Journal of Contemporary Psychotherapy
Vol. 17, No. 4, Winter 1987

Necessary Factors in Psychotherapy: A Model for Understanding Iatrogenic Disturbances

STEPHEN DeBERRY, PH.D.

ABSTRACT: Psychotherapy is conceptualized within a phenomenological framework as a relationship with a focus. Both these factors, the relationship and the focus, are examined as necessary factors for the creation of the therapeutic alliance which is seen as a sufficient condition for intrapsychic change. The proper balancing of the two necessary factors is seen as essential for a therapeutic alliance to evolve. The relationship factor is described in existential terms as a special form of the "I-Thou" encounter, while the focus factor is examined as part of the diagnostic aspect of psychotherapy. Iatrogenic distortions in psychotherapy are discussed in terms of distortions in the necessary factors—the focus and relationship. Four types of iatrogenic distortions are described: (1) overemphasis of the relationship and focus, (2) underemphasis of the relationship and focus, (3) overemphasis of the relationship and underemphasis of the focus and (4) underemphasis of the relationship and overemphasis of the focus.

Arriving at a satisfactory yet meaningful and consensual definition of psychotherapy is, as Herron and Rouslin (1984) have pointed out, a most difficult task. Yet, any study of psychotherapy must somehow deal with the inveterate dilemma of defining it. One method of avoiding this conceptual trap however, is to describe, rather than define, *the process of psychotherapy*. In this sense, a descriptive-phenomenological mode is a useful way of side stepping the thorny question of what psychotherapy is, as well as who should be doing it. Readers intent on examining issues related to defining psychotherapy are referred to the third edition of *The Technique of Psychotherapy* (Wolberg, 1977).

Psychotherapy can be described as a delicate and purposeful relationship between at least two people that is developed towards

an expressed end. Both these factors, i.e., the relationship and the expressed end, which I shall call the focus, are as inherently delicate as they are essential to the technical process of achieving therapeutic change. Because the focus and the relationship are essentially delicate, the harmony of their existence, alone and in relationship to each other, can easily become disturbed. The relationship and the focus may be considered two necessary factors under which a number of other variables are subsumed. In this case, the relationship and the focus may be considered generic factors independent of any one particular theoretical orientation. The two factors are as important to classical psychoanalysis as they are to behavior modification.

A necessary factor is a condition for the occurrence of a specified event in whose absence the event cannot occur. Life is full of relationships and focused encounters, yet most are not defined as psychotherapy. However, when a relationship and a focus are combined within the context of psychotherapy, a sufficient condition known as the therapeutic alliance is created (Zetzel, 1970). A sufficient condition for the occurence of an event is a circumstance in whose presence the event must occur. Obviously, there may be numerous necessary factors for the occurence of an event, all of which must be included in the sufficient condition.

The therapeutic alliance, or the working alliance (Greenson, 1968) may be considered the sufficient factor for the occurence of psychotherapy. The alliance, is the unique result of a successful therapeutic encounter in that it reflects the particular combination of the necessary factors, viz., the *relationship* and *focus*. While numerous relationships in life may manifest aspects of the relationship and focus e.g., marriage and business, it is only in the psychotherapeutic encounter that the two become skillfully blended to produce a new and vibrant relationship called the therapeutic alliance.

It is within the therapeutic alliance that the patient's struggle to change takes place. Within this special relationship of controlled closeness the patient can learn new and healthier ways of behaving, thinking, and feeling. The purpose of this focused relationship is always in the patient's best interest, that is, towards behavioral, affective, and cognitive improvement. If there is no therapeutic alliance (the sufficient factor) there can be no psychotherapeutic change. If the focus and relationship factors (neces-

sary factors) are not skillfully managed, there can be no therapeutic alliance.

The present paper concerns itself with disturbances in the necessary factors that are either caused or exacerbated by the therapist. Therefore, they may be considered iatrogenic problems of psychotherapy.

The Reality of Negative Effects

It is now recognized that psychotherapy does produce negative effects. Crown (1983) describes four possible factors associated with negative effects: (1) the patient or therapists personality, (2) the patient therapist interaction, (3) faulty technique, and (4) the unresolvable social situation of the patient. Strupp (1977) in a comprehensive review of the literature on negative effects in psychotherapy summarizes the basic factors which predispose treatment towards the negative as: (1) inaccurate or deficient assessment, (2) therapists personality, (3) therapists training, and (4) misapplications or deficiencies is technique.

Thus, it seems that the process of psychotherapy contains rather substantial potential for error. It becomes incumbent therefore, that the therapist always operate according to a set of rules. Furthermore, the therapist must always critically evaluate, review and reevaluate his rules and interventions, in order to insure that the "rules and interventions" are not actually enhancing factors associated with negative effects. This reevaluation process becomes especially critical when parameters, that is, modifications of the basic rules are involved.

In The Patients Best Interest

In all treatment, of paramount importance is the rule that whatever the therapist does (or does not do) must always be in the patient's best interest. The primary responsibility of the therapist is not that the patient stay in therapy, learn to accept the therapist's point of view, gain insight, or learn new behaviors, although conceivably any of these might be considered desirable outcomes. Rather, the therapist's primary responsibility is to *always act in the patient's best interest.* Therefore, one does not, for example, force interpretations or behavior change, significantly raise the fee af-

ter an intense transference relationship has developed, allow a truly suicidal patient to leave the office, or leave for vacation on one week's notice. Obviously, this list could be extended indefinitely. It is my contention however, that if the therapist constantly evaluates his or her behavior in terms of the focus and the relationship, that many of the factors associated with negative effects could be circumvented or managed within the therapy. Awareness of the focus and relationship can at least prevent an iatrogenic exacerbation of a therapy that already contains the seeds of distortion (Gruenbaum, 1986).

An Eclectic Conceptualization

Emphasis on the proper balancing of focus and relationship factors represents an eclectic conceptualization of iatrogenic difficulties associated with: (1) the patient/therapist interaction; (2) faulty technique (Crown, 1983), and (3) misapplications or deficiencies in technique (Strupp, 1977). This viewpoint, assumes of course, that there are no deficiencies of diagnosis, the patient/therapist personality variable, therapist training or an unresolvable social situation in the patient's life.

Psychotherapists would probably agree wholeheartedly with what has just been stated. Perhaps most would consider the issue self-evident. Unfortunately, the necessary factors are often considered simple and self-evident and therefore not important or, so obvious that it is assumed that everyone who practices psychotherapy understands how to balance them. This is not necessarily so.

As the supervisory process reveals, each therapist has a relatively distinct and individual way of responding. Since the therapeutic process, at best, is an experience of creativity and spontanaiety this individuality cannot be avoided. In fact, it should not be avoided. However, the therapists adherence to a set of necessary factors becomes critical, precisely because there is such room for individual variation and likewise, no complete method of evaluating what happens in each session.

Effects of Therapist's Reaction on Resistence

Problems occur when either of the factors—the relationship, the focus, or both—are missing, overemphasized, or deempha-

sized to the point where the factor no longer seems of concern. Sometimes this becomes evident to either the therapist or the patient and is openly acknowledged and corrected within the context of therapy. More often than not, however, it is brought out in supervision and the therapist is forced, so to speak, to recognize the problem. Of course, this possibility assumes that the therapist is being supervised. Again, this is not always the case. In any event, it is rare that the patient is so sophisticated as to realize there is a problem with one of the two necessary factors. The very nature of "being a patient" involves putting oneself in a vulnerable and dependent position and presupposses an ignorance of these factors. This ignorance is fairly well recognized as a characteristic of most patients, unless of course the patient is a psychotherapist. In that case, there is at least a certain intellectual understanding of what therapy should be and if the relationship or focus is not correctable the patient leaves for a more suitable therapist.

Patients however, usually do not leave therapy for such logical reasons. Treatment is terminated because they are not able to tolerate what is occuring: for example, the closeness, the emergence of primary process, disturbing thoughts or affects, or a growing awareness of alternatives to their present life. The dynamic of resistance is a well known and understood phenomena. What is less understood or even acknowledged among therapists is how *their actions, more precisely, their reactions towards their patients, intensifies the resistance process.* This hardening of resistance, when brought about by the therapist's ignorance or mismanagement of the two necessary factors, in my opinion, leads to irrepairable ruptures in the therapeutic alliance, that is, *the working, focused relationship* between the two people engaged in the process of psychotherapy.

Many patients who have been victims of iatrogenic disturbances caused by distortions in the necessary factors of psychotherapy are angry at their therapist. At least the healthier ones are. Patients with more serious pathologies, especially, those with lower-level borderline, preoedipal, or narcissistic disturbances are more unconscious of their anger and are thus more likely to get caught in sadomasochistic stalemates with their therapist. When the problem is iatrogenic, and is not a direct result of the patients psychopathology, the patient's anger is always justifiable. To interpret such anger as a repetition of earlier relationships is a definite mistake.

ESTABLISHING AND MAINTAINING THE THERAPEUTIC ALLIANCE

The Relationship

The relationship part of psychotherapy represents a genuine contact between two or more human beings. By *genuine* I refer to an authentic I-Thou relationship (Buber, 1958) in which an existentially mutual encounter occurs. In an I-Thou relationship the other is met as a complete yet separate individual. By *complete* I mean that all aspects of the person's being are allowed to be available within the relationship; that is, one does not have to pretend, act, or be deceptive about aspects of self.

False-Self Encounters. Clinicians adhering to an interpersonal or object-relations approach such as Sullivan (1954), Winnicott (1965, 1974, 1975), Fairbairn (1954), Guntrip (1969), Horner (1984), and Laing (1969) have cogently described, quite clearly in the tradition of existential philosophy, Buber (1970), Satre (1957), Kierkegaard (1944) and Nietzche (1967) and existential psychiatry, Binswanger (1963), how disturbed relations between people can be conceptualized as false-self encounters (I-It or It-It).

An I-It relation is described as a subject-object relationship whereby one person becomes a thing, i.e., a property or object of desire and manipulation. I-It relationships are characteristic of three basic pathological forms of relating. These forms are described as: (1) relating to others as self-objects, (2) relating to others as transitional objects and, (3) relating to others as part objects (Brice, 1984). The relationship factor of psychotherapy, within the context of the focus, attempts then to shift the patients style of relating from part to whole objects, that is, from an I-It to an I-Thou state of being. That is, the therapist seeks to change the patient's style of relating from an alienated I-It relationship to the more dynamic, although more anxiety provoking style of an I-Thou relationship.

Although the English language becomes somewhat awkward when describing such phenomena, one might say that the wholeness of the therapist (i.e., all the therapist is in his or her work) meets the wholeness of the patient (i.e., all that the patient is). Schaeffer (1984) describes this encounter as the complete involve-

ment of the work ego of the therapist with the ego of the patient. Such a relationship requires the development of trust, and of course, the development of trust takes honesty and time.

Psychotherapy however, is a special form of the I-Thou encounter, in that the therapist, acting always in the patient's best interest, seeks to alter certain aspects of the patient's self. An I-Thou relationship in psychotherapy is not unconditional love or acceptance for at times the psychotherapeutic I-Thou encounter means redirection or interpretation. This redirection, or unacceptance of certain aspects of the patient's being, always causes anxiety and resistance in the patient. Yet, if the patient trusts that the therapist honestly has his or her best interest at heart, that is, if there is a genuine meeting of two people where one "helps" the other and the other accepts the help (I-Thou), then, despite anxiety and resistance, change may occur.

The psychotherapeutic relationship is unlike any other relationship in that although the therapist might have to accept the patient's pathological state, it is understood that this acceptance is a transitional state until a healthier way of being can be achieved. Although certain behaviors are expressly unacceptable; for example, suicide, self destructive actions or acting out, it is further understood that the therapist will not abandon the patient out of intolerance or frustration. Rather, the therapist engages in a facilitating relationship and attempts to create conditions so that the patient can change. These conditions are created by the therapist's use of his own self as well as interventions ranging from the more basic techniques of pacification and unification to higher level techniques such as interpretation and reconstruction.

The Focus

The focus part of psychotherapy concerns itself with the diagnostic aspect of the relationship. In this sense, the focus fits nicely into the medical model, that is, a disease-oriented, problem-focused, symptom-directed, deductively logical mode of inquiry. The patient has a problem, that is, a symptom or set of symptoms which he does not understand, The symptoms cause distress, thus forcing him to seek the assistance of an expert, in this case the psychotherapist. Contractually, what should be mutually understood is that the psychotherapist will diagnose, that is, identify and explain the patient's symptoms. Diagnosis can occur on several in-

clusive levels: genetic, biological, psychological (developmental and structural) interpersonal, familial, spiritual, environmental, and educational.

The diagnostic process of placing the patient's problems within an understandable and recognizable framework is an enormously reassuring event for the patient. There is usually some degree of relief which accompanies this process along with an easing of tension that helps solidify the budding alliance.

Now that the "problem" has been narrowed down and identified a focus of treatment has come into being, Often, there are several focal points, or, manifestations of the basic problem. Some are closely related to the main focus while others are peripheral and are "put on the back burner" to be looked at later. The discovery, identification, and agreement of the focal points always takes place within the context of the relationship and may, depending on the person's problem and the therapist's orientation and the type and frequency of sessions, take anywhere from one to hundreds of sessions. In some psychotherapeutic encounters the focus is indeed an ongoing, always changing, never ending process.

For example, behavior therapists, or practitioners of short-term dynamic therapy actively pursue and work with a clear focus. Therapists adhering to a more traditional psychoanalytic perspective let the focus change or shift in order to let new material emerge. Each theoretical orientation has its traps, in that each has a proclivity for an iatrogenic problem to emerge in the general factor that it tends to either most emphasize or deemphasize. Thus, the psychoanalytic practitioner must be wary that the focus is not lost to free association while the behavior therapist must, likewise, be cautious that the relationship is not sacrificed in the name of technical intervention. However, regardless of orientation, iatrogenic problems can and do emerge in both the focus and relationship sphere in all therapeutic encounters.

TYPOLOGY OF BASIC DISTORTIONS OF THE NECESSARY FACTORS

There are four basic distortions that may occur within the necessary factors. These may be described as follows:

Type I—Overemphasis of Both Relationship and Focus

Type I disturbances are perhaps the most benign distortion. They are usually manifestations of over zealous, aggressive, or over eager therapists. Type I disturbances are usually fairly obvious and are likewise very amenable to a general slowing down and waiting on the part of the therapist.

Type II—Underemphasis of Both Relationship and Focus

This type of disturbance is common and is usually attributable to the therapists inexperience, ineptness, and or confusion. Therapy containing Type II distortions is manifest by wild, incoherent, nonproductive and aimless sessions. The encounter is not really psychotherapy at all. Typically the patient is a lower level borderline or psychotic person with strong manipulative or psychopathic tendencies. Sometimes the patient is extremely charming, interesting, or fascinatingly bizzare, perhaps with strong narcissistic features. In any event, the therapy goes awry in that the therapist, usually due to inexperience, becomes so involved in what their patients are saying, that is, in the content, or in the persons themselves (e.g., stemming from a need to be liked, accepted, or gratified by the patient), that the therapy lacks direction. There is no clear focus and the relationship is controlled by the patient. Type II distortions are likewise easy to identify and are usually the result of a total patient/therapist mismatch either due to inexperience or countertransference problems. Thus, they can be corrected through the proper training, supervision and/or psychotherapy of the psychotherapist.

Type III—Overemphasis of the Relationship and Underemphasis of the Focus

This type of distortion occurs quite often in psychotherapy yet, because of their nature and are more difficult to detect in comparison to type I and II distortions. They are phasic in that there may be certain periods, particularly in lengthy psychotherapy, when, because of the patient's symptoms or personality or perhaps what the patient is currently expressing or experiencing, that the therapist lets the relationship predominate. At times this

is clearly in the best interest of the patient as when the therapist needs to create a warm, safe holding environment.

In order that the patient does not feel overwhelmed during periods of intense anxiety or decompensation, it is likely that the therapist will rely more on the empathic components of the relationship and alliance. The treatment of certain psychotic, borderline, and severe narcissistic disorders depends in part on pacification and unification, techniques which are highly dependent upon a successful, warm, and trusting relationship (Balint, 1968).

Another example of proper emphasis of the relationship, is of course, when transference material emerges. This is a highly desirable and important phenomena that in most analytic psychotherapies is encouraged, explored, and interpreted. This is especially important when the transference can be interpreted on a specific genetic level (Langs, 1973) that can be connected to present behavior; for example, "you are feeling abandoned by me much as you felt abandoned by your mother and presently feel abandoned by your wife." Such interventions are usually quite productive and represent a proper use of a relationship that employs the therapist as a neutral person. Distortions occur when the therapist uses the transference and/or real relationship in an exploitive manner. Such exploitation occurs when the relationship itself becomes the focus and takes precedence over whatever else is happening with the patient, for example, symptoms, life circumstances, or other personal issues. Overemphasis of either the transference relationship or the real relationship represents a serious distortion and is almost always a manifestation of unresolved countertransference problems on the part of the therapist. Examples of such therapist problems include, excessive narcissism or grandiosity, an overwhelming need to be linked, to be in control, to be needed, depended on, or to be the focus of the patient's life (Herron & Rouslin 1984). The following case study offers a example of problematic countertransferential reactions.

Case 1

John D, a 29 year old electrical engineer had been in psychoanalytic psychotherapy three times a week for approximately four months. Mr. D had entered treatment because he began feeling increasingly anxious in relation to his impending wedding date.

The patient was engaged to be married in three months. As the wedding date approached, he grew increasingly anxious and began perceiving his fiancee as cold and indifferent to his problems (which she was). His therapist, Dr. P, an attractive 38 year old female, interpreted his anxiety as being related to issues of fear and anger in relation to disturbed relations with his mother (a correct interpretation). During this period, the patient began feeling increasingly attracted to and was openly acknowledging of the intense feeling he had towards his therapist. During the 5th session he told Dr. P. that she was "very beautiful" and that he "wished his financee was as warm and understanding as she." Dr. P's response to such statements was to further encourage John to get closer to her, that is, "to get in touch with the intense feelings you have for me," Dr. P strongly felt that the patient's anxiety towards his fiancee could be best modified by concentrating on the transference (which was true). However, John had rigid intellectual defenses and was of course extremely ambivilant about being close with a woman. The patient became anxious about Dr. P's wanting to get closer, viewing it as an example of "women's posessiveness" with him. John quit therapy abruptly in the fourth month, telling Dr. P in their final session that "you are crazier than me for wanting to work on our relationship as a means of therapy." He also felt that she was jealous of his financee and wanted to "ruin his engagement." Dr. P called the patient several times at his home before she began to realize what had occurred.

Ultimately, psychotherapy is a relationship. Furthermore, it is well understood that it is within the context of the relationship and the transference that change occurs. What is sometimes forgotten however, *is that the relationship is not for the benefit of the therapist but is simply a vehicle, a field of human connectedness, in which conditions for change are created.* Psychotherapy is not a "pure" relationship, nor is it a relationship of unconditional love. Such concepts are idealistic abstractions that increase unhealthy dependence and foster the magical fantasy that such love and intimacy is obtainable on a regular basis. The following passage from a chapter on the psychotherapy of cocaine abusers (Resnick and Resnick, 1984) exemplifies conditions which foster type III errors:

> . . . these powerful emotions then can be identified, verbalized and re-experienced in an atmosphere of *unconditional caring and love,* so that they

> are *gradually and spontaneously transformed,* allowing the *inborn capacity for love of self and others to unfold.* . . . When the therapist deeply honors and respects each person's uniqueness and relinquishes judgments and preceptions about how other people should be, *unconditional love becomes central to the treatment relationship.* In this way, self-esteem and autonomy can be restored, thereby enabling the patient to experience the satisfaction that comes from *genuine intimacy* and feel whole when alone. Cocaine begins to lose its appeal when the treasured state of meaningfulness and euphoria (well being) is discovered in the *warmth of human relationships.* In this discovery, healing occurs and psychotherapy becomes what it literally means: the healing of the soul (pp. 725–726; my italics).

Emphasizing the relationship because of its more human, warm, and agreeable nature can easily be distorted into a paid friendship exploitation of the patients dependency and vulnerability. The therapist begins to be seen as omnipotent, irreplaceable, ideally loving, and lovable or even seductive. At times the therapist might seem to resemble pathologically seductive figures from the patient's past e.g., mother or father. Obviously the therapist's identification and interpretation of the patient's perceptions as transference phenomena fails if the therapist has been behaving in such a manner.

Type IV—Overemphasis of the Focus and Underemphasis of the Relationship

The increased interest in psychobiology, psychopharmacology, cognitive/behavioral therapies, and neuropsychology, has resulted in an increase in Type IV distortions. The strong behavioral and biological basis of the DSM-III and the medical psychiatric model, as well as the "empty organism" or "organism as mediator" approach of the cognitive/behavioral schools are especially likely to result in iatrogenic disturbances of a type IV nature.

When psychotherapy is over scientific, intellectual, or authoritarian it is seldom effective. Balint (1968) emphasizes the importance of warm effective communication within the doctor-patient relationship not only in terms of psychotherapy, but likewise, in reference to medication compliance and recovery from physical illness. Biological reductionism and behavioral empiricism are not necessarily going to change anyone. How correct the therapist is in diagnosing and exploring the patient's problems, in isolation,

have little relationship to changes in the patient. Marmor (1985) states;

> . . . the primary danger from relying too heavy on a predominantly biologic approach to our psychiatric patients . . . lies in reductionistic thinking that tends to minimize the importance of our patients subjective experiences and reactions. To ignore these reactions and the external events that may have contributed to them is to fail to understand the total biopsychosocial nidus in which most psychopathology develops (p. 478).

Type IV disturbances are characterized by psychotherapies that are dry, lifeless, over intellectual, reductionistic, and mechanistic. Obsessive patients or patients who highly value intellectual defenses are highly vulnerable to the effects of these distortions. Since the type of therapists who makes type IV errors are usually obsessive and controlling themselves, the combination with a patient of similar dynamics is often very unproductive. As in Type III distortions, the problem is usually one of unresolved countertransference, in this case, of the opposite nature, e.g., the need to be distant or aloof, the need to do something in a medical-scientific manner, the need to be important and knowledgeable, fear of being helpless in the patient's eyes, and/or fear of intimacy.

Case 2

Mrs. J, an attractive, high functioning, depressed 36 year old female had been in twice-weekly psychotherapy for 13 weeks. Her therapist, Dr. H, felt that Mrs J's mild bulimia was a critical behavior that had to be "dealt with before anything else." Mrs. J had entered therapy due to, what she described as "unsatisfactory relationships with men and a problem with food." Dispite the fact that her bulimic episodes occurred approximately once a month and were not life threatening, Dr. H focused the therapeutic time essentially on the behavior and dynamics of food related issues. Not surprisingly, Dr. H had once been extremely overweight and had not thoroughly worked through, or resolved issues pertaining to his own obesity. By the 6th week (12th session) the patient had begun complaining about what she perceived as the therapist's preoccupation with a rather minor issue. Dr. H handled her protests as resistance, interpreting her reluctance to focus on her eating behavior as a primitive means of maintaining control based on

earlier empathic failures in her maternal relationship (a correct interpretation). The patient however, being no way ready to process this information, became increasingly anxious, frustrated, and more demanding of Dr. H's time (increasing weekend phone calls). She began to view her problems as a difficulty in her relationship with Dr. H (which it was). Dr. H viewed these changes as increasing evidence of the patients resistance to exploring her problems. By the time Dr. H recognized what Mrs. J was asking for, that is, for a more patient, accepting, and open relationship, the patient terminated therapy. A three month follow-up inquiry indicated she has resumed treatment with another therapist.

Emphasizing the focus, because of its more objective, scientific, and technical nature can easily become distorted into a type of detached aloofness. The therapist begins to be perceived by the patient as cold, distant, disinterested, mercenary, or sometimes punishing, even to the point where the therapist begins to resemble, that is, act like certain punishing figures in the patient's past. If the therapist has been technically correct in his or her balancing of the necessary factors, this event can be identified as a transference problem. If indeed, it is truly transference phenomena, then gentle interpretations usually lead to new insight and the possibility of genuine change as the patient begins to recognize how patterns from earlier relationships are affecting present ones. However, if the therapist has neglected basic aspects of human relatedness in order to "cure" the patient through therapeutic manipulation, then the patient's resistance, anger, and perhaps "escape" from therapy become justified.

The preceeding discussion of necessary factors and iatrogenic problems is by no means exhaustive. There are innumerable variables, phenomena, and metaphenomena all of which are part of the complicated process of psychotherapy and which, likewise, must be explored and understood as part of the total process of iatrogenic problems and negative effects. However, the relationship and focus does provide a conceptual model in wich some of the more basic problems associated with negative effects can be viewed. Furthermore, it provides a schema in which the therapist can examine his own rules and behaviors, specifically in terms of how they relate to the sufficient condition of establishing and maintaining the therapeutic alliance.

REFERENCES

Balint, M. (1968). *The basic fault.* London: Tavistock Publications.
Binswanger, L. (1963). *Being-in-the-world: selected papers.* New York: Basic Books.
Brice, C.W. (1984). Buber's theory and object-relations theory. *Psychiatry, 47,* 102–123.
Buber, M. (1970). *I and thou.* Translated by W. Kaufman. New York: Schribner.
Crown, S. (1983). Contraindications and dangers of psychotherapy. *British Journal of Psychiatry, 143,* 436–441.
Fairbairn, W.R.D. (1954). *An object-relations theory of the personality.* New York: Basic Books.
Greenson, R. (1970). *The technique and practice of psychoanalysis.* New York: International Universities Press.
Gruenbaum, H. (1986). Harmful psychotherapy experience. *American Journal of Psychotherapy, 40,* 165–176.
Guntrip, H. (1969). *Schizoid phenomena, objects relations and the self.* New York: International Universities Press.
Heron, W.G. & Roslin, S. (1984). *Issues in psychotherapy-volume I.* Washington D.C.: Oryn Publications.
Kierkegaard, S. (1944). *Either/or.* Princeton University Press.
Laing, R.D. (1969). *The Divided Self.* New York: Pantheon.
Laing, R.D. (1969). *Self and Others.* harmondsworth Enland: Penguin.
Langs, R.J. (1973). *The Technique of Psychoanalytic Psychotherapy,* Vol 1. New York: Jason Aronson.
Marmor, J. (1985). Biologic psychiatry and the psychosomatic approach. *Psychosomatics, 26,* 478.
Nietzsche, F. (1967). *The will to power.* Edited by W. Kaufman. New York: Random House.
Resnick, R.B. & Resnick, E.B. (1984). Cocaine abuse and its treatment. In C.R. Lake (Ed.) *The Psychiatric Clinics of North America: Clinical Psychopharmacology II.* (pp. 726–727) Philadelphia: W.B. Saunders.
Sartre, J.P. (1957). *Existentialism and human emotion.* New York: Philosophical Library.

Soundview Clinic
731 White Plains Rd
Bronx, NY 10473