2004 Counseling Theories and Techniques for Rehabilitation Health Professionals
Fong Chan, PhD, Norman L. Berven, PhD, and Kenneth R. Thomas, DEd

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1982 Disabled People as Second-Class Citizens
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1981 The Psychology of Disability
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Counseling Theories and Techniques for Rehabilitation Health Professionals

Fong Chan, PhD
Norman L. Berven, PhD
Kenneth R. Thomas, DEd
Editors
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Preface

The purpose of this book is to provide a state-of-the-art treatment of the dominant theories and techniques of counseling and psychotherapy from a rehabilitation perspective. In all cases, the chapters were contributed by rehabilitation professionals who have special, if not extraordinary, expertise and national visibility in the content areas addressed. The book is intended to be useful for practitioners, as well as for upper-level undergraduates and graduate students in rehabilitation counseling and psychology, and in other rehabilitation health care disciplines, such as nursing, occupational therapy, physical therapy, speech and language therapy, recreation, and social work. The chapters are written from a rehabilitation perspective, using rehabilitation examples when appropriate. Authors were asked to include a case example in each chapter to highlight the application of theories and techniques in working with rehabilitation-specific problems with people with disabilities.

It is not our philosophy that people with disabilities necessarily require different theories or interventions than nondisabled people. In fact, the opposite is true. People with disabilities or the agencies serving them may, however, present special needs or have special goals that require certain emphases and modifications in the application of particular theories and techniques. Although general textbooks on the theories and techniques of counseling and psychotherapy provide excellent discussions of those approaches, we feel they need to be supplemented with material that is specific to applications in rehabilitation settings. This book attempts to fulfill this need.

We are pleased to be part of this particular project for several reasons. First, it gave us an opportunity to work with rehabilitation professionals from around the United States who are clearly among the most esteemed leaders and academic scholars in our field. Many of these authors were once graduate students at the University of Wisconsin-Madison, and others have been professional associates of ours for many years. Some have worked with us in the past on scholarly projects, and we have known others through our work with professional associations. Still others we knew only initially through reputation, but we are now extremely pleased to have had an opportunity to work with them on this project.

Another reason for our pleasure in undertaking this project is our love of counseling. To us, counseling is the core of the rehabilitation process, and it is in all its various aspects the reason why most students and profession-
als are attracted to the field. The provision of vocational and psychosocial
counseling is the unique contribution that rehabilitation professionals, gener-
ally, make to any multidisciplinary (or even interdisciplinary) effort to im-
prove the lives of people with disabilities. We sincerely hope that the offerings
in this book will not only excite and inform the reader about the counseling
function and process, but ultimately will also benefit the thousands of clients
with whom the readers will eventually have contact.

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Section I

Introduction
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An Introduction to Counseling for Rehabilitation Health Professionals

Norman L. Berven, Kenneth R. Thomas, and Fong Chan

As stated in the preface, the purpose of this book is to provide a state-of-the-art treatment of the dominant theories and techniques of counseling and psychotherapy from a rehabilitation perspective. This initial chapter presents several introductory topics, including definitions and terminology, the importance of counseling in professional practice, a historical context for understanding theories of counseling and psychotherapy, and the efficacy of counseling and psychotherapy. In addition, a brief overview of the remainder of the book is provided.

DEFINITIONS AND TERMINOLOGY

Counseling and Psychotherapy

Counseling and psychotherapy are commonly used terms, but they often mean different things to different people. Generally, counseling and psychotherapy are defined as encompassing a counseling relationship in which a professional interacts with one or more individuals who are seeking assistance in dealing with difficulties and making changes in their lives. In the context of rehabilitation settings, the individuals seeking assistance have disabilities or other special needs. The process may occur not only in a traditional office setting but also in a wide variety of community
settings that provide opportunities for interaction between professionals and individuals who are seeking assistance.

According to the Scope of Practice for Rehabilitation Counseling, developed by the Commission on Rehabilitation Counselor Certification (CRCC, n.d.), counseling as a treatment intervention is defined as

the application of cognitive, affective, behavioral, and systemic counseling strategies which include developmental, wellness, pathologic, and multicultural principles of human behavior. Such interventions are specifically implemented in the context of a professional counseling relationship and may include, but are not limited to: appraisal; individual, group, marriage, and family counseling and psychotherapy; the diagnostic description and treatment of persons with mental, emotional, and behavioral disorders or disabilities; guidance and consulting to facilitate normal growth and development, including educational and career development; the utilization of functional assessments and career counseling for persons requesting assistance in adjusting to a disability or handicapping condition; referrals; consulting; and research. (p. 2)

Counseling and psychotherapy share much in common with other human interactions that individuals may find helpful when they are struggling with problems, life decisions, or desired changes in their lives, whether the interactions occur with professionals, family members, or friends. A variety of rehabilitation health professionals other than those with the specific titles of counselor or psychotherapist attempt to understand the behavior and needs of others and to collaborate with them in devising strategies to accomplish change, including rehabilitation medicine specialists and other physicians, occupational therapists, physical therapists, speech and language therapists, audiologists, rehabilitation teachers, orientation and mobility specialists, and recreation therapists. The effectiveness of services provided by rehabilitation health professionals depends on their effectiveness in establishing a therapeutic working relationship with the individuals served; communicating with individuals in facilitative, helpful ways; obtaining information from individuals in a comprehensive and thorough manner; helping individuals to tell their stories and explain their problems and needs; understanding and conceptualizing behavior and problems in ways that will facilitate treatment and service planning; and facilitating follow-through on commitments and compliance with treatment and service plans that individuals have decided to pursue. All of these professional tasks may be conceptualized as components of counseling and related interactions, and professionals from a variety of rehabilitation health professions can thus benefit from an understanding of counseling theories and techniques.
Distinctions between the terms *counseling* and *psychotherapy* are ambiguous and have often been controversial. Some authors, such as Gelso and Fretz (1992), suggest that psychotherapy, in contrast to counseling, has greater depth and intensity, is of typically longer duration, and addresses personality reorganization and reconstruction, as opposed to the more reality-based problems addressed in counseling. Some (e.g., Tyler, 1958) would also suggest that psychotherapy is used to provide treatment or services to individuals with severe pathology, whereas counseling is applied to more “normal” problems of living, decision making, and personal growth. In addition, Sharf (2000) points out that terminology sometimes varies according to the setting in which practice occurs, with the term *psychotherapy* being more popular in medical settings and *counseling* more popular in educational and human service settings. However, many authors (e.g., Patterson, 1986) have long maintained that the definitions of psychotherapy and counseling overlap substantially and that the distinctions between the two are at best differences of degree, and at worst, arbitrary and meaningless. The views of Patterson and other authors will be followed here, and the terms *counseling*, *psychotherapy*, and *therapy* will be used interchangeably throughout the book.

**Individuals Seeking Assistance from Rehabilitation Professionals**

Different terms are also commonly used to refer to individuals engaged in treatment or service with rehabilitation health professionals, including *patient*, *client*, *consumer*, and *customer*. *Patient* has been traditionally used by physicians, nurses, other medical professionals, and practitioners in inpatient hospital treatment and mental health. In addition, practitioners who identify themselves as psychotherapists are more likely to use *patient* than those identifying themselves as counselors. *Client* has been commonly used in rehabilitation counseling and in community-based rehabilitation programs, with *consumer* emerging more recently and *customer* even more recently. There are different connotations associated with the various terms. For example, *patient* may imply a medical model to some professionals in conceptualizing needs, with a concomitant tendency on the part of people receiving services to defer to service providers in making treatment and service decisions. In contrast, the other alternative terms may be viewed as implying greater sharing of decision making or even complete control of decisions on the part of the individual served. Advances in the disability rights movement emphasizing consumerism and empowerment (e.g., see
Introduction

Campbell, 1991; Holmes, 1993) have heightened sensitivity to terminology and its effects on people with disabilities, and the newer terms of consumer and customer have thus emerged. Terminology has become highly controversial. For example, Thomas (1993) has argued passionately that the term client is preferable, while Nosek (1993) has argued with similar passion that the term consumer should be used. Partly for historical reasons, including attempts to preserve some of the terminology used by theorists in their original work, the terms client and consumer, and sometimes patient, are used interchangeably, and it is hoped that no readers will be offended by any of the terminology used.

IMPORTANCE OF COUNSELING AS A PROFESSIONAL FUNCTION

Rehabilitation counseling is one profession where considerable research has been devoted to empirically defining roles, functions, and knowledge and skill domains for professional practice, and counseling has repeatedly emerged as an essential function (e.g., Leahy, Shapson, & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salomone, 1969; Rubin et al., 1984). In the seminal role and function study in rehabilitation counseling, Muthard and Salomone reported that state vocational rehabilitation counselors divide their time roughly into thirds: one third to counseling and guidance; one third to clerical work, planning, recording, and placement; and one third to professional growth, public relations, reporting, resource development, travel, and supervisory and administrative duties. In a recent study, Leahy, Chan, and Saunders (2003) surveyed certified rehabilitation counselors to examine the perceived importance of knowledge areas underlying credentialing in rehabilitation counseling, identifying six essential domains: Career Counseling, Assessment and Consultation; Counseling Theories, Techniques, and Applications; Rehabilitation Services and Resources; Case and Caseload Management; Healthcare and Disability Systems; and Medical, Functional and Environmental Implications of Disability. The first two represent knowledge domains in counseling and are related specifically to the content of this book.

The knowledge domains identified by Leahy, Chan, and Saunders (2003) reflect the current practice of rehabilitation counseling in private for-profit, private not-for-profit, and public rehabilitation settings. Regardless of practice settings, however, it is well documented that vocational adjustment is greatly affected by psychosocial issues and needs (O’Brien, Heppner, Flores, & Bikos, 1997). Not surprisingly, Rubin et al. (1984) found that
affective counseling was one of the most important functions of rehabilitation counselors and that counselors spend considerable time focusing on the psychological counseling process aimed at changing the client’s feelings and thoughts regarding self and others. Because of the generic professional counselor licensure movement in the United States, many rehabilitation counseling programs are changing from requiring 48 credit-hours for master’s degrees to 60 credit-hours. This move is intended to ensure that master’s degree graduates in rehabilitation counseling will have sufficient training in the foundations of human behavior and behavior change techniques. Also, many practitioners in the field are demanding that they be prepared as a professional counselor first and then practice rehabilitation counseling as a specialty within counseling. Currently, 47 states have passed legislation to regulate licensed professional counselors, and rehabilitation counselors are expected to have a solid grounding in theories and techniques for changing human behavior in a rehabilitation context. Similarly, many other rehabilitation health professionals, including rehabilitation nurses, occupational health nurses, social workers, and occupational, physical, speech and language, and recreation therapists, have become increasingly aware of the effects of psychosocial factors on rehabilitation outcomes and the importance of one-to-one and group interactions in professional practice. As a result, professional education programs in various rehabilitation health professions have begun to incorporate interviewing techniques, counseling interventions, and psychosocial adjustment content into their training curricula.

HISTORICAL CONTEXT FOR THEORIES OF COUNSELING AND PSYCHOTHERAPY

Psychological, sociocultural, and systemic theories typically guide the process of counseling and psychotherapy, facilitating the understanding of behavior and the formulation of intervention strategies that hold promise for accomplishing the desired changes. In fact, it is difficult to imagine a practitioner being able to function with any degree of effectiveness without the guidance of at least some basic theoretical direction. As stated by Prochaska and Norcross (1999):

Without a guiding theory or system of psychotherapy, clinicians would be vulnerable, directionless creatures, bombarded with literally hundreds of impressions and pieces of information in a single session... theory describes the clinical phenomena, delimits the amount of relevant information, organizes that informa-
Early Historical Roots

Arguably, the first psychotherapeutic treatment of a potential rehabilitation client took place outside Vienna between 1880 and 1882. The “counselor” was a Viennese physician named Joseph Breuer, and the patient was Bertha Peppenheim. Bertha, who is better known as Anna O, presented an array of symptoms, including paraphasia, a convergent squint, severe disturbances of vision, paralyses of her upper and lower extremities, eating and drinking disturbances, and a severe nervous cough (Breuer & Freud, 1893–1895/1966; Freud, 1910/1955). The treatment itself, which consisted primarily of hypnosis and catharsis, provided only temporary relief of Bertha’s “conversion hysteria,” and she experienced several relapses and hospitalizations after the premature termination of the treatment (Jones, 1953; Summers, 1999). However, the long-term ramifications of the treatment would eventually prove to exceed the wildest dreams of either Bertha or the physician. Breuer, who was a close friend, mentor, and early benefactor of Freud, was even credited by Freud, at least initially (e.g., see Freud, 1910/1955), for the creation of psychoanalysis. During the treatment, Bertha herself originated such famous terms as the talking cure and chimney sweeping, thus demonstrating remarkable insight into the dynamics of these early psychotherapeutic interventions and providing her own very substantial contribution to counseling and psychotherapy. Although the treatment itself was essentially a disaster, with Bertha having a hysterical pregnancy with Breuer as the alleged father and Breuer abandoning the treatment in fear of losing his professional reputation (Jones, 1953), the basis was laid for Freud’s later, lifelong development of his theories and therapies of psychoanalysis.

One of Freud’s dreams was that the benefits of psychoanalysis could eventually be spread to the general populace by using a cadre of trained, nonmedical therapists. It was, in fact, Freud’s strong belief that psychoanalytically trained “laypersons” rather than physicians would make the best therapists (Freud, 1926/1959). Although this dream was never realized, especially in the United States, where a very restrictive medical community virtually prevented nonphysicians from receiving psychoanalytic training under the auspices of the American Psychoanalytic Association, Bertha’s “talking cure” provided the basis for a variety of counseling and psychotherapeutic interventions, both psychoanalytic and otherwise.
From a rehabilitation standpoint, Bertha would have been, at least eventually, a remarkable success story. Despite her subsequent hospitalizations, she went on to have a distinguished career as a social worker, feminist, and writer and is, in fact, one of the most important individuals in the history of European social welfare. Although modern-day rehabilitation professionals use methods that are vastly different in scope and form from those used by Breuer, the goal of helping distressed individuals live more productive and happy lives is essentially the same.

More Recent Evolution of Theoretical Approaches

From the early roots of psychoanalysis, a variety of theoretical approaches to counseling and psychotherapy have developed. Garfield and Bergin (1994) reviewed the evolution of theoretical approaches, indicating that Freud’s psychoanalytic theory, along with derivatives due to some of his followers, such as Alfred Adler, Carl Jung, Karen Horney, and Harry Stack Sullivan, were “from the end of the nineteenth century to about the 1960s, the dominant influence” (p. 3). The client-centered or person-centered theoretical approach, developed by Carl Rogers (1942), represented one of the major early departures from psychoanalytic theory, emphasizing the potential of people to self-actualize and the therapeutic qualities of empathy, unconditional positive regard, and genuineness that could nourish and release this positive growth potential toward constructive personality and behavior change. Behavior therapy, although beginning many years before, did not gain popularity until the 1950s, with the publication of Wolpe’s (1958) book on reciprocal inhibition as an approach to psychotherapy. The community mental health movement in the 1960s brought a new focus on the mental health needs of low-income people, along with community-based treatment and crisis intervention. Long-term psychotherapy, particularly psychoanalytic approaches, were generally used by middle- and upper-income people, and briefer forms of counseling and psychotherapy became more popular leading to the rise of many different theoretical orientations.

A proliferation of approaches to counseling and psychotherapy has emerged over the years. Garfield (1982) identified 125 different approaches to psychotherapy in existence in the 1960s, and in the 1980s Herink (1980) identified more than 250 and Kazdin (1986) estimated more than 400, with most having received little or no systematic empirical evaluation. Adding to the variety of theoretical approaches in use is the popularity of eclecticism among practitioners, who draw from and integrate concepts
and techniques from multiple theoretical approaches, rather than adhering to a single approach. Jensen, Bergin, and Greaves (1990) surveyed practitioners in psychiatry, clinical psychology, social work, and marriage and family therapy and found that 68% of respondents identified themselves as eclectics. Thus a wide variety of theoretical approaches to counseling and psychotherapy are in use by professional practitioners in rehabilitation and health settings, with many drawing from and attempting to integrate multiple approaches in their work.

Prochaska and Norcross (1999), compiling data from three different surveys (Norcross, Karg, & Prochaska, 1997; Norcross, Strausser, & Missar, 1988; Watkins, Lopez, Campbell, & Himmell, 1986), identified predominant theoretical orientations of practitioners in counseling and psychotherapy in the United States, including clinical psychologists, counseling psychologists, psychiatrists, social workers, and counselors. As was found in other studies, eclectic orientations were the most frequently indicated orientations among all of the respondent groups, varying from 27% of the clinical psychologists to 53% of the psychiatrists. Psychoanalytic/psychodynamic orientations were indicated by a large number of psychiatrists (35%) and social workers (33%) and also by a number of clinical psychologists (18%), counseling psychologists (12%), and counselors (11%). Cognitive-behavioral orientations tended to be most predominant among psychologists and counselors, with 27% of clinical psychologists indicating either cognitive or behavioral orientations, in addition to 19% of counseling psychologists and 16% of counselors. Humanistic orientations tended to be most predominant among counseling psychologists and counselors, with 21% of counselors indicating either Rogerian/person-centered or existential/humanistic orientations, in addition to 14% of counseling psychologists.

Since large numbers of practitioners in counseling and psychotherapy indicate that their orientations are eclectic, it should also be informative to ask eclectic practitioners about the theoretical orientations that they draw upon in forming their eclectic orientations. Jensen et al. (1990) asked this question of the 283 eclectic practitioners in their study, and they found a mean of 4.4 theories identified as influential, including dynamic (72%), cognitive (54%), behavioral (49%), and humanistic (42%), among those theories most frequently identified. On the basis of the available evidence, it would appear that a diverse array of theoretical orientations influence the practice of counseling and psychotherapy. In addition, it would appear that individuals who follow an eclectic orientation may often be influenced by diverse theoretical orientations themselves, suggesting
the importance of understanding a variety of different theories of counseling and psychotherapy.

EFFICACY OF COUNSELING AND PSYCHOTHERAPY

Over the past several decades, psychotherapy researchers have devoted concerted efforts to examining the efficacy of counseling and psychotherapy. Recently, Wampold (2001) examined thousands of studies regarding the efficacy of psychotherapy using meta-analysis and concluded that at least 70% of psychotherapeutic effects are due to common factors, while only 8% are due to specific ingredients. The remaining 22%, which are unexplained, are due in part to client differences. Common factors are ingredients that all forms of counseling and psychotherapy share and exist across all forms and types as they are typically practiced. For Wampold (2001) the common factors include goal setting, empathic listening, and such considerations as the following:

- Allegiance (i.e., the degree to which the practitioner is committed to the belief that the therapy is beneficial to the client)
- The therapeutic alliance, defined pantheoretically by Wampold to include the following:
  - The client's affective relationship with the therapist
  - The client's motivation and ability to accomplish work collaboratively with the therapist
  - The therapist's empathic response to and involvement with the client
  - Client and therapist agreement about the goals and tasks of therapy

Conversely, specific ingredients, as distinguished from the common factors, include actions or techniques that are both essential and unique to a particular theory. Wampold (2001) has clearly demonstrated an important empirical link between common factors in the counseling relationship and outcomes. However, counselors must still formulate hypotheses about client problems and facilitate interactions with clients based on certain theoretical orientations. It can be argued that not every counselor will be comfortable with only one form or approach to counseling and psychotherapy. Conversely, the same is probably true for clients seeking assistance from professionals. In order to maximize the effects of the
common factors, it might be critical to tailor counseling interventions to the individual differences and needs of rehabilitation clients. In a multimodal way, the method of treatment would depend, at the very least, on the needs, context, expectations, personality, and problems of the individual seeking help.

**OVERVIEW OF SECTIONS AND CHAPTERS**

In providing coverage of counseling theories and techniques for rehabilitation health professionals, the book is organized into sections, with each section comprising multiple chapters. After the present introductory section, the following sections are included: Counseling Theories, Basic Techniques, Special Considerations, and Professional Issues.

The Counseling Theories section provides reviews of 10 different theoretical approaches to counseling and psychotherapy, with an emphasis on their applications in rehabilitation settings. To the extent possible, each chapter is organized according to the following structure: History, Major Concepts, Theory of Personality, Description of the Counseling Process, Rehabilitation Applications, Case Example, Research Findings, and Prominent Strengths and Limitations. Thus, in addition to discussing the major components of each theoretical approach, each chapter emphasizes practical applications in rehabilitation health practice, including case examples to demonstrate applications. As previously discussed, there are literally hundreds of theoretical approaches to counseling and psychotherapy that have been developed, so the selection of theories to include was not an easy task. In general, an attempt was made to select the most prominent theoretical approaches, while also representing a broad spectrum of theories that have potential applicability in rehabilitation settings.

The Counseling Theories section is divided into three subsections, representing major categories of theoretical approaches. The first subsection is Psychodynamic Approaches, with two chapters covering psychodynamic therapy and Adlerian therapy. Psychodynamic approaches follow from Sigmund Freud’s psychoanalysis and, as in the surveys previously cited, are popular among contemporary practitioners in counseling and psychotherapy, particularly among psychiatrists and social workers but also among those from other disciplines. In addition, as discussed by Corey (2001), the psychoanalytic model has been a major influence on all of the other formal systems of psychotherapy. Some are basically extensions of psychoanalysis, others are modifications of analytic concepts and procedures, and still others are positions that emerged as a reaction
against psychoanalysis. Many of the other theories of counseling and psychotherapy have borrowed and integrated principles and techniques from psychoanalytic approaches. (pp. 7–9)

The second subsection under the Counseling Theories is Humanistic Approaches, including three chapters that cover person-centered, Gestalt, and logotherapy approaches. In addition to being termed humanistic, these approaches could also have been categorized as experiential, existential, and relationship-oriented. Seligman (2001) categorized these three theories as “treatment systems emphasizing emotions and sensations,” and Patterson and Watkins (1996) categorized person-centered and Gestalt approaches as “perceptual-phenomenological” and logotherapy separately as “existential psychotherapy.” As indicated above, humanistic approaches would appear to be most widely used by counselors and counseling psychologists, among the various disciplines that practice counseling and psychotherapy. Because of their application in initiating counseling relationships and facilitating client exploration, including the exploration of emotions, some textbooks (e.g., James & Gilliland, 2003) place humanistic theories as the first theories covered. In addition, humanistic theories, particularly person-centered theories, emphasize the relationship between counselor and client, and this emphasis has been influential in the evolution of many other theoretical approaches.

The third subsection under Counseling Theories is Cognitive and Behavioral Approaches, comprising five chapters covering behavioral and cognitive-behavioral approaches, rational-emotive behavior therapy, reality therapy, and trait-factor theory. These five approaches are all systematic and action-oriented, and authors of textbooks on theories of counseling and psychotherapy have used terms such as action (Corey, 2001) and action-oriented (James & Gilliland, 2003) to refer to this category of approaches. As indicated in the surveys of practitioners discussed previously, cognitive and behavioral approaches are highly influential in the work of many practitioners in counseling and psychotherapy, particularly clinical psychologists, counseling psychologists, and counselors. Cognitive and behavioral approaches do not ignore emotions, but they tend to view emotions as a product of the ways that an “individual perceives, interprets, and assigns meaning” to events (Warwar & Greenberg (2000, p. 585), and interventions designed to influence emotions are primarily directed at thoughts and behaviors.

The Basic Techniques section begins with a chapter on communication and counseling techniques that are basic to both formal counseling interac-
tions and to other interpersonal interactions between practitioners and clients. The next two chapters focus on group and family counseling, respectively, which are two types of counseling interactions that have a number of unique features relative to individual counseling. Finally, the section concludes with a chapter on career counseling, which represents an important specific component of counseling in rehabilitation settings.

The Special Considerations section discusses counseling and service considerations that are related to specific types of disabilities. As was true in selecting counseling theories, there were many potential choices as to the specific types of disability and client groups to include. The chapters in the section address four broad disability groups: substance abuse, physical disabilities, psychiatric disabilities, and mental retardation or cognitive disabilities. A fifth chapter in the section addresses multicultural considerations in counseling and psychotherapy, a particularly important and timely topic.

The Professional Issues section focuses on three general topics that are directly related to the practice of counseling in rehabilitation settings. The first chapter focuses on clinical supervision, a critical function in monitoring and improving the quality of service and treatment provided to clients; in addition, supervision is a critical function in facilitating the professional development of practitioners, as well as the learning and development of students preparing for professional practice careers. The second chapter in the section focuses on risk management in professional practice, including ethical issues, and the final chapter focuses on the conceptualization and measurement of rehabilitation outcomes.

In conclusion, the book provides an overview of prominent theoretical approaches to counseling and psychotherapy, along with some of the ways in which they can be applied in rehabilitation settings to assist people with disabilities. In addition, special considerations related to specific types of disabilities are presented, along with a discussion of selected professional issues related to professional practice. It is hoped that the content will help professional practitioners and students in rehabilitation health professions to better understand counseling and psychotherapy practice and the potential applications of theories and techniques in rehabilitation settings.

REFERENCES


Section II

Counseling Theories
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Psychodynamic Approaches
Chapter 2

Psychodynamic Therapy

Hanoch Livneh and Jerome Siller

Within counseling and psychotherapy, psychoanalytically and psychodynamically based interventions are distinguished by a focus on the importance of early experience and the role of unconscious mental functioning. In common with other approaches to counseling and psychotherapy, considerable attention is paid to family, social, vocational, and other aspects of life. It is the manner in which these nonpsychodynamic “realities” are viewed analytically that claims distinctiveness. Character change is usually the goal of psychodynamically oriented treatments, which strive to facilitate self-understanding. Alleviation of symptoms in effect is viewed as a by-product of characterological change. Psychoanalytic theories of personality development and structures serve as the basis for interventions to facilitate self-awareness, through which the consequences of developmental distortions, conflicts, and arrested development can be changed.

Within psychoanalysis and its various offshoots is much variation in theory and treatment procedures. Within rehabilitation, classical psychoanalytic treatment is not typically feasible, but a variety of psychodynamic procedures would appear to clearly have a place. Fundamental psychodynamic concepts deriving from psychoanalysis would appear to be invaluable for understanding the situations of people in general, including those with disabilities. Specific rehabilitation procedures can be informed by these concepts, including those that are not specifically psychodynamic (e.g., interventions involving mourning experiences). Sharp distinctions among various psychoanalytic “schools” or between psychoanalysis and psychotherapy in this context are not necessary. However, to convey the developing nature of psychoanalytic thought and treatment and its present status, a historical view of psychoanalysis follows. By focusing on the
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vicissitudes of mainstream psychoanalysis, we hope to represent the fundamental thrusts of psychodynamic thinking and applications to rehabilitation.

HISTORY

Pine (1988) suggested that clinical psychoanalysis has led to the development of four conceptually separate perspectives on the functioning of the human mind: psychologies of drive, ego, object relations, and self. The four perspectives overlap and add to an understanding of both theory and clinical treatment. In addition, expression of the four perspectives can be found in both psychodynamic and nonpsychodynamic approaches to counseling and psychotherapy.

In Freud's drive theory, mental life emerges from strong urges and wishes that are shaped by early bodily and family experiences and that power conscious and unconscious fantasies and behaviors. Many fantasies are experienced as dangerous and engender anxiety, guilt, shame, inhibition, symptom formation, and pathological character traits. Early bodily and family experiences are influential in determining personality, and, as pointed out by Siller (1976), early bodily experiences can be particularly important in the development of persons with physical disabilities or deformities. Fundamental concepts of drive theory include a presupposition of universal laws that govern all mental life, both normal and abnormal; psychic determinism; the human organism as an energy system; a personality structure with the constructs of id, ego, and superego; and a complex of other interrelated concepts, including an active unconscious with primary and secondary process modes of thought, repression, resistance, and transference. Among widely used terms originating in drive theory are the id, psychosexuality, libido, fixation, repression, defense mechanisms, narcissism, the pleasure principle, and metapsychology.

The catch phrase “where id was there ego shall be” (Freud, 1933/1964, p. 80) characterizes the therapeutic goal of treatment based on drive theory, with interpretation of the force of unconscious processes and the analysis of resistance and transference as the forces for change. Developments beyond pure instinct theory facilitated an oncoming ego psychology, and structural theory was also introduced (Freud, 1923/1961), along with a signal theory of anxiety (Freud, 1926/1959). Freud postulated, in place of conscious and unconscious systems in mental life, new structures of the id, ego, and superego, explicating their roles in intrapsychic conflict. According to Freud, anxiety is the fundamental phenomenon and focal prob-
lem of neurosis. He expanded the concept of anxiety from earlier conceptions where it was seen to result from the discharge of repressed somatic tensions (libido). Freud saw anxiety as a signal of danger to the ego and differentiated among three types: reality, neurotic, and moral. Defenses were then conceptualized as ego functions, and psychoanalytic treatment expanded from its initial somatic base. In addition to the translation of id forces into consciousness as a treatment goal, analysis of ego functions also came to be emphasized (Freud, 1926/1959).

Ego psychology emerged during the 1930s as the preeminence of the id began to be shared with that of the ego. The id had been seen as carrying all of the innate instinctual energy, with the ego emerging from the id and serving mainly to intervene with the environment to satisfy id-based wishes. Now the functions of the ego were emphasized in terms of capacities for adaptation, reality testing, and defense. A landmark in the development of ego psychology was Anna Freud’s book on the relationship of the ego to the mechanisms of defense (A. Freud, 1936/1946). Leaders in pursuing psychoanalytic ego psychology were Heinz Hartmann, Melanie Klein, Ernst Kris, and Rudolf Lowenwstein.

Hartmann (1964) introduced a significant emphasis on adaptation to the average expectable environment, attempting to systematize and resolve contradictions in psychoanalytic theory. His conceptions included disagreements with major propositions of Freudian thinking in the development and functioning of the ego, the importance of ego structure in the totality of personality, and the relationship of the person to reality. Adding to the Freudian conception of the id existing at birth and the ego developing out of the id, Hartmann suggested that life begins with an undifferentiated phase during which both the ego and id form out of the totality of the individual’s psychological inheritance. Ego development was viewed as an interactive function of biology and environment where heredity and maturation interact with the environmental forces of learning. Erik Erikson (1950,1968) also contributed substantially to conceptions regarding the ego and psychosocial development, and he was also identified as an ego psychologist. His contributions have been widely recognized; they widened the purview of psychoanalytic thinking by vividly demonstrating the role of the ego in relating to the environment and the continuing development of personality into adulthood and old age.

Ego psychology expanded psychoanalytic theory to encompass normal as well as abnormal phenomena. Psychoanalytic theory became more receptive to the idea of environmental forces serving as key influences in psychological development. Consciousness and cognitions came to have
Psychodynamic Therapy

importance, and therapeutic interventions were then geared to all levels of personality, with the present and recent past being viewed as relevant, along with conscious awareness. Interpretations, while still symbolically based, tended to be less so, and current situations, needs, and explanations were given more attention. Object relations theory continued the movement of psychoanalytic thought from drive and instinct theory. Reactive to this movement, some psychoanalysts attempted to integrate object relations concepts with structural theory, while others strove to replace structural concepts with those derived from object relations. The origins of object relations theory can be found in the writings of Freud, Sandor Ferenczi, and Melanie Klein. Klein stimulated the writings of British analysts such as D. W. Winnicott, W. R. D. Fairbairn, and Harry Guntrip, whose work on object relations from the 1940s to the 1960s has had a profound influence in extending psychoanalytic theory and intervention. The psychology of object relations differs appreciably from the transactional or interpersonal theories of H. S. Sullivan, K. Horney, and E. Fromm, which stress the social and interactive nature of human relations and tend to downplay intrapsychic events. Object relations theory focuses on internalization of psychic events and intrapsychic processes. It is the representation and symbolization within the person of the other, rather than the actual transaction between them, that serves as the focus.

As characterized by Sandler and Rosenblatt (1962), through conscious and unconscious memories derived from early childhood, an internal drama occurs in which individuals enact one or more of the roles. New experiences are not experienced entirely as new, but are rather processed through internal images that are to varying degrees based upon childhood experience. Consistent with the psychoanalytic orientation, these internal dramas are dominated by experience with the primary objects of childhood. What the child experiences, however, is not a “true” representation of the relationship, since object relation consists of memories structured by feelings and wishes active at the time of the experience. As with ego psychology, object relations psychology readily fits within the psychoanalytic model and provides insights into such classical conceptions as transference and countertransference, early psychic development, and ongoing subjective states.

The fourth and most recent psychology identified by Pine is self-experience and is the source of much contemporary attention: “what I shall work with as the domain of psychology of self-experience is subjective experience specifically around feelings of self-definition in relation to the object” (Pine, 1988, p. 574). This domain involves seeing the individual in terms of
the ongoing subjective state, particularly around issues of boundaries, continuity, and esteem, and reactions to imbalances in that subjective state (Sandler, 1960). Attention is also paid to such central features of the subjective state as degree of differentiation of self from other, separateness of boundaries, and loss or absence of boundaries.

Self-psychology, as developed by Heinz Kohut, has moved away from customary psychoanalytic thought. Kohut (1971, 1977, 1984) approached self-psychology in terms of narcissistic development. He conceptualized the emerging self as composed of the grandiose and idealizing lines of development. Phase-appropriate minor “failures” in empathy of “good-enough” parents can lead to healthy development. Disturbances in the self arise from severe, phase-inappropriate, and/or chronic frustration of the child’s needs from mirroring of grandiosity and models worthy of idealizing.

The present writers hold with Pine (1988) that all four of the psychologies used as the organizing basis for this review are legitimately psychoanalytic and that they require just such a complex and multifaceted view of functioning that only psychoanalysis provides. The above considerations are not intended as “jurisdictional” quibbling but rather are meant to alert those not operating within the psychodynamic/psychoanalytic perspective to the vitality, flexibility, and growth within this framework that can be applied to the multinatured demands of rehabilitation.

**MAJOR CONCEPTS**

Psychoanalytic theory is all of the following: (a) a system of psychology and philosophy (metapsychology); (b) a theory developed by Freud and his followers to describe, explain, and analyze human emotional, cognitive, and behavioral processes; and (c) a therapeutic approach for the treatment of maladaptive feelings, thoughts, and behaviors (Cook, 1998; Fine, 1973). Psychodynamic theoretical systems, while varying in many ways from classical psychoanalysis and its later derivatives, draw considerably from the psychoanalytic theoretical base. Fundamental techniques and concepts of treatment from psychoanalysis are expanded, transformed, or dropped, depending upon the thrust of a particular psychodynamic orientation. In moving to psychodynamic, as contrasted with psychoanalytic, counseling and psychotherapy, certain constraints and procedures appropriate to the psychoanalytic process may be relieved and a wider assortment of interventions considered.

A core concept from early psychoanalysis that persists in psychodynamic theory is hedonism: striving for pleasure and avoiding pain. In Freud’s
instinct theory, Eros, the life drive, is based upon general biological energy (libido), which is guided by the pleasure principle and is expressed through self-love, love of others, and the uninhibited pursuit of pleasure. This drive is located in the unconscious and is represented by the id. The core of personality evolves out of a need to reach a compromise between the “pleasure principle” and the “reality principle,” the latter embodying parental and societal demands, restrictions, and obligations in the act of seeking gratification. A second major drive proposed by Freud, Thanatos, the death drive, has never received general acceptance and will not be discussed here. Other basic concepts include the idea of a dynamic unconscious, the basic importance of early developmental history and experience, and the preeminent nature of repression. It has already been noted above that contemporary thinking has not been receptive to the energy theory of drives and other aspects of libido theory, including the well-known development of psychosexual stages. Thus libido theory and psychosexual stages are not fundamental concepts in psychodynamic theory, but the concepts of psychosexuality and character neurosis are important.

Primary perspectives in psychoanalysis include the following: (a) a physiological perspective emphasizing biological development; (b) a psychological perspective concerning inner psychological states of consciousness and unconsciousness; and (c) a sociocultural perspective including the importance of early, family-based experiences in shaping the life (psychological reality) of the individual, and the influence of sociocultural beliefs, values, demands, and expectations on families and child-rearing practices (Fine, 1973; Ford & Urban, 1998; Maddi, 2000). Modern psychodynamic models borrow from earlier psychoanalytic concepts but typically focus on a restricted range of personal and interpersonal domains, such as separation/autonomy versus merger/independence tendencies (e.g., the work of Angyal and Bakan); interpersonal transactions (e.g., the work of Kiesler); and in disability, work by Siller on attitude structure and Shontz on adjustment to disability.

THEORY OF PERSONALITY

As characterized by Dewald (1978), elements of personality emerge from inevitable conflicts experienced by the infant and young child in its interactions with important people in its environment and is elaborated in various intrapsychic functions and mental processes. Constitutional determinants are highly influential, and the process leads to the establishment of the “core” of personality and psychic function. The core psychic functions and
organization are reasonably well established in most individuals with the passage through the Oedipal phase, and in ordinary psychic development these core psychological functions undergo repression with the onset of latency. As Dewald pointed out, following Rappaport (1960), “‘psychic structures’ merely describes and defines specific individual psychological functions that, once established, tend to be stereotyped, automatic, unconscious, and tend to have a slow spontaneous rate of change. In other words, the core structures tend to be established early, and to remain relatively unchanged as the basic foundations of subsequent personality development” (p. 536).

Dewald (1978) emphatically rejected the idea that personality development ceases around the time of resolution of the Oedipus phase, or that there is a direct causal relationship between psychic functioning in the adult and the core psychic structures established during childhood (the genetic fallacy). Rappaport and Gill (1959), supplemented by others such as Arlow and Brenner (1964) and Fine (1973), identified the minimum number of assumptions upon which the system of psychoanalysis is based. The clinical implications of this conceptualization, as Greenson (1967, pp. 21–22) indicated, are “that in order to comprehend a psychic event thoroughly, it is necessary to analyze it from six different points of view—the topographic, dynamic, economic, genetic, structural, and adaptive.”

- **Topographic.** Human consciousness includes a complex hierarchical layering from unconscious (perceived as the most significant determinant of behavior), to preconsciousness, to consciousness. Whereas unconscious activities are governed by primary thought processes, the remaining two are mostly influenced by secondary thought processes.

- **Genetic.** Human behavior follows a temporal process whereby present personality can be explained by earlier life experiences. Present behaviors, including personality traits and neurotic symptoms, are therefore determined by psychosexual phases of development from early childhood and cumulative experience. Biological-constitutional as well as experiential factors are stressed.

- **Dynamic.** Human behavior is determined by the interplay of dynamic impulses or drives. These desire are typically composed of libidinal (sexual) and aggressive drives. Hypotheses concerning instinctual drives, defenses, ego interests, and conflicts are based on this point of view. Examples of dynamics are ambivalence, overdetermination, and symptom formation.

- **Economic.** Human behavior requires energy. As such, it draws, disposes of, and is regulated by psychological energy. This energy feeds
psychic structures and process. The processes of binding and neutralizing energy are referred to as cathexes (to objects such as people).

• **Structural.** Human behavior relies upon the interaction among three main personality structures—the id, ego, and superego. These structures are persisting functional units. The id is the storehouse of all drives and instincts. The ego comprises a group of functions that coordinate and organize behavior, including the anxiety-minimizing defense mechanisms. The superego is the product of moral and social values. The primary function of the ego is to mediate conflicting demands from the id, superego, and external reality.

• **Adaptive.** Human behavior has to conform to the demands of the external reality, in particular, social reality.

Some additional points of view have been proposed, including the following:

• **Psychosocial.** Human behavior is strongly influenced by social forces, especially the early familial context.

• **Gestalt.** Human behavior is multiply determined and multifaceted. Despite its conceptual differentiation into perceptual, motor, cognitive, and affective aspects and the spatial and temporal contexts within which it occurs, it is ultimately integrated and indivisible.

• **Orgasmic.** Human behavior is not performed in isolation but rather is a reflection or component of the total personality. While full elaboration of the different assumptions involved is beyond the scope of this chapter, it seems important to point out the relevance of the theory for real persons in real-life contexts. This relevance is particularly apparent within the structural and functional framework of the total personality. Clinically, behavior performed in isolation from the context or the rest of the personality generally reflects pathology.

The enormous complexity and richness of the points of view or propositions (also referred to as metapsychological assumptions) should be juxtaposed with less ambitious conceptualizations. While full elaboration of the different assumptions involved rarely can be made, it does target an approach that attempts to appreciate real persons in real-life contexts. This complexity is particularly apparent in the area of diagnosis. Diagnostic evaluation from the psychodynamic point of view provides understanding of the psychological state of the person. Psychodynamic approaches deal with such psychological dimensions as growth, experience, family, society,
self, relationships, intrapsychic phenomena, symbolization, subjectivity, spirituality, need, character, defenses, and behavior, among countless others. They also deal with constitution, temperament, and heredity and their roles in interaction with the foregoing dimensions. The whole person is always involved, and diagnosis focuses on such dimensions as ego strength, character style, and insight, with formal objective labels rapidly becoming irrelevant once the course of psychotherapy has been determined.

THE PROCESS OF PSYCHODYNAMIC COUNSELING

Psychodynamic counseling is not a lesser form of psychological intervention than psychoanalysis or any of its variants. It is intended for different purposes and often for different populations. In classical psychoanalysis there are rather stringent requirements for “suitability.” For example, in an encyclopedic presentation of the psychoanalytic theory of neurosis of that time, Fenichel (1945) presented indications and contraindications for psychoanalytical treatment. In 1920 Freud divided neuroses into transference neuroses and narcissistic neuroses, which roughly correspond to neuroses and psychoses. The key criterion distinguishing the two is whether the person is able to establish transference (the warded-off impulses are striving for an expression in connection with a longing for objects). Persons with narcissistic neuroses, having regressed to a preestablished object relations phase, are unreliable in this regard because of a tendency to withdraw. Since the interpretation of transference is the main tool of psychoanalysis, transference neuroses are its indication, but in narcissistic neuroses it is inapplicable.

Specific contraindications for psychoanalytic treatment are elaborated upon by Fenichel (1945) and include advanced age, insufficient intelligence, unfavorable life situations, triviality of a neurosis, urgency of a neurotic symptom, severe disturbance of speech, lack of a reasonable and cooperative ego, certain secondary gains, and schizoid personalities. As psychoanalytic theory has developed, inroads have been made in a number of areas affecting some of these contraindications. For example, older persons in many instances have been found to be suitable for psychoanalysis. Modifications in psychoanalytic technique have opened analytic and analytically based approaches to those with borderline, schizoid, and even psychotic diagnoses. Considerable progress has been made in understanding pre-Oedipal psychic states, and hard-and-fast distinctions between transference and narcissistic neuroses continue to erode as a result.

Fundamental concepts of psychoanalytic therapy include free association, abreaction, transference, resistance, and interpretation (of symptoms,
dreams, fantasies, defenses, and character style). Greenson’s (1967, Chapter 1) review of the components of classical psychoanalytic technique serves as the basis for what follows.

*Free association* has priority over all other means of producing material in the analytic situation. It is the major method of producing material in psychoanalysis, but free association is used only selectively in psychoanalytically oriented psychotherapies.

*Transference* is defined by Greenson as “the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood” (p. 33). Transference repetitions bring into the analysis material that otherwise is inaccessible. Freud also used the term *transference neurosis* to describe that constellation of transference reactions in which the analyst and the analysis have become the center of the patient’s emotional life and the patient’s neurotic conflicts are relived in the analytic situation (Freud, 1914/1958). As Greenson indicated,

> Psychoanalytic technique is so geared as to insure the maximal development of the transference neurosis. . . . The transference neurosis is an artifact of the analytic situation; it can be undone only by the analytic work. It serves as a transition from illness to health. . . . In the anti-analytic forms of psychotherapy the transference reactions are not analyzed but gratified and manipulated and are believed to lead to fleeting “cures” (“transference cures”) and last only as long as the idealized transference to the therapist is untouched. (p. 35)

*Resistance* refers to all the forces within the patient that oppose the procedures and processes of psychoanalytic work. Resistance, regardless of its source, operates through the ego and operates both consciously and unconsciously. Resistance is seen through repetitions of all of the defense operations that the patient has used in his or her past life. A major task of psychoanalytic therapy is to thoroughly and systematically analyze resistance to uncover how the patient resists, what is being resisted, and why the resistance occurs. Ultimately, resistances are efforts to ward off a traumatic state.

In psychoanalysis, a wide variety of therapeutic procedures are used, all having the direct aim of furthering self-insight. Others do not add insight but strengthen those ego functions that are required for gaining insight. For example, Greenson used abreaction as an example of a nonanalytic procedure that may permit a sufficient discharge of instinctual tension to reduce feelings of endangerment and render the ego secure enough to
work analytically. The most important analytic procedure is interpretation, with all others subordinated to it both theoretically and practically.

The crux of actually “analyzing” a psychic phenomenon usually involves four distinct procedures (Greenson, 1967). These include confrontation, clarification, interpretation, and working through.

- **Confrontation** is the first step in analyzing a psychic phenomenon. The phenomenon in question has to be made explicit to the patient’s awareness. For example, failure to show up for a session by Mrs. K. was understood by the analyst as related to a general tendency to avoid unpleasantness. In the previous session, “controversial” material had been discussed that made her feel that the analyst was angry at her (supposed) misbehavior. “The specific fear, embedded in a general avoidance of possible unpleasantness, was then confronted in the next session.” The analyst said, “You missed your last session not because you ‘forgot’ but you were frightened that I was going to be angry with you!”

- **Clarification** refers to those activities that aim at placing the psychic phenomenon being analyzed in sharp focus. Significant details have to be identified and separated from extraneous matter. The particular variety or pattern of the phenomenon in question has to be singled out and isolated. Mrs. K’s characteristic avoidance of her anger by projecting it onto others was shown by invoking instances where she feared retaliation from her own “boldness” (hostility). The clarification demonstrated how she projected her anger onto others, and her subsequent fear of rejection.

- **Interpretation** is the “procedure which distinguishes psychoanalysis from all other psychotherapies because in psychoanalysis interpretation is the ultimate and decisive instrument. . . . To interpret means to make an unconscious phenomenon conscious. . . . To make conscious the unconscious meaning, source, history, mode, or cause of a given psychic event” (Greenson, 1967, p. 39). In the instance of Mrs. K., the interpretation offered was that she was transferring (repeating) toward the analyst complex feelings of ambivalence toward her father, based on both correct and distorted images of him. Specifically, she had the unconscious belief that opposition toward him would lead to rejection and even abandonment. Her family history and personal recollections suggested that while her father was somewhat authoritarian with the children, she greatly distorted the extent of his wrath. Typically, an indication of a correct and timely interpretation is the response of the person, such as the flow of associations.
• **Working through** is the final step of the analyzing process, “a complex set of procedures and processes which occur after an insight has been given. The analytic work, which makes it possible for an insight to lead to change, is the work of working through. It refers in the main to the repetitive, progressive, and elaborate explanations of the resistances which prevent an insight from leading to change” (Greenson, 1967, p. 42). Change actually occurs through the working through. For Mrs. K., one aspect of working through involved demonstrating the many situations wherein hostile feelings on her part were projected onto others, particularly parental figures. The expectation of retaliatory punishment and rejection could then be seen as her own childlike fear of abandonment for noncompliance and willfulness. Insight regarding her use of projection as a resistance against contacting her own hostile feelings was followed up as its many guises were revealed. Self-affirmation began to be distinguished from hostility and selfishness as fears of abandonment abated.

Termination of psychotherapy is arrived at by mutual and satisfactory agreement that the major goals of treatment have been attained by patient and analyst and that the transference has been resolved.

A final concept, the *working alliance*, completes this survey of major analytic concepts and processes. “The working alliance is the relatively nonneurotic, rational relationship between the patient and analyst which makes it possible for the patient to work purposefully in the analytic situation. . . . The working alliance along with the neurotic suffering provide the incentive for doing the analytic work; the bulk of the raw material is provided by the patient’s neurotic transference reactions” (Greenson, 1967, pp. 46–47).

It is the focus on unconscious determinants and the role of transference that distinguishes psychodynamic psychotherapy (Patton & Meara, 1992). As with other counseling approaches, immediate imperatives regarding coping; dealing with affective responses; negotiating familial, functional, social, and vocational consequences; and combating stigmatization dominate encounters. Contents influenced by a psychodynamic orientation regarding loss, grief, self-image, shame, anger, and depression, while not exclusive to psychodynamic exploration, are given a particular slant because practical and socially directed interventions are not necessarily helpful. The role and need for mourning the loss of a function and/or body part and its status as an object loss can be missed in procedures directed toward functional restoration.
Typical rehabilitation situations do not justify the elaborate therapeutic activity of psychoanalysis. Thomas and Siller (1999) have noted that

long-term characterological analysis in the overwhelming majority of rehabilitation situations is not feasible for practical reasons. Short-term, focused psychoanalytic exploration at best inevitably will be the most available. . . . Apart from practical questions of short-term versus long-term, there is the theoretical issue of relative usefulness of intensive character as contrasted with a more focused exploration. First, relatively few persons in the general population meet the criteria or have the desire for intensive character analysis. For most persons newly disabled, the imperatives almost always are elsewhere such as for functional restoration and the medical situation. With this understanding persons newly disabled in most instances will be unsuitable for intensive characterological interventions. . . . Sufficient help can be obtained for both those newly disabled and those with longer lasting conditions through the use of more focused interventions. Intensive character analysis is the choice when the presence of disability is secondary in importance to the general needs and character of the person. (pp. 193–194)

REHABILITATION APPLICATIONS

Psychodynamic and psychoanalytic applications to rehabilitation and disability studies may be conveniently categorized into four broad areas: (a) the use of defense mechanisms by people with physical disabilities during the process of psychosocial adaptation; (b) the effect of disability on the person’s body image and self-perception; (c) the study of reactions to loss, trauma, and disability (e.g., mourning, depression, denial, anger); and (d) the meaning and structure of attitudes toward people with disabilities.

Study of Defense Mechanisms Within the Context of Coping With Physical Disability

A cardinal contribution of psychoanalysis and ego psychology to the understanding of how the onset of physical and sensory disabilities affect the individual is the study of the ego defense mechanisms. Defense mechanisms are viewed as unconscious processes that are mobilized when the ego is unable to ward off anxiety and other disturbing emotions or unacceptable impulses. To succeed in alleviating these noxious internal states, the ego may resort to a number of psychological defense maneuvers:

1. Repression. Forcing out of conscious awareness those intrapsychic conflicts and painful experiences (e.g., the person with a visible,
congenital disability repressing feelings of shame triggered by early-life reactions of others).

2. **Projection.** Casting out or externalizing unconscious forbidden ideas, needs, and impulses and attributing them to others (e.g., the person with a recently acquired disability who attributes lack of progress in rehabilitation to medical staff incompetence rather than to own lack of efforts; the individual who blames environmental conditions for the onset of lung cancer rather than to heavy smoking).

3. **Rationalization.** Using after-the-fact, false reasons for engaging in unacceptable behaviors so that negative emotions or consequences can be prevented (e.g., the person who gradually loses hearing and attributes lack of participation in a conversation to boredom or fatigue).

4. **Sublimation.** Adopting useful and socially acceptable behaviors to express forbidden and socially unacceptable wishes and impulses (e.g., anger toward, and wishes to retaliate against, an uncaring society may be channeled into artistic endeavors).

5. **Reaction formation.** Substituting and expressing responses and feelings that are exact opposites of those that are forbidden (e.g., parents who demonstrate extreme manifestations of loving behaviors or overprotectiveness, rather than the initial feelings of aversion and rejection, toward their child who was born with a severe disfigurement).

6. **Regression.** The reverting to childlike behaviors first exhibited by the individual during an earlier developmental stage (e.g., a recently disabled person whose temper tantrums are activated when needs are not immediately gratified).

7. **Compensation.** Seeking to excel in functionally related (direct or primary compensation) or unrelated (indirect or secondary compensation) activities or behaviors to make up for disability-generated loss (e.g., the person who lost sight at an early age and has achieved success as a musician). Compensatory activities may or may not undercut the satisfaction achieved with success. That is, subjectively, one’s gratification of mastery may become contaminated by a failure to achieve one’s real goal (e.g., wholeness and nonstigmatization).

Finally, related concepts, although not traditionally regarded as defense mechanisms, are primary and secondary gain. Primary gain refers to those symptoms and behaviors directly linked to alleviation of the stress-inducing affect. Secondary gain, on the other hand, addresses some form of exploiting social (e.g., familial, occupational) sanctions, permitting the affected individual not to engage in previously performed roles and activities (e.g., the person with low back discomfort who refuses to discontinue receiving social security benefits or resume household chores, even after the condition has improved).

Disability Impact on Body Image and Self-Perception

Body image is the unconscious representation of one’s own body (Schilder, 1950). Following the early contributions of Head (1920), who proposed that people create a set of reference models (schemata) of their own body structure, Schilder expanded those proposals to perceive body image as residing at the core of self-image, self-concept, and even personal identity and reflecting a three-dimensional image of symbolic and emotional significance including personal, interpersonal, environmental, and temporal dimensions (McDaniel, 1976; Shontz, 1975).

Chronic illnesses and disabilities are thought to alter, even to distort, the body image and therefore also the self-concept, because the imposed physical changes must be confronted by the person (Falvo, 1999). Furthermore, problems that stem from the new disability-associated reality (e.g., pain, disfigurement, sensory and mobility limitations, cognitive distortions) all threaten the stability of the body image and necessitate changes in its structure and dynamic operations (Bramble, 1995). Successful psychosocial adaptation to a disabling condition includes the integration of the imposed physical changes into a reconstructed body image and, therefore, personal identity. Unsuccessful adaptation, in contrast, is marked by physical experiences and psychiatric symptoms that often include psychogenic pain, chronic fatigue and energy depletion, feelings of anxiety, depression, and anger, social withdrawal, and attempts at denying loss or impaired functioning of the involved body part(s).

In the context of psychoanalytic theorizing, the onset of adventitious physical disability is tantamount to a profound narcissistic injury, since narcissism and body image progress in parallel routes during the course of normal human development (Grzesiak & Hicok, 1994). Moreover, since the body (or part of the body) is the initial object being cathected by the developing ego (Siller, 1988; Szasz, 1957), the body image acquires archaic
and symbolic meanings. Injury to the body, therefore, particularly at early developmental stages, often results in identity confusion, impoverished self-esteem, and emotional distress (Greenacre, 1958).

In a similar vein, Neiderland (1965) and Castelnuovo-Tedesco (1981) contended that an early body defect leads to a narcissistic injury (at times referred to a narcissistic ego impairment) and, therefore, to an unresolved conflict because of its concreteness, permanency, and association with archaic forms of anxiety (e.g., body disintegration anxiety, castration anxiety). This unresolved narcissistic injury results in a disrupted body image and, consequently, may lead to an unrealistic self-concept that, although often distorted, may also give rise to heightened intellectual and artistic creativity. When the narcissistic injury expresses itself in a compensatory fashion, it may lead to increased aggressiveness, excessive vulnerability, impaired object relations, self-aggrandizement, and even delusional beliefs (Castelnuovo-Tedesco, 1978, 1981; Grzesiak & Hicok, 1994; Krystal & Petty, 1961; Neiderland, 1965).

Of utmost importance is the developmental stage during which the disability was acquired. Narcissistic injuries during the separation-individuation, Oedipal, and adolescent stages are thought to render the individual most vulnerable to body image distortion, self-representation instability, and self-concept traumatization (Castelnuovo-Tedesco, 1981; Earle, 1979). Loss or removal of body parts is fraught with potential psychological disturbances, and their gain or addition (e.g., organ transplantation) could be equally disturbing. The transplant situation triggers heightened life-death anxieties because the transplant organ is often obtained from a dead person or from a donor whose life may now be in greater jeopardy (e.g., kidney donors). Thoughts may then result of having robbed the donor of vital organs and the accompanying feelings of guilt, self-blame, and fears of punishment (Castelnuovo-Tedesco, 1978). Further discussion of the role of body image in the context of disability studies may be found in Block and Ventur (1963) and Lussier (1980).

**Psychosocial Reactions to Loss and Disability**

Numerous theoretical and clinical accounts of the nature, structure, and temporal sequencing of psychosocial reactions to the onset of chronic illnesses and physical disabilities have been provided in the literature. Tacit in all of the accounts is the assumption that a discernible order of reactions exists to account for the ways that the individual responds, copes with, or reacts to the newly acquired condition. Among psychoanalytically influ-
enced writings are those of Bellak (1952), Blank (1961), Cubbage and Thomas (1989), Degan (1975), Engel (1962), Gunther (1971), Kruger (1981–82), Krystal and Petty (1961), Langer (1994), Neff and Weiss (1961), Nemiah (1964), Siller (1976), and Thomas and Siller (1999). Most of the above writers view the process of psychosocial adaptation to the onset of a physically disabling condition as (a) reflecting a symbolic transition from possessing a “normal” or “whole” body (“former self”) to that which is not complete or whole (“present self”); (b) having to accept a loss of previously attained physical, psychological, and social selves; (c) creating a need for a period of mourning (grieving) for the lost body part or function that, upon its successful resolution, leads to a reconstructed self-image as a person with a disability; (d) being determined by the symbolic meaning (both in its narcissistic connotations and functional impairment) of the disability and body parts involved, to the individual and society; and (e) following a complex series of psychic activities in which (i) cathexes are first withdrawn from the injured ego as well as from the outside world, and then after a period of denial (serving as a defensive role in minimizing the disability and its consequences), (ii) energies are gradually reinvested in a new body and self-images, alternative needs and gratification, and the reestablishment of contact with a newly perceived reality.

The following reactions of adaptation to the disability experience (often viewed as mostly internally determined psychosocial phases) are typically addressed in the psychoanalytically derived literature: (a) shock, disbelief, and chaotic disruption; (b) anxiety (injury, loss, and disability, such as blindness and amputation, are said to reawake archaic castration anxiety); (c) grief, mourning, and depression related to real object loss (and the necessitated changes in narcissistic investments, emotional cathexes, and self-image); (d) denial of illness or disability (denial of affect associated with the nature, functional implications, extent, or seriousness of the condition); (e) anger and aggression (turned inwardly and resulting in feelings of guilt and shame, or turned outwardly to trigger feelings of other-blame and need for revenge); and (f) adjustment and restitution (a successful resolution of the “work of mourning” and reformation of the self-image).

Attitudes Toward People with Disabilities

The origins, formation, and structure of attitudes toward people with disabilities have been addressed extensively from a psychodynamic perspec-
Earlier psychoanalytic views posited that the often observed negative societal attitudes toward people with disabilities may be traced to (a) the belief that disability is an unjust punishment for sinful acts; (b) the projection of one's unacceptable impulses and wishes upon those with disabilities (those who were justly punished) since they are least likely to retaliate; (c) the perception that, if disability is an unjust punishment, then the person with disability is motivated to commit an evil act to counteract the injustice and is, therefore, dangerous and should be avoided; (d) unresolved conflicts over scopophilia and exhibitionism, during early psychosexual stages of development that trigger fascination/attraction versus repulsion/avoidance conflict over seeing a person with a disability; (e) “guilt by association” that may render the nondisabled person as maladjusted, possibly resulting in social ostracism if interacting with people who are disabled; (f) guilt of being nondisabled when the other person has lost an important body part or function and is permanently affected by it (akin to the “survivor’s guilt” phenomenon); (g) disability as a reminder of death, since loss and disability symbolize death and destruction, thereby rekindling archaic fears of annihilation and serving as reminders of mortality; and (h) disability as a threat to one's intact body image that reawakens earlier castration anxiety, along with fears of losing physical integrity (Barker, Wright, Meyer, & Gonick, 1953; Blank, 1957; Degan, 1975; Livneh, 1982; Siller, 1976, 1984; Siller, Chipman, Ferguson, & Vann, 1967; Wright, 1983).

Siller and associates (Siller, 1970, 1984; Siller et al., 1967), in a multifaceted and extended series of studies, investigated the structure of attitudes toward persons with various disabilities. They concluded that attitudes toward persons with disabilities are, indeed, multidimensional in nature and typically reflect such components as interaction strain, rejection of intimacy, generalized rejection, authoritarian virtuousness, inferred emotional consequences, distressed identification, and imputed functional limitations, each of which may have different developmental and personological roots.

**CASE EXAMPLE**

Mr. J. B. was referred by his attorney to one of the authors (JS) for psychological counseling, in part to support a legal action for damages received while at work, and in part to provide psychological support for emotional distress in connection with his disability. The first session occurred approximately one year after an accident where Mr. J. B. was hit and pinned against a wall by a heavy weight that lurched forward because of a mechani-
cal failure of a restraining part. His injuries included a crushed left leg that required an above-knee amputation and “minor” head injuries requiring stitches in the temporal area. A psychological report stated that his memory and other cognitive symptoms seemed to be “consistent with a post-concussion syndrome.” About three months later, he was fitted for a prosthesis and began physical therapy and walking instructions that were continued at the time he was first seen in counseling.

Mr. J. B. was 49 years old at the time of the accident and had been working as the manager of the machine shop when injured. He was born and raised in Greece, and he moved to the United States about 10 years before the injury. His wife and two children lived in Greece, and long periods of separation from his family had been a way of life, although he was now considering returning to Greece. Since his injury he has lived with a brother and his family.

While profoundly distressed about his new status as a person with a disability, his presence in counseling was initiated by his attorney, primarily as a legal strategy. He appeared to be a pragmatic, sincere, and serious family and work-oriented person who was accustomed to working methodically, independently, and responsibly. The aftermath of his injuries was devastating, and he was trying to reconstitute himself functionally through applying himself to the prosthetic program. His emotional state was more problematic because he had no clear reference as to how to cope with strong feelings of stigmatization, shame, and diminished self-regard. He was seen for psychological counseling once per week for almost six months.

The first five sessions were focused mostly on information, limited mostly to the accident and present rehabilitation efforts, daily life, and background status. As focus shifted from the “external” situation to feelings about insecurities and fear of the future, a modified form of psychoanalytic psychotherapy was used. His report of dreams was encouraged, but interpretations were conservatively advanced and limited to issues germane to rehabilitation. A major stimulus for the shift to psychodynamic intervention was emotional distress created by the realization that prosthetic restoration had reached a plateau and was being terminated, far short of achieving his expectations.

Within the five sessions, the first three concentrated upon the themes of prosthetic restoration and his insecurity about his mobility, language, and memory. At the fourth session he began to speak of his sensitivity and awkwardness in being seen by people who knew him from before the accident, separation from his family, and feelings of “being less than a man.” Transference occurred to the therapist as a rational authority; the
therapist was viewed impersonally as a possible vehicle of benefit with expert status regarding disability. He experienced despair about his ultimate ability to use his prosthesis comfortably and effectively, although he was actively walking and exercising. Major resistances then appeared to be based in denial of the functional consequences of his amputation and concealment of the affect of shame. He was also concerned about his short-term memory. Neuropsychological testing revealed difficulty in attending and concentrating, slow but within normal range motor speed, no perceptual or auditory dysfunction, no evidence of aphasia, but significant impairment in linguistic skill, with an IQ in the average range and memory within normal limits. The cognitive difficulties, particularly in attention and concentration, appeared to be symptoms of postconcussion syndrome, possibly accounting for the self-reported memory difficulties.

The nature of counseling changed by the sixth session, since he was distraught about the failure of the prosthesis to return him to his original functional status. The therapist confronted him, indicating that he was underestimating the value of his prosthesis, because it was enabling him to move and travel quite well. Referring to a phrase he had already used, “I feel less of a man,” an interpretation was offered: “You are feeling inadequate as a person physically and sexually, and in most respects your fantasy of being made whole by the prosthesis has been exploded.” It was suggested that the main purpose of treatment was to restore his self-regard and appreciation of himself in a realistic context. His emotional distress enabled expansion of counseling from the prosthetic and functional focus to questions of self-regard, manhood, social worth, and more. His reticence about opening up emotionally to a stranger lessened and a new phase began.

The extended and only partially successful efforts at prosthetic restoration complicated body and self-image adaptation. Socket adjustments were frequently being made. Phantom sensations were present but did not seem to be a general concern. At the sixth session, when asked if anything was bothering him, he replied, “One of the worst times for me comes when retiring for the night. Taking off the prosthesis gives me the reality that I’m missing my leg.” Talking about sleep and having to see his stump opened two lines of inquiry: the nature of his dreams and the process of mourning his lost part and status.

He generally did not have disturbing dreams, although there was a recurrent dream about a feeling of falling in space. He was not attuned to probing his dreams and was unable to pursue an associative path. He was asked whether he had such dreams before the injury and whether he felt that they were now connected with the injury. He did not remember having
them before but stated that they might be connected to his balance and walking with a prosthesis. While agreeing that it was a likely connection, subsequent intervention was designed to go beyond the physical to more general insecurities. In effect, the therapeutic direction was to confront and to clarify the resistance through which he was trying to contain the unpleasantness of his self-feelings as a diminished man by focusing upon the functional/physical realm. Counseling returned to issues previously touched on at a more intellectualized level, such as stigmatization and fear of the future, with an extended perspective based upon transference and resistance.

In the next session, he was urged to further address feelings about seeing his stump. There appeared to be mixed feelings about his level of impairment, and the discussion was directed to the connection between his despair and his embarrassment at being seen by those who knew him from before. He observed that he was less uncomfortable at home with his brother’s family, and for the first time the session was almost entirely directed toward emotional matters.

Prior adaptations to the expectations of his family and self now needed revision to restore value in his own eyes. Returning to an early theme of the need to mourn, the concept of mourning his loss of limb was discussed, along with impaired mobility and self-regard. As he was getting more comfortable with and less defensive about such considerations, the naturalness of mourning, placed in the context of all significant losses, became more acceptable and not a sign of weakness and unmanliness. During this period, there was an exacerbation of disturbing dreams involving potential danger (e.g., being on a ship in a hurricane, recurring thoughts of the accident). Work on interpreting dreams, along with discussions about his past and present relationships and feelings, helped to expand his sense of self and the disturbed dreams became less threatening. Near the end of counseling, he was much more active and insightful as to how much he determined his emotional state.

After some 20 sessions, Mr. J. B. left for a visit to family in Greece, and soon afterward a settlement was reached in his legal action, and he returned to Greece permanently. A telephone follow-up indicated that sensitivities, anxieties, and mood swings continued, but that he had a generally better feeling about his condition. Encountering former friends or coworkers had become easier. There were few disturbing dreams, and when they occurred, he thought of them along the lines that we had addressed. He also commented about more appreciative feelings toward his prosthesis.

The counseling experience was successful to the extent that a lessening of most of the complaints was achieved and the ability to appreciate the
value of his prosthesis was enhanced by attention to the magical thinking surrounding it. Facilitating mourning by interpreting denial of affect and questions of "manhood" helped to make the prosthesis a support rather than a failure of fantasies about restoration. Technically, the major vehicle of change resided in a shift in transference. Rather than seeing the counselor as an objective and impersonal "disability expert," a more positive transference developed: seeing the counselor as a source of help with feelings and as someone who would not devalue him when he revealed his self-doubts and fears. Analytic tools of dream analysis, interpretation, confrontation, clarification, insight, working through, and analysis of resistance were used, but primarily in a modulated and selective way.

RESEARCH FINDINGS

Because of the scope and focus of this chapter, it is not reasonable to provide complete coverage of the extensive research findings generated by psychodynamic theory and therapy. Three broad research trends are evident in the extant literature: (a) the study of psychoanalytically derived concepts, such as defense mechanisms, the nature and function of dreams, and unconscious motivation; (b) the effectiveness of psychodynamic therapy; and (c) disability and rehabilitation applied research (e.g., the symbolic meaning of loss and disability, the structure of attitudes toward people with disability, body image and disability).

Research on Freudian Theory

Freud was quite skeptical of the value of empirical research on psychoanalytic concepts and procedures. For him, each session was an experiment in itself, and psychoanalysis needed no other support. For many years research on psychoanalytic theory and practice did nothing to disabuse this notion. More recent work is more reflective of the true character of the phenomena studied, and optimism is increasing regarding the possibility of subjecting psychoanalytic concepts to more adequate verification (e.g., Bornstein & Masling, 1998; Fisher & Greenberg, 1978, 1985). Significant problems, however, must be recognized. For example, Freudian theory, rather than being a unified coherent theory, is an amalgam of many theories. Further, as a psychology stressing unconscious phenomena, it deals with derivatives of the unconscious not directly reflected in behavioral acts. In addition, the complexity and abstractness of many psychoanalytic concepts render them very difficult to measure. The tautological nature of some of
the constructs also may preclude direct refutation of their existence and operation. Yet, an enormous body of empirical research has been accumulated on psychoanalytic theory and practice. The results are equivocal, but as Kline (1981) concludes after a major critical review of empirical research on psychoanalytic theory: (a) much of the metapsychology is unscientific in that it cannot be subjected to any kind of empirical test and so be refuted (e.g., death instinct, pleasure principle); and (b) much of psychoanalytic theory consists of empirical propositions that can be tested, and many of the Freudian concepts most important to psychoanalytic theory have been supported (e.g., repression, the Oedipus complex). Kline concludes, “The status of psychoanalytic theory must now be clear. It must be retained not as a whole but only after rigorous objective research has revealed what parts are correct or false or in need of modification” (pp. 446–447). The reader may find additional sources on empirical studies in Bornstein and Masling (1998), Fisher and Greenberg (1978, 1985), and Maddi (2000).

Despite the equivocal empirical support, psychodynamic theory and research have enriched psychological testing immensely by introducing projective techniques into the mainstream of assessment. Projective tools include the Rorschach Inkblot Technique, the Thematic Apperception Test (TAT), the Draw-A-Person Test, the House-Tree-Person Test, the various word association procedures, the Blacky (Pictures) Test, and the more recent measures of defense mechanisms, including the Defense Mechanisms Inventory (DMI; Gleser & Ihilevich, 1969) and the Repression-Sensitization (R-S) Scale (Byrne, 1961).

**Effectiveness of Psychoanalytically Derived Psychodynamic Therapy**

It has been argued that adequate empirical studies to assess the effectiveness of psychoanalytically oriented therapy are scarce because of its complexity and the virtually impossible task of trying to control the many variables involved (Arlow, 2000). Moreover, Fisher and Greenberg (1985) speculated that comparisons of therapeutic efficacy between psychoanalytic therapy and other therapeutic approaches are doomed to failure because “the evidence indicates that there is no one conception of what psychoanalytic therapy is” (p. 41) and many analysts do not view change, especially behavioral change, as a primary therapeutic goal.

Earlier efforts by Fenichel (1930) and Knight (1941), as well as occasional studies by the American Psychoanalytic Association (Arlow, 2000;
Fisher & Greenberg, 1985), suggested that successful therapeutic outcomes typically ranged from a low of 25% (for patients diagnosed with psychoses) to a high of 65–75% (for patients diagnosed with neuroses). Meta-analytic studies in the 1980s and 1990s (Lipsey & Wilson, 1993; Prioleau, Murdock, & Brody, 1983; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980) found psychoanalytic and other psychodynamic therapies to be equal to slightly less effective than cognitive-behavioral therapies. In their review of controlled outcome research, Prochaska and Norcross (1999) concluded, “The measurable outcomes of psychoanalytic psychotherapy and short-term psychodynamic psychotherapy are superior to no treatment and slightly to considerably inferior to alternative psychotherapies” (p. 60).

The efficacy of psychotherapy is a complex and thorny issue. Psychodynamically based therapies do not foster a direct cause-and-effect link, and their effects are more diffuse and character-related. Goals and outcomes that focus on behavioral change only depict one isolated aspect of the complex nature of human experience. For other detailed reviews of the efficacy of psychoanalytic therapies, the reader is referred to Fisher and Greenberg (1985), Meltzoff and Kornreich (1970), Prochaska and Norcross (1999), and Roth and Fonagy (1996).

As methodological improvements occur and more appropriate evaluation and research studies are reported, increasing evidence will be forthcoming to substantiate the value of psychoanalytic psychotherapies. In 1997, Psychoanalytic Inquiry (Lazar, Ed.) published a supplement to their journal, with 12 articles supporting psychoanalytic therapies in various terms, including cost-effectiveness, clinical effectiveness, and public health. For example, Doidge (1997) reviewed the empirical evidence for psychoanalytic therapies and psychoanalysis and indicated that they are the most widely practiced of the more than 100 different types of psychotherapy. The results of studies consistently confirm the effectiveness of both psychoanalytic therapy and psychoanalysis when used with appropriate patient populations, with improvement rates of 60–90%.

Applied Research in Disability and Rehabilitation

Body Image and Adaptation to Disability

In a series of studies, Druss and associates (Druss, 1986; Druss, O’Connor, Prudden, & Stern, 1968; Druss, O’Connor, & Stern, 1969, 1972) explored changes in body image and psychosocial adaptation of patients who underwent colostomy and ileostomy following chronic ulcerative colitis and
bowel cancer. The authors noted that, immediately after surgery, patients experienced shock and depressive reactions. Loss of a highly valued organ, the sense of mutilation, and heightened body awareness appeared evident. Furthermore, support was found for the notion of parallelism between surgery and feelings of castration and between the stoma and phallus. Research on disturbances of body image was also reported following spinal cord injury and brain injuries (Arnhoff & Mehl, 1963; Fink & Shontz, 1960; Mitchell, 1970; Nelson & Gruver, 1978; Shontz, 1956; Wachs & Zaks, 1960) and following limb amputation (Bhojak & Nathawat, 1988; Centers & Centers, 1963; Rybarczyk, Nyenhuis, Nicholas, Cash, & Kaiser, 1995).

**Castration Anxiety, Death Anxiety, Object Representations, and Attitudes Toward People With Disabilities**

The relationships between attitudes toward people with disabilities and several psychoanalytically derived personality constructs have been investigated. A number of empirical studies focused on the relationship between castration anxiety and intrapsychic perceptions (expressed as endorsed attitudes) of people with physical disabilities. The authors (Baracca, 1991; Fine, 1979; Follansbee, 1981; Gladstone, 1977; all cited in Thomas & Siller, 1999) investigated the effects of castration anxiety and level of object representation on attitudes toward persons with disabilities, using the Siller et al. (1967) Disability Factor Scales-General (DFS-G) measure. The findings suggested, albeit weakly, the following: (a) heightened castration anxiety is positively associated with more negative attitudes toward those with disabilities; (b) among preschool children, those who scored higher on castration anxiety (using the Blacky Test) also manifested more negative attitudes toward others with disabilities; (c) increased narcissistic vulnerability was found to be associated with more negative attitudes; and (d) those with more rigid defense mechanisms (using the Defense Mechanisms Inventory) were more rejecting of persons with physical disabilities (object relations theory views defenses as a central function of the ego in its efforts to ward off anxiety and stress, both triggered by a threat to one’s own body integrity).

Finally, negative attitudes toward those with physical disabilities are posited by psychoanalytic theory to be linked to fears of insults to one’s own body integrity (e.g., castration anxiety) and also to loss of one’s life (i.e., death anxiety). Indeed, it was conjectured that archaic fears of physical deterioration and death are triggered when faced with situations that consti-
tute symbolic reminders of death, such as the presence of a person with a visible disability. Empirical support for these notions was reported by Enders (1979), Fish (1981), and Livneh (1985).

**Loss, Mourning, and Disability**

Classical psychoanalytic theory regards the mourning process as a gradual decathexis of the mental representation of, and the affective investments in, the lost object (Frankiel, 1994). Disability-related conceptualizations equate the mourning process engendered by the death of significant others (interpersonal loss) with that triggered by loss of body parts or functions (personal loss). Research by Parkes (1972a, 1972b, 1975) comparing the psychosocial reactions of widows and people with amputation indicated that similar phases of grief and realization (e.g., shock, denial, depression, anger, acceptance), as well as defensive processes, were experienced by both groups.

**PROMINENT STRENGTHS AND LIMITATIONS**

**General Strengths**

- Psychoanalytically derived psychodynamic insights have been applied to therapy, dream interpretation, humor, child-rearing practices, educational and learning experiences, vocational development and occupational choice, history, religion and mythology, art, music, literature, political and social organizations, anthropology, psychological testing (projective techniques), and daily human experiences (slips of the tongue, gestures, symptomatic acts).
- Psychoanalytic theory provides the clinician with an extremely rich perspective on human emotions, cognitions, and behaviors. Its conceptual structure offers an unequaled opportunity to enjoin human functioning as a multileveled and multidetermined phenomenon.

**Rehabilitation-Related Strengths**

- Psychoanalytically derived psychodynamic concepts are well entrenched in rehabilitation practice (e.g., defense mechanisms, secondary gain, and body image).
- Adopting a psychodynamic perspective enables rehabilitation practitioners to focus on subjective and unique meanings of loss, grief,
and disability on the part of the affected individual and his or her family members.

- The psychodynamic approach affords the rehabilitation practitioner a dynamic and developmental perspective on the process of adaptation to disability across the lifespan (Cubbage & Thomas, 1989; Thurer, 1986).

**General Limitations**

- Problems of tautology, refutability, and controlled research make global assessment of the theory and its elements impossible. There is no global theory and, while various elements have received support, others have not, and many simply have not been adequately defined or tested (e.g., cathexis, id, libido).
- Clinical observations from case studies are often anecdotal in nature, uncontrolled for bias, and not representative of the general clinical population.
- Some classical psychoanalytic concepts, such as castration anxiety, penis envy, libido, and development of the woman’s superego, have been strongly criticized as being gender-biased.
- Psychodynamic therapy focuses primarily on intrapsychic issues and conflicts and neglects broader social contexts (e.g., family dysfunction, social problems). This limitation, while operating in certain instances particularly in the past, seems archaic in the face of the reality of modern psychoanalysis. The role of the family and society was fundamental to psychoanalysis from the beginning, and nonlibidinal object relations, self theory, and adult relationships abound as prime factors in theory and clinical work.
- Assessment measures of clients’ affective status and behavior have low validity and reliability (e.g., projective techniques), are highly subjective, and often lack standardization in administration, scoring, and interpretation (Ford & Urban, 1998; Liebert & Liebert, 1998; Maddi, 2000; Prochaska & Norcross, 1999).

**Rehabilitation-Related Limitations**

- Earlier, a rationale for short-term focused psychoanalytic exploration in the rehabilitation context was offered. Time constraints, lack of trained personnel, inability to meet the prerequisites of verbal capac-
ity, diminished personal insight, and limitations induced by certain cognitive impairments (e.g., MR/DD clients, clients who sustained traumatic brain injury, clients with severe mental illness) are realities in rehabilitation. The practice of rehabilitation appropriately recognizes the importance of the “here and now” for the client.

- Psychoanalytically derived therapy emphasizes abstract, reflective, and insight-building processes, while rehabilitation focuses on concrete and pragmatic goals, emphasizing vocational and independent living pursuits.

- The goal of psychoanalytically driven therapy in rehabilitation is likely to focus on symptom alleviation and anxiety reduction rather than reconstructing personality, supporting defenses and dealing with self-feelings and projections into the future. As stated by Siller (1969), “The aim of [rehabilitation] is to assist the person toward reformulating a self that approves of continuing to be despite important discontinuities with its past identity. Specifically this means the promotion of a new self-image predicated on worth, rather than on deficiency and self-contempt” (p. 20, in Siller & Thomas, 1995). Rehabilitation requires a larger canvas within a team environment, merging medical attention, skill acquisition, education, and adaptation to disability. Psychoanalytic sensitivity to unconscious issues such as mourning and object loss can be invaluable for a newly disabled individual. The psychodynamic intervention, therefore, must occur within the larger rehabilitation context.

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