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### Beyond Psychotherapy: Dialectical Therapy

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*Dialectical therapy is a common factors approach to psychotherapy integration, in which four general therapeutic strategies are taken as the cardinal points of a map of the field. It is said to be “beyond psychotherapy” because what is commonly referred to as psychotherapy is more than psychological treatment. It is a dialectic between two basic levels or axes: the psychological-remaking, which deals with defect-driven disorders, and the philosophical-uncovering, which deals with conflict-driven problems. The first level can be graphically represented as the horizontal axis of the field, connecting a “maternal” and a “paternal” pole, in which the therapist responds to the basic psychological needs of secure attachment and responsible cooperation. The second level can be represented as the vertical axis of the field, connecting a K (knowledge) vertex and an O (unknown) vertex, in which the therapist responds to the basic philosophical needs of knowledge (“know thyself”) and of unknown as unknowable (the noumenon of all phenomena, the source of generative and healing powers). A map is necessary to organize the basic therapeutic needs, and the range of responses to them, in a coherent pattern. As a good map can help in orienting empirical research, this in turn can help in constructing better maps.*

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A question I have been trying to answer for a long time is whether psychotherapy really exists – that is, it is a robust phenomenon - or the word “psychotherapy” is just a nominal container for disparate and incongruous practices. If to this question we answer: “Yes, it exists, and I know what it is”, we risk taking the position of one who says “Come follow me, I have the answers” (Goldfried, 1980). If, on the contrary, we choose a contextualist-postmodern attitude (Messer, 1997) we risk joining those who pulverize the field into a tower-of-Babel drift. Coherence and systematicness are good, but too much of these virtues stifle creativity and freedom. Pluralism is good, but too much of it makes communication impossible. Is there a middle way between too strong and too weak an answer?

A *middle way* is already the beginning of an answer. A middle way between too strict and too loose does not mean fifty percent strictness and fifty percent looseness. To be balanced means to look for the right mixture, the right combination that is required by any specific situation. It has been observed (Hanna, 1994) that the “metaphysical” presuppositions on which the many hundreds of psychotherapeutic schools are grounded emphasize each one of two polar opposites to the detriment of the other (e.g. insight vs. behavior or vice versa). If a metaphysical attitude posits arbitrary postulates and builds theories on such ground, a dialectical attitude takes nothing for granted, but moving among the many contradictory principles of the therapeutic process points to overcoming their one-sidedness, towards new syntheses (e.g. as a vicious circle can be broken sometimes through an interpretation, some other through a behavioral prescription [Wachtel, 1977], the therapeutic process will have to combine or meld ad hoc the two).

The term “dialectical” is commonly used for a general, anti-intellectualistic attitude, and less for a more systematic attempt to describe the basic oppositions that characterize a field and to organize them in a comprehensive pattern. I will use it in both meanings. In my opinion two fields, in particular, are very much in need of dialectical treatment: the first is the field of psychotherapeutic integration, the second is that of psychotherapeutic theory and practice.

The first of these fields is divided into three generally accepted ways of combining the methods and the concepts of two or more schools of psychotherapy: technical eclecticism, theoretical integration and common factors approach (Stricker and Gold, 1996). I have observed<sup>1</sup> that these three ways can be reduced to two, and these two are the poles of an opposition that apparently deny, but substantially *need* each other: which is the essence of dialectics.

I will treat this dialectic in another paper. In this one I will follow a common factors approach to show that *a basic unit of all psychotherapeutic methods is to be found in a developmental perspective*. Indeed any method, whatever its theoretical premises, must meet the basic developmental

needs of the human being. There is a convergence of psychotherapeutic, anthropological and anatomical data that I summarize with this formula: *two architectural levels of human brain (mammalian and human proper) harbor the inborn dispositions for the two developmental lines (natural and cultural) that are met on the two axes of any psychotherapeutic practice: remaking and uncovering.*

Dialectical therapy, the name I have chosen for my approach to psychotherapy integration, is in line with similar others, as Linehan's "Dialectical behavioral therapy" (1993), Hanna's "Dialectic of experience" (1994), Basseches' "Dialectical-constructivist view" (1997), and shares with them a common perspective on human experience.

In comparison with those who have preceded me on this line, my attempt may be more ambitious<sup>2</sup>. First, I have not named my approach behavior therapy nor psychotherapy, but just therapy, because the point I want to make is that what is commonly referred to as psychotherapy is more than psychological treatment. I do not claim that I have gone beyond psychotherapy: psychotherapy has always been, since its modern, Freudian inception, beyond mere psychological treatment. Indeed Freud was very precise, and even a little disparaging, in underscoring the difference between his creature, psychoanalysis, and ordinary psychotherapy. The difference, in his opinion, was that an ordinary psychotherapist tries to bring a direct emotional influence to bear on his or her patients, while a psychoanalyst remains as neutral as he or she can, and restricts himself to mirroring back what he sees.

The difference is today no more as sharp as Freud wanted it to be. Not only psychotherapists of other schools have obviously refused to recognize a higher rank to psychoanalysis, viewing it as just one more therapy among many others; but the psychoanalysts themselves have more and more blurred the border between their discipline and ordinary psychotherapy, acknowledging that the analytic relation is always and anyway an interaction, whatever the analyst does to look impersonal (Wallerstein and Dewitt, 1997); and furthermore admitting that in many cases a personal, emotional involvement is desirable or even necessary, especially when what the analyst has to face is not conflict-driven, but defect-driven material. The "emotional corrective experience" is no more a heresy to many or most psychoanalysts today (Migone and Liotti, 1998).

If psychoanalysis is an interaction, and an emotionally charged one, and on the other side every psychotherapist does some kind of interpretive work, what is left of the difference between the two fields? Surely there exist no more two fields, but only one, segmented into many schools and orientations, each one emphasizing one or more sides of the whole. This, however, is no authorization to dismiss the original Freudian distinction. It is still there, but *the line does not run anymore through the field* (the analysts on one side, the therapists on the other side): *it runs inside every single therapist* and every single therapy. It is the line that separates the two levels or axes of any psychotherapeutic enterprise: the *remaking* and the *uncovering*.

## PSYCHOLOGY AND PHILOSOPHY

I maintain that only the former of these two operational levels can be properly labeled as *psychological treatment*, or psychotherapy in the strict sense, as the latter should be more correctly referred to as *philosophical treatment*. I say this for both historical and substantial reasons. Historically, it is well known that the conception of philosophy as therapy of the soul was common to all ancient (Greek and Roman) thought, but was especially espoused by the Hellenistic thinkers (Nussbaum, 1996). The famous and very much quoted Epictetus' sentence "Men are disturbed not by things which happen, but by the opinions about the things", epitomizes both stoical and cognitivist theory. It is hardly the case to point out how far and how deep contemporary therapy of the soul is influenced by western, and more recently also eastern, philosophy. Nobody would deny this. But why should one distinguish the philosophical component of the therapy from the psychological proper?

*Psyche*, as everybody knows, is a Greek word that was translated in Latin as *anima*. And *anima* is what all animals, man included, have in common. All animals have a sensorimotor apparatus. The *anima* is the place of all representations, connected to pleasant and unpleasant affects, that animals make of the world and themselves, and it is where strategies of satisfaction of needs and desires, aimed to survival and reproduction, are elaborated, tested and implemented.

It is obvious that man is a very peculiar animal, and in old ages the word *spiritus* was created to name this peculiarity. In the A.D. 869 the fathers of the Church met in Constantinople and decided

that man was no more made up of three parts: body, *anima* and *spiritus*, but only of two. The spirit was abrogated as an autonomous part and reduced to a faculty of the soul. Our time has perfected that operation abrogating the soul, which in turn has been reduced to a faculty of the body. The usefulness of this reduction can be however questioned, because, as far as we are concerned, if we have just one word - *psyche* - for the mental life of animals and man, it is easier to blur and lose the difference.

But a difference does exist: to tell it, we only have to compare the animal muzzle and the human face, which is different because the brain behind it is different. In the frontal lobes abides the neural base of *human* thought. What human thought is, can be said only in part from a psychological point of view, as its peculiarity is in fact that of transcending that point. The psychologist - qua psychologist - cannot say what human thinking properly is. Only the philosopher - or the psychologist who has gone beyond psychology - can do it. Philosophy means love of wisdom. Love of wisdom - the search of what is right and true, beyond what is useful for the attainment of vital aims - is not a property of animated beings, but only of *spiritual* beings: category of which man is the only known member, though he or she may be reluctant to claim this membership.

The discovery that man is a spiritual being was made in the Western culture by Socrates (Sarri, 1997), the first man to know that he does not know. All animated beings know, only the spiritual being knows that he or she does not know - that is, she neutralizes all pretensions to know that are rooted in her soul, and in the soul of those surrounding her. This suspension allows her to come nearer to an impartial and sweeping understanding, overcoming the ignorance of ordinary knowledge conditioned by specific interests and standpoints; and to exercise a will that is grounded on a free appraisal of whatever happens, unconditioned by sanctioned or canonized values.

I state that (psycho)therapy is by its very essence dialectical, and so is every good therapist, even if he or she knows nothing of dialectics, because man is both an animal and a spiritual being. Both sides have to be taken into account in every session of every therapy, and a right, or at least the best possible balance between them, has to be found. If the therapist is too much identified with his psychological role - if he is too much concerned in offering a corrective emotional experience - his patient can be very happy to finally find something she has never found elsewhere, but on the other hand her conviction that she really needs what she wants, that she is entitled to receive it and cannot do without it, can be strengthened as a final result. If, on the contrary, the therapist is too little identified with his psychological role - if he is too much neutral - he runs the risk to treat his patient as though she were more adult than she actually is (probably no one ever grows so "adult" as to completely transcend her psychological needs: the need for attachment, for instance, is "from the cradle to the grave" [Bowlby, 1988]).

The therapeutic field can be therefore described as the space defined by two orthogonal axes: natural and cultural (or psychological and philosophical, or remaking and uncovering), in which therapist and patient have to find moment by moment the best position required by the developmental process.

#### THE PSYCHOLOGICAL AXIS

It may be a truism that an organism could not survive, adapt to its environment and carry out its programs if it had not innate dispositions to survival, adaptations and self-organization. It may be equally obvious that those innate dispositions must meet environmental conditions that allow for their actualization. If those conditions are absent, the organism will die or will be seriously crippled; if they are only partially present or not good enough, the organism will develop an illness, and this illness will be cured, partially or completely, by the administration of those essential factors that have been lacking.

The implication of this evidence is not that all is needed in therapy is the administration of the lacking factors: i.e., some kind of corrective emotional experience. The psychoanalytic tradition has collected an enormous amount of data to support another core therapeutic idea: the human mind is endowed with an extraordinary capacity to heal itself, provided that it can bring to consciousness what is buried in its unconscious (since the ancient times "know thyself" has been the formula for this basic healing principle). But the psychoanalytic tradition has so much emphasized this second, higher-order principle of mental functioning that the first and more basic one has been given too little attention, when it has not been totally neglected.

As I have remembered above, things have changed: almost no one these days questions any more the evidence that the therapeutic relation must be the place of some kind of emotional remaking,

beside offering a unique occasion of self-knowledge and awareness. Most of the literature describing the features of the corrective relation includes terms like secure base, attachment, holding, containment. A remarkable exception is Marsha Linehan (1993), who writes:

"The most fundamental dialectic is the necessity of accepting patients just as they are within a context of trying to teach to change... it requires moment-to-moment changes in the use of supportive acceptance versus confrontation and change strategies" (p. 19).

In few words is described here the basic dialectic of the remaking axis: *acceptance versus confrontation, maternal versus paternal mode*<sup>3</sup>. As both modes are necessary for the development of the psychological self in the family, if this line of development has been more or less defective, the immature and/or distorted self must find in the new environment of the therapeutic relation both sources of psychological help.

The need of being accepted as one is, with no pressure to be anything else, is obviously the most basic demand of every human being in every relation in any age of life. As this need is usually met in a far from optimal way in commonplace relations, it is no surprise that most patients expect to find in the therapeutic relation a better response to this need than those found elsewhere. And they mostly find it in fact, as this is the feature, if there is any, on which all schools agree. In all manuals of all methods the construction of a secure, warm, holding, accepting environment is recommended.

To respond from the maternal vertex of the therapeutic field requires first of all empathy, i.e. the experiencing as one's own of the feeling of another. The empathic listening is a therapeutic factor in itself, but in the maternal mode it is not carried out in the neutral, non judgmental way as in phenomenological observation or in Self psychology, where empathy means above all "vicarious introspection" (Kohut, 1984). The maternal mode is not an unbiased attitude, as it transmits the following message: "I am here with you, I am on your side, I know that you are basically good and worthy".

The *maternal bias* brings the therapist to think, and firmly believe, that the patient is a fundamentally innocent and valuable person. This bias translates into supporting as much as possible the patient's views, in suppressing any criticism, in finding the grain of truth in the most delusional idea. The interpretations given from this vertex are structured around the point that the main cause of the patient's sufferance is the lack of empathy and understanding in the environment.

In this vertex the therapist creates a new environment in which the patient can feel accepted, validated and appreciated. Of course every patient has usually many traits of personality or behavior that the therapist cannot accept, nor validate or appreciate. The therapist moves then to the opposite pole of the remaking axis - the paternal vertex - whenever the necessity of change is on the forestage. The *paternal bias* consists in the conviction that the patient has the capacity and the duty to face, gradually and in due time and with adequate support, all the contradictions that are on his or her way.

The two basic psychological modes cannot be separated in a clear-cut way, as they are mixed in a variety of combinations in any therapeutic interaction. Moment by moment, in every session, the therapist has to shift from one position to the other, or find the right balance between the two that is required by the ongoing process. To have a maternal or paternal bias is fine, if it fits the needs of the patient in a given moment of a given session. It is not if a maternal or paternal bias is steadily installed in the character or the theory of the therapist. Any attitude or approach that is not flexibly employed according to the needs of the patient is potentially abusive. In particular, the allegiance to any theory - the identification with a theory, versus its flexible use when appropriated - leads very easily to various forms of *theoretical abuse* (Basseches, 1997).

A dialectical attitude may be the best antidote to theoretical abuse: it means a special attention to any stereotyped approach, in both members of the therapeutic couple, the search for the missing pole, i.e. the one that is denied by the stereotyped position, and the activation of a dialectic between the two. I shall try to show how this applies to the basic psychological polarity.

The therapeutic relation is first of all a secure base, a place where the patient can feel unconditionally accepted. On the other hand, conditions are inherent to the therapeutic contract: in the first session the patient is informed that the therapy is possible only if she is capable and willing to accept a set of rules. The necessity of a right balance is clear if one considers the effects of too loose or too rigid settings. For example, if the patient is entitled to cancel the sessions for reasons that she deems valid, the possibility of a serious work on resistances is lost: this is the case of many non-analytic therapists, who offer brief treatments with limited goals (but many patients may need longer and deeper treatments, difficult to realize if the patient is given the possibility to cancel the sessions).

On the other side we have very rigid settings, as for instance that imposed by R. Langs (1986) with the deliberate intention of evoking strong claustrophobic feelings in the patient, which in his theory are basic to every psychopathology. The risk of theoretical abuse is here obvious, because the conviction that one theory is valid for every patient is taken for granted.

The maternal vertex of the therapeutic field is a safe place where the patient feels free to talk of whatever she likes or comes to her mind, and is encouraged to do so, without censoring or inhibiting anything (this is the “fundamental rule” of psychoanalysis<sup>4</sup>). This would foster a “pure psychoanalytic process”, but

“we would like to contrast the conception of the process as an ongoing, temporally unlimited focal therapy with qualitatively changing focus to the fictive notion of a puristic psychoanalytic process” (Thomä and Kächele, 1987, p. 352)

In other words, the polarity to consider here is between a free flowing, unfocussed process, and another in which the foci of attention and work are negotiated along the whole course of the treatment. Once again, too much “maternal” freedom is at odds with the necessity of commitment on definite issues that is required by any therapy, while too much “paternal” engagement may leave too little room for the corrective experience of a holding environment that is crucial for many patients.

All therapists agree on the obvious necessity of rules, most agree on the nearly equally obvious focal nature of any therapeutic process, but many, particularly in the psychoanalytic field, seem to think that all that one has to do with a focal theme is to pay attention to it, talk about it, analyze it. There is a serious underestimation, in this area, of the irreplaceable function of the paternal mode - which is fully appreciated, on the contrary, by behavior therapists. For many analysts the *analysis of resistance* - which consists basically in confronting the patient with *how she is trying to avoid what* - is the only acceptable and coded confronting technique. Indeed it is true that for some patients it may be all they need to stop escaping and to face correctly the feared experience. But for many others, I would say the majority, it is surely not enough.

First of all, the statement “Continuing an ineffective therapy is unethical” (Linehan, 1993, p. 98) - which from the maternal (unconditionally accepting) standpoint can be seen as “blackmail therapy” - transmits the message: “Without your active collaboration we go nowhere”. From the paternal vertex the patient is informed that talking is not enough - therapy is not just a “talking cure”. Some doing is necessary, i.e. practical and definite actions and exercises aimed to learn how to tolerate whatever one has not yet learned to tolerate, to balance emotions one has not yet learned to balance, to build self-care and social skills one has not yet built.

The pertinent question, in the paternal vertex, is not what do you feel, or what comes to your mind, but: what do you want? And if the patient answers: I want to be happy, the next question is: in which way do you want to be happy? And if the patient says: I don’t know, the next question is: do you want us to work together to find it out? And so on. The purpose is to get from the patient a clear commitment on definite programs aimed to realistic goals.

A psychoanalyst could object: I don’t do such things, I am not a behavior therapist and I am not interested in integration. I would answer: the point is not how you label yourself, or if you are interested or not in integration. The very point is: what does your patient need? If you are not interested in this question, you are not a very therapist. And if you say: that is right, I am not a psychotherapist, I am a psychoanalyst, my question is: who needs your analysis, your patient or you? Indeed when a therapist (or an analyst) avoids the question *who needs what*, it usually is because he takes for granted that people who come to him need just what he has to sell - a sound commercial principle, but one that very easily leads to theoretical abuse.

## OBSERVATION AND THEORY

As Basseches (1997b) has pointed out

“insofar as the therapist equates his or her professional expertise with particular theories, skills, techniques, or experiences, this actually will make the therapist more vulnerable to inflicting theoretical abuse”.

Conversely, dialectical thinking can help prevent this sort of abuse:

“appreciation of contradiction as a form of relationship between systems which holds within it transformative possibilities is what makes it possible for dialectical thinkers to simultaneously adopt and advocate for contradictory ways of making meaning”.

If the identification with any theory, skill or technique “will make the therapist more vulnerable to inflicting theoretical abuse”, it is implied that the therapist should be able to take a distance from any theory, which means that she should be able to stand on a metatheoretic, or theory-free, ground. On the other hand, it has been observed that any attempt to produce a metatheory easily turns into a new theory<sup>5</sup>. For example, one could say that the psychological axis of the therapeutic field, connecting a maternal and a paternal pole, is nothing but my theory. This would be just one more case of a therapist who, standing firm on his theory, struggles against all other theories or imagines being above the fray.

To this objection there are two possible answers, corresponding to two different meanings of the word *theory*. First, if theory means “a way of seeing” (from the Greek verb *theorein*, to contemplate), it is obvious that we cannot transcend our theories: we can only speak of our views (unless we speak of the views of others). In this case our aim is to produce *better* theories, that is ones that include more facts and are organized in a more coherent and convenient way, and to take a more *dialectical* stance towards them, that is an “attitude of welcoming amendment, of realization of their limits, of looking forward to discovering what they leave out” (Basseches, see preceding note). In this sense of the word, I could say that I am presenting here a *theory of the unified therapeutic field*, which I believe to be more inclusive and more coherent than any other so far produced in this field.

The second commonplace meaning of the word theory is “a hypothetical, conjectural construction”. In this sense, a theory is not our view, but the interpretation that we produce in the attempt to reconstruct what we *do not* see. Nothing is wrong in interpreting, on the contrary: but problems arise when our interpretations inadvertently become our views. When the mind stuff of our constructs becomes a barrier that “obscures the world of pure experience” (Hanna, 1994), it is of vital importance to put interpretations and theories back to their place and return to “the things themselves”, according to the well known Husserl’s motto. Of course this return is a problematic one: nobody believes in an “immaculate perception”. A description requests an observer and the observer a point on which to stand. Any description is influenced by this point, which includes many parameters that define the observer's position. But in principle a description is a description, and an interpretation is an interpretation - though many objects are of a mixed nature, partly descriptive and partly interpretive (for the dialectic between description and interpretation, see below: THE K VERTEX).

To avoid confusion, I prefer to use the word *theory* to mean a hypothetical construction, and the word *phenomenon* to mean an object of perception or description. In a time-honored line (suffice it to recall Newton’s motto *hypotheses non fingo*), my attempt is to *describe*, as faithfully as I can, the *basic structure of the therapeutic field*, that is the cardinal positions that any therapist, of whatever school, must occupy, in response to the basic therapeutic needs of any patient. I have found four basic needs, to which correspond as many cardinal positions. I would have no difficulty to enlarge the field to include more vertices that I may have not considered thus far. But I do not think I would abandon this definition: *the therapeutic field is the relational space generated by the inner logic of the therapeutic process, not by the therapist’s personal or ideological preference* .

The above definition implies that a therapeutic field will not be generated if the relevant questions are: is this patient analyzable? or: will this client comply with the rules of my manual? But if the relevant questions are: what does this person need? how can I meet her needs? am I willing to do something that my school or my character do not foresee, or even proscribe, in order to meet her needs? am I willing to put myself (my habits, my convictions and allegiances) at stake, as I ask my patient to do?

It is evidently unfair to ask our patients what we are unwilling to do. Yet it seems perfectly obvious to some therapists (as to some parents and teachers) that patients (sons or pupils) are the ones who are supposed to change and grow, while their own personalities and manuals are not at issue. Manual-based treatments are necessary for research aims, but in real therapy the strict observance of a manual is almost inevitably conducive to theoretical abuse. It is fine to *start* with a manual, provided that one is ready to forget it, when the process requires something else. But more than a manual, what I would warmly suggest in real therapy is a *map*.

A map is the representation of a territory. The territory in issue is *the area of all possible therapeutic interactions, when the therapy is the relation itself* - that is to the exclusion of pharmacotherapy, musicotherapy and so on.

Basically, therapy means treatment of a disorder. A therapeutic relation is the treatment of a disordered relation (of the individual with him or herself, the others or the existence as a whole). As the first disordered relations occur in the family, the therapeutic relation must try to repair first of all that disorder, offering as much as possible what was lacking there, and remaking what was not made well enough - including unmaking of whatever was ill made. A therapeutic relation is therefore primarily the place of a *corrective emotional experience*, a new relational environment where to cope with what was lacking or wrong in the old.

The family has two basic psychological functions. The first is to offer a secure base, or a holding environment, where the child can feel unconditionally accepted, appreciated and validated. As this is originally the mother's competence, we can call it *maternal role*. The second function is to encourage, and if necessary push, the child (the boy, the girl) to face the inevitable gap between his or her expectations and the reality. We can call it the *paternal role*, as it is preeminently the father's competence.

In an ideal case, when both functions have been good enough, we expect to find a well-developed *psychological self*, i.e. a reasonably consistent and compact self endowed with a good enough capacity of adaptation. In less than ideal cases - the majority of cases - we expect to find a more or less injured or defective self.

The maternal and the paternal role the therapist has to take on to restore the psychological self and foster its maturation must be clearly distinguished from the *maternalistic* and *paternalistic* ones. The point to be made is that correct therapy is like correct parenting: *the therapist, like the parent, should never take his or her role for granted*. This means that the patient, like the child, is never a passive receiver of manualized care, but since the very beginning a person in his or her own right who contributes in a decisive manner to the regulation of the relation with the messages sent all the time to the caregiver. And the caregiver has to pay the greatest attention to, and decipher such messages not in order to give good interpretations or to better apply a preset plan, but *to modify moment by moment the interaction to fit the needs of those to whom the care is given*.

What do we know of the needs of a growing or a psychologically suffering person? The first and indisputable evidence is that good maternal and paternal care, as defined above, is necessary to every growing child, and to every adult whose psychological growth has been defective because of defective parental care. But which particular form will these needs take, which individualized mixture of maternal and paternal factors is required at every moment, which are the responses that are possible and compatible with a therapeutic relation, which are the modifications it must undergo to meet those needs: all this is far from defined once and for all, but must be checked, monitored, negotiated, tried and corrected all the time. This is what happens in fact in the *heuristic* therapies, and what does not happen in the *stereotyped* ones (Peterfreund, 1983).

The need to preserve one's own professional identity can make a therapist extraordinarily blind to his or her patients' needs. For instance, I feel very much attuned with a psychoanalyst like Killingmo (1989), who distinguishes two levels in the clinical material, respectively deficit- and conflict-driven, to which the analyst responds in two different modes defined "affirmative and interpretive interventions". It is very much the same distinction that I have made between a remaking and an uncovering level<sup>6</sup>. I would unconditionally subscribe the following Killingmo's statement: "From a therapeutic point of view, we may say that the patient in a deficit transference is a person in need of an object able to provide the proper conditions for correction of distorted object representations and for internalization of object functions". But which are the "proper conditions for correction"? One would say that they are those in which an "object" (a person) is present, which embodies some crucial features that were absent or defective in the past experiences. It is no surprise, however, to a customary reader of the psychoanalytical literature, to discover that all the analyst is to do is to "give empathic understanding of how it must be not to have received the wished-for recognition when it was most needed and rightly to be expected, thereby justifying that the patient feels as he does". The conclusion is that "no change in basic [psychoanalytic] attitude seems necessary either theoretically or clinically".

As a second example I would like to cite the most influential Gill's article "Psychoanalysis and Psychotherapy: A Revision" (1984), in which the interactional character of any therapeutic

relation, psychoanalysis proper included, was given a full acknowledgement. A criterion of what is psychoanalysis, versus what is psychotherapy, was found in the overriding primacy of the *interpretation of transference*, where transference meant the experience of the interaction with the analyst in the here and now, including the realistic perception of the analyst behavior. It was implied, by this “intrinsic criterion”, that the “external criteria” (frequent sessions, the couch, a relatively well integrated patient, a fully trained psychoanalyst), posited by Gill himself 30 years before (Gill, 1954), and widely accepted by the psychoanalytical community, were abrogated. It was a revolutionary turn, as

the classic psychoanalytic setting was no more taken as a neutral container: “no universal meaning of any aspect of the analytic setting can be taken for granted” (Gill, 1984). For example, it was no more taken for granted that the patient, in psychoanalysis proper, had to lie on a couch, but the “optimal position” (the couch or the chair) was to be found in every single case. If the analytic setting could and should vary according to the particular needs involved in any individual case, one would have expected the same for every aspect of the therapeutic interaction: that is, one would have expected that the ongoing analysis of the transference (i.e., the experience of the interaction) were utilized to correct at every step the interaction to meet the therapeutic needs of the patient, as they are highlighted and understood in the analytic work. But again, it is no surprise to learn that “psychoanalytic technique aims towards as complete an exposure of the transference as possible while the new experience is not deliberately engaged in as such but is an inherent accompaniment of the treatment as a whole and particularly of the technique of analyzing the transference” (Gill, 1984). The classic, neutral analytic stance is once more confirmed, and any deliberate engagement in a new experience is ruled out as a form of “manipulation” or “suggestion”.

In both cases two otherwise courageous and innovative analysts were incapable to draw the obvious consequences of their own premises. Killingmo could not see that “an object able to provide the proper conditions for correction of distorted object representations” could be nothing else but a “new object” of experience, one endowed with some crucial features the patient strongly needs to find somewhere (and where else, if not in the relation with his or her therapist?). Gill was unable to see that, if the analytic relation is always an interaction, whatever the analyst does or does not, and no universal meaning of it can be taken for granted, the neutral, classical analytic stance cannot be taken for granted either. As every single bit of the relation between an analyst and a patient can take on different meanings, in each of its aspect it can be either therapeutic or pathogenic, and therefore it must be all the time corrected and modified to neutralize its pathogenic sides and to increase its therapeutic potential. To think that in order to accomplish that, one has just to give good interpretations, is to take for granted one thing after having declared that nothing should be taken for granted.

#### THE MATERNAL VERTEX

The therapist has many ways to meet her patient’s need to feel contained, from the constancy of space-time conditions to the tone and the choice of the words. Beyond the specific modes, what is decisive is the attitude that transmits to him a message of unconditional acceptance, of acknowledgment of his worth and dignity independently of any work, project, or assumption of responsibility.

One should always recall Gill’s warning (though he himself, as was seen above, did not do so): nothing in the therapeutic interaction bears a universal meaning. The couch can be a comfortable cradle to one person, a Procrustean bed to another. The silence of the therapist is to some patients a room in which they feel welcome and free to move as they like, to others a sign of unbearable coldness and detachment. It follows that only an inexperienced or insensitive therapist can impose indiscriminately the couch, prolonged silences or whatever.

The need to find a secure base is very much variable from patient to patient, both in intensity and in quality. Some can be contained and guided in a process of change only in a definitely rigid setting, while other proceed in a softer and more flexible environment. What is reassuring to a person is intolerable to another. There is no way to know it in advance: only the careful listening to all explicit and implicit demands, and the unprejudiced observation of the reactions to any intervention can serve as a guide in a genuine relation.

The understanding and justifying attitude is implicitly based on the interpretation of a child who is naturally oriented to reality, growth, and self-realization, one who stops growing, regresses and heads

for perverted and destructive aims only as a defensive reaction to traumatic lack of support and empathy. While in the Freudian perspective the child is seen as originally oriented to pleasure and not to reality, and therefore intrinsically perverted, in the writings of authors like Fairbairn, Winnicott and Kohut the infantile perversion is not original at all, but corresponds to the corruption to which is inevitably destined the child in a defective environment. Both interpretations are legitimate, provided it is recognized that they are just interpretations: the therapist *chooses* to stay in one perspective or the other. The relevant difference is that the stereotyped therapist transforms her interpretation in a fixed paradigm which excludes contrasting views, while the *dialectical therapist* chooses to be “Freudian” in some cases and moments, and “Kohutian” in others - or the convenient mixture of the two that is required by the circumstances.

The conviction that the child is originally innocent and spontaneously oriented to reality, or the opposite conviction that he is originally perverted and uniquely directed to pleasure, inasmuch as they fix and transform in ideologies, become an obstacle to the understanding of the real needs of the patient. It is true that the lack of proper maternal care, or of a secure enough base, is apt to foster regressive and perverted choices in those who have suffered from it. But it is equally true that similar tendencies can be detected in those who may have not specially suffered from inadequate maternal care, but have not been properly trained (by a paternal figure) to face the *normal* losses and frustrations that occur in everybody’s life. In other words: *the human being is certainly and originally oriented to reality, but shows an equally certain and original disposition to avoid it and to escape into the imagination.* A bad adaptation or a developmental disorder can be the consequence of a lack of maternal care, or of an excess of it, as much as of the weakness of the father, or of his excessive harshness.

In the maternal vertex the therapist receives the unstructured or chaotic signals that the patient sends to her, and gives them back to him partially elaborated, so that he can begin to integrate them in meaningful connections. This operation, compared by Bion (1962) to the maternal reverie, is different from the classic, Freudian interpretation, because its aim is not to uncover unconscious meanings (therefore it does not belong to the uncovering axis of the therapeutic relation), but to meet an actual inadequacy with the offer of an auxiliary container for the experience that the other is not yet able to keep and elaborate autonomously. This kind of interpretation does not face a resistance, but meets an incapacity: it is directed to a patient who “cannot”, rather than to one who “does not want”.

As Stevenson and Meares (1992) point out,

“a certain kind of mental activity, found in reverie and underlying symbolic play, is necessary to the generation of the self. This kind of mental activity is non-linear, associative, and affect laden. In early life its presence depends on a sense of ‘union’ with caregivers, in which they are experienced as extensions of the developing individual’s subjective life. Development is disrupted through repeated ‘impingements’ of the social environment”.

In case of early development disruptions, the therapist endeavors to provide a reparative environment:

The first task is to establish the enabling atmosphere in which the generative mental activity can arise. In order to do so, the therapist must imaginatively immerse himself or herself in the embryonic inner life of the patient. Empathy, however, inevitably fails. The second main task of the therapist is to detect these failures, to focus with the patient on his or her experience at the moment of the failures, and then to allow these experiences to be the starting point of experiential explorations. Such empathic failures, or disjunctions, are indicated by 1) negative affect (e.g., deadness, anxiety), 2) linear thinking, 3) an orientation toward events and the outer world, 4) a change in self state (e.g., devaluing, grandiose), and 5) emergence of transference phenomena (Stevenson and Meares, 1992).

This approach, clearly inspired to Piaget (1959), Winnicott (1965), and Kohut (1984), highlights the basics of the therapeutic work in the maternal vertex: the therapist tries to create a relational atmosphere in which the patient can feel unconditionally accepted and understood, and then she works through the unavoidable failures of her endeavor. This is exactly what any good enough mother does: she does what she can to meet her child’s needs, she is alert to her inevitable failures, she accepts them (she accepts her limits, she does not become anxious or guilty or vindictive because of them), she works them through (she works on herself to become more patient and more available). Like the

mother, the therapist offers her capacity to tolerate what for the patient is still intolerable (Sandler, 1992).

Only in exceptional cases does the therapist take on herself the whole of the work. In most cases she asks the patient to do his part of the work. This brings us to the next vertex of the therapeutic field.

#### THE PATERNAL VERTEX

The therapist settles in the paternal vertex of the field when he asks his patient to do some work, that is an activity implying effort and toil, in contrast to the maternal environment characterized by free expression and play. Collaboration and commitment are requested to the patient, now addressed as a *responsible person*, endowed with a relatively autonomous decision center.

When the child's development has gone so far as to make perceivable the first core of a responsible agency, this is addressed by the father - father or mother, but in a paternal role - to encourage the first issues from the symbiotic enclosure. One general way to characterize the paternal relation is to say that the child is accepted here in a *conditional* way, no more unconditional as in the maternal space, where she knew that she had a worth just because she existed. This new dimension is risky: the child can fail and be defeated, respect and esteem are no more granted, but depend on the results of her struggles and labors.

The therapist helps his patient to become more responsible, and to face whatever is on her way, in different modes and styles. The most obvious way to make a person responsible is to ask her something that demands a response.

If the person whom you have called does not respond, let her go; if she responds, it is the very action she does that modifies her, maybe without her even knowing it, maybe not in the way you had figured it out, but it modifies her... Getting her to work you have set the powers of her soul in motion, and put her in the necessity of mastering and balancing them (Spinelli, 1987).

The responsibility is, literally, the capacity to respond of one's own actions. When this capacity is mature, one responds to him or herself; but one begins with the calls of the others. For the child to learn to respond, one has to call her, and this is specially the father's competence, as the mother has a primary relationship with the *infant*, the child who does not speak and does not respond, if not inside an empathic correspondence.

The plainest way to obtain the cooperation of the patient, is to ask for it directly, since the first session (Linehan, 1993). From a paternal vertex, the therapist makes it clear since the beginning that little can be done without her cooperation. A laboratory is created, where a work is to be done. At every step the patient is required to codetermine the laboratory agenda, with explicit questions or in more subtle ways.

One of the merits of the Ulm's school, as was seen above, is to have shown that the notion of a "pure" psychoanalytic process is fictitious, because the process always gets organized around a limited number of focal themes, interactively determined and deliberately chosen (Thomä and Kächele, 1987):

"The psychoanalyst makes a selection according to his tactical (immediate) and strategical (long-term) goals" (p. 346). "We believe the sequence of the focusses to be the result of an unconscious exchange between the patient's needs and the possibilities open to the analyst" (p. 348). "In every session a situation inevitably arises in which a decision must be made as to which direction to take" (p. 352).

First, there exists no pure therapeutic process, determined only by the free associations of the patient and the free floating attention of the therapist. On the contrary, the process results from a selection, partly conscious and partly unconscious, of focal issues. Second, the patient takes part in the choice of the foci, but, according to Thomä and Kächele, only in an unconscious way. The position of these authors, usually open and nonconformist, is here instead in line with the psychoanalytic orthodoxy. The patient's contribution is only unconscious: surely, if she is not allowed to contribute differently. If the patient is informed in the beginning of the rules of the treatment, to which she is not allowed to propose any modification, nor is she permitted to contribute to define the short- and long-term goals (both things would be interpreted as resistances, given that her duty is only to free associating), she

has no other way left than suggesting “unconsciously” to the therapist the themes on which she would like to work. The patients have often a very great capacity of adapting to the therapist’s wishes. If they understand that he appreciates much the unconscious productions, and much less the conscious ones, they content him, and the therapy goes on; yet it would go on better if the conscious contribution were appreciated and made use of as much as the unconscious one.

All the time a decision must be made as to which direction to take, say Thomä and Kächele. That is right: but if this decision is made only by the therapist, the patient is deprived of her responsibility. If on the contrary the principle is posited, that the patient has the right at every moment to renegotiate the aims and the modes of the treatment, she is made since the beginning coresponsible of the state of the therapy, in all of its phases and aspects. This principle is not contradicted by the decision of the therapist to take on a prevailing maternal role even for prolonged periods, in which the patient is relieved of most or all of her responsibilities (but those to come to the sessions and respect minimal rules of behavior): it would be a mistake to impose to her a more responsible attitude, when her main need, as it is manifested by her and perceived by the therapist, is to merge in a relation of an essentially maternal quality, in order to restart from there a process that may have halted in a very early phase. Yet it would be equally mistaken to keep the patient from the beginning to the end in a state of infantile dependence, without leaving to her, and without stimulating, the faculty to responsibly contribute to the regulation of the relationship.

Of course, once the principle of the responsible participation of the patient has been established, she could appeal to it to take issue with everything all the time, preventing any useful work: it is obvious that this right can be put to the service of the resistance, but it should be equally obvious that it is not necessarily so. The therapist should not assign to himself the monopoly of the decision of what is or is not a resistance, and above all he should not make use of such exclusiveness to define as such any attempt on the part of the patient to modify the rules of the play.

The choice for the dialogue does not imply the offer on the part of the therapist of a fictitiously equalitarian relation. The greater responsibility in the conduction of the treatment remains his, yet he does not exert it to get obedience and submission, but to obtain that the other takes on her own. This is the essential function of the paternal role, when it is correctly wielded. If on the contrary the responsibility remains all on one side, as when the therapist is the only one who sets up the rules of the treatments and decides the themes to work on, this is not a paternal vertex, but just another case of all too common paternalism: the degradation of the paternal role that occurs when the other is not involved in the choices concerning her, but one decides for her, *for her own good*.

## THE PHILOSOPHICAL AXIS

The therapeutic functions described so far are meant as a response to the basic psychological drives of the human being: *attachment* and *cooperation*, which are rooted in the limbic system, our “mammalian” brain. As social animals, we must learn the basic behaviors of attachment and cooperation, and if this learning has been defective (as for instance in case of insecure or disorganized attachment), we must try to repair it through corrective emotional experiences, or through critical reflection leading to different interpersonal behaviors and different modes of managing painful emotions (Liotti, 1999).

As was remembered above, an organism could not survive, adapt to its environment and carry out its programs if it had not innate dispositions to survival, adaptations and self-organization; but these innate dispositions must meet environmental conditions that allow for their actualization. On this background the *bottom-up* direction of change has been described as follows:

“The fact that often insight gained after the painful and anxiety-provoking overcoming of resistance is not the prerequisite of change, but rather the *consequence* of a positive, anxiety-reducing change in a significant relationship such as the therapeutic one, was observed by Alexander in 1930, and was emphasized later by him when he proposed the concept of ‘corrective emotional experience’ (Alexander *et al.*, 1946, p. 20). The therapeutic process, in summary, runs as follows: first, there is a new intersubjective context, positively related to the patient’s innate values or (adaptive) plan (the context for a corrective emotional experience created by the therapist who is ‘passing the test’); second, the patient is calmer and/or more interested in the therapeutic process, because this process now promises a better fulfilling of an innate adaptive value; third, the consciousness emerging from the matching between the patient’s value-category and this new relational reality

becomes the prerequisite for the conscious scrutiny and revision of the previously unconscious pathogenic belief tacitly held within the patient's value-category memory" (Migone and Liotti, 1998).

In the bottom-up change, pointed out first by Alexander, the corrective emotional experience, i.e. the work on the horizontal-psychological axis of the therapeutic relation, precedes and paves the way to the insight. In the *top-down* change the opposite occurs: a cognitive-interpretive work brings about an insight into a pathogenic belief underpinning a maladaptive plan. The pathogenic belief and the maladaptive plan are criticized and abandoned. The original, adaptive plan is activated and can now be completed by new experiences to build up adaptive personality structures, e.g. patterns of secure attachment and responsible cooperation.

In both directions, bottom-up and top-down, the aim is psychological, that is *adaptive*. These two basic ways of integrating the horizontal and the vertical axes of the therapeutic field are both adaptation-centered. Could we say, therefore, that adaptation is the final aim of all therapies? Can we state that when working patterns of secure attachment and responsible cooperation have been installed in the self the therapy is over? Of course patient and therapist can content themselves with what they have got at every step of the walk; yet one can hardly say that adaptation is all one needs for a *human* life. There is something more than a pro-adaptive attitude in the therapist's stance. To understand what it is, we can start with the basic suggestion that Freud gave to the analysts: to keep a free-floating, or evenly suspended attention.

It has been observed (Galimberti, 1979) that while Freud aimed to give a scientific foundation to psychoanalysis, his clinical attitude was more phenomenological than scientific, in the sense of natural sciences. That is, the basic analyst's *neutrality* is very much the same thing as the phenomenological *epoché*, the mode of experiencing in which all ordinary motivations are bracketed out. Ordinary means psychological: our attention can be evenly suspended inasmuch as we can suspend all ordinary, psychological motivations, all plans that the evolution of our species, and the conditions of our upbringing, have installed in our brain.

Neutrality is a problematic notion (see next section: The K vertex); there exists no static neutral stance, but an ongoing neutralization of all current motivations is possible. More than possible, it is necessary: no therapy would ever be feasible without the ongoing detection and neutralization of all non-therapeutic factors. Failing this, there would exist only indoctrination, or adaptation to all sorts of plans preset by nature and nurture. As was seen above, adaptation is *part* of the therapy, not the *whole* of it. It is of vital importance that we know, and take account of, all natural and cultural conditions of our life; but it is no less vital to recall that "man is characterized above all by the overcoming of a situation, for what he can do of what has been done of him" (Sartre, 1960).

If on the horizontal-psychological axis the aim is adaptation – the remaking of all that was ill made to bring about good enough attachment and cooperation patterns – on the vertical-philosophical one the intent is *awareness*. This means to become conscious of all conditions, past and present, of one's life, to uncover or make their meaning, to decide what to do with them (to adapt to, or to transcend them). We can transcend any psychological condition inasmuch as we can draw upon the *unconditional* core of the self – that is, inasmuch as we can realize the attitude that Bion (1970) pointed up as *F in O*, which means faith in the unknown.

If the philosophical work were only a cognitive enterprise – if *knowledge* were its only aim – we would be helpless before of the limits of what is at any moment knowable. We could never renounce our basic assumptions, lest we fall into bewilderment and confusion. But philosophy means love of wisdom, not of knowledge: Socrates was said by the oracle to be the only wise man because he was the only one who knew that he did not know. The basic philosophical stance – knowing that one knows nothing for sure, or the suspension of any presupposition – is the point of departure for any travel into the unknown. Which can lead either to new knowledge, or to the uncovering of the generative or healing power of the unknown in its own right: F in O means that the therapeutic end is not always and not necessarily that of transforming the unknown into knowledge (or the unconscious into consciousness), as it can also be a matter simply of trusting the unknown as such, as *unknowable*. Therefore Bion (1970) said that the therapist must be both a scientist and a mystic (or an artist). The two vertices united by the philosophical axis of the field: K (for knowledge), and O (for unknown), will be shortly described below.

## THE K VERTEX

The K vertex – the position the therapist takes when her priority is knowledge – is the most basic of the field: it is where she must return all the time to understand what is happening moment by moment in the relation. It is also from this vertex that understanding can serve for deciding if, how, and when to temporarily leave this base, in order to respond to extracognitive needs of her patient.

Some basic cognitive operations can be described in any kind of therapy. Every therapist must be able to oscillate between an empathic position of participating observer, and one of objective, detached observer; she has to reconstruct through interpretations what is not directly observable, but has to be hypothesized to fill in the blanks so as to make material understandable; and finally she has to avoid the scientist's *hybris*, by drawing a line in her cognitive activity, signaling a limit beyond which there is an unknown that she must face as such.

Empathic listening is a way of perceiving from inside: a “vicarious introspection”, in Kohut's terms (1984). This is the basic phenomenological operation: a most receptive condition, in which the observer brackets out as much as she can all judgements, preconceptions and personal motivations, to let the other person reveal in the most unconditional way his or her essence, meaning and value. Listening in this way becomes a response in itself, and all the more when the therapist voices what and how she hears in hopes of conveying and having the other feel what she feels that he feels: it is a response of resonance, which is as faithful as she has been able to suspend any interfering judgment or preconception. It is a response of understanding, one of emotional resonance connected to a cognitive content, a meaning that has been intuitively caught through the immersion into the experience of the other.

The counterpart of this synthetic operation is an analytic one, in which the therapist takes a distance from what she has felt, and makes of it an object of examination. The experience becomes here a material to be compared with others, drawn from the same patient in preceding moments, from other patients with similar problems, from cases described in the literature. The therapist does not content herself here with an intuitively caught meaning: she looks for its derivation from other experiences and its connection with needs, desires, and conflicts. She does not only try to understand, but also to explain, to find reasons and causes. In this she makes use of all explicative schemes that are available to her, and actively interrogates the material. As Gadamer (1965) puts it:

“There is no experience without asking questions. To acknowledge that things are different as one thought in the beginning requires that one has passed through the phase of questioning. One has to ask whether things are this or that way. The opening that is implicit in the essence of the experience is the opening of ‘this way or otherwise’”.

One way of listening is receptive, synthetic, meaning-finding; the other is active, analytic, meaning-making. Some schools of psychotherapy privilege the first, some others the second, but both are necessary:

“Human experience is unitary. Affect and cognition are not totally separated phenomena, but are different facets of intrinsically integrated events. Therefore, a genuinely neutral reading of the patient requires a combination of both empathic and cognitive modes of perception. Empathic perception alone too quickly fades into the projection present in the empathic imagination. Cognitive reading alone too quickly fades into wild analysis. And either alone too quickly permits the analyst to base his facts on his prior conclusions. For true neutrality, music and words must be combined. Either alone is misleading” (Poland, 1984).

*Neutrality* is the term that better than any other defines the position of the therapist in this vertex. A technical neutrality is inherent to any profession, but in the case of psychotherapy the distinction between what is pertinent and what is foreign to it is not as easy as in the cases in which the subjectivity of the operator is well separated from the objectivity of the operation. In any relation there is an ongoing, inevitable, and unintentional interaction (Katz, 1998), driven by what both partners need to stage and the response that both give to the representation of the other. But a relation is made therapeutic by the decision and the capacity, on the part of the therapist, to neutralize all the time all that is not therapeutic. This implies for the therapist: first, to filter and to avoid expressing, as much as possible, all that belongs personally to her, and is not functional to the process; second, to allow and to further any emotional enactment that the patient needs to be enacted.

The therapeutically useful enactments are of two categories. The first includes the pathogenic scenes that the patient needs to stage to work them through, because "when all is said and done, it is

impossible to destroy anyone in absentia or in effigie" (Freud, 1912). It is essential for the therapist, in this case, to allow herself to be involved in the interaction:

"The kind of repetition that is likely to occur when the analyst is trying hard to avoid participating in a way that is complementary to the patient's manner of relating is one that is apt to be more deleterious to the process as a whole than the kind which is likely to occur when the analyst has a readiness for a more spontaneous kind of responsiveness", Hoffman and Gill (1988).

The second type of enactment is fostered by the patient's need for a new interaction, one that offers those essential developmental factors that have been lacking in past relations (when his problems seem to be more defect-driven than conflict-driven, where else can he find something of what he needs if not in a therapeutic relation?).

With the first type of enactment the therapist remains in the K vertex, as the interaction is aimed to insight and working through (to an orthodox analyst, like Katz, this is the only acceptable interaction). With the second type, the therapist shifts to the remaking line of the field, to the one or the other of its poles, where she tries to produce the conditions for a new developmental experience (here many interactions that are familiar to therapists of non-analytic schools take place).

Any therapist, of any school and orientation, must rely on intuition and common sense for the "free-floating responsiveness" (Sandler, 1976) that any flexible and process-sensitive therapy requires. Often a therapeutic interaction may look very much like an ordinary conversation. What gives the interaction its distinctive therapeutic character is the *ongoing attention to the meaning that both members of the therapeutic couple give to whatever is said and done*. This allows for the consequences of every action to be detected: it can happen, and has been often observed, that a mistake produces therapeutically useful effects, while a theoretically and technically correct intervention leads to undesired results.

Neutrality, therefore, is not a static, uniform, and impersonal position, but *the dynamic capacity to recover all the time a neutral position: the bracketing of every motivation, the suspension of every preconception and judgment*. It is the attitude that makes knowledge possible, and is common to both phenomenological observation and objective science. The synthetic, meaning-finding, and the analytic, meaning-making approaches are both necessary to determine what is meaningful in the process. But the suspension of all ordinary, cognitive and affective, certainties is threatening for the ego and almost unbearable as long as "F in O" has not been set (Bion, 1970): that is, as long as the unknown is not experienced as a generative dimension.

The unknown is the only possible foundation of knowledge. If this foundation has not been set, that is, if the therapist cannot abide in a theory-free space, listening is obviously conditioned by all theories that have not been suspended by her, out of fear of falling into emptiness. If F in O fails, true neutrality is impossible. The false neutrality that is found in its place simply conceals the theoretical presuppositions that the therapist cannot suspend, because if she cannot rely on the unknown, she cannot help but grasp at anything known. A serious difficulty for our discipline in becoming a science is that our most influential theorists, as was shown by Bernardi (1989), hold tightly to their own paradigms. The usually unconscious transformation of theories in means of identification and power, brings to their automatic convalidation and to the metamorphosis of the scientist into a dogmatist.

Deprived of their non-theoretic foundation, theories are bound to become dogmata. The same happens to the synthetic (empathic, meaning-finding) counterpart of knowledge. Empathy (*Einfühlung*) presupposes "one-pathy" (*Einsföhlung*; Fornaro, 1993): a "transformation in O", a temporary loss of the ego boundaries. Those who imagine entering into another without bracketing out their feelings and intuitions, do nothing but project into the other their own imagination.

## THE O VERTEX

To learn to experience anxiety, said Kierkegaard, is "an adventure through which every one should pass, in order not to go astray because he has never felt anxiety, or he has lost himself in it; but who has learnt to feel anxiety in the right way, he has learnt the highest lesson" (*The Concept of Anxiety*, chapter 5).

*To feel anxiety in the right way* is the key: and the right way is, as always, the middle way. If we are open to learning, it will lead us unflinchingly to the place of all that, in the world and ourselves, holds for us the value of irreplaceable security. Affective ties, the body, images, internal and external

objects, all that identifies us and makes of us what we are: nothing of that is secure, all is precarious and can be wiped away at any moment. Even when the threat is not actual, anxiety reminds us of this possibility.

The school that Kierkegaard invites us to attend begins where all the other have completed their course. We have learnt how to procure us the corrective experience we need in the therapeutic relations, or in the couple, or somewhere else. We have built secure enough patterns of attachment and responsible enough patterns of cooperation. We know how to work through our lacks and mournings in a cognitive mode. We have built up a reasonably compact and balanced self. We have a good repertoire of techniques, devices and tricks to keep anxiety at bay. Can it be enough?

We can have adaptive patterns for many conditions, not for all. We will have to face, sooner or later, something to which we are not adapted. We can have cognitive tools to solve many problems, but the unknown surrounds us on all sides. Anything we rely upon can break apart any moment. And, most important, all that is finite is bound to end. We know it, but we do not think about it. The end is put off to an indefinite future, it is trivialized as “one dies”, we do not have to worry about it now (Heidegger, *Being and Time*, § 51).

If we allow anxiety to dismantle all our certainties, one by one; if we give up fighting it, and put aside the heap of chemical, physical, mental, and spiritual means employed to keep it under control, we get to the point where the only safety from the end of all that is finite is found in what, having no beginning, cannot have an end. The Bion’s “O” is a line with no beginning and no end, a symbol for the generative unknown. It is the noumenon of all phenomena, the non-theoretic foundation of all theories, the ground of all that thrives.

An O vertex is essential in the therapeutic relation, because if the unknown ground, and the trust in it (F in O), is not found, another ground, on anything known, is inevitably substituted for the one that is not found. And this is precisely what usually happens, when the ground of therapy is the therapist’s theory: be it a school theory, or the idiosyncratic theoretic blend of a therapist. I do not mean, by this, that it is not a good thing to have a theory or a combination of theories. On the contrary, it is quite impossible to work without a theoretical-technical base of reference. The richer, and the better integrated is this base, the greater will be the potentiality of the therapy. The crucial point is whether the theory is a *reference* or a *foundation*. It is a reference if it is applied as a tool for having a first orientation into the process and some strategies at hand to work on it. The tool is precious, but nothing more than a tool. If it happens to be not very useful to illuminate and treat the ongoing problem, it is put aside, and alternative tools are taken into consideration, or quite new ones are forged. If on the contrary the theory is not a reference, but a foundation, the allegiance to it is mandatory, because without it the therapist is utterly lost and helpless.

When the therapist is not rooted in O, but in K, it is not easy for him to avoid the uncritical allegiance to his paradigm that is conducive to dogmatism. An alternative to it is *assimilative integration*: the therapist remains firmly grounded in his theory (Messer, 1992), whose underpinnings are not questioned, but he assimilates parts of other theories and techniques, which he reformulates in his own logic and language. It should be clear that, in a sense, assimilative integration is what we all do: it is virtually impossible to be a therapist without learning from our patients and colleagues, and integrating in our own systems what we learn step by step. But, again, the crucial difference is whether the theory from which we start to assimilate is a reference or a foundation.

The importance of a “firm grounding” in any one theory can be understood, if one thinks of the “groundless” practice of so many messy eclecticism. There is indeed a healthy eclecticism, which means an openness to multiplicity; but too much openness is dangerous, if we cannot return all the time to a firm ground, where to integrate what we have learnt. Either this ground is theoretic (K), or it is transtheoretic (O). A theoretic ground is better than no ground (therefore assimilative integration is good in itself), but a transtheoretic one is still better, in my opinion, for at least two reasons.

First, failing a transtheoretic ground, we are bound to reformulate everything in the terms of our theory. From the patient’s standpoint it can be felt as reassuring, as well as constrictive, when her need is not adequately covered in her therapist’s paradigm. It is true, as Stricker and Gold (1996) state, that “the process of accommodation is an inevitable partner of assimilation”. But these authors properly define “assimilative” their approach, because in any theoretical integration an assimilative attitude is necessarily prevalent, to the detriment of accommodation. The latter will be admitted only when it is unavoidable, and even in this case the therapist will try to bring the foreign element back to familiar concepts and terms (if it were not so, the grounding in one’s theory would not be “firm”).

In a dialectical approach assimilation is not elected against accommodation. The basic dialectic on the vertical axis of the therapeutic field can be described as an oscillation between an open attitude, where “memory and desire” are suspended, and the opposite one, where all existing perceptive and conceptual schemes are reactivated. In the former (O vertex) the therapist allows for the present situation to *inspire* him, to suggest him anything unheard or unforeseen by his theory. He is here like a *mystic* or an *artist*. In the latter (K vertex) he compares his inspiration with his usual theoretical and technical procedures. The new synthesis or integration that results can be more assimilative or more accommodative, depending on the peculiarity of the ongoing experience, not on any prejudgmental attitude of the therapist.

As there are therapists who are firmly rooted in their theories, there are others who are no less firmly rooted in a conception of therapy as art, as a creative process of narratives, actions, or works. The former feel more comfortable in the K vertex of the field, the latter in the O vertex. There will always exist therapists of the scientist-type, and therapists of the artist-type, nothing is wrong in it: but this division should not be taken for granted. If we are the scientist-type of therapist, we had better try to wake up and train the small artist in ourselves, and viceversa. The quality of our work will surely benefit, if we manage to improve our balance on the vertical axis of the field.

The second reason for preferring a transtheoretic ground is that the firm grounding in one’s theory or paradigm prevents the metatheoretical dialogue with colleagues who hold different world views. But a meta- or transtheoretic approach is possible. This is an example:

“The recent shift in behaviorally oriented theory toward an emphasis on self-acceptance rather than self-control (Jacobson, 1994) provides an example of the type of metatheoretical elaboration that can result from dialogue among different theoretical traditions. Although it has not not been uncommon for behavior therapists to borrow techniques and concepts from other traditions, *they are usually assimilated into a fundamental world view* that emphasizes the importance of self-control. By explicitly proposing that change be viewed as self-acceptance, an outlook typically associated with the experiential tradition, Jacobson is *challenging the underlying paradigm* through which change is understood” (Safran and Messer, 1997. *Italics mine*).

If Jacobson had chosen to remain firmly rooted in his tradition, the above shift would not have been possible. This shift is obviously potentially beneficial for many patients (those who need learn more self-acceptance [maternal] than self-control [paternal]), as well as for the dialogue among colleagues. But how is it possible to challenge one’s own paradigm, and face the risk to fall into utter confusion and bewilderment? The falling apart of one’s own paradigm is experienced by anyone as a catastrophe, and a catastrophe is panic-ridden and obviously refused, if it is seen as a purely deadly event. It can on the contrary be accepted, and even invited, if it is seen as a transformative and regenerative event. But this is possible only if faith in the unknown is present: as Bion pointed out (Eigen, 1985), there is a necessary connection between the capacity to go through a catastrophe and F in O.

A truly dialectical (and dialogical) attitude is based on the intuition (more and more confirmed by experience) of the spontaneous generation of new syntheses, which are more likely to arise if one loosens an overly stiff attachment to any one of the conflicting terms. This implies a full reversal from our ordinary, self-centered therapeutic attitude. As in the famous, and often misunderstood, surgeon metaphor by Freud (“Je le pensais, Dieu le guérit”, 1912), the true therapist is not the therapist, with his whole baggage of theories and techniques: it is the *process*. What we can do is *facilitate* the process, not produce it. If we see ourselves as facilitators, theories and techniques can be very useful. If we think that our theories and techniques are decisive, we will be at risk to put ourselves in the way of the process.

## THE DIALECTICS

I have considered different levels of dialectics. The first is between the two axes of the field: the remaking-psychological and the uncovering-philosophical. Because of this first and most basic level I prefer the denomination *dialectical therapy* to *psychotherapy*, as it makes it clear since the beginning that in therapy something more than psychology is implied. In the first polarity the question is: does this person need to understand anything (or become aware of, or redefine, or elaborate, or create a new narrative), or does she need a new emotional (or affective, or interpersonal) experience, or some combination of the two?

A second level is internal to each of these axes. On the horizontal axis: does this person need to learn primarily self-acceptance or self-control? Is the repair of a defective self-development to occur through internalizing a secure attachment pattern, or a responsible cooperation pattern, or some combination of the two? And on the vertical axis: does this patient need to acquire new knowledge (make or find meaning, implement a cognitive restructuring), or to learn to face and trust the unknown as unknowable? Does she need to find in her therapist a scientist, an artist, or some combination of the two?

Then comes a third level: in each of the four vertices of the field, corresponding to the poles of the two axes, we can see a further polarity between an analytic and a synthetic mode. For instance in the maternal vertex the therapist can privilege an affective approach of unconditional acceptance with minimal cognitive elaboration, as in the Rogerian method, or a more cognitive approach of “holding” interpretation, as in the style of Winnicott, Kohut, or Bion (each of these authors has different nuances, different modes of mixing affect and cognition, and of combining the maternal with the other vertices – but they have all in common a greater emphasis on the maternal than on the paternal pole).

I do not want to push too far this play of polar oppositions, as one can find new ones at every step of every therapy. I only want to underscore the value of a dialectical approach as an antidote to all sorts of one-sidedness that still heavily encumber our field. I agree with Basseches (1997): a dialectical stance is the best protection against theoretical abuse; but I dare go further, saying that a dialectical approach is *intrinsic* to therapy because human existence is unconceivable outside the basic polarity of nature and culture. If nature wins over culture, or viceversa – if one pole suppresses the other - the result is perversion, or neurosis, or any of the numberless disorders that affect our species. Hence the necessity of a dialectical approach: one in which the conflicting terms (the primary as the secondary and so on) are subsumed in view of a synthesis that at once includes and transcends them.

I do not mean, by this, that *all* contradictions are dialectical: some are obviously not. Nor do I aim at any sort of Hegelian hegemony over therapy: on the contrary, I see dialectics as a world view at the service of therapy. My point is that dialectics is intrinsically connected to one of the two main therapy integration modes: the *common factors approach*. This approach describes the general therapeutic strategies (Goldfried, 1980), and cannot obviously content itself with one or more lists of factors or strategies. In order to overstep the point of mere enumeration, it has two ways in front of itself. One is that of empirical research: one single strategy is investigated in the context of different therapeutic methods, for its usefulness in coping with different problems or pathologies. The second one is that of producing *maps* or *charts* of the field, in which the basic therapeutic strategies are taken as *cardinal points*. Dialectics is obviously intrinsic to any mapping: to look for the right balance between two poles (maternal/paternal, knowledge/unknown, or any other that can be detected), at every step of every therapy, is a basically dialectical operation. One further dialectic, then, could be operated between these two ways: as a good map can help in orienting empirical research, this in turn can help in constructing better maps.

A map is obviously not the territory. But a good map, being a good description of the territory, bears a good resemblance with it. It approximates its true conformation, it reflects its real structure. Besides, there could exist no map, if there existed no territory. Of course, one could argue that what I call a map is not really a map, but just one more theory. In a radically constructivistic perspective, there is nothing like *one* territory, as every theorist constructs his or her own territory. But this objection, like any other produced by radical constructivists, is itself a mere construction, with no possible value of truth or reality. In the real world, it is not difficult to tell the difference between the map of a city and the theory of a city, or between the description of a cat and the theory of a cat.

Therapy is a peculiar thing. In part it exists in the world, with its rules and laws, like every other phenomenon, and can be described as such; in another sense it is the construction of any particular pair of people who engage in it. Just as a physical bridge is a construction that can only work well if it conforms to the precise laws of bridge building, so it is for therapy. Therefore, to the question I have asked at the beginning of this paper – is therapy a robust phenomenon or just a nominal container – I can give a positive answer. The proof that it exists is that I can draw a map of its territory. Surely not a definitive map, but one good enough to help keep us from going astray.

The second main therapy integration mode, theoretical integration, is basically assimilative, as the common factors approach is basically dialectic. I do not think that we have to choose between them, as both are necessary, each in its own right. I have given some hints to a possible higher-order dialectic between these two modes. I will discuss this possibility in a further paper.

## Notes

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<sup>1</sup> This observation was made in a message on the SEPI listserv, on 17 August 1998.

<sup>2</sup> My approach has always been dialectical, since the beginning of my career as a therapist. The final chapter of an essay I wrote 25 years ago (*Principi di terapia psichiatrica*, 1974) was entitled “The dialectics”. Its final words were: “Whenever a onesided claim is made, the consideration of its opposite takes away that claim, introduces a new difference and invites to a new synthesis... In front of any onesided phenomenon, as is any symptom, the dialectical method searches for the missing part, to reconstruct the polarity, and therefore the movement. It is not just a relational perspective, because the point is not just to put something in relation with something else. A relation is defined only in view of its development or overcoming. Reciprocally, a phenomenon can be understood only from a point that goes beyond it. In this continuous passage from a limit to its overcoming, from knowing to doing, lies the dialectical method. More than that, it is the method of any living being, which on one side is based on a precise and rigorous organization, on the other side can never be enclosed in an accomplished definition, because all the time it gets over itself, and only for this it is alive”. The last version of my dialectical approach (“Il campo della psicoterapia. Un modello a quattro vertici”) was posted in 1998 on the Internet: *Psychomedia Telematic Review*, [www.psychomedia.it/pm/indther/ptanndx1.htm](http://www.psychomedia.it/pm/indther/ptanndx1.htm).

<sup>3</sup> The terms “maternal” and “paternal” do not imply obviously that the respective modes are exclusive of the mother or the father, as in fact each of them can be exerted by both parental figures, as also by anyone, as a therapist, in a nurturing position. These terms are chosen, however, because unconditional acceptance is mainly a maternal role, as confrontation is mainly paternal: a child with an accepting father and a confronting mother could have problems in gender identification.

<sup>4</sup> In fact the “fundamental rule” requires that the patient take the commitment of speaking also of what seems to her unpleasant, shameful or ridiculous. Therefore it cannot be seen as a purely “maternal” mode. Probably no therapeutic technique is purely anything. We can only speak of the prevalence of one or the other mode.

<sup>5</sup> In a personal communication, Michael Basseches wrote to me: “I would not want to claim that my contribution represents theory neutral observation, as I am skeptical of the "pure observation" or 'pure experience" claim, although I have read with interest the efforts to defend that view. I believe the framework that I am offering should be held with the same attitude of welcoming amendment, of realization of its limits, of looking forward to discovering what it leaves out, that I am advocating for therapist's in their relationship to the other theoretical frameworks which they use. If anything is different about my contribution, is that is derived from a broad way of understanding human development and dialogue, and seeing psychotherapy as a special case of those phenomena, rather than being derived from a particular view of human dysfunction which gives rise to a specific therapeutic methodology for ameliorating such dysfunction. In some sense, you could say I am doing metatheory of therapeutic process, but Carl Rogers thought he was doing metatheory of therapeutic process too, and his work has clearly turned into a theory of therapy. So I would not make too big a deal about this distinction”.

<sup>6</sup> The similarity between Killingmo’s approach and mine was pointed out by Meir Perlow, in the IJPA Discussion group, Bulletin no. 147, 25 November 1998.

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