DEVELOPMENTALLY BASED PSYCHOTHERAPY

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INTERNATIONAL UNIVERSITIES PRESS, INC.
Madison Connecticut

Chapter I

Introduction to Developmentally Based Psychotherapy

Most psychotherapists use a developmental framework in their clinical work. Many recent developmental discoveries, however, have not yet found their way into this evolving frame of reference.

Developmentally Based Psychotherapy presents a new developmental theory that unifies and extends the practice of psychotherapy. It formulates therapeutic strategies based on recent discoveries of early presymbolic levels of adaptive and disturbed personality functioning, emerging understanding of the phases of development throughout the course of life, and observations of the biological aspects of symptom and character formation.

Over the past forty to fifty years, there has been an increase in both the types of problems presenting for psychotherapy and the available therapeutic approaches. Typical problems include circumscribed difficulties, such as anxiety states and phobias, and a growing range of character pathologies and borderline conditions dealing with self-esteem, narcissism, depression, relationships, and psychological boundaries. The growing array of

psychotherapeutic techniques to meet these diverse problems includes psychodynamic, object relations, and supportive approaches, as well as behavioral strategies and short-term therapies which use relationships, transference phenomenon, or guidance.

Many experienced therapists, however, rather than following a specific approach, have evolved their own unique eclectic approaches, which often contain a number of dynamic, relationship, and behavioral principles, coupled with what has been described as "nonspecific" factors, all seasoned with an emerging developmental framework that organizes and directs the therapeutic effort. The following list describes some of these tried and true tactics: (1) Forming a relationship that conveys a sense of warmth and acceptance and yet has boundaries that must be respected; (2) empathizing with the patient's difficulties as well as joys and satisfactions; (3) helping the patient fully describe problems, strengths, the subtleties in their relationships, and the full range of their feelings; (4) expanding the patient's ability to elaborate intentions, wishes, feelings, and fears; (5) assisting the patient in recognizing patterns in relationships, feelings, and difficulties; (6) increasing self-awareness of feelings, intentions, and interactive patterns that are not obvious to the patient; (7) helping the patient identify opposing tendencies or conflicts; (8) using imagery to understand inner life and, when appropriate (as in cognitive behavioral therapy), explore or construct new images to guide behavior; (9) breaking down complex behavioral patterns into smaller, learnable steps; (10) creating conditions for behavioral change (as in the differential reinforcement, i.e., encouragement or reward, of selected "appropriate" behaviors); (11) increasing tolerance for anxiety through systematic exposure to images or situations that are difficult (as in a desensitization procedure); and (12) helping with regulating and organizing attention and mood through support and guidance.

Many strategies on this list make "developmental sense." They contain the elements that promote emotional growth. In employing a variety of useful approaches, however, therapeutic efforts can sometimes work at cross purposes. Consider, for example, a person who never had successful relationships and avoids

them. He is inadvertently pushed out of therapy by a therapist who begins interpreting his "passive-aggressiveness" and his unwillingness to be committed and motivated when he keeps trying to change appointments. A different therapist empathizes with the patient's need to control the relationship, and at the same time tries to build a relationship by becoming as flexible as possible, offering telephone consultations and changes within a reasonable range. He does much better with this patient who was just learning to form relationships and was not yet able to reflect on the feelings associated with relating to others.

Alternatively, consider a person who was on the verge of talking about longing or needy feelings that he had avoided for a long time. He was introducing these feelings by talking about how the therapist was not active enough and did not at that very moment meet his needs. The therapist offers advice to show he is a giving, caring person, but in so doing, misses an opportunity to help the patient become more aware of and learn to elaborate feared-and-avoided longing feelings.

In these two examples, an understanding of exactly where the patient is in his emotional development and therapy would enable the therapist to pick the right technique; in the first instance, providing more support for developing relationships and in the second instance providing more opportunity to explore feelings rather than to meet expressed needs directly.

In addition, with the greater diversity of approaches currently available, individuals often select the type of therapy that they feel would be helpful to them. This "choice," however, can be a two-edged sword. On the one hand, it gives the patient a chance to choose. On the other hand, it provides an opportunity for the patient to select an approach that may fit with and actually support his characterological difficulties rather than help him get over them. For example, a patient who has a fundamental problem with experiencing and finding symbols or words for a range of feelings may understandably select an approach that emphasizes only changing behavior or using medication, even though his most significant problem has to do with learning to experience and elaborate feelings. Alternatively, a person who is comfortable

talking and is already a poet of his or her feelings, but avoids certain types of life endeavors, may elect a type of "talking" therapy or a therapist that enables him to "continue to hide out" from avoided challenges. Similarly, an individual who tends to control his feelings may elect a cognitive-behavior therapy because he is attracted to its precise, planned nature. Images can be anticipated. Such an approach, however, may support an unrealistic desire to control his inner world.

We need to move to a position where the patient does not simply knock on the door to obtain what he wants (because what he wants may not always be what is needed), but where the therapist helps educate the patient about what approach would provide emotional growth.

Seasoned therapists tend to construct their own developmental road map to deal with these challenges and guide their efforts. They also use theoretical concepts related to developmental understanding of the personality, such as concepts of separation and individuation developed by Margaret Mahler and those on the formation of the self described by Heinz Kohut.

Most clinicians of all persuasions, however, believe there is a need for a more systematic understanding of human development, for example, in psychodynamic approaches to fill in the missing pieces of emotional development and in behavioral approaches to identify better the most relevant patterns of behaviors, thoughts, and reinforcers.

Clinical observations and studies during the last twenty years have made it possible to construct a more comprehensive developmental framework. The pioneering developmental discoveries of Freud and Anna Freud, as well as Piaget, Erikson, Mahler, and Kohut, have been added on to by a variety of studies (see Appendix for review). For example, we have been able to conduct clinical studies of development in the face of family and psychosocial challenges, biological and maturational challenges, and in normative contexts. From these observations, we have constructed a systematic, biopsychosocial developmental model (Greenspan, 1989, 1992).

In the following chapters of *Developmentally Based Psychotherapy,* we will examine the implications of these insights about human development and emotional learning for the practice of psychotherapy. We will build a model of psychotherapy that is grounded in the processes of emotional and cognitive growth. This model, which incorporates therapeutic principles that many clinicians have found helpful, will facilitate clinical observation, judgment, planning, and research. Most importantly, this developmental road map will make it possible to construct new strategies, particularly for the most difficult clinical conditions.

For example, it has constructed new tactics to work with a wide range of clinical problems, including the following types of challenges:

1. Physical and temperamental differences in patients including five characteristic constitutional types that predispose to anxiety disorders, disturbances in affect, aggressive or antisocial behavior, tendencies toward self-absorption and reality testing problems, oppositional defiant and compulsive patterns, and problems with regulating attention, impulses, and behavior.
2. Problems in forming, maintaining, and deepening relationships, including dealing with relationship capacities that are superficial, unstable, rejection-sensitive, and/or avoidant.
3. Difficulties at the deepest levels of character structure, including distorted affective expectations and responses, such as suspiciousness, and depressive, impulsive, and passive avoidant patterns.
4. Deficits in the ability to form inner images (mental representations) and construct feeling states, wishes, and fantasies from preverbal intentions and dispositions.
5. Problems in building logical, reality-based bridges between different intentions, wishes, and feelings, self and other images, and engaging adaptively in relationships and feelings characterizing such advanced levels of development as forming an integrated capacity for morality,

carrying out the responsibilities of adulthood and parenthood, and negotiating the aging process.

A new developmental paradigm for psychotherapy is especially important at this time. Numerous approaches are being used, but in an unintegrated manner. Classical psychoanalytic and derivative approaches are being used less and less, both because of the number of individuals with severe psychopathologies that lie outside the range of classical analytic techniques and the economics of mental health services, demanding shorter, less in-depth approaches. Short-term eclectic, supportive, behavioral, somatic, and guidance-oriented approaches are on the increase.

With these current trends, there is some danger that we will lose in-depth understanding of the mind. Developmentally based approaches, however, have the potential for investigating the depth of the mind in a way that stays close to clinical observations. Building on the insights of reconstructive work, a comprehensive developmental model preserves the dynamic, in-depth focus so necessary for a functional understanding of human beings. At the same time, it provides the basis for developing techniques that can meaningfully extend the practice of psychotherapy.

Chapter 2

Principles of Developmentally Based Therapy

The overarching principle of a developmentally based approach to psychotherapy is mobilization of the developmental processes associated with an adaptive progression of the personality throughout childhood and adulthood. The therapeutic relationship is the vehicle for mobilizing developmental processes in the therapy sessions and for helping the patient create developmentally facilitating experiences outside the therapy situation.

Patients present to therapy with a variety of challenges, some of the most familiar of which have to do with anxieties and conflicts that interfere with healthy adaptation. More commonly, however, patients present with ongoing characterologic difficulties where patterns of experiencing emotions, thoughts, and behaviors are either unmodulated, constricted, or reflect developmentally early interactions, rather than age-appropriate ones. Still other patients present with deficits in core capacities, such as emotional or behavioral regulation, or the organization of affect and thought. This latter group also often demonstrates patterns of interaction related to very early levels of character formation.

Helping patients verbalize feelings, alter their behaviors, and alter patterns of thinking are all potentially helpful for aspects of a problem or certain narrowly defined problems. Rarely, however, do they provide the basis for facilitating the overall growth of the personality, and often may not suffice to reverse the more challenging types of symptoms or behaviors. A series of principles will now be described that form the basis for a developmentally based approach to psychotherapy. These principles outline processes that attempt to mobilize the individual's capacity for an overall developmental progression, as well as overcoming severe emotional and characterological challenges.

The first and foremost principle. in the developmental model is that we try to build on the patient's natural inclinations and interests to try to harness a number of core developmental processes at the same time. These core processes have to do with self-regulation, forming intimate relationships, engaging in simple boundary-defining gestures, and complex preverbal, self-defining communication. They also have to do with representing internal experience, including representing and abstracting wishes, intentions, and affects, and finally to become able to differentiate these internal representations and build bridges between them. Where the patient has not reached a certain level, the therapist engages him or her at the levels that have been mastered, and begins the process of working toward experiences that will facilitate the new levels.

In traditional psychoanalytic and psychodynamic therapies, it is mistakenly assumed that many patients can use a highly differentiated representational system to perceive, interpret, and work through earlier experiences and conflicts. Patients are thought to regress from higher to lower levels of thoughts, affect, wish and behavior while retaining the necessary ego functions for representation and self reflection. For example, as noted in the previous chapter, we sometimes assume that almost all patients can picture and verbalize their wishes and feelings, and step away from the urgency of their feelings long enough to explore where they came from and what they mean. Most patients, however, do not have a highly differentiated representational system. Many cannot represent wishes and affects or can barely represent only certain

wishes or affect states, let alone explore their meanings. Others cannot sustain relationships or regulate mood impulses or sensations. More often than not, these limitations are *not* regressions from advanced states of ego organization, but limitations or constrictions stemming from the types of interactions that were experienced during development. Therefore, one must work clinically at a number of developmental levels at once. We cannot maintain an illusion that patients function at a higher developmental level than they do.

The core developmental processes that we see in normal development can go awry in one form or another, resulting in various kinds of psychopathology. For each of the stages and processes, which will be described in detail in the following chapters, a patient may have a deficit or a constriction. A deficit means the processes that ordinarily are mastered at that stage were not mastered. A constriction means the processes for a particular stage were partially mastered. The patient may have a constriction in terms of the range of emotions mastered or the stability of the processes under challenges. For example some patients may have a deficit in representing any affect and instead act out their feelings. Other patients may only have a constriction in representing selected feelings such as anger or may loose their capacity when anxious. Through the psychotherapeutic process, these developmental stages and processes are reworked. For example, the withdrawn patient needs to be engaged; the patient who escapes into fantasy needs to learn to build on the communications of others; and the concrete, acting out patient needs to learn to symbolize or represent intentions, wishes, and affects. Developmentally based psychotherapy creates a therapeutic relationship where all the core levels are supported at the same time. The therapist attempts to mobilize attention, engagement, prerepresentational and representational communication patterns, and when they are not present helps the patient construct them.

Mobilizing developmental process does not mean structuring experience. The therapist must follow the patient's internal inclinations through his spontaneous communications. The patient's affects, behaviors, and words tell the therapist where the patient

is in his development. They also create an emotional-personal basis for growth.

Some of the traditional perspectives in therapy only support one or two of these core developmental processes and not others. Approaches which tend to integrate more of these developmental processes are going to be more potent in helping individuals overcome difficulties. The developmental model also offers a framework for comparing different therapeutic approaches and seeing which ones are likely to be helpful, under which circumstances, and for which kinds of psychopathologic conditions.

The second principle involves the therapist always meeting the individual that he or she is working with at the patient's specific developmental level. It is essential not to make the mistake of communicating with the patient in a manner that is inappropriately abstract or primitive. For example, some individuals do not have the capacity for verbal expression of emotions. They may operate on a more primitive level where affect spills over immediately into behavior. They stomp and yell and scream when they are angry; they cling when they are needy. They don't commonly (unless you put the words in their mouths) say, "I feel angry" or "I miss you so much that I think about you all the time." We often put those words in a patient's mouth, yet they really may not be able to abstract affect in that way. If such patients should begin to act out aggressively or withdraw after the therapist's vacation, for example, offering them an interpretation like, "Gee, you must have missed me and are showing me your anger by stubbing out your cigarettes on my couch," will go right over their heads. The patient may nod, but if he is operating at a more primitive level, he simply won't get it. It won't be a meaningful intervention because the patient would have to be at a very highly differentiated level to process that kind of interpretation. Not only would such a patient need to be able to represent affect, he would have to be able to see connections between different affects ("I missed you, and therefore I'm mad"), and he would have to be able to self-observe while he was seeing this connection.

We find ourselves inadvertently pitching a high-level interpretation when the patient is still at an earlier level, and often

the exchange has little value to it. It makes us feel we are earning our fee, and not just sitting there wasting our time, but it is not very meaningful to the patient beyond conveying our interest or concern. The challenges of regulating and attending, relating with depth and intimacy, and sending and responding to nonverbal gestural cues without distortion can occupy the therapeutic stage for a considerable period of time. Ignoring these issues or seeing them as secondary to problems at a higher level can create rather than help overcome therapeutic obstacles.

We often make the parallel error of underestimating the patient's developmental level. Take, for example, a person who is capable of representing affects and understanding connections. We may try to overnurture them by being extra supportive and empathetic, not realizing that we are infantilizing them. They may actually operate at a level where they can see connections between different wishes and affect states and figure out things on their own. Thus, we may inadvertently lull them into a state of greater dependency than they need to be.

It is evident, then, that we have to make an initial developmental diagnosis of the patient's character structure (see Appendix). In focusing on the developmental level a patient has more or less attained in his communicative capacities, one also looks at the different themes of emotional life, including dependency and closeness; pleasure, excitement, and sexuality; assertiveness, curiosity, competition, anger, and aggression; self-limit-setting; and empathy and more mature forms of love. These themes encompass much of the emotional human drama.

When considering the above themes, remember that dependency includes separation anxiety, and that the flip side of aggression includes fears and worries about aggression. We look at the degree to which a developmental level can organize certain themes and not organize others. For example, how does a person deal with dependency and closeness? Does he use highly differentiated, extended representational capacities, or just gestures? Does he become aloof and distant when he is dealing with themes of dependency, avoiding engagement almost entirely? It should

be pointed out, however, that the person invariably communicates about all these emotional themes in one way or another. Even disengagement and aloofness are ways of communicating.

As indicated earlier the clinician needs a sense of the developmental levels mastered by a given patient in terms of the relative degree of deficit in any level versus mastery at that level. He or she also needs to have a sense of the range and specific types of emotions or experiences that can be organized at each particular level, in terms of the different thematic, affective domains. With this knowledge to hand the clinician is in a good position to anticipate some of the issues that will be coming up in his or her therapeutic interventions. The clinician can anticipate whether the main issue will be fostering engagement and relatedness, or whether it will be even more basic, such as helping the person organize behaviors, affects, and thoughts; or whether the main issue will be in helping the person broaden his or her ability to elaborate certain feelings and themes.

As the therapist gets a sense of where his patient is developmentally, and anticipates where some of the initial therapeutic goals and objectives will lie, he or she is also anticipating some of the issues that may get played out between clinician and patient. Consider a concrete example. The patient misses sessions and is aloof as the therapy sessions come to an end. The therapist may be tempted to say, "I can see that you've become a little bit aloof and preoccupied every time you seem to be angry with me. This seems to occur just before the end of the session as you're anticipating my ushering you out of the door. Frequently, you miss the next session."

If, however, the therapist sees the patient is not able to represent affects and see connections between them, the only way he might have of dealing with that coolness is through the quality of his or her own engagement and relatedness. In fact, drawing a patient's attention to the possible sequence of his thoughts may have no impact. Such an intervention may be contraindicated because it may drive the patient away from therapy, overloading him with representational information which he cannot comprehend and which he may experience as hostile and threatening.

When patients have been driven from therapy by having been asked prematurely to look at connections between feelings that they cannot yet represent, therapists often mistakenly think it is because they are pushing the patients to look at "repressed feelings" too quickly (i.e., by interpreting their anger or sexual wishes). In many instances, however, the problem is not so much the premature discussion of a repressed or unconscious impulse, but is instead the inability to relate to patients at their own developmental levels. It is this inability that such patients experience as sadistic and rejecting. It tends to overload patients who already may be feeling overloaded by their own affects, which they can barely organize or represent.

The clinician might well wonder how he would use developmental understanding to deal with a person who was becoming more aloof before the end of the session, but who had not achieved a mastery of representational capacities to handle such feelings. He might, for example, as the patient was beginning to withdraw, metaphorically reach out by using an especially soothing tone of voice and assuming a gentle facial expression and nonthreatening motor gestures. He might also empathize aloud with the fact that sometimes beginnings and endings are best approached gradually. The therapist may focus on behavioral and some general affective components of the transition, and not on feelings. He might try to see the adaptive side of the patient's becoming aloof, which is to prepare for what may be a very difficult transition (e.g., "sometimes it's easier to say goodbye slowly"). A developmentally derived, seemingly supportive comment is not of less value than a representational one. It greets the patient where he is developmentally, much as later on in the therapeutic relationship, an insight about the sequence of the patient's thoughts and feelings may greet the patient where he or she is at that particular point.

In addition to commenting on how hard it is to make the transition, and doing extra wooing and reaching out with voice and gesture (of course being respectful of the person's need to also keep his distance), the therapist might also pay attention to

the apprehension around leaving. He might talk in a very concrete sense (using behavioral imagery) about what will happen the next day or during the next session. What will it be like when the person returns? What might the person want to look at or talk about? Also, he might ask in a rather concrete, behavioral sense about what experiences the person might anticipate between the two sessions-things that will be going on at home, school, or work. In this way, there are concrete behavioral details of a person's life that are helping to make a transition from the images at the end of the session to the images between the sessions or of the next session. This sort of bridge will help the patient make the transition, yet it does not push him to abstract feeling states, such as how he feels about leaving or how he will feel while away. It creates a sense of security for the next steps in the therapeutic process.

An early step in the therapeutic relationship, therefore, is to gain a sense of where the person is developmentally so that the clinician can select an approach that is therapeutically appropriate. It is worth emphasizing that the diagnostic process used to determine the developmental level of the patient and its relationship to more traditional diagnostic categories, need not be confined to the initial set of interviews. In a developmental psychotherapeutic approach, the therapist is continually monitoring and revising his or her impressions of the person's developmental level. As therapy proceeds and development moves ahead, the developmental level may well be moving to higher and more progressive levels. In fact, the most appropriate way of assessing the progress in therapy is through assessing the shifts in the patient's developmental level and the broadening of experiential realms that can be organized at each level (see Appendix). This, along with changes in symptoms, is the appropriate way to look at the efficacy of psychotherapy (Greenspan and Scharfstein, 1981).

The third principle is that a therapist should aim to effect change by helping the patient negotiate the developmental level or levels he has not mastered, or only partially mastered. They may have been bypassed earlier in life, which at present is in evidence as a deficit or constriction. In facilitating the negotiation of a developmental level,

the therapist is not simply a commentator or insight giver, but a *collaborator in the construction of experience.* The therapist does this within the traditional boundaries of the therapeutic relationship, arid not by role-playing or reenacting "real" relationships. Collaborating in the construction of experience should not be confused with historical tactics, such as a "corrective emotional experience" where the therapist may, for example, deliberately take an extra vacation to stimulate certain feelings in the patient. Such contrived strategies can undermine the naturally occurring affects that will characterize the therapeutic relationship.

Rather, the therapist uses the tools of communication available to him or her within the confines of the therapeutic role of following and dealing with the patient's spontaneous communications, verbal and nonverbal. As a collaborative constructor of experience, the therapist is aware of the different developmental levels of the therapeutic relationship. He does not limit himself to exploring only the more representational levels. He is also aware of the importance of the interactive experience, guided by the patient's natural inclinations. He responds to the patient's inclinations and communications, rather than initiating the themes, but does so at multiple developmental levels. As a collaborator of experience, the therapist has to be especially aware of his or her own countertransference tendencies so that the therapeutic explorations reflect the patient's natural, spontaneous inclinations and communications at multiple developmental levels. The therapist listens, empathizes, and offers developmentally useful communications, while the patient explores his experiences as best he can. In maintaining the integrity of the therapeutic relationship, he allows for future transference configurations.

While the subsequent chapters will provide the principles and clinical illustrations to amplify how the roles of constructor and collaborator work, a brief illustration may be helpful at this point. Consider a patient who tends to withdraw during the sessions and become aloof and mechanical in his affect. Traditionally, the therapist might be very patient and comment once or twice about the patient's aloofness or tendency to withdraw, but not do anything to alter that state of withdrawal directly, other

than comment on it intellectually. Months, or even years, may go by with a relatively mechanical therapist and an equally mechanical patient, with little or no affect exchange taking place. If the patient were at an advanced representationally differentiated level and could abstract affect and see connections, the therapist might be able to effect change by this approach. For example, the therapist might muse along the lines of, "Every time you seem mad at me, you tend to withdraw." Such a comment may help open up the patient's associations.

But with the patient who is not representationally differentiated, and who is, instead, primitively organized and tends to withdraw anytime he feels intensity of affect of any kind, the therapist must pay attention to and focus on subtleties in the patient's nonverbal behavior and affective tone. Let us postulate, for example, that this person's mother was intrusive and his father was very emotionally removed. Neither parent successfully found a way to woo this very sensitive person into a more intimate pattern of relating. The therapist pays careful attention to his mood and physical sensations while the patient is in various states of attention and relatedness. The therapist, rather than using the tone he uses with most other patients, needs to find a particular tone and rhythm (e.g., using voice tone and rhythm and facial gestures, to maintain a sense of relatedness) that will work with this particular patient. The establishment of this pattern may be a critical first therapeutic step. Rather than comment on how the patient is afraid of his direct gaze, the therapist maintains the rhythms that increases relatedness and wonders about what type of voice tone or looks the patient finds most comforting. For example, the therapist notes that when he talks assertively and looks directly at the patient the patient becomes more aloof. When he talks softly and looks slightly to the side of the patient, only periodically looking directly at him or her, the patient is more engaged.

The therapist and patient then observe and experience different states of relatedness together; they explore at the same time. Initially, they do not explore historical or even current complex patterns of wishes and feelings. They explore, in a supportive manner, aspects of their interaction (e.g., the patient may be

helped to see if he finds the therapist's voice soothing or irritating). The therapist uses the boundaries of the therapeutic relationship in a new way, but still maintains those boundaries.

In general, the therapist is attempting to first broaden the range of experiences dealt with at the developmental level where the patient is. For example, if the patient avoids assertion or aggression or intimacy, the therapist's initial goal is to facilitate a full range of feelings at his current level. The next goal is to help the patient move up to the next level. For each developmental level, each chapter will discuss in some detail how to meet these two goals.

The fourth principle, while generally accepted in most dynamic therapies, is often ignored. The therapist should always promote the patient's self-sufficiency and assertiveness. The way learning occurs in life, and particularly in the psychotherapeutic process, is through the person's own active discovery in the context of the relationship he develops with the therapist. For example, it is often not helpful to make comments on the person's behavior or affects, while the person nods acceptingly, and then goes on free associating. On the other hand, it is the active learning done by the patient himself, as opposed to the passive nodding acceptance of what the therapist says and does, that proves to be more helpfill. Always promote the person's own assertiveness, self-sufficiency, and active construction of their experiences, as opposed to the more passive, compliant acceptance of what we may have to offer them. Not infrequently, in the enthusiasm of the moment, we assume that the patient's nod or compliant free associations along the lines we suggest is proof of the value of our insight.

Part of the individual's self-sufficiency is rooted in his or her ability to create growth producing experiences in other relationships in addition to the therapeutic one. As a particular issue is being mastered, the therapist needs to actively explore factors that might be interfering with the patient taking this step.

The therapeutic goal, then, is to build on the patient's natural inclinations and interests (i.e., follow his lead) and look for opportunities to collaborate in recreating developmental experiences that are going to help the individual negotiate for the first

time, or renegotiate, aspects of development that he was never able to resolve for himself. The preceding four generic principles of (1) harnessing core processes; (2) meeting patients at their developmental levels; (3) renegotiating bypassed levels; and (4) promoting the patient's self-sufficiency, form the framework of this developmental approach to therapy.

These four principles, however, rest on an understanding of the six core developmental processes that are part of all therapeutic relationships (Greenspan, 1989, 1992). Of special importance to better understanding the developmental basis of psychotherapy is the fact that the representational system, so central to most dynamic therapies, only deals with the most surface aspects of ego functioning. The ability to represent experience and elaborate representations, and the ability to differentiate between representations, are the two levels of ego functioning acquired in later stages of ego development (i.e., when children are already verbal and symbolic). There are four earlier levels that must also be dealt with, which deal with the way experience is organized prerepresentationally. They include how regulation (sensory reactivity and processing) occurs; the way early engagements and relationships are formed and elaborated; and how early simple and complex, intentional, gestural communication becomes a part of a prerepresentational pattern of mental organization.

By being aware of early stages of ego development, the therapist has greater empathetic range. He can go beyond empathy to be an actual facilitator of new ego development. While intuitive therapists have always been able to empathize with early affective states, most therapists will be aided by a theoretical road map indicating what sensory, regulatory, gestural, behavioral, and affective signposts to look out for. Blind spots due to countertransference phenomena and the therapist's own experiences naturally limit one's empathetic range to some degree.

The patient who does not come into therapy at a level of representational differentiation requires assistance in moving up the developmental ladder. Remember, only the rare representationally differentiated patient is capable of abstracting affect states, making connections between them in the present and the

past, and observing their relevance for his or her behavior, moods, and wishes. For most patients, the therapist must negotiate two roles: empathizer-clarifier (and eventually interpreter), regulator-engager-interacter, and collaborative constructor of experience. The therapist's dual role will be highlighted in later chapters describing clinical work on early and later states of ego organization.

AFFECT AND INTERACTION: THE BASIS FOR EGO DEVELOPMENT AND INTELLIGENCE

The therapist's role is based on the critical notion that development occurs from interaction. This notion emerged from our observation that both emotional and intellectual growth depend on affective interactions and these interactions can be harnessed in various contexts. Putting affect and interaction in the central role in mobilizing development as well as change and growth in the therapeutic situation is supported by our observations of infants and children. In this model, interactions are, in a sense, the fuel that mobilizes the mind's various functions. These interactions create opportunities for affective interchange and these affects are then vital to the way in which the mind organizes itself and functions. Each interaction gives rise to affects such as pleasure, annoyance, surprise, sadness, anger, curiosity, and so forth. Variations in the quality and intensity of these and other affects make for almost infinite variety of affect patterns. As will become clear shortly, the affects, in many respects, operate as the orchestra leader, organizing and differentiating the mind's many functions. Affects stemming from interactions become the foundation for both ego growth and differentiation and, more broadly, for intelligence (Greenspan, 1979). Developmentally based therapy promotes intelligence as well as emotional growth and serves as a general and basic mobilizer of developmental processes. While ego growth is not a surprising concomitant of affective interchanges, cognitive or intellectual abilities are not usually thought

of as stemming from interactive and affective patterns. To see why they do, consider the following.

A child is learning to say "hello." Is this seemingly simple cognitive task learned by the child being taught to say hello only to close friends, relatives, and those who live within a quarter mile of his house? Does he think to himself with every new person, "Where does this person live in relationship to me?" Or, is the decision when to say hello mediated by an affective cue, such as a warm feeling in one's own body as one sees a familiar, friendly face, which, without even thinking, leads to the smile, the hello, and an extended hand. If it's the latter, we would promote it by creating opportunities for interactions where the child could link his affects, thoughts, and behaviors.

In an even more elaborate example, we posed a simple question to three young boys: What do you think about people who are bossy or try to boss you? First to reply was a five-year-old who, because of developmental difficulties early in life, lacked the emotional pathways that permitted creative and intuitive thought. "Well," said this articulate youngster, "let's see. Parents are bosses and teachers are bosses and sometimes baby-sitters are bosses." He then tried to list other types of bosses with no other elaborations or discussion. Rather like a living computer, he rattled off a formal classification of different types of bosses, but made no observations that tied these categories to his own life. A five-and-a-half-year-old without developmental or emotional difficulties gave a strikingly different response. "Most of the time I don't like being bossed," he said, "especially when my parents get too bossy and try to tell me when I can watch TV and when I should sleep, and I'm big enough to decide that myself." This youngster found his answer in his own, apparently generally irritating, brushes with bosses. Rather than simply cataloguing categories or incidents, however, he abstracted a principle from their emotional core ("most of the time I don't like it") and then illustrated with a case in point ("especially when my parents . . .") that he supported with a possibly controversial, but nonetheless reasoned, argument ("I'm big enough to decide that myself.")

A normally developing eight-year-old gave an even more refined answer. "Sometimes I don't like it," he said, "especially when there are things I want to do and they don't let me, but sometimes it's OK because adults know best." He next listed examples of unreasonably bossy parents and teachers, then went on to relate his own reaction to his mood. When he was in a bad mood, he particularly resented being bossed, but at other times he didn't mind so much. He even noted different styles of bossiness. Sometimes people were nice about it; bosses who don't show "dagger eyes" didn't bother him nearly as much as those with a "mean tone of voice." Asked to sum up, he offered, "I guess I don't have just one answer, but there are times when I don't like it and times when it's OK. It depends on how they do it and what kind of mood I'm in."

We see that such an elaborate intellectual activity requires two components: the affectively mediated creation of personal experience and the logical analysis of these experiences.

We have observed that almost every intellectual experience an infant, young child, or adult has involves these two components: an affective one as well as a more purely cognitive one. This process begins early in development. The earliest experiences are double-coded according to both their physical and affective properties. The affects, in fact, appear to work like a sensory organ, providing critical information. For example, the ball is red, but looking at it also feels nice, scary, or interesting. The food is yellow and firm and affectively is delightful or annoying. As a child learns about size, shape and quantity, each of these experiences are also both emotional and cognitive. For example, "a lot" is more than you expected. "A long time" is the rest of your life. The ability to count or formalize these quantities is simply the formal classification of what you already affectively know.

Complex abstract concepts, like love, honor, or justice, are also the products of these same processes. The word has a formal, cognitive definition, but to comprehend or create this definition requires a range of personal affective experience. "Love," for example, is pleasure and excitement, but it is also commitment and loyalty, as well as the ability to forgive and recover from anger.

Taken together, these affective experiences associated with the word give it its full abstract meaning. We have observed that children and adults who remain concrete have difficulty with integrating multiple affective experiences into a word or concept.

Affects are also, as indicated earlier, at the foundation of our most basic ego functions. Our sense of "self" and "other" differentiates out of literally an infinite number of subtle affective interchanges at each of the stages of ego development. In addition, the selection of defenses or coping strategies is often mediated by affects. When a child avoids an angry encounter and becomes compliant and sweet, there is often the affect of fear mediating this change in the child's behavior, feeling tone, and ideas. When an adult avoids intimacy or competition, there are sometimes unpleasant affects associated with these types of interactions mediating the avoidance. As we will describe in more detail later, there is a hierarchy of ways in which the ego copes with underlying affects. These include disorganized behavioral patterns, states of self-absorption, intentional impulsive patterns, somatically experienced affects, polarized, global emotions and beliefs, and represented, symbolized feelings and experiences (from fragmented to cohesive integrated forms).

In our developmental model, therefore, interactions and their associated affects mobilize all aspects of development, emotional as well as cognitive. A wise person is both intellectually and emotionally wise. The two can't be separated. There are, of course, individuals who have isolated areas of cognitive skill (perhaps in science, math, or the arts) and there are other individuals who may have highly differentiated ego structures who lack some of these areas of skill. But overall intelligence, wisdom, and emotional maturity are part of one and the same process. An integrated and differentiated human being is one who can negotiate all the areas of their age-expected functioning, emotional, social, and intellectual.

The affects, as they come into place and as therapeutic experiences harness them, however, not only differentiate and develop our personalities but they serve as the "orchestra leader" for our many ego functions and capacities. When we are trying to

remember something quickly or figure out which cognitive operation to use, we don't logically explore all the various alternatives. We quickly come to the strategy or memory through our emotional orchestra leader. The emotions in this sense provide the software programming that organizes and differentiates our intelligence. Similarly, when we automatically use a particular defense coping strategy or regressive route, these same affects are determining the selected operations.

Therapeutic interactions, which generate affects, are at the foundation of developmentally based psychotherapy. In the chapters that follow, we will see how each component of ego development requires certain types of interactions and affective experience. The challenge of the therapeutic process is to figure out ways to harness these as a part of the therapeutic relationship. One must always remember, however, that the therapeutic relationship is only a component of the person's overall set of relationships and, therefore, one needs to help the patient create opportunities for interactive and affective experiences in other sectors of his life. The therapeutic relationship that attempts to provide the critical experiences in the patient's life, rather than assist the patient in orchestrating such life experiences, may limit necessary and healthy age-expected interactions.

SIX LEVELS OF THE MIND (EGO)

In addition to facilitating intellectual and emotional growth in a general sense, affective interactions bring together biology and experience and lead to the construction of a number of basic ego capacities. Observations, clinical work, and studies of infants and young children have enabled us to describe these interactions and formulate six early stages and processes in ego development. In addition, new insights have revealed to us how these stages and processes are formed, including the relative contributions from various sources, biological (constitutional and maturational variations), environmental, cultural, and interactive.

The sequence of intrapsychic organizations that characterizes early ego structure formation includes the organizations that precede our ability to represent experience. In addition, there is emerging understanding of how *individual differences,* in terms of biological aspects of constitutional and maturational phenomena, contribute to the structure of the ego. This is in keeping with Freud's goal of understanding the biological aspects of ego development, especially the biological aspects of defenses (see chapter 3). The organizational levels encompass the following six formations:

l. Self-regulation, in which perceptual differences in sensory-affective reactivity and processing as well as behavioral sequencing contribute to the capacity to deal with the world and the development of specific types of personality or character structure.
2. Formation and maintenance of relationships as a basis for the capacity for object relatedness and intimacy.
3. Boundary-defining, prerepresentational interactions, which contribute to the formation of discrete wishes, affects, intentional behaviors and the most basic sense of reality and a partial self-differentiation.
4. The emergence of a presymbolic complex sense of self and "other" through interactive sequences that involve behavioral and affective patterns contributes to character tendencies around core emotional themes such as dependency, pleasure, gender, assertiveness, aggression, love and concern for others.
5. Representational elaboration as a basis for symbolizing wishes and affects, creating fantasies and constructing internal self and object, representational elaborations.
6. Representational differentiation as a basis for reality testing, impulse control, stable moods, self-observing capacity and internal self and object differentiations and integration.

The different levels of ego organization not only have certain structural features, but there are certain themes or "content"

that go along with either mastering the stage or having difficulties with the stage. A few examples will follow.

From the stage and processes of self regulation, attention, and interest in the world, children and adults get a sense of confidence in their ability to be calm, regulated, and interested in the world. They also may have a feeling of basic security in the way their bodies work, especially their perceptual and motor equipment. A sense of control often goes along. When difficulties during this stage arise, we not infrequently see themes concerned with being overwhelmed, falling apart, as well as at times, attempts at omnipotent over-control creating order and manipulating selected sensory or motor experiences.

The second stage and set of processes dealing with engagement and patterns of intimate relating can provide the basis for warmth, security with dependency feelings and a sense of optimism and pleasure in relationship to others. In addition there are also themes of positive nurturance. In contrast, difficulties with this stage and its processes can be associated with feelings and themes of isolation, emptiness, greed, preoccupation with inanimate objects, and overreaction to expectable relationship challenges, such as temporary losses or disappointments. At times one also sees compensatory themes centered around grandiosity and the need for unconditional love.

At the third stage and set of processes, the capacity for intentional gestural and affective communication can be associated with constructing more defined affective states such as pleasure, joy, anger, fear, feeling asssertive and confident, as well as developing curiosity about others and the world. A "can do" sense of mastery also emerges from this level. Difficulties with this stage may be associated with the sense that interactions can be chaotic and fragmented, helplessness about one's ability to have impact on others, passivity, fears of unpredictability, and lack of an emerging differentiation of different feeling states, wishes, and intentions.

From the fourth stage and set of processes dealing with a complex sense of self, a number of life's basic emotional needs and themes become defined (not in a symbolic sense, but in the

sense of coming together in an organized pattern of behaviors which can be used to negotiate underlying wishes, needs, and intentions). For example, dependency, assertiveness, exploration and curiosity, pleasure and excitement, anger and aggression, a beginning sense of gender and an initial capacity for self limit setting emerge. In contrast, if there are challenges at this level, the child or adult may experience patterns such as narcissistic self-absorption or preoccupation with polarized feeling states and themes such as grandiosity, suspiciousness, somatic concerns, and/or global self-deprecation. One may also see preoccupation with fragmented partial needs and wishes, for example, certain types of limited pleasures.

At the fifth stage (representational elaboration) and its associated processes, we often observe the construction of a rich pattern of imagery concerning inner wishes, ideas and feelings. Fantasies emerge which are part of an elaborate imaginative capacity. Fantasies can embrace most of the major themes of life from dependency and separation anxiety to curiosity, assertiveness and aggression. In short, a rich intrapsychic symbolic life is created. In contrast, challenges at this level can be associated with fears of separation, concerns with danger, as well as tendencies to experience and rely on action patterns rather than ideas and reflection.

In the sixth stage (representational differentiation) emotional thinking and its associated processes, we may see interests in being logical, organized, and reality-based as well as inclinations to construct more complex fantasies, which have their components cohesively and logically tied together. Here too, themes may cover the broad range of human dramas from dependency to aggression. We also may see a more integrated sense of gender emerging along with interests in different aspects of sexuality and pleasure. Often quite prominent are themes of power, being admired, and being respected. Some degree of concern with shame, humiliation, loss of love, fear of injury to self and others is also expected. When there are challenges, one may see polarized rather than integrated themes (preoccupation with things being all bad or all good). We may also see massive preoccupations

with order, control, or limited types of pleasure or sexuality. In addition, we may see paralyzing preoccupations with shame, humiliation, loss of love, and injury or harm to self or others.

These stages and processes are described in subsequent chapters and in some detail in *The Development of the Ego* (Greenspan, 1989), as are the types of problems that are related to each level.

There are biologically based constitutional and maturational differences which contribute to ego structure. They are based on differences we have observed in infants and young children, as well as older children and adults. In each sensory pathway, sensory and affective experience can be characterized as hypo- or hyperreactive. In addition, each sensory channel can have differences in the way sensory, interpersonal, affective, and cognitive information is processed (e.g., auditory-verbal, visual-spatial). Furthermore, motor tone and motor planning abilities can vary significantly among individuals. These patterns and the observations they are based on are described in Greenspan (1992). What Hartmann (1939) described as the autonomous ego functions can actually vary quite a bit from person to person, and contribute to character formation and pathology.

When certain biological patterns are coupled with certain environmental patterns, they can intensify each other. We can observe, therefore, what Freud had anticipated: the ways in which the biological influences on character structure and the selection of defenses operate. For example:

1. Individuals who are overreactive to touch or sound and have stronger auditory processing abilities and relatively weaker visual-spatial ones tend toward the hysterical, depressive, and anxiety disorders. Those who have difficulty with movement in space tend toward phobic disorders.
2. Individuals who are underreactive to sensations and have low motor tone tend toward more withdrawn behavior. They tend to escape into fantasy, and, in the extreme, evidence more schizoid and autistic patterns.
3. Individuals with hyporeactivity to sensations along with stimulus craving patterns, coupled with high activity levels

and organized gross motor patterns, tend toward risk taking, and, if there is emotional deprivation, antisocial patterns.

4. Individuals with relatively stronger visual-spatial processing and overreactivity to certain sensations tend toward patterns characterized by negativism, stubbornness, and compulsiveness.

It should be emphasized that when environmental conditions enhance flexibility rather than pathology, we tend to see healthy character formation, but with a tendency toward one or another of these characteristics. For example, instead of panic or anxiety or depression, we see a sensitive person, who is reactive and alert to others' moods and behaviors.

In this model of development, biological, including genetic, influences do not act directly on behavior. They influence what the child brings into his interactive patterns. Cultural, environmental and family factors influence what the caregiver brings into the interactions. The interactions then determine the relative mastery of the six-staged process described. Symptoms or adaptive behaviors are the result of these stage specific-affective interactions.

CONSTRUCTING THE DEVELOPMENTAL PROFILE

Understanding the six levels and building blocks of the mind, and the related biological and environmental contributions, enables the clinician to construct a developmental profile. As indicated earlier, while the higher levels of ego functioning are explored and the content of the patient's mental life is being elaborated, it is especially important to construct a full developmental profile which includes all the mind's levels. This endeavor is critical to determining the best therapeutic approach and the focus of that approach. In considering different types of problems and personalities, one is often tempted to go where the action is, getting caught up in the conflict of the moment (the family

drama or, understandably, the patient's anguish). However, after one has listened and observed for a reasonable period of time, one should construct, in a systematic way, a full developmental profile so that both the content and structure of mental life is understood.

The profile, which is described in more detail in the Appendix, begins with a description of individuals' regulatory capacities-the ability to remain calm, attentive, and process and respond in an organized way to the variety of sensations around them. Next is a rich description of their style and capacity for engaging, followed by their capacity to enter into reciprocal affective gesturing in a full range of emotional and thematic realms. Then comes their ability to organize their behavior and affects into purposeful patterns that take into account the expectations of their environment. These presymbolic capacities are followed by the ability to represent wishes and ideas, and then to create bridges between different represented experiences.

In each area of the profile, one also looks for deficits (where the ability is not attained at all), or constrictions (where the ability is there but not at its full, robust, and stable form). Constrictions may involve a narrowing of the thematic or affective range (only pleasure, no anger), a lack of stability (the child can engage, but loses this capacity and becomes self-absorbed whenever anxious), or a lack of motor, sensory, cognitive, or language support for that capacity (e.g., the child can be assertive with words, but not with motor patterns).

After an individual's profile is constructed two contributions to the challenges or strengths of that profile are explored. These are the biologically based regulatory contributions, which are discussed elsewhere, and the family, cultural, and interactive contributions.

To illustrate the importance of constructing such a profile, consider the following example. A six-year-old girl presented with an inability to talk in school and only an ability to talk to her mother. She had always been a very dependent, clingy, quiet, and passive little girl, had a lot of separation anxiety in going to school, and had always had difficulty interacting with the other

children. However, her difficulties were getting worse over the prior two years. It will be instructive now to look at the profile that had been constructed for this little girl from numerous play sessions. She took a long time to connect with the therapist doing the evaluation each and every session. She would initially fiddle with toys or other objects in a seemingly self-absorbed way and only with a great deal of vocal overtures would she enter into a state of shared attention where she was looking and paying attention to the therapist. The therapist had to maintain a fairly high level of activity to maintain this state of shared attention. Similarly, while she had some warmth and the therapist found herself looking forward to seeing the child, the therapist kept feeling she had to work hard to maintain the sense of engagement. There was some emotional expressiveness and some back and forth smiling and smirking, suggesting some capacity for emotional reciprocity, but often the emotional responses were either very inhibited (lacking) or global, with seemingly inappropriate giggling or repetitive, tense, discharge-oriented play (such as banging a doll). Often the content of the play, such as banging the doll, was not connected to the affect (which might be a smile, as she banged the doll aggressively). She was purposeful and organized in her interactions and play, but during times of transitions, going from one activity to another, she would seem to get lost in her own world again, and the therapist would have to work to regain a sense of organized interaction. She used lots of ideas and was able to build bridges between her ideas (answering "what" and "why" questions), but her imaginative play was focused on only a few themes in a very intense and repetitive manner. She had dolls undressing and had one doll doing aggressive things to the genital areas of the other dolls. In one scene, she had monsters blocking some of the dolls from getting their clothes back, with sadistic fights ensuing. In this profile, then, we see a child who has marked constrictions at the presymbolic areas of development around attention, engagement, and reciprocal affective gesturing and cueing, as well as a preoccupation and constriction at the symbolic or representational level.

In cases like this, with a little child who could elaborate themes, I found that many therapists would focus predominantly on the content of the child's themes (in this case, her preoccupation with sexual and aggressive themes) and obviously want to explore the family dynamics that were contributing, including questions of sexual abuse, sexual play with other children or babysitters, or overstimulation due to exposure to sexual materials or witnessing sexual scenes. But our profile, in addition to alerting us to these factors, also alerts us to the fact that there is a lack of mastery of critical early phases of development, including an ability for consistent attention, engagement, and the earliest types of reciprocity. When, for example, a child can't match the content of her interests with her affects, it often suggests that early in life a caregiver was unable to enter into reciprocal gesturing around certain affective inclinations. For example, the way a child learns to match content with affect is by demonstrating different affects as an infant in association with different kinds of behavior; perhaps, knocking the food off the table with a look of defiance or surprise. In return, they get a reciprocal affect or gesture back from Mommy or Daddy. If the parent freezes or withdraws at that moment, however, there is no return affective gesture and the child's content (i.e., throwing the food on the floor) now has no reciprocal affects associated with it. As a consequence, the child doesn't develop the rich connections between interactive affects and content. Obviously, various types of processing problems can also contribute.

In terms of regulatory patterns in this case, the little girl did have some overreactivity to touch and sound and some mild motor planning problems, but was quite competent in her auditory and visual-spatial processing abilities. There were both physical differences and interactive ones contributing to her profile.

As we look at her developmental profile we are therefore alerted to the fact that there are a number of prerepresentational issues that need to be worked on in the therapy as well as issues involved in her emerging symbolic world. As we are speculating from her profile, we're wondering whether there were some profound difficulties ongoing in the early relationship between this

child and her caregivers as well as some current experiences that are leading to her preoccupation with sex and aggression. We are also wondering about current trauma, severe enough to disrupt basic presymbolic abilities (if, for example, they were formerly attained).

As a result of this profile, the therapist who had started with twice-a-week sessions to work on the content of the child's play, and once-a-month sessions with the parents, shifted her approach. It was decided that it was important to develop a deeper alliance with this family to explore the nature of this little girl's preoccupation with sexual and aggressive content and, therefore, they needed to be seen at least once a week. It was also determined that because there were a number of constrictions of the prerepresentational capacities, the therapist needed to work with the parents' interactions with their daughter in order to foster mastery of these basic interactive capacities around attention, engagement, and reciprocal affective interchange. He also began working on the issues directly in therapy, paying more attention to affects and gestures, the tone of the relationship itself, as well as the understanding of verbal content.

A developmental profile systematically done will help the therapist look in a balanced way at the whole individual and, most importantly, it will help the therapist raise hypotheses about where the challenges may lie and even some potential reasons for the challenges. The profile enables the therapist to develop a therapeutic strategy that will further explore the initial hypotheses. Without such a systematic profile, it's easy for the therapist to get lost in the content or symptoms of the moment without a full appreciation of all the areas of challenge and the likely experiences that might be associated with them.

In some respects, the developmental profile, by focusing on the patient's fundamental capacities, may reveal aspects of the patient's developmental history that the patient's "memories" are unable to reveal. The processes that the developmental perspective helps us observe reveals where the patient has been and, even more importantly, where he or she needs to go.

To assist in visualizing the developmental approach to mental health and illness, the following schematic outline may be useful. For each fundamental capacity, there are a range of possibilities from very adaptive and healthy to maladaptive and disordered. This type of approach may prove more useful than narrow-based, symptom-oriented approaches and could even be used for research applications. Each capacity could be rated on a 20-point scale, for example, and the totals summed for a more global picture. Preliminary studies based on rating videotapes of children suggest that these categories can be rated reliably.'

Our clinical work with infants and young children helped us understand early affective interactions. We began our explorations of the presymbolic levels of the mind in the early 1970s, observing infants and young children first in a variety of day care settings and then in the context of our studies of infants in multi-risk families and infants with biological challenges. Building on the work of pioneers such as Erikson, Piaget, Spitz, Bowlby, Anna Freud, Escalona, Murphy, and Sander, we looked at the different stages infants and young children passed through, the types of adaptive and pathologic patterns that were possible at each stage, and the contribution of both individual biological (constitutional and maturational) and environmental differences. We also formulated models for the relationship between affects and intelligence and healthy and disturbed ego formation (Greenspan 1979, 1981, 1984, 1989, 1992).

In this model, the presymbolic and early symbolic world contains six levels including a number of basic capacities and critical aspects of character and personality. The importance of the pre symbolic aspects of the ego have also been emphasized in recent developmental investigations into several aspects of presymbolic learning, sometimes referred to as "implicit learning," "tacit knowledge," or "procedural knowledge." For example, based on experiments where subjects learned the rules of a new grammar (certain sequences of letters), while consciously attending to a

'For further information on the reliability studies, contact Georgia Di Gangs at the Reginald Lourie Center, 11710 Hunters Lane, Rockville, MD 20895.

SELF REGULATION 6 14

0			20
Attention is fleeting **(a few seconds here or there) and/or very active or agitated or Mostly self -absorbed and/or lethargic or passive.**	When very interested or motivated or captivated can attend and be calm for short periods (e.g., 30 to 60 seconds).	Focused, organized, and calm except when overstimulated or understimulated (e.g., noisy, active, or very dull **setting); challenged to use a vulnerable skill (e.g., a child with weak fine motor skills asked to writ, rapidly),** or ill,	Focused, organized, and calm most of the time, even under stress.

ENGAGEMENT

0	6	14	20
Aloof, withdrawn and/or indifferent to others.	Superficial and nee d-oriented, lacking intimacy.	**Intimacy and caring is present but disrupted by strong** emotions, like anger or separation (e.g., person withdraws or acts out).	Deep, emotionally rich capacity for intimacy, caring, and empathy, even when feelings are strong o r under stress.

INTENTIONALITY

0	6	14	20
Mostly aimless, fragmented, **unpurposeful behavior and emotional expressions (e.g., no purposeful grins or smiles or reaching out with body posture for warmth or closeness).**	**Some need-oreiented purposeful islands of behavior and emotional expressions.** No cohesive larger social goals.	Often purposeful and organized, but not with a full range of emotional expressions (e.g., seeks out others for closeness and warmth with appropriate flirtatious glances, body posture, and the like, bill becomes chaotic, fragmented or aimless when very angry).	Most of the time purposeful and organized behavior and a wide range of subtle emotions, even when there are strong feelings and stress.

THE PREVERBAL SENSE OF SELF: Comprehending Intentions and Expectations

0	6	14	20
Distorts the intents of others (e.g., misreads cues and, therefore, feels suspicious, mistreated, unloved, angry, etc.).	In selected relationships can read basic intentions of others (such as acceptance or rejection) but unable to read subtle cues (like respect or pride or partial anger).	Often **accurately reads and re sponds to a range of emotional signals, except** in certain circumstances involving selected emotions, very strong emotions or stress or due to a difficulty with processing sensations, such as sights or sounds, e.g., certain signals are confusing.	**Reads and responds to most emotional signals flexibly and accurately even when under stress (e.g., comprehends safety** vs. clanger, approval vs. **disapproval, acceptance** vs. rejection, respect vs. humiliation, partial anger, etc,).

CREATING AND ELABORATING EMOTIONAL IDEAS

0	6	14	20
Puts wishes and feelings into action. Unable to use ideas to elaborate wishes and feelings (e.g., hits when mad, hugs or demands physical intimacy when needy, rather than experiencing idea of anger or expressing wish for closeness).	Use s ideas in a concrete way to convey desire for action or get basic needs met. Does not elaborate idea of feeling in its own right (e.g., "I want to hit but can't because someone is watching" rather than "I feel mad, like I'd want to hit").	Often **uses ideas to be imaginative and creative and express range** of emotions, except when experiencing selected emotions or when under stress (e.g., cannot bring anger or despondency into verbal discussion or pretend play).	Uses ideas to express full range of emoti ons. Is imaginative and creative most of the time, even under stress.

0	6	*14*	*20*
Ideas are experienced in a piecemeal or fragmented manner (e.g., one phrase is followed by another with no logical bridges).	Thinking is polarized, ideas are used in an all or nothing manner (e.g., things are all good or all bad. There are no shades of gray).	Thinking is constricted (i.e., tends to focus mostly on certain themes like anger and competition). Often thinking is logical, but strong emotions, selected emotions, or stress can lead to polarized or fragmented thinking.	Thinking is logical, abstract, and flexible across the full range of age expected emotions and interactions. Thinking is also relatively reflective at age expected levels and in relationship to age expected endeavors (e.g., peer, spouse, or family relationships). Thinking supports movement into the next stages in the course of life.

related task, Arthur Reber suggested that "unconscious cognitive learning" was a very important aspect of cognitive development. Others have included in procedural knowledge social conventions, implicit rules, and expectations such as the ordinary rules of grammar or expectations for responses to transgressions (Clyman, 1991; Emde, et al., 1991; Erdelyi, 1985; Horowitz, 1991; Kihlstrom, 1987; Papousek & Papousek, 1979).

Early unconscious and presymbolic learning, however, may be more dynamic than these descriptions suggest. Our work with infants and young children suggests that a number of critical psychological structures involving the formation and definition of the self as well as others are formed through early interactions (Greenspan, 1979, 1989). For example, during a stage of presymbolic learning involving two-way intentional communication (i.e., learning through back and forth [reciprocal] interactions) there is not only the formation of interactive expectations, but an early differentiation of the ego, including, for example, the boundary between parts of the self and non-self and early drive and affect proclivities.

Furthermore, these early-formed psychological structures are based on a dynamic interaction between the infant's early wishes and affects and significant caregivers. Contrary to what Reber

suggests, these early-formed capacities are not robust in the face of challenges or insults, nor are they independent of age, intellect or individual differences. In fact, in our work with children with biological or environmental risk (children with pre-autistic patterns and children in multi-risk families) (Greenspan 1987, 1992), we have observed that these early patterns can be easily derailed. In addition, individual differences in motor capacities, sensory modulation and processing and caregiver responses play a large role in determining the character of these early presymbolically-learned patterns. In our view, presymbolic learning is dynamic and interactive. It is sensitive to infant and caregiver characteristics and formative in the building of critical lifelong, psychological structures.

The presymbolic stages and related structures of the ego and personality deal with such basic issues as regulation and security, the depth, range and stability of relationships, and the formation of drive and affect patterns, the early formation and differentiation of a sense of self and the formation of early character patterns (including the negotiation of basic emotional themes such as safety, approval, acceptance, anger, loss, separation, and so forth). In a sense, before symbols are formed to any great degree in the latter part of the second into the third year of life, we have a sense of who we are, what we want and how others will treat us. Symbols and words help us open up this emerging inner world, allowing for more flexible thought, creative excursions into fantasy, imaginative trips into the past, present and future, and elaborate types of logic and thinking. Our capacity for creating symbols is initially simply a shorthand way of indicating and making sense of what we already know at the deeper levels of our mind.

APPLICATIONS OF DEVELOPMENTAL PRINCIPLES TO DIFFERENT TYPES OF THERAPY

In presenting a model for developmentally based psychotherapy, it is useful to be mindful of the traditional distinctions between different types of therapies that use exploration of feelings and

thoughts as a means for facilitating emotional growth or supporting current levels of functioning. Included in the different approaches are psychoanalysis, psychoanalytic psychotherapy, and supportive psychotherapy. Recent reviews of these point to the goals, processes, and techniques that characterize and distinguish them (Allison, 1994; de Jonghe, Rijnierse, and Janssen, 1994). It is also useful to be mindful of the goals, processes, and techniques that characterize behavioral and cognitive behavioral approaches. The principles of developmentally based psychotherapy, while constituting a unique type of psychotherapeutic process in its own right, can also enrich the therapeutic approaches of the above therapies.

In psychoanalysis, understanding developmental principles at the foundation of developmentally based psychotherapy will enable therapists to work with prerepresentational transferences. In addition, it will enable therapists to work with prerepresentational expressions of wishes, conflicts, and defenses. Most importantly, it will guide therapists to examine the structural elements outlined earlier and discussed in the following chapters. These structural elements, as indicated, are necessary for any analysis of representational level wishes, conflicts, defenses, and compromise formations. In dealing with these prerepresentational and structural issues, the intensity of the psychoanalytic situation makes it possible to use the analytic relationship as the primary vehicle for exploring experience and constructing new types of developmentally necessary experiences.

In supportive psychotherapy, the developmental principles from developmentally based psychotherapy offer explicit descriptions of the types of experiences needed for structural growth. It allows the therapist to position himself alongside the patient as a collaborator in the process of helping the patient embrace developmentally facilitating experiences in his or her daily life (e.g., maintaining nurturing and supportive relationships, elaborating and communicating wishes and feelings, etc). This may also include helping the patient comprehend the patterns he or she uses to avoid or undermine developmentally needed, structure-building experiences. In supportive psychotherapy, the goal is

to support current functioning and help the patient maintain experiences and relationships that will facilitate gradual emotional growth. The therapeutic relationship itself is not the centerpiece of renegotiating emotional experiences.

Hybrids of the analytic and the supportive approaches, including analytically oriented psychotherapy, would use elements of both of these. In combining explorations of the transference relationship to reveal certain repetitive emotional patterns with growth-facilitating relationships and experiences, analytically oriented psychotherapy can avail itself of the developmentally based psychotherapy principles to more clearly define the patient's developmental needs and the types of intratherapeutic and day-today interactive experiences that are likely to facilitate emotional growth. For example, the patient who has difficulty reading nonverbal cues, and therefore distorts experience and fills in with his own favorite, and often painful, fantasies needs to be helped through explicit attention, both in the therapy situation and in day-today interactions, to comprehend these types of presymbolic distortions. The therapist needs to know the level of development that is consistent with these types of distortions in order to be helpful in both understanding the problem and assisting the patient in working it through.

Behavioral and cognitive behavioral approaches, because of their lack of a developmental road map, have no systematic theory to determine which behaviors or thoughts should be changed, in addition to the presenting symptom. Similarly, the lack of a developmental road map makes it hard for the therapist to know how or if the symptoms are part of a larger pattern and what new potential patterns, other than simply removing the symptoms, would lead the patient toward a developmentally more advanced psychological configuration. For example, if our anxious, phobic individual has even more significant difficulties with suicidal ideation and a lack of pleasure in intimacy, it is possible that these more significant difficulties, if they weren't explicitly revealed by the patient, might not be included in the treatment program. In addition, in behavioral approaches, there is no systematic developmental theory to help the clinician determine which discriminative and reinforcing stimuli would be relevant to the patient.

The clinician's "green thumb" is often used in the absence of a developmental clinical theory.

The principles from developmentally based psychotherapy can assist behavioral and cognitive behavioral clinicians in constructing the broader behavioral, cognitive, and affective patterns, within which the patient's symptoms reside. Furthermore, it can assist in creating the developmental goals for the patient and in clarifying the types of discriminative and reinforcing experiences that are likely to be relevant to a particular patient.

While not discussed in this work, the relevance of these developmental constructs for couples and family therapies is addressed in *The Development of the Ego* (Greenspan, 1989).

The developmental concepts in this work will, therefore, prove helpful to a variety of therapies that have as their goal personality change and growth. The main goal of this work, however, is to create a set of clinical principles based on how emotional development takes place tinder natural circumstances. Developmental constructs based on the principles of natural growth and development may provide an especially valid theoretical framework for both understanding and constructing the psychotherapeutic process.

FREQUENCY AND INTENSITY OF THERAPY

Some patients require a very intense therapeutic relationship, which occurs on an almost daily basis to create the circumstances for psychological change and growth. Other patients require understanding of how they avoid growth-producing experiences and how to construct them in their lives. Such understanding often involves deep psychological insights, but this group of patients has the capacity to become involved in growth-producing experiences outside the therapeutic relationship, using the relationship to assist them in constructing such experiences. Traditionally, it has been thought that a certain group of relatively healthy patients with deep-seated, but organized, neurotic configurations, require

the intensive therapeutic relationship, where the therapeutic relationship, using especially the transference, becomes the main vehicle for change and growth. Along with this traditional view has been the notion that less well put together patients who have, perhaps, very severe character pathologies or borderline pathologies may not be able to utilize the intensity of an almost-daily therapeutic session and have to settle for a less ambitious therapeutic goal through a combination of supportive and insight-oriented therapy once or several times a week. In this view, then, the relatively healthy individual should receive the most intensive work because a certain degree of health is necessary to participate in the intensive therapeutic process (e.g., the ability to observe one's own feelings and behaviors). The developmental perspective suggests an alternative way of determining the optimal therapeutic program for a given patient. It would suggest that the goal of the therapeutic work is to help the patient progress to higher levels of structural organization and broaden the affective and thematic range and stability at that level. For relatively healthy individuals who can fully engage in many of life's experiences, the patient and the therapist can collaborate in helping the patient understand his or her maladaptive patterns (e.g., patterns of avoidance or patterns of misperception) and construct and stay with developmentally facilitating experiences. Examples might include learning to tolerate the feelings of loss in a relationship where typically one would act out in a counterphobic way, or learning to tolerate the anxiety that arises out of periodically having to tolerate passive feelings associated with being in a relationship with an authority figure. Our relatively healthy individual uses the therapeutic relationship to understand the nature of growth facilitating experiences, the nature of his or her own misperceptions and maladaptive behaviors, and tries to use real life experiences with spouse, friends, or boss as the basis for change and growth. The transference in this context is understood as part of comprehending the patterns in the therapeutic relationship that need to be understood as they play out in other relationships. The working through of the transference in the therapeutic relationship in this context is not the primary agent of change.

Rather, the primary agent of change is the day-today coping with a wider range of affects, emotional themes, and the use of developmentally higher structural capacities. These higher developmental structural capacities arise from relationship patterns both in the therapeutic situation and in one's day-today life.

Central to growth producing experiences is the experience of affects that are natural and spontaneous. As intense as a therapeutic relationship becomes, for the individual capable of a rich range of developmentally expectable relationships (e.g., marriage, close friendships), the therapeutic relationship can never hope to attain the intensity or saliency of these daily relationships. If it does, it suggests that perhaps the patient's ability to engage in these real daily relationships is not as healthy and flexible as one thought. The spontaneity and naturalness of the patient's affects are perhaps the central feature of his growth. The patient's affects propel him into interactive patterns which, in turn, create opportunities for achieving higher and higher levels of structural organization. It is the patient's ability to abstract from his own affective experience in day-today relationships that creates the growth of the personality in the ordinary sense. This growth gets derailed when the patient's conflicts and anxieties or structural limitations derail this process of day-to-day, interactive, affective experience, and the abstractions from these experiences. To get this process back on track, the therapeutic relationship creates the circumstances for change and growth. Therefore, where this can occur in the ordinary day-to-day way, in part guided by the therapeutic relationship, the intensity and naturalness of the affects will be far more conducive to structural change and growth than where these experiences have to occur through the therapeutic relationship. In this context, the use of the therapeutic relationship as the primary vehicle for change and growth is not the preferred choice, because in the therapeutic relationship it is usually not possible for affective experiences to have the same degree of naturalness and saliency they do in everyday life. For patients, however, whose ability to construct day-to-day experiences is necessarily limited by the nature of their psychopathology, the therapeutic relationship must serve a more dominant

role, at least initially. With the more flexible, healthier, neurotic patient, however, it may be possible in many circumstances for day-today experiences to provide a more optimal medium for change and growth.

Patients, however, with a certain level of character pathology (usually in the moderate to severe range) may not be able to avail themselves of day-today experiences that could potentially facilitate change and growth. Their patterns of avoidance, acting out, or misperception are too severe and encompass too wide a range of experiences for them to do anything other than repeat their maladaptive patterns, which pervade most of life's major arenas, including family, friends, work relationships, and the like. In such a situation, the therapeutic situation may be the only relationship where new experiences can be organized and tolerated. The patient initially can only collaborate a little bit in the construction of such experiences and the therapist, in the way he deals with the transference feelings, plays a significant role in creating the circumstances for change and growth. Many of the examples described in these chapters will illustrate how the therapist works with the patient to create circumstances that will support structural change and growth.

Another group of patients who evidence more severe pathologies including various borderline conditions and severe disturbances of affect have traditionally been thought of as too vulnerable to tolerate an intensive four- to five-times-a-week therapeutic relationship. However, such patients may also require the therapeutic relationship to be the primary vehicle for change and growth similar to our patients with moderate to severe character pathology. The greater vulnerability of such patients may mean that the therapist is working with them on more basic and earlier developmental levels. For the borderline patient, for example, issues of preverbal, presymbolic, as well as symbolic self and other organizations may be prominent. For the patient with extreme disorders of affect, regulatory phenomena may be a vital focus. Therefore, such patients may also require intense, almost daily therapeutic sessions and a therapeutic relationship which can be

the major vehicle for change and growth, only here the focus becomes developmentally earlier issues.

With the foregoing conceptualization, we would shift the recommendation for the most intensive psychotherapeutic processes to the patients whose disturbances are relatively greater. The relatively healthier patients may be able to use the therapeutic relationship to construct the conditions for change and growth using the real daily experiences of their lives. This approach would alter the recommendations we might make in relationship to current practices. For example, for the relatively healthy neurotic patient with a flexible ego structure, the recommendation might be for the less intensive approach. On the other hand, for the individual whose neurotic structure pervades major and significant areas of his or her life, and where the capacity to construct growth facilitating experiences with the consultation of the therapist is unlikely to occur, intensive therapeutic work may be indicated. Similarly, for the severe character pathologies, the borderline conditions, and severe disorders of affect, the most intensive approaches may be absolutely necessary, with, however, a focus on developmentally early issues and an understanding of the limited structural capacity of the individual. In this way, the therapeutic relationship would not overwhelm an already fragile person, but would initially create the support, regulatory, and interactive experiences for both stability and gradual change and growth. For example, as will be described in greater detail in the chapters on regulatory difficulties and difficulties with engagement and presymbolic communication, many patients will require long periods of working at presymbolic levels. Some patients will require extraordinary patience and flexibility in the development of a therapeutic relationship.

CONTENT AND PRESYMBOLIC STRUCTURES

Certain assumptions from psychoanalytic approaches have influenced the practice of psychotherapy. A particularly important one relates to the central role of verbal discussions of "represented"

experience. The following sections of this chapter will discuss this assumption. This section may be of special interest to those with a strong psychoanalytic background.

Psychotherapy which focuses predominantly on discussions of verbal content may only utilize a small part of the human mind. *Developmentally Based Psychotherapy,* in contrast, is based on emerging insights regarding the different levels and processes of the mind and attempts to work with a number of different levels simultaneously.

It is not surprising that most current therapeutic approaches focus only on a small aspect of the mind's capacities. Historically, most therapeutic work has helped a patient with verbal understanding of the nature of their difficulties and the dynamics of their personality. Verbal insight, however, relates to the mind's capacity for symbolic or representational thinking. It deals with the "content" of affects, wishes, fantasies, and thoughts. The level of the mind that deals with understanding, while important, is only one small component of the mind. As will be seen in the chapters that follow, we have learned about other levels and processes of the mind that exert an important influence on our behavior and mental functioning.

The emphasis on verbal content is based on an assumption that most individuals can symbolize or represent wishes, affects and more broadly experiences. While as we will see this assumption may be untrue, the emphasis on using symbolic processes and verbal content is understandable in light of the history of psychoanalysis and psychodynamic approaches. Many of Freud's seminal contributions had to do with certain universal mental contents (e.g., the oedipal conflict, earlier psychosexual fantasies, including oral, anal, and phallic patterns, the castration complex, penis envy, etc). Interestingly, many of the recent critiques . of Freud and psychoanalysis concern the fixed or rigid way these mental contents are held onto, and the lack of data to support them.

Different facets of mental content are the focus of different therapies: the affects, underlying wishes, unconscious conflicts,

the relationship patterns and/or the repetitive ways of thinking, feeling, and behaving.

The "content" of the mind is the focus even in developmental inquiries, especially when we look at how developmental insights are used in the therapy situation. There are Freud's contributions to understanding psychosexual development and the generic content of unconscious fantasies (1905), and Erikson's psychosocial perspective (1959), which highlights the unconscious themes of mental life. Freud's theory of ego structure (e.g., his work on dreams and mechanisms of condensation, displacement, etc.), early object relationship theories, and Anna Freud's formulations of defenses (1965), in part do focus on certain functions of the ego. Similarly, Margaret Mahler's work on separation and individuation (Mahler, Pine, and Bergman, 1975) and object constancy, her insights into the earliest stages of infancy, including the toddler's struggles to become more individuated and the preschool child's struggle to develop a stable internal image of his loved ones, also relate to certain ego functions. As these insights from Freud (1911), Mahler et al. (1975), or object relations theorists (e.g., Kernberg, 1975) are reworked in adults, they are reworked from the perspective of the content of the individual's mental life. In the actual therapy situation, explorations of these issues are done in the same verbal, content-oriented, self-reflective way as difficulties related to sexual conflicts or conflicts emanating from later stages in development. It is as though the individual already has the capability for representing wishes and feelings and reflecting on feelings; a capacity which itself depends in part on resolution of the very challenges being worked on, such as separation and individuation. Similarly, an object relationships approach might help a patient examine the projections he manifests in his therapeutic interactions and at the same time ignore the fact that he does not have the capacity to observe his own patterns. How one can and should work with such a patient will be discussed in the following chapters.

Advances based on the work of Heinz Kohut and his followers (self psychology and intersubjective phenomena), while extremely useful in understanding narcissistic disorders and the vicissitudes of empathy and of the affective interchanges between

parent and child, also utilize similar types of content-oriented self-reflection. The therapist may be sensitive to the lack of (or misguided) empathy in the patient's formative years and in the therapeutic situation, as well as feelings of humiliation and rage. He may understand how these lead to narcissistic character patterns. The intervention strategy, while focusing on the earlier relationship patterns and the empathetic tone of these, nonetheless uses self-reflection and verbal discussion of content to work through different affects, thoughts, and underlying wishes and feelings.

Similarly, the work of colleagues who have discussed the implications of infant research for the psychotherapeutic process (e.g., Emde, 1983; Stern, 1985; Lichtenberg, Lachmann, and Fosshage, 1992), while discussing interpersonal dimensions, have focused mostly on verbal exploration of the "content" of mental life.

At this point, the reader may well say, Of course! What else can be worked with in the therapeutic process, other than verbal exploration of the content of mental life-the patient's wishes, conflicts, thoughts, behaviors, and feelings! It is interesting to talk of the aspects of the mind, but how can you' access them if not through the one sector of the mind having to do with verbal exploration? He or she may add, And, it's been very helpful to have even a partial developmental road map, which includes the insights of individuals like Mahler et al. (1975) and Kohut (1971), as well as others such as Hartmann (1939), Hartmann, Kris, and Loewenstein (1946), Spitz (1965), Kernberg (1975), and Fraiberg (1979), to help figure out what type of dramas are being played out in the mental life of the patient. Is it a drama having to do with lack or loss of empathy? Or is it a drama having to do with separation-individuation and object constancy? Or is it a drama having to do with conflicts over sexuality or aggression? In this way, the reader may argue, at least within the in-depth psychological approaches, the therapist is armed with an understanding of aspects of the content of the patient's mental life. But as indicated, what if the individual does not have the capacity to observe

or reflect on mental contents? After all such an ability usually suggests an advanced state of mental health.

There is good reason to believe that large segments of the population lack many critical capacities, such as self observing abilities, necessary for mental health, and that even patients who have them, have them only in part. These capacities which can be called "structural capacities" (Greenspan, 1989) have to do with critical abilities such as self regulation, relating, presymbolic-affective communicating, representing and differentializing experience and self observation. These structural capacities make up the stage upon which our psychological dramas can play out. They eminate from the different levels of the mind and are necessary for mental health and overcoming psychopathology.

Using mostly verbal content exploration as a vehicle for psychotherapy as is indicted overutilizes a narrow section of the mind having to do with already represented and differentiated experience. It assumes most patients have abilities which they do not. Understanding the development of the structure of the ego, along with understanding the content of different unconscious or partially conscious themes and dramas, therefore, will provide a more meaningful model for the psychotherapeutic process. In fact, as will be shown in this work, one cannot properly either understand, analyze, or alter a drama without also taking into account the stage upon which this drama is being played out. Structural capacities, when not dealt with directly in the psychotherapeutic process, often result in compromised outcomes or therapeutic failures.

In therapeutic terms how does one build the ego structure, including for example regulation of attention, mood, and behavior; forming, maintaining, and negotiating relationships; understanding the intentions and emotions of others; organizing and controlling one's impulses; and learning to delay, pause, and tolerate frustration? How does one learn to represent feelings, affects, and wishes that have never been represented before? How does one learn to differentiate and build bridges between different wishes and feelings? How does one build bridges between the past, present, and the future, when one's past interactions may

have been concrete and grounded in the day-to-clay meeting of needs? How does one work on increasing the depth of intimacy and relatedness and overcoming a sense of empty deadness or hollowness, when one doesn't have the ability to represent or abstract the affects associated with these patterns? How does one deal with affects, feelings, and failures of empathy, when there is no ability to represent or put the feelings into words, and when the therapist's attempted verbalization has no symbolic reference point? Similarly, how does one deal with issues of merging and separation-individuation for which there are no verbal or representational analogues in the patient's personality? How does one deal with proclivities for aggression and fears of annihilation, when these potential conflicts exist as fragmented, prerepresentational, behavioral, and somatic tendencies-a series of fragmented, affect, and behavioral discharge states.

At this point, some readers may wonder how an individual could experience mental life without representing feelings, affects, or wishes. Since many therapists experience life via their ability to represent or symbolize wishes and affects ("I feel sad or mad or want this or that"), it becomes difficult to imagine an individual who does not possess this capacity. Interestingly, while most therapists are trained to watch out for projecting their own inner "content" onto others (e.g., assuming the patient is angry when the therapist is feeling angry), they are not trained to be alert to the more profound problem of projecting their own personality "structure" onto the patient. Many of us make an assumption that other human beings are similar to us in certain fundamental ways, including how we perceive sensations, use symbols and representations, and the like. As the following chapters will discuss, human beings vary more than is commonly assumed in these structural foundations of the personality. Individuals, for example, experience sensations such as touch, sound, sight, and movement quite differently. Many individuals do not represent wishes and feelings. This doesn't mean they don't have a wish or feeling, but it may exist more as a somatic and behavioral pattern and not as a representational-symbolic one. For example, instead of feeling angry and being able to reflect on this feeling ("I am

angry. I wonder why?"), the individual without the ability to represent anger may simply experience an urgent desire to hit the person next to him at the bar, and will then do it. Later, the person can describe his behavior, but not the feeling that preceded it. Descriptions of behaviors (sometimes after the fact) and somatic states ("tension in my muscles") occupy mental life rather than what will later be described as abstracted affect states or the representation of wishes and feelings.

Life for many is experienced as concrete, here-and-now behavioral patterns and somatic states. Such individuals can be quite intelligent and use symbolic capacities having to do math, or can figure out a variety of academic problems. They may even discuss, in an intellectual way, many subtle issues about human relations or, in general, people's motivations for doing this or that. They, however, cannot employ these same capacities in their own inner world of wishes and affects.

It is not, however, only our capacity to represent experience that we tend to project onto our patients. We mistakenly tend to project other structural capacities as well, including our capacities to process and regulate sensations, relate, engage, and communicate with preverbal patterns. We tend to assume that people are similar in these fundamental ways; that to most individuals a soft sound sounds soft, a pleasurable touch feels good (unless there is mental conflict), and nonverbal gestures, including looks, glances, affects, body postures, and interactive behaviors are "read" in the same way as part of a common biological or cultural set of norms.

Each developmental level of ego structure, however, has different perceptual, relational, interactive, and communicative features. Individuals function at different developmental levels and their conflicts, fantasies, and interactive patterns have meaning only in the context of the developmental level that organizes them. Understanding the structure of these organizations will provide its with a technology for intervention that will lead to interactions that work both with the content of the drama and the structure of the stage. This framework may also facilitate empirical research on the development of ego capacities in therapy

that would relate to promising content oriented approaches to the therapeutic process (e.g., Luborsky and Crits-Christoph, 1980; Gill, 1984; Weiss, Sampson, and Mt. Zion Psychotherapy Research Group, 1986; Horowitz, 1991; Miller, 1993; Hartley, 1993; Perry, 1993). .

DYNAMIC, DEVELOPMENTAL, AND STRUCTURAL PERSPECTIVES: COMPLEMENTARY OR COMPETING

We have been outlining the ingredients of a developmental approach to therapy and discussing the explication to clinical problems. Many clinicans with a strong background in psychodynamic theory and practice may, however, have many questions about the real differences between developmental, structural, and dynamic perspectives and the degree to which they can truly complement and strengthen each other. The following section will discuss some of the most frequently raised theoretical and clinical questions.

The question often arises whether there is an antithesis between the structural and dynamic perspectives, the latter focusing on unconscious wishes and conflicts. Each perspective is quite necessary, and both can be viewed as essential elements of the multiple points of view necessary for an understanding of the mind. It is easy to focus on only one perspective, such as the dynamic, and lose sight of the fact that every dynamic drama must take place in the context of a particular structure or set of structures. In addition, when focusing on structural perspectives, it is easy to lose sight of the fact that structures provide the housing, so to speak, for different dynamic dramas, each one with its own content or meanings.

Looking at the development of therapeutic approaches over the last forty or fifty years, one can observe a movement from a focus on unconscious wishes and conflicts to an emphasis on current patterns of relationships (in part related to prior relationships and related unconscious wishes) and habitual patterns of thinking and feeling, including specific techniques to interrupt

these. In a sense, there has been a movement from approaches that focus on historical and unconscious factors, to those that focus on relationships and cognitive and affective patterns in the here-and-now, with relative degrees of attention to their origins. Yet, in spite of these shifts, the focus on mental content and the emphasis on verbal-symbolic interaction has remained. The point is, early preverbal interaction patterns are thought to be workable with verbal reflective therapeutic strategies even when the individual's early difficulties preclude their having these reflective capacities.

Interestingly, many observations of the psychotherapeutic process suggest a lack of specificity in the most important common elements or active ingredients. For many years now, factors such as the relationship itself, warmth, empathy, acceptance, and understanding have been suggested as being critically helpful aspects of the psychotherapeutic relationship. These types of experiences are based on the tone or affect in the relationship and on many subtle features of the interaction, of which verbal description is only one part. These types of experience, which are related to structural development, have never achieved the degree of conceptualization or centrality as has the focus on mental contents such as wishes, conflicts, or internal fantasies. They may, however, only be the tip of the iceberg in terms of the truly operative elements of the therapeutic process..

Therefore, in attempting to improve our clinical tools, it is especially important clinically to understand the structure of the ego, in addition to the particular dynamic "contents" that the ego is struggling with at any moment in time. Such understanding may enable us to develop a more explicit, systematic, and developmentally based set of therapeutic principles.

It is especially necessary to broaden our stockpile of therapeutic tools because, as indicated, large numbers of individuals who come for treatment, or who could benefit from such treatment, have important structural limitations.

The "ideal" neurotic patient allegedly has intact structural capacities working for him or her, and needs only the therapeutic process, including a transference relationship and the skillful

guidance of a seasoned therapist, for opportunities to be made available for new growth. Most patients, however, come into the therapeutic situation with limitations in their ability to represent experience in general or in terms of specific affect realms or with regard to specific wishes. Even those patients who can represent many aspects of intrapsychic experience often have difficulty creating connections or bridges between different aspects of their intrapsychic world.

Furthermore, as indicated earlier, many patients are quite limited in their self-reflective capacities, that is, in being able to observe their intrapsychic world as a dynamic process and as part of the treatment situation. Even more importantly, large percentages of patients who present to us have difficulties at prerepresentational levels, with such basic issues as forming and deepening a relationship, or reading and responding to nonverbal, interpersonal affect cues. In addition, we have discovered large numbers of patients who have basic difficulties in what may be termed regulatory processes (see chapter 3). These are the difficulties in regulating or processing sensation or modulating motor responses.

Understanding the structural development of the mind provides us with a way of comprehending how an individual learns to regulate the intensity of sensations, and later, the intensity of internal wishes and affects. It also provides us with a way of understanding how individuals process, that is, comprehend and organize sensations, wishes, and affects and organize both motor and communication patterns.

Furthermore, our structural perspective deals with understanding how individuals learn to become part of a relationship and share a sense of humanity with others. It demarcates the processes involved in early prerepresentational interactions and differentiations. Beginning with part internal object interactions and partial differentiations, it describes how we progress to prerepresentational (presymbolic) whole self and object patterns and further prerepresentational differentiations.. It demarcates how these prerepresentational patterns serve as a foundation for the construction of a representational system, that is, the ability to

abstract wishes and affects in a representational form. Most importantly, it helps us understand biologically based constitutional and maturational differences.

Furthermore, the structural perspective seeks to understand how early representational capacities coalesce into internal self and object organizations, and how constitutional and maturational patterns contribute to these early structural capacities. For example, we are able to understand how overreactivity to sound and touch will lead toward one type of organization, while underreactivity will lead to another. It also helps us identify specific interactive patterns that support or undermine particular structural capacities. In addition, it helps us understand how representational, internalized self and object organizations become further differentiated, as a basis for the development of basic ego functions. These functions include reality testing, impulse control, stable mood, stable internal representations of self and object, and stable differentiations between the internal representations of self and object. It also outlines how a differentiated ego structure leads to further growth and development, in terms of shifts from dyadic to triadic structures to those structures dealing with group phenomena as well as more advanced, internalized phenomena.

DYNAMIC CONFLICTS AND LEVELS OF EGO DEVELOPMENT

It is sometimes tempting to explain symptoms or behaviors completely in terms of dynamic conflicts. There are enormous differences in one's approach to conflicts, however, depending on whether this conflict is operating at one level of structural organization or another. Consider, for example, a conflict over aggression, having to do with a wish to hurt the object and, in turn, a fear of being annihilated by the object. If it is operating at a representational level, we may see it reflected in the play of a child, who has one doll hit another doll, followed by a hurricane, where the first doll gets submerged under crumbling buildings.

There may be affects of fear and anxiety. While playing this out, however, the child is using words, maintaining a descriptive or reflective attitude, and, when getting anxious about the hurricane, putting into words aspects of the anxiety and saying, perhaps, "Mommy, I need a hug."

The same conflict played out at a prerepresentational level, where experience cannot be represented, might have the child yelling and screaming at the real object, not the pretend toys, or biting, kicking, or hitting the real object. Following this, in anticipation of severe punishment, the child might experience diffuse anxiety in a more bodily and behavioral sense (e.g., increased diffuse aggressive activity, changes in heart rate and muscle tone, etc.)

A child at the prerepresentational level is unable to represent the expected retaliation. The child is more like a person in a fight who throws a punch, and, simply from the other person's behavioral pattern, anticipates a punch back. Our prerepresentational, conflicted individual, therefore, may pinch, bite, or throw a tantrum and then up the stakes, increasing his own aggression because of the anticipation of counteraggression. Or he may withdraw into a state of unrelatedness. In either case, he does not have the capacity to represent (i.e., create) a multisensory, affective picture of the pattern, which is simply "behaved" out, including expectations of the other's behavior.

What we see here is a drama that is not represented, but a drama played out in the actual reality of a relationship. The content of the drama is not symbolized in representational elements through pretend, or elaborated in words (as in the free associations), but instead is behaviorally enacted in a direct and visceral fashion. The drama is perceived as real, not as a set of feelings or wishes: "He is going to hurt me" rather than "I feel as though I will be hurt." Descriptive words do not reflect on the drama that is part of a "behavioral" pattern. One may further speculate that a drama acted out behaviorally and viscerally might be associated with more primitive and overwhelming fears.

In this sense, the structure of the ego affects the content and vice versa.' However, it would be a mistake to think of these fears

as having representational forms. Rather, they are experienced in a visceral and behavioral sense (e.g., "My muscles were exploding as I was hitting him").

Using traditional diagnostic thinking, one would see the more representational individual as having a more mature personality structure, capable of more traditional therapeutic exploration, whether it is a child using pretend play, or an adult using words and descriptions, or reporting his or her associations or dreams. The individual who expresses the conflict in terms of direct behavioral phenomena is exhibiting a more primitive character disorder. Such an individual might come to treatment after having been involved in a fist fight or physically acting out of marital problems. We might feel less optimistic about his or her ability to participate in a dynamic therapeutic exploration.

Regardless of our prognostic thinking about these types of individuals, the structure of the personality and ego is obviously critical in understanding the nature of their conflicts and anticipating the type of therapeutic work to come. Helping an individual shift from behaving out their conflicts to representing their conflicts, might be seen, in fact, as the first order of business. Without this step, little growth can occur in the individual's overall personality. One cannot fully understand the drama without knowing the organization within which the drama is being played out. In addition, one cannot fully comprehend the nature of the ego structures without having a comprehension of the drama being played out in it. Both aspects are obviously critical to a successful resolution of a patient's problems.

Structural challenges that are based in early developmental stages are especially interesting. There are many patients who are overreactive to basic sensations, such as touch and sound. They are likely to feel overwhelmed by affects, and in situations involving lots of people or noise, may feel fragmented, fearful, and suspicious. Yet later, in a quiet room with one or two people, they may be organized, reflective, and secure.

In therapy, working with these perceptual differences, and helping the patient understand them and their connection to

feelings and wishes, can be critical. Many patients have left therapists who interpret these perceptual differences as "passive-aggressive," and have done well with therapists who explore the physical differences in their own right in a supportive and respectful way. But if the therapist is not alert to looking for these perceptual differences, they are likely to be missed.

CASE ILLUSTRATION OF WORKING WITH DEVELOPMENTAL LEVELS AND DYNAMIC MEANINGS

It is easy to assume that a patient constructs a "meaning" the same way the clinician does. The therapist may be at a different developmental level. The therapist may, for example, "represent" the patient's fear of being hurt, while the patient experiences it as just described as a behavioral expectation, not as a represented or symbolized affect. Furthermore, the second half of the question and its implied answer: often, approaching a structural problem only via its dynamic meaning will not help the person sufficiently resolve the structural difficulty.

Consider the following example: a middle-aged depressed woman had grown up with an extremely intrusive, controlling mother and a very available, but passive father who deferred to mother. As near as can be reconstructed (some of it intellectually from mother's behavior), even as an infant and toddler when this woman was growing up, her every reach for any sort of dependency gratification or for closeness was met by her mother's intrusive, controlling, and, sometimes rejecting responses. Most importantly, the patient later came to feel that her mother's behavior was aimed at humiliating her. Much of her latency, adolescence, and now adulthood were geared to never showing weakness or vulnerability or neediness in regard to her mother.

In addition, this patient had a history from her own recollection, as well as from her parents' descriptions of her, of overreactivity to basic sensations, such as touch and sound. She was gifted in her use of language, but had relatively weaker visual-spatial processing capacities. These patterns continued into adulthood,

leaving her prone to feeling "overloaded," "fragmented," or "falling apart." She would, for example, experience "overload" when in a noisy room or when in a group with people brushing up against her, and was much better at recalling details than "seeing the big picture." Her "loud," forceful, "top sergeant" mother, for example, made her "cringe" when she would surprise her and walk into her room.

The patient's tendency to become overloaded and fragmented, and her difficulty in visual-spatial abstracting, in terms of regulating patterns, would have made it hard, under any circumstances, for her to engage in the full range of organized behavioral and emotional patterns as a toddler. Fragmented, piecemeal patterns would be more likely to occur. Likewise it would have been similarly difficult for her to conduct organized and integrated mental representation as a preschooler. Again, fragmented patterns would be more likely from the combination of overreactivity and relatively weak integrating capacities. With an intrusive, overwhelming mother, however, what might have been difficult to master became almost an impossibility. The relationship with the mother, therefore, accentuated her constitutional and maturational weaknesses. A very soothing, comforting mother might have helped her overcome her vulnerabilities. At the same time, the dynamics of her relationship with her mother were intensified by her regulatory patterns. A child with excellent self-calming and self-soothing abilities, and strong integrating capacities, might have been able to deal with an intrusive mother by becoming a little stubborn or negative, or simply, strong willed. This patient's degree of rage and humiliation and sense of fragmentation were all quite intense, in part because of the regulatory pattern.

As she progressed into her representational phases, she was, therefore, unable to fully represent nurturing, caring interactions in a stable manner, since they weren't occurring at the behavioral interaction level.

Contributing to this woman's depression in adulthood was an inability to represent longing feelings for anyone in her life, including her husband, who was thoughtful and very devoted to her; her child; or the therapist. During the therapist's vacation times, the patient would find herself getting agitated and uncomfortable, but could never picture the therapist away on vacation or experience longing or angry feelings. All she would experience was "a vague sense of anxiety, tension in my muscles, and a feeling like I'm going to fall down." Intellectually, being a sophisticated individual, she said, "I'm probably missing you, but I'll be honest, I don't feel a shred of it, although I feel physically lousy when you're away." Interestingly, she felt similarly when she had an urgent work project and needed to talk with her husband when he was away on a business trip. During the day, she would get agitated, headachy, dizzy, and experience patterns of disorganized thinking. When she was having a big meeting with her bosses, she could never imagine being soothed by her husband or calling him up for a pep talk beforehand. "The image just never occurred to me."

This person, like many who are prone toward depression, may lack the ability to represent in the most fundamental sense, wishes and affects having to do with longing feelings. They are, in fact, better at representing anger or aggression than they are at the longing side of life. They have conflicts with aggression, but an even more fundamental issue is the very lack of ability to represent critical affects. This type of difficulty has also been observed in patients with psychosomatic and substance abuse difficulties (Nemiah, 1977).

The ability to represent certain longing feelings can be viewed metaphorically as each individual's ability to create a personal internal Linus-type security blanket. Early in development, children initially are at a level where their own real behavior and the behavior of their caregivers as well as the presence of specific concrete objects serve security and communicative purposes. Around 18 to 24 months, however, under optimal circumstances, they develop the ability to create internal images, as Mahler and others described so well. These internal images become invested with certain wishes and feelings. Once a child can create images, they can obviously be used for self-soothing, as well as for fantasizing about anger. Once an individual has the flexibility of creating

representational images, he or she can create a temporary sense of security and experiment with anger, while embraced in a safety of one's real relationships. Many individuals, for a variety of reasons, cannot create aspects of mental representations, often because of early conflicts in their prerepresentational stage and/or certain regulatory patterns. I believe this scenario holds true for the woman discussed here, where the seeking of dependency and support was involved in behavioral level conflicts with her mother. Such people cannot chance creating the representational image of these wishes. This patient may have given up those types of seeking behaviors before she was even 2 years of age. The only memory she had was of things that were told to her; for example, that she either ran around without purpose or withdrew and was sometimes defiant. She never sought out her mother to cuddle or hug. She always treated her mother as a person who could give her things. She was more warm and nurturing with her father, and could seek support from him albeit in concrete ways.

In our developmental model, then, an important aspect of certain types of depression is not necessarily the loss of the real object, but the loss of, or never having the ability to create, the internal representation of the object, particularly in its soothing and dependency-oriented patterns. This leaves the person at the mercy of direct, concrete behavioral patterns. A sense of internal self-esteem, based on representations of the object, in terms of soothing, admiration, respect, and reassurance, is not present. Therefore, it is not the loss of the real object but the internal representation that may be a critical aspect of certain types of depression. Interestingly, the biological components of depression may be mediated through the regulatory patterns (hyperreactivity and/or visual-spatial integration), rather than as a direct effect on mood. Therefore, there is an interaction between experience and biology.

We see a relationship between a dynamic interaction at a critical age of development and an important structural deficit. Here the dynamic interaction may have occurred during the toddler phase of development, and influenced the transition from what I have called the behavioral organizational level (the toddler

phase of early development) to the representational phase (from about 16 months to about 30 months). While one cannot make direct correlations between experiences in infancy or early childhood and later adult behaviors and phenomena, one can gain insights about types of structures that did not form optimally in the ordinary sense. When these subsequently have not been formed because certain patterns got set into place and new experiences are not of sufficient quality to alter the early patterns, a structural deficit arises. Obviously, intense affects and conflicts can make these deficits worse.

These considerations would then play out in the treatment of this patient. Simply clarifying and interpreting these patterns would not be sufficient, and might be counterproductive. First, the therapist must always meet the patient at the developmental level of his or her ego structure. For this patient, it meant dealing directly with her regulatory patterns, not only by helping her describe them, but by creating in the office a regulatory environment (e.g., not talking too fast or intrusively and finding soothing vocal rhythms and tones). Second, attention should be paid to the behavioral expectations, which in this case included being intruded upon and the woman's countertendencies to withdraw or become fragmented in speech or behavior. Here, it was insufficient to simply point out that whenever the patient felt needy, she expected the analyst to intrude and overwhelm her as she felt her mother had done in the past. Because this was a behavioral, rather than representational, expectation, it was experienced not as "I *feel* as though you will control me." Instead, it was "You are going to control me," or with regard to her withdrawn or fragmented behavior, "You are *overloading* me."

The therapist was verbally very interactive to maintain a sense of relatedness when the patient was withdrawing. His counterbehavior was geared to increase the patient's behavioral and affective range. He attempted to help the patient organize communications when she became fragmented (e.g., "I lost your last idea"). When she became very fragmented, he increased visual and behavioral interchange through gestures, to maintain organization. When there were gestural indications in terms of

tone of voice, motor gestures, or affect cues of dependency feelings, the therapist would attempt to maintain and further elaborate these through the interactive dialogue, which would provide an experience of nonintrusive comfort. As the patient withdrew or became hostile, in anticipation of intrusiveness, initially the therapist did not clarify or interpret underlying feelings or wishes. Such comments would have been at a different developmental level than the patient's current level at that point. Instead, the therapist maintained the dialogue with behavioral descriptions: "You see me as doing this or that to you, rather than being comforting, etc."

As the patient became more flexible, the therapist then helped her identify those affects that led to withdrawal or fragmentation, which were initially at a somatic, physical level. "My muscles are tense"; "My heart is beating fast." Detailed somatic descriptions led to abstracted affect descriptions and representational-type patterns ("I feel like I'm falling apart"; "I feel empty"; "I feel lonely and isolated"). Eventually, states of longing and need could be communicated in terms of "missing feelings," and the capacity to represent dependency and longing emerged, perhaps for the first time in the patient's experience.

Once she could represent experience, it was possible to use clarifying and interpretive comments to help her deal with pathologic defenses and work through her conflicts. She could then further develop her capacities for representational differentiation and self-observation. There are a number of representational levels (from concrete to more abstract and reflective) that are described in subsequent chapters.

Some of these strategies are no different from approaches that many intuitive therapists have been following for years. But they are viewed, often, as "intuitive" and not systematic or central to therapeutic growth. The developmental perspective can help systematize them and open up new areas for inclusion, such as constitutional and maturational differences, and the different developmental levels which are not always intuitive. In addition, some will argue that such developmentally guided clinical strategies are part of preparations for intensive psychoanalytic therapy

or psychoanalysis. To those who take this point of view, I would suggest that many more patients have these early difficulties than is often recognized, and that for these patients, regardless of the treatment approach, one needs to focus in some depth on these issues as a substantive focus in the therapy. To think of it as preliminary to something else may be a bit like considering the meal to be preliminary to the dessert.

THE DEVELOPMENTAL APPROACH AND PSYCHOPATHOLOGY

The developmental perspective pertains to many types of psychopathologic configurations we deal with, and can help inform our therapeutic approaches for disorders ranging from symptom and character neuroses to character pathology, borderline conditions, and the psychoses. Often, for example, neurotic patterns involve various degrees of circumscribed lack of representational differentiation for certain wishes and affects. Character pathology frequently involves marked constrictions in representational elaboration and in behavioral organization as well. Borderline and psychotic patterns often arise out of significant regulatory difficulties, related to sensory reactivity and processing difficulties, and problems with early presymbolic differentiations of behavior and affect.

It is, as indicated, often assumed that patients with some of these types of psychopathology can participate in the psychotherapeutic process. Such participation can take place through collaborative discussions, self-observation, interest in seeing connections and an ability to make connections between different thoughts, feelings, and ideas, in terms of patterns, and an ability to relate feelings to behaviors and daily events in one's life. In fact, as also indicated, many patients have difficulties with these very capacities that are often thought to be essential for participation in the psychotherapeutic process. The difficulties the patients have cannot necessarily be attributed to motivation or lack of interest. For example, the patient who does not talk, reflect, or make

connections may be mistakenly labeled as "resistant" or psychologically or unconsciously "disinterested" or consciously "unmotivated" due to character pathology. Far from being uninterested, many such patients would like nothing better than relief from their symptoms, and actually do not possess the very capacities that are viewed as essential for participation in the psychotherapeutic process. Furthermore, the very problems patients have and the symptoms they manifest may be related to structural personality deficits that are an integral part of the difficulty they have in participating in the psychotherapeutic process in the ordinary way. Such patients may have difficulties, which are part of their core personality deficits, in the very capacities that we often view as ordinary and expectable in terms of psychotherapeutic collaboration. To call such a patient unmotivated is a bit of a tautology. It is a way by which therapists have for years escaped the painful conclusion that the techniques they make available may only be useful for a small number of patients. This is not because other patients are unmotivated, and are therefore inherently incapable of participating, or simply don't want to, consciously or unconsciously, but because our techniques are not able to deal with the deficits the patient brings to us. The deficits on the one hand result in their symptoms, and on the other hand result in their inability to collaborate in the ordinary and expectable psychotherapeutic strategies we make available to them.

There are a variety of core capacities that patients often have trouble with, that result both in their symptoms and their difficulty in using the psychotherapeutic process as it is usually conceptualized. These incapacities include difficulty in representing or labeling feelings along with an inability to construct patterns of feelings, behaviors, and ideas (i.e., building bridges between different internal wishes, feeling states, and behaviors). On an even more basic level, many patients have difficulties understanding the meaning of other people's behaviors. Such patients have difficulty understanding the intentions of others ("Did he intend to be mean, or hurtful, or supportive?"). It is not unusual for patients to be preoccupied with trying to figure out what so-and-so meant by their look, glance, body posture, tone of voice, or by

the particular way they phrased a word. This difficulty in assessing the intentions of others is far deeper than just understanding the meaning of words. It is not understanding the meaning of peoples' behavior and affect.

On an even more basic level, patients have difficulty with maintaining a psychological boundary, in terms of a sense of self and a sense of the other person. It is hard for them to know which feelings are theirs and which are the other person's, or where their inner reality begins and ends and someone else's begins and ends. We see patients who have difficulty with forming relationships or those who can form relationships, but have difficulty in maintaining a certain degree of stability in those relationships. (The slightest bit of stress, threat of separation, anger, or frustration leads to a breakup of a relationship.) Furthermore, we see patients who can form and maintain some degree of stability in relationships, but who have no emotional depth or range to their relationships, which are shallow and mechanical and concerned with concrete needs, rather than deep feelings of pleasure, dependency, and intimacy. Some patients can tolerate relationships, but only in one area of emotion. They can be dependent or needy, but cannot tolerate assertiveness or explorativeness. Thus we see a range of difficulties just in the ability to negotiate a relationship in terms of its formation, stability, its depth or shallowness, and the range of feelings accommodated. Such difficulties with relationships, at this most fundamental level, are different from the relationship difficulties which have to do with symbolized or represented conflicts or anxieties. A person who is conflicted over sexuality may shy away from sexual intimacy in a relationship, but otherwise experience a broad range of feelings in a stable and ongoing manner. This is contrasted with the more fundamental problem in relationships where from early in life, there is evidence of a pattern of superficial or concrete ways of relating or withdrawing at the first sign of stress or anxiety. In this case, patterns learned in the early years of life are the issue; for example, here what is relevant are the basic ways of relating *before* relationships became represented and symbolized and became affected by one's internal conflicts.

We also see difficulties in individuals' capacities for self-regulation. This involves how individuals respond to and process sensation, noise, touch, sight, smells, and their own movement patterns. Some people are overloaded by information that comes in through sounds and words; others are more confused by information that comes through the visual-spatial domain. Affect expressions communicated through sounds can be confusing to some, while affects that are expressed in visual terms are confusing to others. As seen in our earlier clinical example, simply being in a noisy room will overwhelm certain individuals and make them feel suspicious or paranoid. Being in a crowded room where people are brushing up against them, can lead many people to feel overwhelmed. This difference in physical sensation is common among patients, and challenges the traditional notion that most of us hear, see, smell, and experience touch in similar ways. In fact, we have discovered that there are enormous differences between the ways in which individuals experience basic sensations in terms of reactivity to sensation and the ability to process information through different sensory channels. These "regulatory" difficulties are a very basic level of psychological adaptation and determine how individuals organize their experiences and negotiate many aspects of their psychological lives.

Thus we can see that many patients have difficulties with those core abilities that connect emotions, ideas, and behaviors and that symbolize or represent ideas (i.e., form an intrapsychic, symbolic world). They struggle with their inability to comprehend their behavior in terms of patterns and misunderstand other people's intentions as expressed in behaviors and affects. Patients may lack the ability to form psychological boundaries involving their own reality and someone else's reality. They may be unable to form, maintain, and have deep, wide-range, and affectively ranging relationships. They lack the ability for self-regulation (i.e., regulating and organizing sensations). These fundamental abilities, which clinicians will readily see as an important part of personality structure and an essential foundation for healthy personality functioning, cannot necessarily be taken for granted. Many difficulties are part of deficits in these core abilities, and as

indicated above, these core abilities are part of the symptom picture and also form part of the essential way patients relate in the therapeutic relationship. It will be seen later in this work that the relative mastery of various core abilities is inextricably related to the mastery or lack of mastery, of different developmental stages. As the following examples illustrate, core difficulties play out in two ways in the symptom picture and in the way in which the patient negotiates the therapeutic relationship.

Let us consider the example of the person who does not see his or her own patterns of behavior and cannot comprehend the behavior and intentions of others. Such an individual is likely to have a variety of severe character pathologies. These may involve fixed attitudes, such as depressive or paranoid attitudes because, not having the capacity to read others' intentions, they are constantly misreading others' intentions. Closeness may be perceived as hostile; independence on the other person's part may be perceived as rejection; and depressive or suspicious attitudes may be the result.

In the therapeutic situation, such individuals may have difficulty with perceiving the intentions of the therapist. The therapist's fatigue may be perceived as a rejecting or hostile attitude;
his apparent neutrality may be perceived as critical. More importantly, such patients who have trouble with perceiving the intentions of others and understanding their own behavioral patterns and those of others, are unlikely to be able to symbolize or represent affects. They are, therefore, unable to label affects in themselves or others and to see emotions and affects as mediators between their own wishes and behaviors. Life for them is a series of interactive behaviors, rather than feelings leading to behaviors. Therapists often wind up labeling behaviors for such patients and giving the patients affect labels, which the patients do not comprehend, but may obsequiously agree to.

Consider another example of patients with regulatory difficulties. Such patients who are overreactive to sound and touch, may, on a physical basis, be prone to anxieties and fears and
patterns of avoidance and inhibition. Such patients may develop

attitudes and feelings having to do with fears, worries, and anxieties, including anxious, fearful preoccupations, which are derivative from these physical differences and intensified by their interactions with others in their environment. In the therapeutic situation, such individuals may form very dependent and even seemingly symbiotic relationships with their therapists, looking for protection from their fears, worries, and anxieties. They may seem to free associate, often in a fragmented and overwhelmed way, and with rich ideation (particularly if they are bright). They and the therapist may ignore the fact, however, that there is a strong physical component to their difficulties, and that they have a tendency to psychologize their own sensory response tendencies. For example, standing in a crowd packed shoulder-to-shoulder caused such a patient to feel overwhelmed and fearful. Fantasies of intrusion, sexual molestation, or even rape are not unusual. The ability to see that certain characteristic feelings of being overwhelmed and certain fantasies (which have their psychogenic components) are precipitated by feeling physically overloaded, leads such patients into perpetual therapeutic stalemates, where they endlessly review the salve feelings with little relief, other than the day-to-day relief of the support of the therapist. Working through such difficulties often requires understanding their own historically based responses to their own physiologic makeup, and how others in their environment dealt with them in response to their own physiologic makeup. This helps them, when they're in the middle of a crowded room, realize that the mere brushing of shoulders and body contact overloads them and that going to a corner of the room can be helpful. They can become wary of their own suspicious and paranoid attitudes, with the therapist helping them develop some self-observing capacity, regarding their own physical profile. This then helps them separate out the physical from the psychogenic (i.e., how early in life parents and others may have dug the hole deeper for them by certain ways in which they responded to the child's feeling overloaded or overwhelmed).

The early chapters of this book will further discuss the above examples and difficulties in labeling or representing feelings and

making connections between feelings; forming psychological boundaries; and forming stable and deep intimate relationships patterns. Each developmental level will be discussed. Readers unfamiliar with this developmental framework may also want to study Greenspan (1989, 1992).

In each of the following chapters we will discuss therapeutic principles geared to working with each stage of development and level of the mind. We will observe how the principles outlined in this chapter can be utilized in the psychotherapeutic process. Each stage of ego organization will be seen to elucidate therapeutic principles and tactics, which collectively will form the basis for a developmental model of psychotherapy.