disappoint and fail to meet his or her own and the patient's expectations. But hope will not die easily, and it becomes part of the therapist's task to encourage these
re-awakened yearnings by his or her professional commitment and an open attitude of being responsive to the patient's need for understanding. A cold rigidity during these early phases of resistance analysis can be like a killing frost, and a therapeutic process may not ever develop. For in essence, resistance is nothing but fear of being traumatically injured again. The decisive event of resistance analysis is the emergence of the patient's courage out of the experience of being accepted and empathically understood rather than being judged by the therapist. Such an accepting ambience facilitates the effectiveness of resistance interpretations, which otherwise fall on deaf ears whether they are correct or not. I believe this ambience to be more important than the exact verbal content of the resistance interpretations. The analytic situation beckons regression and mobilization of repressed and disavowed selfobject needs, while at the same time threatening traumatic disappointment. The therapist's calmly responsive strength facilitates the mobilization, while his nonjudgmental interpretations of the resistances diminish the fear of a repetition of the trauma. A vignette will illustrate:

A woman, a mental health professional, came thirty-five minutes late for her first appointment and announced that she did not really come for treatment but to have some things explained to her. I confess that I considered reminding her that I was seeing her as a therapist, not as an instructor, that I wished and had chosen to do analytic work with people who desired such services, and that I was not in the business of teaching or explaining psychotherapy in my office. As you can tell, I felt hurt, and I came close to revealing my injured self, which was demanding patient-like behavior from my prospective patient. But my momentary outrage passed as I began to listen and to hear a desperately fragile self open itself up ever so slightly to being injured again, while ostensibly surrounding itself with a barrage of denials of its needs. So I said very little, and very soon we made another appointment to which the patient came only twenty minutes late. I won't draw out this vignette. Suffice it to say that it did not take very long for a genuine treatment situation to evolve, which, however, could not be explicitly acknowledged by either one of us for a long time. Eventually, of course, the defensive behavior—personally, I don't like the term "resistance" because it has taken on some moral connotations of evil—could be interpreted explicitly. Had I actually needed appropriate patient-like behavior on that first day in order to properly feel myself a therapist, I wonder if I would have found this patient untreatable. Or perhaps I would have thought her a borderline.
Transference Mobilization

The second step in the disruption-restoration process is the spontaneous mobilization of the patient's selfobject transferences. I wish to stress that patients are in constant conflict. The conflict is between the constant need for selfobject responses, on the one hand, and the fear of the self's being injured, on the other hand. Most of the time, the fears are dominant and they thwart movement toward establishing selfobject relationships that can become self-sustaining selfobject experiences. Consequently, the patients coming into treatment are usually starved for needed selfobject responses. When the therapeutic ambience, in combination with resistance analysis, creates an experience of relatively greater safety for the patient, then the balance between need and fear shifts, the ever-present hope is encouraged, and the rising expectation that the selfobject needs will be heard and understood leads to an intensification of these needs, which then override the fear. Though at first revealed only hesitantly, the most important of the patient's expectations of the therapist is to be understood. The therapist's empathic understanding brings about a general mobilization and revival of archaic, repressed, and disavowed selfobject needs that determine the expectations focused on the therapist and thus shape the selfobject transference: a mutual experience of well-being testifies that a harmonious transference has emerged.

Transference Disruption

The third step in the process ensues when the spontaneously established sustaining selfobject transference is disrupted. This transference disruption comes about just as spontaneously as the establishment of the transference, and it occurs inevitably because the therapist is bound to "fail" in maintaining a total and perfect empathic "in tuneness" with the patient. At some point, the patient suddenly feels outraged, often thinking that the therapist seems more interested in his or her own agenda—which is making a correct interpretation—than in the patient's burning concern at that moment—which is to be compassionately understood. And, indeed, the chances are that the patient's perceptions are correct and not a distortion. For at that moment the patient does not really wish to be
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scrutinized and analyzed and hear an interpretation, but wants to experience the therapist's empathy. Yet, to point this out would be just another instance of the same misunderstanding and widen the breach. Before such an interpretation can usefully be made, therefore, the therapist must acknowledge the patient's perception of the therapist's "failure" as real, regardless of whether it is the result of the patient's distortion or not. The patient's experience must be validated before it can be usefully interpreted.

Transference Regressions

Disruptions of the selfobject transference cause a temporary regression to previous, more archaic modes of relationship, which then may be characterized by defensively distorted and exaggerated demands on the therapist or by defensively motivated distancing and withdrawal and sometimes also by acting out. Please note that distorted perceptions of the therapist by the patient are not the cause of the disruption, but may be the result. Also note that defensiveness here does not mean defense against instinctual intrusion; on the contrary, the temporary regression of the self to a state of lessened cohesion in this case is often accompanied by some disintegration of the self with the emergence of distorted fragments of sexuality and aggression, for example, perversions and other forms of acting out.

The defensive nature of these more archaic modes of relating, that is, the detachment, or the sexualization, or the aggressivization, is evident from their being used in the defense of the remaining self-structure. The disappointing selfobject may be held at a safer distance by the often obnoxious quality of these defensively used manifestations of disintegration, or it may be brought closer by the evident neediness. Either way, the self, though in pain and need and at reduced functional capacity, tries to marshal whatever resources, including the products of its own disintegration, to influence the carrier of the selfobject function into a posture of supplying the need.

It is the archaic, distorted, and imperative nature of the revived selfobject need that often makes it, in fact, counterproductive in ordinary social intercourse. In the therapy, however, at least ideally, the therapist by virtue of his or her empathy and theoretical orientation, can recognize the legitimate selfobject needs underlying their
distorted and archaic manifestations, manifestations that he or she experiences often with some discomfort as well.

Transference Restoration

This then leads to the fourth step, the restoration of the self-object transference through proper interpretation of the transference disruption. The therapist explains and interprets to the patient the sequence of events that led to the disruption. This requires tact, an empathic understanding of how the patient experienced and thought about the disruption, and, last but not least, how it was experienced and understood by the therapist. Because he is introspectively in contact with his own inner psychic reality and empathically attuned to his patient's different reality and suffering, the analyst is in a good position to discern what actions committed or omitted may have precipitated the present impasse. Perhaps he will come to the recognition that the disruption is due to a break in correctly sensing each other's inner experiences: not only an erroneous attunement of the analyst to the patient's needs but also an equally erroneous reading of the analyst's intentions on part of the patient, the latter often as a result of transference of archaic fears and expectations. The therapist therefore will explore for clues that will explain the disruption and grope for ways of communicating his understanding, that is, conveying his insight to the patient via interpretation. This exploratory and explaining effort of the analyst is experienced by the patient as evidence of his concerns being taken seriously. For both, but especially for the analysand, this is an experience of his own efficacy in eliciting an attuned response, of having made a dent, of being somebody, a confirmed self. Healing experiences in psychoanalytic treatment require (1) a sense of being understood by the other and (2) a sense of one's own efficacy regarding the other. We cannot, with our present state of knowledge in psychoanalytic psychology, say much about the relative contribution of the various types of mirroring, idealizing, or alter-ego self-object experiences nor of the experience of efficacy to the cohesion of the self. But it seems clear that all of them are essential requirements for the emergence of a strong self. One could conceptualize the need for efficacy pleasure as a variety of a needed mirroring experience. However, in view of its extra-analytic valida-
tion by mother-infant observations involving responses from a non-living object, I think it best to conceive the need for efficacy experiences as a separate kind of need (cf. pp. 60-62).

Conceptually, it is important to point out that the disruptions, like the preceding harmonious selfobject transference, are not new experiences with a new object. Rather, what is new is that the therapist does not respond in the manner of an ordinary social situation, but responds by explaining and interpreting on the basis of an empathically informed understanding. More specifically, although the therapist's initial posture may have been experienced by the patient as if the therapist were a figure from the past—and, indeed, the therapist for his or her own reasons does act very often as if he or she were a parent or other closely related individual—the therapist also acts differently by taking an emotional distance, that is, by accepting the patient's experience without insisting that his or her own experience be the measure of all things. Even the therapist's well-thought out explanations are subject to correction by the patient. Such explanations given within an accepting ambience based on the therapist's empathic attunement to the patient are not gratifications of a need—neither of a selfobject need nor of an instinctual wish or need—except for the need to be understood. By again feeling understood, the empathic flow between therapist and patient is restored.

A successful disruption-restoration process restores the mutual reciprocal empathic flow between patient and therapist. One commonly observes that the restored empathic bond is stronger and less vulnerable to repeated disruptions. However, disruptions will still occur, albeit less frequently and less intensely loaded with affect, when the inevitable disjunctions in the reciprocal empathic flow recur. Yet unmistakably, the patient's self grows stronger and its selfobject needs are gradually transformed into more mature, age-appropriate modes. The patient's extra-analytic functioning improves, as does the quality and the satisfactions derived from extra-analytic relationships.

It is easy to explain that intra-analytically the self's strength is restored with the resumption of the empathic bond because the analyst again is available as a provider of sustaining selfobject experiences. But the observation of a self stronger than before the disruption and, particularly, a self gaining new strength outside the analytic situation requires the assumption that the disruption-restoration
experience is equivalent to a learning experience that has resulted in a rearranged or reorganized self structure. Apparently, the regression brought about by the analytic process is a precondition for this reorganization. The patient exercises some of the functions of the self that are involved in scanning, perceiving, and responding to a self-object matrix, perhaps for the first time since infancy and childhood. These functions can now be exercised in the analytic situation because of the ambience of safety created by the analytic therapist. Exercising these functions strengthens them the way muscles are strengthened by use.

The mutual reciprocal empathic therapeutic dialogue is such an exercise, and it is fundamentally different from pretherapeutic dialogues with family and friends. One difference is the therapeutic regression, which allows the involvement of formerly deeply hidden and unconscious aspects of functions. The other difference is the consistent attitude of empathic understanding by the analytic therapist. The patient’s experience of safety and trust gradually extinguishes the almost automatically reflexive defensive maneuvers, thereby facilitating experimentation with new modes of perceiving and responding. The experimental modes that have worked in the therapeutic situation can then be tried outside this sphere of relative safety, where the patient discovers, to his or her surprise, that benign self-object experiences can also occur outside the therapeutic relationship. The responsiveness of extratherapeutic self-objects further strengthens the self. The pretherapy vicious cycle of faulty responses leading to fragmentation, leading to more faulty responses has been replaced by a cycle of appropriate responsiveness leading to greater cohesion, leading to better functioning. It is a learning process that depends not on information supplied by interpretation but on an experience that can be explained.

The Mutative Character of Disruption–Restoration Experiences

But, one may ask, how does an experience become mutative, that is, how does the experience change the self in such a way that it is stronger after the mutative experience than before? Let us recall
briefly that the very emergence of the self depends on appropriate
selfobject experiences, among which the mirroring selfobject expe-
rience is an essential component. To paraphrase this mirroring
experience one might say that one exists as a self because a signifi-
cant someone knows and addresses us as a person, a self. This
significant someone has been designated by self psychology as a
selfobject, and its function in evoking the self experience in the
subject has been called a selfobject experience. I have also mentioned
that regardless of presenting symptoms or behavior—whether anx-
ious, hostile or depressed, whether arrogant or pleasing, compliant
or rebelliously acting out—there exists, ubiquitously, in the patient a
feeling of badness of the self. It is a more or less unconscious but
apparently unshakable conviction of one’s self (and person) being
faulty and unacceptable in some fundamental way that already be-
came part of the self’s very structure when it was constituted and
emerged as a self. The baby’s natural and blissful experience of itself
in its grandiose glory was spoiled almost from the start by a patho-
genic mirroring selfobject experience: the selfobject acted or func-
tioned as if the baby was experienced by the selfobject as bad.
Perhaps this represents the selfobject’s psychopathology, or perhaps
it reflects unfortunate circumstances that skewed the selfobject expe-
rience and warped the emerging self.

In the analytic situation when, after much analytic work, the
layers of defenses, symptoms, and behavior have been laid bare for
both analyst and analysand to see, there then remains the patient’s
core conviction of essential badness. No words, no verbal interpreta-
tion alone can correct this depressive core. Even the explicit reassur-
ance by an empathic analyst during an intense transference relation-
ship will not remedy any more effectively than the compassion of
friends and family. Neither empathy nor love cures.

I have described the therapeutic process that culminates in
disruption-restoration sequences. Under certain conditions such a
disruption-restoration experience may reach the depressed core of
the self and change it by rearranging its constituents. To achieve such
a desired outcome there have to be (1) a regression that is deep
enough to loosen the self’s structure without endangering its cohe-
sion and boundaries, and (2) an analyst who not only is able to
skillfully manage the disruption-restoration process but who, in
addition, knows with sincere conviction that, indeed, the analysand is
not bad but human, with inevitable frailties and limitations. This analyst cannot help but create a selfobject experience for the analysand that is different than the one with the original selfobjects; that is, the self that emerges from the therapeutic regression will have as part of its constitutive experience the conviction of essential goodness. Over time and many disruptions and restorations, this patient will gradually gain a new perspective on his person and self that will imbue him with the strength to cope with the human condition.

REGRESSIONS

The analytic disruption—restoration process just outlined is predicated, among other factors, on the self being sufficiently strong to withstand the stress of the emotional upheaval, and, especially, the painful disruptions of the transference, without undue regression or total and perhaps irreversible fragmentation of the self.

Therapeutic Regressions

In the psychoanalytic situation, especially, a regressive process in the patient is facilitated. The basic rule to say everything that comes to mind, thereby requiring the patient to relinquish some control over his or her speech, imposes tension, as does the frustration evoked by not being responded to in a normal social manner. In addition, the patient is in a supine position and unable to see the therapist, who is sitting behind him or her. As a patient regresses, the process has a loosening effect on the structure and boundaries of the self, with a further mobilization of the residuals of long repressed or disavowed selfobject needs. These changes brought about by the regressive pull of the therapeutic situation facilitate the analytic work, because the mobilized archaic structures thus can become the core of the selfobject transferences. The regression also interferes with learned logico-cognitive thought-processing and lessens the firmness of the self's boundaries, making them more permeable to empathic communications. Usually, such a mild regression engendered by the analytic situation has no deleterious consequences and makes the therapeutic process possible.
Severe Regressions

In some people, however, the fragile structure of the self makes the self vulnerable to uncontrolled regression. That is, there is a danger that the regressive process, once initiated, cannot be satisfactorily controlled and may progress to a psychotic-like state. In most people with such vulnerable selves, defenses have been erected during development to protect the self against these dangerous regressions. These defenses take various forms; among them, schizoid mechanisms, paranoid mechanisms, and the rigidities of certain obsessive-compulsive preoccupations have been described in great detail in the psychotherapeutic and psychoanalytic literature.

These defenses serve to keep the person relatively isolated and away from noxious relationships that might lead to traumatic self-object experiences. The diagnosis of borderline state is often applied to such people. People with such vulnerable selves manifest in the analytic situation the symptoms associated with these defenses. Symptoms of unward regressions should alert the therapist to take steps to slow the regressive process until the self has gained sufficient strength to maintain control over its own state of organization. Among the various interventions in the therapist's armamentarium are medications (anti-depressants, anxiolytics), changing the frequency of sessions (some respond to a reduction in frequency, others to an increase), changing from the use of the couch to face-to-face treatment, and focusing away from the exploration of fantasy to a more reality-directed concern.

Treatability

Psychological treatment facilitates regression and increases the vulnerability of the self to react to noxious stimuli with decreased cohesion, increased permeability of boundaries, and mobilization of repressed or split-off affects. The capacity to regress, therefore, is a necessary precondition for making repressed and split-off parts of the self accessible to the interactive therapeutic process. On the other hand, excessive regression may mean dangerous degrees of loss of cohesion, that is, fragmentation, and, similarly dangerous degrees of losing boundaries. Therefore, it is necessary to evaluate the regres-
sive potential early in the assessment of patients for psychoanalytic treatment. The conventional classification into psychoses, borderline states, and personality disorders is not always a reliable guide, nor does a diagnosis of a classical psychoneurotic syndrome rule out the possibility of untoward regressions. The criteria of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III-R) allow one to classify into appropriate categories after one has made a judgment regarding the regressive state and potential. How does one arrive at that judgment?

The most important information comes from an accurate history, since in almost all cases the danger of excessive regression is signaled by a history of prior occurrences of such regressive episodes. On the positive side, a history of a prospective analysand's having withstood severely traumatic events associated with intense states of fear, anger, or depression without signs of serious loss of self-control in behavior or serious disturbances in usually solid interpersonal relationships bodes well for also withstanding the rigors of a psychoanalytic endeavor without undue consequences. To gather this information takes time and mutual trust. The therapeutic undertaking must proceed with a certain tentativeness while watching how the therapeutic regression is developing. The decision to treat someone psychotherapeutically, regardless whether the mode of treatment is supportive, relationship therapy or psychoanalysis, is not a one-time act but emerges as an ongoing process of observation and reevaluation. Although, perhaps, psychotic patients regress more easily or deeply than borderline patients and neurotic patients, and personality disorders usually are less inclined to undergo severe regressions, this is not at all a reliable guide. Diagnostic assessment and treatment decisions are not safely made before treatment starts but grow out of the treatment process itself. Patients who have never achieved a cohesive self are most vulnerable to excessive regressions and not suitable for regression-inducing treatment modalities. Patients with a history of psychosis, particularly schizophrenia and severe dysthymic disorders usually ought to be managed with the aid of psychopharmaceuticals.

*What About the Psychoneuroses?*

Injured selves that nevertheless achieved a measure of cohesion such as we find in the narcissistic personality disorders and in the narcissistic behavior disorders are the prime candidates for psycho-
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THE THERAPEUTIC PROCESS

therapy. What about the psychoneuroses? In my experience, pure
symptom neurosis has become a rarity, and the patients with whom I
have had the privilege of working during the last years all suffered
from primary selfobject relations pathology. Many also suffered from
a variety of neurotic sexual pathology derived from pathological
oedipal complexes, but in each case the oedipal pathology was the
result of faulty responses by the oedipal selfobjects of childhood.
Psychoneurosis thus seems to be a particular variety of selfobject
pathology and is treated as such. 4

FURTHER COMMENTS ON TREATMENT AMBIENCE

I have designated the experience of the psychotherapeutic situation
and process the psychoanalytic ambience (Wolf, 1976a). The very
possibility of the therapeutic process occurring and progressing to-
ward increased strength of the self concomitant with improved
comprehension of the self by the self is contingent on the establish-
ment and maintenance of an analytic ambience of respect, accep-
tance, and understanding. It is important to remember that the
psychoanalytic process explores experiences, not absolute truth.

A variety of descriptive terms are in common usage, and they
can be paired, for example, tense versus relaxed, warm versus cold,
accepting versus rejecting, critical versus nonjudgmental, reasoned
versus dogmatic, misunderstanding versus understanding, friendly
versus hostile, cooperative versus adversarial, interested versus indif-
ferent, and so forth. Different people probably would not agree in
their assessment of a particular ambience, especially if they were
judging as nonparticipant observers—attempting to be objective
from the outside, so to speak. It seems, similarly, that each of the two
participants in an analytic situation and process often experience a
rather different ambience.

4. Self psychology is frequently misunderstood to be dismissing all sexuality as
mere disintegration products. To be sure, pathological and neurotic sexuality are
conceptualized as deriving from faulty selfobject experiences which have fragmented
the self and yielded disintegration products that have been organized into neurotic
symptoms or sexualized behavior. But even the healthy single individual with a
firmly cohesive self must be seen as incomplete in the larger context of a life, and
normally will be striving to complete himself or herself by sexual union with an
individual of the opposite sex.
Patients also differ widely in their experience of the therapeutic ambience. What one patient might perceive as warm and friendly might be experienced by another as cold and distant. In the analytic situation one man's meat truly is another man's poison. The analytic ambience as experienced by the patient determines to a large extent whether the analytic process will stalemate and derail or whether it will go forward.

Transference Interpretation

Kohut (1971, p. 291, 291n.) stresses, like Freud, the great importance of avoiding premature interpretations of the transference. According to Kohut, the analyst should not interfere (either by premature interpretations or by other means) with the spontaneous mobilization of the transference wishes. The interpretive work concerning the transference should begin only at the point when, because of nonfulfillment of the transference wishes, the patient's cooperation ceases, that is, when the transference has become a resistance. Interpretative references to the transference, especially early in the course of the analysis, will be correctly understood by the patient as prohibitions. No matter how friendly and kindly the analyst expresses himself, the analysand will hear him say: "Don't be that way—it's unrealistic, childish!" or the like.

On the other hand, Kohut speaks of three common resistances surrounding the transference as it is being established, and he does advocate their early interpretation. Three fears predominate during this initial analytic phase, and they all relate to dangers associated with the analytic process. Kohut (1971, p. 88) mentions the patient's fear of regression, his apprehension vis-à-vis a difficult task, and his fear of the extinction of his personality by the deep wish to merge with and into the idealized object. Kohut suggests that the analyst acknowledge the presence of all these resistances and define them to the patient with friendly understanding, but he need do nothing further to provide reassurance. In a more general vein, analysts must realize that there are indeed moments in an analysis when even the most cogent and correct interpretation about any detail of the patient's personality is out of place and, for instance, unacceptable to the patient who seeks a comprehensive response to a recent important event in his or her life (Kohut, 1971, p. 121).
Freud told us that, like government, we are engaged in an impossible profession. Perhaps that is true if our aim is to change us and make the world a reasonable place. Instead, we may have to be satisfied with gaining a few increments of sense and strength with which to push back the encroachments of unreason. We have not got much to show for our efforts, except that our patients lead fuller, more creative, and more satisfying lives. And that is a lot.