THE DYNAMICS OF PSYCHOTHERAPY IN THE LIGHT OF LEARNING THEORY[1]

Franz Alexander, M. D.

There are few fields of therapeutic endeavor, other than psychoanalysis, where the techniques of treatment used today are essentially similar to those used 50 years ago. The reasons for this can be speculated about. Was the original model perfect? Have changes been resisted because of some sociological factors? The early analysts may have felt great need for unity, inasmuch as they were at the forefront of a psychological advance which was strongly resisted by the culture in which it developed. On a similar basis, a need to maintain identification with Sigmund Freud may have persisted. Perhaps human low tolerance for uncertainty leads to a need for a defensive dogmatism to help deal with the infinite complexities of psychodynamics.

In the literature on psychoanalytic technique, there has been controversy over the relative importance of cognitive insight versus the emotional experience of the therapeutic relationship in achieving therapeutic results. My concept of the corrective emotional experience emphasizes the differences between the transference relationship and the childhood relationship with the parents. The patient makes an effort to

1. Summary of the scientific meeting of the Southern Calif. Psychoanalytic Society, October 21, 1963.

repeat his childhood relationship in the transference, but the therapist does not join in this. I have advocated that the therapist create an interpersonal climate in the transference to contrast as much as possible with the patient's childhood and give the patient an opportunity for a new settlement of his childhood conflicts. Good therapists do this intuitively, but some conscious effort to achieve it may be necessary. Such conscious effort on the part of therapist is no more artificial than the effort to maintain the classical posture of complete detachment.

The significance of the therapist's emotional involvement with the patient is more frequently noted in modern psychoanalytic literature and it is generally agreed that the analyst is not just a blank screen. Whether the feelings of the analyst are a contaminant to be avoided as much as possible or whether they can be an asset is a subject of some debate. Some authors feel that the analyst's ability to understand his own feelings may be a valuable tool to increase his understanding of the patient. In my thinking, the countertransference is helpful when it is very different from the response the parents showed to the child, but countertransference may result in a therapeutic impasse if the analyst's response to the patient is the same as that of his parents.

In recent years, myself and a group of colleagues have conducted a research project at Mt. Sinai Hospital into the nature of the therapeutic process, and I would like to present

some of our preliminary observations. The essential element in the research situation was the observation of the therapeutic process by non-participating psychoanalytically trained observers. It immediately became apparent that the concept of transference was not sufficient to explain all the interpersonal dynamics of the analytic situation. Patients react to the analyst as a concrete person and not simply as a transference object. In the same way, the analyst's reactions to the patient are more than countertransference. He unavoidably conveys to the patient his own values, and with non-verbal as well as verbalizations, the analyst responds to the patient as a person and to the patient's responses to him. The treatment process can be seen as a truly transactional interchange.

The interchanges observed between the patient and the analyst can be understood in the light of learning theory. There are two principal models for learning theory; the older, Pavlovian model, and the Gestalt model. The common basis of both models of learning theory consists of the forging of connections between the motivation, the behavioral response to the motivation, and the reward for this behavior.

In attempting to establish a relationship with the analyst, it can be observed that the patient initially tries to utilize the inadequate patterns of his childhood. Then, influenced by the responses of the analyst, he learns and applies better and more mature methods until he is rewarded by the establishment of a less-conflicting, better relationship with the analyst, then

with his environment and, finally, with his ego ideal. The patient senses the analyst's expectations and tries to live up to them, as well as trying to live up to his own values. Thus, a common source of therapeutic impasse may be a wide divergence between the value systems of the patient and the therapist. This process could be followed clearly by observers, and the process has proven invaluable for studying therapeutic transactions.

Dr. Norman Levy emphasized that the therapist's expectations are communicated to the patient, and the patient's use of learning process is based on this awareness. This can be seen as an adaptational process in which the patient lives through a new experience with a new parent, one who is more interested in the patient's welfare and who offers a better figure for identification. This is possible because the therapist, in contrast to the parents, is not dependent on the patient for gratifications of his own. The patient constructs a more adequate and a truly gratifying internal parent out of the therapist's maturity.

The emphasis of this material on the emotional aspects of the relationship between patient and therapist should not lead us to overlook the importance of cognitive insight. It also must be remembered that the therapist has a built-in, pre-existing parental attitude towards his patients, probably an important, unconscious motivation for becoming a psychotherapist. It is possible that the patient's transference, in which he sees the therapist as a parent, is a response to the therapist's parental attitude.

Dr. Judd Marmor expressed uneasiness about Dr. Alexander's

apparent advocacy of a kind of conscious role-playing on the part of the analyst, in an effort to provide a more striking contrast to the patient's parental relationships. It seems difficult to reconcile this with the emphasis on mutual honesty which is so essential in psychoanalysis. We, as analysts, do not play roles with our patients but, rather, automatically modify what we do in terms of each specific patient and our objectives for each patient.

It should be emphasized that the learning in psychoanalysis is resisted by the patient, and the overcoming of this resistance is the core of the whole process. Working through can be seen especially clearly as a kind of learning.

Learning in psychoanalysis can be put under four different headings: (1) the trial and error, Pavlovian type of learning, (2) the Gestalt type of learning, (3) the conditioned, corrective emotional experience, type of learning and (4) learning through imitation and identification.

Learning theory has shown that reward is much more effective than punishment in stimulating learning. In the face of frustration, regression may occur. I believe that a considerable amount of infantile transference neurosis is the result of frustration in the analysis.

In replying to the discussion, Dr. Franz Alexander emphasized that he definitely is not advocating role-playing in his concept of the corrective emotional experience. The therapeutic relationship always exists in a particular climate

which can be controlled by the therapist. Even the maintenance of the classical uninvolved, incognito position of the analyst represents a deliberate creation of a particular climate. I believe that the therapist can do deliberately what often occurs intuitively; that is, maintain the therapeutic relationship in a climate which contrasts with the climate of the patient's childhood and brings out his maladaptive psychological maneuvers in particularly sharp relief.

John S. Peck, M. D., Reporter