The Dynamics of Psychotherapy in the Light of Learning Theory

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It is fitting that one of Franz Alexander's customarily lucid and percipient papers should introduce the material in this volume. More than any other psychoanalyst of the modern era, Alexander was a pathfinder who had the courage and the vision to integrate the newer findings of behavioral science into his theoretical and clinical perspectives without abandoning what was useful in the old.

The following paper and that of Marmor which follows it were two of the earlier psychoanalytically oriented efforts at expressly linking psychoanalytic therapy with the process of learning. Thus they created the basis for a bridge between dynamic psychotherapy and the behavioral therapies that expressly derived their techniques from learning theories.

These were not, however, the earliest attempt at such integration. As far back as 1933, Thomas French, in a lengthy and occasionally abstruse article, explored the "Interrelations between Psychoanalysis and the Experimental Work of Pavlov" (American Journal of Psychiatry 12:1165-1203). The article did not exert much influence, probably because the conditioned reflex theories of Pavlov were not as adequate to explain the complexity of learned behavior as were the later theories ofGestalt learning and Skinnerian operant conditioning, which are here emphasized by Alexander.

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Most of what we know about the basic dynamic principles of psychotherapy is derived from the psychoanalytic process.

One of the striking facts in this field is that the intricate procedure of psychoanalytic treatment underwent so few changes since its guiding principles were formulated by Freud between 1912 and 1915.[7-11] Meanwhile, substantial developments took place in theoretical knowledge, particularly in ego psychology. Moreover, in all other fields of medicine, treatments underwent radical changes resulting from a steadily improving understanding of human physiology and pathology. No medical practitioner could treat patients with the same methods he learned 50 years ago without being considered antiquated. In contrast, during the same period the standard psychoanalytic treatment method as it is taught today in psychoanalytic institutes remained practically unchanged.

It is not easy to account for this conservatism. Is it due to the perfection of the standard procedure, which because of its excellence does not require reevaluation and improvement, or does it have some other cultural rather than scientific reasons?

Among several factors one is outstanding: to be a reformer of psychoanalytic treatment was never a popular role. The need for unity among the pioneer psychoanalysts, who were universally rejected by outsiders, is one of the deep cultural roots of this stress on conformity. The majority of those who had critical views became "dissenters" either voluntarily or by excommunication. Some of these became known as neo-Freudians. Some of the critics, however, remained in the psychoanalytic fold.

(Some analysts jocularly expressed the view that the stress on con-

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formity was a defense against the analyst's unconscious identification with Freud, each wanting to become himself a latter-day Freud and founder of a new school. Conformity was a defense against too many prima donnas.) Another important factor is the bewildering complexity of the psychodynamic processes occurring during treatment. It appears that the insecurity which this intricate field necessarily provokes creates a defensive dogmatism which gives its followers a pseudosecurity. Almost all statements concerning technique could be legitimately only highly tentative. "Tolerance of uncertainty" is generally low in human beings. A dogmatic reassertion of some traditionally accepted views-seeking for a kind of consensus-is a common defense against uncertainty.

In spite of all this, there seems to be little doubt that the essential psychodynamic principles on which psychoanalytic treatment rests have solid observational foundations. These constitute the areas of agreement among psychoanalysts of different theoretical persuasion. Briefly, they consist in the following observations and evaluations:

1. During treatment unconscious (repressed) material becomes conscious. This increases the action radius of the conscious ego: the ego becomes cognizant of unconscious impulses and thus is able to coordi nate (integrate) the latter with the rest of conscious content.

2. The mobilization of unconscious material is achieved mainly by two basic therapeutic factors: interpretation of material emerging during free association and the patient's emotional interpersonal experiences in the therapeutic situation (transference). The therapist's relatively objec tive, nonevaluative, impersonal attitude is the principal factor in mo bilizing unconscious material.

3. The patient shows resistance against recognizing unconscious content. Overcoming this resistance is one of the primary technical prob lems of the treatment.

4. It is only natural that the neurotic patient will sooner or later direct his typical neurotic attitude toward his therapist. He develops a transference which is the repetition of interpersonal attitudes, mostly the feelings of the child to his parents. This process is favored by the therapist encouraging the patient to be himself as much as he can during the interviews. The therapist's objective, nonevaluative attitude is the main factor, not only in mobilizing unconscious material during the pro cess of free association, but also in facilitating the manifestation of trans ference. The original neurosis of the patient, which is based on his childhood experiences, is thus transformed in an artificial "transference neurosis" which is a less intensive repetition of the patient's "infantile neurosis." The resolution of these revived feelings and behavior pat terns—the resolution of the transference neurosis —becomes the aim of the treatment.

There is little disagreement concerning these fundamentals of the treatments. Controversies, which occur sporadically, pertain primarily to the technical means by which the transference neurosis can be resolved. The optimal intensity of the transference neurosis is one of the points of contention.

This is not the place to account in detail the various therapeutic suggestions which arose in recent years. Most of these modifications consisted in particular emphases given to certain aspects of the treatment. There are those who stressed interpretation of resistance (Wilhelm Reich, Helmuth Kaiser), while others focused on the interpretation of repressed content. Fenichel stated that resistance cannot be analyzed without making the patient understand what he is resisting.[6]

It is most difficult to evaluate all these modifications because it is generally suspected that authors' accounts about their theoretical views do not precisely reflect what they are actually doing while treating patients. The reasons for this discrepancy lies in the fact that the therapist is a "participant observer" who is called upon constantly to make decisions on the spot. The actual interactional process between therapist and patient is much more complex than the theoretical accounts about it. In general there were two main trends: (1) emphasis on cognitive insight as a means of breaking up the neurotic patterns and (2) emphasis upon the emotional experiences the patient undergoes during treatment. These are not mutually exclusive, yet most controversies centered around emphasis on the one or the other factor: cognitive versus experiential.

While mostly the similarity between the transference attitude and the original pathogenic childhood situation has been stressed, I emphasized the therapeutic significance of the difference between the old family conflicts and the actual doctor-patient relationship. This difference is what allows "corrective emotional experience" to occur, which I consider as the central therapeutic factor both in psychoanalysis proper and in analytically oriented psychotherapy. The new settlement of an old unresolved conflict in the transference situation becomes possible not only because the intensity of the transference conflict is less than that of the original conflict, but also because the therapist's actual response to the patient's emotional expressions is quite different from the original treatment of the child by the parents. The fact fhat the therapist's reaction differs from that of the parent, to whose behavior the child adjusted himself as well as he could with his own neurotic reactions, makes it necessary for the patient to abandon and correct these old emotional patterns. After all, this is precisely one of the ego's basic functions-adjustment to the existing external conditions. As soon as the old neurotic patterns are revived and brought into the realm of consciousness, the ego has the opportunity to readjust them to the changed external and internal conditions. This is the essence of the corrective influ-

ence of those series of experiences which occur during treatment[2,3]. As will be seen, however, the emotional detachment of the therapist turned out under observational scrutiny to be less complete than this idealized model postulates.

Since the difference between the patient-therapist and the original child-parent relationship appeared to me a cardinal therapeutic agent, I made technical suggestions derived from these considerations. The therapist in order to increase the effectiveness of the corrective emotional experiences should attempt to create an interpersonal climate which is suited to highlight the discrepancy between the patient's transference attitude and the actual situation as it exists between patient and therapist. For example, if the original childhood situation which the patient repeats in the transference was between a strict punitive father and a frightened son, the therapist should behave in a calculatedly permissive manner. If the father had a doting, all-forgiving attitude toward his son, the therapist should take a more impersonal and reserved attitude. This suggestion was criticized by some authors, that these consciously and purposefully adopted attitudes are artificial and will be recognized as such by the patient. I maintained, however, that the therapist's objective, emotionally not participating attitude is itself artificial inasmuch as it does not exist between human beings in actual life. Neither is it as complete as has been assumed. This controversy will have to wait to be decided by further experiences of practitioners.

I made still other controversial technical suggestions aimed at intensifying the emotional experiences of the patient. One of them was changing the number of interviews in appropriate phases of the treatment in order to make the patient more vividly conscious of his dependency needs by frustrating them.

Another of my suggestions pertains to the ever-puzzling question of termination of treatment. The traditional belief is that the longer an analysis lasts, the greater is the probability of recovery. Experienced analysts more and more came to doubt the validity of this generalization. If anything, this is the exception; very long treatments lasting over many years do not seem to be the most successful ones. On the other hand, many so-called transference cures after very brief contact have been observed to be lasting. A clear correlation between duration of treatment and its results has not been established. There are no reliable criteria for the proper time of termination. Improvements observed during treatment often prove to be conditioned by the fact that the patient is still being treated. The patient's own inclination to terminate or to continue the treatment is not always a reliable indication. The complexity of the whole procedure and our inability to estimate precisely the proper time of termination induced me to employ the method of experimental

temporary interruptions, a method which in my experience is the most satisfactory procedure. At the same time it often reduces the total number of interviews. The technique of tentative temporary interruptions is based on trusting the natural recuperative powers of the human personality, which are largely underestimated by many psychoanalysts. There is an almost general trend toward "overtreatment." A universal regressive trend in human beings has been generally recognized by psychoanalysts. Under sufficient stress everyone tends to regress to the helpless state of infancy and seek help from others. The psychoanalytic treatment situation caters to this regressive attitude. As Freud stated, treatments often reach a point where the patient's will to be cured is outweighed by his wish to be treated.

In order to counteract this trend a continuous pressure on the patient is needed to make him ready to take over his own management as soon as possible. During temporary interruptions patients often discover that they can live without their analyst. When they return, the still not worked out emotional problems come clearly to the forefront.*

Furthermore, I called attention to Freud's distinction between twc forms of regression. He first described regression to a period of ego-development in which the patient was still happy, in which he functioned well. Later he described regressions to traumatic experiences, which he explained as attempts to master subsequently an overwhelming situation of the past. During psychoanalytic treatment both kinds of regression occur. Regressions to pretraumatic or preconflictual periods-although they offer excellent research opportunity for the study of personality development-are therapeutically not valuable. Often we find that the patient regresses in his free associations to preconflictual early infantile material as a maneuver to evade the essential pathogenic conflicts. This material appears as "deep material" and both patient and therapist in mutual self-deception spend a great deal of time and effort to analyze this essentially evasive material. The recent trend to look always for very early emotional conflicts between mother and infant as the most common source of neurotic disturbances is the result of overlooking this frequent regressive evasion of later essential pathogenic conflicts. Serious disturbances of the early symbiotic mother-child relation occur only with exceptionally disturbed mothers. The most common conflicts begin when the child has already a distinct feeling of being a person (ego-awareness) and relates to his human environment, to his parents and siblings as to individual persons. The oedipus complex and sibling rivalry are accordingly the common early sources of neurotic patterns.

* "This type of "fractioned analysis," which was practiced in the early days of the Outpatient Clinic of the Berlin Institute, is an empirical experimental way to find the correct time for termination.

There are many exceptions, of course, where the personality growth is disturbed in very early infancy.

Another issue which gained attention in the post-Freudian era is the therapist's neglect of the actual present life situation in favor of preoccupation with the patient's past history. This is based on the tenet that the present life circumstances are merely precipitating factors, mobilizing the patient's infantile neurosis. In general, of course, the present is always determined by the past. Freud in a rather early writing proposed the theory of complementary etiology. A person with severe ego defects acquired in the past will react to slight stress situations in his present life with severe reactions; a person with a relatively healthy past history will require more severe blows of life to regress into a neurotic state.[12] Some modern authors like French, Rado, myself, and others feel that there is an unwarranted neglect of the actual life circumstances.[1,15] The patient comes to the therapist when he is at the end of his rope, is entangled in emotional problems which have reached a point when he feels he needs help. These authors feel that the therapist never should allow the patient to forget that he came to him to resolve his present problem. The understanding of the past should always be subordinated to the problems of the present. Therapy is not the same as genetic research. Freud's early emphasis upon the reconstruction of past history was the result of his primary interest in research. At first he felt he must know the nature of the disease he proposes to cure. The interest in past history at the expense of the present is the residue of the historical period when research in personality dynamics of necessity was a prerequisite to develop a rational treatment method.

These controversial issues will have to wait for the verdict of history. Their significance cannot yet be evaluated with finality. One may state, however, that there is a growing inclination to question the universal validity of some habitual practices handed down by tradition over several generations of psychoanalysts. There is a trend toward greater flexibility in technique, attempting to adjust the technical details to the individual nature of the patient and his problems. This principle of flexibility was explicitly stressed by Edith Weigert, Thomas French, myself, and still others.

While there is considerable controversy concerning frequency of interviews, interruptions, termination, and the mutual relation between intellectual and emotional factors in treatment, there seems to be a universal consensus about the significance of the therapist's individual personality for the results of the treatment. This interest first manifested itself in several contributions dealing with the therapist's own emotional involvement in the patient—"the countertransference phenomenon." Freud first used the expression, countertransference, in 1910. It took,

however, about 30 years before the therapist's unconscious, spontaneous reactions toward the patient were explored as to their significance for the course of the treatment. The reasons for this neglect were both theoretical and practical. Originally Freud conceived the analyst's role in the treatment as a blank screen who carefully keeps his incognito and upon whom the patient can project any role, that of the image of his father (father transference), of mother (mother transference), or of any significant person in his past. In this way the patient can reexperience the important interpersonal events of his past undisturbed by the specific personality of the therapist. The phenomenon called "countertrans-ference," however, contradicts sharply the "blank screen" theory.

It is now generally recognized that in reality the analyst does not remain a blank screen, an uninvolved intellect, but is perceived by the patient as a concrete person. There is, however, a great deal of difference among present-day authors in the evaluation of the significance of the therapist's personality in general and his countertransference reactions in particular.

Some authors consider countertransference as an undesirable impurity just as the patient's emotional involvement with his therapist (transference) originally was considered as an undesirable complication. The ideal model of the treatment was that the patient should freely associate and thus reveal himself without controlling the train of his ideas, and should consider the therapist only as an expert who is trying to help him. Later, as is well known, the patient's emotional involvement turned out to be the dynamic axis of the treatment. So far as the therapist's involvement is concerned, it is considered by most authors as an unwanted impurity. The therapist should have only one reaction to the patient, the wish to understand him and give him an opportunity for readjustment through the insight offered to him by the therapist's interpretations. The latter should function as a pure intellect without being disturbed by any personal and subjective reactions to the patient.

The prevailing view is that the analyst's own emotional reactions should be considered as disturbing factors of the treatment.

Some authors, among them Edith Weigert, Frieda Fromm-Reichmann, Heimann, Benedek, and Salzman, however, mention certain assets of the countertransference; they point out that the analyst's understanding of his countertransference attitudes may give him a particularly valuable tool for understanding the patient's transference reactions.[5·13·14·16] As to the therapeutic significance of the countertransference, there is a great deal of disagreement. While Balint and Balint consider this impurity as negligible for the therapeutic process,[4] Benedek states in her paper on countertransference that the therapist's personality is the most important agent of the therapeutic process.[5] There is,

however, general agreement that a too intensive emotional involvement on the therapist's part is a seriously disturbing factor. Glover speaks of the "analyst's toilet" which he learns in his own personal analysis, which should free him from unwanted emotional participation in the treatment. This is, indeed, the most important objective of the training analysis; it helps him to know how to control and possibly even to change his spontaneous countertransference reactions.

I believe that the countertransference may be helpful or harmful. It is helpful when it differs from that parental attitude toward the child which contributed to the patient's emotional difficulties. The patient's neurotic attitudes developed not in a vacuum but as reactions to parental attitudes. If the therapist's reactions are different from these parental attitudes, the patient's emotional involvement with the therapist is not realistic. This challenges the patient to alter his reaction patterns. If, however, the specific countertransference of the therapist happens to be similar to the parental attitudes toward the child, the patient's neurotic reaction patterns will persist and an interminable analysis may result. There is no incentive for the patient to change his feelings. I recommended therefore that the therapist should be keenly aware of his own spontaneous-no matter how slight-feelings to the patient and should try to replace them by an interpersonal climate which is suited to correct the original neurotic patterns.

One of the most systematic revisions of the standard psychoanalytic procedure was undertaken by Sandor Rado, published in several writings, beginning in 1948.[15] His critical evaluation of psychoanalytic treatment and his suggested modifications deserve particular attention because for many years Rado has been known as one of the most thorough students of Freud's writings.

As years went on, Rado became more and more dissatisfied with the prevailing practice of psychoanalysis, and proposed his adaptational technique based on his "adaptational psychodynamics." As it is the case with many innovators, some of Rado's formulations consist in new terminology. Some of his new emphases, however, are highly significant. He is most concerned, as I am, with those features of the standard technique of psychoanalysis which foster regression without supplying a counterforce toward the patient's progression, that is to say, to his successful adaptation to the actual life situation. He raises the crucial question: Is the patient's understanding of his past development sufficient to induce a change in him? "To overcome repressions and thus be able to recall the past is one thing; to learn from it and be able to act on the new knowledge, another."[15]

Rado recommends, as a means to promote the goal of therapy, raising the patient from his earlier childlike adaptations to an appropriate

adult level-"to hold the patient as much as possible at the adult level of cooperation with the physician." The patient following his regressive trend "parentifies" the therapist but the therapist should counteract this trend and not allow himself to be pushed by the patient into the parent role. Rado criticizes orthodox psychoanalytic treatment as furthering the regressive urge of the patient by emphasizing the "punitive parentify-ing" transference (the patient's dependence upon the parentalized image of the therapist).[15] Rado points out that losing self-confidence is the main reason for the patient to build up the therapist into a powerful parent figure. Rado's main principle, therefore, is to "bolster up the patient's self-confidence on realistic grounds." He stresses the importance of dealing with the patient's actual present life conditions in all possible detail. Interpretations must always embrace the conscious as well as unconscious motivations. In concordance with mine and French's similar emphasis[1] Rado succinctly states: "Even when the biographical material on hand reaches far into the past, interpretation must always begin and end with the patient's present life performance, his present adaptive task. The significance of this rule cannot be overstated."

Rado considers his adaptational technique but a further development of the current psychoanalytic technique, not something basically contradictory to it. It should be pointed out that while criticizing the standard psychoanalytic procedure, Rado in reality criticizes current practice, but not theory. According to accepted theory, the patient's de-pendent-in Rado's term-"parentifying" transference should be resolved. The patient during treatment learns to understand his own motivations; this enables him to take over his own management. He assimilates the therapist's interpretations and gradually he can dispense with the therapist, from whom he has received all he needs. The therapeutic process thus recapitulates the process of emotional maturation; the child learns from the parents, incorporates their attitude and eventually will no longer need them for guidance. Rado's point becomes relevant when one points out that the current procedure does not always achieve this goal, and I may add, it unnecessarily prolongs the procedure. The reason for this is that the exploration of the past became an aim in itself, indeed the goal of the treatment. The past should be subordinated to a total grasp of the present life situation and serve as the basis for future adaptive accomplishments.

At this point my emphasis is pertinent, that it is imperative for the therapist to correctly estimate the time when his guidance becomes not only unnecessary but detrimental, inasmuch as it unnecessarily fosters the very dependency of the patient on the therapist which the latter tries to combat. I stated that deeds are stronger than words; the treatment should be interrupted at the right time in order to give the patient the

experience that he can now function on his own and thus gain that self-confidence which Rado tries to instill into the patient by "positive interpretations." No matter, however,-what technical devices they emphasize, the goal of these reformers is the same: to minimize the danger implicit in the psychotherapeutic situation, namely, encouraging undue regression and evasion of the current adaptive tasks. It is quite true that regression is necessary in order to give the patient opportunity to reexperience his early maladaptive patterns and grapple with them anew to find other more appropriate levels of feeling and behavior. The key to successful psychoanalytic therapy is, however, not to allow regression in the transference to become an aim in itself. It is necessary to control it.

In view of these controversies the need for a careful study of the therapeutic process became more and more recognized. Different research centers initiated programs from grants given by the Ford Foundation to study the therapeutic process. At the Mount Sinai Hospital in Los Angeles, under my direction, we undertook a study of the therapeutic process, in which a number of psychoanalysts observed the therapeutic interaction between therapist and patient in several treatment cases. All interviews were sound-recorded and both the participant observer-that is the therapist-and the nonparticipant observers recorded their evaluation of the process immediately after each interview. Our assumption was that the therapist, being an active participant in the interactional process, is not capable of recognizing and describing his own involvements with the same objectivity as those who observe him. His attention is necessarily focused on patient's material and, being himself involved in this complex interaction, cannot fully appreciate his own part in it. This expectation was fully borne out by our study.

As was expected the processing of the voluminous data thus collected proved to be a prolonged affair, which will require several years of collaborative work. Yet even at the present stage of processing, several important conclusions emerge. The most important of these is the fact that the traditional descriptions of the therapeutic process do not adequately reflect the immensely complex interaction between therapist and patient. The patient's reactions cannot be described fully as transference reactions. The patient reacts to the therapist as to a concrete person and not only as a representative of parental figures. The therapist's reactions also far exceed what is usually called countertransference. They include, in addition to this, interventions based on conscious deliberations and also his spontaneous idiosyncratic attitudes. Moreover, his own values are conveyed to the patient even if he consistently tries to protect his incognito. The patient reacts to the therapist's overt but also to his nonverbal hidden intentions and the therapist reacts to the patient's reaction to him. It is a truly transactional process.

In studying this transactional material I came to the conviction that the therapeutic process can be best understood in the terms of learning theory. Particularly the principle of reward and punishment and also the influence of repetitive experiences can be clearly recognized. Learning is defined as a change resulting from previous experiences. In every learning process, one can distinguish two components. First the motivational factor, namely, the subjective needs which activate the learning process and second, certain performances by which a new behavioral pattern suitable to fill the motivational need is actually acquired. In most general terms unfulfilled needs no matter what their nature may be—hunger for food, hunger for love, curiosity, the urge for mastery-initiate groping trial and error efforts which cease when an adequate behavioral response is found. Adequate responses lead to need satisfaction which is the reward for the effort. Rewarding responses are repeated until they become automatic and their repetition no longer requires effort and further experimentation. This is identical with the feedback mechanisms described in cybernetics. Every change of the total situation requires learning new adequate responses. Old learned patterns which were adequate in a previous situation must be unlearned. They are impediments to acquiring new adequate patterns.

I am not particularly concerned at this point with the controversy between the more mechanistic concepts of the older behaviorist theory and the newer Gestalt theory of learning. The controversy pertains to the nature of the process by which satisfactory behavior patterns are acquired. This controversy can be reduced to two suppositions. The older Thorndike and Pavlov models operate with the principle of contiguity or connectionism. Whenever a behavioral pattern becomes associated with both a specific motivating need and need satisfaction, the organism will automatically repeat the satisfactory performance whenever the same need arises. This view considers the organism as a passive receptor of external and internal stimuli, which become associated by contiguity. The organism's own active organizing function is neglected. The finding of the satisfactory pattern, according to the classical theory, takes place through blind trial and error.

In contrast, the Gestalt theoretical model operates with the supposition that the trials by which the organism finds satisfactory behavioral responses are not blind but are aided by cognitive processes. They are intelligent trials which are guided by certain generalizations arrived at with the aid of the memory of previous experiences. They imply an active organization of previous experiences. This organizational act amounts to a cognitive grasp of the total situation. I am not concerned at this juncture with the seemingly essential difference between the con-nectionistic and Gestalt theories of learning. Probably both types of

learning exist. The infant learns without much help from previous experiences. In this learning blind trials and errors must of necessity prevail. Common basis in all learning, whether it takes place through blind trials and errors or by intelligent trials, is the forging of a connection between three variables: a specific motivating impulse, a specific behavioral response, and a gratifying experience which is the reward.

Accepting Freud's definition of thinking as a substitute for acting, that is to say, as acting in phantasy, the reward principle can be well applied to intellectual solutions or problems. Groping trials and errors in thought-whether blind or guided by cognitive processes-lead eventually to a solution which clicks. Finding a solution which satisfies all the observations without contradictions is accompanied by a feeling of satisfaction. After a solution is found-occasionally it may be found accidentally—the problem-solving urge, as everyone knows who has tried to solve a mathematical equation or a chess puzzle, ceases and a feeling of satisfaction ensues. The tension state which prevails as long as the problem is not solved yields to a feeling of rest and fulfillment. This is the reward for the effort, whether it consists of blind or intelligent trials. The principle of reward can be applied not only to a rat learning to run a maze, but to the most complex thought processes as well. The therapeutic process can be well described in these terms of learning theory. The specific problem in therapy consists in finding an adequate interpersonal relation between therapist and patient. Initially this is distorted because the patient applies to this specific human interaction feeling-patterns and behavior-patterns which were formed in the patient's past and do not apply either to the actual therapeutic situation or to his actual life situation. During treatment the patient unlearns the old patterns and learns new ones. This complex process of relearning follows the same principles as the more simple relearning process hitherto studied by experimental psychologists. It contains cognitive elements as well as learning from actual interpersonal experiences which occur during the therapeutic interaction. These two components are intricately interwoven. They were described in psychoanalytic literature with the undefined, rather vague term *emotional insight.* The word *emotional* refers to the interpersonal experiences; the word *insight* refers to the cognitive element. The expression does not mean more than the recognition of the presence of both components. The psychological process to which the term refers is not yet spelled out in detail. Our present observational study is focused on a better understanding of this complex psychological phenomenom-emotional insight-which appears to us as the central factor in every learning process including psychoanalytic treatment. Every intellectual grasp, even when it concerns entirely nonutilitarian preoccupations, such as playful puzzle-solving efforts, is motivated by some

kind of urge for mastery and is accompanied with tension resolution as its reward. In psychotherapy the reward consists in less conflictful, more harmonious interpersonal relations, which the patient achieves first by adequately relating to his therapist, then to his environment, and eventually to his own ego ideal. At first he tries to gain the therapist's approval by living up to the supreme therapeutic principle-to the basic rule of frank self-expression. At the same time he tries to gain acceptance by living up to the therapist's expectations of him, which he senses in spite of the therapist's overt nonevaluating attitude. And finally, he tries to live up to his own genuine values, to his cherished image of himself. Far-reaching discrepancy between the therapist's and the patient's values is a common source of therapeutic impasse.

This gradually evolving dynamic process can be followed and described step by step in studies made by nonparticipant observers. Current studies give encouragement and hope that we shall eventually be able to understand more adequately this intricate interpersonal process and to account for therapeutic successes and failures. As in every field of science, general assumptions gradually yield to more specific ones which are obtained by meticulous controlled observations. The history of sciences teaches us that new and more adequate technical devices of observation and reasoning are responsible for advancements. In the field of psychotherapy the long overdue observation of the therapeutic process by nonparticipant observers is turning out to be the required methodological tool. This in itself, however, is not sufficient. The evaluation of the rich and new observational material calls for new theoretical perspectives. Learning theory appears to be at present the most satisfactory framework for the evaluation of observational data and for making valid generalizations. As it continuously happens at certain phases of thought development in a41 fields of science, different independent approaches merge and become integrated with each other. At present, we are witnessing the beginnings of a most promising integration of psychoanalytic theory with learning theory, which may lead to unpredictable advances in the theory and practice of the psychotherapies.

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