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A 30.9 Eriksonian Clinical Theory and Psychiatric Treatment

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Erik Erikson (Fig. 30.9-1) made significant contributions to a broad range of disciplines, but the application of his theories to clinical practice has not received proper recognition. Although considered among the group of ego psychologists that transformed psychoanalytic theory in the 1950s and 1960s, Erikson's emphasis on how the individual is inextricably bound to sociocultural and historical forces has broad and largely underdeveloped clinical significance.

David Rapaport described Erikson's work as the culmination of ego psychology, the first psychoanalytic theory of the person's relationship to social reality with which the ego is always engaged. Rapaport noted, "[Erikson's] concept of mutuality specifies that the crucial coordination is between the developing individual and his human (social) environment." This concept extends clinical work beyond the boundaries of the individual and opens it to larger scrutiny. From his clinical study of patients, Erikson recognized how the pathology and recovery of patients are linked to how they engage and are engaged by their world.

THEORETICAL ISSUES

Erikson noted that people get as invested in ideas as they do in people. His clinical and theoretical approach included questions of commitment, engagement, and integrity. Integrity was central to psychological health. He defined it as "man's obligation to the most mature meaning available to him, even if this should bring discomfort to himself, deprivation to his mate and offspring, and the loss of friends, all of which must be imagined and endured in order not to be exposed to a final sense of disgust and despair." Integrity transcends the pair, or dyad, and requires discovery of larger social tasks to which the individual can become committed. This formulation illuminates Erikson's clinical perspective of humans as social beings, linked to larger historical and cultural developments. Integrity and psychological health require discovering this connection.

Erikson had a broad view of the task of psychoanalysis. He considered it a tool for examining "that aspect of man which in a given historical period was being neglected, exploited, suppressed by pre-



FIGURE 30.9-1 Painting of Erik Erikson (by Norman Rockwell, Courtesy of Edward R. Shapiro, M.D.).

vailing technology and ideology," Given the immediate dependency on the human environment in early life, he considered the study of children and adolescents a crucial window for developing psychoanalytic theory, Erikson conceptualized the identity crisis that occurred during adolescence as a necessary integration of the adolescents' social reality with their history and new biological capacities. Identity formation is an activity of the ego that derives from the relation of individuals' self-definition to developing social definitions of those individuals as they mature. This notion opened the study of interaction, family process, and social change as mediators of clinical phenomena.

TECHNIQUE

According to Erikson, the ability of the patient's ego to mediate between the demands of unconscious internal pressures (i.e., instincts and affects) and the pressures of the external world (i.e., relationships, social reality) was a primary focus of treatment. In Erikson's thinking, the surface (i.e., the ego) revealed the depth. When he listened to patients, he listened with an artist's ear—he heard the words, saw the spatial relationships, and made temporal links between the somatic, affective, and interpersonal parts of the personality. He listened to texture and saw configuration. He paid attention to the whole life context of any immediate situation. He asked a

number of questions. What is the immediate stimulus for the patient's reaction? What is the acute life conflict, the current developmental stage, the issues that are manifest? In what developmental context did the patient's reaction first occur? Is it now manifest in the relationship to the therapist, in a repetitive conflict, in a characteristic way that the individual solved earlier developmental struggles? In what social context is the individual embedded, what roles are available? What are the typical stereotypes, particular opportunities, and barriers? What are the characteristic ways in which the individual takes in information? What defenses does the individual use? Where are the individual's deepest psychological investments?

Like his contemporary, Donald W. Winnicott, Erikson had a family perspective. He recognized that children react to the shared family unconscious, reading their parents' vulnerabilities and unexpressed wishes with clarity. Studying seriously disturbed patients, he saw that their breakdowns occurred at times of developmental separation or individuation (e.g., physical intimacy, occupational choice, or identity formation). Erikson's study of identity revealed the consistently accruing social value of increasing commitment to and from others. He saw social recognition as providing defenses against impulses, and he saw work as a means to consolidate conflict-free achievements. Work provided an opportunity to resynthesize childhood identifications in new ways in accord with available roles.

Role of the Therapist Erikson felt that, in the consulting room, therapists had to be aware of both their own and the patient's obligations to others. Therapists have methodological responsibilities and must understand both their role and their motivations. Self-observational vigilance is essential, and Erikson believed that therapists cannot see in another what they have not discovered in themselves. For Erikson, the therapeutic contract with the patient is the essence of study. As new data emerge from the patient, the therapist must be committed to continuous conceptual revision. Establishing a state of trust between doctor and patient is a basic requirement. Erikson felt that the therapist needed a sense of personal trustworthiness that could be transmitted to the patient.

CLINICAL ISSUES

Although no independent Eriksonian psychoanalytic school exists in the same way as the Freudian and Jungian schools, Erikson made many important contributions to the therapeutic process, many of which can be gleaned from examining his rare reports of patients he treated. One such case was reported in his seminal paper "The Nature of Clinical Evidence," published in 1957. In that paper, Erikson writes that the concepts of "repression," "regression," "transference," and "libido" are essential to his clinical way of thinking. He adds that he tries "to keep each linked with the observation and experience of the clinical encounter as a new event in the patient's life history." Examination of unpublished aspects of this case (available to the authors) reveals a complex clinical theory that was ahead of its time.

The patient, a seminarian in his 20s, presented with anxiety, hopelessness, "psychic pain" in his body, and suicidal thoughts. He was distressed by impulses to hurt others and obsessively turned to prayer for help, feeling increasingly alone and that his

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impulses were terribly incompatible with his religious aspirations. These symptoms were the latest attack in a series of such symptoms, beginning when the patient was a senior in high school, following his maternal grandfather's death.

The oldest of five children, the patient was unusually close to his mother who raised him according to the rigid schedule then in vogue. He idealized his father, who was largely absent from the home and "unable to deal with feelings." He had significant separation problems in kindergarten. Throughout his childhood, he found his mother to be alternatively happy and depressed, loving and withdrawn, nagging and martyred. The patient was uncomfortable with her physical attention to him and her overprotectiveness. Most of the patient's comments concerning family discord centered around his mother's changing moods and his feeling of impotent rebellion against her. The patient felt he was a great deal more like his mother in personality than his father, which was a source of concern to him. He was very close to his mother's father, with whom he spent summers in a rural community. Mother was very supportive of their relationship. Shortly before grandfather's death during his adolescence, the patient was rebellious to him. Grandfather's death led to a significant depression in the mother. Shy and a good student, the patient was preoccupied with issues of power, prestige, and acceptance by others.

Psychological testing confirmed borderline psychotic features in an inhibited, obsessive-compulsive personality, struggling to maintain control over aggressive impulses but also able to distance himself from these feelings well enough to manage them and examine them in therapy.

Erikson's published summary of this case reports one of the patient's dreams and the clinical crisis it suggested: "There was a big face sitting in a horse and buggy. The face was completely empty, and there was horrible, slimy, snaky hair all around it." The patient stated anxiously, "I'm not sure it wasn't my mother."

The patient's associations indicated that the "horse and buggy" referred to his beloved grandfather. In the patient's history, he had shown delinquent tendencies, defying his grandfather just before his death. Erikson wondered whether the patient felt that his anger had destroyed his identity supports. His mother had been frightened by his rebelliousness, and "he had come to feel controlled by her overprotectiveness. Erikson thought of the Medusa-like image in the dream as the "female void!" and considered the meanings of "loss of face" and lack of identity. The general theme of the dream seemed to Erikson to be "when I have faith in another's love and strength, angry feelings come up and I end up mistrusting, empty and full of despair,"

Dreams and Free Association Like Freud, Erikson worked with the patient's associations to the dream as the "best

leads" to understanding its meaning. He valued the first association to the dream, which he believed to be powerful and important. Ultimately, Erikson listened for 'a central theme which, once found, gives added meaning to all the associated material."

Erikson believed interpretation to be the primary therapeutic agent, sought as much by the patient as by the therapist. He emphasized free-floating attention as the method that enabled discovery to occur. Erikson once described this attentional stance by commenting that in clinical work, "You need a history and you need a theory, and then you must forget them both and let each hour stand for itself." This frees both parties from counterproductive pressures to advance in the therapy and allows them both to notice the gaps in the patient's narrative that signal the unconscious.

In relation to the patient described above, Erikson noted "the seemingly paradoxical fact that during his prior hour [before the dream] the patient had spoken of an increased well-being" or again, "Although the patient acted as if he were close to a breakdown, I had the impression that, in fact, there was a challenge in all of this, and a rather angry one." Beside the central dream image of a horrifying empty face, Erikson notes "omission of important items present in most dreams: motion, action, people, spoken words." He surveys this surface of the dream as a way of placing it in context; each omission or inclusion has potential significance.

Repression Erikson wrote of his patient: "I have to assume that the patient is (to varying degrees) unconscious of the meaning which I discern in his communications, and that I am helping him by making fully conscious what may be totally repressed, barely conscious, or simply cut off from communication." He described his patient—and by extension all patients—as a split or conflicted subject, whose self-esteem, stability, and relationships were precariously maintained by an enduring, unconscious obliteration of some core emotional experience. For Erikson, "the traumatic past is of course a present frontier, perceived as an acute conflict." He saw the ego as an integrative force directed toward overcoming repression.

Regression and the Setting Erikson also described a "regressive trend, a going back to earlier failures in order to solve the past along with the present." This point of view locates Erikson among the developmental psychoanalysts, like Winnicott, who view regression as a persistent, unconscious effort toward reintegration. They thus follow and extend Freud's later theoretical revisions that explore the compulsion to repeat as an effort to master trauma.

In this positive and optimistic view of regression, Erikson does not neglect his clinical responsibility to the patient's functional regression. "Our patient's behavior and report confront me with a therapeutic crisis, and it is my first task to perceive where the patient stands as a client, and what I must do next." Erikson felt the patient's panic in and about his dream. He wrote that "even in the hour of reporting, the dream-state seemed still vivid enough to threaten the patient's sense of reality."

His assessment of the patient's regression not only took into account the emotional tone of the patient's narrative in the session, but "first and last depends, of course, on the *setting* of his work." Since Erikson's patient was in an open residential treatment center (i.e., the Austen Riggs Center), he was already familiar with the setting and its "calculated risks" and "special opportunities." He knew that the patient's adaptation to Riggs had been assessed and established. He could thus conclude that "a dream-report of the kind just mentioned, in a setting of this kind, will first of all impress the clinical observer as a diagnostic sign. This is an 'anxiety dream'." This statement requires emphasis because along with a number of other comments, Erikson pointed to the setting as a "third" element to the patient-therapist dyad. The setting has symbolic meaning that influences the psychotherapeutic work and gives it special meaning. Context organizes meaning, and Erikson expanded the notion of the relevant context to include multiple levels: environment, family, society. Regarding the patient's dream reported on above, Erikson stated: "whether this dream is the sign of an impending collapse, or a potentially beneficial clinical crisis" depends on its context. In this case, the patient's successful adaptation to the environment pointed Erikson toward the latter interpretation (i.e., potential benefit).

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Erikson believed that emotional conflicts of childhood were played out again as part of current developmental tasks. Dream analysis led Erikson to recognize that "these patients [i.e., borderline patients] are deeply, if unconsciously, convinced that they have caused a basic disturbance in their mothers." The "violated" mother" and the associated "images of guilt" become "an obstacle in the resolution of adolescence—as if a fundamental and yet quite impossible restitution were a condition for adulthood." To move forward, Erikson's patient must first move backward; this is regression in the service of the ego.

Erikson elaborated a clinical point of view that considered depending on the analytic setting and the relationship to the therapist central to change. Describing the patient above, he wrote:

[H]e had taken a real chance with himself and with me. Under my protection and the hospital's he had hit bottom by chancing a repetition of his original breakdown. He had gone to the very border of unreality and had gleaned from it a highly condensed and seemingly anarchic image. Yet the image, while experienced as a symptom, was in fact a kind of creation, or at any rate a condensed and highly meaningful communication and challenge, to which my particular clinical theory had made me receptive.

Erikson's view of regression was ultimately an optimistic one. He says, "I would not give the past a kind of fatalistic dominance over the present." He believed that "we all relive earlier and earliest stages of our existence in dreams, in artistic experience, and in religious devotion, only to emerge refreshed and invigorated."

Libido Erikson considered libidinal attachments and experiences of dependence and abandonment of paramount importance. Erikson's concept "specifies that the crucial coordination is between the developing individual and his human (social) environment, and that this coordination is mutual." His theory is not one of quanta of energy but of relationships. Erikson focused on the power of abandonment and dependence. He emphasized and examined attachment, separation, and mutuality in the multiperson system.

Erikson's patient associated the horse and buggy on which the horrifying empty dream-face was seated with his beloved maternal grandfather and, by extension, with the loss of the rural caretaking culture of his childhood. The nostalgia for his grandfather turned out to be the prevailing mood of his mother and the pervasive, unnamed emotional communication from her to her son. Simultaneously, she unconsciously communicated that anything aggressively individuating in him would prove deadly, or at least crushingly disappointing to her. This is a familiar shared fantasy in families of borderline patients, in which the child's separation represents and requires a hateful devaluation of the family. In Erikson's patient, the mother's traumatic loss of her father pushed her unconsciously toward an irrational claim on her son; his necessary developmental process threatened to reopen her repressed grief. Erikson described this as missed mutuality. Although Erikson did not develop a family group formulation, he did highlight the absent father who might have provided both concretely and symbolically some "third" perspective on this conflicted dyad.

In his 1950 paper "The Theory of Infantile Sexuality," Erikson outlined his thinking about "libidinal disbalance" along with a hint of his clinical approach. His crucial leap beyond Freud was to give full recognition to the idea that erogenous zones are the sites of highly charged exchanges and interactions with the environment, another aspect of mutuality. Anality thus represents not only a particular site of stimulation, but the action modes of holding onto or letting go and the relational modes of submission or defiance. Erikson thus described a rudimentary action language that is embedded in the body and that helps structure the psyche. His therapeutic approach requires that clinicians pay attention to the patient's actions, particularly those that have not yet been put into words (e.g., the affects surrounding the dream).

Transference Erikson described transference as an important part of treatment. "I would also acknowledge the power of *transference*, that is, the patient's transfer to me of significant problems in his past dealings with the central people in his life; but I would know that only by playing my role as a new person in his present stage of life can I clarify the inappropriateness of his transferences from the past." He suggests that the context in which transference can be interpreted is the real therapeutic role in the relationship between doctor and patient. Inquiry and care, not indulgence or exploitation, is a new experience for these patients, which contributes to therapeutic change.

Erikson felt that clinical psychoanalysis relied methodologically on "disciplined subjectivity." By that he meant that he not only attended to what patients said about their dreams and how they behaved in the telling, but he attended also to what he himself thought and felt as he sat with the patient. In focusing on the transference, Erikson considered whether the patient was breaking down or trying to communicate. He noted that "the first would mean that he is slipping away from me ... the second, that he is reaching out for me with an important message which I must try to understand and answer." Erikson was completely attentive to the patient's actions in relation to him, and he believed that the therapist had a role-related responsibility for answering or interpreting.

Erikson considered his own reactions to the horrifying empty face of his patient's dream. As the patient reported the dream, Erikson wrote that his "facial and tonal expression reminded me of a series of critical moments during his treatment when he was obviously not quite sure that I was 'all there' and apprehensive that I might disapprove of him and disappear in anger." In analyzing dreams, Erikson believed that the therapist "does well to raise discreetly the masks of the various dream persons to see whether he can find his own face or person or role represented." By so doing, Erikson finds not only transference as distortion but transference as the actual current version of an earlier, but still powerful issue. Indeed, Erikson considers how the patient's transference may be "right" in some aspects. His patient's dream, for example, included both the recent sense that the patient trusted him and an earlier tenuousness in their relationship in response to Erikson's going off for an emergency operation months before. He described that experience as "inflicting his mortality" on the patient. "At the time of this dream-report I still was ... mildly uncomfortable." Thus the patient experienced "conflict between his sympathy, which makes him want to take care of me, and his rightful claim that I should take care of him." Like the dream figure, Erikson had wavy hair.

Erikson comes to a partial interpretation that translates the dream event into a sentence:

I concluded that the empty face had something to do with a certain tenuousness in our relationship, and that one message of the dream might be something like this: "If I never know whether and when you think of yourself rather than attending to me, or when you will absent yourself, maybe die, how can I have or gain what I need most—a coherent personality, an identity, a face?"

Whatever other meanings there might be to the dream, whatever other central life figures might eventually show through the empty face, Erikson emphasized transference analysis. "I put first (the patient's) fear that he may yet lose himself by losing me too suddenly or too early."

Countertransference Erikson did not explicitly name countertransference, yet he was aware of it and used it technically. Recognizing the protection given by his professional role, Erikson noted, "The clinician ... finds himself part of another man's most intimate life history. Luckily he also remains the functionary of a healing profession." With regard to using the Countertransference or, as Erikson puts it, "the disposition of the clinician's 'mixed' feelings," Erikson believed that "the therapist must use his own emotional responses during a clinical encounter as an evidential source and as a guide in intervention ... Patients of the type of our young man, still smarting in his 20s under what he considered his mother's strange emotions in his infancy, can learn to delineate social reality and to tolerate emotional tension only if the therapist can juxtapose his own emotional reactions to the patient's emotions."

Erikson concluded about Countertransference that [a]ny psychotherapist ... who throws out his ethical sentiments with his irrational moral anger, deprives himself of a principal tool of his clinical perception ... [O]ur indignation, admitted and scrutinized for flaws of sulkiness and self-indulgence, is, in fact, an important tool both of therapy and of theory." The therapist's reaction represents, for Erikson, an important aspect of "available emotion and responsive thought." The therapist must maintain a "disciplined subjectivity." He must also, "while facing most intimate and emotional matters ... maintain intellectual inner contact with ...conceptual models."

For Erikson, Countertransference is used to make sense of the transference and also help the patient consolidate reality testing. Erikson described the previous hours and the way in which the patient presented the dream as feeling like an angry challenge. He noted that 'the patient's main resistance consisted of testing me by a whining tone of voice, a child's voice saying, 'I don't want you to go away, but I know I will make you go away by my not wanting you.' " He associated the patient's reaction to his operation and the psychological testing that had revealed the patient's precarious control over his aggression. He communicated this reaction to the patient in the form of an interpretation.

Interpretation Erikson told his patient "without anger, but not without some honest indignation, that my response to his account included a feeling of being attacked." He suggested that the patient was protesting, "Why are you not doing for me what my grandfather did? Why is my father not like my grandfather? Why do all of you father figures abandon me to my mother's masochistic rage? Why is there death, mutilation and rage in the world? How can I sustain love, i.e., *keep your face alive in me*, when my mother's face always disintegrated, making me feel that I had destroyed her?" Erikson goes on to describe feeling worry and pity. He said that he had been touched by the patient but also challenged to prove something. He felt imposed upon with the "burden" of the patient's "future which (the patient) could well learn to manage." Erikson's final interpretation went something like this: "I feel attacked, worried, pitying, touched, and challenged to prove the goodness of mothers, the immortality of grandfathers, my own perfection, and God's grace."

This interpretation, a playful tour de force, took into account the manifest dream, the patient's affective presentation and associations, the transference repetition of the patient's rage at the mother and at the grandfather's death, the narcissistic wishes for an idealized figure around whom to build an identity, and Erikson's Countertransference irritation. Erikson says, "By relating the fact that his underlying anger aroused mine, and that I could say so without endangering either myself or him, I could show him that in his dream he had also confronted anger." This is a way of facing the patient. Erikson is describing the therapist surviving the patient's aggression, without retaliation or capitulation, a capacity now considered essential in work with patients with personality disorders. Erikson says of his patient, "[W]hile accepting his transferences as meaningful, I had refused to become drawn into them." Instead, he compensates for this therapeutic refusal by "offer[ing] him my help as defined by my professional status in attempting to understand what was behind his helplessness."

"Clinical evidence," Erikson writes, "is characterized by an immediacy which transcends formulations." Erikson's patient was "amused, delighted and encouraged" by his confrontative interpretation. Erikson points out that "[t]he patient left the hour—to which he had come with a sense of dire disaster—with a broad smile." He concludes that the 'proof (of an interpretation) lies in the way in which the communication between the therapist and patient 'keeps moving,' leading to new and surprising insights and to the patient's greater assumption of responsibility for himself."

The interpretation condensed Erikson's irritation at the patient's "whining" demand and his "desperate insistence on finding security." while overcoming his Countertransference wish to take care of the patient. The interpretation revealed Erikson's confidence in his patient's capacity to deal with confrontation. It affirmed the patient's inner resources to continue his development, and indicated Erikson's appreciation of the risk his patient had taken by symbolically repeating the original trauma in the dream. The "new relationship" captured by the interpretation is between the patient and an adult in a therapeutic role, in which understanding is possible.

Action and Actuality Not only did Erikson pay attention to action as communication, he also supported it as potentially important engagement. He affirmed the healing role of play and its derivative, work. Erikson defined *actuality* as "the world of participation, shared with a minimum of defensive maneuvers and a maximum of mutual activation." He emphasized how an individual's maturing capacities evoke cooperative responses from others that are needed for joint survival.

Erikson's formulation about actuality derived from his study of Freud's Dora case, during which the treatment foundered on Freud's uncertainty about what Dora needed from him. Erikson argued that Dora needed to have Freud recognize the historical truth of her family's infidelities. Recognition of potential historical truth is not the same as the practice of "validating" historical truth (e.g., childhood abuse). Erikson knew that the therapist could not know the truth in some objective way. That kind of presumed validation can represent a defensive collusion between patient and therapist to ward off the patient's current aggression. To suggest that patient and therapist can know the whole truth collapses the space for inquiry,

for not yet understanding, and for perspective. Erikson means to hold onto perspective. The recognition of potential historical truth has to do with the young person's need to have an adult affirm the reality of family dynamics and the possible accuracy of her interpretation of those dynamics. This testing of reality could be approached another way. The therapist could conduct a family meeting in which the patient's interpretation of her family could be explored and tested. Erikson suggests that Dora required an external affirmation of reality. Only then could Dora consider the role of her own impulses in these

events, Dora's family was an example of failed mutuality. Erikson grasped the way adolescents need help in recognizing and coming to terms with this shared failure before daring to venture beyond.

In the informal clinical notes on his patient, Erikson explored the world of action in some detail. Because his patient felt unconsciously that he had damaged his mother, he found himself preoccupied with sexuality as a means of both separation and reparation. Successful sexual intercourse, he felt, would "break through to reality, establish himself as a man, [and develop] a lasting ability to think clearly." There were certainly women patients at Austen Riggs willing to help him, but in line with his commitment to the patient as embedded in the larger community with its values, this evoked in Erikson the need to "firmly insist on some ... precautions for the protection of Riggs, of the lady (who might become) involved, and of himself." Erikson described these potential partners as "uprooted." They could not be expected to keep faith with the patient nor he with them. He stated, "Neither damnation nor salvation will result from these experiences."

This prohibition served two purposes: it provided a frame within which the patient's anxieties could be contained, and it evoked the patient's transference fantasies that Erikson wanted all the women for himself or, as mother figure, that he would tear out his hair in response to the patient's exploration. When the patient developed sexual fantasies about these women, who were older, Erikson felt he "should not shy away from such material but should rather delineate its reality in an infantile context and its symptomatic nature in the present adult context." By this, he was referring to incestuous fantasies. Erikson encouraged therapists not to avoid guiding patients; he believed that therapists must offer patients both prohibitions and permissions.

Work In his clinical notes, Erikson added to his ideas about identity the relationship to work and the development of a professional role. He noted that the patient's breakdown occurred in the context of an urgent professional dilemma: wanting to become a monk was 'the last step in a series of attempts at becoming somebody who was 'to help weak people,' while recanting all competition."

Joan Erikson, Erik's wife, developed an activities program at the Austen Riggs Center as an "interpretation-free zone" where patients could take up work roles or function as students with artists and craftspeople, without the burden of the patient role. This work space encouraged the play and creativity required for the patients' work development to parallel the process of their therapy. This patient moved from pottery in the program, to musician, to bartender in a local inn, to laborer with a construction business, to his professional career. Erikson notes that the pottery preserved the patient's capacity to function as a "good worker," though he felt the patient was in danger of "becoming a slave" to the clay. As a musician, to his surprise, Erikson's patient felt the fusion of his mother's loving voice with his own noisy infantile one, allowing him to feel a safe connection to her and to realize he had not destroyed her. Once he took a real-world job, he found himself struggling with what Erikson called, "the boss problem ... the co-worker problem and ... the work-role problem," all of which held him safely in a role but pushed him to face his fear of loss of ego boundaries, for example, by reacting to work problems in an all-or-nothing way and ragefully ruining his work in the process. Erikson noted that:

Impulse control is different in a bartender than in a minister, and so are the small social crises—or so it seems, until one tries it out. Then it becomes apparent that positions of trust, intermediary positions between owner and employees, positions highly susceptible to the weaknesses (and confessions) of others, have a lot in common... It is such recognition of the *principles* of a work situation which ... gives the patient eventually the freedom to choose his career not on the basis of role-appearance, but on that of inner compatibility of activity, role and personality.

Erikson's patient eventually became a doctor. Erikson commented:

The patient's medical identity was not the sum of all his identifications with doctors, but... the inner coherence of his gifts and trends quite independently pointed in this direction:

... the wish to help, now relatively freer from soul-saving fervor; the technical gifts of using his hands, now relatively freer from masturbation guilt, and tried on machines; psychological empathy, now relatively freer from over-identification, and tried in an industrial work-situation; an excellent mind for study;

... liking for being depended on and for wearing a halo, now relatively freer from megalomaniac and despotic trends; a freer wish to compete, even with his father for whom he felt a new respect; and behind it all, I assume, the age-old (unconscious) wish of doctors: wanting to cure mother, who seemed so incurable when he was a baby.

Further Clinical Considerations Erikson did not see himself as founding his own school of psychoanalytic psychotherapy nor indeed as departing from Freud in his clinical approach. Though his developmental road map enriches the Freudian psychosexual categories enormously—and offers the possibility of facilitating understanding and change throughout the life cycle—Erikson's clinical theory remained grounded in core psychoanalytic concepts creatively adapted to work with more severely disturbed patients.

Erikson considered the wish to get well, the synthesizing capacity of the ego, and a capacity for mutuality to be important indications that a successful treatment might be possible. He saw developmental trauma and conflicts associated with dependency,

separation, and aggression as indications that such treatment might be needed.

APPLICATION TO PSYCHOPATHOLOGY

Erikson described sequential stages of the life cycle, each representing a success or failure of the mutual coordination between the child's development and the responses of the human environment. He related failures of each stage to particular pathological outcomes.

Basic trust versus mistrust—This stage marked the developmental struggle of early infancy. Failures contribute to depression, hopelessness, difficulties in engaging others, suspicious-ness, and withdrawal (characteristics seen in disorders in the schizotypal and major depressive spectrum).

Autonomy versus shame or doubt—This characterized the period of separation-individuation and toilet training. Failures in this negotiation contributed to narcissistic vulnerability, delinquency, and obsessive behavior.

Initiative versus guilt—This struggle characterized the outcome of the oedipal conflict. Erikson saw failures here contributing to generalized anxiety, phobias, inhibitions, impotence, or psychosomatic illness.

Industry versus inferiority—Failures in this negotiation during the ages 7 to 11 contributed to work inhibitions, feelings of

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inadequacy, or a compensatory and defensive drive for money, power, and prestige.

Identity versus identity diffusion—Characterizing the adolescent struggle, failures here contribute to difficulties leaving home, prolonged dependence, the resurgence of borderline and narcissistic phenomena, and manifestations of role diffusion in work or career.

Intimacy versus isolation—Erikson saw the formation of healthy adult relationships as manifesting successful resolution of this stage.

Generativity versus stagnation—This dimension of mature adult life, which involves ongoing growth and commitment to what one has created, Erikson related to midlife crises.

Integrity versus despair—This late-life phase, having to do with the fulfillment of identity, Erikson connected to the depression-related episodes of old age.

Though Erikson's stage theory was revolutionary in the 1960s, subsequent study of parent-child relations have revealed that these phenomena are infinitely more complex. These stages repeat throughout the life cycle. Residues of earlier difficulties recur, and development has a much less linear shape, as do the influences of the environment. Eriksonian diagnosis reflects this complexity. Rather than insisting on a one-to-one correspondence between developmental phase failure and a specific disorder, Erikson thought that a true developmental diagnosis would describe the range between the initial fixation and the later developmental arrest. In other words, diagnosis has to do with when the trouble started and how far the patient got in development before breaking down.

Goals of Treatment Erikson underlined missed mutuality as a quieter, yet equally traumatic warping of development and considered the restoration of mutuality to be a goal of treatment, as both a way of working and as an outcome. Additional goals included both the developmental advance that follows the resolution of particular life crises (e.g., a restored capacity for trust, the development of more-flexible autonomy, or the discovery of less-inhibited initiative), and the integration of self-awareness and relatedness to the world that combines to make up a coherent and recognizable identity. Erikson's treatment was aimed at helping the patient's ego become stronger and heal itself. A goal of therapy is to recognize how patients have passed or not passed through the various stages of the life cycle and how the various crises have or have not been met. He believed that psychological growth and development can occur throughout the life cycle.

Future Directions Erikson's clinical concepts suggest that learning is a two-way street. Crucial information is gained by 'listening' therapeutically to how the younger generation responds to its interpersonal environment. Erikson adds that "it is in this mutuality of the development of the older and younger generations that certain and universal values such as love, faith, truth, justice, order, work, etc. in all of their defensive strength, compensatory power, and independent creativity become and remain important joint achievements of the individual ego development and of the social process."

Drawing again on the clinical context, Erikson believed that "if 'psychoanalyzed' man learns to recognize the fact that even his previously repudiated or denied impulses may be 'right' in their refusal to be submerged without a trace (the trace being his symptoms), so he must also learn that his strongest ethical judgments are right in being persistent even if modern life may not consider it intelligent or advantageous to feel strongly about such matters." This brings Erikson to an important conclusion: "this means that we somehow harbor a model of man which could serve as a scientific basis for the postulation of an ethical relationship of the generations to each other."

Erikson's gift was to take the psychoanalytic lens, initially developed to look inward, and use it to look outward as well—to play, creativity, the lived and examined life, the social playground, adult development, collective conflicts, and organizational structures. His grasp of the inextricable links between the individual and the context, his recognition of 'the interdependence of individual aspiration and social striving,' and his ability to hold the interests of community and society while strengthening the individual remain as challenges to the future development of clinical work.

SUGGESTED CROSS-REFERENCES

Erik Erikson's life and ideas are further discussed in Section 6.3, and Sigmund Freud's ideas are discussed most fully in Section 6.1. Other theories of personality and psychopathology are discussed in Sections 6.3 and 6.4. Schizophrenia is discussed in Chapter 12, mood disorders in Chapter 14, personality disorders in Chapter 24, and psychosomatic disorders in Chapter 25. Normal child development and adolescent development are discussed in Sections 32.2 and 32.3, respectively; adulthood is discussed in Chapter 50, normal human sexuality in Section 19.1, and normal aging in Section 51.2c. Psychoanalysis and psychoanalytic psychotherapy are discussed in Section 30.1.

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