

therapy on the theory that neurotics had never had this and needed it. This is generally felt today to be an over-simplified understanding of the problem. Thompson says "Ferenczi did not have a clear idea of neurotic love demands."¹ But Ferenczi's work, his "active therapy" as it used to be called, left a strong impact on the psychoanalytic movement, especially in its emphasis on the place of the analyst as a person in the therapeutic process. He felt that it would be difficult for the therapist to help a patient he did not like. All of this pointed in the direction of the more culturally oriented therapy which was to come, and of the study of the therapeutic relationship as such including the real attitude of the therapist. Ferenczi never broke openly with Freud.

Brief mention may be made of Wilhelm Reich, who appears to be an eccentric genius. Noting, in the 1920's, that characteristic emotional states of people are often expressed in postures and modes of physical movement as well as in modes of psychological and verbal movement, he tried to examine these systematically.² He then tried a direct attack on these, calling them to the patient's attention, breaking them down--after which he felt analysis itself begins in the traditional manner. There was in this approach, as Thompson rightly suggests, attention to character trends themselves as problems, not seeing problems solely

¹Thompson, op. cit., p. 186.

²Wilhelm Reich, Character Analysis: Principles and Technique for Psychoanalysts in Practice and Training, trans. Theodore P. Wolfe (New York: Orgone Institute Press, 1945).

of
In the form of symptoms.¹ From this point of view, people like Horney are the heritors of Reich, with their acute dissection of neurotic trends in character patterns rather than just of symptom.

In more recent years Reich has moved to a place where he out-Freuds Freud as far as stressing sex and libido is concerned. He calls his system vegeto-therapy or orgone-therapy.² The "vegeto" is a reference to the basic postures, expressive of character; and the orgone to a fantastically developed theory of the center of potency. I once sat, experimentally, in an "orgone-box," a movable chamber just big enough to sit in on a chair; but I was not rewarded by any immediate access of potency, sexual or otherwise. It could be that my attitude was wrong. At any rate, contemporary Reichianism seems not too far removed from mumbo-jumbo. Reich seems to believe seriously that any one who has true potency in orgasm is mentally healthy. If things were so simple, perhaps the world's problems would be easier. Certainly this is now a cult.

Psychotherapy and Psychosis

At this point we must retrace our steps, chronologically speaking, and consider a different kind of development in psychotherapy. With few exceptions, Freud and the other people we have mentioned in the previous pages dealt almost entirely with neurotic patients. Early experiments by psychoanalysis on psychotic patients

¹Thompson, op. cit., p. 190.

²Wilhelm Reich, The Function of the Orgasm, trans. Theodore P. Wolfe (New York: Orgone Institute Press, 1942).



had proved disappointing. So psychoanalysis was developed almost entirely, until the 1920's, as therapy for certain kinds of neurotic patients. More recently, especially under the early leadership of Sullivan, it has been found that analytic methods, properly adapted, may aid many psychotics.¹ But the bulk of psychoanalytic material and experience, even today, has been built on work with neurotic patients.

Meanwhile, the psychotics were being taken care of in one way or another. In some contrast to the psychoanalytic developments, much that was most new and impressive in the care and treatment of psychotics was developed in the United States.

At this point we need to recall the peculiar social and economic problems which psychosis poses, quite different from neurosis. The neurotic may be unhappy, unproductive, and make life miserable for his family and friends. But apart from rare extreme forms, he does not cost society anything extra, and he does not need a policeman to guard him. Psychosis means segregation temporarily from society and the costs thereby entailed, even before the question of actual treatment arises. Since there are now over a half-million hospitalized psychotics at any one time (although the rate of incidence has not arisen except in older people and that solely because they live longer), this presents a staggering social and economic problem to society, again, even before therapeutic measures are considered.

¹ See especially Frieda Fromm-Reichmann, Principles of Intensive Psychotherapy (Chicago: The University of Chicago Press, 1950).



We may mercifully skip over the ancient history of treatment of psychotics. Until the end of the eighteenth century, there were not even any sustained humanitarian efforts on behalf of these sufferers. Through the nineteenth century, and especially under the prophetic influence of Dorothea Lynd Dix, the principle of hospital care of psychotics became well established in the United States. Because no therapy was at first known except ordinary medical treatment, the physicians became the general overseers of mental hospitals, and what was later to become the American Psychiatric Association was formed in 1844.

For the most part the early psychiatrists (their first name was psychiater) had no therapy at all. Miss Dix called for enlightened care. The possibilities of research into new methods of treatment was envisioned by very few. Even proper classification seemed very difficult; and an even halfway effective system of classification was not achieved until about 1890. The whole problem was further complicated, as Deutsch points out, by the peculiar handling of statistics in the mid-century years, which made it appear that often as many patients were discharged cured or improved as entered, when in fact this was not so.¹ The public got an exaggerated idea of the cures which mental hospitals were bringing about, and expected results from them which they could not produce.

In the latter part of the nineteenth century, and especially

¹ Albert Deutsch, The Mentally Ill in America: A History of their Care and Treatment from Colonial Times (New York: Doubleday and Co., Inc., 1937).

n the twentieth, a few spectacular feats of medical research revealed specific organic etiology in certain disorders whose symptoms were mental enough to have them classed with the psychoses. Best known of these was paresis, found to be caused by the syphilis spirochete, lying dormant in the brain for ten or even twenty years before beginning its ravages in terms of psychological behavior such as grandiose delusions, financial irresponsibility, hallucinations, and the like. For a period this led to the hope that other one-cause etiologies could be found for the other types of psychosis. This hope often led to a neglect of experimentation in psychotherapy with psychotics, as did the bewildering numbers of patients who confronted any mental hospital psychiatrist. In the hospital where I studied (since improved), one physician not trained in psychiatry but expected to serve as psychiatrist was responsible for more than eight hundred patients. He could not even classify them except by a quick look and a social worker's report on what the family said.

In 1900 Freud was unknown, and had just moved from his early hypnotic period into that of psychoanalysis. Whatever might be the relevance of his findings for psychosis (and they became relevant for an understanding of the psychodynamics of psychosis long before there was any effective use of them in therapy), it was to be years before any of this became apparent. At that time a young pathologist at the Worcester State Hospital in Massachusetts became discontented with the dissection of dead tissues and took a new look at mental patients. Adolf Meyer shortly thereafter developed his concept of "psychobiology," and

moved on to Johns Hopkins Medical School and Hospital from which he was to influence quietly but vitally an astonishing proportion of the American psychiatrists of the ensuing half-century.¹

How did a patient get this way? We need, said Meyer, to look at the patient in the psychological as well as the biological dimension. There is a psychodynamics as well as a biodynamics. So the patient, even the psychotic, was not only poked and measured but also listened to, and so was his family. Life circumstance, attitude, and such relatively simple psychological notions became immediately revealing when one gave up the idea that nothing but the microscopic could reveal true etiological factors in disease. Chance remarks, apparently odd facts, e.g., the fact that a sister-in-law lived in the patient's home, might be clues to an understanding of the network of circumstances in which the illness developed.

So there began to develop, under Meyer's influence, the true case history including all kinds of seemingly unrelated information from and about the patient. When studying this, the psychiatrist could often begin to see connections which would help account for the illness. These "histories" have since become the standard practice in mental hospitals. To the diagnostic efforts of the psychiatrist were added those of the social worker, the psychometrist, and more recently many others including the chaplain who, in a good hospital, performs a diagnostic as well as a therapeutic function.

¹ Adolf Meyer, Commonsense Psychiatry: 52 Selected Papers (New York: McGraw-Hill Book Co., Inc., 1948).

The difficulty with the case history, to put it bluntly, is that it has often become almost an end in itself rather than a means to a therapeutic end. Increasingly, and especially after some of the Freudian conceptions had filtered into general psychiatric theory in the 1920's, it was possible to know all about how a patient got the way he was but be able to do nothing to help him get well. The brilliant hospital psychiatrist was the man who wrote the best histories. Few really believed that direct therapy would do much good. Humanitarian care as practiced in the best hospitals, with solicitous fatherly guidance from all concerned, was considered rightly to be helpful. Adjunctive therapies like the occupational therapy shop were properly felt to be valuable. But of direct psychotherapy there was not much except in the expensive private hospitals; and there it was largely a matter of reassurance and suggestion, dealing with symptoms rather than causes.

At least three important factors have entered into this situation in the last twenty years, not necessarily in this order. Perhaps unfortunately, the most widely influential of these so far has been so-called "shock therapy." This consist of a series of chemical (insulin or metrazel) or electrical treatments which "shock" the patient (unconsciousness, spasms, and the like). For some psychotic patients this has proved exceedingly helpful; for many others, of no help at all. What is now being studied most carefully is the kind of indications where it is and is not likely to prove helpful. There is no general agreement about the theory

by which it functions. There are some, of whom I would be one, who believe its operation is, by analogy, like driving out the seven spirits; but that unless concomitant or immediately subsequent psychotherapy is undertaken, there is no guarantee that worse spirits will not return.

The great appeal of "shock" in the face of the enormous number of mental patients has been its mechanical character. For a time some looked upon it as a panaceatic possibility. Now that its limitations are becoming better known, there is again more hard thinking about psychotherapeutic methods with psychotics.

This is leading toward a new consideration of the application of the principles of psychoanalytic therapy to psychotics, the second new factor of the past twenty years. Harry Stack Sullivan was the first to work on this in a new way, in the twenties.¹ More recently the Menninger brothers, Frieda Fromm-Reichmann and others have done significant work at this point.² But as the processes are revealed by which a proper adaptation of psychoanalytic therapy can help many psychotics, it becomes clear that this is not quick, easy, or mechanical. Work is being done on abbreviated methods, utilizing some of the analytical principles, which may prove valuable for the steadily overworked state hospital psychiatrist.

The third development is hard to put a name to, but might

¹ Harry Stack Sullivan, Conceptions of Modern Psychiatry ("The First William Alanson White Memorial Lectures"; Washington: William Alanson White Psychiatric Foundation, 1947).

² Fromm-Reichmann, op. cit.

be called total integrated treatment planning. One sees this at its best in a place like the small Menninger clinic, in which all activities of the patient (including psychotherapy) are considered by the entire staff. Where he lives, guidance on his recreations, and everything else are considered from the point of view of their distinctive therapeutic effect on him. This is much more than the kind fatherly word, or keeping him busy. And it is hopeful for large-scale extension at least in a measure. Even most state hospitals now make a stab at it, however inadequate this may be in practice.

It may be that a fourth development should be added. Although it is administrative in character, it affects vitally the situation of the psychotic sufferer. This is the increasing tendency to have small "intake" hospitals, or mental hospital wings in general hospitals. This is on the theory that many disorders, if treated intensively at once, may be arrested, and this often proves to be the case. Moving backward in time another step, the growth in mental hygiene and guidance clinics may be cited as similar in intent and effect, but getting to people before problems reach psychotic proportions.

Psychiatry, Psychology and Psychotherapy

What we have said so far implies, and correctly, that through the whole period from 1900 until fairly recently the development of psychotherapy has been in the hands of the medical group for the most part, of a small section of it known as psychiatrists, and of the very small part of that group which

has engaged in private practice with neurotic patients. This is an over-simplification, since Jung and Rank, for instance, were not physicians. But it is dominantly true. Where non-medical psychoanalysts existed, they were not university-attached psychologists. Psychotherapy, it is fair to say, has not grown up in the hospital, the clinic, or the university, but in the private consulting room of a very small group of specialized physicians.

Thus far we have considered psychotherapy mainly as depth psychology and psychoanalysis. But if we understand that the principles of understanding people psychodynamically, coming originally out of analytic therapy, and the essence of the therapeutic method of analysis--somehow getting people to confront and assimilate conflicting residuals of past experience--may both be much wider than in their technical application by psychoanalysts, then it is possible to get a broadened view of psychotherapy in which any professional person utilizing these principles is, self-consciously, performing a function of psychological therapy. Many psychoanalysts tend not to like the term psychotherapy at all just because of these extension possibilities which it has.

From this point of view, it becomes clear that a number of professional groups which work directly with people are performing psychotherapeutic functions. Nor are they (including religious workers) mere borrowers, as I have pointed out in detail elsewhere.¹ Taking the psychodynamic and psychotherapeutic lead

¹Beward Hiltner, Pastoral Counseling (Abingdon-Cokesbury Press, 1949), chap. v.

given by psychoanalysis, they have each attempted to develop more appropriate understanding and methods within their own context of meeting the person to be helped.

For some time this was rarely spoken of as "therapy," that term being reserved to the physicians. But it has become clearer that such a distinction is artificial. Where counseling or case work or guidance services end and therapy begins is a question of terminology. But the emotional change which this and related questions carry today should not be overlooked.

Until 1942 the fiction was retained that no one but psychiatrists (plus a few psychologists trained in psychoanalysis, like Fromm) practiced psychotherapy. In that year Carl R. Rogers, published Counseling and Psychotherapy.¹ He, a clinical psychologist, had developed an approach and method of dealing with people's psychological problems which utilized the psychodynamic material originally discovered by psychoanalysis, but with much less interventiveness or direct probing for unconscious factors than had characterized all forms of psychoanalysis. The reaction from the psychiatric group, and especially the psychoanalytic portion of it, was strong--both in terms of his less interventive methods of therapy, and that he as a psychologist should do this and call it psychotherapy. Yet we may recall that even in Freud himself the trend had been in the direction of non-interventive methods.

Freud had said (1927), "... the important question is not whether an analyst possesses a medical degree but whether he

¹Counseling and Psychotherapy: Newer Concepts in Practice (Boston: Houghton Mifflin Co., 1942).

... had the special training necessary for the practice of analysis.¹
... had also written, "Psychoanalysis falls under the head of
psychology; not of medical psychology in the old sense, nor of
the psychology of morbid processes, but simply of psychology."²

Academic or university psychology had demonstrated little
interest in psychoanalysis, in personality study, and the holistic
view until the mid-thirties. The clinical psychologist had, up
to that time, been a measurer. But especially under the leadership
of Rogers, psychology in the university and clinic began to study
not only psychodynamics but also psychotherapy.³ The attitude of
medical psychoanalysts toward this development is now less sweep-
ingly hostile than a few years ago, but is still, to say the least,
ambiguous.

It may be well to note that the psychiatrists and psycho-
analysts, or their leading representatives, have not been hostile
to a social case work or pastoral counseling which, taking a lead
from psychoanalytic theory and therapy, has developed more effec-
tive understanding of people and specific approaches for helping
them than were previously available. But social workers, pastors,
and certain other groups work in a context which is traditionally
different from that of the physician. The clinical psychologist,
if he now receives training in psychotherapy, becomes a direct

¹ Collected Papers, V, 206.

² Ibid., V, 207.

³ Rogers, et al., *Client-Centered Therapy: its Current
Practice, Implications, and Theory* (Boston: Houghton Mifflin Co.,
1951), is much more far-reaching than were the previous writings.

competitor of the psychoanalyst in the sense that he may work in the same kind of context. Whether clinical psychology will succeed in training people adequately for general psychotherapeutic practice, or may permit many of them to fall into semi-quackery under the guise of Ph. D.'s and other academic symbols, remains to be seen. But it seems certain both that there will be more clinical psychologists trained in and carrying out general psychotherapy, and that more of their training will be under university auspices. Little psychoanalytic training to date has been under university auspices, which itself presents interesting problems. In a way, the clinical psychologist now represents university-training against the institute-training of the psychoanalyst.

Horney, Fromm and Sullivan

Our story of psychoanalytic developments has been carried only up to about 1930, and this requires completion. This later history is more difficult to write accurately not only because it is closer to us, but because this same period has witnessed an important shift in the place of psychoanalysis and psychotherapy in society. There are more analysts, more groups of analysts, more public acceptance of what is involved as being more than faddism, and a greater demand for services. Actual practice is, as a rule, very much better than was true in 1930. In almost all groups, it tends to take the individual needs and problems of the patient into account in determining the length and specific techniques in the therapy. Many principles once considered hypothetical, or a cause for division, are now generally agreed to by

nearly all persons with good training. Therapeutic results are probably better as a rule, despite the fact that people with a much wider range of problems and character patterns have sought help through this means. However, there is still little or no statistical evidence on this point.

The great change in the social setting of psychoanalysis should be kept in mind in the following discussion of the newer ideas and methods. In general, the great change in theory has been the growing recognition of cultural understanding for an understanding of the patient, and the general change in therapy has been in the direction of helping the patient to understand his character (characteristic trends or patterns of behavior) instead of an attack upon causes via symptoms.

Cultural understanding is no mere matter of realizing that some act means something different in a primitive society from what it does to an American. It affects, for example, an understanding of the problems of a woman in psychoanalysis, by helping to distinguish socially-conditioned ideas of femininity from those which are biologically determined. On points of this kind, all schools and groups of American psychoanalysis have deviated considerably from Freud.

If analytic work is to deal with the pattern of character, and not conceive its function merely as eliminating symptoms by reaching causes, then the relatively simple spatial metaphors which served as Freud's vehicle for describing both psychodynamics and psychotherapy require modification. Although few of these people are well acquainted with progressive modern philosophy,

in their own way they have been moving away from substantive thinking (at least simple substantive thinking) and towards process thinking. I have tried this point out on several psychoanalysts who had little acquaintance with modern philosophy as such, and have found an immediate responsiveness to it once they grasped what I meant.

So it would seem (acting now as a prophet) that the eventual fate of, let us say, the Id, Ego and Super-Ego is sealed. These were substantive metaphors useful in the early days of psychodynamics and psychotherapy. But neurotic trends, interpersonal relations, parataxic distortions, and psychological field theory are newer terms which suggest the emerging orientation to process rather than substance. The class of facts about human beings which the Id once described is still with us. But our orientation to its meaning and nature has altered. We do not need a new name for it. We need to analyze more accurately the types of phenomena which it represented, and place them in a different kind of context. As I have tried to suggest more than once, Freud moved in this general direction, although becoming fixated at a certain stage of such movement. But in terms of general direction, all of this is no violation of the inherent logic of Freudianism.

We may note one other fact of interest to our later discussion about the development of American psychoanalysis in the past twenty years. Staunchly anti-Hitler in their political and social views, a very high proportion of the Continental psychoanalysts were forced out of their countries during the early and



middle 1930's. Most of them came to the United States. As Thompson points out, "In this way European analytic thought and American analytic thought began to fuse while for the time being at least American and English groups have progressed in different directions."¹

Until almost 1940, American psychoanalysis (not including the Adler and Jung groups) was loosely organized into a single national association with, however, presumed autonomy for local societies and institutes. The largest local group, and that containing the greatest variety in points of view, was in New York City. In 1937 Karen Horney, a German analyst who had come to the United States in the early thirties, published her first book in English, The Neurotic Personality of Our Time.² It was an interpretation of neurosis based on the cultural dimension of personal life. This caused quite some stir, some colleagues feeling she was selling out biology and medicine for a mess of sociological pottage, while others felt she was gaining personal prestige for a viewpoint which was becoming more widespread anyhow but for which she seemed to take all the credit. But the real controversy arose in 1939 when she published her New Ways in Psychoanalysis, a direct attack upon Freud's theory and, in lesser measure, upon his practice.³

Horney wrote, "My conviction, expressed in a nutshell, is that psychoanalysis should outgrow the limitations set by its

¹Op. cit., p. 194.

²(New York: W. W. Norton and Co., Inc., 1937).

³(New York: W. W. Norton and Co., Inc., 1939).

being an instinctivistic and a genetic psychology.¹ In explaining the first point, she wrote:

... when character trends are no longer explained as the ultimate outcome of instinctual drives, modified only by the environment, the entire emphasis falls on the life conditions molding the character and we have to search anew for the environmental factors responsible for creating neurotic conflicts; thus disturbances in human relationships become the crucial factor in the genesis of neuroses. A prevaillingly sociological orientation then takes the place of a prevaillingly anatomical-physiological one.²

As to the preoccupation with genetic factors, she wrote:

Freud tends to regard later peculiarities as almost direct repetitions of infantile drives or reactions; hence he expects later disturbances to vanish if the underlying infantile experiences are elucidated. When we relinquish this one-sided emphasis on genesis, we recognize that the connection between later peculiarities and earlier experiences is more complicated than Freud assumes: there is no such thing as an isolated repetition of isolated experiences; but the entirety of infantile experiences combines to form a certain character structure, and it is this structure from which later difficulties emanate. Thus the analysis of the actual character structure moves into the foreground of attention.³

Horney then went systematically through Freud's theory--libido, Oedipus, narcissism, and so on--and attempted to reformulate it in the light of the basic points we have indicated above. What Horney attacked was a Freudian theory and practice which she felt had become grooved into rigid orthodoxy, the whole being made more difficult because the founder at that time was still living.

Horney has since made improvements and refinements in her theory of neurosis and of psychoanalysis, and has acknowledged such changes in her views since 1939.⁴ What she did not do in

¹Ibid., p. 8.

²Ibid., p. 9.

³Ibid.

⁴Horney, Our Inner Conflicts: A Constructive Theory of Neurosis (New York: W. W. Norton and Co., Inc., 1945), and Neurosis and Human Growth: The Struggle Toward Self-Realization (New York: W. W. Norton and Co., Inc., 1950).

1939, and has not done since, is to look at the movement in Freud's views up to a certain point and then the crystallizing orthodoxy. But the importance of the cultural dimension was certainly highlighted by her, and has become increasingly influential, even if in somewhat less emphatic form, in nearly all groups of psychoanalysts by this time.

In this volume Horney makes some brief remarks on morals. In discussing the perfectionistic type of person, she says he is driven by a need to appear perfect rather than, as she understands Freud to mean, by an ever-increasing perfection.¹ So the moral norms the patient believes he follows are in reality "pseudo-moral aims."²

The pseudo-moral aims, far from being identical with moral norms and ideals, prevent the latter from developing. The type we have been discussing has adopted his standards under the stress of fear for the sake of peace. He complies with them formalistically but with inner opposition. For example, he is superficially friendly to people but feels this attitude--unconsciously--as a burdensome imposition. Only after his friendliness has lost its compulsory character can he start to consider whether perhaps he himself would like to be friendly to others. There are indeed moral problems involved in the neurotic need for perfection, but they are not the ones with which the patient is apparently struggling nor those which he pretends to have. The real moral issues lie in the insincerity, the haughtiness and the refined cruelty which are inseparable from the structure that has been described.³

Two most important things in this passage are the reference to the compulsory character of a trend, and the distinction between true and assumed moral issues. There is an implied assertion that true moral problems exist, even though they are not necessarily

¹Horney, New Ways in Psychoanalysis, p. 215.

²Ibid., p. 230.

³Ibid., pp. 230-231.

what the patient thinks are his moral problems. And it is, in some way, the compulsive character of a trend or pattern which makes it serve a pseudo-moral rather than a moral aim.

After the storm over her second American book, Horney withdrew from the psychoanalytic society and formed a group of her own, now known as the American Association for the Advancement of Psychoanalysis. Although it contains some excellent therapeutic workers, it has not yet produced any other theoretical worker of stature than Horney herself.

This group has admitted only physicians also trained in psychoanalysis to its ranks. Its developments in theory and practice can largely be seen in Horney's own development, and this seems well represented in her writings. What she has constantly sought for is an increasingly adequate theory of neurosis. No one who has ever written about these matters has been so penetrating in finding and elucidating the complex strands of "neurotic trends" within individual psychic life, and the resulting basic patterns of total character portrayal to the world. This has made her increasingly interested in characterology, in basic types of character structure.

In her most recent book, Neurosis and Human Growth, and less clearly in her previous work, Our Inner Conflicts, she arrives at three basic types of character.¹ Simply stated, these are the people whose dominant pattern is defending themselves through mastery of things and people; those for whom it is being dependent;

¹Neurosis and Human Growth (New York: W. W. Norton and Co., Inc., 1950), and Our Inner Conflicts (New York: W. W. Norton and Co., Inc., 1945).

and those for whom it is resignation. Or, still more simply, moving against people, moving towards people, and moving away from people.

Horney has been increasingly impressed with all forms of neurotic disturbance as safety devices, protecting a facade which gives some kind of stability to the personality, but preventing it from genuine growth in a human sense. This is Freud's early concern about the symptom (What is the gain in it?) translated into terms of character pattern.

Another of Horney's notable points, appearing through all her writings, is the generalized form of the distinction we have already noted in relation to morals: the immense difference between any trend of character which is compulsive (blindly protective) and the same trait when spontaneous and genuine. Thus there can be a neurotic need for affection, for mastery, for detachment, and for almost anything else--if the underlying structure of character must grasp compulsively to try to maintain its precarious balance. But there can also be, although Horney has not spelled this out in detail as she has of the neurotic reactions, genuine and spontaneous need for affection, for mastery or creative expression, for solitude, and so on.

It would be possible, without much distortion, to call Horney the contemporary anatomist of sin. For her distinction between what is neurotic and what is not neurotic is not intended to divide people as sheep from goats. When once asked in a lecture whether she had ever known any non-neurotic people, she replied, "Yes, I knew two. But they both disappointed me."

That is, she is describing trends which she believes exist in some measure in every person in our culture.

Horney has made a great contribution to psychoanalytic, and indeed to all psychodynamic, thinking. In terms of therapy itself, there is no evidence that she has made comparable changes except that the thought patterns utilized in the therapeutic process of course follow her theory rather than the crystallized orthodoxy of the Freudianism she once held. There seems little doubt that most psychoanalysts, even without Horney, would have moved in the direction of more attention to the cultural dimension, more process thinking about intrapsychic realities, and the like. But she, however unintentionally, provoked a revolution--the result of which was probably to delay such developments in the more orthodox groups while advancing them in her own. It may not be without significance that Horney's greatest body of professional followers is the social workers, which is understandable in the light of the social dimension of her thought.

The two other leading thinkers in psychoanalysis of the past twenty years have been Erich Fromm and Harry Stack Sullivan. We can refer to Fromm briefly, for his thought will be taken up in detail in a later chapter.

Trained as a social psychologist before taking psychoanalytic training, Fromm early in his career (the late 1920's) decided that Freud's theory of the relation of personality to culture and society was wrong. Like Horney, and before her, he found inadequate the instinct theories and assumptions of Freud, and the biologicistic rendering of cultural phenomena. The basic

difference was perhaps on the nature of human motivation: is this to be seen in "outlet" terms (instinct theory) or in terms of fulfilled or frustrated attempts at creative self-fulfillment? All the complex behavior of man requires for its explanation not just the simple outworking of given instincts, but the personal cultural network over a period of time.

Contemporary man's problems can be understood only in the light of his cultural history as well as his individual psychological history. Here Fromm sees man as having achieved a freedom from various kinds of tyrannies of the past, e.g., back-breaking physical labor. But in the process of achieving this, he has become alienated from his fellows and his own true self, and can not exercise his freedom to develop himself and the solidarity relationship with his fellows. Under this culturally-induced gain and loss situation, he begins to feel panicky, and may become prey to many forms of authoritarianism. Nazism could be understood only as a gigantic attempt to "escape from freedom."¹

Like Horney, Fromm is interested in character patterns rather than symptoms and causes. At this point, as at some others, his basic views are quite similar to those of Horney, except that hers are expressed like "liberal" views in theology, while Fromm's are like the "neo-orthodox." That is to say, Horney asserts and illustrates the differences between her views and those of Freud. Fromm makes clear his differences from Freud, but goes behind these to what he regards as the symbolic truth behind many of

¹Erich Fromm, Escape from Freedom (New York: Farrar and Rinehart, Inc., 1941).

Freud's literal renditions. This type of symbolic searching is very important in Fromm's theory of character types.

Sullivan's theory, in its final form, is remarkably similar to that of Fromm, although arrived at by quite different methods and utilizing a different vocabulary and somewhat different frame of reference.¹ Sullivan began his work as a mental hospital psychiatrist; then took psychoanalytic training, and was perhaps the first successfully to adapt analytic methods to the treatment of psychotic patients. He was particularly concerned with schizophrenics. I recall a scientific meeting where Sullivan was present at which a young psychiatrist presented a paper on schizophrenic thinking, in which the gist was that the bizarre verbalizations and other productions of schizophrenics were just that, that these people were so far gone that their productions did not make sense. Sullivan, in the bitter sarcasm which he exhibited when aroused, made such mincemeat of the young psychiatrist that the wounds no doubt show to this day. Sullivan's point was that these productions of the schizophrenic, or of any one else, are always meaningful and revealing--if we find the key whereby to read them. Besides, they are not only meaningful in the sense of being understandable; they are also the schizophrenic's mode of outreach (the sole one he can use at that time) toward the world, his fellow men, and himself.

Psychological disturbances, Sullivan came to feel, are

¹ Harry Stack Sullivan, Conceptions of Modern Psychiatry ("The First William Alanson White Memorial Lectures"; Washington: William Alanson White Psychiatric Foundation, 1947).

disturbances in interpersonal relationships; and psychodynamics
or, as he himself redefined it, psychiatry) is the study of inter-
personal relationships. Sullivan has marked kinship with George
Herbert Mead at the point of social behaviorism and the human
environment as the creator and molder of selfhood and personality.¹

Human behavior may be seen in terms of the categories of
goals toward which it is directed of which there are two: pursuit
of satisfactions (largely related to biological needs) and pursuit
of security (growing out of man's cultural equipment). Security
is understood very broadly, as having to do with belonging and
being accepted (hence being able to accept oneself). The self
evolves in the process of the child's emphasizing and accepting
those aspects of his behavior which bring approval, while casting
aside, dissociating or repressing those which bring disapproval.
As in Mead, the self is made up of reflected appraisals first of
parents then also of peers. Sullivan deals with much of the life
of ideas and of fantasy as a further extension of interpersonal
relations. When a person reacts to another, his view of the
other is distorted by an image in his own mind which is not cor-
respondent, and "parataxic distortion" is said to take place.
The therapeutic situation itself, therefore, may be viewed as a
movement from parataxic distortion toward a true or straight view.

Sullivan has devoted attention with great penetration to
human developmental stages. And in therapy he has made much of

¹George Herbert Mead, Mind, Self, and Society: from
the Standpoint of a Social Behaviorist (Chicago: The University
of Chicago Press, 1935).

the therapist as "participant observer." He has made several modifications in therapeutic technique, mostly in line with finding out what may better help different types of patients.

As Thompson properly points out, Sullivan has at least come very close to presenting a systematic theory of personality development.¹ As she also indicates, he was impatient with any type of theoretical work which could not be verified at once by empirical observation.² For this reason, Sullivan was not, like Fromm, interested in such areas as ethics. He was also, with all his stress on interpersonal relations, inclined toward a biologism though a modified one.

There are certain implicit concerns of interest to ethics within Sullivan's thought, perhaps well symbolized in the much-quoted maxim, ". . . as you judge yourself so shall you judge others."³ By implication this suggests the circle that needs to be moved on if judgments in general are to be whatever they ought to become: examine your own perspective, realizing that this in turn has evolved out of contacts with others, and so on.

Summary

Psychotherapy is, in all situations, some kind of person-to-person relationship. Even though the therapist concentrates on the feelings, point of view, and problems of the person, he is not thereby himself merely a machine or a silver-reflecting-screen. And even though he is inevitably concerned to help the person

¹Op. cit., p. 217.

²Ibid., p. 219.

³Sullivan, op. cit., p. 7.