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TWO SYSTEMS OF SELF-REGULATION AND THE DIFFERENTIAL APPLICATION OF PSYCHOANALYTIC TECHNIQUE[1]

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Out of our work over the years on child development, clinical technique, and sadomasochism, we have begun to formulate a model of development that describes two possible ways of responding to feelings of helplessness in the face of the challenges of internal and external experience. Any psychoanalytic model has implications for how we think about technique and can be tested on the basis of its utility in generating technical ideas and enhancing our therapeutic repertoire. At this juncture in the history of our field, it is crucial for us to demonstrate that psychoanalytic techniques are effective in helping people enter treatment, change, and finish in a way that consolidates their gains. In this paper we explore the utility of our two-systems model for expanding the discourse about psychoanalytic technique.

KEY WORDS: psychoanalysis; technique; omnipotence; alliance; self-regulation.

Our clinical work on the defensive omnipotent beliefs that organize sadomasochism has led us to think that clinicians need a model that describes two distinct kinds of solutions to conflicts. The concept of two systems of self-regulation rests on the alternative psychoanalytic dual-track model of development rather than the single-track model, with its assumptions of normality growing out of pathology, that underlies much of modern psychoanalytic thinking. In our model, one system of self-regulation is attuned to inner and outer reality, has access to the full range of affects, and is characterized by competence, love, and creativity. We call this the "open system." The other, which we call the "closed system," avoids reality and is characterized by sadomasochism, omnipotence, and stasis (J. Novick and K. K. Novick, 1991, 1996a, 1996b, 2002; K. K. Novick and J. Novick, 1998).

As our ideas about sadomasochism and the closed system have evolved (J. Novick and K. K. Novick, 1972, 1991, 1996a, 1996b, 1998, 2002; K. K. Novick and J. Novick, 1987, 1998), we have developed a view that departs

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from the classical description of "normal infantile omnipotence." In our study on beating fantasies in children (J. Novick and K. K. Novick, 1972), we found it useful to distinguish among wishes, thoughts, and fantasies. Drawing from Schafer (1968), we restricted the usage of "fantasy" to conscious daydreams. Omnipotence is a quality that can be attributed to wishes, thoughts, or daydreams. As such it can be a harmlessly pleasurable element of play or creativity, as long as awareness of the distinction between real and pretend, between thought and action, is maintained. There can be imagined omnipotence accompanying childhood fantasies, including the transitory beating fantasies we found in girls at the oedipal phase (J. Novick and K. K. Novick, 1972). When such ideas meet with external reality factors such as serious medical conditions, death or other accidents of fate, or psychological trauma stemming from parental inadequacy or pathology, an illusion of omnipotence can be converted into a *delusion*. We have more recently found it helpful to make a further distinction between fantasies and beliefs in order to account for patients' subjective conviction of the reality and truth of their conscious or unconscious ideas (J. Novick and K. K. Novick, 2000; Weiss, 1993, 1998). Omnipotent beliefs present as convictions or assumptions that organize an individual's thinking and actions.

In our work we have emphasized that we do not view omnipotent beliefs as part of normal development, nor as equivalent to oceanic feelings, grandiosity, egocentrism, or primary narcissism. Omnipotent beliefs are created in response to reality failures in order to protect the person from physical or psychological trauma. We define omnipotence as a conscious or unconscious belief in magical power to transcend all the limitations of reality in order to control others, to hurt them, to force them to submit to one's desires, ultimately probably to force the mother to be a "good enough," competent, protective, and loving parent.

There are many indicators of hidden omnipotent beliefs in even the most high-functioning neurotic patients. A conscious or unconscious belief in omnipotent power may appear in perfectionism, lack of pleasure in accomplishments, rituals, or a variety of pathological superego manifestations (J. Novick and K. K. Novick, in press). It is important to connect the underlying omnipotent conviction with the experience of helplessness that gave rise to it.

THE CLOSED OMNIPOTENT SYSTEM AND ITS DEVELOPMENT

When faced with overwhelming experiences, whether they originate from internal or external events, all people throughout life must find a way to feel good. If the way they find is through a turn away from reality, safety will continue to reside in an omnipotent solution. Such a learned response can come to feel like the most dependable safeguard, and take on an addic-

tive quality, restricting the person's attempts to essay other solutions and pathways to problem solving and conflict resolution. Rathbone has noted that "the masochistic perversion, besides being a psychosexual deviation, is also a physiological addiction involving the pain- and stress-produced endogenous opioids" (2001, p. 111). The omnipotent system is closed, repetitive, and increasingly resistant to change. In a distorted personality development it can become a structure regulating feelings of control, safety, excitement, and enjoyment. We have described the strands originating in each level of development, starting in infancy, that become braided at adolescence into an unbreakable rope of omnipotent belief that organizes the adult personality (J. Novick and K. K. Novick, 1996a, 1996b). To serve basic needs, the closed system can co-opt drive impulses and gratifications, ego capacities and functions, and superego organization.

Given the security that closed-system functioning provides to the individual, it is indeed questionable why anyone would give it up. What is the alternative? The patient fears that the only alternative is the primitive states of helplessness, rage, or traumatic guilt that originally gave rise to the defensive omnipotent delusions of closed system functioning.

THE OPEN, COMPETENT SYSTEM AND ITS DEVELOPMENT

At any point in experience or development we discern an alternative possible response, a system of self-regulation that is competent and effective, based on mutually respectful, pleasurable relationships formed through realistic perceptions of the self and others, open to experience from inside and outside and thus generative of creativity in life and work. Elements of description of such an open system can be found scattered in the analytic literature (Bowlby, 1969, 1973, 1980; Erikson, 1950; A. Freud, 1965; S. Freud, 1895, 1913, 1920, 1938/1940; Hartman, 1939/1958; Horney, 1939; White, 1959; Winnicott, 1949/1964).

The closed and open systems of self-regulation do not differentiate people, that is, they are not diagnostic categories. Rather, the concepts describe potential choices of adaptation *within each individual at any challenging point in development* and allow for a metapsychological or multidimensional description of the components of the individual's relation to himself and others. One way to characterize the goal of treatment is in terms of movement out of characteristic closed-system self-regulation to greater open-system functioning (J. Novick and K. K. Novick, 2002). Psychoanalysis has traditionally elaborated substantive understanding and treatment of closed-system pathology, but there has been insufficient attention to the coexisting operation of open-system capacities. We can discern both closed- and open-system functioning through the lenses of various psychoanalytic

constructs, for instance, in terms of the transference, therapeutic alliance, defenses, experiences of the self, superego functioning, counterreactions, and so forth.

A major manifestation of open-system functioning in treatment is in the patient's and analyst's joint creation of a therapeutic alliance throughout the treatment. The therapeutic alliance concept functions as a lens that helps us focus on the capacities and motivations, conscious and unconscious, from all levels of the personality and all stages of development that enter into the specific collaborative tasks of each phase of treatment. The specific therapeutic alliance tasks of any particular phase of treatment confront resistances arising from closed-system functioning (K. K. Novick and J. Novick, 1998).

Mastery of alliance tasks and internalization of the therapeutic alliance build on and promote open-system consolidation. Children, adolescents and adults finish good-enough treatment with the potential for adaptive transformations in response to the many challenges of life. These begin in the evaluation phase of treatment, when the analyst works to initiate transformations of self-help to joint work; chaos to order and meaning; fantasies to realistic goals; external complaints and circumstantial explanations to internal meanings, motivations, and conflicts; helplessness to competence; despair to hopefulness. From the alliance task of *being with*, highlighted in the beginning phase of treatment, can come confidence in the capacity to be alone with oneself, to value oneself, and to cooperate in a trusting, mutually enhancing relationship with others. The new level and range of ego functions used to *work together* in alliance with the analyst throughout the middle of analysis can be used for living and for self-analysis. In addition to ego functions such as memory, perception, self-reflection, integration, and so forth are the metacognitive functions that Freud referred to as the executive function of the ego, and that Anna Freud described as the general characteristics of the personality. Included here would be the capacity to plan, anticipate, work through a task from beginning to completion, take pleasure in the process and so forth. These ego functions are consolidated in the *independent therapeutic work* begun during pretermination, then continued after treatment whenever necessary.

Strengthening the open system of self-regulation helps to equalize the forces in the life-long struggle against developmentally determined and culturally reinforced hostile, sadomasochistic, omnipotent solutions of the closed system. Expansion and strengthening of ego functions throughout treatment are at the center of our understanding of analysis as a developmental experience. Recent neurobiological investigations have identified various centers for ego capacities but have also demonstrated that practice and use of ego functions produces actual cortical changes, particularly during the preschool years, as well as throughout life.

Drawing on descriptions from earlier publications (K. K. Novick and J. Novick, 1987; J. Novick and K. K. Novick, 1991, 1996a, 1996b, 2002), we have constructed a chart that presents a schema of the two systems of self-regulation as possible responses to the ordinary challenges facing each person in the course of development. There are many ways to use this chart, but, for the purpose of this discussion, we suggest that the descriptions be used as "developmental images," an aid to the techniques of construction and reconstruction. In this way, current adult material, such as we will present here, can evoke both the multiple determinants of closed-system functioning and the potential from infancy on for open-system functioning in even the most disturbed adult patient.

In this chart you will see that each developmental phase brings its own challenges, with underlying threats of helplessness. In infancy the challenge of forming a secure attachment and dealing with inevitable moments of mismatch can be met by recourse to magical omnipotent belief in power to control the object's responses or by the growth of realistic reliance on mutual contingent responses. The toddler faced with intense feelings from inside and frustration from outside can be helped to modulate and fuse aggression or, if aggression is not absorbed by parents who also maintain their loving investment, can turn his rage into a vicious cycle of sadomasochistic interaction.

The realities of gender and generational differences challenge the oedipal child. With help the child can respond to the frustration of his wishes by a decisive turn to reality and a corresponding ego growth. If the challenge is overwhelming because of overstimulation or abuse, the oedipal child turns to magical belief in oedipal victory. Latency children are faced with the demand to work and enjoy their own and others' growing autonomy. When they can avoid reality, for instance by bullying or victimization, they do not develop competence or the pleasure in competence that helps them consolidate open-system functioning. Adolescence is crucial, because of its immense biological and social challenges. Accomplishing the major task of dealing with the realities of adolescent development means setting aside any earlier closed-system omnipotent solutions. If these are retained, passage into psychological adulthood will be severely compromised.

Through the longitudinal development of the open and closed systems respectively, we may see the open-system effort to transform the self, in contrast to the closed-system aim to control, force, and change others.

APPLICATION TO TECHNIQUE

What are the technical interventions that illuminate the operation of each system, that address resistances and provide open-system alternatives in the day-to-day work of analysis? This is an enormous question that could

CHART. Two Systems of Self-Regulation

Phase Challenge	*Open, Adaptive, Competent Response*	*Closed, Omnipotent, Sadomasochistic Response*
For parents during pregnancy Parental helplessness re physical changes, intactness and safety of baby	Helplessness evokes parents' finding areas of realistic effectiveness and sources of support. Conscious planning to avoid repetition of own negative infantile experience.	Helplessness leads to parental fantasy of baby as controller, devourer, savior. Transference to baby from old relationships. Externalization of devalued/feared/wished for aspects of self on to baby.
For Children		
Infancy Infant's failure to evoke needed response. Transient parental loss of attunement	Mismatch followed by repair. This is root of positive feelings of competence, effectance, and reality-based self-regard. Positive feelings instigate and represent effectance and basic object tie. *Signs* include predominance of positive affect, secure attachment, psychophysiological harmony.	Parent fails child and infant is left in helpless rage, frustration, and traumatic overwhelming. Turn away from reality and competence. Reliance on magical controls. Attachment through pain. *Symptoms* may include gaze aversion, failure to thrive, hairpulling, head-banging, biting.
Toddlerhood Exploration, independence, and assertion frustrated	Child's aggression is absorbed in constancy of parental love. Exploration and assertion protected and enjoyed. Autonomy and independence a source of price, with positive attachment strengthened at new level. Ambivalence can be tolerated with aggression increasingly separated from assertion. Anger and aggressive impulses a useful signal, calling into play ego capacities and realistic use of object. *Signs* include preponderance of joy, swift recovery from negative affects, capacity to accept help of others, to negotiate resolution of conflicts, concern for others.	Assertion defined as aggression, parents helpless to absorb aggression, modulate excitement. Separation experienced as attack. Wishes given stamp of reality—assertion becomes aggression becomes sadism. Self-esteem derived from control of others. Identification with externalizations and externalizing defenses of parents. *Symptoms* may include rages, sleep disturbances, separation problems, attacking other children, interference with development of speech, toilet mastery, bodily control, mastery of feelings (tantrums, inconsolability).

Phallic-Oedipal Reality of gender and generational differences (exclusion from adult activities)	Turn to reality gratifications, internal sources of self-esteem. Development of autonomous superego with both affirming and prohibiting characteristics, open to reality corrections. *Signs* include curiosity in service of growing reality sense, development of independent friendships, capacity to use adults as resources.	Child responds to trauma from overwhelming experiences (primal scene, frightening films, TV, etc) by sexualization, denial, and externalization. Parental collusion with child's wishes promotes formation of omnipotent delusion. Sadomasochistic fantasy organizes superego, which is tyrannical, divorced from reality, unmodified by experience. *Symptoms* include persistence of earlier problems, inability to give up transitional object, bossiness and controlling behavior, provoking attack, obsessional rituals, bedwetting, ego constriction.
Latency Negotiate rules, rewards, demands, and controls of external world.	Good feelings from image of self as competent, effective, capable of learning, playing, negotiating, socializing, controlling self, and changing. *Signs* include successful mastery of impulses, tolerance of ambivalence, development of complex relationships, capacity for pleasure in work.	Self-esteem based mainly on belief in control of others; Real talents and capacities co-opted to maintain delusional image of omnipotent self (entitlement, exception). *Symptoms* include persistence of earlier problems, intensification of obsessional rituals alternating with wild, "hyper," anxiety-driven behavior, lack of pleasure in real achievements, learning problems, bullying, victimization, inability to play, social isolation.
Adolescence Real changes in body, mind, and social expectations.	Ownership of mature sexual body. Consolidation of gender identity. Realistic self- and object-representations. *Signs* include pleasure in appearance and functioning of body, increase in capacity to parent self, constant relationships with peers.	Maintenance of omnipotent beliefs by means of increasingly desperate self-destructive actions. *Symptoms* include pathological use of the body (eating disorders, self-mutilation, suicide, substance abuse, pregnancy, repeated abortion, rapid repeat pregnancy, promiscuity), delinquency, depression, fragmentation of personality, low achievement, grandiosity, social isolation.

encompass the whole of clinical theory. Here we will limit ourselves to looking through the lens of the therapeutic alliance tasks at some technical choices in evaluating and starting treatment with two patients. We will present some vignettes, and then address three dimensions of technique.

The first concerns *what we attend to*. We want to consider how the two-systems model affects our choices, both conscious and preconscious, of what to listen for. The second is the *actual interventions* we make or don't make. Here belong issues of timing, tact, order—how we decide what to do. Third is what this model allows us *to include* as technique that is specifically and legitimately psychoanalytic.

What Do We Attend To?

We suggest that analysts generally attend to as much as they can, perceiving at many levels material of all kinds generated in interaction with patients. But without a framework much of what is perceived slips into the preconscious and is used or not depending on the personal predilections of the individual analyst. The human tendency to simplify is sometimes intensified by analysts creating a rigid analytic superego that sees different conceptualizations as mutually exclusive, even adversarial, rather than enriching and encompassable within the complex, multidimensional tradition of psychoanalytic theory that looks at human phenomena from many points of view. We can too easily lose the comprehensive metapsychological theory that provides a vocabulary or conceptual framework for the full range of what patients bring and the spectrum of how we intervene (K. K. Novick and J. Novick, 2002).

Let us look at some material from two patients whom we have discussed in previous publications from different vantage points.

> Mr. G was a brilliant scientist with a worldwide reputation in his field, but he was, as he put it, "a selfish, obnoxious pain in the ass," tyrannical to his wife, children and employees, and seeming to enjoy his sadism without guilt, remorse or conflict. In his first assessment sessions, he described preschool and school-age memories of doing sadistic things to his younger brothers, his mother and his teachers. When he gleefully recounted jumping on a bed until it broke, the analyst chose not to comment on the obviously expressed sadistic triumph, but noted instead the kinesthetic pleasure of jumping up and down. Mr. G was momentarily startled by this response, and then remembered pleasurable school-age experiences of rolling down a grassy slope, with the warm smells of summer and fun with other children.
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> Mr. G's wife had threatened to leave him unless he sought treatment. He presented a list of abusive behaviors with bravado and a barely concealed challenge to the analyst to reprimand him. Instead, the analyst focused on the essential

needs served by his behavior, adding that everyone has these same needs. Mr. G seemed a little flustered by the analyst's comment but then recovered by saying that he knows how to get what he needs without asking favors of anyone. The analyst then asked Mr. G to tell him about his wife. After some initial grumbling about her being unfair, oversensitive and deserving of his abusive behavior he began to talk about her in a softer tone with admiration for her achievements. The analyst said to Mr. G that, despite the fact that he was so hard on his wife, he seemed to value the relationship. Mr. G began to cry and said he felt he couldn't live without her, that he needed treatment in order to keep her. (adapted from J. Novick and K. K. Novick, 1996b, pp. 87, 363)

In the material from Mr. G's evaluation we are struck by the evident excitement and defiance in his sadistic stance. We know from our previous work that the construction of a closed sadomasochistic omnipotent system is a major psychological achievement serving such vital needs as safety, attachment, protection against destruction of self and/or other, sexual discharge and so forth. At this very early phase of treatment the patient feels the only alternative to closed omnipotent functioning is overwhelming helplessness. In Mr. G's material we see that he has no intention of changing and challenges what he assumes are the analyst's intentions.

We attend also to the aspects of open-system functioning. We look for positive pleasures other than sadistic triumph. We look for signs of love, joy, creativity, and competence even if these experiences are compromised by closed system hostile omnipotence. In our model, closed- and open-system responses are available to everyone from birth on, so we expect to find past and current manifestations of open-system functioning, no matter how disturbed the individual. Along these lines we attend to the adaptive dimension of even the most pathological forms of behavior. In the evaluation phase of work with Mr. G, we note that he did look for treatment, that he was aware of the reality of his wife's threats, that there must be sufficient love and positive attachment for him to seek help. Despite the fact that for considerable time Mr. G attributed his success at work, at home and in his numerous affairs to his powerful voice and his bullying, selfish behavior, we also note the high level of success in his field and his pride in his achievements, seeing these as central manifestations of open system competence.

Mrs. T was a successful businesswoman, married, with three grownup children. She had felt depressed and somewhat empty for a long time, and consulted a psychiatrist, who recommended an antidepressant. Mrs. T was disinclined to use medication, as she felt her friends on pills had lost their zest, even though they claimed to be very happy. She said that she could not decide what to do, so she sought out an analyst, with the idea that he would prescribe analysis. The analyst

pointed out that she seemed to have decided that she wanted analysis but was looking for some expert to take responsibility for the decision. She replied that this was the secret of her success—she had never had to make decisions, but had been pushed throughout her life by circumstances and other people's ideas about her. The analyst wondered about this pattern as a source of difficulty, noting that it implied that she had no wishes of her own, that she had never pursued a desire that could be seen as coming from inside herself. This first verbalization of elements of conflict produced new material. Mrs. T described a number of affairs she had had at conventions in faraway cities and said that she had never told anyone about these before.

The analyst could then discern Mrs. T's conflict over owning her sexual impulses. Rather than interpret at this point on the basis of the content, about which little was yet known, the analyst noted to himself the auguries of erotic transference in this material, and chose first to take up the way Mrs. T's own wishes could only be met with built-in limits and in secrecy. He suggested that understanding this would be something they could work on together. Mrs. T remarked thoughtfully that she would like to be able to feel good more of the time, not only during those brief, secret affairs, that maybe this problem was what her depression was about. Thus the analyst and Mrs. T were able to arrive together at an exploration of her conflicts around pleasure as an explicit goal for her treatment. (adapted from K. K. Novick and J. Novick, 1998)

Mrs. T's material appears to contrast with Mr. G's. She was aware of suffering, she wanted help and needed no convincing that psychoanalysis was the treatment of choice. She appeared at first glance to be the ideal neurotic patient with a good old-fashioned working alliance and no obvious evidence of closed-system, hostile, omnipotent, sadomasochistic functioning. Working with an internal model of two systems, however, we seek to attend to phenomena in the material that derive from both ways of functioning. Analysts are not always in the habit of thinking of expressed positive wishes for treatment as a possible indicator of conflict and resistance. In this case, the analyst paused mentally to assess the status of the evaluation in the light of the appropriate therapeutic alliance tasks, that is, in relation to various transformations that should be started before treatment proper begins. Through this lens it became clear that Mrs. T had not begun to shift to the idea of joint work, had not addressed her fantasies around being told what to do by an expert, and was still dealing with her problems as external—analyst and patient had not yet arrived together at a sense of internal conflict in her. This was the indication that more work was necessary in the evaluation to elucidate her potential for both open- and closed-system functioning.

With Mr. G we looked for manifestations of past and present open-system competent functioning, and with Mrs. T we attended more closely to dis-

guised closed-system manifestations. The potential for open- or closed-system responses exists for each person, including the therapist. One clue to Mrs. T's closed-system response to the stress of the evaluation was in the therapist's counterreaction. He found himself eager to accept her assessment, to go along with her plan for 5 times per week analysis and to view her notion that they were a good analytic match as based mainly on reality. This rush of positive feelings alerted the analyst to the likelihood that both patient and analyst were being swept into a relation of idealizing enthrallment. The two-system model encourages the differentiation of important concepts and phenomena, such as the differences between love in the open and closed systems, or the open- and closed-system determinants in superego development (J. Novick and K. K. Novick, 2000, in press).

With both Mr. G and Mrs. T we attend to open-system functioning as represented in the therapeutic alliance tasks for each phase. Transformation is the task the therapist brings to the evaluation phase; this initiates internal conflict between open and closed system functioning. As we have detailed in previous publications (J. Novick and K. K. Novick, 1996b, 2000, 2002; K. K. Novick and J. Novick, 1998) each open-system therapeutic alliance task challenges a central tenet of the closed system. The closed system is static, movement is illusory and in a closed circle, and change is vigorously resisted. The open system is accessible to internal and external forces; adaptive and creative transformations are the hallmark of this system. Mr. G's defiant sadistic stance was transformed into a source of conflict. Mrs. T's idea that her depression was biological was transformed into an experience of an internal conflict around pleasure. These were the beginning transformations and the basis on which treatment could start.

> The focus at the beginning of Mr. G's analysis was his life-long tendency to provoke battles, to abuse and control others. He recounted his growing up in a home where the men were, as he put it, "sadistic bullies" who dominated and brutalized the women. As his history unfolded and was reexperienced in the transference, he began to see the relation between his early feeling of helpless anxiety and his reaction of identification with his shouting, verbally abusive father. When he was angry he felt a rush, an excitement, a feeling of power and indestructibility.
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> The analyst tracked Mr. G's good feelings in the sessions, not only his sadomasochistic triumph, but also noting when he enjoyed coming and using his mind, and when he felt good about the analyst's meeting of his normal ego needs to be listened to, understood and respected. With this focus Mr. G recaptured early memories of his grandmother who had loved him and treated him as a worthy individual. He recovered a loving, joyful aspect of himself, which constituted the other side of the conflict with an omnipotent, magical, destructive self. The omnipotent defenses made him feel safe and powerful; his love left him feeling

vulnerable, especially to abandonment. Focus on his feelings around being with the analyst, which is the therapeutic alliance task for the patient in the beginning phase of treatment, allowed for full experience of the conflict between two ways of functioning. (adapted from J. Novick and K. K. Novick, 1996b, pp. 365–366)

Mrs. T attended sessions regularly and punctually as she began analysis, and accepted all the analyst's interventions with equanimity. Gradually the analyst began to understand Mrs. T's apparent compliant passivity as her way of being with him. Mrs. T's conditions for the relationship included externalizing her ego capacities for reflection and integration on to the analyst to create a sadomasochistic transference that cast her in the role of a naïve child sitting at the feet of a wise elder. As the images in her material brought this relationship into sharper focus, the analyst pointed out how rarely Mrs. T seemed comfortable with the idea that they were two adults working together, that is, he interpreted the interference with the alliance task rather than the drive elements in the transference. She said that she was sure that she could eventually force him to take care of her and decide everything for her if she only waited it out and did as she was told. This harked back to the initial push to have an expert tell her what was wrong with her and what to do about it. Thinking about the open system potential, the analyst had used the therapeutic alliance task of *being with* as a lens to help him see clearly the dimensions of the sadomasochistic transference as it was emerging. When this was taken up with Mrs. T, an underlying omnipotent fantasy of control emerged and became accessible to the work of the analysis.

As we can see in the continuing material of both these patients, the analysts used the two-systems model to help them maintain equal attention to conflicts around the open- and closed-system aspects of the relationship as it developed. This in turn deepened the transference relationship and paved the way for interpretation and reconstruction.

ACTUAL INTERVENTIONS

The idea of two systems of conflict resolution and self-regulation can lead to a conceptualization of *two kinds of technique,* one that elucidates closed system functioning, another that enhances open-system functioning. Conflicts over open-system functioning usually are expressed in reversion to closed-system omnipotent beliefs, efforts at creating sadomasochistic interactions, and externalization of impulses or ego and superego functions on to the analyst. Technical interventions have differing impacts on phenomena relating to the two systems. Closed-system phenomena require the drive/defense, classical approach of transference and resistance analysis, with the aim of putting the patient in the active center of his pathology. But defense and transference interpretations of open-system functioning can pathologize and drive away competence. Mirroring, empathy, reconstruction,

validation, support, and developmental education, to list but a few, link open-system phenomena with the analyst's functions beyond serving only as a transference object. These techniques applied to closed-system functioning, however, may be at best a palliative waste of time; at worst, they may serve to reinforce a passive, helpless, victimized stance on the part of the patient. Thus, we have to think in terms of expanded and alternative technical options to encompass the open-system dimensions of our patients' personalities and the opportunities of the treatment situation.

Actual interventions are implied in what we attend to, but we can be more explicit about the relation between the two-system model and what we do and say. We do not believe that what we do is foreign or very different from what all experienced analysts do. But a two-system model anchors these interventions in a theoretical framework, one that takes us back to a basic psychoanalytic metapsychological model. It provides an inclusive basis for teaching and describing the range of therapeutic interventions, bringing technical assumptions into the foreground for examination.

Just as each analyst's implicit model of development informs what gets attended to, so each person's model of the treatment process affects technical choices. For many, these models are seldom articulated but nevertheless have an impact on how we view the patient and the subsequent unfolding of material. The impact of the observer on the observed has now become an analytic given, but there is little attention paid to the impact of the analyst's models on the patient. Kleinian patients have Kleinian dreams; Oedipalists have patients who live in triangular worlds of rivalry, jealousy, triumph, and defeat; Self psychologists have patients who exhibit basic self-deficits and so forth. We contend that it is important to articulate one's model but to keep the model in the open system where it is in constant interaction with the external world, ever open to modification and change.

Here is our most recent model of the process of treatment as seen through the lens of the open system therapeutic alliance tasks. As long as we keep in mind that the phases of treatment and the alliance tasks are not mutually exclusive mechanical checkpoints along the road, but rather a heuristic device to describe phenomena that actually persist and overlap throughout treatment, we have found it useful to summarize the tasks highlighted in the work of each phase in the form of a table that delineates the demands on each party to the therapeutic relationship.

We can return now to the clinical vignettes and think about the choices involved in the actual interventions. Mr. G was inviting an intervention in response to his provocative, triumphant sadism. In attending to our own reactions with a person like this, the analyst noted his own annoyance and wish to counterattack. The pull from the patient is to enter into a sadomasochistic interaction, a painful relationship. Closed-system functioning cre-

TABLE 1. Therapeutic Alliance Tasks

	Evaluation	Beginning	Middle	Pretermination	Termination	Postterm
Patient	Bring material Engage in transformation tasks	Being with therapist	Working together with therapist	Putting insights into action Independent therapeutic work Maintain progressive momentum	Setting aside omnipotent beliefs Internalization of alliance Mourning	Use alliance skills for living and creativity
Therapist	Initiate transformations of: • self-help to joint work • chaos to order and meaning • fantasies to realistic goals • external complaints to internal conflicts • despair to hope • helplessness to competence • guilt to usable concern	Feeling with patient	Maximum use of ego functions	Allow for patient's independent therapeutic work	Allow patient's mourning Deal with own loss Analyze to end	Stay available as analyst
Parents or Significant other	Engage in and allow transformations	Allow the being with	Allow for individuation or psychological separation	Enjoy and validate progression	Mourning loss of therapy Internalization of alliance Consolidation in phase of parenthood	Allow continued growth Grow with patient

ates a vicious cycle: traumatic helplessness is avoided by actively seeking a painful interaction; this justifies a powerful sadistic omnipotent response and thus externalizes the helplessness on to others. Already at the beginning of analysis, attention to the closed-system phenomena gives us forewarning of issues that will be central to the treatment. On the basis of our two-system model, however, we refrain from addressing this directly at this point, as interpretation of the sadism would not only meet intense resistance but might even be a dangerous intervention, given that the patient has as yet no alternative available.

When Mr. G described his controlling, abusive behavior with his wife, the analyst chose to avoid being pulled into condemnation and threat. Instead he first focussed on the legitimate needs served by the sadistic behavior. Mr. G responded with interest and then insight into his belief that his success came from his bullying. The analyst again resisted the temptation to respond within the closed-system dynamic of a sadistic externalized superego and stayed instead on Mr. G's functioning as a solution to very deepseated anxieties. At this point the analyst could verbalize Mr. G's need to protect himself and then point out that the solution gets Mr. G into trouble, for instance, his wife's threats to leave him. The analyst verbalized Mr. G's love for his wife, delineating the predicament of two important needs in conflict within the patient. Then Mr. G began to cry. Together they could set a treatment goal of finding more adaptive, open-system ways to protect himself.

Mrs. T's sadomasochistic character pathology emerged clearly during the evaluation, as she described how all her behavior and thoughts, as well as her sexual life, had always been organized around a fantasy of being forced by someone or circumstances to do things. She claimed to have no goals, no desires, except the need to be perfect. She lived in a world devoid of pleasure, joy, or creativity, except for limited moments of stolen, illicit pleasure, as in her brief affairs. Looking at the material of the evaluation phase through the lens of transference highlighted Mrs. T's gratification in sadomasochistic relationships. The lens of the therapeutic alliance, with the transformation tasks of evaluation to address, however, revealed her conflicts over allowing other sources of pleasure. We can see again how attending first to this dimension allowed the analyst to speak directly to conflicts and interferences with open-system functioning, thereby setting a joint goal for the treatment.

With both patients, there was a powerful pull exerted on the analyst to participate in the drama—Mr. G invited the analyst to shout at him and humiliate him, or seized on the slightest pretext to blow up and yell. Mrs. T remained passive, bringing dreams with no associations, recounting elliptical stories about attractive men at work without acknowledging her own

impulses. Entering into the sadomasochistic interaction would have served only to perpetuate it, covertly gratifying the wish for omnipotent control and manipulation. By working on conflicts related to the open system, the analysts elicited the patients' ego capacities, their curiosity, their competence, which in turn sharpened the contrast with closed-system functioning and allowed for awareness of internal conflicts.

Later in Mrs. T's analysis, the analyst was faced with a similar choice point. In the throes of a full-blown crisis of feeling humiliated by any intervention by the analyst, Mrs. T had created a therapeutic impasse. She found a way out through writing stories that she brought into her sessions. For a long time, sessions were filled by the patient reading aloud. It was clear that Mrs. T turned any attempt to take that up into a sadomasochistic control battle. Through the lens of transference, the analyst understood Mrs. T's use of the stories as a hostile defensive resistance to direct experiencing of positive transference and as a reenactment of early sadomasochistic relationships. Focus on the open-system alliance perspective, however, allowed for space to work together on understanding the stories, and for Mrs. T to discover a potential alternative source of good feeling in competence and effectance from the work, rather than from controlling the object. She began to track patterns of fluent thinking, constrictions, and fuzziness, which were noted, then altered and mastered. With one foot firmly planted in the competent pleasures of the open system, both analyst and patient felt safe to venture into the "borderland" of omnipotent sadomasochistic wishes—they shared a sense that this was now an internal conflict between closed and open systems, rather than an external conflict with an analyst who would humiliate her or be destroyed (K. K. Novick and J. Novick, 1998).

WHAT TECHNIQUE IS PSYCHOANALYTIC?

Many analytic controversies, splits and dissensions revolve around issues of training and technique. What is psychoanalysis and who can be called a psychoanalyst are issues that continue to exercise psychoanalysts. Many different psychoanalytic centers are the results of such splits. We think that modern American psychoanalysis is still reacting to the challenges from Alexander, Thompson, Fromm, and Horney. Recent articles have underscored the difficulties analysts continue to have with reality (Friedman, 1999), love (J. Novick and K. K. Novick, 2000; Panel, 2001) and joy (Heisterkamp, 2001).

The two-system model is embedded in our proposition that the core of psychoanalysis is the metapsychological, multidimensional approach to all psychological phenomena. By "metapsychology" we do not mean the ab-

stract theories so cogently criticized as outmoded nineteenth-century science. We understand it to mean Freud's emphasis on psychoanalysis as the only complete, multidimensional approach to all psychic phenomena. Anna Freud (1966) called metapsychology the "language of psychoanalysis." We have argued that reclaiming this meaning of metapsychology allows us to reclaim the richness of psychoanalysis as the most comprehensive theory of human development and functioning (K. K. Novick and J. Novick, 2002). It follows from such a general theory that psychoanalysis is a multimodal therapeutic technique. A two-system model adds movement from closed- to open-system functioning to the goals of analysis. Therefore any intervention that facilitates such movement can be considered analytic. From the very beginning of contact with the patient the two-system model includes as analytic a range of interventions which are generally not discussed, or are excluded from usual practice, or are included only as "parameters" when justified by the pathology of the patient.

The analyst not only carries models but also has attitudes that are overtly or indirectly conveyed to the patient. In our own work we tend to extend the evaluation period longer than most in order to achieve a genuine, reality-based respect for the patient and a positive conviction that analysis can be effective in providing this person with alternative solutions to past and current anxieties. We accept that our own models and attitudes will have a profound effect on the patient, especially at the start, and assume that the analyst's genuine feeling of hope and confidence is essential to start the process of transformation. Further, by including focus on the patient's areas of open-system functioning, we can create joint analytic goals and start a process that will end in restoring the patient's capacity to choose between alternate systems of self-regulation. After an extended period of evaluation Mr. G and the analyst arrived at a formulation concerning his need to feel effective, safe, and in control, while at the same time not alienating his wife. Mrs. T and her analyst could look at her inability to have pleasure as an area worth working on.

Struggle between two ways of functioning continues throughout analysis, becoming increasingly explicit and, by termination, very intense. Without a sense of the differential techniques available, the analyst can be pulled to participate in a mutual closed omnipotent defense against the reality of ending, rather than standing by to support the patient's effort at independent therapeutic work.

> After a termination date had been set, Mr. G felt helpless rage at feelings of abandonment and disappointment. With sustained work he arrived at the base of his sadomasochism and the core of his omnipotent beliefs. He had clung to the magical conviction that his pain and rage could make his mother be a good-

enough provider for his developmental needs. "So there it is," he said. "I have to put aside the idea that my mother could love me in the way I needed and get on with all the good things I now have. Or I can destroy all that I have worked for and go on thinking that there is something I can do to force them to do my bidding. You said there's a lot of work to saying goodbye. I can feel that now, but I think I am ready to do it." (adapted from J. Novick and K. K. Novick, 1996b, p. 373)

Throughout her treatment there was a struggle within Mrs. T between the wish to hold on to past patterns of sadomasochistic relationships, which represented infantile solutions with the hope of magical gratification, and the progressive forces that represented realistic relations with others and the world, mediated by competent functioning and yielding genuine, predictable pleasure.

Mrs. T oscillated between comfort in staying with the reality of the imminent end and fantasies about ways she could get the analyst to change the date, or change their relationship, or change himself. A week before the termination date, she seemed low-keyed, and somewhat quieter than usual. "I'd like to write a different ending to this story," she remarked. The analyst recalled how much they had learned together from the characters in her stories and wondered how Mrs. T would understand a character who tried so hard to redesign the world. Mrs. T snapped back, "I don't need a character to know I can't stand disappointment!" Then she said, "I really surprised myself with that. I guess it was waiting there to come out, but I have been fighting it off. Maybe that's why I've been feeling so subdued." She went on to examine the idea of being disappointed and faced her feeling that the analyst had not been the perfect mother she had always wished for, nor was she ever going to be the perfect person she had striven to be for so long. "Maybe now, though, I won't have to run off to have affairs to let myself know that what I really feel is all right." (adapted from K. K. Novick and J. Novick, 1998)

The two-system formulation leads to delineating two kinds of technique, one that elucidates closed-system functioning, the other that illuminates and enhances open-system functioning. Expanding our repertoire of interventions is an important benefit of this rethinking of a psychoanalytic developmental model. Convergence and integration of a variety of approaches takes place in practical terms through the application of the framework of our revised theory of the therapeutic alliance, with its phase-specific tasks for each party to a treatment. By the end of analysis, the mastery of therapeutic alliance tasks contributes to movement out of closed-system functioning to open-system functioning. The mourning process of the termination phase allows children, adolescents, adults, and parents to internalize and consolidate a loving, trusting, and mutually enhancing relation with the self and others. The ego functions freed for use in the therapeutic alli-

ance become available for the choice of creative living and self-analysis when necessary.

NOTES

1. An earlier version of this paper was presented at the American Institute of Psychoanalysis, New York, February, 2002.
2. Adapted from K. K. Novick and J. Novick, 1998.

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