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Kirk Schneider in psychopathology

BERNADETT DE FREITAS FERREIRA-MARTINS (*)
JOSÉ A. CARVALHO TEIXEIRA (**)

1. AN OVERVIEW OF KIRK SCHNEIDER

Kirk Schneider, as Irvin Yalom, Stephen Diamond and Myrtle Heery all belong to the "Second Generation Theorists of Existential Psychology" in United States. Of the second generation theorists, Kirk Schneider is the most active contributor that is currently writing. In 1978 he completed a Bachelor of Arts degree with his major subjects being Psychology and Philosophy at the Ohio State University. In 1979 he completed a Masters Degree in Psychology at West Georgia College and later in 1984, a Doctorate Degree, also in Psychology at Saybrook Institute.

Kirk J. Schneider is a licensed psychologist and a leading spokesperson for contemporary humanistic psychology. At Saybrook Graduate School, he is an adjunct faculty member, a colleague at the *American Psychological Association* (through Divisions 32 [Humanistic], 42 [Independent Practice], and 12 [Clinical]).

At present, Kirk Schneider is editor of *The Journal of Humanistic Psychology* as well as a member of the editorial boards of the *Humanistic Psychologist*, *Clinical Psychology: Science and Practice* (2002/2004), the *Review of Existential Psychiatry and Psychology*, *Person-Centred and Experiential Psychotherapies, the Society for Laingian Studies*, *The International Journal of Existential Psychology and Psychotherapy*, and the *Psychotherapy Patient*. He is the founding member and past president of the *Existential – Humanistic Institute of San Francisco*.

1.1. *Books and articles published*

Kirk Schneider has published as many articles, chapters and has authored and edited five books, namely:

- *The Paradoxical Self: Toward an Understanding of Our Contradictory Nature* (Plenum, 1990; Humanity Books, 1999);
- *Horror and the Holy: Wisdom-teachings of the Monster Tale* (Open Court, 1993);
- *The Psychology of Existence: An Integrative, Clinical Perspective* (co-authored with Rollo May, McGraw-Hill, 1995);
- *The Handbook of Humanistic Psychology: Leading Edges in Theory, Research, and Practice* (Sage Publishing Co., 2002), and
- *Rediscovery of Awe: Splendor, Mystery, and the Fluid Center of Life* (Paragon House, 2004).

In March 1998, he wrote the lead article in the *American Psychologist* entitled, *Toward a Science of the Heart: Romanticism and the Revival of Psychology*. He also completed (with Larry Leitner) the chapter on *Humanistic Psychotherapies* for

(*) Mestranda em *Relação de Ajuda – Perspectivas da Psicoterapia Existencial*, Instituto Superior de Psicologia Aplicada, Lisboa, Portugal.
(**) Instituto Superior de Psicologia Aplicada, Lisboa, Portugal. Sociedade Portuguesa de Psicoterapia Existencial, Lisboa.

the *Encyclopaedia of Psychotherapy* (Academic Press, 2002). Kirk Schneider also wrote the chapter on *Existential-Humanistic Psychotherapies* for the second edition of the widely distributed *Essential Psychotherapies* (2003), edited by Alan Gurman and Stanley Messer.

Kirk Schneider was a student and colleague of Rollo May at Saybrook in the San Francisco Bay area where Schneider currently teaches. He collaborated with Rollo May in the book: *The Psychology of Existence: An Integrative, Clinical Perspective* (Schneider & May, 1995). This book was May's final contribution to the field, when Rollo May become ill Schneider took on this project, completing it on his own.

Schneider was also the first editor of the book *The Handbook of Humanistic Psychology* (Schneider, Bugental & Pierson, 2001), contributing to several important chapters in this book. His most recent work, for which he is honoured, include listing in Marquis *Who's Who in America, Who's Who in the World* (2004), and the *Rollo May Award for outstanding and independent pursuit of new frontiers in humanistic psychology awarded by the Division of Humanistic Psychology of the American Psychological Association* (presented at the APA Annual Convention, 2004).

1.2. *Influences*

In his book *The Paradoxical Self*, Schneider speaks of *paradox* as it is for Kierkegaard, the founder of this perspective. Kierkegaard's objective was the description of human capabilities and limits, as such, human consciousness and how it is paradoxical. He talks about two extremes which are: the *Finitized* (restriction and submission) and the *Infinitized* (mobility and domination).

Finitized and *Infinitized* expression is often, but not always intimating for people. This expression has different meanings for different people, e.g. isolation or tranquillity is threatening for someone who is dominantly *finitized* or for a dominantly *finitized* individual, having to express himself/herself in public can be a frightening experience. People are considered to be healthy when they see an increase in the opposite behaviour as a means for adaptation rather than as a threat. When the individual is carried out into the *infinite – away from himself* (Kierkegaard, 1954), and sees this as a threat without a capacity to adapt or find a *finitized/infinitized* blend, dysfunction or what Kierkegaard terms *fantastical*, occurs.

Schneider considers the language used by Kierkegaard as difficult, especially for the understanding and application of his work. For these reasons, Schneider compares *Finitize* as "constriction", which is the approach to annihilation of feelings, thoughts and expressions, although one does not literally perceive this. *Infinitize* is compared to "expansiveness", the approach to boundless thoughts, feelings and sensations, not literally boundlessness. Schneider reformulates Kierkegaard's work, calling it *The Paradox Principle*, which has it's grounding on existential-phenomenological traditions in psychology.

1.3. *The paradox principle*

In explaining *The Paradox Principle*, Schneider (1999) describes it as holding three basic assumptions:

- The human psyche is a constrictive/expansive *continuum*, only degrees of which are conscious;
- Dread of constrictive or expansive polarities promotes dysfunction, extremism, polarization;
- Integration of the poles creates optimal or healthy living.

The human psyche shifts from the constrictive and expansive poles. The constrictive pole defined as the *drawing back* of ones thoughts, feelings and sensations, i.e. slowing, diminishing, and retreating. The expansive pole defined as the *bursting forth* of such thoughts, feelings and sensations, i.e. gaining, enlarging and filling.

The individual perceives through *inclusion* and *exclusion*:

- *Inclusion* – Expansive consciousness enlarges one's experiential field and this includes assertion and incorporation;
- *Exclusion* – Constrictive consciousness includes, yielding (conforming to other's views) and focusing (while focusing one excludes aspects of one's own and of others).

The *centric mode* or centric/centre, is the directive core of consciousness, such as the *ego*. The centric is unlike the *ego* in that it doesn't only derive from parental influences or sense perception. The capacity for imagination, affection and intuition may also influence the centric. Its aim is to control psychic forces and to engage all of one's capabi-

lities as permitted in certain circumstances. It's one's capacity of awareness in directing one's one constrictive and expansive potentialities. The greater the awareness the stronger one's centric.

2. SCHNEIDER'S VIEW OF DYSFUNCTION: PSYCHOPATHOLOGY

Schneider describes the extremes of *The Paradox Principal* as *hyper*, therefore referring to *hyper-constriction* and *hyper-expansion* which can be "mild", "moderate" and "severe". Due to their continuous nature, constriction and expansion infringe upon one another at some stage. This happens especially in cases when one represses certain feelings to such an extent that there is a *return of the repressed* (Freud & Jung, 1958). Examples of these are *slips of the tongue* and *accidents*.

In certain cases where one represses expansiveness, such as aggression the more likely it is one will experience its return. Another example could be that of a person who avoids doing his/her work, this avoidance will increase feelings of feeling burdened by that work. Constrictive and expansive extremes are relative and depend on the judgements of the people concerned and their observers. Dysfunctional extremes are also characterized by a *forced* or *compulsive* quality. While *healthier* individuals will engage in exploratory behaviour mainly out of interest, maniac people will engage in such behaviour mainly out of panic. They feel forced to engage in such behaviour.

2.1. *Pathologies in hyperconstriction*

During *hyper-constriction* the individual is either distorted into pieces or surrendered to greater powers. The individual's growth and enrichment is affected in that he/she doesn't expand. The examples are:

- *Depression* – Described by various investigators as perhaps the ultimate collapse of one's experiential world (Beker, 1973; Binswanger, 1975). During the depressive state there is noticeable slowness, isolation, oppression and feelings of impotency. As Beker (1973) describes it: *Depressive psychosis is the extreme on the continuum of too much necessity that is, too much finitude, too much limitation by the body...*
- *Obsessive-compulsiveness* – Is less severe and characterized by extreme focalization and ritualizing. As Von Gebsattel (1958) describes it: *Its characteristics are narrowness, nature less monotony, and rigid, rule-ridden unchangeability...* As seen in the light of *The Paradox Principle*, there is a fear of expansion – novelty, fluidity and even uncertainty into one's world.
- *Dependency* – An over reliance on people in part due to low self-esteem and self-trust, a great part of which is determined by the support of other people. Autonomy is lost, submitting to other's wishes in fear of the loss of other's affection.
- *Anxiety* – Is the fear of one's own potentials and life and as with dependency, self-trust. It holds characteristics such as being apprehensive, tense and hyper-vigilant but not immobile such as in the case of depression and dependency. The anxious individual may be in fear but hasn't given up at this stage the struggle to go on persists.
- *Fears and phobias* – Pertain to a specific area such as the fear of events and objects. The fear here is of environmental trust. Impinging on the individuals own desires and needs. As Binswanger (1958a) describes the time-disturbance by the individual: *... where the world design is narrowed and constricted to such a degree, the self too is constricted and prevented from maturing ...*
- *Paranoid personality* – Focuses on people and the lack of trust on such people. The individual becomes over sensitive to hostility, criticism, accusation and contempt. *The Paradox Principle* describes paranoia as a *constriction of trust*. Contrary to the above the trust issue here pertains to social trust.

2.2. *Pathologies in hyper-expansion*

This would be the expansion of one's experiential world:

- *Mania* – Has as characteristics great bursts of movement, feeling and intention with hyperextension of mood, perceived capability and assertion, the opposite of depression. As Binswanger (1975) describes it, one of the most

extravagant forms of expansion, is a *springing forth*;

- *Histrionic people* – Have a great concern with attention, social image, attention and manipulation. For Klein (1972): *[Histrionics] are fickle, emotionally liable, irresponsible, shallow, love-intoxicated, giddy and short-sighted ... manipulative, exploitative and sexually provocative, they think emotionally and illogically. Easy prey to flattery and compliments ... they are possessive, grasping, demanding, romantic ... When frustrated or disappointed, they become reproachful, tearful, abusive, and vindictive ... Rejection sensitivity is perhaps their outstanding common feature* (p. 237);
- *Antisocial personality* – As with histrionics they are manipulative, dramatic and immediate, as well as rebellious, violent and reckless. As Million (1981) would term it: *A major characteristic is what I would term "hostile affectivity"; this is illustrated by the fact that many of these personalities have an irascible temper that flares quickly into argument and attack ...*

Hyper-expansion can also be witnessed in other syndromes such as: hyperactivity, attention-deficit, oppositionality, explosiveness, impulsiveness, and substance abuse associated with autonomic nervous system arousal, e.g. amphetamines and hallucinogens (see American Psychiatric Association, 1980; Binswanger, 1958a, 1958b; Kantizian, 1985; Kuhn, 1958; Prentky, 1979).

2.3. *Pathologies in mixed dysfunctions*

Mixed dysfunctions are considered to be blends of *constrictive* and *expansive* behaviour, therefore bimodal in character: Tension and release, hardness and softness, rigidity and relaxation … (Foucault, 1965):

- *Schizophrenia* – Probably the highest point of mixed dysfunction due to its varied behavioural patterns. Binswanger (1958a) draws our attention to *various world designs* and not only *one world design* of the patients. Kierkegaard suspected that schizophrenia can signify a battle of cosmological proportions. It can be a battle that transpires far beyond any ordinary, or even extraordinary, boundary of life, (Schneider, 1999);
- *Schizoid* – Feels restricted, tied, trapped. As Laing (1969) suggested, *separation vs. relation* instead of *complete isolation or complete merging of identity*. Here the individual may feel he is *bursting forth* in that he/she feels people are getting into themselves or may feel that they are being overpowered or are losing their personality. Schizoids differ from borderlines in that: *borderlines tend to be more social and emotional* (Millon, 1981). Schizoids avoid social contact and use cognitive defences against bonding and separation while borderlines during certain occasions call for contact and use emotional defences against bonding and separation;
- *Maniac depressive* or *bipolar* – The difference from the maniac depressive to schizoid and borderline differs in the degree of negativism. The maniac depressive individual has more optimism about his/her capabilities, during the maniac phase the individual still finds a reason to live.

3. PARADOXICAL UNDERSTANDING

3.1. *Possible causes of dysfunctional behaviour*

Dysfunctional behaviour is an experience or series of experiences which prompt us to cave in, curl up, or burst apart. The fear of more than death itself, a fear of "groundlessness" … a sense of infinite collapse (Schneider, 1999).

Parental punishment is a form of constriction, maybe even the most profound forms. Other environmental and personal events may incline toward this polarity, such as the fear of teachers, gang leaders or even of other authoritative family members.

Physical disorders may restrict our senses, way of talking, walking simply moving, breathing, our way of being. This may impose physical and even mental limitations, causing traumas. We can try and wish for more but we can only do a *finite* amount.

Catastrophic events: Floods; thunderstorms; natural and mechanical accidents; earthquakes; war; impose barriers and alter our behaviour in a constrictive manner. There may also be events

which trigger fears of expansion, chaos, recklessness. Such triggered fears may arise from: Our parental figures – their authority, their strength, their powers and their demands. We fear our own physical and mental agitations – being lost, facing fears of the dark, nightmares that startle us, fear of certain movies, places and even of certain people. Other environmental events in our *modern* world may also contribute to or fears of expansion. Events including powerful machines – rockets, tanks, jets, bombs, cars, airplanes, humans fear the possibility of a crash of disasters, such fear prevents expansion.

3.2. *Developmental paradoxes*

At birth a child comes into a divided yet wide-ranging world, the child is both limited and free having the ability to tap either mode to a realistic degree (Schneider, 1999). The functional world is based on *realistic possibility*. The dysfunctional world on the other hand doesn't reach this possibility, the individual's actions and feelings become one sided – *hyper-constrictiveness, hyper-expansiveness* or *dysfunctional mixtures*.

At birth a child has two basic influences: temperament and the environment often influenced by parental interactions (Thomas & Chess, 1977). Seen in light of *The Paradox Principle*, these two influences can be selected as being constrictive or expansive. In early childhood the following are of fundamental importance: *How the child perceives him/herself (i.e. his or her temperament); how the child perceives the surroundings, especially caretakers and the extent to which those perspectives are compatible* (Eriksin, 1963; Klein, 1976; Stechler & Kaplan, 1980; Thomas, Chess, & Birch, 1968).

The above being the *perceptual matrix*, we look at *five outcomes* originating from this matrix:

- *Acute trauma* – An event seen as being *immediately* contrary and shocking, sometimes leading to denial;
- *Denial* – Is the refusal to accept or become aware of events one fears (Stechler & Halton, 1987). Denial encourages the next phase in the dysfunctional sequence;
- *Overcompensation* – Is the escapist counteraction of trauma. E.g. *a child would overcompensate for his/her trauma by increasing his/her cry for contact* (Erikson, 1963; Stechler & Halton, 1987). Looking at this example in the light of constriction and *expansion* the rejection of the parent is seen as being constrictive. This constrictiveness is stronger than the child's plea for contact, this contact being the child's expansiveness. The child fears that his/her plea won't be attended to and therefore denies the situation which leads to the persistent cries. Alternatively the child can also *hyper-constrict* due to this acute trauma, by withdrawing. Events and surroundings which impose one's impulses are seen and experienced as being traumatic and even *deathlike*;
- *Chronic trauma* – Is seen in the light of environmental forces or pressures that can't be escaped. Normally with a long-term inability for counteraction as opposed to acute trauma which has a short-term inability in counteraction. As with the above example, a child who's plea is denied for longer will being to view the original aim of contact as being less desirable. This Schneider calls the *traumatic shift*, where trauma is shifted from the lack of success in the child's aim to the aim itself. In this way the child learns to constrict the aim in the future;
- *Implicit trauma* – Is indirect and transmitted to the individual through other people who have a great influence on such individual, usually older family members. Children whose temperament is similar to that of their parents for example will rather model their parent's behaviour rather than resist it.

The fear of *death* and of ceasing to exist gives rise to dysfunctional behaviour.

3.3. *Mixed dysfunctions*

People with mixed dysfunctions have *alternating traumatic patterns* which make them feel both *constrictive* and *expansive*. Such dysfunctions include:

- *Passive-aggressive personalities* – These have their roots in inconsistent parenting styles. Each parent may differ considerably in personality which may contribute to opposing parenting styles or a parent within him/herself may have been harsh in one situation and over sympathetic in a similar other situation;
- *Borderlines* – Parenting styles attributed to these individuals were so disperse and unpre-

dictable that they develop issues with separation – relation matters;

- *Schizophrenics* – Are surly the most affected by having the greatest contradictory developmental experiences (Schneider, 1999). They find themselves tied up in contradictions.

When people are faced with a divergence in what they feel and in what they perceive within their surroundings, the greater the chance for dysfunction. The threat lies in the opposing force which leads to a constrictive or expansive infinitude.

3.4. *"Everyday" manifestations of these effects*

In conventional society there is a great concern with constriction in authority, order, rules etc. While we speak of authority we refer to politicians and religions, all of which provide their own rules and order. There are those within society who oppose constriction which symbolizes for them passivity and entrapment. They are seen as *expansive* individuals who go out of their way to deviate from the *norm* all is artifice, about appearance, holding onto a *shield* which supposedly protect them from the fear of conformity.

Prejudice is a great extreme in constrictive polarization. It is observed in many forms, be it in religion, *hyper-constrictive* political doctrines, in dogmatic oppression towards woman, in wealthy people's stigma towards the less fortunate, in conservative personalities but to this day the greatest prejudice to man is that of race and the issues of *white vs. colour* and vice versa.

Schneider talks about signs, symbols and dreams as means by which humans distort their fears. *The worst fear in human being is fear without end* (Rutan, 1987). Signs are used in culture and society to *localize the infinite*, they provide guides for information, arrange *constrictive* and *expansive* terror conventionally. Symbols on the other hand involve meaning and arrange constrictive and expansive terror personally. When viewing dreams it may be more useful to view them *not as historical by-products, but as "metaphors" for current problems* (Krippner & Dillard, 1988; Fisher & Greenberg, 1985). How do dreams echo the present? By viewing dreams in this manner, *sexual, mythic and separation themes tend to be of only partial significance* (Krippner & Dillars, 1988). The existential therapist may view dreams in terms of *The Paradox Principle*, how the dream reflects the person's constriction or expansiveness at present. In dreams the fear of being abused or trapped relate to the fear of constriction and dissipating.

The Rorschach test is a good example for potential symbolism offering *countless possibilities of perceiving ... providing the testee a freedom of choice* (Schachtel, 1966). In view of *The Paradox Principal* spatiotemporal constrictive and expansive themes should be seen in the Rorschach protocols. As Schachtel (1966) describes these poles in terms of their *specific qualities* on the basis of constriction and expansion: they may be designated as directedness versus diffusion; focused or unfocused, smoothness, evenness versus raggedness, jaggedness; fluid versus angular lines; openness versus closedness; shelter versus oppression; pointedness versus roundedness; completeness versus incompleteness; viable space and freedom to move versus crowdedness and collision.

As there is an increase in dysfunction, polarities become less clear. This happens with neurotics but even more so with schizophrenics. Schizophrenic content is *bizarre*, *otherworldly*, and *cosmic* (Exner, 1986; Wagner, 1981). When schizophrenics refer to sexuality, they are unpleasant, peculiar or contradictory in that they refer to sexuality in a *constricted record* (Shafer, 1948).

3.5. *Favourable confrontations with paradox*

We have seen that Schneider speaks of two human responses to the infinitude, namely *dysfunctional* and *conventional*. The dysfunctional try to avoid their fear through personal means, schizophrenia, depression and the creation of a world rich in symbols. The conventional avoid their fears with the use of drugs, prejudices, religions and in the use of signs. From the existentialist point of view *healthier* people are those who don't avoid or run from their *constrictive* and *expansive* capacities, they confront and challenge such capacities to find a point within the polarities with which they feel comfortable with. These people have a greater sense of purpose they live their experiences of work and love passionately and intensely always aiming at their best. Optimal people have well-developed centers (Schneider, 1999).

3.5.1. "Optimal People" *vs.* "Mad"

Both tend to perceive *constrictive* and *expansive*

extremes and both confront paradox directly. Psychiatric patients as geniuses go to great extremes and find ways to promote them. What happens is that the mad *cave in* at their extremes whereas the optimal redirect and mobilize themselves (Schneider, 1999). Optimal individuals are well balanced, as Schneider puts it, *they know when and in what degree to yield, focus, assert, and incorporate*.

3.5.2. Favourable physical health

Perceptions which blend *constrictive* and *expansive* extremes increase bodily health. People who's perceptions tend to lean towards extremities of the polarities will have *dysfunctions* e.g. depression, anxiety and so on, which will have damaging consequences on the individuals bodily health.

There are a number of aspects which may attribute to incongruence of the polarities and thus to poor health. Such aspects are for e.g. loneliness, as per a study conducted on widowers who had a 40% greater death rate for their age group within the first six months of the death of their partners (Parks, Benjamin, & Fitzgerald, 1969). People with a great need for dominance often have health problems. One's personality and how one perceives one's world influences one's health. Individuals who are greatly affected by stress have constant *fight and flight* urges which deteriorate one's health. From *The Paradox Perspective*, "flight" imposes feelings of constrictiveness as one feels trapped and suffocated with a need for withdrawal and repression, contributing to psychiatric disorders such as anxiety, depression, dependency, as well as obsessive-compulsiveness (Lyketsos & Lyketsos, 1986). "Fight" is related to expansiveness in that the individual has feelings of enlargement and explosiveness and competitively, in "fight" it's common to find mood and impulse disorders. On the other hand, good integration of *flight and fight*, or balance promoting flexibility and control have positive effects on the body.

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RESUMO

Kirk Schneider acentua que a psicologia precisa de uma fundamentação diferente dos pontos de vista tradicionais. Fala-nos de uma perspectiva integrada com fundamentos existenciais, que privilegia métodos qualitativos de investigação, em vez de métodos quantitativos. A experiência humana é vista como artística, criativa, expressiva ("livre"), enquanto que, simultaneamente, pode ser constrangida ("limitada") pelo ambiente e por factores sociais. Como indivíduos, se nos confrontarmos e nos adaptarmos, somos enriquecidos e reanimados. Se escolhermos ignorar a situação, ficamos "polarizados" e daí disfuncionais (psicopatologia). Kirk Schneider caracteriza clinicamente a dialéctica da liberdade limitada, a capacidade do indivíduo para "constringir" (recuar), "expandir" (libertar) e "centrar-se" em si próprio.

Palavras-chave: Livre, limitada, retrair, expandir, polarizado.

ABSTRACT

Kirk Schneider emphasises that psychology needs a different grounding from traditional psychology viewpoints. He talks to us about an existential-integrative psychology grounding which has its basis on phenomenology, which is concerned with qualitative rather than quantitative methods. Human experience is seen as being artistic, creative, expressive ("free"), while at the same time it can be constrained ("limited") by the environment and social viewpoints. If as individuals we confront and adapt we become enriched and revived. If we choose to ignore the situation, we become "polarized" and thus dysfunctional (psychopathology). Kirk Schneider clinically characterizes the "freedom-limitation dialectic" the capacity of the individual to "constrict" (draw-back), "expand" (burst-forth) and of "centring" him/herself.

Key words: Free, limited, constrict, expand, polarized.