Psychodynamic Therapy

SECOND EDITION

A Guide to Evidence-Based Practice

RICHARD F. SUMMERS

JACQUES P. BARBER

SIGAL ZILCHA-MANO

PSYCHODYNAMIC THERAPY

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To
Ronnie, Sam, and Claire
Smadar, Natalie, and Adam; Luke, Jonah, Liam, and Maya
Roy, Daniel, and Ronnie

About the Authors

Richard F. Summers, MD, is Senior Residency Advisor and Clinical Professor of Psychiatry at the Perelman School of Medicine of the University of Pennsylvania. He served as Co-Director of Residency Training at Penn from 1998 to 2017. Dr. Summers is a nationally recognized educator, author, and clinician. He is treasurer of the American Psychiatric Association and past president of the American Association of Directors of Psychiatry Residency Training. He has published widely on psychodynamic therapy, the therapeutic alliance, focus in psychotherapy, physician well-being, positive psychology, and psychiatry residency training.

Jacques P. Barber, PhD, ABPP, is Professor and Dean of the Gordon F. Derner School of Psychology at Adelphi University. He is also Adjunct Professor of Psychiatry at New York University and Professor Emeritus in the Department of Psychiatry and in the Graduate Psychology Group at the University of Pennsylvania. Dr. Barber is past president of the International Society for Psychotherapy Research and a recipient of its Outstanding Early Career Award and Distinguished Research Career Award. He has published numerous articles and books on topics including psychodynamic therapy, psychotherapy research, and the therapeutic alliance.

Sigal Zilcha-Mano, PhD, is Professor of Clinical Psychology at the University of Haifa, Israel, where she heads the Psychotherapy Research Lab in the Department of Psychology. She is Associate Editor of the *Journal of Consulting and Clinical Psychology* and serves on the editorial boards of eight other journals. Dr. Zilcha-Mano is a recipient of the Outstanding Early Career Achievement Award from the Society for Psychotherapy Research, the American Psychological Foundation/Division 29 Early Career Award, and the New Researcher Award from the Society for the Exploration of Psychotherapy Integration. She has published over 160 peer-reviewed research articles on psychodynamic psychotherapy and mechanisms of change.

Acknowledgments

Our gratitude goes to readers of the first edition of *Psychodynamic Therapy* for their interest and their thoughtful reactions. Since the publication of the first edition in 2010, many hundreds of psychotherapists, colleagues, and students have participated in classes, seminars, presentations, and discussions on the ideas presented there. We learned over and over again the excitement and inspiration people find in doing psychodynamic therapy and how moved they are by the meaningful connection they develop in the therapy setting. They have challenged us—What is the value of the core psychodynamic problem concept, the relevance of psychodynamic formulation in a world that focuses on efficiency and brief treatment, and the practicality of learning a set of skills that takes years to master? But our readers have also, over and over again, reminded us of our own excitement and inspiration. These discussions have helped us refine our ideas and push for new understanding in needed areas—for example, how change really occurs in therapy.

We thank our patients who graciously agreed to have their stories told in this book with the hope that others will learn from their experiences. We have tried to convey the spirit of collaboration, honesty, and closeness that we have felt with so many people with whom we have worked in psychotherapy.

Penn Psychiatry residents have been writing psychodynamic formulations for almost two decades now and their application to this task and interest in feedback and discussion have helped clarify our thinking. Most recently, many students' ideas about making diverse identities and the social determinants of mental health an important focus of interrogation in the psychotherapy setting helped us flesh out these concerns.

Kevin McCarthy and Kristin Leight at Penn Psychiatry have championed this book in the teaching program there. Sigal Zilcha-Mano's

team, and Michal Malka especially, in the Psychotherapy Research Lab at the University of Haifa have provided valuable feedback as well as editorial support. We want to thank Ellen Berman, a coauthor of Chapter 15, for her refreshing ideas on combining individual psychodynamic therapy with couple and family therapy.

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Introduction

The COVID-19 pandemic gave us more time to think. We thought about what was important in our lives and what was a distraction. We thought about our families and our work, and how fragile our world has become, or maybe always was. Each of us, a psychiatrist and two clinical psychologists, reflected on the focus of our life's work: psychodynamic therapy as a meaning-making enterprise and a scientifically validated treatment. Maybe we are going to need psychodynamic awareness even more in this fragile, tech-driven, mediated, and politically fractious world. We wanted to incorporate the latest empirical findings in our thinking; widen our awareness of race, culture, gender, and sexuality in the psychotherapy situation; and capitalize on the availability of telepsychotherapy. So, we decided it was time to write a second edition of *Psychodynamic Therapy: A Guide to Evidence-Based Practice* to address these concerns and promote a more personalized psychodynamic therapy approach.

One of us, Rick Summers, served as co-director of Residency Training in the Department of Psychiatry at the University of Pennsylvania for almost two decades. Having trained as both a general psychiatrist with an interest in diagnostic evaluation and as a psychoanalyst in a traditional analytic institute, Rick found a challenging and satisfying role teaching psychodynamic therapy to residents in the context of general psychiatry training. He felt he was able to take the knowledge and experience gleaned from his psychoanalytic work and years of psychiatric practice and make it relevant to a new generation of residents who came of age after the bruising debates about biological psychiatry versus psychotherapy. Now a senior teacher and practitioner, Rick is committed to the next generation of psychodynamic clinicians, teachers, and

patients and to transmitting psychodynamic knowledge, attitudes, and techniques.

Jacques Barber, professor and dean of the Gordon F. Derner School of Psychology at Adelphi University, on Long Island, New York, also serves as an adjunct professor of psychiatry at New York University and Professor Emeritus in the Department of Psychiatry at the University of Pennsylvania School of Medicine and in the Graduate Psychology Group at Penn. He conducted National Institute of Mental Health (NIMH)–funded randomized clinical trials of dynamic therapy versus antidepressants, psychodynamic therapy versus cognitive-behavioral therapy for panic disorder, and a National Institute on Drug Abuse–funded trial comparing psychotherapies and drug counseling for cocaine dependence. Jacques envisioned a new psychodynamic model built on the conceptual advances in the psychotherapy literature and wants to update that work with the most sound theory and current empirical data, and wants to encourage and mentor the next generation of psychodynamic therapy researchers.

The origin of the first edition of this book was a walk across the University of Pennsylvania campus on the way to Psychiatry Grand Rounds, with Rick Summers complaining to his friend Jacques Barber about how hard it was to find readings for a residency seminar on psychodynamic therapy—the literature was either too complex, involved and psychoanalytic, or simplistic and uninspired. With characteristic brevity and clarity, Jacques responded, "Well then, let's write our own."

The germ of the second edition came a few years after the first was published. As Summers and Barber finished teaching a day-long workshop in Tel Aviv in 2011, Sigal Zicha-Mano, then a young clinical psychologist, greeted us with enthusiasm and asked several highly perceptive questions. Sigal is now a full professor and the head of the Psychotherapy Research Lab at the University of Haifa. She was trained in a variety of therapeutic orientations over the years, and remains fascinated by the deep insights of psychodynamic understanding and their contributions to her clinical practice and research. She was exposed to the richness of psychotherapy research and how it could contribute to clinical practice during her postdoctoral studies under the mentorship of Jacques. Sigal has led several clinical trials investigating mechanisms of therapeutic change funded by national and international grants, and published a multitude of articles on the processes of therapeutic change, receiving many international and national awards for her contributions. She is especially excited about making the complex constructs of psychodynamic thinking experience near and accessible.

When the opportunity to write a second edition of *Psychodynamic Therapy* came up, we wondered, what is new, what is enduring, and

what needs to be said in a new way? And Summers and Barber became Summers, Barber, and Zilcha-Mano to extend and deepen our thinking. In a series of early conversations, we concluded that the world has changed, our outlooks have evolved, and the evidence base for psychodynamic therapy is far more robust, varied, and comprehensive than when the first edition was written.

So, what is our purpose in writing this book? It is to promote a personalized psychodynamic therapy built on general psychodynamic knowledge and technique, free of jargon, and tailored to the needs of specific individuals. Personalized psychotherapy requires a deeper look under the hood of psychodynamic therapy; we discuss customizing technique based on a therapeutic strategy for each individual patient that relies on an assessment of their core psychodynamic problem and strengths and weaknesses. *Telepsychotherapy* was an uncommon modality that became ubiquitous during the pandemic, and remains a frequent patient and therapist choice now. New *research on psychotherapy process* leads to new insights for clinicians and new techniques. The recognition of social determinants of health, and of mental health, requires a needed recalibration of the importance of social factors vis-à-vis intrapsychic factors in the psychodynamic model. Adverse childhood experiences are strongly correlated with subsequent depression, alcohol use, and posttraumatic stress disorder (Chang, Jiang, Mkandarwire, & Shen, 2019). The adverse experiences, along with *racism*, *poverty*, *sexism*, *immigration*, and *various forms of oppression*, have profound internalizing effects on identity, attachment, and defenses.

We use over 40 clinical examples of individuals in treatment in the book, several of which are new, with a wide variety of age, gender, race, culture, and sexual orientation. We give plenty of descriptors for the cases, but do not give every social characteristic for every case because sometimes it seems extraneous. Except for specific cases, we use the pronouns *they* and *them* for all patients, as it is the simplest and broadest usage. Many cases are used with the patient's gracious permission, but many are composite cases, created to give a realistic feeling while protecting many individuals' privacy. We are pleased to include Israeli patients and therapists in this edition. Those patients on whom we base the more extensive cases have reviewed the text and given feedback and suggestions to help express their lived experience. Psychotherapy is a personal experience for both the patient and the therapist. Therefore, we have often narrated the examples in the first person in order to include the therapist's thoughts and feelings. In these examples, the narrator could be any of us or one of our trainees.

The first edition has been used in many psychiatry residencies, psychology graduate programs, and social work programs, and was

the basis for many presentations in the United States, Europe, Africa, Australia, China, and the Middle East. Audiences and students seemed to respond especially to the heuristic value of the core psychodynamic problem concept, the usefulness of formulation, and the techniques for promoting change. We have emphasized these ideas in this book, with an extended and empirically derived model of psychotherapeutic change.

We ask the reader questions throughout the book, often about the clinical examples, because being a therapist is about curiosity and learning together. We hope this helps you enjoy the book and find it meaningful and useful. Please feel free to contact us; our emails are easily found online.

PART I

CONTEXT

1

Why Dynamic Psychotherapy?

PSYCHIATRIST: We are here to understand your unconscious.

MASON: My unconscious is none of my business.

—JACKIE MASON, *The World According to Me!*

We each seek the story of our life that makes sense and helps us live. That story can liberate us and constrain us, and the psychotherapeutic relationship is a new connection where a new story can be formed. The therapeutic relationship and the life moment when the patient begins treatment are unique, and there is a fresh opportunity for the patient to bring previously unknown aspects of themselves and their experience into the story. Learning how to be a psychotherapist is about becoming a coach, editor, muse, and protagonist in this drama.

But the purpose of therapy is change. The process of developing the new story and the relationship with the therapist that promotes it must allow the patient to feel different and better. That is what a patient comes to therapy for. Because of its emphasis on emotion, relationships, and the immediacy of the subjective present, psychodynamic therapy is a therapy of stories, where old tired personal narratives become resonant, grounded self-evident truths that open the door to more meaningful lives.

Let's start with an example of one patient and her experience in psychodynamic therapy.

Beth was a 31-year-old single cisgender heterosexual White woman who came for treatment because of depression, loneliness, and problems with relationships. She was a clinical nurse specialist recognized for her compassion and competence. She came from a Protestant, working-class family. She had an edge of insecurity that was partly

obscured by her assertive manner and tall, imposing presence. A middle-aged White male therapist, I felt concerned about her and vaguely unsettled, trying to gauge the depth and severity of her pain.

Beth came for the appointment because she had been jilted by her partner of 2 years and had quickly developed depressive symptoms, including typical neurovegetative symptoms, as well as self-hatred and social isolation. Her story, which tumbled out over the first few sessions, was upsetting to hear. Her father was an alcoholic who had been abusive to her mother, and her parents had divorced when she was 6 years old. Shortly after the separation, she was abducted by her father and taken to stay with him for several weeks in another city. She was physically safe during this time, but only after her repeated pleading did he relent and allow her to return to her mother's home.

Beth's mother struggled to take care of her and her younger sister. When Beth was 10 years old, the mother remarried a rigid man who kept the household under strict control. Beth felt her mother was elsewhere and no one really cared about her. During her adolescence, she drank too much and took hallucinogens a number of times. She went to college and felt lonely and sad. After her sophomore year, she enlisted in the armed forces and was stationed abroad for 3 years. Although these were more stable years, Beth still felt aimless and alone. She had several partners, and each relationship ended with either rejection or the discovery that her partner had been unfaithful. She had a few female nonromantic friendships, but the relationships were not very close, and she seemed to keep herself at a distance.

I quickly forgot Beth's mildly intimidating manner and appearance as I felt more and more compassion for her, and respect for how she had coped with adversity. My initial impression was that she had a very traumatic childhood and that the early strife in her family made it difficult for her to trust closeness. The abduction and the rigid stepfather probably contributed to her fears about men. In her world, women were preoccupied and men were potentially dangerous. Substances and travel helped her get away, but then there was just emptiness.

After 2 months of therapy, Beth revealed that she had been date-raped at the age of 17, and that her most recent partner had hit her. Although I had already felt disturbed by Beth's life of danger and neglect, our connection deepened in this moment. Up to now, she had been reporting about what had happened, and we were making some connections between her early feelings of fear and loneliness and her later isolation and problems with men. But these new revelations were different. As she described them, her fear and anger were in the room. Now I was immersed in the story, not just hearing about it.

Soon Beth returned to the recent breakup and ensuing depression. The abuse from her partner triggered early memories of her parents' divorce and her abduction—she felt out of control with him and had an old feeling of guilt and responsibility. Making the connection between the partner and the father was frightening to her, but after returning to this several times, she began to feel some relief and an unaccustomed sense of calm. She grasped that her upset about the breakup and being abused was complicated, but it was worse and more intense because of her childhood experience.

If the psychotherapist is a coach, editor, muse, and protagonist in a new experience for the patient, how can the reader understand what has happened for Beth so far? What is the therapist doing to facilitate the therapeutic relationship and the new experience for the patient?

In one session Beth tearfully recounted a phone call from the former boyfriend. He tried to seduce her into rekindling their relationship while berating her for not being loyal and affectionate. She was confused about this. She felt badly about his claims, wondering whether she had been at fault for the breakup. She questioned her ability to love and be loyal, but she was excited by the prospect of seeing him again and knew this was a bad idea. She was angry at his manipulation and frightened that she could fall back into the relationship.

I pointed out (perhaps a little too quickly) how destructive the relationship had been and how important it was that Beth keep her distance from him. Suddenly there was a palpable shift in the room, and she seemed to treat me with suspicion and resentment. Up until then, Beth regarded me like a good uncle: helpful and wise. Now, she implied, and then directly accused me, of being controlling and giving advice when I did not know what it felt like to be her. She told me it was easy to tell her to be strong and independent, as I was not there to help her pick up the pieces when she was lonely or afraid. I saw a return of the imposing demeanor I had seen initially; she seemed tall and cold and angry.

This shift occurred quickly, and I was taken by surprise. I just listened, nodding. I was not sure what to say, so I played for time until I could understand what was happening. Soon I realized that I had become the next person (after the father and boyfriend) in a repetitive scenario in which Beth felt dependent on an authoritative and controlling man. She felt I could help her and take care of her, but I could also be untrustworthy, selfish, and possibly dangerous. My encouragement to reject the boyfriend had triggered the strong reaction.

This vignette captures the essence of dynamic psychotherapy: exploration of current conflicts and relationships in order to understand how they relate to the past, listening for and bringing out strong emotions, the search for recurring patterns, and a focus on the therapeutic relationship to see how conflicts are repeated. The treatment challenges the therapist to be warm and empathic in understanding the patient's feelings, but keep cool as the relationship deepens and old patterns are replayed.

There is no doubt that Beth's distant mother and scary father had something to do with why she had trouble with men and why she came for therapy. When she talked about her traumatic experiences in childhood and in the present, and felt intense emotion in the sessions, the therapist became even more deeply engaged. When she suddenly became angry with the therapist, he recognized that her pattern of feeling and relating to others based on a traumatic scenario from her past was now being enacted with him. What was he supposed to do now?

This moment is a relational crisis and a psychodynamic opportunity. The task of the therapy is to elucidate what is going on in the room. The patient did not come to therapy to solve her problem with the therapist but rather to decrease her depression. However, the enactment in the therapeutic relationship makes it possible to understand the underlying issue better and therefore help to resolve it.

DEFINING DYNAMIC PSYCHOTHERAPY

Although widely practiced, the definition of psychodynamic psychotherapy is vague. Typically, it has been regarded as a more efficient but watered-down psychoanalysis—that is, it is usually seen as lying along a continuum, with psychoanalysis at one end and supportive psychotherapy on the other. Many writers have used this fundamental conception (Luborsky, 1984; Rockland, 2003). Clustered at the psychoanalytic or expressive/interpretative end are the classical parameters and techniques, including frequent sessions, therapist neutrality and abstinence, interest in the past, the use of interpretation and attention to resistance (the patient's difficulty in talking about problems), transference (the patient's feeling toward the therapist), and countertransference (the therapist's feeling toward the patient). We discuss each of these concepts later as we describe our pragmatic model. At the supportive end are ego support, advice, guidance, and a greater focus on the present. Psychoanalytic or psychodynamic psychotherapy (we regard these terms as synonymous) mixes and melds these approaches, typically during once- or twice-weekly meetings.

Contemporary writers suggest other definitions. Kernberg (1999) regards dynamic psychotherapy as the judicious use of traditional psychoanalytic techniques. He observed that psychodynamic psychotherapy and psychoanalysis are convergent in their interest in transference, countertransference, unconscious meanings in the here and now, the importance of analyzing character, and the impact of early relationships. His collaborations resulted in transference-focused therapy (Yeomans, Clarkin, & Kernberg, 2015), a manualized form of psychodynamic therapy with specific techniques for treating borderline personality disorder, as well as systematic approaches to the psychodynamic treatment of higher-level personality disorders and personality disorders in general (Caligor, Kernberg, & Clarkin, 2007; Caligor, Kernberg, Clarkin, & Yeomans, 2018).

Gabbard emphasizes the central goal of increasing the patient's understanding and the focus on the therapist–patient relationship, but describes it differently. He defines psychodynamic psychotherapy as "a therapy that involves careful attention to the therapist–patient interaction, with thoughtfully timed interpretation of transference and resistance embedded in a sophisticated appreciation of the therapist's contribution to the two-person field" (Gunderson & Gabbard, 1999, p. 685).

Luborsky's (1984) pioneering work on systematizing the theory and technique of psychodynamic psychotherapy, conceptualized by him as supportive–expressive psychotherapy, has had widespread influence. This dynamic treatment model was further defined by Book (1998) as appropriate for a wide range of patients and conditions. Supportive–expressive psychotherapy, like most manualized psychodynamic treatments, does not prescribe therapist interventions on a session-by-session basis—rather, it provides general principles of treatment and guidelines for therapists. For example, symptoms such as depression are understood in the context of interpersonal/intrapsychic conflicts, which are called Core Conflictual Relationship Themes (CCRT; Luborsky & Crits-Christoph, 1990) in supportive–expressive psychotherapy.

Bateman and Fonagy (2010) single out mentalization, "the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes" (p. 11), as a central feature of mind that can be compromised in those with significant trauma and adversity. They describe the therapeutic engine of mentalization-based therapy, which many regard as part of the psychodynamic therapy family, as the restoration of this crucial healthy mental function.

Stephen Mitchell (1988), whose work epitomizes relational psychoanalysis, emphasized the early interpersonal matrix of the individual, the subsequent intricacies of the connection between patient and therapist,

and the conviction that relationships rather than drives are the engine of psychological life. Relational psychoanalysis drove a transition in the view of the psychotherapeutic setting from a one-person (i.e., about just the patient) to a two-person system, about the therapist–patient relationship.

McWilliams (2004) characterizes the essence of psychodynamic psychotherapy differently: She describes the sensibility of the therapist. For her, the attitudes of curiosity and awe, respect for complexity, a disposition to identification and empathy, valuing of subjectivity and affect, appreciation of attachment, and a capacity for faith are the fundamental ground on which the dynamic therapist's approach rests. Although the essential enterprise is exploratory and reflective, she is less interested in the details of the technique than in the process the therapist attempts to stimulate.

In summary, we see the current practice of psychodynamic psychotherapy as an amalgam of techniques (see Table 1.1), some of which are exploratory, and some supportive, employed in the context of an important therapeutic relationship. Sessions are held often enough that the therapeutic relationship develops sufficient intensity to be a factor in its own right, usually once or twice weekly. The attention to the transference and countertransference and the complexity of the relationship between patient and therapist is common to all of the definitions we surveyed and is a unique and identifying aspect of psychodynamic psychotherapy.

There is a broad trend in the field toward integration of different types of psychotherapy, allowing for inclusion of the most effective elements of each, personalized for the patient. Therapists tend to be educated and identified with one orientation and then add other perspectives.

TABLE 1.1. Essential Features of Psychodynamic Psychotherapy in Current Practice

- Use of exploratory, interpretative, and supportive interventions as appropriate
- Frequent sessions
- Emphasis on uncovering painful affects, understanding past painful experiences
- Goal is to facilitate emotional experience, increase understanding, and improve adaptation
- Focus on the therapeutic relationship, including attention to transference and countertransference
- Use of a wide range of techniques, with variability in application by different practitioners

Recognizing the complexity of human behavior, Eubanks, Goldfried, and Norcross, (2019) refer to the "multiverse" of psychotherapies, and suggest that psychotherapy integration will increase, especially with the growing neurobiological understanding of mental processes and the recognition of the impact of culture and social context on individual experience, including in the consulting room.

The model of psychodynamic therapy we present here is more integrative than pure, yet it incorporates and emphasizes these essential psychodynamic elements of emotional exploration, session frequency, and attention to transference and countertransference. In Beth's treatment, the therapist must figure out how to respond to her anger and mistrust. He could soothe and support, reminding Beth that the therapy was a safe place and that he certainly did not mean to criticize, control, or judge her. This would be a supportive approach, and common to a variety of psychotherapies. He could note that there is a perceptual distortion and ask the patient to evaluate the evidence for this perception. This is a cognitive therapy intervention. Or the therapist could keep the patient's angry feelings in the room, helping to contain them and not argue them away. He could help her observe the feelings and connect them with the themes they have already discussed. This latter approach is unique to psychodynamic psychotherapy.

THE VALUE OF DYNAMIC PSYCHOTHERAPY

Although psychodynamic therapy competes in the intellectual and clinical marketplaces with a range of other psychotherapeutic treatments, primarily cognitive-behavioral therapy (CBT) and the treatments it has spawned, the evidence base for psychodynamic therapy is robust and it has a strong toehold in the mental health professions and in contemporary Western culture.

Empirical Database

Barber, Muran, McCarthy, Keefe, and Zilcha-Mano (2021) conducted a series of meta-analyses comparing randomized clinical trials of psychodynamic therapy to control conditions and to other active treatments. Those summaries of studies were conducted separately for depression, anxiety disorders, and personality disorders. In these three meta-analyses, psychodynamic therapy was significantly more effective than control conditions and did not differ in its efficacy when compared to alternate treatments (see sidebar below). Most recently, Leichsenring and colleagues (2023) conducted an umbrella review based on updated criteria

for empirically supported treatment and concluded that psychodynamic therapy has strong recommendations for those disorders.

A Deeper Dive: Psychodynamic Therapy Outcome Studies

- Barber and colleagues (2021) completed a series of meta-analyses of psychodynamic therapy for depression, anxiety, and personality disorders. Clinical trials of psychodynamic therapy were compared with control conditions and other active treatments.
- For depression, 12 studies with a comparison of psychodynamic therapy with a control condition were found. Psychodynamic therapy was better than control conditions with a medium effect size (g = −0.58, p < .001; Barber et al., 2021). As would be expected, when it was compared to a wait list, psychodynamic therapy was more efficacious than when compared to an active control condition, such as treatment as usual or pill placebo. But in both cases, psychodynamic therapy was significantly more efficacious (Barber et al., 2021).
- There were 20 randomized clinical trials comparing psychodynamic therapy to active treatments, including CBT for depression. According to the meta-analysis, at treatment termination psychodynamic therapy did not differ from other active treatments (g = −0.01). This was also true for comparisons involving psychodynamic therapy versus only CBT studies (g = 0.24, p =.13). Similar findings were obtained at follow-up.
- In order to examine the efficacy of psychodynamic therapy for anxiety disorders, Barber and colleagues (2021) grouped all anxiety disorders that had been studied as part of a randomized controlled trial (RCT) into one group, as there was not a sufficient number of studies for each separate anxiety disorder. As expected, the seven RCTs comparing psychodynamic therapy to control conditions showed that psychodynamic therapy was more effective than control groups (a large effect size g = −0.94). When compared with active treatments (15 studies), there were no differences between psychodynamic therapy and other active treatments (g = −0.01, p = .945) at termination. There were no significant differences in effect size between the comparison of psychodynamic therapy and CBT and the comparison of psychodynamic and non-CBT treatments (g for CBT = 0.07, p = .757). Similar results were found at follow-up.
- This meta-analysis also included 16 trials comparing psychodynamic therapy to other conditions for any type of personality disorder, focusing on several outcome measures. They focused only on core personality disorder symptoms. Among the five studies that included a control condition, psychodynamic therapy was more effective than control (g = −0.63, p = .002). The seven studies of psychodynamic therapy versus other treatments, focusing on core personality disorder symptoms, found no difference between treatments (g = 0.05, p = .708).

- In summary, these three meta-analyses of psychodynamic therapy for depression, anxiety disorders, and personality disorders found that psychodynamic therapy was significantly more effective than control conditions and did not differ in efficacy from other active treatments.

We believe these meta-analytic findings reflect the current state of the literature on the efficacy of psychodynamic therapy and note there are very few studies suggesting that psychodynamic therapy is less effective than other treatments. Psychodynamic therapy is now included as a recommended treatment for adults with depression (*www.apa.org/depression-guideline/decision-aid-adults.pdf*; American Psychological Association, 2021).

Like many therapies in long-standing use, what constitutes "the treatment" is hard to characterize and therefore hard to test. Several investigators developed manuals for dynamic therapy, including Luborsky (1984) for supportive–expressive therapy (Book, 1998) and Yeomans and colleagues (2015) for transference-focused psychodynamic psychotherapy for borderline personality disorder. Other recent psychodynamic therapy manuals include Abbass and Macfie's (2013) work on intensive short-term dynamic psychotherapy; Milrod and colleagues' work on panic disorder (Busch, Milrod, Singer, & Aronson, 2012), child and adolescent anxiety (Preter, Shapiro, & Milrod, 2018), and trauma (Busch, Milrod, Chen, & Singer, 2021); and the work of Diamond, Yeomans, Stern, and Kernberg (2021) on treating pathological narcissism.

Some practitioners have been skeptical about whether the unique personal connection in the therapeutic relationship is lost in manualized treatment. However, Vinnars, Hauschild, and Taubner (2005) compared the efficacy of manualized time-limited supportive–expressive therapy to open-ended nonmanualized community-based therapy for patients with personality disorders in the Swedish health care system. They showed that there was no difference between the two groups at 1-year and at 2-year follow-up.

These findings are an important step forward, but they raise many questions. Do these manualized treatments reflect all aspects of psychodynamic psychotherapy technique, or do they select out certain ones? What are the most important aspects of the technique, what promotes change most effectively, and what kind of change?

Depth

Psychodynamic therapy is also valuable because it has been an incubator of psychotherapeutic innovation for almost a century. Most of the contemporary psychotherapies, and many developed and discarded along the way, have emerged from it. Later treatments were derived conceptually

from the Freudian legacy, or developed by individuals who were trained in or exposed to it. We suggest that the depth of the treatment, intensity of the interpersonal engagement, and the intrinsic sense of meaning that arises when discussing issues of great personal importance, stimulates creative thought. Perhaps this is why dynamic therapy has been so effective in spinning off new ideas. It attracts those with empathy and provides a meaningful model for a deep emotional exchange with a patient. Working with Beth was challenging and emotionally engaging for the therapist. Following a tightly prescribed protocol may not have provoked the same personal involvement and curiosity in the therapist.

A deep treatment is one that embraces fundamental problems and essential solutions. It aims to reshape the individual in some profound way and gets close to the idea of cure. A deeper therapy speaks for itself and provides its own feeling of justification. Psychodynamic therapy may carry the torch for depth in the psychotherapy arena today.

Psychodynamic Narrative Is Woven into Culture

Psychodynamic therapy is valuable because Freudian ideas permeate contemporary Western culture, and have impacted other cultures as well. The unconscious, the effect of early childhood on later experiences, internal conflict as a normal state of affairs, the complexities of attachment, phases of development, and the ubiquity of anxiety are ideas we practically find in our drinking water. These notions are integral to much of the broad range of Western culture's pictures of the individual, the life cycle, and interpersonal relationships. Because they inform and shape our worldview, our treatments must somehow involve, refer to, and embrace these beliefs. Indeed, Jerome Frank (Frank & Frank, 1991) said that therapy must reflect the prevailing values of the culture and address the individual through this language. The upsurge of interest in psychoanalysis and Freud in the humanities over the last several decades reflects how deeply embedded these ideas are in Western cultural and intellectual traditions.

Non-Western cultures and Western subcultures embody alternatives to some of these psychoanalytic notions, such as the importance of the collective over the individual, and alternative roles, definitions, and functions of family members, and this recognition sharpens our awareness of those aspects of experience that are essential and those fundamentally shaped by culture. It challenges aspects of the psychoanalytic culture but allows us to consider ways that psychoanalytic techniques can be meaningful outside of the context in which they were developed.

We suggest that psychodynamically based treatments have a special focus on the rewriting of a personal narrative. The need to develop a

narrative understanding is essentially human, reflected in storytelling traditions, literature, and art, and the autobiographical urge that strikes virtually everyone at some point in time. Psychodynamic therapy takes this fundamentally human task as its challenge and retains its currency because it encourages patients to tell and rework their stories in an intensive way.

Therapy for Therapists

Therapists tend to choose psychodynamic psychotherapy for their own treatment, as documented in a study of psychiatry trainees (Habl, Mintz, & Bailey, 2010). Our impression is that other trainees often choose dynamically oriented treatments, as well. Why this occurs during a time when other psychotherapies are also proliferating is an interesting question. Therapists often enter treatment early in their careers and are influenced by their teachers and mentors, and their treatment choice may simply reflect a cohort effect. As newer psychotherapies achieve greater dominance and their proponents fill the ranks of mentors and teachers, psychodynamic therapy may be a less popular choice.

But perhaps therapists enter psychodynamic psychotherapy because it is particularly useful to them. Perhaps therapists themselves prefer the depth and explicit attention to narrative intrinsic to dynamic psychotherapy. The emphasis on affect and ways of understanding intense affective experiences provides therapists with the clarity and resilience needed to work with distressed and suffering individuals. The intense focus on the therapeutic relationship also helps us understand our enactments, transferences, and countertransferences.

THE CHANGING FACE OF PSYCHODYNAMIC PSYCHOTHERAPY

Few treatments originally invented at the turn of the 20th century have a recognizable presence today. The other medical treatments of Freud's time are almost entirely consigned to history. The currency of psychodynamic therapy speaks not only to its enduring value but also to its constant revision and reshaping over these many decades.

There are new ideas and new knowledge that drove changes in theory and technique, and powerful social forces that shaped its use (see Table 1.2). Some of the most current influences are detailed below.

Many Western nations have begun to reckon with their histories of racism, colonialism, sexism, xenophobia, homophobia, and transphobia and their manifestations in various forms of unconscious bias. Interrogation of the cultural context for early psychoanalytic

TABLE 1.2. New Ideas, Knowledge, and Social Forces Shape Change in Psychodynamic Psychotherapy

New knowledge, social forces	Changes in psychotherapy theory and technique
Importance of gender, race, ethnicity, LGBTQ+ identity on theory and practice of therapy	Increased attention to systemic racism, sexism, and other forms of bias and discrimination; increased focus on the importance of the specific identities and background of patient and therapist
Increased recognition of the importance of the therapeutic alliance	New techniques for developing alliance and repairing ruptures
Convergence of concepts of fantasy, schema, and pathogenic thoughts	Emphasis on schema resulting from traumatic experiences
Reality of trauma; therapeutic relationship a result of patient and therapist factors; awareness of the somatic impact of trauma	Less hierarchical treatment relationship, closer attention to minute-to-minute aspect of process; attention to somatic manifestations of trauma
Importance of narrative	Rewriting of narrative is a focus of therapy
Recognition of the co-construction of the therapeutic relationship	Greater therapist disclosure, close attention to process
Positive psychology	Attention to character, positive emotion, and enhancement
Need to understand psychotherapy in combination with other treatments	Clarification of role of psychotherapy in overall treatment plan
Neurobiological understanding of psychotherapy	May provide additional scientific evidence for psychoanalytic concepts
Concern about efficiency	Time-limited treatment; changes in technique, goals
New technology, large language models	Improvements in access to psychotherapy, changes in technique in virtual therapy, app data capture, routine outcome monitoring

Note: LGBTQ+, lesbian, gay, bisexual, transgender, and queer/questioning.

thinking—turn-of-the-century Vienna—has revealed striking gender, social class, and racial prejudice. This has led to painful and necessary reflections on the assumptions inherent in psychodynamic thinking, and the forms of structural racism and sexism extant in the training and membership institutions of mental health professionals. The door is open to a wider reflection and critical analysis of the patient–therapist

relationship, which includes a much closer awareness of the impact of the personal backgrounds and characteristics of both on their work together. Therapists must be aware of the limitations of their own personal experience and maintain an open and questioning attitude toward their own reactions and attitudes (Connolly Gibbons et al., 2012; Leichsenring & Schauenburg, 2014). Humility and curiosity are necessary to try to understand the patient's experience from the perspective of their race, culture, gender, and sexual identity (Tao, Owen, Pace, & Imel, 2015) and be able to reflect on the therapeutic relationship acknowledging both individuals' identities and differences (Quiñones, Woodward, & Pantalone, 2017).

The impact of the therapeutic alliance on outcome is one of the most consistent findings in the field of psychotherapy research. Flückiger, Del Re, Wampold, and Horvath (2018) found a strong association between therapeutic alliance during therapy (not just in the first session) and outcome. This finding has been replicated despite the fact that the alliance accounts for only a small amount of variance in outcome (Barber, 2009). Since different types of psychotherapy show precious little difference in relative outcome, the development of a strong therapeutic alliance provides a path to success common to all psychotherapies.

Recent findings further suggest that the alliance fulfills different roles in different psychotherapies. In CBT treatments, the alliance tends to serve as a common nonspecific factor in the background of an effective treatment, while in psychodynamic treatments, it has the potential to serve as an active ingredient (Zilcha-Mano & Fisher, 2022). Increased awareness of the importance of the alliance and techniques for addressing rupture of the alliance, with the aim of making the alliance therapeutic in and of itself, have generated new ideas about how this factor can be optimized in psychodynamic psychotherapy. Breaches in the therapeutic alliance are inevitable, and it is increasingly clear that their repair is not just necessary, but the ebb and flow of rupture and repair may be a critical feature of an effective therapeutic relationship. This directs the therapist to pay close attention to potential and actual ruptures and how they can be repaired (discussed at greater length in Chapter 4).

There is a convergence between the psychoanalytic concept of unconscious fantasy and schema, as it is used in schema therapy and CBT. Schemas are the deep cognitive structures that develop out of early life experiences and are maintained by subsequent distorted perceptions; their persistence is the essence of pathology (Young, Klosko, & Weishaar, 2006). This concept shares similarities with Luborsky and Crits-Christoph's (1990) CCRT, which is an example of an interpersonally anchored schema. Slap and Slap-Shelton's (1991) reformulation of psychoanalytic theory around a schema model conceptualizes a central traumatic

scenario in childhood that gives rise to symptoms. Control–mastery theory (Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986) is a related psychoanalytic model developed by the Mount Zion Psychotherapy Research Group, which holds that symptoms arise from "unconscious pathogenic beliefs," which are inferences about traumatic events. All of these contributors point to deep mental organizing principles that are cognitive and ideational. These schemas, or traumatic scenarios, influence subsequent perceptions, feelings, and thoughts.

There is a widespread recognition of the need for special attention to traumatized individuals. This includes recognition of the social context of trauma, which can support resilience or mitigate against it, the critical importance of validating traumatic experiences, and attunement toward preventing repetition of trauma in health care systems. While the psychodynamic frame exposes the role of fantasy and compromise in the patient's inner life, traumatized individuals require that attention to these factors must be skillfully balanced with recognition of the patient's reality experience. This shift brings more reality, more collaboration, and more selective attention to transference events. Understanding of the somatic impact of trauma, though still poorly understood, is a necessary element in its psychotherapeutic treatment.

Just as the critical study of texts forms the basis for analysis in academic humanities departments, methods for using narrative in healing have gained currency in medical circles and have been studied by psychoanalysts for some time (Spence, 1982). There is increased interest in narrative medicine (Charon, 2006), which emphasizes the importance of the patient's personal story as a way of understanding, managing, and healing. These developments have led to an increased focus on the role of narrative in psychotherapy (Madigan, 2019). Coombs and Freedman (2012) suggest specific practices for narrative therapy, including reflection on the "absent but implicit" aspects of narrative as well as the importance of development and "thickening" of stories. We see the central task of psychotherapy as the rewriting of a more complex and useful narrative of the patient's life and experience.

The turn from a one-person to a two-person model of the therapeutic relationship, reflected in the understanding that the transference–countertransference engagement is constructed by both the patient and the therapist's unconscious, has markedly expanded our understanding of the nuances of the treatment relationship. Attention to the nuances of the minute-to-minute interaction, the need for the therapist to maintain an accepting but self-interrogating perspective, and the increased sense of the subjectivity of truth, are all features of the intersubjective, or relational perspective. Techniques suggested by these recent developments include greater therapist self-disclosure and close attention to the

aspects of the therapeutic process generated by the therapist's attitudes, thoughts, and feelings (Mitchell, 1988).

The field of positive psychology, which explores positive emotion, happiness, and techniques for enhancing positive experience, provides a new perspective to psychotherapy (Jankowski et al., 2020; Peterson, 2006; Rashid, 2015; Seligman, 2002). The contribution includes an emphasis on the concepts of character and virtue, the relative independence of positive emotions from negative emotions, and interventions for enhancing subjective satisfaction. Although this work tends to involve an exclusive focus on enhancement and increase of positivity, it can be integrated with more traditional psychodynamic techniques (Summers & Lord, 2015).

Traditionally, psychotherapy was studied within its own "silo," separated from its frequent integration with other treatments—for example, psychopharmacology, couple and systems therapy, and educational and behavioral treatments. The likely synergy (and also tension) with these treatments is just beginning to be studied. The finding that sequential integration of psychotherapy following acute phase treatment of depression (with either medication or psychotherapy) is associated with reduced relapse and recurrence is an example of a recent finding from this new generation of research studies (Guidi & Fava, 2021). Findings like this clarify the role of psychotherapy in general and also, perhaps, of specific psychotherapies in the real naturalistic settings in which they are employed.

New neurobiological findings bear witness to the changes in the brain resulting from psychotherapy and open the door to understanding psychotherapeutic change and the specific changes resulting from specific psychotherapies. A review of neuroimaging findings in psychodynamic therapy suggests that effective psychodynamic treatment is associated with the normalization of synaptic or metabolic activity in the limbic, midbrain, and prefrontal regions (Abbass, Nowoseiski, Bernier, Tarzwell, & Beutel, 2014). Neuroimaging has the potential to shed light on the neurobiological mechanisms that are being targeted in successful treatments. Although we cannot test and improve interventions using neuroimaging data yet, this is a possibility in the future.

There are a number of social forces generating change in the practice of psychodynamic psychotherapy. Patient advocacy organizations have reminded us of the importance of knowledge about illnesses for patient empowerment. This encourages educational interventions about the nature of symptoms and illness, and about treatment alternatives and treatments themselves (Walitzer, Dermen, & Connors, 1999). The need for informed consent for treatment has spread beyond medical and surgical treatments to include psychotherapy and has contributed to a more open, transparent process of diagnosis and treatment selection,

and also of initiation of psychotherapy. Some anticipate that an explicit informed consent process, which includes spelling out the risks of psychotherapy, will become the standard for psychotherapy as it is for other procedures in the medical care system.

Greater concern about efficiency has led to time-limited treatments (e.g., Barber & Ellman, 1996; Crits-Christoph, Barber, & Kurcias, 1991). Both patients and payors are more focused on the speed of treatment, although there is ample evidence that psychodynamic therapy as practiced in the community is cost-effective (Lazar, 2014). The resulting push to target symptoms and focus on goals means an impetus for technical innovation and reevaluation of goals. The pressure to prune the length and expense of treatment has sharpened interest in whether psychotherapy should decrease symptoms or promote healthy development, as well as specific psychodynamic treatments focused on specific disorders (e.g., Milrod, Busch, Cooper, & Shapiro, 1997, for panic disorder; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005, for generalized anxiety disorder). By contrast, a recent randomized clinical trial found that patients who received relatively long-term (18 months) weekly psychodynamic therapy in the British health system were less depressed and better socially adjusted than the patients who received treatment as usual.

The movement toward more specific treatments has also clarified that there is a continuing need for treatment of developmental and life cycle issues that are not symptom based, such as identity formation, intimacy and relationship problems, and loss and grieving. Common clinical scenarios include teenagers in conflict with their parents as they try to "find themselves," young adults with difficulty committing to intimate relationships, and middle-aged adults struggling with adapting to new limitations in career or health.

Finally, technology is profoundly shaping the future of psychotherapy. The uptake of virtual therapy, which began before the pandemic but was dramatically accelerated by lockdown and quarantine, resulted in improved access but raised issues about technique and outcome (Markowitz et al., 2021). Chapter 13 focuses on these questions in more detail. We are just beginning to see the impact of patient data capture on mental health treatment with the increasing use of apps for tracking, monitoring, and reporting on mood, activity, and other mental health indicators. Routine outcome monitoring, in which patients rate their condition regularly and report this to the therapist, has been shown to have significant benefits on outcome (Lambert, Whipple, & Kleinstäuber, 2018). It is too soon to understand the profound ways artificial intelligence and large language models will change the practice of psychotherapy. How the technology will enhance or diminish the relational features of psychotherapy is an open question.

A PRAGMATIC PSYCHODYNAMIC PSYCHOTHERAPY

We have demonstrated the value of psychodynamic psychotherapy and at the same time described some of the new ideas and social forces that suggest how it has to change.

Beth continued weekly psychotherapy for 2½ years. She became convinced that her inner experience of loneliness and mistrust of others, especially men, was triggered by repeated memories of her very painful childhood experiences. She developed a new, clearer picture of her childhood. At the same time, she started to realize that her current life was not so bad. She began dating, and enjoyed it more than before. After a while she met a man who was much more kind, stable, and psychologically healthy than the partners she had been with before. She also began to develop a wider range of nonromantic friendships.

Beth's relationship with me was rocky at times. In addition to trying to understand it, much time was spent helping Beth feel safe and comfortable in the therapy. This included education, explanation about the therapy, and attention to particular moments of mistrust. We explored her feelings about being in therapy with a male therapist almost two decades older than she was. Beth seemed to alternate between trusting, positive feelings and sudden anger, suspiciousness, and withdrawal. She became more and more aware that these reactions reflected her old feelings, which alternated between childlike trust and then betrayal and fear. I became better at anticipating when the shifts would occur and could interpret and clarify them more clearly.

We developed a kind of rhythm—discussion of Beth's new relationship, her periodic interactions with her parents, and feelings and thoughts about me. As she moved from one to the other and was able to apply her understanding of the old relationship templates that played out in each situation, she became stronger and more confident. She also seemed more relaxed, more playful, and wittier than before. This flexibility was evident in her description of her daily life. She said she felt more attractive, too.

Beth was pleased with her new relationship and expected that it might develop into marriage. She ultimately decided it was time to try to live life on her own and end therapy. She had one last spasm of fear, doubt, and suspicion just before the end of treatment when she was unsure if she could manage on her own. This upset resolved quickly when she realized that it was, again, a replay of the same old pattern of loneliness and fear. With her new self-awareness, clearer perceptions of others, and more adaptive behavior, she was ready to move on.

Do you think Beth's treatment was successful? In what ways? The case incorporates traditional ideas about dynamic psychotherapy (emphasis on experiencing affects, exploring the past, looking for patterns, increasing awareness, working on the therapeutic relationship), as well as many of the new ideas we have discussed here (attention to the therapeutic relationship and ruptures, awareness of trauma, attunement to the gender and background of patient and therapist, education and explanation, transparency, rewriting the narrative). The next chapter sets out the basic theory and technique of the updated model, referred to as pragmatic psychodynamic psychotherapy, and the subsequent chapters elucidate these ideas, explaining, giving examples, and providing specific practical tips.

2

Pragmatic Psychodynamic Psychotherapy

Conceptual Model and Techniques

> It is the theory that decides what we can observe.
> —Albert Einstein

Pragmatic psychodynamic psychotherapy (PPP) is based on a developmental and conflict model of mental life and involves clearly defined psychodynamic diagnosis and formulation; a focus on education and transparency; integration with other synergistic treatment modalities; and an active, engaged therapeutic stance. It differs from classical psychodynamic psychotherapy, which has tended to be open-ended, hierarchical, not diagnosis specific, inadequately integrated conceptually and technically with psychopharmacology and other concurrent treatments, less active, and less focused.

The reader's therapeutic urge (and anxieties about what to do with patients) will probably be somewhat frustrated by reading about theory and technical principles. This chapter does not tell you specifically what to do—that comes next. But it provides the larger framework for the rest of the book, which focuses on the concrete, specific, and practical application of these ideas.

CONCEPTUAL MODEL AND ASSUMPTIONS

This section addresses the theoretical underpinnings of PPP (summarized in Table 2.1), including the assumptions and central conceptualizations, while the next section discusses the primary psychotherapy techniques.

TABLE 2.1. PPP Model and Assumptions Compared with Traditional Psychodynamic Psychotherapy

PPP assumptions and conceptualization	Traditional psychodynamic psychotherapy assumptions and conceptualization
Mental life involves ongoing conflict and compromise formation. Behavior is multiply determined.	Mental life involves ongoing conflict and compromise formation. Behavior is seen as secondary phenomenon.
Mental processes—affect, cognition, drives—operate in parallel.	Affect and drive have primacy; cognition is secondary.
Behavior is determined by thoughts and feelings and in turn shapes thoughts and feelings.	Behavior and symptoms are secondary to conflict.
Traumatic experiences in the past prefigure later perceptions and experience. Traumatic scenarios are repeated.	Unresolved conflict leads to developmental fixation and repetition of conflict.
There is an interweaving of dynamic factors with biological, psychological, and social factors, including race, gender, culture, and sexual identity. These factors are all central to wellness and the development, maintenance, and resolution of psychopathology.	Psychodynamic factors are essential factors in the development of pathology, and other factors are epiphenomenal or associated.
There are six mechanisms of change in psychodynamic therapy: mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experience, affect experiencing, fostering more adaptive psychological defenses, and enhancing interpersonal patterns.	Change occurs in therapeutic relationship as a result of insight and new experiences.

Conflict, Conflict, Conflict . . .

The essential and perhaps most enduring legacy of Freud and psychoanalysis is its emphasis on the centrality of unconscious conflict in mental life (Brenner, 1974; Freud, 1916, 1917a). All aspects of mental life can be viewed as part of the ongoing turmoil arising from competing wishes, fears, and prohibitions, and attempts to resolve these contradictions. Some elements of the conflict are conscious while some are unconscious.

Drives and impulses, whether conceptualized as sexual and aggressive in the original psychoanalytic formulations, or intense urges for attachment, bonding, mastery, and affiliation in subsequent thinking, are the motivating sparks that initiate intrapsychic conflict. Drives and impulses appear in consciousness (make themselves known) in derivative form as fantasies, thoughts, feelings, and perceptions. Fantasies involve wishful scenarios, either conscious or unconscious, that are stirred up by these drives and impulses, and are an attempt to find an expression and a fulfillment of these needs. Cognition is a domain seemingly less directly affected by impulses; it refers to our attempt to find reliable, valid, and persisting ideas about ourselves and our world. Many aspects of cognition are affected by conflict, such as pessimistic assessments and negative attributions arising from early loss. Our feelings, which refer to the conscious subjective experience of our emotional or affective states, are a more immediate dimension of our sense of ourselves and our environment.

Each of these aspects of mental experience is involved in intrapsychic conflict, and the conflict model elucidates and identifies the warring elements. The conflict could be between different drives (e.g., love and anger) or between a drive and cultural values (a common conflict in our Western culture is between the wish to be close vs. the need for independence), or between different interpersonal needs. The conflict could also be between a drive and reality, as in the tension between the need for intimacy and the lack of a partner.

The concept of conflict, as originally formulated in the psychoanalytic literature, assumed the classic form of impulse (drive), prohibition (fears or conscience), and defense (means of coping), all of which lead to a compromise formation (symptom, character trait, behavior, attitude; Brenner, 1974). More recent theorists, such as the object relations theorists, focus instead on conflict between internally constructed representations of self and others (Greenberg & Mitchell, 1983; Kernberg, 1988). The feelings engendered by a good and loving mental representation of the mother might conflict with the feelings stimulated by a coexisting representation of the mother as harsh and vindictive. Self psychology speaks to the developmental arc toward healthy self-esteem regulation and the impediments that thwart it (Kohut, 1971, 1977, 1984).

The essence of the psychodynamic model, whatever subtype, is looking at urges, their imagined consequences, and the associated fantasies, thoughts, and feelings—the diverse constituents of mental life—through the lens of conflict and compromise. Of course, the conflict is not open to conscious view by the patient (or the therapist), and recognizing it requires curiosity, attention to associations, and an intensive interpersonal process—that's the reason good psychodynamic therapy

helps people understand themselves more than self-reflection or conversation with close family members or friends.

Conflict is mistakenly equated with pathology. It is normal for there to be chronic conflict. Compromise formations, the result of vectors of conflicting mental urges, are ubiquitous. Better compromise formations are, or should be, our life goal, and they are certainly our therapeutic goal (Waelder, 1936). Any aspect of a person's life can be examined through the lens of compromise formation. Examples of compromise formations include important life decisions, a person's characteristic interpersonal style, beliefs, attitudes, creative productions, and psychological symptoms. For example, a teenage girl with juvenile-onset diabetes who struggled with fear, anger, and frustration about the deprivations and effects of her dietary requirements and injections might choose to become a doctor or nurse. This compromise formation is an adaptive defensive process that helps master the frustration and anger about the illness by becoming a provider of care—in control and not suffering, helping others with problems. An effective young male teacher who was adopted in childhood after several foster placements subsequently has trouble committing to an intimate relationship. He is managing his fears of abandonment by protecting himself from getting hurt again through avoidance of a close relationship, but he expresses his need for closeness through mentoring relationships with his students. Artistic productions are an attempt to express (and sublimate) conflict by portraying them for an audience. Picasso's *Guernica* expresses the horror of an attack on a defenseless Spanish town by transforming it into something deeply engaging, beautiful, and memorable. Thus the painting is a compromise formation, expressing the outrage and fear about what happened and creating something universal and heroic, adding beauty to the pain. Rap music gives voice to the harsh realities of street life expressing both the artist's power and deep vulnerability.

From the conflict perspective, how is a symptom different from these successful examples of conflict and compromise? Like the difference between a weed and a prize botanical specimen, a symptom is a dysfunctional, maladaptive, or unwanted compromise formation, while a successful compromise is a source of strength. Unfortunately, poor compromises are often maintained, as they are the patient's best attempt at resolving conflict at a particular point in time, and they persist long afterward.

The psychodynamic perspective allows us to analyze and deconstruct patients' compromise formations. We look at behavior, symptoms, and feelings and break them down into their constituent parts. But therapy must also help patients rebuild, and the analyzing focus on the conflicted roots of any bit of mental life is balanced by a healthy

appreciation for the carefully constructed compromise formations patients bring us.

Mentalization, the capacity to understand one's self as a need-driven and self-regulated entity, is a second-order aspect of mental conflict—that is, it is a mental capacity born of processing conflict, which in turn helps to manage it.

Jasmin was an 18-year-old cisgender heterosexual Arab Muslim student who lived with her family in a traditional village in northern Israel. With long dark hair, soft brown eyes, and frequent tears, she was hesitant to open up to her young Jewish therapist, whom she saw in a psychotherapy research clinic. Indeed, she was hesitant to be in the counseling service offices at all, because therapy, and talking personally with people outside of her family and village, was considered risky and perhaps dangerous. But, she was depressed and in danger of failing her courses.

Soon enough, Jasmin told her story with much sadness, fear, and confusion. She was at the university because her dream was to earn a degree in social work, helping a broad range of clients, including Muslims, Jews, and Christians, both men and women. She wanted to wear beautiful clothes and dress however she pleased. Although her family allowed her to start school, uncertain of where it would go, they insisted that she would need to return to live in the village upon graduation. But, she had met and fallen in love with a fellow student, a Christian. This was completely forbidden and was the first secret she shared. She felt guilty about her dreams of the future, and certainly about the young man. If her family knew, she would be forced to leave the university, her family would be dishonored, and her younger sister's prospects would be dimmed.

Just when the therapist felt comfortable speaking directly about the painful conflict Jasmin experienced between her wish for a free and modern life, and the realistic barriers to this, an entirely new aspect of the problem opened up. The therapy office became a safer space, and Jasmin revealed that she had been sexually molested by her second cousin for 2 years beginning at 11 years old. She had never told anyone, including her mother, feeling she would not be believed, and fearing it would be swept under the rug.

Along with her obvious relief at sharing this terrible experience for the first time, it was clear to the therapist that Jasmin experienced the molestation as a shameful lapse on her part. She blamed herself for the abuse although she could not really explain why. She was pretty sure it had not happened to her older sister, so perhaps she had done something wrong. Her father suffered a heart attack during

this time and she worried that he had overheard the second cousin and was so upset that he became ill.

Jasmin's depression, distress, failing grades, and family demands seemed to be pulling her away from the university and back to the family and her culturally intended role as mother, wife, and caregiver. As the air of secrecy and danger in the office receded, Jasmin became more comfortable sharing the specifics of her sexual abuse, soaking in the support and nonjudgmental demeanor of her therapist, whom she clearly experienced as the wished-for available and supportive mother.

Jasmin began to realize that her difficulty studying was less the result of depression and problems concentrating, and more an (largely unconscious) attempt to solve her problems by failing and returning home. In response to this insight, and with the therapist's support and trepidation, she told her mother about the abuse. Her mother's shock gave way to warmth and a melting of the usual distant and uneasy way they were with each other.

Meanwhile, Jasmin and her therapist began to connect her intense shame and guilt about the abuse with her guilt about her dreams of freedom and a more secular life. Perhaps her wish for these things was going to be difficult to negotiate because of her background, but at least she could not give up because of her own guilt and shame.

Can you identify Jasmin's conflicts, and distinguish between her struggle with her needs and the real environment and her intrapsychic conflict? The therapist had to acknowledge and work with both, and ultimately was able to help Jasmin see that they were mutually reinforcing. This first theoretical assumption of PPP, that conflict is ubiquitous and central, is probably the most similar to traditional psychodynamic practice and may be the feature that distinguishes it most from CBT and other types of psychotherapy. This example highlights the importance of attention to the social context of intrapsychic conflicts and how gender, culture, ethnicity, and race require attention along with the intrapsychic conflicts.

Parallel Processing: Drive, Affect, Cognition, Behavior

In our pragmatic model of psychotherapy, affects, thinking, and behavior are conceptualized as operating in parallel, without one having primacy over the others. These features of mental life influence one another, rather than operate in a linear sequence. Affects, thoughts, and behavior are derivative of drives, and reflect them.

This perspective contrasts with the traditional psychodynamic view and also with the classical paradigm of cognitive therapy as articulated

by Beck and Haigh (2014). In traditional dynamic psychotherapy, the focus is on understanding drives, affects, fantasies, and how they relate to one another. Relatively speaking, there is less interest in cognition and less focus on behavior. The traditional psychodynamic approach has been to amplify and elucidate feelings over all else.

However, the systematic distortions in thinking that develop over time can have a profound effect on a patient's experience, perceptions, and behavior and have an autonomous life of their own. For example, the repeated negative attribution that a patient may make to each new social contact involves not just a feeling, but also a belief. There is a specific conviction about what will occur next, and what the patient has to do to avoid shame, disappointment, or whatever the feared outcome is. PPP includes a focus on these pathogenic cognitions, as well as the affects and fantasies.

CBT traditionally gives primacy to disturbances in thinking (Beck, 1976; Lazarus & Folkman, 1984). This approach views affect as a result of cognition ("I think, therefore I feel"), and thus spends much time rectifying "inaccurate" cognitions. A primary focus on cognition risks losing the immediacy and conviction that come with a focus on feelings and the access to these important data about the patient's mental life. In our view, affect and cognition are two different aspects of the same process. There may be contexts in which feelings drive thoughts, and other situations in which thoughts shape feelings. The implication for our treatment approach is that we emphasize both affect and cognition in treatment. In fact, we may even recommend to a therapist that if a patient tends to emphasize affect, maybe they should emphasize cognition, whereas if the patient tends to emphasize cognition, they should emphasize affect a bit more. Barber and Muenz (1996) have used the term *theory of opposites* to characterize their finding that depressed patients with obsessive–compulsive personality disorder do preferentially better with an interpersonally based therapy than a cognitively based therapy. They speculated that it is helpful for patients to receive treatment that somehow works against their defensive and personality style.

Behavior and Change, Behavioral Change

In the traditional psychodynamic model, behavior was seen as the downstream effect of where the real action is: in the patient's head. Behavior was caused by conflict and would change when the conflict was untangled. Some believed that resolving the conflict was the only way to permanently modify behavior. At times, traditional psychoanalytic and psychodynamic education showed a surprising lack of interest and

concern about patients' symptoms (and behavior), seeing them as almost epiphenomenal.

PPP regards behavior as just as important as subjective experience and intrapsychic conflict. Behavior is multiply determined by mental events, as well as by somatic and neurobiological factors. Behavior results from mental conflict, but it also has the power to change experience and thus affect intrapsychic conflicts and mental life. This two-way causality is a crucial theoretical aspect of PPP and distinguishes it from the traditional psychodynamic model. New behaviors and the new experiences that result from them may need to be encouraged long before the patient spontaneously generates new experiences and new perceptions of themselves. In this sense, we build on Wachtel's (1997) insight about cycles of behavior and experience—for example, the dynamics of shyness. If one is anxious about being rejected, one tends to avoid meeting new people. This impedes the development of social skills and reinforces the sense of isolation. Therefore, if one is shy, one is likely to become more shy. To break the cycle, one must find a way to do something different, such as learning new social skills that will enable more social opportunities. Traditionally, dynamic therapists have waited for insight that might open up possibilities of behavioral change, whereas we suggest that the patient's behavior may not change on its own.

Tommy was a tall, thin cisgender gay White man in his 30s, whose husband, Jay, struggled with a chronic recurrent depression. He complained that Jay was not interested in him, and he felt rejected and depressed. They spent little time together. He was very involved with their two young children and felt himself to be an exemplary father, in contrast to his feeling that Jay was not very involved.

Tommy was critical of his partner's emotional problems and blamed him for not doing things that Tommy thought would make him feel better. His attitude and demeanor frequently had a judgmental quality as he spoke about Jay in sessions and, it seemed, when he spoke to him at home. Tommy's somewhat patronizing attitude seemed to be a coping strategy for dealing with his pain and disappointment about Jay's condition and helped to defend against his own chronic neediness and sense of emptiness.

Because it was not clear how much Tommy's demeanor was affecting Jay's mood and how depressed Jay actually was, the therapist chose to do a couple assessment as part of the individual therapy. This joint session revealed that Jay was on medication, in his own individual therapy, and seemed far less distant than Tommy had described. Knowing that Jay had support and was functioning allowed the therapist to continue to encourage Tommy to reflect on, rather than act on, his feeling that Jay was helpless.

Although Tommy could begin to see need and longing, and how his critical attitude was defensive, he was absolutely at a loss to see how he could behave differently with his husband. He was aware of the historical roots of this problem: His mother was anxious and her attention always seemed to be elsewhere. He was the fourth of five siblings. But, he kept feeling, what else could he do but try to be helpful and reasonable? After all, he felt he really was doing a good job helping a depressed partner, and he was great with the kids. There was a gap between Tommy's understanding of the pattern he and Jay were in, and his ability to step away from his need to protect himself from pain by being exemplary.

In order to increase his awareness and find ways of experiencing the family situation differently, Tommy and his therapist worked on new ways of communicating with Jay that expressed concern and empathy, but did not offer as much specific help. For example, when Jay complained about feeling exhausted, Tommy said, "You've had a long day," and did not offer to take over unless Jay specifically asked for it. This made it easier for Jay to get more involved. He felt Tommy was more respectful and he was able to exercise more autonomy. Meanwhile, Tommy was relieved he did not have to help as much.

Tommy noted that not only did his husband seem to be more responsive and present but there was something different in how he felt after one of their arguments. He was a little more distant from Jay, saddened perhaps. He felt less burdened, "compelled" by his partner's unhappiness, and there was more spontaneity and a return of their sexual chemistry. Noting all of these feelings, which were a consequence of new behavior, afforded him a new perspective on himself. Tommy could see more clearly his old adaptation to his childhood situation and felt less need to respond reflexively to his current family the same way. He was more aware about the various conflicted feelings he had about his husband, and surprisingly, less dependent on him.

Are you surprised by the psychodynamic therapist helping the patient to develop scripts? This patient learned something about himself by trying something new. Attention to how patients think and feel in psychodynamic psychotherapy helps promote self-awareness, but changes in behavior can result in changes in feelings and perceptions.

"What's Past Is Prologue"

Shakespeare's (2005) pithy phrase is a sound-bite explanation for the formation and perpetuation of psychodynamic problems. Earlier life experiences that are overwhelming and cannot be absorbed, integrated,

or metabolized result in conflicted compromise formations. They are the basis for the patient's subsequent repetitive difficulties. Originally, Freud (1918) hypothesized that psychosexual conflict and the development of the "infantile neurosis"—a flare of symptomatology associated with sexual and aggressive conflict in the young child—was the basis for later neurotic developments. He saw the adult neurosis as a reactivation of the childhood problem.

This aspect of traditional psychodynamic theory was the rationale for the extensive historical explorations and reconstructions that are the hallmark of psychoanalytic treatment, where the past is prologue to the present, and all understanding is historical understanding.

The schema concept, which refers to a deep organizing structure in the mind, is particularly relevant here (Bartlett, 1932; Slap & Slap-Shelton, 1991; Young et al., 2003). Developing out of overwhelming and traumatic experience, the child forms a relatively fixed perceptual pattern with an associated solution or adaptation to this. This pattern is focused into a schema, or traumatic scenario, that is finite and relatively specific, including perceptions of others, feelings, associated thoughts and ideas, fantasies, and the attempted solutions to the traumatic situation. The schemas formed in the wake of traumatic experiences, great and small, become repetitive scripts, activated over and over again later in life. The perceptions, drives, fantasies, thoughts, and feelings are repeated, as are the compromise formations developed to adapt to them.

Bowlby's (1958) attachment model posits early relational trauma as the basis for future attachment difficulty. Problems in early caregiver attachment result in insecure attachment that manifests itself in either clinging or avoidance. Subsequent relationships are experienced and managed according to this old scenario. New intimate partners, who may in fact be highly stable and affectionate, are experienced with the same insecurity as the earlier relationship, and the same clinging or avoidant adaptations show themselves.

Traumatic scenarios or schemas are reactivated by subsequent associated situations, and the same old pattern is enacted over and over again. For example, Tommy's powerful reaction to his husband was based in part on his traumatic experience with his preoccupied anxious mother.

An interest in the past and its effect on the present led Freud and others to the question of childhood trauma. Trauma has been central to the psychodynamic perspective, both informing it and also generating heated controversy and confusion. The contemporary recognition of the frequency of severe traumatic events, including childhood violence, abuse, and serious neglect, required revision of some of the early excessive focus on the intrapsychic factors in response to trauma (Herman,

1997). The field has become much more aware of the importance of social, cultural, and indeed, realistic and practical factors in the response to trauma, and posttraumatic illness has become an important focus of current study.

PPP embraces the kernel of the original Freudian model—earlier trauma generates pathology that is reactivated later in life—but in a more generic mode. Traumas may be acute, externally evident, obviously overwhelming and destructive, or they may be subtle. These subtler but nevertheless serious problems may include a mismatch between needs and opportunities, between temperaments of child and caregiver, or struggles with neurobiologically driven extremes of experience (anxiety, mood lability, perceptual distortions). At the same time that trauma is important, we recognize that memory is actively constructed and can be misleading and distorted; much care must be taken to avoid forcing definitive conclusions about what happened in childhood.

This remarkable work of Kahneman and Twersky (1974), which earned Kahneman the Nobel Prize in Economics in 2002, reminds us that the active construction of memory and its consequent perceptual distortions are fundamental and not limited to the dynamic unconscious, where the individual's unique history is processed through the crucible of conflict and compromise. They eloquently describe the many global and ubiquitous irrational cognitive distortions we observe in patients that are nonspecific and nonpersonal, and reflect the evolutionary adaptation of our brains themselves.

The Biopsychosocial Model: Social Determinants of Health and Psychodynamics

The repetition of the traumatic past, which distorts and reshapes the present in a Groundhog Day style of reliving, is only one explanatory factor in a complex system. A danger of the psychodynamic perspective is that it can become an all-inclusive explanation (Popper, 1962). One can almost always find a conflict-based explanation for a problem, and this can cause the therapist to diminish the importance of other contributing factors. For example, a mother may be depressed because her daughter is ill, and this reminds her of her own childhood illness and the losses that accompanied it, or because of another cycle of her bipolar spectrum illness, or because of her fatigue and sleeplessness associated with a medical problem.

The psychodynamic model selectively focuses on individual factors, rather than the social determinants of mental health. Because we are fundamentally social creatures, the social surround profoundly impacts our intrapsychic life. Global, cultural, and community context can

determine thought, feeling, perception, relationships, and not just our mental health but our physical health, too (Compton & Shim, 2015).

The biopsychosocial model (American Psychiatric Association, 2000) provides the conceptual basis for including the major biological, psychological, and social factors that must be entertained in understanding individual pathology. However, this umbrella concept is somewhat loose in characterizing what data and what kinds of formulations are relevant within each of these three main areas (bio, psycho, and social), and how these factors are specifically related.

The psychodynamic factors are those that affect the meaning of current events because of prior traumatic events. These are distinct from the many nondynamic factors, such as purely cognitive factors that affect the information-processing capacities of the mind; neurobiological factors like temperament; genetic factors in personality; subsyndromal and syndromal psychiatric illnesses; and social factors, such as family system, culture, race, gender, and political power.

Although it is difficult to sort out the relative effects of the various potential causes for symptoms, the PPP model regards the dynamic factors as only one in a series of parallel causal factors. These various considerations form a continuing chain over the life cycle, with the social surround affecting dynamics, which affects neurobiology, which impacts the social milieu, and so on. The case formulation (discussed in Chapter 7) is the vehicle for focusing these different perspectives in an individual case. The rich literature on formulation (Perry, Cooper, & Michels, 1987), and more recent contributions (McWilliams, 1999, 2020; Summers, 2002), discuss the best format for accomplishing this. The formulation is central in PPP because it allows the clinician to focus on what the psychodynamic factors are, and how they are related to the nondynamic factors, paving the way for effective goal setting, treatment planning, and integration with other treatments when necessary.

Therapeutic Change

The goal of PPP is to change how people experience themselves, their relationships, and their world. These changes occur within patients and are a result of engaging mechanisms of change. We distinguish between *mechanisms of change* that are mental pathways and processes present in the patient, and *techniques to promote change* that reflect the technique and activity of the therapist. In this section on the conceptual model of practical psychodynamic therapy, we describe the six mechanisms of change derived from psychodynamic theory and the empirical data on psychotherapy process. In the section on technique

later in this chapter, we describe the therapist's techniques for promoting change.

The six mechanisms are mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experiences, affect experiencing, fostering adaptive psychological defenses, and enhancing interpersonal patterns. Each is a pathway to change for the patient, and different patients seem to need and respond optimally to different mechanisms. There is empirical evidence in the psychotherapy process literature to suggest that each is associated with good therapeutic outcomes (see Chapter 10 for discussion).

Mentalization is the capacity to recognize self and others as subjective beings who are affected by internal and external events and experience conflict. The fundamental capacity to mentalize may be compromised in individuals with trauma. Mentalization as a mechanism of change refers to the development of this capacity for mentalizing through the psychotherapy experience.

Fostering insight into unconscious conflict is the traditional psychoanalytic mechanism of change. It involves increased awareness of previously warded-off feelings and thoughts and recognition of inner conflict, which allows the patient to perceive themselves and others in a new way.

Therapeutic alliance and new relational experience refer to the patient's felt sense of a strong alliance with the therapist that is new and different from other relational experiences. The healing experience of the therapeutic relationship allows the patient to feel differently and better about themselves and their world.

Affect experiencing refers to the repeated attention to painful and warded-off feelings in the safe space of the therapy room. Desensitization to acutely painful feelings, and the greater ability to tolerate and accept visceral emotion, improves the patient's comfort with their affective life. Some patients who have difficulty managing positive affect may benefit from this mechanism of change as well.

Fostering more adaptive defenses builds on the previous four mechanisms of change. A patient who has the capacity for mentalization, some awareness of unconscious conflict, and the ability to tolerate painful affects will be able to reflect upon their typical defenses and evolve more mature and adaptive responses. This mechanism of change refers to the mostly unconscious, but partly conscious, shift from maladaptive immature defenses to mature and adaptive ones.

Finally, enhancing interpersonal patterns is at the apex of the six mechanisms of change, because it relies on capacities evolved using all of the previous mechanisms. Here the patient reflects on current relationships, using mentalization and insight, relational comfort and safety, the

ability to tolerate uncomfortable feelings, and healthy defenses to make the best of important relationships. This means moving toward healthy interpersonal closeness with good boundaries, flexible attachment, and satisfying and invigorating reciprocal interaction.

TECHNICAL PRINCIPLES

Streamlining the conceptual basis for PPP allows for a clearer and easier-to-learn set of therapeutic techniques. Everything in the previous section was about how the therapy works. This section is about what we do as therapists. All too often, in our own training, we were confronted with a bewildering array of interesting, seemingly very important, but often conflicting therapeutic techniques. Our teachers encouraged us with the hopeful words, "It takes experience," to tell us which technique to use when. It does require experience to coax a therapeutic relationship into existence and support an open-ended free-association process. But we think there are guidelines that define, facilitate, and constrain the process to help trainees to set it in motion. Summarized in Table 2.2, these techniques are articulated below and discussed extensively in the rest of the book.

Association: Free, but Not Too Free

Like play, which occupies a space between reality and fantasy, psychotherapy provides the patient with an opportunity to dream while awake, let their mind go, permitting thoughts, feelings, memories, and images to bubble up. This is dreaming in the metaphorical sense, since of course the patient is awake and sitting in a chair looking at the therapist. But the patient is encouraged to put their associations (spontaneous thoughts) into words. This is difficult to do—it is a skill that develops over time and it is subject to the same conflicts the patient is trying to explore.

To this end, PPP uses traditional open-ended interviewing techniques, facilitating the patient's uninhibited expression of emotions, private thoughts, urges, and fantasies (Gabbard, 2000). Sessions begin without a specific agenda, and patients are encouraged to put their thoughts and feelings into words. The technique is to focus on the here and now (in the sense of what the patient is genuinely feeling and spontaneously thinking about) because that is the road to deeper self-awareness. Although the therapist will carefully remember previously discussed material, including an emerging picture of the patient's problems, the patient is given relatively free rein to talk about what is on their mind in the moment.

TABLE 2.2. PPP Technique Compared with Traditional Psychodynamic Psychotherapy

PPP technique	Traditional psychodynamic psychotherapy technique
Free association allows for emotional exploration and reexperiencing of important feelings, fantasies, and thoughts.	Same focus, but more open-ended, unstructured interaction.
The therapist focuses on the development and maintenance of the therapeutic relationship, with consequent focus on current reality, and an active, engaged, empathic therapeutic stance.	Development of therapeutic alliance is important, but a more abstinent and less reactive stance allows for less confusion in observation of transference reactions.
Equal attention is paid to various derivatives of conflicts, including but not focused on transference and the past.	Important to focus on transference, countertransference, and the past.
Identifying the core psychodynamic problem and developing a comprehensive case formulation is essential; this is done early, shared with the patient, and is the basis for collaborative goal setting and treatment planning. Psychotherapy technique is problem specific. Formulation is consistent with the ongoing process of patient developing a life narrative.	Case formulations focus primarily on psychodynamic factors, are developed later in treatment, and not shared with patient. Patient develops insight and awareness of conflicts through therapist's clarifications and interpretations. Psychotherapy technique does not vary across problems.
Goals drive the treatment and are the basis for integrating dynamic psychotherapy with other modalities of treatment.	Elucidation of psychodynamic conflicts and their resolution is the primary focus in treatment; symptom relief is less emphasized. Integration with other treatments is not systematically planned and implemented.
Therapists assess patient strengths and weaknesses and plan and implement a therapeutic strategy that engages mechanisms of change.	Through self-awareness, patients change perceptions and try new behaviors.
The therapist's role, the rationale, and the goals of treatment are discussed in a transparent manner.	Concern about effects on transference and ability to effectively analyze transference results in less direct orientation, education, and explanation about the psychotherapeutic process and maintenance of a more "mysterious" therapist persona.

The therapist attempts to connect the patient's current feelings and thoughts with others that constitute a pattern. If the therapist believes an important issue from the previous session or earlier in the same session has not been addressed, the patient is encouraged to address that topic. Increasingly over a session, connections will be made, and there is an ebb and flow between spontaneous associations and directed exploration of important thoughts and feelings.

The PPP therapist allows for enough open-endedness to help the patient bring new material into the sessions, and experience feelings and thoughts in an unforced and natural way. But they maintain a hand on the tiller, gently steering the session in the direction of fleshing out and working on the central psychodynamic problems, allowing for them to be reexperienced and reconsidered.

Listening to associations does not mean you cannot ask questions or prompt the patient. Often, an empathically attuned and well-timed question will help to facilitate the flow of thoughts, feelings, and memories: "Can you say more about what was happening in your mind at the time?" or "Please tell me more about your relationship with *X*, and some of the moments you have been close, and what that was like for you."

The Therapeutic Relationship

Perhaps the most robust finding in the psychotherapy process-outcome literature, which cuts across types of psychotherapy, is the observation that the strength of the relationship between a patient and their therapist is associated with good outcome (Flückiger et al., 2018). This is true from early in the process, by the second or third session, according to some work (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Martin, Garske, & Davis, 2000). There is an extensive literature on the development of the therapeutic relationship and its maintenance and repair in the case of the inevitable ruptures (Safran & Muran, 2000). PPP defines the development of an effective therapeutic relationship and the skills for maintaining it as central.

Techniques for facilitating the development of the therapeutic alliance include (1) consistent empathic and affective attunement—paying attention to and inquiring about what the patient is feeling in the here and now; (2) clearly defining and negotiating therapist and patient roles (Bordin, 1979); (3) an active and engaged therapeutic stance, including ongoing reaction and interaction, questions, probing, preliminary observations, and feedback; and (4) careful attention to the moments of disappointment, frustration, or disengagement that occur in any continuing therapeutic relationship (Safran & Muran, 2000).

Traditional psychodynamic psychotherapy certainly attends to the therapeutic alliance as well, but it has a tendency to leave the patient and therapist roles less defined out of concern about making transference manifestations harder to see. The traditional psychodynamic therapist maintains a more mirror-like and abstinent attitude. When therapeutic ruptures do occur, they tend to be understood as related to transference reactions, and important "grist for the mill" of understanding. PPP, too, sees ruptures as partly reflective of transference issues, but also of current problems in the alliance; repair and resolution of ruptures, with resumption of a dominant positive tone to the therapy, are regarded as critical.

Nicholas was a White heterosexual cisgender businessman who came for psychotherapy in the wake of his wife's announcement that she wanted a separation. Apparently, she could not tolerate his emotional distance and his controlling, infantilizing behavior toward her. He was in his early 40s, tall, balding, suntanned, and genial. His description of the situation was articulate and logical, and he had a strategic attitude and approach toward the separation, almost like it was a business negotiation. But he was desolate apart from his wife and children, and felt he had no purpose in life.

Nicholas wanted to engage the therapist in a nuanced discussion of how to lure his wife back and persisted with a chess-like analysis of what he should say to her and when. He wanted the therapist to be a relationship consultant and help him achieve his defined goal: resuming the relationship as it had been. The challenge in developing the therapeutic relationship was not simply to help Nicholas reconstitute the relationship as it had been but to help him see the problems that had led to the split. He would never get back with his wife unless he gained some understanding of the emotional issues involved in the separation, his contribution to it, and his reactions to it. In fact, he was angry and ashamed about what had happened.

By consistently empathizing with his feelings of loss, there was some space in the therapy for Nicholas to talk about his deeper feelings, not just his strategy to get his wife back. After clarifying the therapist and patient roles, specifically the therapist's role in listening, understanding, reflecting, and formulating, and the patient's role in exploring, articulating, taking responsibility, and changing, Nicholas was able to discuss the conflict with his wife without slipping back to seeking advice and help. He took some responsibility for seeing the impact his needs had on others. Of course, he did not change this attitude and behavior simply because of an educational discussion about the roles of patient and therapist, but it did give him some awareness of his constant tendency to relate to others as staff that were

disappointing him. Patient and therapist developed a shorthand, each of them commenting at times that he was back into "chess-playing mode," as opposed to thinking about what was really going on.

With this intelligent but concrete and practical man, an active give-and-take between patient and therapist was essential. Nicholas rapidly became anxious and frustrated without ongoing interaction in the therapy, and frequent comments and questions and encouragement from the therapist were very helpful. There had been some discussion about his difficult relationship with his father, and the therapist connected his frustration when the therapist was quiet to his anger at his father, who left his mother when he was 12 years old.

Nicholas continued to get frustrated when I could not give him advice and answers—should he compromise and offer to do more of the household chores, should he push back when his wife said she wanted to go out with her friends? I did not tell him what to do, and then shortly afterward I went on vacation and had to cancel two appointments. When I returned, he seemed preoccupied and much less engaged. He could not explain why, and seemed to get angry when I asked about this. Instead of exploring the transference reactions at that point (his feeling of anger and rejection by me), I reassured him and was a little more active than usual.

In this case, the principle was to meet the patient where he was, and the therapist's judgment was that adopting a more traditional aloof therapeutic stance might have generated some additional insight, but it would compromise the working relationship. When the therapeutic alliance is threatened, the rupture must be repaired; sometimes this means reassurance and reality, sometimes this means interpretation.

All Derivatives Are Created Equal

Sometimes referred to as a "three-legged stool," psychodynamic therapy focuses on incidents in the present reality, the past, and in the relationship with the therapist. In the traditional model, attention to one of these domains should be matched by attention to the others; neglect of any area is seen as a resistance. Although this is consistent conceptually with the PPP model, the pragmatic focus of our treatment model dictates that priority be given to the present derivatives of conflict. All three legs of the stool are not always necessary, and historical reconstructions and feelings about the therapeutic relationship are not more important than derivatives of the conflict present in everyday reality.

Transference is the carryover of old feelings, perceptions, and ideas about early relationships onto later ones. Countertransference refers to the feelings, perceptions, and ideas the therapist has about the patient that derive from the patient's presentation and the actual therapist–patient relationship, as well as from the therapist's earlier life experiences. These two fundamental psychodynamic concepts are discussed in much greater detail in several later chapters. The therapist typically recognizes transference reactions by listening and observing, but also by noting countertransference reactions and relating these to ongoing enactments with the patient. Like the transference, countertransference may be more of a focus in traditional psychodynamic treatment than in PPP. We wish there were more data on which patients benefit from a focus on the present, the past, or the transference.

The bread and butter of PPP is the detailed exploration of and discussion about the many current reality situations, especially those involving narratives about meaningful interpersonal relationships. When the free-associative process leads to memories of the past, or when the discussion of the transference becomes immediate, then these elements become the focus. The exploration of these areas adds depth and a sense of conviction to the process, but this is not absolutely necessary to the therapeutic process. Some patients naturally shift their focus to the past and recall essential memories that help to buttress their understanding of their repetitive scenarios. Some have a particular affinity for seeing how they play out in the relationship with the therapist.

Core Psychodynamic Problems, Comprehensive Case Formulation, and Narrative

Traditional psychodynamic psychotherapy did not focus on diagnosis, either from a psychodynamic or descriptive perspective. It did not matter so much what the diagnosis was, because you went ahead and did the same treatment either way. Psychodynamic formulation, when it was done, was an activity of the therapist and not shared or discussed with the patient; it was almost parallel to the therapy rather than central to it.

PPP starts by identifying the core psychodynamic problem the patient is suffering with. We propose that there are six core problems that are effectively treated with psychodynamic therapy: depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma. These problems are discussed in detail in Chapters 5 and 6. Along with setting up the therapeutic alliance, the therapist's job is to assess the patient and determine which one of these problems (if any)

best characterizes the patient. This seems quite simple, but it was not how prior generations of psychodynamic practitioners were taught.

Identifying the core problem allows the therapist to anticipate the typical descriptive characteristics of the problem and quickly consider the common psychodynamics that go with each. Treatment goals, dilemmas in developing the therapeutic alliance, specific therapy techniques, and common transference and countertransference reactions all revolve around the core problem. If you know the core problem, you will know what to expect in each of these areas, and the road map for the treatment will be quite clear.

Individuals are not reducible to core problems, and this is where comprehensive case formulation comes in. The formulation is the bridge between the core problem and the specifics of the patient's life and history. A comprehensive and pragmatic psychodynamic formulation includes the core psychodynamic problem and the essential psychodynamics (the primary repetitive pathologic scenario), but also nonpsychodynamic neurobiological factors, such as temperament, syndromal and subsyndromal disorders, and the social and cultural context (Compton & Shim, 2015; McWilliams, 1999; Summers, 2002). Chapter 7 shows how to develop a formulation from a patient's history.

A comprehensive formulation includes an articulation of the two-way causality that links dynamic factors and the symptoms associated with psychiatric syndromes. It hypothesizes how the dynamic factors influenced the development of symptoms and syndromes and how the syndromal illnesses affected the dynamics. It is based on a longitudinal history that begins in childhood and includes symptoms, important environmental experiences, life cycle developmental factors, traumatic experiences, medical factors, and the effect of treatments.

Although different aspects of psychodynamic formulation have been written about and studied empirically in the last two decades, they have probably had an impact on clinical practice only in the area of development of brief psychodynamic treatment. Unfortunately, formulations are not widely used in everyday practice.

The PPP approach to formulating patients' problems differs from the traditional one not only in the breadth of the factors included but also in its centrality and transparency. By the second or third session, the core problem should be coming into focus and the beginnings of a formulation should emerge. A few sessions later the core problem and initial formulation can be discussed with the patient. The formulation becomes the shared focus of therapist and patient and can be developed, extended, and amended for the remainder of the therapy. The traditional psychodynamic model rarely diagnoses core problems and takes the position that not enough data are available to make for an accurate formulation early in treatment.

Defining the problem and making a comprehensive formulation often allows for the development of a good collaborative therapeutic alliance. It leads to the effective targeting of symptoms that will potentially respond to psychotherapy and identification of possible obstacles to treatment. The formulation also helps to plan the coordination of the psychodynamic psychotherapeutic interventions with other interventions, such as psychopharmacology, couple or family counseling, or behavioral treatment.

While the ideas that go into the core problem and formulation are based on a collaborative give-and-take with the patient, the task of formulation is the therapist's. By contrast, the development of a life narrative (McHugh & Slavney, 1998; Spence, 1982) is both the therapist's and the patient's responsibility. A narrative understanding of lifetime events, how they relate, and how they come together in the person the patient is now allows a patient to appreciate their strengths, opportunities, advantages, disadvantages, skills, and vulnerabilities. Like a handmade quilt that is pored over, discussed, and worked on together, this careful and collaborative construction is the main work of therapy and also a goal. The narrative is the tangible product of therapy that the patient will appreciate and use. A life narrative will help a patient anticipate how they will react to situations in the future and will help them effectively solve problems and make decisions. It is a basis for realistic and healthy self-esteem (Strupp & Binder, 1984).

A Sharper Tool

Traditional psychodynamic psychotherapy was often described by critics as a "blunt instrument." This means that the technique and the power of the approach are applied to a wide range of problems and done the same way every time. Thus, the therapeutic impact is broad based and not targeted. PPP tries to focus the treatment where it will have the greatest impact and titrates the intensity to the nature of the problem and the goals of the patient.

What does this actually mean? Two key steps in treatment planning are helping patients define their goals and then designing a treatment that will get them there. Directly asking patients about what they hope to achieve is the place to start. Guidance and advice about what can be done realistically helps to set the stage for a successful enterprise. Of course, most patients will not be able to make the extent of change they hope for, but they may be surprised by what they are able to accomplish. A crucial aspect of treatment planning is determining how much to focus on symptoms or areas of difficulty, and how much to work on personal growth and facilitation of life cycle developmental tasks. The distinction between these two areas is not always clear but our experience indicates

that most patients have a strong sense of which of these they are working on, and it is important to maintain the focus where the patient desires.

With a clearer picture of what the patient hopes to achieve, and with the therapist's awareness of the conflicted basis for these treatment goals (remember that even treatment goals are a compromise formation), it is possible to design the treatment using the comprehensive case formulation. This guides patient and therapist to the particular psychodynamic scenarios that should be the focus of treatment.

Because our model identifies nonpsychodynamic dimensions of the patient's problem, targeting the treatment means delivering the psychodynamic aspect of the treatment when the patient is maximally ready. The classic example of this is the severely depressed patient with multiple life stressors and a dysfunctional pattern of dealing with loss, who initially benefits from a symptom-focused treatment, such as psychopharmacology or a highly targeted dynamic or cognitive psychotherapy. Then the patient will benefit from longer-term psychodynamic treatment when the severe depressive symptoms have remitted somewhat. The anxiety-generating aspects of psychodynamic treatment make its use in the initial period contraindicated, but later dynamic work may be effective when the patient is stronger and less symptomatic. Patients who live in acutely stressful life circumstances, including potential abuse or violence, homelessness, or economic instability likely need help getting to a more stable and sustainable living situation before it's helpful to begin to work on their dynamic issues.

PPP is easily combined with other treatment modalities (e.g., psychopharmacology) using the comprehensive formulation as the blueprint. Although the course of treatment is difficult to predict, the core problem and formulation provide a basis for anticipating the course of treatment, including potential symptom relief, maturation, and growth, as well as potential resistances and obstacles. Thus, PPP allows for a more rational basis for combining dynamic and other approaches and recognizes that there are phases of treatment that require more or less psychodynamic attention.

Promoting Change

Personalized psychotherapy means adapting technique to the individual patient. The therapist's strategy for promoting change engages one or more of the six mechanisms of change discussed previously: mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experiences, affect experiencing, fostering adaptive psychological defenses, and enhancing interpersonal patterns. The therapist assesses the patient's strengths and weaknesses and makes an initial

determination about which of these change mechanisms are likely to be more effective for this particular patient. For example, a patient who is insightful but highly avoidant of emotion, might be a good candidate for affect experiencing. A very insecure patient who has the capacity to understand their feelings and those of others, but is acutely sensitive to rejection, would be likely to get results in therapy through the strengthening of the therapeutic alliance and new relational experience mechanism.

Effective therapists evaluate their patients in order to plan therapeutic strategies that take advantage of the patient's strengths to work on their weaknesses. Then they carefully monitor whether their interventions seem to be working or not. Each core psychodynamic problem is associated with typical strengths and weaknesses and this helps in planning the therapeutic strategy. Engaging multiple mechanisms of change is typical and altering the therapeutic strategy based on the therapist's (and patient's) observations helps to optimize the effectiveness of the treatment.

The techniques the therapist uses to promote change are the full range of psychodynamic interventions, from support to exploration and interpretation. Engaging each of the mechanisms of change requires a mix of supportive and expressive techniques. For example, mentalization involves support for and curiosity about narratives regarding the self and others. Fostering insight means relying on the traditional psychodynamic exploration and interpretation of the unconscious (Brenner, 1974; Greenson, 1967). Therapeutic alliance and new relational experience involve support, attention to the here-and-now intersubjective experience, and clarification and interpretation of what is happening in the transference.

Leveraging the effective engagement of mechanisms of change is the focus of much of psychodynamic therapy. The therapist encourages the patient's associations and reflection about current and past experiences, engaging the selected mechanisms of change over and over again. Repeated attempts to deepen insight, or develop mentalizing, or tolerate affects will slowly bear fruit over time. This painstaking work requires patience on the part of the therapist and patient, and frequent observation about the impact on the patient. Fostering adaptive psychological defenses and enhancing interpersonal patterns, the fifth and sixth mechanisms of change, are often employed later in the therapy, when the benefits of engaging the other mechanisms has become apparent and the patient can apply their gains in their relationships and functioning.

Jackie learned that her college-age daughter was gay, and she was distraught. She knew it was important to be supportive; this revelation

was not a choice her daughter was making but rather an aspect of who she was. But it was so disappointing to Jackie, and she was ashamed and confused about why she felt so badly about it. There were times her daughter dressed in an especially masculine way, and this particularly bothered Jackie. Her upset about this progressed to the point where she avoided being alone with her daughter, despite their history of many shared activities and interests.

Through the therapy, Jackie realized that she was dealing not only with the loss of some cherished fantasies about her daughter and how she and her husband would spend time with her and a future family but there were also some specific conflicts of her own. She was the only child of a loving but somewhat demanding mother whom she found oppressive at times. She was covertly angry and never expressed it. It turned out that Jackie interpreted her daughter's lesbian identity as a rejection of herself as a mother. She often interpreted her daughter's behavior as angry and rejecting, just as she felt at times toward her own mother. Her daughter, of course, behaved as she did for her own reasons—her sexual identity was clear to her, and it had little to do with her feelings for her mother. The daughter, it turns out, thought Jackie was avoiding her since her coming out. This made her feel rejected and angry, and she had behaved defiantly and rudely a few times.

Jackie's strengths included her ability to mentalize her secure attachments and ability to tolerate strong emotions. Her weaknesses were her blind spot of self-understanding about what was being repeated from her relationship with her mother in her relationship with her daughter, and her maladaptive defenses and coping strategies for managing the feeling of rejection. Jackie's therapist planned to engage fostering insight into unconscious conflict as the primary mechanism of change, and then subsequently utilize enhancing interpersonal patterns.

After Jackie got clearer about why she was so upset and she realized that her interpretation of her daughter's anger and rejection was wrong, she felt better. But, she was still locked in a negative cycle with her, and when together, she had to do a lot of mental work to remind herself that her daughter was not rejecting her.

In therapy, Jackie was encouraged to confront her fears head on and try some new behavior, such as speaking with her daughter about her concerns. At her daughter's next visit home, she arranged to spend as much time together as possible and asked her about her dating life, friends, and even about her plans in the future about having children. Jackie was worried she would find out how bad their relationship really was, but the opposite turned out to be true.

When Jackie used her increased self-awareness to step aside from her old perceptions (angry daughter, insensitive mother) and try a new interpersonal pattern (interest and engagement), her daughter melted and explained that she was afraid of being criticized and rejected. She was who she was, and she wanted to be close and have a family in the future. Jackie felt immeasurably better. Jackie was able to put aside her more traditional dreams for her daughter once she knew that her relationship with her daughter was different from her relationship with her own mother.

The therapist observed that engaging insight allowed Jackie to understand her feelings more deeply, leading to greater flexibility in managing her mother–daughter feelings. She then addressed her dysfunctional interpersonal pattern effectively by leveraging this new self-experience and greater flexibility to try new behaviors with her daughter that led her to greater relational intimacy and satisfaction.

Transparency

The relationship between patient and therapist is a necessary (but not sufficient) vehicle for therapeutic change in PPP. It is the medium in which the techniques take place, but it is also an irreducible element in healing. The empathic and affective bond between patient and therapist must have a real and immediate element, as well as a transferential and countertransferential dimension. The pragmatic psychodynamic therapist is professional and relatively anonymous in demeanor, but understands the need for engagement and the inevitability of enactment in the fantasies and needs of the patient. For example, the bias is in favor of responding to patients' inquiries and attempts to engage the therapist. Respond to questions first, and you can analyze and understand the interaction later; but do not forget to inquire about how your response was heard and integrated. It is surprising how patients are able to respond to direct communication from the therapists and also maintain curiosity and interest in the transference.

We find transparency about the treatment to be quite helpful. An explanation of the core problem, formulation, treatment methods and alternatives, and even elements of treatment technique is an important element in therapeutic success. This approach is not only consistent with contemporary medical–legal requirements, such as informed consent (Beahrs & Gutheil, 2001), but also increases the degree of reality in the psychotherapy relationship and supports the patient's healthy adult functioning. It includes educating the patient about their problem and the life cycle issues that may be salient. Traditional dynamic therapy involves a more "mysterious" role for the therapist and lacks the emphasis on

explaining to patients what is happening with them and with the treatment.

In medical care in general, the empowerment of patients through increased knowledge, although resisted by some clinicians because it can be upsetting, time-consuming, and sometimes inaccurate, more often than not turns out to be helpful. Providing information is a nonspecific intervention that decreases the frequent sense of being out of control and helps patients select more appropriate treatments that they pursue with more full compliance. Transparency refers to open and full disclosure about issues that are central to the patient's condition, prognosis, and treatment. This does not necessarily refer to therapists' personal reactions that need to be monitored and used carefully. Needless to say, openness to consultation and outside input is also part of a transparent approach to psychotherapy.

SUMMARY

PPP has clearly delineated theoretical principles and techniques. It emphasizes a developmental and conflict model of mental life and organizes treatment around psychodynamic diagnosis and formulation. This treatment approach encourages patient education, greater transparency in the therapist, integration with other synergistic treatment modalities, an active engaged therapeutic stance, and specific attention to change. These characteristics differentiate PPP from traditional psychodynamic psychotherapy and other psychotherapies.

3

Psychodynamic Therapy and Other Therapies

We are healed of a suffering only by expressing it to the full.
—Marcel Proust

In this chapter, we summarize the sweep of psychotherapy history, as it helps to put our pragmatic model in context. We give an overview of the main schools of therapy in the 20th and 21st centuries and comment on the emphasis each psychotherapy places on (1) cognition versus emotion, (2) a technique versus attention to the relationship, and (3) the development of a narrative of the patient's life. We also describe in some detail the five main psychoanalytic theories, as they provide the language used in formulating individual patient dynamics. Finally, we compare CBT with psychodynamic psychotherapy to illustrate the similarities and differences.

PSYCHOANALYSIS

Psychoanalysis was founded on the centrality of drive, unconscious conflict, and fantasy. Other ideas fundamental to this model are the developmental perspective, as played out in normal and pathological developmental struggles, and the insight that psychological symptoms are neurotic solutions to intrapsychic conflict. Although Freud longed for an overarching biological theory, his work on hysteria led him to conclude that there was no biological map that could explain the clinical phenomena he observed. Instead, he developed a psychic map.

Because neither biology nor conscious awareness could explain patients' symptoms, Freud postulated the existence of the dynamic unconscious. To make the unconscious accessible, Freud had the patient

lying on the coach, coming for daily sessions for several months, with encouragement of free association, saying whatever comes to mind. Unlike the Freudian caricature of cold therapist anonymity, lonely free association, and relentless interpretation of conflict, the actual early practice was warm, personal, often even overinvolved by today's standards. Advice and support were ubiquitous. Patients would go on walks with Freud, eat with him on occasion, and even go on vacation with him.

Framed in scientific language and mechanical metaphors, the classic psychoanalytic technique emphasized catharsis and emotional expression and attempted to pair this with insight. It emphasized techniques designed to increase insight and regarded the actual relationship between analyst and patient as less important. A new picture and different understanding of the patient's early and current life was the gold nugget patient and analyst searched for, and this new insight was regarded as the new truth.

Psychoanalysis is interested in ideas and understanding, as well as emotion. It is both a well-described procedure and a new relationship experience for the patient. Narratives are important, although there is the implication that the story developed is true and based on historical reconstruction. Some analysts focus more on cognition and insight than emotion, while some certainly emphasize the patient's new relationship experience with the therapist.

Psychoanalytic thinking branched successively into five main directions over the next 75 years. These schools of psychoanalytic thought—ego psychology, object relations, self psychology, mentalization, and relational—form the backbone of ideas about psychopathology then and now. Each is a worldview replete with assumptions, observations, and terminology, all plausible but not proven. Together the five perspectives make a rich web of connections for understanding a person's life. Our clinical experience leads us to suggest that the core psychodynamic problems are best understood with a multidimensional perspective, but there is usually one or two psychoanalytic models that seem to "fit" each problem and each patient best. We discuss each of these five models, providing succinct summaries after each, in order to compare and contrast the psychoanalytic model with the psychotherapies that evolved over the course of the 20th and 21st centuries.

Each of these theories may speak to you professionally and personally, and may strike you as intuitively accurate or not. As is true with your patients, this affinity likely reflects something about your own background, personal and developmental, and your intellectual experiences. Often people become interested in psychodynamic psychotherapy because they have been exposed to one or another of the theories and they resonate with the depth of understanding that is conveyed. But as

searching and evocative as these theories are, they can rapidly become overly complex, arcane, and difficult to penetrate. Students tend to pick just one and run with it. Our approach is more patient specific: each core problem is best understood using one (or sometimes two) of the theories. We explain the six core problems and associated theories in Chapters 5 and 6.

EGO PSYCHOLOGY

This is the classic theory that earned psychoanalysis respect; it became particularly established in North America. Ego psychology focuses on the theoretical concepts of intrapsychic conflict, the unconscious, and the constant pressure of drives seeking expression. These concepts were the original creative wellspring of psychoanalysis, and sometimes they are also the focus of criticism and jokes about psychoanalysis, as they present a particularly deterministic and reductionist view of the role of base instinct in human life. In this model, the mind contains warring drives (sexual and aggressive impulses) and reactions to these drives coming from the conscience, or superego. The ego attempts to arbitrate, prioritize, plan, and compromise among the impulses, conscience, and the demands of reality. All thoughts, feelings, fantasies, and behavior are conceptualized as resulting from the complex interweaving of these demands and the attempts to resolve them. The ubiquity of conflict and compromise is the major contribution of this model, while its view of the individual as a solely drive-satisfying organism is its downfall.

Superego is the aspect of mind that represents the conscience—that is, the rules and prohibitions about what is forbidden. Thoughts and feelings, as well as behavior, can be forbidden and can be the source of guilt and shame. Conflicts between the drives and the superego are many, and defenses such as repression, displacement, and sublimation are used to manage these seemingly clashing internal needs (Freud, 1926). The ego is the part of the mind that employs defenses, attempting to continuously develop solutions to conflicts. Ego function is the capacity to flexibly and effectively make compromises, and the ego must take account of external reality and the demands and constraints it requires (Freud, 1926).

Ego psychology also focuses on psychosexual development. The distinction between the oral, anal, and genital (or oedipal) phases determines both the form and content of conflicts. Here the sexual and aggressive impulses unfold over time in a predictable sequence and dominate the individual's experience. They represent developmental challenges that must be addressed and resolved. For example, the child in the anal

stage must find a way to satisfy the powerful urges to retain control over their bodily functions while obeying the demands of the parents for toilet training, resolving competing feelings of love and hate, autonomy, and submission. Later, oedipal libidinal urges toward a parent can result in complicated problems of guilt. Problems encountered during a developmental phase leave a fixation, or scar. Defenses patch or contain the unresolved conflict, and these scars are carried forward and express themselves in subsequent situations reminiscent of the earlier ones. Erikson's (1964) work extended these ideas from childhood through the entire adult life cycle. The term *derivative* refers to thoughts, feelings, or behavior that derive from major conflicts. Derivatives are the bits of experience that are often the focus of therapy.

According to the ego psychology model, pathology occurs when compromises do not work very well (A. Freud, 1936). Instead of a smoothly flowing mental life with comfortable and consistent mental functioning, pathology is like lumpy batter, with globs of punitive conscience, slippery impulses, and unstable and dysfunctional behavior.

Ego Psychology

- Id, ego, superego, sexual, and aggressive drives
- Compromise formation results in defenses and symptoms
- Psychosexual developmental stages set the stage for potential conflicts

OBJECT RELATIONS

Whereas the ego psychology model conceptualizes a mental apparatus directed toward satisfying instinctual needs and compromising between internal and external demands, object relations theory emphasizes the primacy of the need for closeness and relationships. The essential urge is toward satisfying and close relationships, not toward sex and war. For the object relations theorist, sex is the sublimation of the love relationship, while for the ego psychologist love is the sublimation of the sex drive. The suckling infant certainly needs food but wants closeness more. Eagle (1984) argues for this theory, citing Harlow's work in the 1950s on young monkeys' preference for soft, yielding cloth "mothers" over wire "mothers," even when the wire "mother" provides food. This line of investigation was further developed by Bowlby (1958) in his work on attachment. According to the object relations model, relationships, and the fulfillment and frustration they bring, determine everything. Winnicott (1953), Mitchell (1986), and Kernberg (1975) are major clinical contributors to this model.

The term *object*—an unfortunately cold word—refers to another person who is the object of one's interest and impulses. But this theory with the cold-sounding name is really quite warm, organized around understanding the patient's early experiences with parents and other caregivers and how those relationships are internalized.

If you close your eyes now and begin thinking of your mother, the visual representation that you summon will be associated with feelings, recollections, and ideas from the past. This is an internalized image, or as the theory calls it, an object representation of your mother. Children internalize those who take care of them. These internal images are called introjections when the child is young. It is like the whole of another person gobbled up and lodged in the child's mind. When the child grows older, these introjections become identifications, and the internal images become more abstract and based on the parent's qualities and attributes—now, along with the image and feeling about the person, the ideas and beliefs the person stands for are in the individual's mind.

Introjects are very different from identifications. An introject might live on if there is a parent who was aggressive, frightening, and abusive. One hears and experiences the introjected parent almost as real, but stuck in one's head. In a healthy relationship, the introject becomes transformed into an identification. Identification is a gentler process; an example of this is the feeling that one is like one's father. According to object relations theory, humans inevitably form introjects and then identifications with important early caregivers, and they live on in us as sources of nurturance, satisfaction, criticism, or guilt.

Healthy object representations are like loving companions. However, when there has been serious conflict, the object representation may be split into a good object invested with loving feelings and perceptions, and a bad object representation invested with hate and negative perceptions. Object constancy is a developmental achievement. It means that important objects are not split, and loving feelings and aggressive feelings toward these individuals are integrated and synthesized. When the caregiver is gone, the child is able to remember the caregiver and feel confident that the goodness and care will return. Object constancy means the individual trusts others. Lack of object constancy means that when the caregiver is gone, the child feels alone and lost because the remembered hate and negativity drowns out the memories of love and affection.

Developing a stable representation of the self is a developmental achievement, too. This is a synthesized, multidimensional picture of one's self that allows for imperfections and incompleteness, but also includes one's best side. Under the stress of powerful feelings of fear and abandonment, or of anger and aggression, there is a tendency to develop

a split self-representation, analogous to the split object representation. This would allow for preservation of a good sense of self, but it would result in alternating, dysfunctional, and uncoordinated responses to others in relationships. We discuss this idea further in the section on the core problem of fear of abandonment in Chapter 6.

Like a play in the theater of the mind, object relations theory emphasizes the internal interactions and conflicts between self and objects, and identifications and introjections. Every new relationship stimulates old scenes, old interactions, and old feelings. Although this sounds highly theoretical, the theory fits with intuitive observations we all make: "That person reminded me of my father, and so I was upset and just reacted."

The central question in ego psychology is What is the conflict and what is the compromise? The central question in object relations theory is What earlier relationship is being replayed, and what self- and object representations are stimulated? The goal of therapy from the object relations perspective is to help patients get in touch with feelings about these old relationships and notice their influence on the present; this helps the patient develop a more comprehensive, realistic, and flexible sense of self and others. Turning old, rigid, and person-like representations into new, flexible, abstract identifications is the goal. The story of Beth, the 31-year-old nurse, was told using the language of object relations. The therapist's conceptualization and the patient's narrative are about the repetition of old dysfunctional relationships and how current relationships stimulate old introjects and identifications and result in painful emotion and dysfunction (e.g., father, boyfriend, therapist). Beth's self-representation and object representations were formed long ago, and her current relationships triggered those old experiences. Her therapy allowed her to rework and reinterpret her past so that these old identifications had less impact on her current experience.

Object Relations

- Primacy of need for and wishes for relationships with others
- Representations of self and other, based on introjections and identifications
- Conflict between internal object representations

SELF PSYCHOLOGY

If ego psychology is about impulses, prohibitions, and defenses, and object relations is about the repetition of old relationships in the form of introjections and identifications, self psychology focuses on the development and maintenance of self-esteem. Kohut (1971, 1977, 1984) and

subsequent contributors (see, e.g., Baker & Baker, 1987) recognized that the development and maintenance of self-esteem is a separate line of life cycle development. Kohut defined the new term, *selfobject*, as an ideal relationship between parent and child where there is optimal empathy and support. For Kohut, narcissism is the problem that develops when there is not enough selfobject function—that is, when the growing child does not receive the empathy needed to deal with the inevitable frustrations of life. The selfobject relationship protects the child from too much disappointment; it provides validation of emotional experiences and guides the child with an optimal mixture of dependence and independence. The selfobject relationship also allows the child to experience some frustration, as this promotes the ability to master life's disappointments. In Kohut's formulation, healthy self-esteem results from this optimal balance of empathy and frustration.

When there is not sufficient empathy and validation, or if there is excessive empathy that does not allow the child to learn to manage problems, the child struggles with terrible feelings of anger, fear, and inferiority. They are unable to contain and modulate these frightening experiences without lasting feelings of shame. Alternatively, there is so much protection that the child never experiences the optimal degree of frustration needed to develop strength, confidence, and independence. Grandiosity and elation are reactions to the child's feelings of inferiority and shame, and this is how impaired self-esteem can show itself in narcissism.

The need for selfobjects is greatest during childhood, but this need continues through adulthood and finds its expression in intimate love relationships, close friendships, and close family relationships. Early problems with selfobjects make it harder to perform the selfobject function for others later in life. In other words, it can be difficult to empathize if one has not been deeply empathized with.

Self Psychology

- Focus on the development and maintenance of self-esteem
- Selfobjects in childhood, providing optimal frustration, facilitate healthy self-esteem regulation, with inner sense of vitality and aliveness
- Psychopathology involves compensatory grandiosity and entitlement

MENTALIZATION-BASED THERAPY

Mentalization-based therapy, created by Anthony Bateman and Peter Fonagy (2012), relies on the notion that central to psychological function is the capacity to mentalize. This refers to the ability to see and

experience oneself, and others, as a psychological being, affected by mood states, motivations, and impacted by the subjective states and behaviors of others.

Mentalization and theory of mind, a mainstay of the conceptualization of autism spectrum disorder, are both metacognitive notions about the ability to see the world through the experience of others, but mentalization emphasizes the affective and relational aspects of this experience, whereas cognition and intention are primary in theory of mind. Mentalization-based therapy, and the theory underlying it, focuses on the normal development of the capacity for mentalization and the adverse experiences that can interfere with its development, whereas autism spectrum disorder is understood as a neurodivergent capacity of the areas of the brain that subserves social communication.

Mentalization theory asks what experiences are necessary to develop the capacity to understand the motivations and experiences of one's self and of others. Healthy reciprocal relationships that include an adequate capacity for feeling understood, affirmation of one's understanding of the other, and allow for subsequent containment and regulation of emotions, facilitate the development of mentalization. The world makes sense to the child, and the child makes sense to themselves.

Disturbed and detached caregiving relationships, with inexplicable responses from others, lack of validation and affirmation of the child's experience of the world, and confused or misleading understanding of others, leads to the inability to mentalize and the use of dissociation. Traumatic experiences are pathognomonic for failure to mentalize. The overwhelming experience of the traumatized person—in acute danger, persecuted and/or powerless, confused and unable to comprehend—makes mentalization impossible. Childhood trauma is an obstacle to the capacity to mentalize and this continues on into adulthood.

The goal of this therapy is the development of the ability to mentalize, which allows the patient to have new experiences of safety, self-containment, and intimacy, which makes dissociation and its sequelae no longer necessary. Epistemic trust, the belief that others have generalizable and meaningful knowledge that can be useful to the patient, is another goal of this treatment.

Mentalization-based therapy attends to both cognition and emotion in that it aims to correct perceptual disturbances and the feelings that go with them. It is much more focused on the therapeutic relationship as a vehicle for the development of mentalization than it is on the specific technical interventions. And the new narrative that evolves is one that is organized around themes of subjectivity and what makes the patient, and others in their life, feel and behave the way they do.

Mentalization

- The capacity to understand one's own subjective experience and the subjective experience of others
- A developmental achievement that can be compromised by trauma, with dissociation and acting out as a result
- Mentalization-based therapy aims to facilitate the patient's capacity for mentalization with explicit validation and affirmation of the patient's experiences of self and other in the present

RELATIONAL PSYCHOANALYSIS

Relational psychoanalysis evolved in the 1980s as an attempt to bring together two related but disparate therapeutic points of view. The early proponents of this point of view were Greenberg and Mitchell (1983), and subsequent writers included Aron, Renik, Stolorow, and Benjamin. The detailed attention paid to interaction in the present, part of the tradition of interpersonal psychoanalysis, as exemplified by Harry Stack Sullivan, Frieda Fromm-Reichmann, and others, emphasized the unique nature of the therapeutic relationship and the personal contribution of the analyst, as well as the patient. This perspective arose in opposition to the sense that the Freudian "one-person psychology" was organized solely around the patient's intrapsychic life, and this seemed to minimize and sanitize the particularities of the analyst's personality, background, and mode of interacting with the patient. Relational psychoanalysis aims to integrate the interpersonal school's attention to the person of the analyst with the object relations model, concentrating as it does on the internal representations of relationships as they occur in the mental life of the patient.

Relational psychoanalysis achieves this synthesis of attention to the co-constructed nature of the therapeutic relationship and the attention to the patient's internalized object relations through the notion of the "two-person psychology." Everything that happens in the therapeutic relationship is a product of the patient and their internalized object relations, and how this interacts with the analyst and their internalized object relations. Understanding this relationship, in all its complexity, is the ultimate focus of therapy and the road to understanding and change.

Relational analysts focus on the lively experience of interaction more than on free association, which can be the iatrogenic result of a therapeutic relationship where the analyst is both powerful and withholding. Aron (1990) wrote,

> Central to a relational, two-person model is the notion that the seemingly infantile wishes and conflicts revealed in the patient's associations are not only or mainly remnants from the past, artificially imposed onto the therapeutic field, but are rather reflections of the actual interactions and encounters with the unique, individual analyst with all of his or her idiosyncratic, particularistic features. (p. 475)

Thus, relational analysts focus on the conflicts in relationships rather than between drives and defenses, and the technique involves a commitment to close attention to the minute-to-minute interaction to determine the contributions of both parties and the subtle manifestations of dissociation that occur in the patient in response to prior traumatic experiences. The patient's interest in knowing the analyst, and exploring their subjectivity, is seen as a natural aspect of the therapeutic process, rather than as a specific transference manifestation (Aron, 1991).

A major contribution of relational psychoanalysis is its interest in, and reflection on, the role of self-disclosure in psychoanalysis. Traditionally eschewed because of the potential to distort the transference and impose an emotional burden on the patient, self-disclosure, appropriate and modulated, is seen as necessary to evoke a genuine and meaningful therapeutic relationship.

Relational Psychoanalysis

- Two-person psychology as a paradigm for understanding patient experience
- Development of a healing relationship through understanding of the patient and therapist's contribution to the therapeutic relationship
- Patient's healthy interest in analyst's subjectivity means some self-disclosure is appropriate and important

The five major psychoanalytic theories (summarized in Table 3.1) used to be primary routes for learning about psychoanalysis and psychodynamic therapy. You learned about psychoanalysis and about psychodynamic therapy by learning about the theories.

We propose a more delimited role for the theories. We recognize the depth, complexity, and rich picture each theory paints of the mind and its pathology, and we regard each as a language that can be used to articulate the nature of individuals' problems. Each theory is particularly valuable for describing particular core psychodynamic problems. For example, the object relations relational models fit the experience of those with fear of abandonment, ego psychology is especially helpful for panic and obsessionality, the self psychology model usefully explicates

TABLE 3.1. Psychoanalytic Theories

Ego psychology	Object relations	Self psychology	Mentalization	Relational
		Key terms		
Drive, superego, defense, ego function, compromise formation	Identification, introjection, self- and object representation	Selfobject, self-esteem, narcissism, grandiosity	Mentalization, trauma, dissociation	Two-person psychology, co-construction of therapeutic relationship, self-disclosure
		Model of conflict		
Drive–defense conflict, derivatives, compromise formation	Conflict between internalized object representations, use of characteristic defenses, such as splitting, projection, introjection	Struggle to achieve healthy self-esteem, loss, frustration with caregivers	Struggle with feelings of dissociated anger, sadness, frustration	Conflicts of both patient and therapist manifested in the therapeutic relationship, patient's conflicts not viewed in a vacuum
		Developmental aspect		
Psychosexual development	Object constancy	Healthy self	Ability to mentalize	Capacity to experience genuine self, awareness of therapist's subjectivity
		Psychopathology		
Conflict between impulses, superego; development of compromise formations that limit function	Split self- and object representations, chronic conflict and anxiety in relationships, use of primitive defenses for managing internal conflict, dysfunctional attempts to solve relational conflict	Intense feelings of inferiority and defectiveness alternating with grandiosity, idealization, and devaluation in relationships; inability to tolerate frustration	Inadequately affirming and validating early relationship and/or trauma leads to inability to mentalize with dissociation and acting out as a result	Dissociation in the face of painful affects that interfere with intersubjective relationship

(*continued*)

TABLE 3.1. (*continued*)

		Concept of health		
Effective compromise formations which minimize anxiety and allow for flexible functioning and satisfaction of needs	Object constancy, well-rounded self- and object representation, stable and satisfying object relationships, less conflicted identifications	Good self-esteem, vigorous assertiveness and tolerance for frustration	Capacity to understand one's subjective experience and that of others	Satisfying and fulfilling relationships with others associated with an understanding of attachment needs, unconscious interpersonal patterns
		Focus of psychotherapy		
Elucidation of conflicts, defenses, compromises, development of more effective defenses and compromises	Awareness of self- and object representations and their conflict, increased integration of split objects, more satisfying relationships and less conflicted identifications	Development of selfobject relationship with therapist that allows for repair to self-esteem and increased capacity for closeness in context of optimally empathic relationship	Focusing on relational experiences, including the therapeutic relationship, with explicit validation and affirmation of the patient's experiences of self and other in the present	Development of truly healing relationship with patient rather than attention to specific insights

low self-esteem, and mentalization may have a special role in treating fear of abandonment and trauma.

SHORT-TERM DYNAMIC PSYCHOTHERAPY

From the earliest days of psychoanalysis, a movement to keep psychoanalytically inspired psychotherapy brief and concise arose in response to more complex theoretical notions and extended treatments. Ferenczi (1926), Rank (1929), and Alexander and French (1946) were the pioneers who recommended an active stance in therapy to hasten the exploration of unconscious material. In spite of their efforts, however, most psychoanalysts and psychodynamic clinicians responded to these ideas by regarding brief dynamic therapy as inferior to the lengthier psychoanalytic treatment.

Not until Malan (1976a, 1976b), Mann (1973), Sifneos (1979), and Davanloo (1980) was brief psychodynamic psychotherapy deemed a valuable treatment option. Malan's emphasis on the importance of careful patient selection through the screening of inappropriate referrals and trial interpretations attracted therapists to the effectiveness of brief dynamic therapy for a subset of the patient population. Malan and Sifneos were among the first to stress the significance of defining and maintaining a therapeutic focus.

Condensing the often theoretically complicated and vaguely described psychoanalytic model, Malan explicitly defined the essence of psychodynamic treatment through the description of two triangles. The "triangle of conflict" has apexes corresponding to defense, anxiety, and an underlying feeling or impulse. The second triangle, known as the "triangle of person," has relationships with current figures, relationship with the therapist (representing transference), and relationships with important figures from the past (e.g., parents) on its three corners.

According to Malan (1979), the therapist's task is to expose the underlying feelings and impulses that the patient has been protecting via defense mechanisms and elucidate the role of the defenses in reducing the anxiety that the feelings create. He posited that the patient's hidden feelings were originally experienced in relation to the parental figures at some time in the past, and since then have frequently recurred with other significant figures in the patient's life, including the therapist. During therapy, the patient must understand the hidden impulses underlying each of the relationships described in the triangle of person. Typically, insight into a current relationship (either with a significant other or the therapist) is achieved first and is then related back to the parental figures. Crits-Christoph and colleagues (1991) considered the writings of Malan (1976a, 1976b), Mann (1973), Sifneos (1979), and Davanloo (1980), the four "traditional" approaches to brief dynamic therapy.

The second generation of contributors to short-term psychodynamic therapy includes Horowitz and colleagues (1984), Luborsky (1984), Strupp and Binder (1984), and Weiss and colleagues (1986). This new group, like the emerging cognitive therapists (e.g., Beck, Rush, Shaw, & Emery, 1979), can be distinguished from previous generations by their greater interest in the empirical status of their treatment approaches. Perhaps resulting from their interest in research, this new generation has written intricately detailed descriptions of their clinical approaches that are very helpful for training and monitoring clinicians in the adequate use of their techniques. In fact, many of these books are considered treatment manuals and have been used in empirical research addressing the efficacy of these therapeutic methods.

Abbass and colleagues followed the work of Davanloo (1980) with their intensive short-term psychodynamic therapy, which has been studied in a wide range of rigorously designed clinical trials, including for treatment-resistant depression (Town, Abbass, Stride, & Bernier, 2017; Town et al., 2020). Other contributions of this generation of sophisticated clinician-researchers are Diana Fosha's (2021) accelerated experiential dynamic psychotherapy, Hana Levenson's continuation of the work of Hans Strupp and Jeff Binder (1984), and George Silberschatz's contribution adding to the tradition of Weiss and colleagues (1986).

CORE CONFLICTUAL RELATIONSHIP THEME

The CCRT method was developed by Lester Luborsky (1977), another third-generation clinician and researcher whose work has received meaningful research support (e.g., Leichsenring & Leibing, 2007). The CCRT method is a way to formulate and formalize core conflicts or central issues, and this can be included in a more comprehensive dynamic formulation of the patient's problems. The CCRT has received a great deal of research attention (see Luborsky & Crits-Christoph, 1998).

At the center of the CCRT are data extracted from patients' spontaneous narratives about their interactions with other people. The CCRT has three components: what the patient wants or desires from the other person (wish); how the other people react (response of other [RO]); and how the patient, or "self," reacts to their reactions (response of self [RS]). The following example of a CCRT formulation is provided by McAdams (1990):

> a man[']s] first memory was that of being held in his mother's arms, only to be summarily deposited on the ground so that she could pick up his younger brother. His adult life involved persistent fears that others would be preferred to him, including extreme mistrust of his fiancée. (p. 441)

In this man's narrative recollection of an early interaction with his mother, the wish expressed is "wanting to feel securely loved by mother"; the mother's response (RO) is "rejection," and the boy's response to this rejection (RS) is "mistrust" (Thorne & Klohnen, 1993).

The recurrence of CCRT components (wishes, ROs, and RSs) across relationships forms the person's overall CCRT. The assumption is that these recurring themes capture the central relationship patterns or schemas that underlie a person's typical ways of relating to other people. These central relational patterns are thought to be the product of highly ingrained patterns of relationship with significant others, especially

emotionally laden interactions with parental figures in the earliest years of life (Bowlby, 1988). Thus, CCRTs can be considered to be components of dynamic character structure (Wiseman & Barber, 2008; Wiseman & Tishby, 2021) and are highly relevant to the formulation.

The CCRT and other short-term dynamic psychotherapies have a strong influence on our pragmatic approach because they distill the essential features of the psychoanalytic tradition—a balance between the cognitive and emotional aspects of treatment, and an interest in both technique and a new relational experience for the patient—and they explicitly recognize the development of a new narrative (see, e.g., Strupp & Binder, 1984). Short-term dynamic psychotherapies also attempt to focus on the problems needing the most attention, with the understanding that effective work on those key problems will allow the individual to regain a healthier developmental pathway.

COGNITIVE-BEHAVIORAL THERAPY

CBT integrates aspects of both behavior and cognitive therapies and emphasizes changes in both cognition and behavior. The Skinnerian and Pavlovian behavioral models and learning theories are the conceptual basis of behavior therapy, which identifies dysfunctional behavioral strategies for managing anxiety and other unpleasant experiences. According to this model, the symptom is the focus of treatment, rather than some underlying condition or "disease." Treatment involves the systematic dismantling of these dysfunctional behaviors and their replacement with more effective and adaptive behaviors. A detailed examination of subjective experience and behaviors is the basis for designing treatments where new behaviors can be tested, learned, and routinely applied.

Behavior therapy is the epitome of an experientially based treatment, because it is the new experience itself that allows for change. No new narrative is developed, because the treatment does not focus on the meaning of thoughts and feelings. In this model, the new behavior precedes new thinking and feeling. Thus, behavior therapy emphasizes both the technique and the experience of treatment and regards narrative understanding as less important.

Whereas behavior therapy emphasizes the primacy of behavior, cognitive therapy regards cognition as central. From a psychodynamic perspective, Aaron Beck and colleagues' (1979) cognitive therapy seems to continue the tradition of ego psychology by further emphasizing the "rational" aspect of human nature, and deemphasizing its "irrational" counterpart. But for Beck, the irrational is not motivated by unconscious forces, it is the result of faulty thinking that can be corrected.

Furthermore, Beck added aspects of activity and transparency to the therapy by being very goal directed during the session and explicit with clients about what he intends to do. He initially focused on the treatment of a single disorder, depression, and included a variety of helpful behavioral interventions, such as the scheduling of pleasurable activities, in order to get the patients active. One of his significant contributions was to use evidence from systematic research to elaborate his theory and to evaluate the efficacy of his interventions. Most recently, Beck's cognitive therapy has been applied successfully to anxiety disorders, personality disorders, and even schizophrenia (Rathod, Kingdon, Weiden, & Turkington, 2008). Not unlike early psychoanalysis, the scope of cognitive therapy is widening, and now includes more complex and difficult cases (J. S. Beck, 2005). Therefore, the treatments are not always short.

Cognitive therapy departed from the psychodynamic tradition by emphasizing the role of cognitions and attitudes in the genesis of feelings and behavior. Furthermore, Beck suggested that the best way to change cognition is to provide the individual with new data. Cognitive therapy's standardized assessment, outcome, and training techniques have led the way to modern empiricism in the field of psychotherapy. Because of its focus on empirical validation, cognitive therapy has been able to clearly define its target and its methods and consequently demonstrate effectiveness in a wide variety of conditions. Compared to psychodynamic psychotherapy, as its name suggests, cognitive therapy clearly relies on a more cognitive and less emotional understanding of the psychotherapy process. It is more focused on technique than on the therapeutic relationship experience and has little interest in the development of a new narrative.

If the "first wave" of CBT was Skinner and the behaviorists, and the "second wave" was Beck and his formulation of cognitive therapy, the "third wave" of CBT includes a broader array of interventions that include mindfulness, a focus on acceptance, and a move beyond symptom reduction to a more broadly enhanced experience of living. Acceptance and commitment therapy (Hayes, 2004) involves systematic attention to experiencing, accepting, and making workable painful and unpleasant feelings leading to a way of living that is more adaptive and fulfilling. Dialectical behavior therapy (Linehan, 2014), involving individual and group components, offers a range of techniques to address acute distress and suicidal behaviors. Last, schema therapy evolved as an integration of CBT, psychodynamic, and Gestalt therapies, targeting treatment-refractory patients (Young et al., 2006).

We refer to CBT throughout this book as an umbrella term, rather than cognitive therapy, behavior therapy, dialectical behavior therapy, or acceptance and commitment therapy, as the work in this area

increasingly involves the amalgamation of these approaches. For example, some contemporary behaviorists (see Foa, 2011) have reformulated their exposure work into a more cognitive language. It is interesting to note that CBT in this broader sense encompasses attention to both cognition and emotion and emphasizes both procedure and new experience, while the development of a new narrative is still not of great importance in this treatment model.

PSYCHODYNAMIC PSYCHOTHERAPY COMPARED WITH COGNITIVE THERAPY

Because CBT is the predominant alternative to dynamic therapy, it is especially important to understand the differences and similarities between them. However, because CBT includes a wide range of theories and techniques, we decided to focus our comparison of dynamic therapy to only one model of CBT—namely, cognitive therapy. Both psychodynamic therapy and cognitive therapy aim to reduce painful affects, bringing out aspects of the patient's experience that were heretofore unclear, and both treatments aim to make perceptions more accurate. But their approaches are quite different. We contrast the two techniques in a variety of domains (summarized in Table 3.2).

Both psychodynamic and cognitive therapies regard patients' understanding of their situations as essential data. How patients perceive and process their experiences and the meanings they attribute to them are central. The cognitive therapist focuses on identifying core beliefs, cognitive rules and assumptions, and the repetitive negative automatic thoughts they generate. The traditional psychodynamic therapist deals in associations, feelings, wishes, fears, and fantasies, and includes thoughts, but regards them as likely secondary to feelings. Relationships and feelings about relationships are most important for the psychodynamic therapist. However, as we noted above, some dynamic models are more cognitive than others (e.g., control–mastery theory) and some therapists put a greater emphasis on cognitions than others.

In cognitive therapy, the therapeutic relationship is a vehicle for facilitating learning for the patient, not an important focus in and of itself. Following the dictum of "If it ain't broke, don't fix it," the cognitive therapist does not focus much on the therapeutic relationship unless it is threatened or the pathogenic beliefs cause a rupture. Beck recommends a good ongoing collaboration, which he calls "collaborative empiricism" (Tee & Kazantzis, 2011). The psychodynamic therapist has an active interest and a focus on the therapeutic relationship. It is an opportunity to observe repetitive patterns and also allows the patient a new kind

TABLE 3.2. Comparison between Psychodynamic and Cognitive Therapies

Cognitive therapy	Psychodynamic therapy
Therapeutic relationship	
• Relationship rarely the focus of discussion • Relationship required to enable learning	• Relationship may be important focus of discussion • Relationship required to enable learning • May observe patterns in transference • Relationship is corrective emotional experience
Focus	
• Automatic thoughts • Thoughts and cognitions • Core beliefs about the self and world • Schemas • Symptoms • Beliefs about others	• Associations • Feelings, motivation • Wishes and fears • Fantasies, traumatic scenarios, mechanisms of defense • Present and past, character or long-standing traits • Interpersonal relationship patterns
Main techniques	
• Identification of automatic thoughts and schema • Exposure • Evaluating evidence for beliefs, homework • Problem solving, developing skills	• Looking for repetitive patterns • Uncovering meaning • Interpreting defenses, resistances, transference • Understanding, working through
Process of treatment	
• Highly structured to maintain focus • Transparent • Education, therapist is explicit	• Less structured to access less conscious material • Abstinent • Minimal education about treatment
Mechanisms of change	
• Changing underlying beliefs • Teaching compensatory skills or strategies • Changing behaviors	• Increasing self-awareness • Working through, developing new perceptions • Improving relationships, trying new behaviors
Underlying assumptions	
• Problems = symptoms • Remove symptoms = remove the problem • Sometimes changing underlying beliefs is required	• Problems are not necessarily the symptoms • Improving adaptation to conflict is solution

of positive relationship experience. In Beth's treatment, the therapist was interested in her sudden upsurge of suspicion when he suggested a course of action with her boyfriend. This became a window for examining her tendency to be dependent and then angry and mistrustful. The therapist was careful to let this reaction blossom and then explore it. A cognitive therapist would most likely have maintained the collaboration by encouraging a thoughtful evaluation of the reality of the mistrust; from the cognitive perspective, healthy evaluation of relationships is an important social skill that needs to be developed, especially for people with troubled relationships or social phobias.

The cognitive and psychodynamic perspectives focus on different aspects of mental life. Where the cognitive therapist sees automatic thoughts, cognitions, and core beliefs, the dynamic therapist sees associations, feelings, motivation, wishes, and fears. In CBT, schemas are the legacy of the past and the driver of perceptions and current ideas, causing symptoms and beliefs about others. In a parallel fashion, fantasies, conflicts, and defenses are the vehicles through which the past influences the present in psychodynamic therapy, and they determine character traits, attitudes, and relationships. Beth's therapist let her associate and tended to let her flow of thoughts and feelings structure the sessions. A cognitive therapist may have organized the time and led the patient through a sequence of activities that would help to demonstrate pathogenic schemas and their reflection in the patient's automatic thoughts and facilitate the ability to correct these.

The main cognitive techniques are identifying automatic thoughts and pathogenic thought patterns reflected in the content of the sessions, behavioral homework, and the use of special questionnaires like the triple-column thought record. Exposing the thought patterns allows for evaluating their accuracy and reality, and thus decreases their power. Once the automatic thought is exposed, cognitive therapists ask the three basic questions: (1) What is the evidence for the belief?, (2) Is there an alternative way of looking at the situation?, and (3) What are the implications of the belief? Because cognitive therapy also involves behavioral techniques, assignment of behavioral activation tasks helps to decrease depression, while exposure to feared stimuli is used to decrease anxiety (through desensitization, habituation, or cognitive reframing). The psychodynamic therapist looks for painful emotions and elicits the thoughts, feelings, memories, and associations to these painful experiences, searching for repetitive patterns and uncovering their meanings and historical roots. The work aims to expose to conscious awareness a repetitive pathogenic scenario through interpreting resistances, defenses, and transference, allowing the patient to work through old experiences and change feeling, perception, and behavior. Beth's therapy

revolved around her increasing understanding of a recurring scenario involving dangerous men and abusive experiences. She became aware of this repeating pattern and how it played out in her relationships. This understanding was elicited through observing Beth's associations and memories and by helping her sort through her various defensive strategies for minimizing her painful recollections. Cognitive therapists may also target the recurring pattern but would access it via distortions in thinking and then use cognitive techniques for correcting inaccurate thoughts.

Cognitive therapy is relatively more structured than PPP, and the therapeutic process is transparent, with explicit education about the treatment. Psychodynamic therapists tend to avoid too much structure, preferring instead to facilitate patients' access to less conscious material by giving them support, empathy, time, and space. The therapist's traditional abstinence and neutrality help this. Minimal explanation about the procedures and mechanisms of psychodynamic treatment is given for the same reason. Beth's therapist provided enough support that she felt comfortable expressing her deeper and less rational feelings; the therapy was open-ended and unstructured, which allowed for some regression and a greater ability to observe the transference. There was less education and description of the treatment and why these techniques were used—the therapist wanted to let the relationship unfold. If Beth were in cognitive therapy, the tasks of therapy and the reasons for them would have been more clearly specified and transparent.

The hypothesized primary mechanism of change in cognitive therapy is modification of underlying beliefs and assumptions. Changes in core or surface beliefs are thought to lead to changes in emotions and in perceptions of self and others. Compensatory skills and strategies are also taught (Barber & DeRubeis, 1989, 2001; Bruijniks, Los, & Huibers, 2020) with the goal of bolstering new, more adaptive, and accurate beliefs. In CBT in general, the symptoms tend to be the problems, and when the symptoms are removed or decreased, the problem is solved. However, in some forms of CBT, and in most accounts of cognitive therapy (e.g., J. S. Beck, 2005), there is a belief that the underlying schemas need to be changed to prevent relapse. The mechanism of change in psychodynamic psychotherapy emphasizes increasing awareness of repetitive patterns regarding self and others, leading to less painful affects, new and more adaptive perceptions, and new behaviors with others (especially improved relationships). The problem is the power of the old, partly unconscious, repetitive patterns that are reflected in symptoms, and the problem is solved when the maladaptive power of the pattern is decreased, not only when the symptoms are decreased. It

is noteworthy that there is not much empirical evidence that changes in schemas are responsible for change in cognitive therapy (e.g., Barber & DeRubeis, 1989). In cognitive therapy, Beth most likely would have been seen to suffer from depression. In psychodynamic therapy, her problem is the destructive feelings stirred up in close relationships arising from her traumatic past; better relationships and getting better from depression depend on working through these feelings.

INTERPERSONAL PSYCHOTHERAPY

With its historical roots in the interpersonal psychoanalytic perspective of Harry Stack Sullivan (1947), interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) was empirically derived by looking for factors that predicted successful resolution of depression from psychotherapy. Interpersonal psychotherapy conceptualizes depression as a result of neurobiological vulnerability and role transitions that require flexibility and adaptation. This therapy includes education about depression and was designed specifically for depression. Subsequent study of interpersonal therapy has shown efficacy for posttraumatic stress disorders (PTSDs), and especially a history of sexual trauma (Markowitz et al., 2015; Markowitz, Neria, Lovell, Van Meter, & Petkova, 2017).

Some see interpersonal psychotherapy as a modified form of focused psychodynamic psychotherapy, while others regard it as a unique format. It has a strong narrative component and offers the same specific narrative to all patients: The patient has an illness (depression), and it has affected their life in many negative ways. The patient has had losses that need to be mourned in order to make a new adaptation to the new circumstances. Interpersonal psychotherapy involves both cognitive and emotional elements and emphasizes technique more than new experiential elements. In interpersonal psychotherapy Beth would have seen the cause of her depression as resulting from her biological vulnerability and the breakup with the boyfriend. Her difficulties in developing a new adaptation to being single would be the primary focus.

HUMANISTIC PSYCHOTHERAPIES

Other modalities of individual psychotherapeutic treatment, including client-centered therapy, developed by Carl Rogers (1959, 1961), Milton Erickson's unique psychotherapeutic technique (Erickson & Rossi,

1981), Gestalt therapy (Greenberg & Watson, 2005; Perls, Hefferline, & Goodman, 1951), experiential therapy (Elliot, 2001), and existential psychotherapies (May 1969a, 1969b; Yalom, 1980), have generated significant interest and activity. Emotion-focused therapy (Greenberg & Iwakabe, 2011) is a time-limited therapy combining client-centered elements (unconditional positive regard, congruence, and empathy) with experiential interventions designed to facilitate and deepen emotional processing. The goal of the treatment is to help patients become aware of, accept, and make sense of their emotional experience.

These approaches have influenced many practitioners, but they do not seem to have become dominant forces on their own. Some of their ideas seem to have been integrated into eclectic practice. For example, the importance of therapist empathy and the need to communicate sincerity and acceptance to patients is an important and lasting legacy of client-centered therapy, while flexibility and an active and engaged, almost playful, attitude was encouraged by the Ericksonian tradition. Similarly, experiential therapies, such as Gestalt therapy, emphasized the intensity of experience in the present, and have been assimilated by some therapists in their focus on patients' experience during therapy.

SYSTEMS THEORY, COUPLE THERAPY, AND FAMILY THERAPY: COMBINING TREATMENTS

Systems theory, and its impact on marital, couple, and family therapy, represents another major development in psychotherapy in the modern era (Becvar & Becvar, 2017; Glick, Rait, Heru, & Ascher, 2015). The recognition that dysfunction and pathology reside in relations between people and not simply inside people resulted in the development of treatment approaches that focus on the interconnections and relationships with the family: reciprocal attachment styles (Johnson, 2017), communications, and feedback loops of behavior (Gottman, 2016b). These offer a new and powerful set of tools that can be used as a primary treatment or in conjunction with individual psychotherapies. Culture is a critical factor in understanding families and systems, and careful attention to the larger system in which an individual is embedded allows for broader possibilities for collaboration and more creative treatment. Depending on the family/systems approach, cognition and emotion may each be a primary focus, and the patient's experience of treatment is important, as are the specific technical procedures. A new narrative picture of the family system is an important goal of these treatments.

RECENT TRENDS

This history of the arc of psychotherapies in the past 100 years helps to place psychodynamic therapy. What are the trends that will help us anticipate the psychodynamic therapy of the future?

Following the decade-long trend toward more diagnosis-specific psychotherapies, which resulted in research demonstrating robust outcomes for psychodynamic therapy (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014), CBT (Foa & Rothbaum, 1998), interpersonal psychotherapy for depression (Markowitz et al., 2015), the cognitive-behavioral analysis system of psychotherapy (CBASP), and an integrative cognitive therapy for chronic depression (McCullough, 1999), the field has reversed direction and become more interested in transdiagnostic thinking. Pressing questions are: What are the mechanisms of change in psychotherapy, and how can they be harnessed to evolve more effective treatments and better matching of patients to treatments? This is closely connected to the notion of personalized medicine, or individually tailored psychotherapy. These questions are addressed in depth in Chapter 10.

Routine outcome monitoring is another important trend. When patients provide checklist feedback to therapists prior to every session, there seems to be a marked positive impact on outcome. This suggests that attention to matching specific techniques to patient experiences at particular moments may enhance therapy effectiveness. Because this exciting finding cuts across a range of diagnoses, it adds to the increased attention to transtheoretical and transdiagnostic factors in psychotherapy technique and outcome.

The rise of telepsychotherapy, turbocharged by the pandemic, and now embraced with enthusiasm by patients and therapists alike, was a product of necessity and now we will live with it. This has raised many interesting questions about therapy access, the necessary conditions for evolving a strong therapeutic relationship, the importance of body language, and boundaries when patient and perhaps therapist are in personal rather than professional spaces. We consider these questions in detail in Chapter 13.

One cannot discuss modern-day psychotherapy without considering the role of psychopharmacology. Every new psychopharmacological development has advanced our thinking about the mind and about psychotherapy. The effectiveness and frequent use of psychopharmacology challenges psychotherapy theory and technique by raising questions about the essential nature of psychopathology, which modes of intervention are most effective, and how and when psychotherapy and

psychopharmacology should be combined. Practical and theoretical questions are still unsettled about how these two approaches can be integrated to optimize the effectiveness of each (Guidi & Fava, 2021), while new psychodynamic techniques and conceptualizations to enhance psychopharmacological effectiveness have been proposed but have yet to be tested (Mintz, 2022; see Chapter 14). There is surprisingly little evidence supporting the use of combined treatment (Barber et al., 2021; Keller et al., 2000; Thase et al., 1997). Indeed, in anxiety disorders, there is evidence that CBT in combined treatment has a less enduring effect than when delivered on its own (Barlow, Gorman, Shear, & Woods, 2000).

SUMMARY

In summary, psychodynamic therapy was the first psychotherapy of the modern medical and psychological era and it has spawned a broad range of treatments with a wide range of applications. The psychotherapies vary as they reflect the inherent tensions between emotion and cognition, healing subjective experience versus technique, and they may focus more or less on new narratives (see Table 3.3). The field of psychotherapy may be moving more toward a unified and transtheoretical model of treatment, away from a focus on specific diagnoses, and toward individual tailoring of therapy, telepsychotherapy, and real-time outcome monitoring.

TABLE 3.3. Essential Elements of the Psychotherapies

Psychotherapy	Cognitive versus emotional	Procedure/technique	Role of narrative
Pragmatic psychodynamic psychotherapy	Cognitive = emotional	Experience = technique	++
Freudian psychoanalysis	Cognitive = emotional	Experience < technique	++
Ego psychology	Cognitive = emotional	Experience < technique	++
Object relations	Cognitive < emotional	Experience = technique	++
Self psychology	Cognitive < emotional	Experience > technique	++
Mentalization-based therapy	Cognitive = emotional	Experience > technique	+
Interpersonal psychoanalysis	Cognitive < emotional	Experience > technique	++
Short-term dynamic psychotherapy	Cognitive = emotional	Experience < technique	+
Cognitive therapy	Cognitive > emotional	Experience < technique	+
Behavioral therapy	Cognitive < emotional	Experience > technique	
Interpersonal psychotherapy	Cognitive = emotional	Experience < technique	++
Couple and family systems therapy	Cognitive = emotional	Experience > technique	+
Group therapy	Cognitive < emotional	Experience = technique	+
Interpersonal psychoanalysis	Cognitive < emotional	Experience > technique	++
Gestalt therapy	Cognitive < emotional	Experience > technique	+
Humanistic–Rogerian psychotherapy	Cognitive < emotional	Experience > technique	

PART II

OPENING PHASE

4

The Therapeutic Alliance

Goal, Task, and Bond

I felt it shelter to speak to you.
—Emily Dickinson

The therapeutic alliance is the holy grail of psychotherapy effectiveness because of its special role in the empirical literature on outcome and its intuitive appeal to practitioners. The therapeutic alliance is a relationship created by the patient and therapist that cuts across many types of psychotherapy. It begins even before the first contact with the feelings and fantasies the patient and therapist have about each other.

We clinicians all think we are above average in our ability to develop a therapeutic alliance; after all, most of us were told for years before becoming therapists that we are "good with people." What is this generic interpersonal skill? Is it something that can be taught, or something given?

Like the songbirds that need to hear songs at critical periods to develop the ability to sing, we need early relationship attunement and subsequent rich interpersonal lives to develop and hone this ability. There is a neurobiological component to the ability to form an alliance. Facial recognition and the capacity to conceptualize others as thinking, problem-solving, emotional entities are hardwired aspects of brain function (Baron-Cohen, 1997). Mirror neurons fire in the same areas of our brains that neurons are firing in the brains of those with whom we empathize, and this wiring gives us access to important data (Rizzolatti, 2005). Social and emotional intelligence is built upon these capacities. If psychotherapy is a highly specialized form of social interaction designed to promote emotional learning, then social interactional skills, which

have been found to facilitate neuronal plasticity (Shamay-Tsoory, 2022), are surely critical to what makes the alliance therapeutic.

But what makes one easygoing with new acquaintances, judicious and reasonable with loved ones, and a social success is not what allows one to develop a therapeutic alliance. The ability to balance closeness and separation, nurturance and reflectiveness, and ambition and acceptance, marks the sensibility of a therapist who has a strong therapeutic alliance with a patient. Learning how to develop a therapeutic alliance is like learning to play a sport: the basic materials must be there, but the ability can improve over time with attention and practice.

It is usually apparent to the therapist when a strong therapeutic alliance fails to develop. Something falls flat in the interaction, and there is a feeling that you and the patient are missing each other. You feel you are not reaching the patient and not meeting their needs; or the patient seems satisfied, but you have no idea why, and you do not feel you are really contributing anything. On the other hand, when the alliance is strong, there is a safe space for patient and therapist to be together, for the patient to share troubling or shameful thoughts and feelings, and for the therapist to have the time and space to formulate their observations and notice their reactions. And there is the flexibility that is so necessary in any close, attuned relationship.

This chapter reviews the concept of the therapeutic alliance, gives clinical examples, reviews the literature on learning how to develop a therapeutic alliance and some characteristics of effective therapists, and concludes with specific techniques and approaches you can use to facilitate the alliance.

CONCEPT OF THE THERAPEUTIC ALLIANCE

Referred to variously as the therapeutic, working, or helping alliance, the idea that the therapeutic relationship is important for therapeutic success was foreshadowed by Freud's (1912) comments on the positive feelings that develop between doctor and patient. Subsequent psychoanalytic writers, such as Greenson (1967) and Zetzel (1956), articulated this concept more fully, distinguishing between the "real" and adaptive dimension of the treatment relationship and the transferential and fantasy-laden aspect. In his client-centered therapy, Rogers (1965) identified the empathic bond between the patient and therapist as the essential therapeutic agent in treatment.

Although the concept of the alliance has emerged historically in the psychodynamic literature, the strength of the collaborative relationship between patient and therapist has been recognized as crucial

by therapists from different theoretical backgrounds. Most theorists, including Beck and colleagues (1979), emphasize the establishment of the patient–therapist relationship as an important first step of treatment. There is evidence suggesting that a trait-like component of the alliance, present in patients, is similarly expressed in different types of psychotherapies, while there is a state-like aspect that may be distinct among the therapies (Zilcha-Mano, 2017).

The correlation between therapeutic alliance and outcome has been extensively studied and estimated to be .275 in the most recent and comprehensive review (Flückiger et al., 2018), and the ongoing chicken-or-egg question of whether a better alliance causes better outcome or early improvement causes a better alliance has been largely resolved by the finding that early alliance predicts subsequent change in depression (Barber et al., 2000).

Goal, Task, and Bond

Seeking to operationalize this concept and apply it more generally across psychotherapies, Bordin (1979) identified three components of the therapeutic alliance: goal, task, and bond. He saw the therapeutic alliance as a mutual construction of the patient and therapist that includes shared goals, recognition of the tasks each person is to perform in the relationship, and an attachment bond. His clarification of the components of the therapeutic relationship is helpful in thinking about how therapists can build their skills by developing the therapeutic alliance.

> George was a 42-year-old cisgender married White heterosexual man who came for consultation in a crisis. His partner was 3 years older than he, and they had been married for 15 years. She had just told him she was having an affair with a colleague following a long-standing and close work relationship. The two had traveled to meetings together, often working late into the evening. George had been unhappy and worried about that relationship, discussing it often with her over the preceding several years. His wife had always reassured him that the relationship was platonic, but she had just revealed to him that the other relationship had become sexual, and she wanted to leave the marriage. George and his wife parented well together and were both devoted to their three preteenage daughters.
>
> George was honest and likable in the initial interview. It was easy to empathize with his plight. He was tearful, angry, and shocked. He expressed righteous indignation about the wrongs his wife had committed, and seemed to be realistic and brave about bearing up to the loss of his marriage. He was very angry, and the end of the

marriage seemed inevitable. He was distraught about his children and the impact this would have on them. His father had died when he was 10 years old, and he had grown up with his mother as the sole parent.

George was very open, and the first two or three sessions were full of information and emotion. There was the sense of a patient starting an active and engaged therapy, but I kept having a feeling in the session that when he finished a topic there was a long pause until I asked a question. I was not sure what to ask him about and what to explore.

George told me he had a lifelong best friend, and he spoke with him often and told him about what he was going through. He was not sure that he needed to come to the therapy just to feel things and express himself; he was doing plenty of that already. He did not think that his marriage was repairable, and even if it was, it was pretty clear to him that his wife did not want to repair it. He felt he was going to try his best to work with her to minimize the impact on the kids, and develop a plan to co-parent while living apart.

I kept asking myself, what are we doing together in the sessions? George was accepting the losses, had plenty of supports, seemed to be functioning well, and was practical and realistic about how to work with his partner to take care of his daughters. He was talking about all of this. Was he too well adjusted to really need therapy, or were we missing something?

Do you think the patient and therapist are off to a good start? What is the meaning of the therapist's feeling that there was something going on in the silences, and the sense of not knowing just what they were working on? Bordin's (1979) perspective can help to understand this better. What was happening in the therapeutic relationship in terms of goal, task, and bond? Task refers to each person's role in the therapeutic dyad. The patient's job is to come to the appointment, describe their thoughts and feelings honestly and openly; try to listen to, understand, and accept the therapist's observations; and maintain an active and collaborative stance. When the time comes, it is also their job to try to employ the understanding they have gained and consider how they could change and then work on making that happen. The therapist's job is to listen hard, use all of their resources to understand, become aware of and manage biases, develop an understanding of the patient, and effectively share this understanding (Luborsky, 1984). They should facilitate new perceptions, new approaches to solving problems, and new potential behaviors. The therapist must be open to the patient, but provide input and assistance.

With George, the task component of the working relationship was going well. He was certainly doing all that one would hope for. He was

describing his life and his experience, both emotionally and practically, trying to understand the events, and maintaining an open interest in anything the therapist said.

Bond refers to the attachment between patient and therapist. It is the emotional link. Does the patient feel safe in the therapy and feel a sense of warmth and empathy from the therapist? From the therapist's perspective, is there a feeling of emotional engagement or the particular feeling of caring with some distance that allows us to do our best work? Here, too, George and the therapist seemed to be doing well. He expressed a sense of comfort and trust and seemed to feel that the therapist liked him, cared about his situation, and felt engaged with him in his troubles.

Goal refers to the shared goals of the therapist and patient. What is the patient working toward, what do they want to understand or change? What is their ambition in therapy? What area of their life do they want to do something about? The therapist must understand the patient's goals and work toward them as well. For example, if the therapist sees the problem as depression and difficulty with closeness, and the patient thinks the problem is a parenting issue with a difficult child and an unhelpful spouse, not only are the pictures of the difficulty different but the goals will be also. The therapist will address the depression, expecting the other problems to improve as a result, but the patient will feel blamed and misunderstood by the therapist.

I realized that what was missing in the developing therapeutic alliance was clarity about George's goals of therapy. What were his goals, and what was in my mind? I had asked him in the first session what he wanted to get out of therapy, and he said that he needed help "talking it out" and surviving the ordeal. I had agreed that this was a reasonable and sensible goal, but now I wondered whether we meant different things by this.

Toward the end of the second session, and then several times again in the following two sessions, I commented that George seemed to have put up with a lot from his wife over a long period of time. He knew there was something wrong in the marriage, and he had felt that her close relationship with her colleague was a symptom of that. She continued that relationship despite his repeated expressed concerns. I said it was striking that he had felt upset and frustrated but had gone along with the relationship as it was for years. Why was this, and while he had tried to ignore it, what had he known or worried about all along? What were his disappointments with her, his contributions to the relationship unhappiness, his ideas about what could have been done, or should have been done, to alleviate their problems?

When I suggested this, George became suddenly more alert and looked me directly in the eye. Up until now, he had been talking in sessions, but I realized that I felt it was not really to me. When I wondered aloud about his feelings and his role in the marital breakup, he responded that he did not know exactly what I meant, but he thought there was something true about it. He had always been agreeable, and maybe he tried harder than most people would have to meet his wife's needs. Maybe he tended to be this way in general, but what was the matter with that? I realized that he had been rather agreeable with me, too, and we had not really connected.

By the fourth session, the therapeutic alliance seemed more set. This consolidation of the alliance happened as we had had clearer shared goals. The therapy would be partly about expressing the hurt, loss, and fear George was experiencing, but it would also focus on his way of experiencing relationships, his characteristic way of handling his upsetting feelings, and perhaps, what this had to do with his own childhood. Answering the question of why he kept going the same way in the marriage when he knew there were such serious problems was a new shared goal.

This example illustrates how the therapeutic alliance is more than just having a relationship with the patient. It shows the close interrelationship between the three components and how the therapeutic alliance was cemented when the goal was clarified. Effective performance of tasks and shared goals will facilitate the bond because the patient feels closer when the work is going well. The bond in turn facilitates the development of the tasks and goals because the patient feels safe enough to share deeper concerns. This allows for more ambitious goals because the bond helps a patient persist at the difficult task of being in therapy during emotional and upsetting periods.

Another brief example illustrates the task component of the therapeutic alliance and the importance of helping the patient say what is on their mind.

Jen was a 29-year-old cisgender woman with long dark hair and a slightly disheveled appearance. In her first appointment, she looked like a college student rushing out to class in the morning, but she had finished law school 4 years before.

Jen had been an associate at a prestigious law practice and had been laid off as financial pressures hit the firm. Shortly thereafter she had had a serious motor vehicle accident with multiple injuries requiring an extended rehabilitation. Her convalescence was complicated by depression, binge drinking, and demoralization. She seemed far from the successful young lawyer she had been just 3 years before, and I

thought that she was like Humpty Dumpty—she had fallen and could not put herself back together.

After the layoff, accident, and rehab, Jen could not get back on track. She had distanced herself from her former friends, and now wondered whether they had been friends at all. She lived with an aunt who was retired, and her parents gave her a little money to live on. She could not imagine being rehired after this extended hiatus from law and employment. There was a nagging feeling in my mind, and in hers, she implied, that the accident had almost provided a cover for her implosion. If it had not been the accident, it would have been something else. She said she was not abusing substances.

When we discussed her goals, Jen said quickly that she needed to get back on her feet. She realized this would be difficult, but she had been in therapy with a senior, well-known clinician while in college, and he had helped her tremendously through the right mixture of advice and insight. She thought therapy would help again. I gently suggested that the responsibility was on her to take charge and get back to work, even though it would be difficult. I was alarmed at her inactivity and what I imagined was her magical expectation that I would help her and give her direction; I could not tell yet whether an affective connection (bond) would develop.

In the first appointment, an extended evaluation session, I just stuck to my tasks: ask questions, try hard to understand, be open-minded, and not inject my values and opinions. Jen seemed to perform her tasks as well: she was talkative, self-revealing, and expressed a striking degree of self-awareness. She knew she should get back to work, but she was not going to accept just any job she was offered; it had to be pretty good. She felt that she got along well with people, but did not suffer fools gladly, and she tended to get annoyed and critical if she felt others were not intelligent or reasonable. She was a high-performance sports car; give her the right fuel and the right conditions, and she was terrific. But if she was not treated well, then she could not work.

After an hour and fifteen minutes, Jen looked at me and said, "Well, you seem honest and also smart, so I might as well tell you the rest. I don't want you to jump to a judgment about this, and you might, but you seem like you might not." She revealed a crucial additional piece of history. During her convalescence, while feeling ill, taking painkillers and sedatives, she had stolen jewelry from her aunt, sold it for a substantial sum, and had found a way to cover her tracks.

Jen had decided to perform the task of the patient: honest revelation about one's history and the details of one's life, including those elements that are shameful, embarrassing, and painful. Of course, this opened

up her feelings of guilt, entitlement, and self-esteem. And, the revelation further increased my concern about her problems, her capacity for destructive behavior, and her substance use.

How are you feeling about Jen? The previous example demonstrated the development of shared goals—this case shows the evolution, in a patient with some antisocial features, of the task component of the therapeutic alliance. What about the bond component? In our experience, trainees learning psychotherapy tend to focus on the bond component, especially in the beginning. They want the patient to feel good about them, and they are especially concerned about whether they "like" the patient, and the patient "likes" them. They tend to be enthusiastic about patients with whom there is a good bond and report that "things are going really well." Perhaps this reflects the universal wish to be liked and loved, but trainees may also focus on the therapeutic alliance because it is an easier skill to develop than technical competence.

How should the bond feel for the therapist? There is a particular quality of feeling that one has toward a patient when the therapeutic alliance, and the bond in particular, is strong. One feels very involved and cares greatly about what happens to the patient. There is a feeling of affection and respect for the patient's strengths, their ability to withstand and adapt to travail, and for their talents. The patient's weaknesses, frailties, limitations, and annoying habits are there, but they do not bother the therapist. One can easily imagine how others experience the person—for example, their relationships with friends, family, or spouses. Yet, despite the sense of connection and closeness, the therapist does not really want to talk with the person outside the office and would not particularly look forward to being inside the patient's home and would not really choose to be at a family wedding.

It is the very separateness of the therapeutic relationship, the one-sidedness of it, that allows the therapist to feel so close and so positive. If it were a real relationship outside the office, the therapist would have their own needs to contend with. The patient's limitations would be frustrating, or their strengths might bring up competitive feelings.

One of the most wonderful things about being a therapist is that you have the opportunity to get to know many people, often so different from those you would meet in the course of everyday life. You get to know them so well in a particular way that allows you to see them at their best, and from a vantage point that allows you to relate to them at your best. The lay person imagines that being a therapist is focusing on people's problems; therapists know it means realizing their resilience, forbearance, adaptability, and stoicism.

How does the bond develop? It requires more than the passage of time. It is based on the patient's capacity for trusting relationships and the therapist's capacity for warmth and affection. The bond grows stronger

when both are effectively performing tasks and working together on goals. The patient's experience of the bond can be a powerful therapeutic element—that is, it can be a "corrective emotional experience" (Alexander & French, 1946; Sharpless & Barber, 2012). The bond reflects the potential of the therapeutic alliance to be therapeutic in and of itself. and we discuss the therapeutic alliance as a mechanism of change at greater length in Chapter 10.

At the same time, therapists' positive feelings toward patients can be a taboo topic, of course, because affection can lead to boundary violation, and this is all too frequent and destructive. But, warm and affectionate interest in someone else, and the acceptance and empathy that come with it, is the sine qua non of the bond from the therapist's perspective.

THE THERAPEUTIC ALLIANCE AND PSYCHODYNAMIC PSYCHOTHERAPY

So far, the discussion has been about developing an alliance with patients, without specific reference to psychodynamic psychotherapy. Bordin's (1979) ideas, although based on psychoanalytic concepts, were designed to have broader application. The examples given were from the first few sessions, rather than later in a longer treatment. What additional components, both theoretical and conceptual, are specific to psychodynamic therapy?

Greenson (1967) distinguishes three dimensions of the patient's relationship with the therapist: the therapeutic alliance, transference, and real relationship. The therapeutic alliance component is what we have been discussing all along in this chapter. The transference refers to the feelings, thoughts, perceptions, and fantasies the patient has about the therapist based on earlier life experiences, especially those experiences with primary caretakers during childhood. It is usually expressed through action, body language, and the feeling in the room before it is able to be articulated and put into words. Understanding the transference is a gold mine in dynamic therapy, because it allows the patient and therapist to see and experience old reactions right in front of them in the office. The therapeutic alliance is a construction in the here and now by patient and therapist, and it rests on an adult collaboration on goals, tasks, and bond. The transference is not current and not realistic; it is the expression of feelings, beliefs, and perceptions based on relationships in the past.

Last in Greenson's (1967) scheme is the real relationship. This refers to the particulars of this therapist and this patient, and their actual interaction, not necessarily in relation to the therapeutic task. An example of the real relationship would be the fact that a therapist speaks accented

English, and the patient does, too. Indeed, all of the aspects of the therapist's and patient's racial, ethnic, and gender/identity will be part of the real relationship. The real relationship may contribute to the therapeutic alliance (or impede it), and it may help to shape the transference reaction, but it is not essentially part of either. Other examples would be the therapist's work or vacation schedule, the proximity between the therapist's office (or home) and the patient's home, or the actual fact of time spent between patient and therapist.

The real relationship obviously exists, it is fodder for the development of the therapeutic alliance, and it certainly contributes to the transference. It is of great concern to beginning therapists who may be anxious about what to do if they meet a patient in the elevator, at a restaurant, or as it happened to one of us (JPB), in a dorm room in a youth hostel in a foreign land! Telepsychotherapy may show patient and therapist glimpses of private spaces.

There are forces that work against the development of the therapeutic alliance. The patient's drive to repeat and reenact experiences from earlier in life will conflict with the development of the therapeutic alliance. This conflict gives rise to the concept of resistance. The term is unfortunate because it implies that the patient has a conscious negative stance toward the treatment, when, in fact, it is largely unconscious. The patient may be truly attempting to build a therapeutic alliance with the therapist. But at the same time, there are feelings, perceptions, and thoughts based on past experiences that impede the alliance. For example, a patient may experience the therapist as intrusive, demanding, and self-centered from the beginning, when the clinician has truly been rather empathic and respectful. For this patient, the experience of being asked questions by another person stimulates such powerful feelings of intrusion that a basic element of the therapeutic alliance is hard to accept.

In the early phase of treatment, the therapeutic alliance needs the attention. Later, when it is solidly in place, the field is set for exploration of the transference. We observe that some trainees make the mistake of commenting on the transference too early, before an adequate therapeutic alliance has been built. This may contribute to early dropout. On the other hand, many trainees are reluctant to point out the transference for fear that the patients will think they are self-centered and egotistical. This will also slow the work, because transference manifestations, whether positive or negative, loving or hateful, may be present in the consulting room and if they are ignored by the therapist, may just be acted out by the patient.

The concept of resistance is just another way of thinking about transference, because they are both manifestations of conflict in the

therapeutic relationship. The term resistance emphasizes the way that old conflicts prevent open discussion of the problems the patient came to address in treatment. Transference, which refers to the same problem, emphasizes the historical background and sources of the resistances.

The therapeutic alliance and the transference will always coexist. The effective therapist keeps a finger on the pulse of both, looking for manifestations of each. In the example of Beth in Chapter 1, who had been abducted by her father, the therapeutic alliance developed slowly but surely in the first few months of treatment. She collaborated well with the therapist until the moment when she became suspicious of him after he discouraged her from returning to her boyfriend. At this point, it became clear that she had a negative transference reaction based on her relationship with her father. Prior to this point, there may have been an unrecognized positive transference reflecting whatever trustworthy relationships she had as a child, perhaps with her mother. The assumption that resistance and transference inexorably arise in the treatment relationship is a distinguishing feature of dynamic psychotherapy and becomes a tool for helping the patient understand themselves.

The concept of enactment, which refers to the replaying of (reenacting) earlier experiences in the therapeutic relationship, was introduced to help detect subtle but important manifestations of transference and countertransference. While transference refers to what the patient feels and does in response to old relationships and experiences, countertransference reflects the therapist's engagement with this old script. Sometimes the unspoken assumptions and unconscious reactions of both the patient and therapist come together to produce a way of relating to each other that is not readily observable to either. Examples of enactments could include a feeling that the therapist is an inquisitor and the patient is the victim, or the patient is special and deserving and the therapist is the admirer. The transference and countertransference become evident in the playing out of roles.

Thinking about what kind of enactment might be going on is a particularly useful approach to help answer a therapist's inner question of why they feel a certain way in a session, or why they relate in an uncomfortable or unusual way with a patient. The concept of enactment reminds us that we do not simply react based on the patient themselves, but we also bring subtle and even not so subtle reactions and feelings of our own. What happens in the relationship arises out of an interlocking of both of these feelings, and has a life of its own. Psychotherapy is an encounter between two people and all of their baggage. This encounter includes the transference, the therapeutic alliance, and the ways the real relationship influences both of those elements.

An example will help to tease out the aspects of therapeutic alliance and the transference (including resistance and enactment). Distinguishing between the alliance and the transference is cleaner conceptually than practically, but it is essential to try to catch the unfolding of each in the therapeutic relationship.

Juan was a pleasant and likable young cisgender heterosexual Latino surgeon who came for consultation because he was trying to repair his marriage after having been caught in an extramarital liaison. His other problem was that he was very anxious that his patients might suffer complications of the procedures he performed.

Juan was the middle of three children of a warm and loving father and a strong and ambitious mother. His childhood experience was complicated—there was much love and support, but he always had the feeling that his position in the family was insecure. He felt he had to compete hard for acceptance and attention, especially from his mother. She expected that her sons would be paragons of success in the community. Juan was an excellent athlete and he remembered wanting to win so badly in his soccer league that he publicly embarrassed himself with aggressive and unsportsman-like behavior. He was a very successful student and managed many experiences of microaggression and discrimination by suppressing his resentment and doubling down on his successes. When patients and family mistook him for support staff in the hospital, he corrected them with a cheerful demeanor, and when he was unfairly passed over for chief resident in his training program, he sought out a research project to prove his skills.

This young physician had always valued his attractiveness to women, and had numerous affectionate and sexual relationships. Women found Juan very desirable, and he often felt that he fell into relationships as though he had little choice about it. He married an accomplished White woman, but several years into the marriage he became infatuated with a Latina colleague who was rather needy and demanding. He could not say no, and they had a brief affair. He ended the relationship, but the scorned partner told his wife what had happened. Juan's wife loved him and wanted to try to repair the marriage, as did he.

The focus of Juan's therapy was on understanding what drove him to the affair, as well as working on his anxiety about his patients' developing a surgical complication. In his practice, he frequently became intensely worried and guilty and assumed he had made careless errors or was just plain incompetent. He was sure he would be sued, found guilty, and would be embarrassed in front of colleagues

and the other patients in his practice. His rumination about this could be all consuming. Juan wanted to be respected and popular.

In the evaluation and subsequent therapy Juan was talkative, cooperative, motivated, and interested in feedback and observations. He was always more comfortable talking about what he was afraid of (being sued or getting in trouble) than what his urges were (success, victory, admiration). There was no overt conflict or misunderstanding between us, and he seemed to view me as positive, helpful, and kind. The therapy seemed easy and productive. But I had the nagging feeling that therapy never goes entirely smoothly, and if it does, there is probably a reason. Juan was genial about and dismissive of inquiries about how he felt as a Latin man in therapy with a White therapist.

Juan's core problem was low self-esteem, and two interconnected themes emerged in the therapy. He needed to be loved and tried hard in each and every situation to elicit affection and interest from others, especially women. This came out in his romantic relationships, relationships with women at work, and, of course, his mother. He was also intensely competitive and wanted to do better than other men, while feeling at times that he did not measure up. He was afraid that he would be found out to be inadequate, and would be cast out and punished for his attempts to be a successful man. Both his affair and his professional ambition had roots in his need to prove how lovable and valuable he was. Juan felt guilty about the intensity of his wishes (for both romantic and career success) and worried that he had hurt someone else because of them (wife, lover, and patients).

What do you think of the therapeutic alliance here? How does Juan's demeanor toward the therapist reflect the transference, therapeutic alliance, and real relationship? What manifestations of resistance do you see? He certainly formed an effective therapeutic alliance—he was a regular and steady participant in the therapy, committed to goals, performing his tasks well, and there was a strong bond with the therapist. He knew he wanted to be loved and admired—by mother, wife, girlfriend, father, colleagues, and therapist. But the competitive theme of his relationships with men was subtly present as well.

Juan's demeanor constituted a resistance in therapy because it impeded direct discussion of some of his major conflicts; he spoke easily of his fears, but tended to hide his competitive feelings. It was also an expression of the transference because it involved themes in his relationship with his father (avoidance of conflict). He never competed with the therapist directly, but there was a certain amount of excessive respect, and less collaborative give-and-take than with many patients. This was an enactment. When the therapist realized it and pointed it out to Juan,

he could see that he wanted to see himself as a faithful student of the therapist. He also acknowledged that occasionally he felt competitive and wanted to be seen as better than the therapist, like he wanted to be better than his colleagues.

Juan's loyal and pleasing demeanor was his technique for dealing with the conflict between his competitive feelings and his need to be liked—if he was likable then he would not be seen as aggressive, and if he was not aggressive, he would be loved and admired. The real relationship, including many elements, but importantly the patient's and therapist's ethnic identities, was openly talked about only later in the treatment. Juan's abiding concern about the therapist's judging him and competing with him were influenced by concerns about discrimination as well as transference.

It is important to recognize that resistance, enactment, and transference exist alongside the patient's many strengths. He is conflicted, but also a healthy, mature adult with a realistic and contemporary focus—that is, Juan also had an accurate mode of perception and good problem-solving skills.

ALLIANCE RUPTURE AND REPAIR

The therapeutic alliance can be therapeutic in and of itself when there is a state-like strengthening of the patient's experience of the relationship with the therapist. State-like strengthening may result from supportive interventions that create a corrective relational experience, or they may occur following alliance rupture and repair. Rupture in the alliance is usually defined as deterioration or tension in the alliance (Safran & Muran, 2000) and it may manifest as a minor tension between patient and therapist in the components of the alliance (bond, tasks, goals), or as a more serious break in therapy.

Alliance ruptures are a ubiquitous part of treatment, and have been identified in 91–100% of sessions (Muran, 2019). They may also be integral to what makes the therapeutic alliance therapeutic, as resolved alliance ruptures are significantly associated with better treatment outcome (Eubanks, Muran, & Safran, 2018). There are two main types of alliance rupture: withdrawal and confrontation (Safran & Muran, 2000). In withdrawal ruptures, patients either distance themselves from the therapist and the treatment in a submissive manner, or relate to the therapist in a way that denies an aspect of their experience. For example, in a withdrawal rupture, a patient may respond to an interpretation by saying, "I don't know. Maybe," followed by a long silence. Patients express anger directly in confrontation ruptures. For example, a patient may respond to an empathic comment from the therapist, such as "It

must be so difficult to be in this situation," with a hostile and confrontative response, such as "No, it's not. You didn't understand a thing of what I just told you. This therapy is not helping me at all."

Resolution strategies differ in how complex and fundamental they are. Some resolutions include strategies that seek to repair the rupture immediately (e.g., explaining the rationale for an aspect of the treatment or the therapist's intervention, or changing the intervention), and others focus on exploring the rupture and what underlies it (Eubanks et al., 2018). Resolution is successful when the patient and therapist resume collaborating on the work of therapy with a strong affective bond (Safran & Muran, 2000).

POSITIVE AND NEGATIVE EMOTION

Positive and negative emotions meet in psychotherapy in the therapeutic alliance. Essentially, the alliance is a new kind of relationship where old, painful emotions coexist with new, positive ones. The alliance reflects respect, affection, and interest from the therapist and engenders these feelings in the patient toward themselves. The field of positive psychology, which emerged in the late 1990s, makes positive emotions a direct subject of inquiry. Fredrickson's (2001) broaden-and-build theory locates the value of positive emotions in an evolutionary context. She attempts to explain why there are positive emotions and what survival value they may have. If anxiety promotes vigilance and survival, and depression reflects loss and attachment, then what is the purpose of happiness and joy? Fredrickson's theory is that positive emotions build relationships and the capacity for resilience and problem solving. More specifically, Fredrickson shows that positive emotion is valuable because positive affective states promote improved capacity for problem solving, prior positive emotional experiences increase resilience when there is a new current problem to solve, and positive emotional experiences that increase interpersonal connections increase social resources. Thus, positive emotion causes a broadening of coping strategies and a larger repertoire of potential solutions to a problem (Fredrickson, 2001).

An essential part of the bond in the therapeutic alliance involves experiencing positive emotion at the same time as the negative emotions associated with the patient's problems. It may be this admixture of the negative and positive that is an essential element in the therapeutic relationship, which makes it so different from other relationships. This new relationship, like all attachments, must involve something positive. The broaden-and-build theory gives a conceptual framework for understanding this clearly felt but little-discussed aspect of the therapeutic alliance.

In the traditional psychodynamic literature, supportive interventions were contrasted with exploratory ones. Comments that support, validate, and encourage were seen as useful but antithetical to exploration and deeper understanding. We suggest, however, that positive, encouraging comments, shared humor, direct praise, recognition of patient strengths, and expressions of optimism serve to elicit positive emotions in the patient. These positive emotions do not suppress negative emotions and make it harder to explore areas of conflict. Rather, the positive emotions exist alongside the negative emotions that have brought the patient to treatment, and indeed there is evidence to support the notion that positive and negative emotions are not highly correlated (Watson, Clark, & Tellegan, 1988). Positive emotional experiences enhance the therapeutic alliance and thereby increase the patient's problem-solving capacity the way Fredrickson's broaden-and-build theory suggests. With more positive emotion, a patient will have a greater ability to separate themselves from painful feelings and reflect on them and deal with them more creatively. When such successful experiences of self-reflection are repeated, there is greater resilience in the therapeutic relationship, which only serves to embolden the patient further to talk about upsetting and difficult things.

For example, direct expressions of empathy are traditionally thought to enhance the patient's sense of safety and comfort in the therapeutic setting, build the observing ego, and deepen the therapeutic relationship. But, they also feel good for the patient. There is typically a strong positive feeling toward the therapist when one feels understood. It feels like the therapist likes you and cares about you.

Another example of positive emotion as a critical ingredient in the therapeutic alliance is when the therapist helps the patient identify strengths. Noting patients' psychological mindedness, or resilience, or stoicism helps the patient to appreciate those strengths and is often quite encouraging. Courage, humility, appropriate pride and other strengths are so often present in our patients who are struggling.

THERAPEUTIC ALLIANCE, SKILL DEVELOPMENT, THERAPIST CHARACTERISTICS, AND OUTCOME

How does one facilitate the development of the therapeutic alliance, and what is the best way to learn this? What therapist qualities seem to predict better treatment outcome? Some data are available on these crucial questions, but we need to know so much more. Patient qualities, therapist qualities, and therapist "technical activity" are the broad categories of factors that are thought to affect the development of the therapeutic alliance.

Moras and Strupp (1982) noted that 25% of the variance in a patient's collaborative participation in therapy is linked to qualities of the patient, such as the nature and quality of the patient's other interpersonal relationships. In support of this, Satterfield and Lyddon (1995) found that therapists' prior dependent relationships predict a negative view of the therapeutic relationship.

Patients' expectations of improvement predicted a better therapeutic alliance early in therapy, and previous hostility in relationships predicted a poorer alliance (Connolly-Gibbons et al., 2003). Not surprisingly, the same is true of the therapist. Dunkle and Friedlander (1996) found that less self-directed hostility in the therapist, more perceived social support, and comfort with closeness led to a stronger bond component of the therapeutic alliance.

The therapist "technical activity"—that is, what the therapist does, represents perhaps the most teachable component of the therapeutic alliance. Grace, Kivlighan, and Kunce (1995) demonstrated that counselor trainees who were taught to explicitly discuss patient nonverbal communication had improved therapeutic alliance scores compared with trainees who simply expressed empathy. Weiden and Havens (1994) identified specific behavioral techniques for improving the therapeutic relationship with severely disturbed patients. Crits-Christoph, Barber, and Kurcias (1993) reported that accurately interpreting patients' core conflicts early in treatment results in increased therapeutic alliance later on in treatment.

The ability to repair the inevitable ruptures is essential for strengthening the therapeutic relationship (Eubanks et al., 2018), and studies suggest that providing therapists with training on how to strengthen the alliance and how to identify alliance ruptures and resolve them may result in the strengthening of the alliance and reduced dropout (Crits-Christoph et al., 2006; Muran, Safran, Samstag, & Winston, 2005). Findings further suggest that different patients may benefit from different techniques to strengthen their alliance based on the pretreatment level of insight (Yaffe-Herbst, Krapf, Forteza-Rey, Peysachov, & Zilcha-Mano, 2023).

Therapeutic alliance skills may develop with clinical experience and duration of training. Mallinckrodt and Nelson (1991) looked at the relationship between training and measurable therapeutic alliance in the Bordin (1979) model. They found that greater experience is associated with higher goal scores, less powerfully with improvement in task scores, and is not correlated with bond scores. Dunkle and Friedlander (1996) found that training experiences did not predict increased goal and task scores. Crits-Christoph and colleagues (2006) trained a small group of relatively naïve therapists in what they called alliance-fostering therapy, and they were able to show at least moderate effect size change in the patients' rating of the therapeutic alliance with the training.

Kurcias's (2000) qualitative study of psychology trainees and their supervisors showed increased trainee sophistication, complexity, and focus in their conceptualization of the patient and of the alliance, greater comfort in discussing patient–therapist relationship issues, greater patience with the slow pace of change, and increased recognition and more skillful management of relationship ruptures over the course of their training.

Muran and colleagues (2005) studied brief relational therapy, short-term psychodynamic therapy, and CBT and found that brief relational therapy produced fewer dropouts. They suggest that focusing on facilitating state-like changes in the therapeutic alliance—that is, changes in the immediate experience of the relationship—results in greater commitment to the treatment.

While the therapist contribution to the therapeutic alliance and therapist overall effectiveness are distinct concepts, they are likely related, and it is humbling to look at the estimates of therapist impact. Baldwin and Imel (2013) identified 46 studies using random effects and found the therapist effect on outcome was a surprisingly low 3.0%. A more recent review of therapist effect found an average of 8.2% in RCTs and 5.0% in naturalistic studies (Johns, Barkham, Kellett, & Saxon, 2019). Wampold and Owen (2021) conclude that therapist interpersonal skills and a professional commitment to improve these skills seem important in therapist effectiveness and conclude that "the evidence for what characterizes effective therapists is best described as nascent" (p. 319). We must remember that other major variables affecting therapy outcome include patient characteristics, patient–therapist fit, and treatment.

In our review of teaching about the therapeutic alliance (Summers & Barber, 2003), we urged more focused didactic opportunities, increased attention to this area in supervision, and the use of therapeutic alliance rating scales to help trainees learn more about their patients' perceptions of them in this area. The data on rupture repair, focus on state-like changes in therapeutic alliance, and the learnability of therapeutic alliance skills add to these conclusions. We also speculate that routine outcome monitoring could provide a worthwhile learning opportunity for therapists in training.

Therapeutic Alliance: Key Empirical Findings

- The correlation between alliance and outcome was most recently estimated at .275 (Flückiger et al., 2018), and early alliance was found to predict subsequent change in symptoms in brief dynamic therapy (Barber et al., 2000).
- There is some evidence that therapeutic alliance skills can be taught and ample anecdotal evidence that these skills improve with experience.

- The therapist effect on therapeutic outcome has been estimated between 3 and 8% (Johns et al., 2019).
- Focusing on patient state-like changes in the therapeutic alliance may decrease dropout (Muran et al., 2005).

STRATEGIES FOR FACILITATING THE THERAPEUTIC ALLIANCE

This chapter has outlined the concept of the therapeutic alliance and its key components. Each component was illustrated with examples, and we reviewed many issues involved in learning how to develop a good therapeutic alliance. Now here are some practical tips on how to facilitate it.

1. Give a brief explanation of the procedure of psychotherapy. An example is "We will meet weekly to talk about what you are feeling and what you are struggling with, so that you can better understand what is going on and so you will be able to figure out what part of it is baggage from your past and what part is really a problem in the present. This will allow you to see things as clearly as possible and then decide how you would like to manage and deal with them."

2. Maintain your curiosity and self-awareness in the relationship. Your ability to try to see your blind spots and your patient's, or at least your attempt to do so, will embolden the patient to do the same.

3. Have faith that if you inject warmth, enthusiasm, support, and empathic skepticism about the patient's coping strategies, they will become interested and focus on problems and patterns. If the patient becomes focused and interested, you have truly developed an effective therapeutic alliance.

4. Find those qualities that are likable in your patient rather than ones that are not, and periodically acknowledge them. Enough people in the patient's life have found them unlikable.

5. Keep a continuing focus on your own feelings, using them to understand potential countertransference reactions and emerging enactments. Use whatever degree of genuine warmth and interest you feel to facilitate the bond. It is an essential part of the therapeutic relationship to develop some kind of positive emotional experience between therapist and patient. You must be an active participant in this. Positive emotion will augment the empathy you offer, and this will strengthen the patient–therapist bond.

6. Stick to your essential tasks: listening, understanding, reflecting, empathizing. Gently educate the patient about what their tasks in the therapy are: honesty, verbalizing what is on their mind, sticking to it

when they feel upset and anxious, coming to appointments, and valuing curiosity. Encourage and counsel patience.

7. Try to understand the patient's goals, implicit and explicit, and develop a clear understanding of what you and they will be working on (discussed further in Chapter 8).

8. In your conceptualization of your developing relationship with the patient, distinguish between those aspects of the relationship that reflect the therapeutic alliance and those involving transference and resistance. Resistance and transference are inevitable, and your attitude toward them should be curiosity and interest, not judgment and criticism.

9. Every comment about resistance should be preceded by an empathic comment implying your understanding that the patient is in pain—for example, "When you talk about the arguments with your husband, you seem to focus on all of the ways that he has hurt you and how angry you are. That is really understandable, as it has been devastating, but doing so seems to prevent you from stepping back and trying to understand how you are reacting and relating to him."

10. Watch for too much pleasure or too much anxiety on your part. These are clues to an enactment that you must understand in order to help the patient reflect on themselves and their impact on others.

11. Note the inevitable disruptions in the therapeutic alliance (Muran & Safran, 2002). When it happens, ask the patient about it, validate it, try to understand what happened, and do not be afraid to apologize. Spend a moment letting the patient feel and express the hurt, and sit with it as the therapist. Connect this feeling of hurt, loss, or resentment, at some subsequent time, to the other settings where these feelings are evoked.

12. See the best in human nature, having empathy for the patient's unique trials and tribulations, but do not let them off the hook in being accountable for how they affect others. Your patient needs to deal with reality, and they know it. They will look to you to judiciously remind them of it.

13. Tips about your manner and approach to the patient:

- In your overall demeanor and manner, behave toward the patient like they are someone sitting next to you at a pleasant dinner party—interested, open, curious.
- Keep an eye on the anxiety thermometer; too little makes for pleasant conversation but not much therapy, too much creates excessive discomfort for the patient.

- Understand what the patient is looking for emotionally in each session, and make sure they get a little bit of it.
- Hold in mind the healthy side of the patient—that is, the part that is distressed by what they are doing, feeling, and experiencing.
- Maintain a reasonable degree of focus, enough so that the anxious patient feels they are taking something specific from the sessions, but loose enough to shake off the prearranged agendas.
- Do not work too hard in the session, or remain passive and do too little.
- Do not encourage the patient to like you, but to respect you.
- This is not about you. Keep your integrity by trying to reach a shared understanding of what is going on, not by being right.

The application of these strategies helps the therapist build the therapeutic alliance while observing the unfolding relationship. Core problems, conflicts, resistance, enactment, and transference are expressed from the beginning and all through the treatment. Learning how to be a psychodynamic therapist involves a high-wire balance of working with these conflicts while attending to and cementing the healthy aspects of the therapeutic relationship at the same time.

SUMMARY

The therapeutic alliance is essential to effective psychotherapy. The three components of the alliance—goal, task, and bond—each require attention and focus by the psychodynamic therapist, and especially to the pragmatic psychodynamic psychotherapist. Potential ruptures in the alliance are inevitable but important to repair. Empathy, attunement, education, early identification of the patient's core problem, and professional demeanor on the part of the therapist help to build the alliance, and there are a host of specific techniques and tips that will strengthen it.

5

Core Psychodynamic Problems, Part I

> In preparing for battle I have always found that plans are useless, but planning is indispensable.
>
> —Dwight D. Eisenhower

An energetic cisgender White woman in her early 50s with closely cropped dark hair and alert eyes quickly took in the office surroundings. Her husband had announced that he was thinking of leaving her. She was completely taken by surprise. She felt scared, ashamed, guilty, and angry, and said, "I just want him back, I'll do anything." She was devastated and felt she was teetering on the edge of a serious depression. Quickly, she described her relationship with her husband, and all that she did for him and their family. She described her concerns about him, and about herself and their children. She talked about typical family arguments, issues about money, and one child's health problems.

How do you begin to conceptualize this person's problem? Are there hundreds or thousands of different human problems, each distinct from one another? Or is there a finite number of problems that have individual variations? To practice therapy effectively you need to be able to pay exquisite attention to each person and empathize with each experience discussed. But you must also look for essential patterns, and not reinvent the wheel with each treatment.

The patient who says to their therapist, "I'm sure you have heard this sort of thing before, it must be boring," is wrong, because no one has ever felt and seen the world like them before, and because it is almost always interesting to listen to people talking honestly about themselves. But they are also right in the sense that their problem is probably a

version of something common, and recognizing common problems helps therapists understand and anticipate.

We know there is strong evidence that psychodynamic therapy is effective for a number of conditions; there are relatively few problems for which it has been shown to be unhelpful, and some disorders for which there are little data. What are the boundaries and limits of the treatment, and what problems is it best for? Which diagnoses, personality types, symptoms, and in what contexts does this treatment lead to good outcomes?

We contend that there are six core psychodynamic problems—depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma—that account for 80–90% of those who are appropriately treated with psychodynamic psychotherapy. These common psychodynamic problems have either clear empirical data or clinical experience to support responsiveness to psychodynamic treatment. Certainly these are not the only problems that respond to dynamic treatment, but they are the most common ones. We are not suggesting that dynamic therapy is the best or only effective treatment for these conditions.

Six Core Psychodynamic Problems

- Depression
- Obsessionality
- Fear of abandonment
- Low self-esteem
- Panic anxiety
- Trauma

Although it is easy to concisely describe a list of problems, the process of searching for and recognizing these problems in actual therapy may be much more difficult. Some patients easily fit the profile of one problem well, and some have features of more than one. Each of these core problems contains characteristic patterns and manifests in typical ways. Although there are *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR; American Psychiatric Association, 2022) diagnoses that map well onto some of these problems, we organize and describe the problems by both their surface manifestations and their deeper characteristics.

It has been said that psychoanalysis is in dire need of a "theorectomy" (Klein, 1976; Kohut, 1959), a surgical removal of unused and incorrect aspects of its theory. With more than 100 years of development, the proliferation of theories has resulted in multiple, overlapping ideas, with older theories littering the landscape coexisting with more recent

ones. Nowhere is this truer than in talking about diagnosis and disorders. Among therapists, patients' problems are described in different ways, using different diagnostic terms, employing theoretical models that are numerous and confusing. Because there are so many ideas, and so many are difficult to disprove, there has been little systematic elimination of the less useful terms and theories. For example, the word *narcissism* is used colloquially to refer to selfishness, diagnostically to refer to an abnormal vulnerability in self-esteem, theoretically to refer to a normal and universal aspect of human life, and developmentally to define an aspect of the self that changes throughout the life cycle (Pulver, 1970).

A century of theoretical and conceptual work on diagnoses, usually done with an impulse to split rather than lump, certainly leads us to be humble in defining a list of core problems. We firmly side with the lumpers, and our menu of problems is relatively simple and coherent. Our scheme could be critiqued by those who support alternative classifications, undoubtedly with merit, but we maintain that the ability to learn and practice psychodynamic psychotherapy has been hampered more by the sheer volume and variety of schemes than it has by attempts to simplify and clarify which lack subtlety.

We use the term *core psychodynamic problem* to denote problems that have common underlying patterns. Historically, psychoanalysts have spoken of psychoanalytic diagnoses—for example, obsessional neurosis, hysterical character, and phobic neurosis, among others. These were relatively well-defined entities, with characteristic symptoms, identifiable (although inferred) dynamics, and hypothesized etiologies. But the psychoanalytic diagnostic system was unreliable and difficult to apply clinically because of its reliance on a high degree of inference. One man's obsession was another man's phobia.

Some of the classical psychoanalytic diagnoses are useful, intuitive, and fairly easily observable, but they also carry theoretical assumptions that may not be true and are unnecessarily complex. For example, the presumed cause of classical neurosis is developmental fixation—that is, trauma during a particular developmental phase. Supposedly, this defining event and the phase when it occurred determines the subsequent type of neurotic symptomatology. But did all patients with obsessions have anal-phase trauma, and did all eating disorders result from early feeding problems? Although theoretically elegant and certainly intuitive, there are little data to support this radical privileging of early developmental experience over genetic vulnerabilities, subsequent environmental factors, and later life experiences. In summary, the classical psychoanalytic approach to diagnosis, which was based on inferred dynamics and a deterministic view of early relationships, has suffered because it does not fit the data and is rigid and laden with excess assumptions.

DSM-III was the first psychiatric nosology that was organized around observable (relatively) symptoms and signs and that attempted to be free of theoretical bias about the causes of disorders. DSM-IV, DSM-5, and DSM-5-TR continued in this vein, tweaking the descriptions, and rearranging the diagnoses. The weaknesses of this system have been extensively discussed in the mental health literature (see, e.g., Sadler, 2002), and include the grouping of problems by phenomenological features rather than by underlying entities or diseases, and an implicit bias toward equating symptoms with illnesses and effective treatment with symptom reduction. In recent years, there has been a push in psychiatry and psychology to speak about transdiagnostic treatments—that is, treatments that focus on underlying mechanisms rather than surface manifestations. Each of these six core problems refers to an underlying set of adaptive mechanisms that are reflected in the symptomatology and addressed directly in the treatment.

It is not clear how widely accepted the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006), PDM-2, and the *Operationalized Psychodynamic Diagnosis* (OPD Task Force, 2008) are. This tradition of work expresses a complex psychodynamic and multidimensional understanding of personality, but has been noted to be unwieldy and difficult to implement for clinicians.

The six problems we highlight and embrace here are psychodynamic (and psychoanalytic) in format, and they provide a helpful narrative understanding of a person's condition. We regard them as organizing explanations that encompass underlying mechanisms, rather than specific symptomatic manifestations. A useful list of psychodynamic problems that helps the practitioner understand and practically treat patients should have neither the excessive conviction of classical psychoanalytic theory nor the surface orientation of DSM diagnoses.

We use a heuristic approach to categorization, aiming for what is clinically useful. The six problems are characterized by (1) their key psychodynamic conflicts, historical and current conceptualizations; (2) the psychoanalytic model(s) most useful for understanding them; (3) the strengths that are most affected in those suffering from the problem; and (4) the usual treatment goals. They are recognizable by therapist and patient alike.

These are problems that can be understood and worked with therapeutically, not necessarily genuine disease entities with the theoretical baggage of etiology, structure, course, and so forth. In the actual clinical world, these problems can present singly or in combination, and a particular problem can dominate the patient's life (and therapy) at one point in time and may be replaced subsequently by another. The student of psychotherapy would be well served by developing an intellectual and

"gut" understanding of these essential problems. During the early stages of learning, pattern search and recognition is a deliberate, effortful, conscious, and rational process that later becomes rapid and intuitive.

References to relevant literature are included in our descriptions, but we cannot possibly do justice to the rich psychoanalytic and empirical literature, which includes a tremendous breadth of descriptive, theoretical, and clinical writing about these problems. We also make no claims of originality in our description of these problems, but rely heavily on classical and current conceptualizations that we have found useful.

No scheme is objective and without social determinants, and this is not even an appropriate goal for what is, after all, fundamentally a human and relational experience. Instead, we regard the core psychodynamic problems described here as a starting point for the engagement of patient and therapist, which includes curiosity, engagement, and reflection about their unique identities and backgrounds.

Gender, race, culture, and ethnicity (as well as history) shape individuals' problems and how they are perceived. Some problems seem to be found more among one sex, or perhaps among specific subpopulations. For example, fear of abandonment may be seen relatively more among women than men, and this undoubtedly reflects gender-based expectations about relationships, social definitions of what constitutes a problem, and typical pathways for coming to treatment. This categorization scheme certainly sits within a current social context: Western, academic, and secular. A theme that runs through this book, and the numerous clinical examples, is that the identities of patient and therapist present unspoken assumptions and result in unrecognized perceptions that can only be addressed by conscious attention, questioning, and humility.

STRENGTHS AND PROBLEMS

Strengths coexist with problems. The traditional psychodynamic approach attends greatly to problems and their resolution and trusts that well-being will follow. We suggest that a well-rounded view of our patients takes both pathology and strengths into consideration because treatment may need to build strengths while it diminishes problems. This is particularly relevant in thinking about mechanisms of change in therapy (see Chapter 10) because our model emphasizes the leveraging of patient strengths to address areas of vulnerability or weakness.

Peterson and Seligman (2004) have enumerated character strengths and virtues, developing an "un-DSM" that describes strengths, instead of illnesses, that are present across time and across cultures. They define six virtues as overarching categories—wisdom and knowledge, courage,

humanity, justice, temperance, and transcendence—and each is composed of three to five character strengths. This is another important way of thinking about patient strengths. Their taxonomy has generated significant interest in empirical research on personality strengths (Seligman, Steen, Park, & Peterson, 2005). This research has spawned positive psychotherapy (Rashid & Seligman, 2018) and other positive interventions, which have been studied in a variety of settings (Ochoa, Casellas-Grau, Vives, Font, & Borràs, 2017; Walsh, Cassidy, & Priebe, 2017). These treatments focus on enhancement of existing strengths as the mechanism of change, eschewing the traditional focus of most psychotherapies on ameliorating symptoms, pain, and discomfort.

But, not only do positive treatments turn their therapeutic attention to strengths, they also turn much of traditional psychodynamic thinking on its head and consider what strengths are compromised in the face of illness, and what illnesses are actually a reflection of limitations or excesses of strengths. For example, depression seems to sap one's courage, humanity, and capacity for transcendent experiences, and obsessionality undermines one's wisdom and humanity. Positive psychology has championed the fundamental observation that positive emotion and negative emotion coexist, often without substantial correlation, and patients can experience intense negative emotion and suffering while they also manifest important strengths. Traditional psychotherapy does indeed target negative emotions, but relies greatly (as discussed in Chapter 10) on mechanisms of change involving new relational experiences and the development of new strengths, such as the capacity to mentalize.

From a pragmatic perspective, we see strengths as important in psychodynamic therapy in the following areas: development of the therapeutic alliance, the personal narrative, mechanisms of change, and degree of resilience after treatment is over. We discuss the typical strengths associated with each core psychodynamic problem and also note the ways that the core problem can compromise the positive psychology character strengths.

WHICH PROBLEM DOES THE PATIENT HAVE?

Table 5.1 summarizes the psychodynamic problems and describes them in detail. This includes the key conflicts and psychodynamic conceptualization, associated DSM-5-TR diagnoses, treatment goals, character strengths affected, psychodynamic model that best explicates the problem, typical resistances, transferences, countertransferences, CCRT themes, and techniques. Our subsequent discussion of each problem outlines the evidence base for the treatment of each.

TABLE 5.1. Core Psychodynamic Problems and Their Treatment

Depression (Peter; Chapter 5)	Obsessionality (Raymond; Chapter 5)	Fear of abandonment (Sarah; Chapter 6)	Low self-esteem (Stan; Chapter 6)	Panic anxiety (Alice; Chapter 6)	Trauma (Ellen; Chapter 6)
		Essential problem			
Loss and self-criticism	Rumination and resentment	Attachment and abandonment	Self-esteem and protection	Acute paroxysms of anxiety	Safety
		Key conflicts and problems			
Abandonment, loss, conflict over aggression	Autonomy, fear of loss of control, conflict over aggression	Abandonment, attachment, primitive defenses	Low self-esteem, abandonment, compensations	Separation, repressed anger	Fear of loss of bodily integrity, attachment and abandonment
		Predominant psychodynamic model used for formulation			
Ego psychology	Ego psychology	Object relations, relational psychoanalysis, mentalization	Self psychology, relational psychoanalysis	Ego psychology	Object relations, mentalization
		Typical CCRT			
Wish to be loved; rejected by others; feel depressed, angry	Wish to be in control of emotions and impulses; others are controlling me; feel angry, anxious	Wish to merge/be close; people are abandoning me; feel abandoned, angry	Wish to be taken care of, loved, respected, or admired; not given enough respect, love, or admiration; feel empty and not admired	Wish to be close and loved; people leave me; feel loss, fear, anger	Want to trust and be safe, others violate my trust, feel afraid and not trusting

(*continued*)

TABLE 5.1. (*continued*)

		Most associated DSM-5-TR diagnoses			
Major depression, persistent depressive disorder	Obsessive–compulsive personality disorder, subclinical obsessive–compulsive disorder	Atypical depression, Cluster B personality disorder, somatic symptom disorder, eating disorders	Narcissistic personality disorder, persistent depressive disorder	Panic disorder with or without agoraphobia	PTSD, Cluster B personality disorder, atypical depression, somatic symptom disorder, eating disorders
		Psychodynamic treatment goals			
Decreased vulnerability to abandonment, decreased self-punishment	Decreased guilt, increased tolerance of affective experience	More stable image of self and other, decreased mood reactivity, increased stability of relationships	More accurate and positive self-image, increased ability to tolerate vulnerability	Increased independence and ability to be assertive without overwhelming anxiety and anger	Increased sense of security and empowerment, increased healthy trust in relationships
		Typical strengths			
Courageous, humane, emotionally available, relatable/social	Knowledgeable, careful and prudent, hardworking	Motivated for relationship, action oriented	Insightful, sensitive, motivated to get help	High trait-like alliance	Resilient, stoic, introspective, insightful

(*continued*)

TABLE 5.1. (*continued*)

		Therapeutic alliance issues			
Empathy, encouragement, instillation of hope, education about depression	Psychoeducation about therapy and importance of affects, elicitation of feelings	Empathy, development of contractual relationship leading to relationship development	Attention to empathic bond	More frequent sessions, empathic attention to episodes of panic, close exploration of precipitants, psychoeducation about panic, ability to tolerate the patient's necessary discomfort	Clearly spelled-out boundaries and expectations, mutual respect, attention to fact and reality
		Typical resistances			
Overwhelming affects, hopelessness, passivity	Characteristic obsessional defenses (intellectualization, isolation of affect, reaction formation, etc.), overvaluing of thought over feeling	Fear of abandonment, premature ending of therapy	Inevitable ruptures in empathy	Dependency, avoidance	Fear leading to reenactment of traumatic situation
		Technique issues			
Initial phase: empathy, support, encouragement of function; second phase: identification of key themes of abandonment/	Active listening, focus on feelings, gentle but firm confrontation, attention to anger and guilt, some directiveness, use patient's	Emotional containment; appropriate management strategies; variety of approaches, including focus on mentalization, transference-focused work, focus on	Consistent emphasis on ruptures in empathy, repair and recognition of this continuing vulnerability	Identifying precipitants, challenging avoidance, interpreting conflict associated with panic, focusing	Collaborative and flexible attitude, focus on empowerment and realistic perceptions, truth telling, respect for boundaries

(*continued*)

loss and conflict over resentment about losses; maintenance phase: early recognition of increased conflict and planning for effective solutions	cognitive skills to help identify patterns	relationship development, dependency, and true working alliance		primarily on precipitants but connecting to historical antecedents and transference, encouragement of widened scope of behavior	
		Typical transferences			
Abandonment, dependency, idealization, anger	Controlling, passive-aggressiveness, "resistant," anger and hostility, anxiety about being controlled, struggle for freedom and autonomy	Abandonment, rage, dependency, projective identification, micro-psychotic episodes, especially related to transference abandonment	Mirroring, idealizing, twinship	Separation, loss, abandonment; anger about loss; fear of further loss or retribution because of anger	Lack of trust, fear and vigilance, rage at lack of help, need to control therapist, reenactment of trauma
		Typical countertransferences			
Rescue fantasies, feeling incompetent, sucked dry	Frustration, feeling of being controlled, retaliatory fantasies, boredom, distance, futility	Helplessness, anger, guilt, impulse toward boundary crossing	Rescue fantasy, grandiosity, anger at feeling defeated, boredom	Parental, rescue and caregiving, frustration with dependency and rejection	Identification with victim, helplessness, identification with perpetrator, bystander/witness guilt, secondary PTSD, confusion

We encourage clinicians to think about which core psychodynamic problem best characterizes the patient. Our students like the clarity of the six psychodynamic problems, and they rapidly recognize their patients in the descriptions. They find it helpful to be able to quickly recognize the core issues. When they begin to employ the conceptualizations with ease, the user-friendliness of this scheme leads to an interesting clinical problem. How do you determine which problem best fits an individual patient? Sometimes they are able to build a case for several problems for a given patient. The considerations in making this choice are:

- What is the dominant painful affect or symptom the patient is struggling with (e.g., does the patient complain of depression, frequent losses, panic attacks, or insecurity)? Does the patient have some degree of recognition of this psychodynamic problem? Can they see it when discussed?
- Do the problem and the associated dynamics help explain essential history, current problems, and the patient's troubling emotions? Is it the clearest, simplest, and most comprehensive explanation of the six problems?
- Will working on this core problem allow the patient to do the work they need to do to change?

Some problems are at a deeper level of inference, such as obsessionality and trauma. Patients are less likely to self-report these problems and less likely initially to recognize them in themselves. But initial patient acceptance is not the only consideration, and accuracy and thoroughness are ultimately more important.

The era of one-size-fits-all psychodynamic psychotherapy has been fading since the development of DSM-III and the recognition that the empirical study of psychopathology trumps theory as the driver of new ideas about treatment. We regard the PPP model presented here as "problem specific" and see tailoring the treatment to the problem as important in personalizing psychodynamic psychotherapy. Specific problems are best treated with specific treatments. Although the descriptive and very specific diagnoses used in DSM-5-TR are essential for overall treatment planning and perhaps for guiding the timing and type of psychotherapy, we suggest that the "diagnoses" that are most relevant for planning and carrying out psychodynamic psychotherapy are the six core psychodynamic problems.

Our view of each problem reflects a synthesis of the literature and our clinical experience. We do not propose a novel treatment model for each of the six problems. Rather, we have integrated the work of many clinicians and researchers in our recommendations and reference the major influences on our thinking. Trainees will need to supplement our

brief discussion of each problem with further readings of the literature to treat these problems most effectively. This chapter discusses depression and obsessionality, and Chapter 6 covers fear of abandonment, low self-esteem, panic anxiety, and trauma.

DEPRESSION: LOSS AND SELF-ESTEEM

> I am in that temper that if I were under water I would scarcely kick to come to the top.
>
> —John Keats

Past losses make people sensitive to new losses, and depression is the most common problem that brings people to therapy. Under its broad tent coexist sadness, loss, melancholy, boredom, frustration, irritability, fear, abandonment, and hopelessness. Although these feelings are ubiquitous and present transiently for most everyone, when they persist they often start a vicious cycle of negativity—sadness, loss, withdrawal, demoralization, and increased self-criticism—leading to further withdrawal and negative outlook. Subjectively, depression involves prominent persisting feelings of self-criticism, negativity, and loss. From a symptom perspective, depression is often associated with the typical somatic symptoms, including changes in sleep, appetite, and energy, along with problems in focus and concentration and the ability to enjoy oneself. Suicidal thinking and urges may creep in, and there may be loss of sexual interest.

Youthful and intense, Peter, an 18-year-old White cisgender heterosexual young man, walked into the office for his first appointment late in the first semester of his freshman year of college. His steady gaze was framed by long, dark hair and punctuated by gold wire-rimmed glasses. He started right in with an exceptionally articulate description of his inner pain—he was anxious, self-critical, afraid, and certain that he would not succeed socially or academically. His suffering was intense and palpable.

Peter was the eldest of three children, the only son, born to a quiet engineering professor and his wife. He was quick to express his frustration with his mother, who talked excessively and seemed to take everything about their relationship too seriously, including telling him about her disappointments with his father. He was close to her but angry about her neediness. His father was kind but remarkably aloof, almost a caricature of an engineer; he was stuck in his "left brain."

Peter had intense crushes on several girls at college; he was fascinated and preoccupied with each. But he was so focused on being

accepted and loved that it was hard for him to think about how he really felt about them. He was easily wounded and angry when he was hurt. He ruminated about what the girls thought and felt and what move he should make next. He had some good male friendships, but they were not nearly as important to him as his intense need for a romantic relationship. He felt very lonely and insecure.

Peter had difficulty sleeping, constant sadness and anxiety, trouble concentrating, loss of the ability to enjoy himself, and he often thought of suicide. Prior to coming for treatment, he had considered purchasing a gun to shoot himself in the head. It was just too painful to live this way, and when he felt rejection by a girl or a slight from a friend, he was catapulted into intense hurt, anger, hopelessness, and suicidal preoccupation.

Peter was very smart and thought about things carefully—he had organized a high school initiative for climate change and mental health and had creative and interesting ideas for his coursework. But he regularly became bogged down while working on projects and was filled with self-doubt, self-criticism, and fear that he would be seen as mediocre and unimportant. His procrastination caused him tremendous anxiety, and he had to take a semester's leave because of poor academic performance.

Psychodynamic Conceptualization

Freud's (1917b) profoundly original conceptualization of depression in *Mourning and Melancholia* emphasized the importance of loss of close relationships as the cause of depression. Contrasting the self-limited sadness of grieving with the self-critical despair of depression, he hypothesized that those we lose (referred to as the lost "object," in psychoanalytic parlance) are internalized, taken into our minds, and identified with—they become part of us. Anger at the lost object becomes directed to where the object now lives, in the self. This leads to the criticism and anger directed toward the self that is so characteristic of depression—for example, self-doubt, self-criticism, and guilt. It was hard to miss from Peter's history that his problems became full-blown when he left home for college. He loved his parents and sisters and was usually annoyed and disappointed with them, but they were his closest relationships; although he was thrilled to leave the demands of his family behind, going to college was a tremendous loss of these loving relationships.

Melanie Klein (Mitchell, 1986) put forward a similarly brilliant but also somewhat tortuous theoretical conceptualization of depression. She held that early infantile experiences of love and hatred (based on frustration) are managed by projecting such feelings onto the mother (and now

we would include the father) and then introjecting them (a primitive form of internalizing) back into the self. Like mother birds that predigest food for their young, human mothers must be present and close enough to their very young children to allow them to engage in this projection and introjection, allowing the children's anger to be detoxified. Klein defined the stage dominated by this feeling about the mother as the schizoid position because the love and hate are so split apart. In the next stage, the depressive position, the child brings together the feelings of love and anger, recognizing their coexistence, and tolerates the depressing feeling of hating the very same person they love. Klein's contribution to theoretical thinking about depression emphasizes the struggle between loving and angry feelings and the experience of depression as fundamentally tied to the difficulty in attachment to early caretakers and the subsequent stand-ins for these important relationships. Peter was seething with conflict about his love and hate—his mother was his closest confidant, and he disliked both himself and his mother for this. He got very attached to potential girlfriends, but he was more often angry and frustrated with them than loving toward them.

Edward Bibring (1953), a European psychoanalyst émigré who settled in Boston, developed a theory that is easier to understand. Relying on the concept of the ego ideal as the part of the mind that contains the hopes and dreams about what kind of person one wants to be, Bibring hypothesized that good self-esteem depends on how close your perception of yourself is to your ego ideal. Live up to your dreams and you will be free of depression. Be the kind of person you really are, and if it is far from your ego ideal, you will be depressed. Bibring's view illuminated part of Peter's depression. He was in great pain at the difference between who he wanted to be—loved, handsome, smart, successful—and who he felt at times he really was—insecure, unattractive, deficient, unlovable.

Heinz Kohut (1971), the father of self psychology (discussed in Chapter 3) took the study of narcissism and narcissistic personality as his starting point. He noticed that there was a subgroup of patients who found the rigors of classical psychoanalysis especially difficult, feeling ashamed, self-protective, and constantly hurt by the distant analyst and lonely couch. He distinguished a particular type of depressive feeling in those who feel chronically insecure, unloved, and susceptible to searing feelings of loss, abandonment, and shame (he called these patients narcissistic). He saw the Freudian and Kleinian depressions as arising from internally conflicted anger and love and related to these drives and how they are managed. By contrast, he was interested in the effect of a lack of closeness, reciprocity, empathy, and affirmation in relationships. He saw these compromised attachments as frequent and debilitating and a cause of a new type of depression. Thus, the Kohutian depression is one

of limited attachment, as well as chronic subacute disappointment and abandonment. Indeed, Peter felt lonely, detached, and dangerously thin-skinned when it came to relationships. His strong feelings of shame and low self-esteem were matched only by the intensity of his self-criticism and self-flagellation.

Though there are many other thoughtful and penetrating writers about depression, Busch, Ruden, and Shapiro's (2004) monograph on the psychodynamic treatment of depression provides a very useful synthesis of the main ideas. They bring together the Freudian and Kleinian attempts to understand aggression in depression, as well as the Kohutian focus on self-esteem and intimacy. Their formulation is that frustration with early attachment leads to anger and guilt; this anger is turned back on the self in the form of self-criticism. The patient with depression then attempts to salvage a sense of self-esteem and well-being by trying to connect to others, idealizing them and hoping to rescue self-esteem through the love of a new, loving parent. This is doomed to disappointment because of the depressed person's high and unrealistic expectations. The latter part of this dynamic, the self-esteem salvage operation, makes use of Bibring's and Kohut's thinking about the importance of the patient's low self-esteem and the use of relationships to heal and save.

Busch and colleagues' (2004) cogent formulation provides a structure for organizing Peter's symptoms, history, and dynamics. His relationships with his needy mother and distant father resulted in intense feelings of loss, frustration, and anger. His feelings of loss were accompanied by anger and guilty self-criticism. These strongly ambivalent feelings also led to an uncertain sense of self and fragile self-esteem. Peter sought out new relationships with romantic partners to soothe his sense of loneliness and emptiness; these partners were idealized, and thus the fantasy of being with them made him feel loved and whole. But he was constantly disappointed because his hopes were unrealistically high. These rejections fueled his anger and frustration, some of which was turned onto himself with self-criticism and occasional self-destructive behavior.

The twin themes of self-esteem fragility with cycles of hope and disappointment and of frustration leading to angry self-criticism reinforced each other. When the therapist first met Peter, he was terribly insecure and angry at himself. With time, he came to understand that he was also very angry with both his mother and father, the former for being excessively indulgent and the latter for being too distant. Peter's wobbly self-esteem rose and fell in response to how others felt about him; this preoccupation with how the others responded to him made it hard to go through the day, do his schoolwork, and socialize with friends.

Needless to say, the psychodynamic conceptions of depression do not preclude the importance of genetic and biological vulnerability but they do help to understand the mental processes as they are, and they propose a developmental narrative of how the characteristic feelings come into being.

Strengths

Awareness of Peter's strengths balances the discussion of his problems. Depressed patients are often courageous, humane, and emotionally available. Peter had a strong sense of conviction and independence, yet this was particularly challenged by his concern about what others would think of him and the terrible upset he experienced when he felt rejected. His frequent inhibition, ambivalence, and uncertainty seemed to reflect his illness and the struggle with it.

From the character strengths perspective, Peter's humanity, characterized by love, kindness, emotional availability, and social intelligence, was an area in which he was especially well endowed. It was not surprising, but it was striking to note that when not depressed, his function in each of these areas was so much better and deeper, and so much more limited when he was. It is hard to be loving, compassionate, and perceptive when one is desperately preoccupied with keeping one's emotional head above water. It is hard to be kind when one feels angry about being rejected. Likewise, with his strengths in the area of transcendence—Peter was a talented writer, and he had strong moral convictions and a belief that society could be better. When depressed, he procrastinated terribly in attending to his work, and he lost interest in thinking about his larger community and its problems.

Goals of Treatment

The goals of the psychodynamic treatment of depression are to decrease the patient's vulnerability to abandonment and decrease the tendency for harsh self-criticism. Although this seems simplistic, it helps the therapist keep an eye on the future of the relationship, what to look for to assess whether there is progress, and the combination of openness and curiosity and a guiding hand on the tiller that makes for good therapy. The goals for Peter were to develop the ability to ride out the expected bumps in friendships and close relationships by tolerating and surmounting the inevitable feelings of abandonment he will experience, and have a healthier and more positive sense of self that will be more immune to self-criticism when he is angry and hurt. He will look more to himself to feel good, and less to others, and set himself up less for hurt and disappointment.

The psychodynamic treatment of depression combines a detailed exploration of how the patient reacts to the present as though it were the past, with support for behavioral change. Our treatment discussion is also primarily informed by Busch and colleagues' (2004) monograph. An important caveat is that depression is a heterogeneous problem, and we assume here that appropriate diagnosis and treatment selection have already taken place. This means that the patient has been screened for possible medical disorders (e.g., hypothyroidism), and what appears to be depression is not actually something else, such as acute grieving, substance abuse, or a psychotic disorder. A clinical history with emphasis on neurovegetative signs and symptoms, other active psychiatric symptoms, and a screening for medical symptoms will provide the data needed to clarify the diagnosis.

Developing a Therapeutic Alliance

The therapeutic alliance with patients with depression develops rapidly when the patient is scared and suffering. Dependency in the patient, when the therapist is supplying all of the energy, hope, and constructive attention, will certainly make for a quick, powerful attachment. But developing a good alliance requires more than the patient liking the therapist. It also requires the patient to perform the necessary tasks of self-reflection and trying new things. The therapist must take a practical perspective and push the patient to be as active as possible, both in the hard work of therapy and in the engagement with the world.

Some patients who are depressed and hopeless may have little interest in developing a new relationship. Why would therapy work when they have so little to live for? So an essential aspect of treating depression is helping to rekindle hope in the patient. This is done directly through encouragement, as well as through education about depression and how treatable it is. The hopeless patient needs some time to have small successes or moments of satisfaction. It may be hard to avoid overidentifying with the patient and begin to feel hopeless, too. There can be a very powerful pull in this direction. You may need to step back from the patient's own experience of their situation and consider it from the outside: Is the degree of pessimism warranted? Might some people find a way of adapting and working through the problems?

We may alternate between excessive ambition for our patients and hopelessness and detachment. Both of these positions involve some avoidance of feeling what the patient is feeling: misery and hopelessness. The empathic link is so uncomfortable the therapist can become desperate to change the patient or detach from even trying. This alternation can reach an extreme in dealing with the severely depressed or

suicidal patients. Because it is so painful to be with patients who are in acute anguish and who are also very angry about their losses, therapists tend to detach without realizing it. Similarly, depressed patients' significant others respond to their depression by distancing themselves (e.g., Coyne, 1976). Therapists do this, too, to manage helplessness or anger at patients for making them feel so powerless (see Maltsberger & Buie, 1974, for a well-described discussion on this dynamic). But despite this description of the dynamics encountered in developing a therapeutic alliance, most depressed patients step into their role in therapy and develop a good alliance.

Technique

The initial phase of therapy involves promoting a supportive environment and providing education about depression (Luborsky, 1984). The educational part is rather straightforward. The syndrome of depression means that upset feelings, typically about loss, have taken on a life of their own, and the patient is preoccupied with negative, hopeless thoughts, and neurovegetative symptoms. In the state of depression, it's hard to have positive expectancy and it helps to point this out to patients. It helps to point out the vicious cycle of isolation, fear of rejection, and further isolation, and encourage and support the patient in working against it. There is usually a mix of genetic vulnerability and life stressors that precipitate and maintain the depression. Patients need to be told about the diagnosis and encouraged that this problem will get better from a variety of treatments. They should be informed that they will be vulnerable to depression in the future.

Sometimes just starting therapy results in the patient becoming more active, but often it is helpful for the therapist to specifically encourage activity and engagement in the areas the patient identifies as important and rewarding. Doing things and engaging in physical activity usually makes people feel better. Encouraging activity does not limit the potential for learning from the transference in therapy, and it is certainly required in many situations. There is often an improvement in mood and function during the first phase, and these gains ideally will be maintained through the second phase.

The second phase of therapy focuses on identifying the key themes of (1) abandonment and loss and (2) resentment about the loss and subsequent conflict over this resentment.

> First, Peter worked hard on recognizing the typical sequence of feelings he struggled with in his social life: rejection sensitivity, resentment about feeling so hurt, guilt and worry about his anger. He

experienced this repeatedly in the therapy, feeling it deeply, then looking at and discussing it. The therapist asked about his feelings and perceptions of the situations where he felt rejection and loss. Over time he began to feel that his reactions were excessive and that the degree of anger and worry about his anger was misplaced. He did want to make friends, and be close to others, but he began to feel that his reactions were out of proportion to the situations he was really in. He became able to connect his intense responses to friends with old feelings about his parents, and he could see how much his current feelings about loss and rejection were really the reactivation of old feelings about his parents in childhood.

With this increasing awareness, Peter could more flexibly consider his friends and what they were like, and whom he really liked and didn't like. He could see them more for who they were, rather than as a reflection of his feelings and needs. He saw his tendency to idealize others, especially women, and how this set him up for disappointment. With this recognition, his dating pattern began to change. He was able to approach women less intensely and wait to see whether they were genuinely interested in him. He worked harder at being active and outgoing, knowing that this increased his social circle, even when he felt discouraged, breaking an old pattern of retreating when he felt hurt.

The techniques we described for increasing self-awareness, changing perceptions, and trying new behaviors are the main focus of this phase of treatment. Some patients become increasingly upset as they explore current and old feelings of loss, and sometimes they feel worse during this phase. These bursts of intense pain are usually accompanied by a return to an even mood—that is, the patient becomes more resilient and gains confidence that when they are upset they will be able to figure it out and feel better.

The third phase of the psychodynamic psychotherapy of depression, which could be seen as more of a maintenance phase of treatment, focuses on consolidation of the understanding achieved in the second phase and a deepening and working through of these feelings. The attention here is on early recognition of situations that bring up conflicts and recognition of the differences between old and current feelings. The patient works consciously to plan for solutions to these problems. Late in Peter's treatment, he could analyze situations himself and report on them in the next therapy session.

Some patients do not linger in the maintenance phase, and move on quickly to termination. Not surprisingly, this last phase of treatment can be especially potent because patients with depression may reexperience

their earlier losses with the loss of the therapist. They may also be afraid of a recurrence of depression, as the natural history of depression often involves relapses, and there are always interpersonal losses. The general issues of termination are discussed in more detail in Chapter 16, but our experience is that this phase of the treatment of depression involves a genuine sense of loss, both reexperienced via the transference, but also of the realistic aspects of the treatment relationship. The relationship with the therapist is a deep one, and there is an aura of sadness that both therapist and patient will likely feel. It is important to accept this and let the patient grieve in a healthy way. You should caution the patient (and yourself) that a future relapse does not mean the treatment has not been effective, as even the best therapy may leave the patient vulnerable to future depression.

Transference and Countertransference

The most frequent transference reaction of the depressed patient is a feeling of abandonment and hunger for a closer connection. This transference is typical of patients who have a more anaclitic, or abandonment-related, depression. It is frequently associated with a dependency reaction, where the patient regards the therapist as an essential helper. Patients may feel they cannot function on their own and regressively expect and hope the therapist will take care of them. Some patients idealize their therapists, seeing them as the bountiful source of emotional supplies they need to survive. The other side of this dependent transference reaction is the angry transference, where the patient is filled with a sense of rejection and disappointment. Early losses are replayed with the therapist in the role of the absent or hurtful parent. Patients with introjective, or guilty, depression tend to experience the therapist as critical and rejecting.

It is the therapist's task to note these transference reactions and see them as a reflection of the typical dynamics of depression. Patients are expected to have transference reactions and become able to identify and understand them, but this takes time. Therapists are expected to have countertransference reactions, but when they rise to the level of dominating our feelings and affecting our actions in any tangible way, there is a problem.

A common therapist response is the rescue fantasy, a countertransference reaction in which you feel you personally can make the patient better. You feel you can help them become healthy and whole through a close relationship with you, and you feel that your interest and warmth will make the patient feel that life is worth living. Some patients feel so deprived, and are so pleased with the therapist's attention, that they

treat us and make us feel like we are wonderful rescuers. Of course, this is too much of a good thing. There is a big difference between being a good therapist trying to help, and feeling that you are going to rescue the patient. In a healthy therapeutic relationship, the patient is expected to take responsibility and do work on their own, and use you as well as others for help.

Frequently, therapists react to sad and hopeless patients by feeling incompetent and like they are unable to do anything right. This often occurs in response to patients' transference reactions of anger and disappointment. Connected to this response, but a little different, is the countertransference feeling of being sucked dry. Here the therapist has tried to help, but empathy, support, suggestions, and interpretations all feel like they have not had much effect. The patient is still suffering and not much has changed. This is very frustrating and can lead to resentment and detachment on the part of the therapist. Of course, these are the therapist's feelings and not necessarily an accurate representation of reality. We discuss the therapist's strengths and capacities that will help you manage these experiences in Chapter 12.

Therapists conducting dynamic therapy must be aware of and monitor these countertransference reactions, connecting them to the patient's transference reactions. Your goal is to be able to distinguish—and help the patient distinguish—between what is current and realistic, and what is old and transferential.

Outcome and Evidence Base

Through therapy, Peter achieved both symptomatic improvement and a change in his sense of himself and the strength of his relationships. He will probably always have a vulnerability to rejection and loss, but it is now muted, more expected, and predictable. He is quite good at recognizing when he is overreacting to the present based on his sensitivities and when he is looking to a relationship to provide salvation. He makes better decisions about his relationships. His mood is more stable, and he tends to "go with the flow" more. He chose a career path and is pleased with it despite how hard he has to work. He is dating and deals with the uncertainties and opportunities in his relationships with far more equanimity than in the past. In the past, he was terribly anxious about his relationships, always concerned about whether he was liked and loved, and had difficulty enjoying being in the moment. Now he is more able to appreciate people for who they are, and more open to spontaneity.

This is the hoped-for outcome of psychotherapy for depression. The patient no longer has specific symptoms of depression, and has not had them for several years. But the change is deeper than this, as Peter's

experience of himself, his relationships, and his work is also different. He is not desperate, and he can enjoy himself, follow his interests, deepen his talents, and appreciate others for who they are. He is probably less vulnerable to relapse as well, and this is reflected in the fact that he has not been depressed for about 5 years.

Increasingly, psychotherapy outcome studies of major depressive disorder have shown equivalent effectiveness for psychodynamic and cognitive therapy. Leichsenring (2001) published a meta-analysis comparing brief dynamic therapy to CBT and found almost no difference in outcome. In that meta-analysis, Leichsenring, like Crits-Christoph (1992), included interpersonal psychotherapy as a form of dynamic therapy. There is a controversy, which we will not try to resolve here, about whether interpersonal psychotherapy is a psychodynamic treatment. Interpersonal psychotherapy is similar because it focuses on repetitive scenarios involving loss and transition and uses empathy, exploration of painful affects, and occasionally transference. Of course, it is different in that it is highly focused and includes a major educational component. Without making a judgment about whether interpersonal psychotherapy should be included, both meta-analyses reported that their main results were not changed if interpersonal psychotherapy was excluded.

More recently, Leichsenring, Rabung, and Leibing (2004) identified 17 well-conducted studies of short-term psychodynamic psychotherapy published after 1970 and found that these short-term psychodynamic psychotherapies yielded large pretreatment–posttreatment effect sizes for target problems (1.39), general psychiatric symptoms (0.90), and social functioning (0.80). According to Leichsenring and colleagues, the effect sizes of this treatment significantly exceeded those of waiting-list controls and treatments as usual. No differences were found between short-term psychodynamic psychotherapy and other forms of psychotherapy.

Although meta-analyses are powerful because they allow us to review a large number of studies and average effect sizes across different studies, their weakness is that they rely on the quality of the studies that they include. Meta-analyses by Driessen and colleagues (2021) and Barber and associates (2021) included several types of psychodynamic therapies: interpersonal psychodynamic therapy (not interpersonal psychotherapy), time-limited psychodynamic (including supportive–expressive) therapy, and supportive dynamic therapy. Overall, the few studies examining the efficacy of dynamic therapy for depression indicated that dynamic therapy is no less effective than other established treatments and more effective than control conditions (e,g., Barber et al., 2021). It is noteworthy that Barber, Barrett, Gallop, Rynn, and Rickels (2011) found preliminary evidence (that needs replication)

that supportive–expressive therapy, a form of manualized time dynamic therapy for depression, was more effective for ethnic minority males than either medication or placebo. For White males, they found that placebo was more effective than either medication or dynamic therapy. For White women, dynamic therapy and medication were more effective than placebo (the expected finding). For ethnic minority women, there was no difference among medication, pill placebo, or dynamic therapy.

In summary, depression is described here as a core psychodynamic problem that is frequently conceptualized using the ego psychology model. Old experiences of loss lead to anger and frustration that becomes internalized and leads to ill-fated attempts to restore self-esteem, which only lead to further disappointment. We have described typical goals for the psychodynamic treatment of depression, as well as expected resistances, transferences, countertransferences, and essential techniques. This discussion establishes the format for our discussion of the other five core psychodynamic problems.

OBSESSIONALITY: CONTROLLING FEELINGS

> BAILEY: I happen to have a human thing called an adrenaline.
>
> SPOCK: That sounds most inconvenient. Have you considered having it removed?
>
> —*Star Trek*

Raymond, a successful Black cisgender heterosexual lawyer in his 50s, described in detail his frustrations at work. He was elegantly dressed and stopped to carefully sip water from the sculpted metal water bottle he brought to the appointment. He described the long hours he worked and was very careful to make sure everything he said was reasonable and moderate. His style of speaking was polished and smooth.

Raymond's rough-and-tumble professional world, populated by personal injury clients who were hurt, damaged, and angry, and demanding but poorly prepared judges, was stressful but lucrative. He tried to take care of his clients, and had a strong need to be seen as kind and helpful. In an area of the law where ethical boundaries are sometimes crossed, he worked hard to do the right thing. He had few hobbies or leisure pursuits and did not keep up with friends much.

Raymond came from a family with strong traditional values—his father was a pastor and mother a homemaker, and his younger brother was a policeman. His father had been tough and stern, and growing up he had to hide any interest in romance, alcohol, or other indulgences until he left home to go to college.

Raymond's main complaint was that he felt he didn't have enough "peace and calm" in his life. He was mad at his colleagues, who took advantage of him, especially a new younger associate with an overly casual demeanor. He felt some of his clients were entitled and disrespectful, and his wife of over 20 years frequently pushed him to come home earlier and spend more time with the second of their two daughters, a middle schooler who was on the high end of the autism spectrum. He was deeply concerned about this child, but frustrated with her frequent complaints of loneliness and rejection, cyberbullying and exclusion—there always seemed to be a problem. Raymond felt he did more for his aging parents than his brother who lived in another city. He lost his temper at his daughter, and exploded with anger and frustration when his wife confronted him about this.

I wondered why Raymond chose, and how he felt speaking with, a White male therapist. I asked about this and Raymond said pleasantly that I had been recommended and made clear he wanted to leave the conversation there.

In the early sessions, Raymond had a way talking that made it difficult for me to get a comment in. When he listened, he was polite but unresponsive, and somewhat distant and stiff. There was not a lot of back-and-forth in our sessions, almost like we were each reading from a script rather than interacting. There was a feeling of tension in the air and I could not put my finger on why. Raymond had trouble acknowledging any of his outbursts or more subtle social misjudgments, and he vacillated between defending the anger he seemed to feel toward virtually everyone, and explaining why others' behavior was so bothersome. He could not explain his clearly ambivalent feelings toward his daughter, and said little about his marriage or his other daughter. He was rather rigid in his outlook and his way of being together, and seemed to have quite a bit of shame and remorse.

With some discomfort, after a couple of months of weekly appointments, I realized I was beginning to be irritated with Raymond. He seemed smooth and controlling. It was hard to connect with him and simply talk about what he was feeling. He needed to explain and justify rather than communicate. Was this related to his anger and defenses against it, to my feeling of being held at a distance, and/or to the important and as yet unexplored question of how our different races and backgrounds were shaping our experience together?

Mr. Spock, the Vulcan on *Star Trek*, was a caricature of the classic obsessional patient—preoccupied with rules, ideas, and procedures, and distant from feelings or emotion. But, Raymond was just as obsessional.

He needed to control himself and others, and like many obsessional patients, had very strong emotions. He regarded his emotions as an "inconvenience," a problem, and a threat to well-being.

Shapiro's (1965) discussion of obsessionality begins by noting Wilhelm Reich's apt description of an obsessional patient as a "living machine." The style of thinking is rigid and hard to influence, and Shapiro observes that the patient is dominated by the feeling of having no autonomy. He feels "I should" instead of "I want," and maintains an iron discipline in hewing to the line in doing what "should" be done. These patients experience a subjective sense of loss of autonomy because they have difficulty making decisions. Shapiro claims that these patients are indecisive because the emotions involved in decision making are not given much free play. Finally, he notes that obsessional patients constantly doubt because they lack a deep personal sense of conviction and instead follow their sense of what should be done. Raymond speaks of responsibilities and requirements rather than emotions and needs. He is in charge, yet he does not feel he has choices.

The core psychodynamic problem of obsessionality does not map cleanly onto the DSM-5-TR system. DSM-5-TR distinguishes between two forms of obsessionality. Obsessive–compulsive disorder is a genetically loaded and self-perpetuating illness that involves irresistible repetitive, intrusive thoughts or powerful urges to repeat irrational ritualistic behavior like cleaning or checking. Obsessive–compulsive personality disorder is a lifelong disorder involving preoccupation with details, interpersonal aloofness, interest in form over substance, and tight control over emotions and relationships. Both disorders can be characterized by similar psychodynamic patterns, which we describe below.

Psychodynamic therapy is probably indicated only for obsessive–compulsive personality disorder (Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997), the aloof, inhibited version of the problem, and for milder and subsyndromal forms of obsessive–compulsive disorder, the highly ego-dystonic variant. Psychodynamic therapy for full-blown syndrome of obsessive–compulsive disorder has historically not been recommended, though an RCT of this treatment will be underway soon (Leichsenring & Steinart, 2016). Hence, we use the term *obsessionality* for the core psychodynamic problem that is similar in both of these conditions, and which is amenable to psychodynamic therapy. From a DSM-5-TR perspective, Raymond has obsessive–compulsive personality disorder, with characteristic attention to rules and procedures, perfectionism that results in difficulty completing tasks, excessive devotion to work at the expense of leisure and personal relationships, inability to delegate, and rigidity.

Psychodynamic Conceptualization

The main theme in the psychoanalytic literature on obsessionality is the conflict over aggression and the use of specific defenses. The initial psychoanalytic interest in obsessionality focused on the concept of anality and the developmental issues of autonomy and control. Abraham (1923) described the anal triad: cleanliness, orderliness, and parsimony. Psychoanalytic writers connected these characteristic anal preoccupations with the way that obsessional neurotics seem to value order, ritual, and thought over emotion, and proposed that obsessionality had its origin in anal phase developmental problems (Freud, 1908). There are few data to support this notion.

Subsequent thinking, primarily from the ego psychology school of psychoanalysis, emphasized the obsessional patient's feeling that anger is bad; it is to be gotten rid of, controlled, and disarmed (A. Freud, 1966). This relieves the patient of guilt, leaving a feeling of goodness and cleanliness. The patient accomplishes this by using characteristic defenses, each of which operates unconsciously and results in the patient feeling less conflict, especially less anxiety about anger.

There are five characteristic defenses. Intellectualization is the focus on complex cognitive processes rather than gut feelings. Isolation of affect is the separation of thoughts from feelings. Reaction formation involves substituting a positive feeling for a negative one. Displacement means shifting the feelings and conflicts from one situation onto another that is unrelated, like road rage after a family argument. Doing and undoing refers, like it sounds, to the tendency to express something (verbally or through behavior) and then undo it by expressing the opposite. Making a humorous critical comment followed by the smiling aside, "Just kidding," is an example of this. Raymond had many typical obsessional characteristics: His seamless and careful exterior, controlling conversational style, interpersonal distance, attempt to disavow his anger, and difficulty tolerating and expressing his feelings illustrate the core psychodynamic problem well.

Salzman (1968) extended the central formulation of obsessionality: conflict over aggression resulting in prominent guilt. He observed that patients with obsessional problems maintain, and feel a need to maintain, strict control over their emotions. They need to control others so that their own feelings do not get too stirred up. Raymond was chronically angry about the burdens and obligations he lived with and had impulses to tell off his clients, partners, and family, but was so anxious and guilty about these angry thoughts that he had to manage them with the usual obsessional defenses. He needed to control himself lest he feel angry, guilty, and then anxious. He rarely let the therapist speak because

he was so intent on keeping his conflicts under control. If the therapist spoke, Raymond was afraid he would get too stirred up, so he either talked a lot, or listened in a detached way.

As society has become more complex, with technology and bureaucratic procedures involved in every facet of life—work, government, household management, and even leisure—the obsessional patient's qualities have more adaptive value. Our veneration of and ambivalence about coolness and rationality, sticking to procedures, and "machine-like" functioning are epitomized in the meme of the "spectrum-y" Silicon Valley nerd.

Strengths

Although they possess much rational knowledge, obsessional patients show doubt or rigidity. They tend to be hard workers, show perseverance and courage in the face of difficulty, and have strong conceptualizing abilities. They are prudent and thoughtful (though often indecisive) and not impulsive.

The personality strengths of wisdom and knowledge (requiring judgment and conviction, seeing the forest for the trees) are often compromised because of their excessive attention to granular detail. They may not strongly manifest humanity, as they have limited access to their feelings of love, empathy, and altruism. The personality strength of transcendence, which calls for the ability to experience inchoate emotions like beauty, gratitude, hope, and humor, is difficult because it requires flexibility and irrationality, and the obsessional patient must maintain control. The goals of treatment of a patient struggling with obsessionality, discussed below, involve a decrease in the degree of conflict, but also an attempt to help patients deepen their capacity for flexible thinking and deeper feeling.

Goals of Treatment

The treatment goals for obsessionality reflect the psychodynamic theories for understanding it. The chief aims are (1) helping the patient experience a wider range of emotions; (2) increasing tolerance and acceptance of negative and positive emotions; and (3) decreasing the degree of guilt that drives the defenses and the need for self-punishment, with increased acceptance of imperfections and faults.

The heart of the problem in working with obsessional patients is their difficulty in tolerating and experiencing emotions, especially painful emotions. Anger is the most difficult emotion, and obsessional people worry about being destructive. This often leads them to feel out of

control and worry about retaliation by others. The goal for obsessional patients is to help them experience more pleasure, spontaneity, emotion, and autonomy and decrease the burdensome sense of pressure, guilt, anger, and fear. This happens through experiencing and reexperiencing anger and loss in current life situations, the past, and in the treatment relationship without the feared consequences.

Developing a Therapeutic Alliance

Obsessional patients are so concerned that their feelings are bad that interpretations about using the defenses of intellectualization and isolation of affect can easily feel like criticism. Therefore, the therapist needs to be sensitive to possible ruptures in the alliance and must confront obsessional individuals carefully. One of the early ways to increase the alliance is by encouraging patients to conceptualize their problem. This helps to give them a sense of control and mastery as they proceed and promotes the alliance as long as the therapist does not get seduced into too much theoretical back-and-forth. Some intellectualization can help to promote the therapeutic alliance.

Interpretations (in general, not just with obsessional patients) should start with empathy, move on to observations about the patterns, and conclude again with empathy. An example of this would be:

> "You feel so much responsibility it is crushing for you. I think that maybe you are also feeling angry about how much responsibility you have, but you feel very guilty and afraid of the angry feeling. This guilt is so powerful, and you are so afraid of what you might do if you really got angry, that you need to make sure you control this, and so you are good and responsible and nice."

Raymond initially declined to discuss how he felt as a Black man in therapy with a White therapist, and why he had chosen this. Probably, this question had to be discussed in order to deepen the therapeutic alliance. Raymond had many experiences of racism in his career (and his life), with other lawyers and judges especially, where he was treated in a biased and discriminatory way, sometimes in microaggressions and sometimes overt behavior. Although he occasionally referred to these experiences, these references were more like headlines than actually talking about the experiences. After one such reference, the therapist commented that Raymond must have very strong feelings about what he had put up with. Eventually, Raymond explained that he did not want to discuss race and racism in therapy because he thought the therapist would not understand. He did not want to feel frustrated and

disappointed by this, and did not want to feel misunderstood and badly treated in the therapy, as he had in so many other settings. This was the beginning of a greater sense of closeness and connection in the therapeutic relationship.

Technique

All psychotherapy patients may benefit from psychoeducation, an explanation of the treatment, and how it will help with the problem. Obsessional patients are particularly interested in this preparation for therapy because of their love of rules, procedures, and ideas. A good, simple explanation of what psychotherapy is, how it is done, and how change occurs is in order. The patient's main responsibilities—to talk about what is going on in their mind and what they are feeling—are emphasized as a simple prescriptive.

You must look for affects and elicit them carefully with obsessional patients. You cannot simply listen, support, and vaguely evoke feelings. Directly inquire, observe body posture, and explore the subjective experience of each type of feeling and each experience. In other words, you need to help the patient recognize the affect that is being avoided—for example, "When you came home to an empty house last night, what did it feel like?" or "When she said that, what was that like for you?" You may point out common reactions to situations the patient is in and ask the patient whether they are having those reactions. You might need to keep the questions open-ended but not give up on getting an answer when the patient demurs. You may need to return to important questions.

Later on, you can focus more on the anger and ask what it feels like—for example, "What are you afraid of when you are feeling this way?" Emotional experiences must be clarified and named. Mirroring, empathizing, and active expressions of acceptance of feelings are helpful, as obsessional patients have strict superegos, with harsh self-criticism and shame. Remember, these patients are focused on what they should feel, trying to avoid the upset of what they do feel.

More than any of the other psychodynamic problems, treating obsessionality requires persistence and an active stance. Patients may debate a course of action over weeks. Action should be encouraged, and then later the results can be examined and dissected. The obsessional patient's tendency to ruminate rather than act needs to be met with a firm guiding hand, encouraging practice, trying new behaviors, and experimenting. Of course, there is a danger of enacting a control battle in the name of good therapeutic intentions, and therapists should try to find a way to guide and encourage with a light touch, avoiding

a potential counterproductive control struggle. Even when guiding and directing, the emphasis is always on the emerging affects.

Harold, a thin, polite, cisgender heterosexual man in his 40s used to leave the house to go running several evenings per week just around the time that his young children needed to go to bed. It was a typically chaotic moment in the house, and his wife was frazzled and the kids were demanding. Harold felt angry at his wife for her insistence on help from him and her frequent criticism of him. He revealed his habit of escaping into a run with some embarrassment, but discussed it as though he simply needed to leave because it was so loud in the house.

It was clear to me that Harold could not stand the conflict and emotionality of the household at that time of day. Everyone was tired, worn down, and vulnerable to erupt. So was he. When probed gently for what he felt, Harold insisted that he just wanted to be somewhere quiet and by himself. He did not know why. As he spoke about this again, I detected a moment when he seemed annoyed with his wife, and I asked him more about that. After a few questions along these lines, he finally acknowledged that he did not like the way she treated him when they were getting the children ready for bed, and he wanted to get away. But he was not sure why he needed to leave and appeared more ashamed of this than before.

Several weeks later the same topic came up, and we got a little further. Harold was talking about his wife and her strong personality, and how this was tiring at times, and irritating. He was able to express, with much empathizing and support from me, that he got angry at her often, and did not know what to do. He felt guilty because she is a good person, and a good wife and mother. I connected this with his nightly escapes and wondered whether he left because he was angry with her and did not like the feeling. Perhaps it scared him? This time, he was aware of feeling angry and having the urge to escape. But it was followed quickly by feeling embarrassed. I commented that he seemed ashamed, which was understandable when looking at it from a contemporary adult perspective, but that maybe there were some deeper emotions and fears that were not so rational.

Slowly, and in fits and starts, Harold began to see his pervasive pattern of anger and his fear that the anger would go to generate terrible conflict. This was triggered especially when he felt a sense of rejection or loss. He was afraid that others (his wife, colleagues at work, children) would get angry with him and reject him. There often seemed to be a greater intellectual awareness of this pattern than an emotional familiarity, and we returned to it over and over again.

It was hard at times because we seemed to go over the same ground repeatedly, but usually I was aware that it did not feel like the same ground to Harold. Each time was a little more revelation, with a little more emotion. The dilemma was to keep it fresh and not sink into intellectual repetition, and to keep the focus on the emotions he was experiencing: naming them, helping him to see the pattern, empathizing with his struggle, and encouraging new solutions to the emotional conflict.

Transference and Countertransference

Typical transference reactions for obsessional patients include the need to control the therapy and the therapist. This is usually a desperate attempt to manage the possible emergence of bad and dangerous feelings. It accounts for the sometimes dry and distant tone of the sessions with these patients, who may struggle for control to preserve their freedom and autonomy, and thus may frequently regard you as controlling. They will rebel or avoid you as though you were an implacable force set on stamping out their autonomy. They may test you and your tendency to want them to be a certain way or make certain decisions. There may be overt feelings or indirect expressions of anger and hostility. This type of transference reaction may be more evident in patients who are less compensated and adapted to their obsessional conflict, or as the treatment progresses and the patient becomes more able to tolerate their anger.

Common countertransference reactions are frustration and the feeling that the patient is deflecting and not engaging with the therapist. In the example of Harold, it required patience to stay with the slower pace of understanding and analyzing the troublesome repeated scenario. The therapist could feel angry and have the urge to push through the patient's carefully constructed defenses, or could feel boredom and distance. Sometimes the game of cat and mouse feels futile and pointless. One may also find oneself responding to the patient's underlying anger, which is repressed or suppressed so carefully.

Outcome and Evidence Base

Raymond's treatment continued for over 2 years. Slowly, he began to be able to use the space and time in therapy to explore his feelings of anger and frustration without reflexive self-criticism and the need to defend himself. Yes, some of the clients were difficult, and his partners could be selfish. Yes, there was disappointment that his daughter had a lot of challenges and maybe her successes, social and academic, would be less

than he hoped. We spent much time helping him simply express and sit with a wider range of emotions than usual; this included sadness, loss, and compassion, as well as the usual anger.

He was able to explore his self-critical, guilty, and shameful feelings, connecting them with the values of his upbringing and his father's strict values, and consider his strengths, as well as his limitations. He could experience mixed and ambivalent feelings toward his patient and resilient wife, including anger at being criticized, as well as love and companionship. Raymond was actually quite scared of his anger, feeling it could be dangerous, and his personality style was an attempt to contain this. He had angry and competitive fantasies about his father, but maybe they were only thoughts and not behaviors.

The therapeutic alliance evolved through extensive collaborative work on the many vignettes Raymond brought for discussion, and through the numerous conversations about race, especially the ambivalence Raymond had about opening up with a White therapist. It was only toward the end of treatment that he acknowledged, with some discomfort, that he had been quite frustrated in not being able to find an older Black male therapist and had settled for the current arrangement. In that setting, Raymond imagined that he would have felt closer and more understood and felt some bitterness as a result. The therapist acknowledged this as a realistic disappointment and resentment, and perhaps also as a transference longing. Raymond was clearly more comfortable with himself and his feelings, and his ability to talk about this disappointment and resentment was a therapeutic achievement.

Barber and colleagues (1997) studied the efficacy of moderate-length (52 sessions) supportive–expressive therapy (Barber & Crits-Christoph, 1995; Luborsky, 1984) in patients with avoidant or obsessive–compulsive personality disorders. By the end of treatment, 39% of the patients with avoidant personality disorder still met diagnostic criteria for their disorder, while only 15% of obsessive–compulsive personality disorders retained their diagnosis at the end of treatment. These data, although tentative, suggest that supportive–expressive therapy was quite effective at helping patients with a diagnosis of obsessive–compulsive personality disorder. Other studies have looked at patients with personality disorders treated with dynamic therapy, but most of them did not break out their results for obsessive–compulsive personality disorder.

SUMMARY

A clear definition of the six core psychodynamic problems allows the clinician to rapidly recognize typical patterns, bring to bear useful

psychodynamic conceptualizations, anticipate challenges in building the therapeutic alliance, employ effective problem-specific therapy techniques, and be aware of likely transference and countertransference reactions. The first two psychodynamic problems, depression and obsessionality, were discussed in this chapter, and the remaining four are the subject of Chapter 6.

6

Core Psychodynamic Problems, Part II

You will find yourself running through the six core problems in your mind as you interview patients, trying to decide which one fits best. If the patient seems to have more than one problem, which problem seems to capture the patient's current experience and includes the data you have gathered? Which problem would the patient find most useful to work on initially, and which problem will result in the patient doing the work needed to change and feel better? Review Table 5.1, pages 106–109, for determining the core psychodynamic problem for a particular patient. In this chapter, we review the remaining four problems: fear of abandonment, low self-esteem, panic anxiety, and trauma.

FEAR OF ABANDONMENT

> We long for an affection altogether ignorant of our faults. Heaven has accorded this to us in the uncritical canine attachment.
>
> —George Eliot

Unfortunately, the completely secure and uncritical attachment Eliot speaks of happens with dogs more than humans. Some people are much more sensitive to loss and abandonment than others. Fear of abandonment is the problem of insecure attachment to others, with persisting feelings of separation and abandonment. Patients with fear of abandonment use desperate strategies to stay connected with others; they have difficulty tolerating the overwhelming feelings of loss and loneliness they experience. If you constantly feel alone and are scared of losing what little you have, you may appear chaotic and unstable to others because of the strategies you employ to try to stay secure.

There is a spectrum of fear of abandonment, ranging from very symptomatic and dysfunctional to reasonably functional with uncomfortable inner experiences. Kernberg's (1975) and Gunderson's (2000) studies of borderline personality disorder describe typical characteristics of patients with severe attachment problems: intense feelings of abandonment, chronic anger, multiple physical and psychiatric symptoms, splitting (i.e., alternating good and bad internal representations of self and others), absence of good sublimations (engaging and successful involvement in activity), frequent feelings of emptiness, impulsivity, use of the characteristic defense projective identification, and a tendency to briefly lose touch with reality in intense interpersonal situations. Some patients have significant problems with separation and abandonment, manifesting in relationship instability with dependency and anxiety. These more functional patients have fear of abandonment, but they struggle with less intense loneliness and emptiness. Their use of splitting is less severe and less pervasive, they are less prone to projective identification, and they are more able to use higher-level defenses like sublimation and humor.

Psychodynamic Conceptualization

The classical psychodynamic and psychoanalytic literature discusses abandonment fears in terms of the diagnosis of borderline personality disorder. The term *borderline* itself has a pejorative connotation in the mental health arena. It came about innocently, used to describe people who seemed, from the perspective of 1950s psychoanalysis, to be on the borderline of psychosis. But the word contributes to stigma, alienation, and objectification and this is painful and destructive for patients and brings out less attractive responses in therapists as well.

The traditional literature, including the work of Mahler, Gunderson, and Kernberg and his colleagues, brought out the key concepts of separation and individuation, and borderline personality organization as a structure. Two subsequent conceptualizations of fear of abandonment evolved from these ideas: Bowlby's work on attachment and Bateman and Fonagy's elaboration of mentalization.

Margaret Mahler (1972) described a critical period of development in the attachment of the toddler and mother (caretaker). Following the normal symbiotic exclusive relationship between mother and baby comes a period of separation, individuation, and rapprochement (the normal alternation between closeness and separation), which ideally results in a secure sense of self and confidence in the presence of the mother. Mahler's theory located the source of the difficulty for borderline patients in the rapprochement phase, concluding that they were not able to successfully try out independence, reconnect and refuel with the mother, and then

separate again. Her theory was not based on longitudinal developmental data but rather on the similarity between observations of this childhood phase and the dynamics observed in adult patients.

Otto Kernberg's (1975) dense and brilliant writings systematically combine these descriptive characteristics and the language of object relations to describe the inner world of borderline patients. He characterizes the borderline personality organization, a set of underlying pathological structures, which manifest in the typical primitive defenses and can present in a variety of forms, including the classic borderline personality, but also narcissistic personality and forms of antisocial personality. His object relations perspective emphasized the fundamental object relations units that make up the personality, and whose incomplete structuralization results in the typical borderline phenomena. Kernberg was influential in his emphasis on the aggression and rage these patients experience. He posited a constitutional excess of aggression that was intensified and accelerated during the rigors of the separation process. Kernberg's recommendation to address the rage directly, especially in the transference, is one of the hallmarks of his treatment approach.

Kernberg's work has been fruitful in generating subsequent work on a more comprehensive model of personality disorder and treatment (Caligor et al., 2007, 2018), and the evolution of an empirically supported manualized treatment, transference-focused psychotherapy (Yeomans, Clarkin, & Kernberg, 2015).

The attachment paradigm developed by John Bowlby (1958) provides a broader context for understanding this problem and a useful construct for understanding and treating patients. Bowlby established a connection between theory and observable behavior. He took an ethological—that is to say, he observed behavior—approach to understanding the problem of attachment, and the simplicity of his framework provides a remarkably useful, experience-near account of abandonment and its vicissitudes.

Bowlby and Ainsworth observed toddlers in the process of separating from and returning to their mothers. They studied this process in detail, observing their behavior and emotional expression, and described four types of attachment: (1) secure attachment, in which the toddler is able to leave the mother and feel good alone and upon reunion with the mother; (2) anxious attachment, where the toddler responds to separation with apparent anxiety and clinging when the mother returns; and (3) avoidant attachment, when the child stays away from the mother upon reunion, as though fearful of feeling connected and then abandoned again. He later added the notion of (4) disorganized attachment, which occurs in those who manifest chaotic and poorly organized responses to separation. These notions have received significant empirical support in subsequent work (Cassidy & Shaver, 2016).

Anthony Bateman and Peter Fonagy (2012) proposed the concept of mentalization as a critical developmental achievement that is compromised when early and important relational experiences are confusing, contradictory, and inexplicable. Patients with fear of abandonment are seen as lacking the ability to fully mentalize—that is, to understand and empathize with the subjective experience of others—leading to abandonment vulnerability, poor object constancy and a profound sense of insecurity and aloneness.

Sarah was a scared White heterosexual cisgender 27-year-old social work student who tended to get overly attached to potential partners, and whose mood fluctuated with each phone call, casual meeting, or date. A small woman with blond curly hair and a pixie-ish demeanor, she was very smart and successful at her academic work. She felt desperately alone in the middle of a busy academic program with many like-minded peers. She had an intact family that included her father, mother, and a younger brother. But no one among her peers or in her family seemed trustworthy, and unless they pledged endless loyalty, she constantly tested those she hoped to count on. Her mistrust led her to use poor judgment. When she dated another student, she sent him an email using someone else's address to ask whether he was dating anyone.

Sarah's obsession with relationships showed itself in the therapy as well; she strolled by my office when she did not have an appointment, looking to see who was in the waiting room. She saw the office door open, and looked in, staring intently. It was a chilling experience—as though she was intensely connected way beyond what seemed to be the reality of our relationship after 10 weeks of treatment, and I felt anxious, guilty, and a little violated. She found my home address in a directory and mentioned it one day when she was feeling particularly upset.

Sarah's fear of abandonment was so clear. She made occasional suicidal threats, veiled references to how desperate she was, and she developed an insistent focus on me. She needed to be and stay intensely connected. Nothing mattered as much as the feeling of being loved; it was not an erotic, sexual love, but rather a parent–child, caregiving, enveloping love that she seemed to want so badly. Everything that happened with me, or with her friends and family, meant that she was loved and cared for, or it confirmed her feeling of loss and abandonment. She had to lasso others into a safe and unbreakable bond.

The chaos that may surround abandonment-sensitive patients results from their chief technique for dealing with their overwhelming

insecurity—they try to control relationships and feelings, both in the external world and inside themselves. They prevent the experience of abandonment by keeping others bound to them. Sarah's attempts (often so unsuccessful) to achieve security with boyfriends, and her therapist, were the external manifestation of this painful endeavor. She demanded so much of others that they often rejected her and kept their distance.

Inside, Sarah experienced the split sense of self so characteristic of this problem, and did everything she could to keep current the positive valued self-image (Kernberg, 1975). In childhood, Sarah developed two distinct images of herself and of those around her. Her good self was the loving, helpful, interested, competent, lovable self she both was and wanted to be entirely, but alongside of this, there was a dark side. She was angry, frustrated, destructive, and convinced of her unlovability. This was especially painful because it made her feel that all of her misery was her own fault; maybe her loneliness was because she was so unlikable and bad. This duality extended to her view of others. People were loving, maternal, nurturing, rescuing, and ideal, or disappointing, inconstant, selfish, rejecting, and unavailable. Though ambivalence is a ubiquitous experience, and involves feeling both good and bad about oneself and others, splitting is different because there are no shades of gray and the patient feels either all good or all bad.

Splitting causes confusion and dismay in those around the patient with fear of abandonment, but it also helps the patient maintain a beacon of love and hope inside. It allows for a positive sense of self and a positive feeling about others, untainted by anger and hatred. Splitting maintains that sense of goodness and allows for something inside that the patient can count on. But, of course, this defensive operation causes a tremendous amount of collateral damage.

Many of the other core features of fear of abandonment follow from this understanding. Sarah had difficulty finding activities to invest in (although she had her academics) because they seemed unimportant compared with her emotional need for attachment—that is, she had few activities that sublimated her intense emotional need. She was impulsive about expressing her positive and negative feelings in relationships, depending on what was most prominent at the moment. Sometimes she felt empty, sensing that there was nothing inside her that was stable and truly her; she was just the sum of her fears and insecurities. Sarah's attachment system was consistently activated. Her occasional loss of reality testing occurred when she was in the thrall of her negative and bad views of others. She could only see the other person as a bad object, and not a fully developed person with good and not-so-good qualities.

Many abandonment-sensitive patients have less severe symptomatology; they use more developed and mature defenses and may not

manifest splitting as overtly as Sarah did. Bowlby's concepts of clinging attachment and avoidant attachment are helpful explanations. These patients tend to manifest their abandonment fears in more stable significant relationships and experience insecurity and fearfulness about any perturbation or change in those they rely on. They can tolerate more conscious experiences of loss and aloneness. This milder version of fear of abandonment appears as a proneness to dependency. Some people have overt clinging-type behavior in relationships, while others hold themselves apart or reject others before they are rejected, to manage their experience of abandonment.

Sarah's capacity for mentalization was quite impaired and her sense of what was happening in her parents or partners' minds was distorted and inaccurate. It was hard for her to see herself as someone feeling loss and fear, and others as having their own subjective experience and needs. Her cynical and anxious perceptions lacked empathy and nuance.

Strengths

Patients with fear of abandonment are action oriented and very motivated for change. But, some of their character strengths are limited by this problem. For example, their humanity—the ability to feel love, altruism, and empathy—is challenged because both sides of the split representations of self and others are inaccurate and wrong. The patient is neither as good nor as bad as their self-representations portray, and others are neither so lovable nor as evil as they seem. A strong sense of humanity requires the ability to manage and experience ambivalence, and justice, which includes citizenship, fairness, and leadership, is compromised as well. When one is fighting for one's life, it is easy to lose sight of others and their needs. Because the urge for secure attachment is paramount, and justice essentially requires an ability to step outside oneself and see oneself in a larger context, this broader perspective is particularly difficult.

Much of the traditional psychoanalytic literature on fear of abandonment emphasizes the patient's anger and pathological defenses, and deals extensively with the countertransference dilemmas stirred up by splitting. Identifying strengths and supporting them are essential tasks for the therapist of patients with fear of abandonment, and we discuss the importance of coaching more fully in the section on treatment.

Treatment Goals

The treatment goals for fear of abandonment include a more stable and integrated (good and bad) image of self and other, decreased emotional

reactivity, and more stable relationships (see Gunderson, 2000). The therapeutic challenge is to help these patients contain their destructive emotions, develop an increased ability to be effective and active in the world outside treatment, and increase their self-reflective functioning and mentalize (Bateman & Fonagy, 2012)—that is, understand and accept their own needs and feelings and those of others. The goal is to help Sarah feel she is lovable, neither perfect nor awful. She should be able to count on loyalty from others, but accept that they have their own needs and cannot always do what she wants. For those patients with more mild abandonment issues, the goal is a more secure attachment in Bowlby's sense, and an ability to weather the inevitable sense of threat they feel in close relationships.

Building a Therapeutic Alliance

What distinguishes the patient whose core problem is fear of abandonment from patients with other core problems that also involve experiences of abandonment, such as depression, panic, and trauma? The centrality of relationship loss and the overwhelming sense of aloneness in the patient's current experience, and the use of defenses to manage it, are the main features of this problem. Not surprisingly, these defensive strategies for dealing with abandonment are rapidly enacted in the relationship with the therapist.

The therapeutic alliance is built under the sway of the patient's intense need to connect, and their fear of separation and loss. Confidence in the therapist can go from 0 to 60 miles per hour in a single session, with the patient concluding that the therapist is the best ever, with absolute confidence that the relationship will be sustaining and productive. Or the therapist is seen as cold, rigid, and uncaring because of the seemingly short duration of the session, or the fee, or something in the interaction. The relationship may begin one way and change by the next session, and then change back. Therefore, calmness, patience, and unflappability on the part of the therapist are a must.

A strong alliance is more likely to develop through repeated experiences of containment and coaching. Understanding the patient's vulnerability to abandonment and proneness to split will give you some detachment, as well as fortitude when it inevitably occurs. The goal is for the patient to be aware of both sides of the split, because this makes the self-experience more stable, perceptions of others more accurate, and it leads to better adaptation to the stresses of relationships. This will take quite a while, but early empathy for the difficulty of extreme mood and perceptual oscillations, frequent educational remarks about how this is a consequence of feeling abandoned, and understanding of how it helps

to protect but also causes new problems will help to build the alliance. In fact, there is evidence that patients who improve most in mentalization-based therapy have a greater therapeutic alliance (Folmo, Stänicke, Johansen, Pedersen, & Kvarstein, 2021).

Technique

The three contemporary psychodynamic treatment models for fear of abandonment are Gunderson's (2014) good psychiatric management, transference-focused psychotherapy (Yeomans et al., 2015), and mentalization-based therapy (Bateman & Fonagy, 2012). For the abandonment-sensitive patient, verbalizing feelings of loss and anger is important. But putting these deep feelings into words is only the beginning, and sometimes it makes the patient feel worse. Encouraging behaviors that help the patient self-soothe may be necessary: exercise, rituals, meditation, religious observance, music, or television. The notion of containment refers to helping patients tolerate extreme negative affects, such as rage or despair, without resorting to parasuicidal or suicidal behavior.

Gunderson's update (2014) of his previously articulated treatment approach for borderline personality disorder (2000) is especially clear and practical, and the principles are appropriate for the broader group of patients with fear of abandonment. His updated approach emphasizes the importance of psychoeducation, focus on case management and support for the practical life of the patient, inclusion of a wider range of psychotherapeutic modalities including group therapy, and the importance of strengths and positive experiences.

Gunderson's initial phase is devoted to developing the treatment contract; fleshing out this understanding usually involves some testing of the therapist. Next is the phase of relational development, which means the patient and therapist begin to engage on a deeper, more emotional level. Transferences and countertransferences are noted but are not the focus of treatment. The phase of positive dependency is next; here the patient begins to use their other relationships to try out new self-perceptions and perceptions of others. They practice the ability to be connected and close to someone else, vulnerable to hurt and loss, but they begin to be able to avoid splitting to the same previous pathological degree. The last phase is called the working alliance, used here somewhat differently from our usual discussions of the therapeutic alliance. Gunderson refers to it as a hard-won achievement and a state of the treatment relationship in which the patient can begin to do traditional psychodynamic work—insight-oriented attention to the past, present, and transference, with the use of interpretations, as opposed to the degree of coaching and support that has been present up until now.

Gunderson suggests that it takes almost 6 years to be able to work through these stages in the typical treatment of patients with borderline personality. This time frame seems reasonable for patients with more severe fear of abandonment, but many with less serious attachment problems achieve important gains in much shorter periods of time. Often patients with more severe fear of abandonment move from one therapist to another, and different parts of the work may be accomplished with different therapists.

Transference-focused psychotherapy usually lasts 1–3 years with twice weekly appointments and has a here-and-now focus on the treatment relationship that allows patient and therapist to see and work with the dynamics of abandonment and splitting in real time. There is a detailed treatment contract and specified personal goals. The clear focus and strong framework for treatment allows for attention to the patient's reality testing, identity, aggression, defenses, and interpersonal relationships. One uncontrolled study suggests that after a year of transference-focused psychotherapy, 52.9% of the subjects no longer met criteria for borderline personality disorder (Clarkin et al., 2001).

Mentalization-based therapy focuses on nurturing the patient's capacity to understand themselves and the impact of others on them. Developmental interpretations are avoided and the phases of treatment—assessment, mentalization development, and enhancing social and interpersonal functioning—proceed with increasing attention to developing a comprehensive narrative about the patient's and others' subjectivities. An intense loss and abandonment experience would be seen in good psychiatric management as part of the individual's pathology and typical experience, reflecting the structures of self and other. Transference-focused psychotherapy would focus on this abandonment by emphasizing the patient's experience of and demands for the therapist. But, the mentalization-based therapy approach would be to empathically help the patient tolerate this and other experiences of loss. The patient will become more able to feel and accept that these losses occur and recognize how the disappointing other might experience them. They can develop an attitude of compassion and acceptance for the inevitable subjective responses of themselves and others.

The initial phase of Sarah's treatment focused on coaching and support. This meant pointing out her social awareness and good judgment when she was not upset. It also meant emphasizing her considerable academic talents and encouraging her persistence and ambition. Coaching is different from support because it means discussing the very specific problems the patient is facing, and encouraging their solution through the application of strengths. Coaching helps create success experiences for the patient that will promote growth. For example, after Sarah

emailed her date under an alias, the therapist encouraged her to think about whether this approach was likely to help her feel good about herself (although it would reassure her about her fears). The discussion was about what behaviors could help her feel strong, confident, and how she could improve her ability to assess her date's interest.

For patients who struggle with intense and overwhelming feelings, it is important to have a treatment contract that spells out what behavior is acceptable in session, the limits for behavior outside sessions, and the patient's responsibility for potentially self-injurious behavior. There also must be a clear plan for the therapist's role in crisis stabilization and management of self-injurious behavior. A typical contract is discussed and negotiated with the patient early on. It takes the form of the therapist offering to work closely with the patient if the patient is able to follow the terms of the contract, and a discussion of the contingencies if the patient is not. This might mean transfer to another therapist, fewer sessions, hospitalization, and so forth. Kernberg and his colleagues' discussions of the treatment contract (Selzer, Koenigsberg, & Kernberg, 1987) and Gunderson's (2000) description of working with borderline patients in the earlier phases of treatment is also helpful. Linehan's (1993) dialectical behavior therapy relies on the extensive use of patient self-soothing skills, which are valuable tools for patients with more severe fear of abandonment.

Because enhancing the patient's strengths is a treatment goal, it is important to avoid a regressive relationship in which the patient develops excessive reliance on the therapist and calls too frequently outside of appointments. Flexibility, availability, and responsiveness are necessary because the core problem is, after all, fear of abandonment. Reasonable limits are helpful because they encourage the patient to contain emotions and at times actually try to repress them.

Sarah continued in the psychotherapy for almost 2 years. The first year or so included frequent testing of the strength and the limits of the therapeutic relationship. She called the emergency number one night after an apparent breakup with her boyfriend, sobbing and overwhelmed, after having taken a few pills from his medicine cabinet. She felt bereft, alone, scared, and desperate, and she took pills to get away from these overwhelming feelings. She also seemed to want to be taken care of. A few months later, after my 2-week vacation, she did not show up for two appointments and needed two phone calls to convince her to return. She was detached and angry and decided to cut off the relationship with me because I was so cold and uncaring. During this brief hiatus in treatment, Sarah hooked up with a male student whom she would subsequently have to see regularly in her classes.

I met Sarah's impulsive behavior with empathy for her sense of loss and abandonment. I suggested that she was trying to detach from me to handle her anger and hurt and encouraged her to consider more adaptive ways of managing these powerful feelings. I offered regular guidance and coaching (much more than I would have with a less chaotic patient) about her academic work, dealing with a professor she had conflict with, whether she should continue the relationship with the fellow student, and about a problem with her apartment that caused her to argue with her landlord. Each of these discussions included some observations about her emotional vulnerability to loss and her tendency to manage her emotionality in a dysfunctional fashion. But I pointed out her healthier wishes and the strengths she was using and encouraged her in her healthy assertiveness.

We suspect that the mechanism of therapeutic change in patients with fear of abandonment relies more heavily than the other psychodynamic problems on the new experiences inside and outside the therapeutic relationship. The use of the transference to both understand and provide new experiences, and accumulation of positive life experiences—of safety and security in relationships, effective function in work and life, or the ability to manage stormy emotions—provides the patient a more balanced experience of themselves and the world.

Transference and Countertransference

Patients with fear of abandonment often see the therapist as all good, helpful, and the longed-for loved parental figure, or as selfish, evil, dishonest, and frightening. These alternative and alternating reactions reflect internal splitting. Patients on the less severe end of the abandonment spectrum tend to feel powerful dependency. Countertransference reactions are profound and are more often the cause of the demise of psychotherapy than the patient's transference reactions or the acting out. The aphorism, "If you don't make it worse, it will get better," captures the therapist's task well.

It is the therapist's job to manage the powerful countertransference reactions, chiefly the feelings of helplessness, of being abused, or anger and hostility, and of careless detachment. It is easy to see how these feelings are stirred up in the therapist by the patient's struggle with powerful alternating split-off experiences of merger and abandonment. It is not easy to keep a healthy distance and not act out oneself. There is a tradition of blaming these patients for their interpersonal difficulties, and it is surprising how frequently trainees and faculty make derogatory jokes about these difficult patients, creating distance and blaming the victim.

Vaillant (1992) notes that the term *borderline personality disorder* is used as an epithet and often reflects unrecognized countertransference.

The therapist can use several techniques to cope with the intensity of working with patients with fear of abandonment. Focus some of your attention on the patient's positive qualities and the positive feelings about the patient that you naturally have, and give frequent voice to these feelings. Stay aware of the extent and depth of the patient's struggles, remembering that behind every difficult behavior is pain and fear of abandonment, and any aggressiveness or manipulativeness is an attempt to stave off these painful feelings. Find ways to step back from the experience of being rejected or criticized by the patient. As painful and immediate as it is to be criticized, this is a reflection of the patient's anger and it is not about you. Be respectful of how resourceful these patients can be.

Evidence Base

Relevant for patients with fear of abandonment, there is increasingly powerful evidence that forms of psychodynamic therapy for borderline personality disorder, such as transference-focused psychotherapy, mentalization-based therapy, and Gunderson's model, are as effective as dialectical behavior therapy (Linehan, 1993) and more effective than treatment as usual or control conditions.

In her meta-analysis, Cristea and colleagues (2017) concluded that "psychotherapies, most notably dialectical behavior therapy and psychodynamic approaches, are effective for borderline symptoms and related problems" (p. 319). Storebø and colleagues (2020) conducted a Cochrane review of psychological therapies for borderline personality disorder, including 75 RCTs with patients who participated in more than 16 different kinds of therapies. In the comparison between psychotherapy versus treatment as usual, there was a meaningful and significant difference especially for mentalization-based therapy and dialectical behavior therapy versus treatment as usual; differences were especially strong using severity of borderline personality disorder as a measure of outcome (Storebø et al., 2020).

Clarkin, Levy, Lenzenweger, and Kernberg (2007), from Kernberg's group, randomized 90 patients with borderline personality disorder to transference-focused psychotherapy, dialectical behavior therapy, and supportive treatment. Improvement in suicidality was observed in both transference-focused psychotherapy and dialectical behavior therapy. However, only in transference-focused psychotherapy were there reductions in anger, irritability, and assault (verbal and actual). Doering and colleagues (2010), who are independent of Kernberg's group, showed

that transference-focused psychotherapy was more efficacious than treatment by experienced community psychotherapists. Patients receiving this treatment were less likely to drop out or to attempt suicide, and had a significant increase in reflective functioning compared with no change in reflective functioning in the control group (Fischer-Kern et al., 2015).

At the 5-year follow-up, Sahin and colleagues (2018) showed that among patients with borderline personality disorder with lower psychiatric severity, those patients receiving transference-focused psychotherapy did better than those receiving a version of dialectical behavior therapy or control, while those with higher psychiatric severity showed no differences in outcome. On the other hand, Giesen Bloo and colleagues (2006) found that transference-focused psychotherapy was efficacious at reducing borderline personality disorder symptomatology, but schema-focused therapy was more effective.

McMain and colleagues (2009) found no difference between Gunderson's treatment approach and dialectical behavior therapy despite the fact that dialectical behavior therapy patients received more therapy sessions (individual and groups). McMain, Guimond, Streiner, Cardish, and Links (2012) showed that those benefits were maintained over a 2-year follow-up.

A recent meta-analysis including 33 RCTs of specialized psychotherapies for borderline personality disorder versus nonspecialized psychotherapies supports the efficacy of mentalization-based therapy for these patients (Cristea et al., 2017). Other recent RCTs have found that mentalization-based therapy in both adult and adolescent patients is typically associated with medium to large or very large effect sizes on a wide variety of outcome measures (Volkert, Hauschild, & Taubner, 2019), and more than a dozen naturalistic studies have consistently shown similar effects of mentalization-based therapy in patients with borderline personality disorder (Volkert et al., 2019).

LOW SELF-ESTEEM

> Trust yourself, then you will know how to live.
> —Johann Wolfgang von Goethe

Stan was a White cisgender married heterosexual man who came for treatment shortly before his 45th birthday, depressed and ruminative. He was a talented and likable pharmaceutical company executive with a fleeting broad smile that lit up the room when he spoke of his past accomplishments, but he was generally dejected and his clothes were rumpled and his shirttail was out.

Stan had been summarily rejected by a younger woman with whom he was having an affair. She broke off the relationship, concluding that he wanted more from her than she wanted to give. Stan felt she did not need him any longer, as she had already gained access to his valuable business contacts. Stan was disenchanted with his long-suffering wife, and he was despondent that a long hoped-for promotion had not materialized.

Stan was brilliant and was an accomplished pianist and tennis player, yet he alternated between reveling in his accomplishments, and experiencing a terrible feeling of aloneness, smallness, and loss. He was either elated and excited about the future, or hopeless and negative. He was very ambitious and believed "the sky's the limit," and felt he could do and be whatever he wanted. Yet he was terribly envious and competitive and paid a lot of attention to others' money, status, and opinions of him.

Stan came for treatment because he felt depressed and demoralized. In advance of the first appointment, he asked if he could forward a series of emails from the girlfriend so that I could see what had happened. I agreed, thinking this might help in developing the therapeutic alliance. In the initial meeting, he asked for help because he felt so bad and wanted assistance in figuring out what was really going on with the girlfriend and why she had broken up with him. He was confused, stunned, broken, and beaten. I empathized with his pain and rejection and commented that the girlfriend seemed rather manipulative.

The beloved only child of upwardly striving working-class parents, Stan felt that his mother had focused all her hopes on him. His father had worked hard as a subway operator and was out of the house for very long hours. Sadly, he developed lung cancer and died when Stan was 16 years old. He felt his mother was overly dependent on him; when he was a child she needed strength and emotional support, and when he was an adult, she frequently asked him for money.

Stan's focus in the therapy was mostly on himself, how he felt, and what would help him to feel better, more successful, and more secure. Despite his descriptions of success and talent (and he really was talented), it quickly became clear that inside he felt helpless in a world in which others took advantage of him.

Stan despaired about the end of his affair, and the breakup made him feel unattractive and unlovable. He missed the relationship and the feeling of closeness, but the acute pain was how badly he felt about himself. He fantasized about being back with the girlfriend, and this made him feel healthy, strong, and appealing.

Stan initially declined a couples appointment with his wife that the therapist suggested to assess their relationship and its strengths and vulnerabilities. Later in the therapy, after his mood stabilized, Stan agreed and the assessment suggested that his wife was a self-aware person who recognized her husband's fragile self-esteem and struggled with his demands and self-preoccupation. I could see that Stan's worry about his mother's demands caused him to keep distance in the marriage, which left both he and his wife feeling very lonely.

Psychodynamic Conceptualization

Freud was very interested in those who struggle with low self-esteem and noted that their problems caused them to tend to focus on themselves. Characteristically, Freud (1914) looked to development to understand the roots of this problem. His formulation was that infants and very young children are normally focused entirely on themselves. This state of "primary narcissism" involves intense impulses for food, holding, warmth, and bodily relief; the needs are all-consuming and the infant cries out and waits for satisfaction. Maturation and development lead to the awareness of others and their needs, and compromises must be made between impulses and the needs and the constraints of the environment. Thus "secondary narcissism" occurs when there is a developmental interruption—a crisis in which there is too much loss or too much anxiety—and a return to this earlier narcissistic state. A sick person who cannot focus on anything but their aches, pains, and bodily ills, or a grieving person who withdraws from the outside world thinking only of the terrible loss are examples of Freud's concept of secondary narcissism.

When this self-focus is persistent, it insulates the individual from feelings about others. There is an avoidance of the painful feelings of rejection that inevitably come from involvement in close relationships or meaningful work. The core psychodynamic problem of low self-esteem involves an inner experience of insecurity and loneliness that is managed through self-preoccupation and self-oriented gratification. In our work, we do not use the term *narcissism* because that refers to the compensatory strategy these patients use, rather than the problem itself, and it tends to make patients feel criticized and ashamed, rather than understood and supported.

Kernberg (1975) distinguished between those who are narcissistic and borderline by calling attention to the grandiose, entitled, excited, and ambitious attitudes that narcissistic patients have. Different from the borderline good and bad self, the narcissist has a hugely exciting and magnificent self, and a sad, small, depleted, shameful self. Kernberg

posited severe frustration in early parenting as a cause, and noted that narcissism often helps people become successful in the earlier part of their lives, but becomes a problem in midlife. High self-regard, competition, and a drive to master can lead to early success, but in midlife, satisfaction, love, and close relationships become more valuable than fame, wealth, and competition. Gore Vidal (2006) quipped that "a narcissist is someone better looking than you are" (p. 22), calling attention to the intense feelings of envy that are also part of the picture. Others seem to have the love, beauty, strength, wealth, or position that those with low self-esteem covet.

Kohut (1971, 1977, 1984) changed the field of psychoanalysis with his sensitive awareness that many patients, including those Freud would have described as being in a state of secondary narcissism, are so filled with shame, inferiority, embarrassment, and low self-esteem that virtually everything they think, feel, do, and say is directed at trying to feel better about themselves. He acknowledged Freud's description of entitlement and megalomania, but his contribution was to explore and articulate its painful underbelly. Entitlement is a reaction to feelings of powerlessness, loneliness, and fear.

Kohut defined a normal part of parenting as providing a "selfobject" for growing children. This merger of child and caretaker, with optimal empathy, validation, and protection of the budding self in the child, is necessary for the development of healthy self-esteem. Neither too protected nor too exposed to frustration and hardship, the child who is part of a selfobject develops self-love, vitality, creativity, and assertiveness, as well as healthy love and empathy with others. In his later work, Kohut went on to suggest that narcissism had its own distinct developmental progression, which was necessary alongside of other developmental achievements like cognition, psychosexual, and physical.

Kohut's emphasis on anger and entitlement as secondary to hurt differed deeply from Kernberg's view. Kohut and the self psychologists see these classic narcissistic symptoms as a reaction to the environment, perhaps the unhealthy environment, rather than an irreducible drive. Kohut used the term *vertical split* to refer to sectors of the personality dominated by differing self-images, both grandiose and inferior.

From Kernberg's perspective, Stan is an angry, frustrated man whose splitting and grandiosity help to maintain the sense of a loving self and a loving object in a world of anger. Kohut's Stan is a sad, scared, lonely, and vulnerable man whose elation and entitlement is a last-ditch effort at security, and who only gets angry when he feels deeply rejected.

The relational psychoanalytic perspective expands on these fundamental perspectives on low self-esteem. Because this theory prizes

attention to the nuances of the therapeutic relationship, including the moment-to-moment shifts in the experience of both members of the dyad, it is very helpful with patients who are sensitive to feeling understood and evaluated critically. The continuous awareness of the state of the relationship, along with the recognition that the experience of both therapist and patient is co-constructed, makes this a valuable model for understanding low self-esteem.

Strengths

Patients with low self-esteem tend to be highly attuned to how they are treated by others, and they can be insightful about relationships, albeit with a bias toward themselves. They are often quite motivated to change. Yet, some of Stan's innate strengths were compromised by his problems; excessive focus on the self made it difficult for him to love, and his social intelligence had blinders at times because of his concern about being manipulated and taken advantage of. Stan's exquisite sensitivity to humiliation and shame rendered temperance and the strengths of forgiveness, humility, prudence, and self-regulation in short supply. Humility is confused with inferiority, and prudence hardens to defensive manipulation in a dangerous and uncertain world. Self-regulation is difficult when you are starved.

Treatment Goals

The treatment goals for those with low self-esteem are a more accurate and positive self-image and a greater ability to tolerate vulnerability in relationships. Helping Stan to reconcile his disparate views of himself and understand how they came about, along with helping him build new, healthier relationship experiences, will decrease the painful, shameful inferiority, as well the counterproductive grandiosity. He will be able to approach the second half of life and its challenges with a greater opportunity to have support from family and friends.

Patients who feel insecure, ashamed, defective, or unlovable tend to be skeptical about treatment. Initially, the positive regard for the therapist, or the fantasy of magical transformation, is sustaining. But soon enough, the old feelings return and the patient feels that talking about feeling bad just does not help. The therapeutic relationship is fundamental to bringing about change here, perhaps even more than with the other psychodynamic problems. The patient must feel known, admired, and supported. The narrative, although important, is in some ways less complicated, more conscious, and less powerfully mutative than for other problems.

Building a Therapeutic Alliance

Self psychology regards anger as the result of frustration and the failure of empathy in childhood and adult relationships. In Stan's treatment, the therapist met his anger at his girlfriend and wife (and, occasionally, at the therapist) with empathy and an attempt to restore the empathic bond. Indeed, the development and maintenance of the therapeutic relationship is central to the psychodynamic treatment of this problem because it restores the selfobject function for someone who has lost it.

The essential technique is to support and empathize, watching for and dealing actively with the patient's inevitable disappointment, hurt, and anger in the therapeutic relationship. There is an extensive literature on ruptures in the therapeutic alliance (e.g., Eubanks et al., 2018; Muran & Safran, 2002), concluding that this is a ubiquitous phenomenon in psychotherapy. But it may be most problematic in patients with fragile self-esteem. If you feel insecure, you will be especially sensitive to criticism and rejection by your therapist. Ruptures and their recognition are seen as essential to maintenance of the alliance. Each rupture, the precipitants, the feelings stirred up, and the repair, are like a "teachable moment," where another building block of security and self-esteem is added.

> Stan successfully negotiated a business deal that involved making a contact, Al, who subsequently offered him a very lucrative position in his company. Stan reported on the contract negotiations in some detail. Al was friendly and seemingly generous, but as the dialogue proceeded, Stan felt that Al was not giving enough and did not recognize his potential contribution to the new company. Al began to seem disrespectful and devaluing. It was not overt, but Stan sensed it, and felt a tone was being set for the future. He became quite angry. In several sessions he railed against Al and the new company, accusing them of manipulation and arrogance; he was clearly afraid Al was going to take advantage of him.
>
> It was hard to fully appreciate both sides of the situation. Stan's perceptions almost always had an accurate core, but the weight of his past experiences of exploitation and insensitivity probably also distorted his perceptions in that direction. I commented that he had a particularly acute sense of when he was being taken advantage of, because he felt he needed to do what his mother wanted or else she would be unhappy and disappointed with him. I told him it did seem like he might be in some jeopardy, but the intensity of his feelings was probably greater than was justified by the real current situation. He was interested in this clarification, agreed, and discussed this at some

length. Shortly, he became angry, critical, and self-justifying about Al again. This interaction continued over several appointments, as the job offer seemed to be foundering. I sensed that the new company was getting tired of Stan's aggressiveness and souring on the relationship.

While remaining polite, Stan was clearly increasingly angry with me. I was pointing out his "flawed" reactions repeatedly. To him, I was taking their side, as though I was like his mother, not seeing his feelings, perceptions, and needs. He missed an appointment. When I realized what was going on, I tried to repair the rupture in our relationship. This involved a number of genuine expressions of concern, validation of his perceptions of Al (who had now withdrawn the offer), and empathy for his feeling that I did not understand him. It did not matter that my comments might have been useful insight and advice. This content had to go by the wayside in the face of Stan's feeling of being criticized. We could, and did, come back to Stan's contribution to the conflict with Al later.

Technique

Early-career therapists find this kind of shifting position uncomfortable, and they can get caught up in the question of who and what is right. It is an easy trap to fall into. As therapists, our role is often to "suspend judgment." We may focus on the ideas discussed rather than what is happening in the relationship, and what needs to happen—empathy, a concern for reality and the need to deal with it, and then empathy again about how this is difficult. This is the essential "self-object" function that Kohut talks about. Putting this into action over and over again in the treatment seems to be the essence of what helps.

Another way to conceptualize this central element in the psychotherapy of low self-esteem is that you are helping patients understand and try new skills in interpersonal relationships. You are reminding them of their impact on others, something that they are not aware of because of their low self-esteem. You are trying to help them increase their social intelligence by helping them see what is really happening in an interaction from both sides, and supporting them in their side and their needs.

The psychotherapy of low self-esteem is rarely short, because it depends so heavily on the relationship itself. There are no quick insight fixes. Sometimes these patients come to treatment for a while, discontinue, and come back when they have been hurt and disappointed again in their lives, and then repeat this cycle. The traditional psychoanalytic view is that this represents the acting out of negative transference, usually the feeling of being criticized and envious. This may well be true,

but it may also turn out to be a reenactment of the healthy separation process, depending on the parents, being with them, leaving, and then depending on them again. The development of a healthy selfobject function requires that the object be there when needed and not have overwhelming personal needs.

This process may also be conceptualized as the development of strengths in the context of a therapeutic relationship. For Stan, the resolution of moments of therapeutic rupture provided a new sense of connection, safety, and enhanced self-esteem. He could be more self-aware, more empathic, more stably confident, and less demanding of others.

Transference and Countertransference

Kohut's (1971) work laid out the common reactions of the patient with unstable self-esteem to the therapist and suggested that these transferences are ways to recognize and diagnose the problem. *Mirroring*, Kohut's term for the intense need for admiration and empathy, is a replay of old needs that went unfulfilled, and may have an insistent quality because painful feelings of shame and unlovability are always just around the corner. Idealization of the therapist soothes the patient because it restores the feeling of being close to someone so special, loving, and wonderful. Even though these reactions may be excessive in relation to adult needs, they are often desirable for the therapy and therefore should not be challenged initially.

The therapist's job is to support these feelings, allowing them to take root, and help the relationship withstand the inevitable threats that make patients feel hurt, rejected, and misunderstood. Like the parent who must gradually but decisively expose a child to reality, protecting and then challenging, the therapist gradually tempers these perceptions with more realistic ones. The patient's rigid requirement for constant mirroring becomes a need that can be fulfilled more easily and more flexibly. Idealization is gently challenged and reality is tested, and over time the patient does not need it as much.

The philosophy of this approach is that what the patient needs must be fulfilled by the therapist (or the parent), and that this fulfillment slowly results in developmental change. Thus, the common countertransference reactions include a rescue fantasy that the therapist will be the first really good person in the patient's life and will provide the love and kindness that will make everything better. Other reactions include enjoyment of the idealization without gently pointing out its unrealistic nature, boredom with repeated vignettes with the same themes, and resentment about feeling defeated or controlled by the patient's great

focus on themselves. If the transference and countertransference are clear to the therapist and the gradual process of working out ruptures and misunderstandings takes place, these patients can greatly benefit from the treatment.

Evidence Base

In their review of the literature on personality disorders, Crits-Christoph and Barber (2007) did not find any study that examined the efficacy of dynamic therapy for patients with narcissistic personality disorder, the descriptive diagnosis closest to low self-esteem. There are some studies focusing on changes in self-esteem as a secondary outcome of a variety of treatments. Ritter, Leichsenring, Strauss, and Stangier (2013) found that psychodynamic therapy and CBT both improved explicit and implicit self-esteem in patients with social anxiety disorder. There are no data on the potentially specific effect of techniques based on the self psychology perspective and we see this as a fertile field for further study.

PANIC ANXIETY

> A wave of panic passed over the vessel, and these rough and hardy men, who feared no mortal foe, shook with terror at the shadows of their own minds.
>
> —Arthur Conan Doyle, Sr.

Panic attacks are acute paroxysms of anxiety that appear to arise spontaneously. Profound somatic symptoms, such as shortness of breath, palpitations, sweating, and trembling, are often accompanied by feelings of overwhelming fear, dying for air, or feeling of imminent doom. People who experience panic attacks may become sensitized to locations where the attacks occurred, and agoraphobia results when there is a constriction in the radius of activity and the places that feel safe from panic.

Alice was a 28-year-old White cisgender lab technician with brightly dyed hair, dark makeup, and artistic garb who reported at the beginning of her first appointment that she felt "just fine." Yes, she had been experiencing disabling panic attacks, but she could handle them. Approximately two to three times daily she felt acute anxiety with typical somatic symptoms, and the attacks seemed to flow from one into the next over the course of the day.

Her first panic occurred when Alice was 6 years old. The attacks became full-blown in her teens. Her coping strategy was to "take ownership of my mind and body." She forced herself to continue with what she was doing and make sure she could function. She was the

eldest of four children, and the only one from her mother's first marriage. Her mother had an extended period of depression when Alice was young and had abused substances to blunt her emotional pain. During this period of her childhood, Alice acted upbeat and tried to cheer her mother up with jokes and distraction. As a girl she had felt "alone, in a bubble," and remembered that she tried to be cool and in control like Mr. Spock and not let herself be disturbed by the intense sad and fearful feelings inside.

Alice had a boyfriend with whom she was quite enmeshed at the beginning of treatment. Although she saw him all the time, she hung on his phone calls and contact, feeling alternately pleased and gratified when he contacted her, and anxious and abandoned when he did not. She helped nurse his emotional wounds when he was in trouble, but felt taken for granted. The usual precipitants to her panic attacks were anticipating or experiencing rejection by the boyfriend, or feelings of fear of failure when she had to speak up at lab meetings in front of her colleagues.

Alice was smart, verbal, insightful, energetic, creative, and intense; she was like a coiled spring. Her distinct pattern in each session was to express her sadness, anger, or disappointment, and then immediately take it back reassuring me that none of this bothered her.

Psychodynamic Conceptualization

Early psychoanalysis was founded on the study of anxiety and anxiety symptoms in young women like Alice. More recently, panic disorder became a favorite problem for cognitive-behavioral therapists and psychopharmacologists to treat. In behavioral and medication treatment, the panic symptom is regarded as the illness; from the psychodynamic perspective, the panic is seen as a symptom of underlying conflicts that need to be addressed.

Freud's first conceptualization of panic was that it was an "actual neurosis"—that is, the result of an "actual" traumatic experience. His later formulation of anxiety neuroses (1926) posited that unconscious conflicts produce signal anxiety—that is, small, tolerable amounts of anxiety that serve as a signal or stimulus to the ego to develop defensive reactions and protect the person from the greater anxiety connected with the repressed material. This signal anxiety is conscious, and the only aspect of repressed conflict the patient is aware of. Neurotic symptoms develop when this smoothly functioning system involving conflict, signal anxiety, and defense is interrupted by a powerful stressor, or when the defenses no longer hold. Thus, panic is the breakout of symptomatic anxiety in response to underlying conflict.

As you read about the various psychodynamic problems in this chapter, you have probably noted that the characteristic conflicts associated with each problem seem to have similarities: loss, abandonment, anger, guilt, and so on. But why is the symptomatic presentation different for each core problem, while the underlying conflicts are not as distinct? Why a particular symptom develops is known as the problem of "neurosogenesis" in the psychoanalytic literature. Is there a one-to-one correspondence between the nature of the underlying conflict and the type of symptoms that result? We think the connection is fuzzy, and in keeping with our pragmatic perspective, we regard this as a conceptual problem, but not a major practical and therapeutic one. Remember, the core psychodynamic problems are attempts to build a coherent and useful framework for understanding the problems; they are useful heuristics.

Over our careers, each of us has struggled with this paradox. We have a complex and interesting explanatory theory, but it does not really determine specific symptoms. Is it really a scientific theory, then? One of us (RFS) felt deeply convinced of the psychodynamic thinking early on in training and practice and has had several periods of skepticism and cynicism since. During those phases, psychodynamic theory seemed to explain such a small part of motivation and ignored so many other important, practical factors. But then, after a powerful experience working with a patient who changed more than expected, or after hearing a brilliant and incisive case discussion, what had seemed like limitations in the psychodynamic model seemed more like personal limitations in applying the ideas. With more conviction, more sensitivity, and less personal baggage, maybe more therapy experiences could be this powerful.

Yes, depression, obsessionality, and panic all seem to involve anger toward others, and defenses against anger. Fear of abandonment and low self-esteem are characterized by attachment problems, as is panic. We do not know why one person's attachment problem emerges as low self-esteem and another's as abandonment sensitivity. Nor do we understand why anger results in either depression or obsessionality. We do know, however, that from the patient's perspective it feels very different to be depressed than obsessional, and each has a distinct narrative that helps a patient understand themselves. The core problems satisfy the subjective need of patients (and therapists) despite their unclear epistemological status.

Milrod and colleagues (1997) performed systematic psychoanalytic interviews of patients with panic symptoms, attempting to define their essential conflicts with the goal of developing a focused psychodynamic psychotherapy. They reviewed the psychoanalytic literature—including Andrews, Stewart, Morris-Yates, Holt, and Henderson (1990); Freud

(1895); and Tyrer, Seivewright, Ferguson, and Tyrer (1992)—as well as the psychiatric literature. Milrod's group developed a formulation for panic disorder that integrates neurobiological vulnerability with experiences of separation, anger, fear of expression of anger, specific child–parent interactions, and current stressors. She and her colleagues note that the central conflicts in patients with panic involve separation and loss, inhibited aggression, and sometimes anxiety about sexual excitement. Their work was updated and extended to other anxiety disorders in their subsequent manual (Busch et al., 2012).

Panic anxiety is an especially interesting symptom because the "fight-or-flight" response has deep roots in our evolutionary heritage. The neurobiological literature on anxiety (LeDoux, 1996) suggests explanations for panic anxiety, but they do not satisfy the need to connect panic symptoms with precipitants and maintaining factors in the patient's life. Neurobiologically vulnerable children, such as those with behavioral inhibition or shyness, may be sensitive to the normal separation experiences of childhood. They tend to experience anger and frustration, and they become conflicted about this. They fear that their anger will hurt the relationships with caretakers and that it must be inhibited. This results in separation sensitivity, dependency, and inhibited anger, and out of this brew comes a readiness to develop panic in the face of losses or increases in demands by others in relationships or at work.

The panic expresses the loss and fear, defensively hides the anger, and maintains a position of dependency. Those who are not shy or behaviorally inhibited (panic symptoms without the neurobiological vulnerability) usually have a history of more overtly conflicted relationships with parents, with significant losses or abandonments, and real compromise in their close relationships when anger was expressed. Shear, Cooper, Klerman, Busch, and Shapiro (1993) observed that dependency in patients with panic manifests in a "separation-sensitive" presentation with excessive reliance on others, and a "suffocation-sensitive" type in which patients are uncomfortable with their dependency needs. Zilcha-Mano and colleagues (2015) found two subtypes of panic: nonassertive patients who lack confidence and avoid interpersonal situations requiring them to stand up for themselves, and domineering-intrusive individuals who need to take control to avoid the fear and humiliation of acute panic symptoms.

Alice was probably not neurobiologically vulnerable to panic; she was not a behaviorally inhibited child. But her early losses, including her parents' divorce, her father's departure from their life, and her mother's subsequent depressions and addiction, likely contributed to the development of her panic. Indeed, her symptoms started at age 6 after the parents split and while her mother was ill. The later exacerbation of

her panic symptoms came during periods of loss and separation along with the development of other defensive strategies. For example, during adolescence she had eating disorder symptoms, and in her early 20s after leaving college, she engaged in recurrent self-cutting. This ended about 2 years before she came to treatment for her panic. When she was engaged in cutting, Alice had minimal panic symptoms, and when she was able to stop cutting, her panic recurred. This illustrates the notion that an underlying separation conflict can manifest in a variety of symptoms and suggests that a purely symptom-focused treatment might not have helped this patient get better.

Alice struggled with her feelings of dependency and attachment. Her panic attacks worsened when she moved away from the city in which she had grown up, and she dealt with this by forming the enmeshed relationship with her boyfriend that was an initial focus of treatment. She panicked when she was afraid he would not call her or see her. She was angry with him but had great difficulty expressing this. Instead, it came out through panic. Her other precipitant for panic was speaking up in her classes. She discussed this at length, and it became clear that she was worried that shining in class would alienate her from her classmates and expose her to the possibility of being the teacher's favorite—she might not be able to live up to that, and then she would lose the special relationship with him.

Strengths

Patients with panic often have high trait-like alliance capacity—that is, they are typically prone to develop a strong alliance. This strength can be leveraged in the therapy to help explore and understand their separation conflicts.

From the perspective of character strengths, the fear and anxiety panic patients experience make it difficult to feel courageous and behave courageously. Their very immediate sense of danger and worry makes it difficult for them to let themselves go enough to engage the personality strengths of transcendence. Appreciation of beauty, awe, spirituality, and humor occur when the person has a basic degree of security. We comment in the technique section below on the specific approaches for addressing courage and transcendence.

Treatment Goals

The goal of psychodynamic treatment for panic is to help the patient understand the conflicted feelings of dependency and anger that have been outside of awareness and allow them to manage relationships and

activities in a more adaptive way. These patients need to develop a more realistic and contemporary view of how much closeness and intimacy they really require. Increased assertiveness and the capacity for independence will render the panic dynamics less relevant and lessen the intensity and frequency of symptoms.

Developing a Therapeutic Alliance

The development of the therapeutic alliance is intertwined with the patients' struggle with their symptoms—that is, the new relationship may provide an opportunity for support and increased confidence and a buffer for their marked sensitivity to separation and loss. For Alice, there was a rapid attachment to the therapist and a quick reduction in symptoms. This reflected her high trait-like alliance capacities. Although this is sometimes called a "flight into health," we see it as an opportunity, as it buys time to work on, and through, the conflicts. Such rapid response is often seen as a shift in defenses, but the notion of "sudden gains" (Tang & DeRubeis, 1999) between sessions has gained traction as a type of genuine therapeutic response to treatment.

Patients who use avoidance to deal with their symptoms—either through rigid control over their attention, or their activities, or in frank agoraphobia—tend to have a more difficult time developing an alliance. They may protect themselves from the therapist because they are concerned that the new and potentially challenging relationship will destabilize them and expose them to frightening feelings of loss or anger. They fear the therapy might precipitate panic. These patients are actually correct, as effective therapy for patients who are avoidant does encourage them to come into close contact with upsetting feelings, which may increase panic. Indeed, the domineering-intrusive patients with panic tend to show less strengthening of the therapeutic alliance over time than those of the avoidant-nonassertive subtype (Zilcha-Mano et al., 2015).

There are several techniques for facilitating the development of a strong and stable therapeutic alliance. Frequent sessions promote security and consistency. This makes sense because these patients are so sensitive to separation and aloneness. Careful empathic attention to panic attacks and close exploration of the precipitants to panic help the patient reflect on the symptom and provides some distance from it. Education about the psychodynamic model of panic gives the patient perspective and a rationale for therapy—early loss, anger, and somatic vulnerability can allow a person to avoid feeling frightening emotions, maintain repression, and struggle with panic symptoms rather than with the underlying upsetting feelings. The panic attacks are terrible, and patients will

do practically anything to prevent them, but they are only subjectively uncomfortable, and in fact, the patient is physically and mentally safe. From the therapist's perspective, it is important not to overidentify with the patient and these symptoms. If you cannot tolerate your patient panicking, you will not be able to help the patient tolerate the painful feelings that need to be uncovered over the course of treatment.

The typical resistances in psychotherapy for panic reflect the challenges in developing a therapeutic alliance with these patients. The most common resistance is excessive dependency. Patients feel you can solve their problems and guarantee their security. They want you to take care of them and prevent them from feeling alone. Other patients with panic come for treatment because they know they need it, or they have been pushed into it, but they do not really want to feel anything uncomfortable. Avoidance as a resistance can be internal (use of repression, suppression, disavowal) or external (proscribed behaviors, agoraphobia, use of phobic companions to allow engagement in anxiety-producing behaviors). Patients often try to control the interaction in the therapy to maintain their avoidant stance.

Technique

The course of treatment has been clearly described by Milrod and colleagues (1997) and Busch and associates (2012), and our comments are based on their work. With the goal in mind of decreased symptoms, increasing independence, and the ability to be assertive, the initial phase of treatment is characterized by the development of a therapeutic alliance and exploration of the panic history. The detailed exploration of panic attacks, especially looking at the precipitants to panic, both historical and current, sets the stage for the treatment. Often patients are unaware of the psychological meaning of the events that trigger panic and feel the attacks come on entirely unconnected to these events. It is striking how often one can construct a meaningful narrative about the events that precede panic. Usually it comes back to loss or separation in some form, or the fear of anger and losing one's temper destructively about a loss or rejection. But the first phase is collecting the information and developing a good database of panic attacks and their surrounding context.

In those patients who are not actively panicking, but who have this as an important part of their history, or those whose lives are organized around phobic avoidance of the panic, the treatment will stall if the patient feels no anxiety and simply continues the avoidant behavior. One patient kept her husband with her for most of her errands; she also cleverly but unconsciously changed the subject over and over again in

sessions. Confrontation of the avoidance in external behavior and in the relationship with the therapist is a staple of treatment for patients in this phase. The confrontation takes the form of pointing out the avoidance, not telling the patient how to behave. Typically, patients who are avoidant need this intervention a number of times before they can begin to take conscious responsibility for pushing themselves.

Next, interpretation of current panic allows the patient to begin to see the repetitive pattern. This takes the form of connecting the precipitating event and the experience of separation, or anger about separation, and the panic attack itself. This must be repeated numerous times ("worked through") with different experiences of panic or limited-symptom panic attacks. The work is bolstered by historical interpretations about the same dynamic in the patient's early relationships, and it will certainly manifest itself in the transference and countertransference as well. One hopes to ultimately be able to make an interpretation that ties together the repetitive pattern in the past, present, and transference. An example of this kind of interpretation is

> "Your drive on the turnpike, where the infrequent exits make you feel trapped on the road, brought up a frightening feeling of being alone and unable to control your environment. This triggers an old feeling of separation and aloneness, like when your parents were fighting, leading them to not pay attention to you and your needs. Back then, you were afraid you would entirely lose your base of security at home, and this was terrifying. This is also like the feeling you had when I told you I would be on vacation next week, leaving you to deal with your panic 'by yourself.' You were also angry at your parents, and maybe at me, too, about this separation. Each of these situations triggers a feeling of loss that leads to panic and fear of more panic. This comes out as a panic attack, which prevents you from feeling the feelings directly, and you are left with a confusing but terrible symptom."

The work on panic implicitly encourages patients to widen their scope of behavior, including those situations that expose them to separation triggers. The new awareness that panic is related to old historical danger situations, rather than elevators, shopping malls, and enclosed spaces, for example, emboldens most patients to want to try to expand their sphere of activity.

Recognizing that the separation fears are old fears, with the accompanying decrease in panic anxiety, gives patients with panic increased confidence in their ability to withstand stressful and upsetting life experiences. This increases their resilience and courage to take on new

challenges. It can be helpful to explicitly recognize and validate this when patients begin to change their behavior and expand their sphere of activity. The strengths grouped under the rubric of transcendence (appreciation of beauty and excellence, gratitude, hope, humor, spirituality) seem to naturally reawaken with decreasing panic symptoms. These qualities emerge spontaneously with reduced anxiety.

Transference and Countertransference

The typical panic transferences involve separation and loss and the patient's various reactions to these. Feelings of closeness and separation are prominent early in the treatment. But rescheduled appointments, lateness, and vacations are felt keenly as separation, and they stimulate earlier feelings of loss and aloneness, and sometimes panic itself. One patient had her first panic attack in months the evening after a therapy appointment when ending treatment was first tentatively discussed.

The patients will experience you as the person who abandoned them—whether this experience is rooted in a frank abandonment or the kind of temperamental mismatch that leaves a child feeling misunderstood, unvalidated, and scarily alone. Typically, these patients experience separation as overwhelming and inchoate—their world will come to an end, or they will not be able to take care of themselves. It is hard to describe in words. But the quality of the feeling is such that they do not feel the feeling of aloneness clearly; instead it is felt in the body as an intense and frightening physical sensation: the panic attack. There can be covert anger at the therapist because of the separation, which may trigger feelings of fear and guilt, as the patients usually feel that their anger is part of the reason that parental figures abandoned them. In addition to these dynamics, there is anticipatory anxiety about having another panic attack.

Typical countertransference reactions include feeling a parental caretaking urge. This reaction denies the separations and losses the patient may be experiencing and allows us to avoid painful feelings about our own separations and losses. But frustration with the patient's dependency may also surface, with a need to reject the patient, pushing them out of the nest, and freeing the therapist from the incessant demands for closeness. Both of these reactions are natural counterparts to the patient's own dependency struggle and represent our difficulties in confronting and interpreting these problems for our patients because the treatment is painful for them.

As the treatment draws to a close, it is no surprise that transferential feelings of separation and loss come to the fore, and there is potential for the resurgence of panic symptoms. Because of the work done on this

already, it should be possible to connect these feelings to the recurring interpretations about separation and panic.

Evidence Base

Panic-focused psychodynamic psychotherapy (PFPP; Busch et al., 2012; Milrod et al., 1997) was compared with applied relaxation training in a pilot RCT (Milrod, Leon, Busch, et al., 2007), and a large effect size improvement was noted. In a follow-up analysis, Milrod, Leon, Barber, Markowitz, and Graf (2007) reported even greater superiority for this dynamic treatment among patients with panic disorder and a comorbid personality disorder.

PFPP has been further evaluated in three RCTs. An American two-site study compared this manualized treatment with CBT and a control condition (Milrod et al., 2016). At the Cornell site, all three treatments improved at the same rate—however, CBT and the control condition showed greater improvement than PFPP in the Philadelphia site, where the patients were more symptomatic and more likely to be medicated. In the second study, PFPP was evaluated in a complex doubly randomized controlled preference trial in Sweden where patients were assigned to PFPP or panic control treatment, a CBT-oriented treatment (Svensson et al., 2021). Overall, they found no difference between the choice or random assignment arms—however, both were significantly superior to the control. Finally, in Germany, Beutel and colleagues (2013) randomized patients with panic in routine care to PFPP or to CBT and found no significant differences between the groups, but the study was not powered for detection of nonequivalence of the two treatments.

TRAUMA

> Pain is inevitable. Suffering is optional.
> —Dalai Lama

People who are traumatized have experienced something outside the realm of normal that threatens their sense of safety and well-being. They have had real-life tangible experiences that are more than just psychologically threatening. The human organism has been shaped by evolution to respond adaptively to dangerous events, and while sometimes trauma leads to illness, we are far more often resilient to external threats than we are made ill by them (Bonanno, 2005; Konner, 2007).

Patients who are traumatized have reliving experiences, including flashbacks, dreams, and other forms of reexperiencing. They experience

ongoing mistrust of others, difficulty in close relationships, and problems in self-esteem, identity, and a sense of autonomy and competence. They do not feel powerful. There is invariably avoidance of stimuli reminiscent of the trauma, and it is striking how a person who is traumatized can become acutely agitated and distressed when triggered by something reminiscent of their traumatic experience. Avoidance can also be manifested in a kind of global numbing of feeling. Vigilance and hyperarousal, a tendency to dissociate and detach from everyday experience, vulnerability to a wide range of physical symptoms in multiple organ systems, and secrecy are all part of the picture. Often these patients have not had predictably good responses to psychotherapy or psychopharmacology, and there may have been boundary problems in the treatments and intense countertransference reactions by the therapist. Those who do not naturally recover from the impact of trauma have a persisting sense of distress and an oscillating state of mind. Trauma survivors are often intensely reactive, with rapid decompensation and recovery. Just as quickly as they feel worse, they rapidly get so much better. In summary, the fear and intensity of the original traumatic experiences lives on in the minds of victims and is palpably present in the experiences they have with others.

Psychodynamic Conceptualization

The history of psychoanalytic thinking on trauma is checkered, with important insights and missed opportunities. Although early psychoanalysis helped to understand the extent and impact of childhood sexual and violent trauma, subsequent thinking was dominated by excessive attention to the intrapsychic meaning of trauma. This turned attention away from the need to recognize, address, and deal with the impact of bad external events. All too often, the attention was on how a patient might have been ambivalent or even gratified by the traumatic experience. Rather than review the very extensive literature on this debate (Herman, 1997), we present a contemporary perspective on trauma arising from the psychotherapy literature, and informed by insights from biology and cognitive processing.

A trauma is an overwhelming event that threatens the health, safety, and security of the individual and cannot be emotionally and cognitively processed. Preexisting conflicts are stirred up, and the emotions of shock, fear, and danger that are generated by the trauma are too much for the person to tolerate and to relate to other usual life experiences. For example, how could it be that the perpetrator of the trauma is someone who otherwise seemed safe, or upon whom the victim is dependent. The bubble of safety in which we live is invaded and something

inconceivable has occurred. Previously trusted people may turn out to be untrustworthy, or situations previously innocent are now revealed to be dangerous. Detachment from reality, dissociation, and the development of a split in the personality result when the experiences associated with the trauma are not integrated with the dominant associational network of memories. Inevitably, the dissociated part of the self leaks back into awareness, leading to reliving experiences; meanwhile, avoidance of stimuli reminiscent of the trauma helps maintain the split in memories and feelings.

The object relations, mentalization, and relational psychoanalysis models are all useful in understanding the patient who is traumatized. The impact on internalized object relations from having been traumatized by another person, the potential interference with mentalization and the capacity to empathically understand one's other and others' subjectivity in the setting of profoundly confusing interpersonal relations, and the importance of the unique intersubjective experience of the psychotherapy relationship make each of these models immediately relevant.

Ellen was an intelligent, compassionate, warm, and caring White heterosexual cisgender woman with a very strong sense of values and ethics. She was deeply committed to her family and was a sensitive and thoughtful wife and mother. Her middle-class upbringing was normal in many ways, but her brothers engaged in inappropriate and demeaning sex play with her as an early adolescent. During this time, a boy from school sexually harassed her regularly on her walk home from school. As an adolescent she was raped on a date with a man who was a number of years older than she. Anxious, guilty, and insecure, she could not tell her parents about any of this.

Ellen's marriage to a kind, strong, loyal man helped her launch an adult life with children, religious observance, and altruistic activity in her community. Several years before she came for treatment, she was approached by a friend of her husband's, a predatory man, who convinced, manipulated, and cajoled her into an affair. He threatened her to try to prevent her from exposing the relationship, and Ellen had the awful feeling she could not escape. She had been depressed before this, but now her terrible feelings of shame and guilt tortured her to the point of suicidality.

Initially, Ellen was acutely agitated, focused only on how unforgivable her behavior was. She remained quite functional and was generally able to take care of her children and husband. Sometimes she took to bed when her children went off to school and got up shortly before they came home. But she had periods of detachment, drinking

binges, and sudden intense self-critical episodes. She avoided men, including her brothers. She could almost hear a man's voice in her mind criticizing and demeaning her, but she knew it was her own thoughts heard aloud. Over the course of her treatment, she often felt rapidly worse and then better, and struggled with terrible feelings of mistrust toward her parents and siblings.

Ellen's prior traumatic experiences predisposed her to the advances of this manipulative man because she relived the experiences of her childhood, feeling helpless and powerless and under the influence of males who were aggressive and selfish. Despite her values and current emotional connections, she experienced this new trauma according to the same template as the old ones: fear, powerlessness, and passivity. The problem with un-worked-through trauma is that the thoughts and feelings related to the traumatic experience are generalized to many subsequent adult experiences (Charney, 2004). It was Ellen's shame and distress about what she had done, and her confusion about how it was so different from the person she thought she was, that brought her to treatment.

Common secondary effects of trauma include a disturbance of identity, which Ellen had—although she had a sense of herself as intact, compassionate, and helpful, there was a persisting feeling of being ugly and bad. Her secrecy and avoidance of her brothers and the man with whom she had the affair, along with feelings of isolation, anger, fear, sadness, and loss of hope are characteristic, too. Common adaptations include perfectionism, avoidance, repetition of the traumatic situation, and dissociation. Sometimes there is a counterphobic reaction in which the trauma victim becomes very aggressive, fearless, and almost the mirror opposite of the usual fearful avoidance. Some traumatized people develop "street smarts" that allow them to become exquisitely sensitive at seeing the potential for evil and danger. Others develop a strong capacity for dealing with pain. Most gain a gritty realism from their suffering.

Strengths

Common strengths among patients with trauma are resilience, stoicism, introspectiveness, and insight. Indeed, Ellen was a woman with quiet natural courage and a powerfully nurturing, loving nature. She was patient and thoughtful and valued self-awareness. These qualities were evident even in the midst of her worst suffering.

The character strengths of courage and humanity can be worn away by traumatic experiences, and trauma victims learn that courage

can sometimes result in worse harm. Faith in humanity—their own and others'—is shaken and tested by the awareness of what others can do to them. In the case of natural and environmental trauma, the veil of safety provided by close relationships is revealed to be thin indeed. Working through the trauma and restoring empowerment and accurate perception will help to restore these character strengths. It was ultimately very important to Ellen when she understood that her traumatic experiences led her to mistrust, anger, and fearfulness, and that she was able to recognize and own her adventurous, strong, loving feelings, and able to manifest them with great personal meaning in a human services volunteer role she took on.

Treatment Goals

The treatment goals for patients who are traumatized are focused on empowerment and an increased sense of safety and security. Knowing the difference between trustworthy relationships and those that are unhealthy leads to increased trust and a greater ability to feel close and safe. It is necessary to reexperience old traumatic experiences, seeing them as unavoidable consequences of being in a dangerous situation. Reexperiencing takes the form of telling the story and feeling what it really felt like. This helps patients decrease the many negative conclusions and attributions they make: it's their fault, they deserved the pain and suffering, it will happen again, they cannot and should not try to protect themselves, and so on.

The treatment of trauma restores the sense of empowerment and reality to the patient, reconnecting split-off and overwhelmed feelings with the main experience of life and dismantling past useful responses that are no longer necessary. This discussion of treatment generally follows the work of Judith Herman (1997). The goal is an accurate narrative of the past, an increased sense of security and empowerment, and increased healthy trust in relationships. Our definition of this problem refers primarily to those with a history of trauma perpetrated by others, whether it is physical, sexual, or mental, and is less immediately relevant to those with traumas from natural disasters.

Building a Therapeutic Alliance

Traumatized people often do not trust others to maintain healthy boundaries and engage in a mutually respectful relationship. This is especially true if the trauma has involved violence or sexual abuse. Thus, the task of building and strengthening the therapeutic alliance is carried on continuously during the entire treatment. It takes time for the patient to

develop trust that the therapist will follow the appropriate tasks and have the appropriate goals.

Because the trauma has often been denied or ignored, or at least downplayed by others, these patients are especially focused on the question of what is real, and what really happened. Did they exaggerate, did they make up their memories? Are they complaining excessively? Are their memory and judgment intact? Accepting and believing that what happened really happened, and that it had a huge impact, is a painful but essential element of trauma treatment. The resistance of not knowing, or not really believing, is very common. In working through trauma, there are frequent cycles of feeling it and believing it, and then denying it.

This uncertainty manifests itself in the treatment relationship as well. The patient is often very concerned with what is really going on in the treatment relationship—what you are really thinking or feeling, or why you responded in a certain way. There is, early on especially, difficulty in looking at these feelings as transferential. The patient wants to know what is real and is made more anxious by attempts to explore fantasies or feelings about the therapist. The patient may have experienced psychological manipulation in the past, or the uncertainty itself may provoke anxiety. Thus, the therapist must commit to genuineness in the relationship, and not hide behind therapeutic neutrality, even if this is well-intentioned. For this reason, the detailed reflection on the therapeutic relationship that is characteristic of relational psychoanalysis is so helpful. If the therapist is not able to see and acknowledge the personal reactions, points of view, and emotion that comes up in the therapeutic relationship, the patient will be much less likely to experience a sense of safety and be able to fully explore their traumatic experiences.

Clarity, honesty, and transparency are necessary. You continually have to prove that you are not an abuser. This requires confidence in yourself when you are accused or regarded with suspicion. You have to focus your attention so that you do not inadvertently do the things the patient is frightened of, such as minor expressions of anger, retaliation for the patient's difficult behavior, or overly personal expressions of affection. But even if you do all of this, a patient with a history of physical abuse may worry that the therapist will get angry and attack. It might take repeated calm expressions of interest and positive regard, and time in therapy, before the patient can settle down enough to be able to begin to see these fears as self-generated and transferential, as opposed to a result of a real danger situation.

The resistances manifested in the treatment of trauma are the patient's attempt to manage feelings of fear or contain anger. Trauma results in the splitting off of traumatic memories and responses, and this

dissociation then shows itself in the treatment. There are periods of time when the patient does not seem to have much to work on, and other periods when the patient is so overwhelmed by emotion that they do not feel they can leave the office and reenter the world. The therapeutic alliance will strengthen if the therapist encourages discussion of the traumatic memories, feelings, and reactions, but leaves enough time at the end of appointments for the patient to reconstitute and return to the contemporary reality. Patients may dissociate in session under the sway of these memories and feelings, and you will need to help them find a safe place to be after sessions, and find techniques for soothing themselves when they are distressed outside the session.

Technique

The road map for treatment starts with education about the arc of psychotherapy for trauma—empowerment, exploration, and evaluation of memories—and use of that knowledge to inform current relationships and decisions. The initial phase of treatment involves a cautious exploration of the present and past, with support, empathy, and the maintenance of a clear perspective—that is, the therapist expresses the conviction that the bad things that happened were wrong, they should not have occurred, and they produced possibly lasting effects. But the trauma is in the past, and in the present the patient will be able to develop techniques for managing the emotional sequelae and be in charge of current perceptions and decision making. The painful memories and emotions need to be contained in the therapy, using support, appropriate availability outside the appointments, and clarifications about the reality of the therapeutic relationship. This includes discussion focused on restoring mentalization capacities, helping the patient understand why they reacted as they did, and sometimes also trying to understand (if not accept) the subjectivity of the abuser.

The next phase, working through, involves repeated discussion of the traumatic memories, but also the many current life situations and how the traumatic experiences may be distorting current perceptions. The patient recovers a sense of control, mastery, and confidence by taking charge of how they see things in the present and makes new decisions freer from repeating aspects of the old traumatic scenarios. For example, the patient does not have to shrink back from situations that are not really dangerous but are reminiscent of the trauma, nor does the patient have to counterphobically prove themselves to be safe. They do not have to doubt their perceptions, which will sometimes include skepticism or criticism of others' behavior, and do not have to second-guess their perceptions and decisions in the same way.

The working-through phase will, to some degree, involve a deeper experience and exploration of the traumatic transferences (and, for you, the countertransferences), and a deeper kind of trust will enter the therapeutic relationship. Treatment will draw to a close when the old traumatic feelings and perceptions are relatively less powerful and the patient has a renewed sense of self-efficacy and mastery. Here, the curiosity, openness, humanity, and humility of the relational psychoanalytic model allows for the deep sense of honesty and trust needed for the treatment of trauma.

Transference and Countertransference

Traumatic transferences are often quite specific—that is, the patient feels things about the therapist that are replays of traumatic experiences in earlier relationships. For example, a male patient who had been sexually abused in childhood by an older woman felt the female therapist was dangerously seductive when she smiled because his abuser had smiled at him in a particular way. A female patient had difficulty looking at the therapist because the male therapist's eye contact reminded her of a manipulative man with an aggressive stare who had once threatened her. For another patient, the long hallway outside the therapist's office often triggered memories and feelings related to the hallway in her childhood home where abuse took place.

Frequently the patient regards the therapist as a potential abuser of some kind and brings to the relationship a lack of trust. It is often incomprehensible to a patient who is traumatized how the therapist could only have the agenda of listening, helping, and trying to understand, and not have more selfish motivations that will lead to dangerous behavior. The patient is afraid of the therapist and feels that the only way to protect themselves is to maintain constant vigilance. It is important to be on guard, not reveal too much that might make one vulnerable, and never relax too much, or something dangerous could suddenly occur.

The rage victims of trauma feel toward those who hurt them is often reawakened in the transference, accompanied by guilt or fear that the abuser (therapist) will retaliate in some way. This reflects the bind they felt as helpless victims. Another variant of this problem is when the transference is based on those who were bystanders and did not help. Other family members who did not come to the rescue, or who helped to maintain secrets, were a focus of anger and mistrust, and the therapist can be seen in this light. Here the anger is about the bystander's betrayal, passivity, or cowardice. It is important to distinguish between these two reactions, both based on anger—anger at being hurt and anger at not

being protected—because they each reflect an important aspect of the legacy of trauma and its effect on subsequent relationships.

Patients who are traumatized present many challenges to the therapist, although ultimately it can be a deeply satisfying experience if one is able to help them regain a sense of control and mastery over themselves and their lives. Countertransference reactions tend to be strong, like the transference reactions. There are six common countertransference reactions. First, one may identify particularly strongly with the patient's suffering and the overwhelming sense of hurt, fear, and rage. As always, empathic identification helps one understand what the patient is feeling and struggling with, but it can cause difficulty because it is harder for the therapist to take a dispassionate view and push the patient to help them move forward. The identification can turn into overidentification and downright passivity, hopelessness, and loss of the helping role.

Second, you may downplay the seriousness of the trauma. A therapist is especially vulnerable to this when the patient is minimizing or in denial of the significance of the abuse. Therapists deny abuse because it is so awful to consider, and empathizing with the abuse leads to painful emotions—fear, anger, vulnerability, hopelessness.

Third, the therapist may identify with the perpetrator. In this case, the therapist feels angry or controlling feelings toward the patient, subtly slipping into regarding the patient's needs and feelings with disrespect, like they are not quite equal. When there is a traumatic reenactment going on—the patient is feeling that the therapist is abusive—even the therapist may experience themselves that way. This is often accompanied by feeling guilty and bad. Sometimes, the therapist treating a patient who is traumatized just feels bad and guilty, even if there does not seem to be anything realistic to base it on.

Fourth, you may feel helpless. In response to the patient's passive bystander transference, you can feel like you are just not doing enough. You are witnessing a person in extraordinary pain, and you are just standing by doing nothing. In reality, talking, reflecting, and problem solving are the very things the patient does need, but sometimes it feels like the therapist's work is so ethereal or so minor, it is practically trivial. This is the countertransference guilt of being the bystander.

Fifth, you may feel overwhelmed with feeling. Hearing about trauma, especially when there are repeated instances, becomes overwhelming at some point. Patients need to be able to talk about their experiences as much as they want, and they will need to repeat their stories numerous times. Indeed, in prolonged exposure, the efficacious structured behavioral treatment for PTSD developed by Foa, Hembree, and Rothbaum (2007), patients verbalize their major traumatic experiences many times.

Hearing over and over again about trauma can lead to a subtle form of PTSD, with avoidance, anxiety, and reliving experiences. The best approach to dealing with these feelings in yourself is supervision and discussion with peers. You need some support and guidance in processing your own powerful responses to hearing about the trauma, in a fashion parallel to the patient's therapy. It might be important to limit the number of patients who are seriously traumatized you treat at any one point in time.

Last, there is a particular type of confusion you may experience that is actually a form of countertransference. You may forget parts of the patient's history, or what was discussed at the previous session, or you may find yourself not being able to synthesize your understanding of what the patient is talking about. Your thoughts and feelings may swirl, or you may retreat into a state of anxious confusion. This is often the kind of feeling the patient had in response to the trauma. It is the subjective state of being so overwhelmed that the usual cognitive functions are interrupted. It may help you understand how the patient felt or feels sometimes now in dealing with the traumatic memories. Indeed, the therapist's own capacity for mentalization can be temporarily compromised.

We have described the issues involved in developing a therapeutic alliance and the usual transferences and countertransferences with patients with trauma at somewhat greater length than with the other psychodynamic problems because they are so powerful that the treatment will likely become derailed if they are not recognized and attended to.

Evidence Base

A systematic literature review by Paintain and Cassidy (2018) found three studies suggesting that psychodynamic therapy is an effective form of treatment for PTSD. Roggenkamp, Abbass, Town, Kisely, and Johanssen (2021) found that intensive short-term psychodynamic therapy for PTSD reduced health care expenditures, improved general psychiatric outcomes and maintained reduced health care costs at follow-up. Abbass and Macfie (2013) tracked PTSD symptoms over 29 months in response to psychodynamic therapy and reported significantly decreased overall distress, preoccupation with trauma, and dissociation. Kellett and Beail (1997) found a steady decline in nightmare frequency and distress. Using trauma-focused inpatient psychodynamic therapy, Lampe, Barbist, Gast, Reddemann, and Schüßler (2014) reported symptom reduction in several outcome scales assessing mood, life events, and overall symptoms. Despite the positive outcomes reported by these researchers,

not all of the studies involving psychodynamic-based approaches yielded significant positive results. Britvić, Radelić, and Urlić (2006) measured symptoms of PTSD intensity, neurotic symptoms, and defense mechanisms in a study of long-term dynamic-oriented group psychotherapy. They found reduced intensity of PTSD symptoms, but no significant change in neurotic symptoms and defense, even after up to 5 years of treatment. In addition, evidence provided from control groups in longitudinal treatment intervention studies suggests that PTSD has a variable course, dependent on factors including population, traumatic event, and community context, but with a trend toward reduced symptomatology, intensity, and prevalence over time (Santiago et al., 2013).

There is not a single modern RCT comparing dynamic therapy to CBT for PTSD. Brom, Kleber, and Defares (1989) compared a short-term psychodynamic treatment based on Horowitz's (1976) form of time-limited dynamic therapy to systematic desensitization and hypnotherapy. They found that 60% of patients in each group improved. In addition, they reported that psychodynamic psychotherapy resulted in greater reduction of avoidance symptoms, while systematic desensitization and hypnotherapy resulted in greater reduction of intrusion symptoms. Despite these positive results, we are not aware of any studies continuing this promising line of research.

SUMMARY

This review of the six core psychodynamic problems—depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma—helps the therapist recognize and anticipate the unfolding of each type of patient's psychotherapy. Having identified the core problem and begun to develop the therapeutic alliance, your next task is to develop a comprehensive formulation with the historical and personal data you have gathered.

7

Psychodynamic Formulation

> The formulation of a problem is often more essential than its solution.
>
> —Albert Einstein

When we were in training, those teachers who could listen to a case presentation and instantly grasp the patient's essential problem had a luminous quality for us. They perceived the patients' key conflicts and used them to explain everything important in their lives. This almost magic ability seemed unattainable, and we saw it as the ultimate skill in our new field. Now we know that what appeared to be magic is actually the learned ability to formulate a case rapidly.

Perry and colleagues (1987) make the important point that writing out a formulation is not just an educational exercise—rather, it is an important and concrete way of making sure you commit yourself to a way of thinking about the patient. They refer to E. M. Forster's alleged comment, "How can I tell what I think until I see what I say" (1927, p. 152). Although open-mindedness and an ability to be flexible and change one's mindset are essential skills for the therapist, vagueness and ambiguity have too often allowed us to hide our confusion and muddy thinking, and a thoughtful formulation is an attempt to move past that.

How does one integrate all of the material about the patient's life with the core psychodynamic problem, illustrating the central conflicts and discussing neurobiological factors that are important but which we can only guess at? Is it clear how the patient's age, culture, race, gender, and sexuality shaped their experience and was incorporated into identity and internal representations? Like any complex new mental task, writing a formulation is best accomplished by breaking it down into its parts, focusing on the completion of each component and waiting for the moment when it all comes together. Our trainees feel overwhelmed with

the first formulation they attempt, but it gets easier with experience. By their third attempt, they are writing successful formulations and are struggling instead with a deeper understanding of the patient, realizing that the formulation writing is a worthwhile tool for pushing them to clarify their clinical thinking.

Here is a formulation for Peter, the young man with depression discussed in Chapter 5. We have learned from our students that it is helpful to read through an entire formulation first before discussing the structure and the components. Each component of the formulation is labeled for easier reference.

Part 1: Summarizing Statement

Peter is an 18-year-old White heterosexual cisgender man in his freshman year of college with chronic low-grade depression, social anxiety, disappointments in love, and high academic achievement. He describes feelings of extreme loneliness, anxiety, and constant suicidal preoccupation. He experiences a great longing for intimacy, both in a romantic relationship with a woman and in friendships with men, and feels constantly disappointed. He has difficulty completing his work and meeting deadlines. The most intense periods of depression, anxiety, and suicidality follow social disappointments. He had marked childhood shyness, depressive symptoms beginning in the preteen years, and a family history of depression and schizophrenia.

Part 2: Description of Nondynamic Factors

Peter's Protestant family has a culture of emotional restraint and formality. The family is financially comfortable and places a strong emphasis on individual achievement and identity, and traditional gender roles. Peter meets the diagnostic criteria for major depressive disorder. His paternal grandmother had paranoid schizophrenia, and his father, an esteemed academician, is described as emotionally aloof, overly rational, and inhibited. His mother suffers from chronic low-grade depression and is often needy for his attention. Peter was an anxious and chronically shy child with behavioral inhibition. He had a prepubertal onset of intense social anxiety and a markedly fluctuating mood with low self-esteem. Prior traumatic experiences included frequent teasing and humiliation by other boys during the teenage years, and rejection and public humiliation by his first girlfriend. He found prior psychotherapy helpful and responded fairly well to prior treatment with serotonin reuptake inhibitor antidepressants with reduced interpersonal sensitivity and less catastrophic responses to disappointment.

Part 3: Psychodynamic Explanation of Central Conflicts

Peter's core psychodynamic problem is depression. The main conflicts involve his early sense of loss, with anger, guilt, and a tendency to idealize others and be disappointed by them [*statement of core psychodynamic problem and essential conflicts*].

Peter recalls persisting feelings of loneliness as a child and many memories of his mother confiding in him about her frustrations and disappointment in her marriage, and complaining about his father's lack of warmth. She made a big point of thanking Peter for touching her shoulder at her father's funeral [*specific childhood vignette*]. His mother's singling him out for special companionship made him feel very close to her but overwhelmed by her neediness. She seemed to want a companion who would be tied to her, which felt good, but he also wanted to feel independent and vigorous. His father was hyperintellectual, and Peter never felt comfortable with him, and longed to feel more masculine. His feelings of disappointment were associated with much anger at both parents, and intense guilt about this [*psychodynamic explanation of childhood vignette*].

These issues are also reflected in Peter's pattern of difficulty completing college courses, meeting work deadlines, and being consistent about extracurricular activities. In high school, he initiated a one-person environmental campaign, writing articles about environmental threats in the school paper and organizing meetings. Yet he did not reach out to include others in his protest [*seminal life event*]. He expressed his anger through this protest, which did not make him feel guilty. By not including others, he avoided rejection and subsequent resentment, but caused this at the same time. In this example, he managed his neediness through aggressive and even argumentative behavior [*psychodynamic explanation of seminal life event*].

After a recent romantic disappointment, Peter cut himself superficially on the thigh [*recent experience*]. He had become increasingly depressed, angry, and suicidal over the recent semester, feeling lonely and rejected by several girls. He experienced intense rejection, feeling that everyone but him was paired off with a romantic partner and this made him very angry at the women who rejected him. The cutting expressed his hurt, self-directed anger, and yearning for understanding [*psychodynamic explanation of seminal life event*]. He yearns for closeness with men—other students and professors—wanting to be guided and protected. The family culture of individualism probably intensified his sense of loneliness and difference [*impact of culture, race, gender, sexuality on shaping experience*]. He responds to this

need for others and his fears of not measuring up with self-defeating behavior, such as turning in work late, keeping others waiting, and confessing excessively about his history of depression [*additional psychodynamic explanation of seminal life event*].

The CCRT for Peter would be a wish to be close and idealize others, a response that others are disappointing and rejecting, and a response of self of disappointment and anger, with angry and clinging behavior [*optional: CCRT*].

Striking intelligence, articulateness, and a kind of dogged persistence helped Peter deal with all of this travail. He was a "fighter" [*strengths*].

Peter's neurobiological vulnerability to social anxiety and shyness, as well as his predisposition to depression, probably contributed to proneness to rejection as a child and intensified his experiences of disappointment and anger. This likely made him even more dependent on his mother, and more sensitive to the disappointments in his relationship with his father. His schizotypal vulnerability (grandmother with schizophrenia, father with some schizotypal traits) may cause his reaction to these losses and frustrations to be more chaotic and disorganized than otherwise expected [*biology affecting psychodynamics*].

On the other hand, Peter's fear of rejection, and the self-defeating behavior that has become associated with it, tend to perpetuate the recurrent depression and social anxiety. His sensitivity to rejection is a trigger to episodes of illness. Thus, his depressive psychodynamics likely reinforced his biological vulnerabilities, resulting in the acute symptom picture he presents in coming for treatment [*psychodynamics stimulating biological vulnerability*].

Part 4: Predicting Responses to the Therapeutic Situation

Peter has many positive prognostic features, including a high level of academic function; consistent and stable, if conflicted, relationships with parents; and a history of prior participation in therapy. His trait-like ability to form a strong alliance, intelligence, verbal facility, and persistence will be helpful and probably critical to weathering the transference storms.

Following the development of an initial positive transference attitude, Peter's angry and competitive feelings associated with his father and the conflicted dependent feelings related to his mother may begin to develop toward the therapist. Thus, he might feel disappointed and rejected, and there could be self-destructive behavior or an angry counterdependent reaction. Peter's attitude toward

psychopharmacology may follow the same pattern, with a wish for help but ambivalence when it is received.

What were your reactions to reading this formulation? We hope it conveys this patient's themes of hurt, anger, and self-defeating behavior and traces them from early origins to current presentation. It also attempts to demonstrate the relationship among those dynamics, the cultural context, and the biological vulnerability. Although a comprehensive formulation can provide a rich picture of the interweaving strands of experience and vulnerability, it often raises as many questions as it answers.

As you can see, a formulation is not a history. It is a pithy summary condensed around one core psychodynamic problem. It organizes the patient's symptoms, experiences, important relationships, and seminal life events into a focused and coherent whole. There is always a tension between waiting for an understanding of the patient to "bubble up" through extended exploration and discussion, and reaching a judgment about what the core problems are. If we rush the process, our conclusion will be formed too early in the treatment based on incomplete data and understanding. But caution has its costs as well. The conservative stance, waiting until all things are clear and the patient arrives at a concise picture themselves, is often slow and unrealistic. It exposes the patient to too much uncertainty and anxiety and the feeling of floundering. This is one reason patients complain their therapists are not "doing anything" for them.

The formulation enables you to apply your understanding of the six core psychodynamic problems, generic as they are, to the unique patient in front of you. It also helps you define appropriate treatment goals and anticipate the unfolding of the therapeutic relationship. Most forms of therapy emphasize the need to derive a formulation to guide the goals of treatment and to decide on the best interventions (see Eells, 2022, for a comprehensive overview of formulations). The formulation approach we describe here is comprehensive, meaning it includes the neurobiological, social, and systems aspects of the patient's problem, as well as the psychodynamic aspect. This approach requires you to judge the relative importance of psychodynamic factors compared with other factors in the development and maintenance of the patient's condition.

The example of Peter illustrates the structure and content of a formulation. In this chapter, we describe its evolution as a clinical tool and the data you need to gather to derive it. We conclude with some of the practical pitfalls and problems you may confront in generating formulations.

THE TRADITION OF PSYCHODYNAMIC FORMULATION

Freud made succinct conceptualizations of his patients without using the term *formulation*—for example, in the famous case of Dora (Freud, 1905), he pinpointed the patient's conflicts with her father and other men. Much subsequent interest in the structure and format of psychodynamic formulation came from educational rather than clinical settings. Formulation was seen as a good way of helping junior clinicians sharpen and clarify their thinking about patients and a stimulus for good discussion with teachers and supervisors (MacKinnon & Michels, 1971; MacKinnon & Yudofsky, 1991; McWilliams, 1999). We agree with this, and think it is a worthwhile habit for all clinicians, junior or senior. We identify a core problem with all of our patients and develop a formulation, although having done this for a while, we no longer write it out. Writing the formulation seems especially helpful for those in training.

A close look at the use of psychodynamic formulation began with Perry and colleagues' (1987) elegant review. They presented a format for a concise formulation that we follow here. The four essential parts are (1) a general summary of the case; (2) a review of "nondynamic factors"; (3) a description of core psychodynamics using the ego psychology, object relations, or self psychology model; and (4) a prognostic assessment that identifies potential areas of resistance. Although Perry et al. refer to the importance of including neurobiological factors in the formulation and comment on the relevance of a psychodynamic formulation to nondynamically focused treatments, they do not provide a systematic format for including these elements.

The CCRT method, developed by Luborsky (1977) to facilitate research on psychodynamic processes, provides a clear formulation. The CCRT can help the clinician, especially the new clinician, focus and organize clinical material and may usefully serve as a component of the more multifaceted psychodynamic formulation we describe here.

Summers (2002) provided an updated structure and format for the psychodynamic formulation, building on and extending the concepts set forth by Perry and colleagues (1987)—that work, along with the CCRT, provides the basis for this chapter.

A strong tradition of cultural formulation (American Psychiatric Association, 2013; Lewis-Fernández, 2002), mostly existing outside of the psychodynamic and psychoanalytic literature, must now be considered a critical element in a comprehensive formulation. The notion of cultural formulation has expanded into a more general awareness of the social determinants of health and mental health (Compton & Shim, 2015). The Psychodynamic Formulation Collective (2022), a group of psychoanalytic thinkers who came together after the George Floyd

murder in 2020, advanced psychodynamic formulation by explicitly acknowledging the profound impact of socially determined life experiences on the conscious and unconscious mind. This includes more general cultural influences, but especially the underrecognized effects of racial trauma, economic deprivation, discrimination, and oppression on identity, conflicts, experience, and symptoms.

HISTORICAL TIME LINE

The first clinical data you will collect are about the patient's current and past subjective experiences. What has been upsetting and painful and difficult, and what are the feelings, thoughts, and fantasies associated with those painful experiences? What are the prominent symptoms and the repetitive experiences or behaviors?

Your task is to develop a historical time line with a clear picture of the waxing and waning of symptoms over time, and the experiences that seem to have precipitated them. Focusing on potential triggers is extremely important, and one should gently but firmly inquire about this, despite a patient's insistence that the symptoms appeared out of nowhere. Like the character Columbo in the old TV series of that name, a therapist needs to take a modest, understanding, but persistent stance in delving into these questions with the patient. An uncomplicated, direct, curious manner helps to draw patients out. Be skeptical but respectful!

You may gather the developmental history and sweep of experiences over the patient's life by asking more open-ended questions when a patient is talkative and interested in discussing their history. Other patients may require a session or part of a session that is more specifically focused on the early history. Here, the therapist asks about the family background and each period of the patient's life, starting from the beginning.

The history includes not only symptoms but also the important experiences of the patient's life. Don't make the common mistake of focusing so much on the patient's symptoms that you neglect the patient's seminal life events and the nature of the patient's strengths. Relevant interpersonal issues and cultural and social context are crucial parts of the picture. For example, a patient who comes to treatment concerned about feeling withdrawn, anxious, and afraid, and whose marriage is breaking up, is understood differently from a patient who has the same feelings, but whose marriage is intact. What is the patient's race and culture, and what about the key members of the family? What was the patient's lived experience with discrimination, racial trauma, and economic opportunity?

The context for understanding a person's problems also includes an assessment of neurobiological vulnerability, which is established through family history or specific psychiatric symptoms. Usually you will rely on the patient's report of symptoms and family history. It will be difficult to determine what is a neurobiological factor, and what is related to psychodynamics. We discuss this important but thorny issue shortly.

PSYCHODYNAMIC FORMULATION WORKSHEET

We use the Psychodynamic Formulation Worksheet (see Figure 7.1) to keep track of the domains of data that are essential to the comprehensive formulation and to remind us to look for information over the longitudinal course of the patient's life. The worksheet makes the task of gathering information more concrete. The boxes need to be filled in over the course of the first four to six sessions. Of course, the unique and complex history of a person requires more than a series of small boxes to express, and sometimes the patient has not discussed important parts of the history. But you should take a first pass at identifying important issues in each of these building blocks of development. The worksheet illustrated here has notations about Peter's history. We use an additional column for each subsequent decade of life (e.g., 20–30 years old, 30–40 years old).

The top row is for *important life events*, including major family changes or disruptions; traumatic or medical events; life-changing developmental events, such as starting a new school or leaving home; and occupational or relationship events. We also include race and culture as a reminder to consider the social aspect of the experiences noted on the worksheet. This includes observations about key cultural values, such as individualism versus collectivism, traditional cultural beliefs, and gender roles. This category reflects external reality: the things that happened in the patient's life.

Key subjective experiences refer to the patient's description of frequent mental states or experiences and is connected to psychiatric symptoms, such as marked anxiety, depression, or obsessional behavior. It includes both how the patient feels and felt and the symptoms that developed. Examples of entries in this row include more general experiences such as loneliness, fear, and contentment, as well as more specific experiences such as worry about physical attractiveness, anxiety about money, or confusion about career. More information is better than less here. The patient's gender and sexual identity are noted here.

The role of trauma as an external factor in the development of psychopathology is clear, as is its often profound effect on personality

	0–5 years old	5 years old–puberty	Adolescence
Important life events, cultural and racial context	Needy mother and aloof father. Two younger siblings. White Protestant traditional culture with individualism and traditional gender roles.	Teasing, some social alienation.	Rejection by girl and public humiliation. Subsequent rejections by others. Good academic performance but much struggle and procrastination. Leave home for college.
Key subjective experiences, psychiatric symptoms, gender, sexuality		Social anxiety, low self-esteem, mood fluctuations. Longing for closeness.	Chronic low-grade depression, parasuicidal behavior. Procrastination about academic work. Social anxiety. Suicidal after social disappointments.
Neurobiological factors, syndromal pathology	Shyness, family history of depression and psychosis.	Prepubertal social anxiety.	Depression, social anxiety.
Psychodynamic themes	Attachment problems with mother, some degree of intrusiveness.	Father distant, ambivalent identification. Mother a little enmeshed. Guilt and anger about relationship with mother, also father.	Identity issues, depression. Social alienation and conflicted relationships with friends. Looking for partner, friends, idealizing others, frequently disappointed. Anger and guilt after rejections. Competition.
Treatments and response			Previous psychotherapy with some response. Good response to antidepressant, with decreased mood reactivity and interpersonal sensitivity.

FIGURE 7.1. Psychodynamic Formulation Worksheet for Peter.

development and intrapsychic life. A psychodynamic formulation will need to carefully conceptualize the effects of single traumatic experiences, recurrent trauma, and recurrent micro-trauma on experiences of self and other, self-esteem, and subsequent psychopathology. The traumatic experiences will be noted with important life experiences and

the associated recurring subjective experiences and symptoms along that row. It is important to maintain a curious and open attitude when inquiring about trauma and not to suggest or encourage memories.

Neurobiological factors refer to those nondynamic aspects of the patient such as proneness to mood disorder, psychosis, anxiety, substance use, eating disorder, and attentional problems, or biologically driven temperamental or personality factors. It is certainly an inference to determine whether there are neurobiological factors in the patient's presentation, but the formulation is an inference and a working document that can and should change with time. We recognize the need to develop hypotheses about the impact of early relationships and conflicts on the patient—we are bold about hypothesizing and modest about concluding—and there is no reason not to take the same attitude when hypothesizing about what is biologically and what is environmentally driven.

Summers (2002) recommended assessment of the following factors:

1. The role of temperament, that innate part of the personality, importantly determines behavior and experience, and surely affects the child's emerging experience of self, and others (Chess & Thomas, 1996; Rutter, 1987). Psychodynamic formulation should attempt to clarify what may derive from intrapsychic conflict and/or developmental difficulties, and what may be temperamental.

2. Better classification and identification of childhood psychopathology has helped to elucidate the potential impact of childhood psychopathology on development and adult psychopathology (Biederman et al., 1993). This would include identification of learning difficulties and other neurodevelopmental vulnerabilities and their impact on the individual and on personality dynamics (Brown, 2000). Childhood psychiatric diagnosis should be included and its impact discussed.

3. The influence of subsyndromal illness on emotional development has not been well studied (Akiskal, 2001)—for example, mild mood syndromes that later become full-fledged illness, or anxiety problems that do not meet severity threshold. The possible subsyndromal symptoms that even young children experience may have a profound impact on the development of self-esteem and may be crucial factors in emotional development (Biederman, Hirshfeld-Becker, & Rosenbaum, 2001). This may be evident retrospectively only when reconstructing an adult patient's development.

4. With the advent of increasingly effective and powerful pharmacological treatments, there are many individuals who have had effective

medication treatment over an extended period of time and at earlier critical developmental periods. Surely these interventions, and their effect on patients' experiences, have also shaped their experience of self. These effects must now be considered to be important environmental experiences in their own right that effect subsequent development.

Syndromal pathology refers to the presence of frank psychiatric symptoms that are part of a longitudinal illness. The diagnosis of a syndrome, or the appearance of a neurobiological vulnerability, should be noted when it is apparent in the history. We are aware that collecting information about neurobiological factors may be difficult, and the patient may not be able to provide enough information. In some instances, you may want to include family members in gathering the history. This listing of neurobiological factors is intended as a prompt to ask about these areas; it is not necessary to comment about them in the formulation unless they are relevant.

Reflection on the nondynamic factors in a patient's formulation reminds us of the crucial distinction between person and illness. The person has psychodynamic conflicts, while the illness is something that happens to the person, affecting them and affected by them. Psychiatric illnesses, such as bipolar disorder, schizophrenia, addiction, or obsessive–compulsive disorder, are important nondynamic factors. Although psychosocial stress is a risk factor for each of these illnesses, we do not understand these illnesses as psychodynamically determined—that is, specifically causally related to the dynamics of identity, relationships, and developmental trauma.

In the years of discussing the core psychodynamic problems with many audiences, we were often asked about why addiction was not included as a distinct core problem. This thoughtful question was born of clinician's experiences working psychotherapeutically with individuals struggling with addiction and their clinical observation that psychotherapy was helpful. The response lies in this distinction between the person and illness. Most clinicians, including psychodynamically oriented clinicians, recognize that addiction is an illness that has profound effects on identity, mood, functioning, and psychodynamic conflict. Baurer (2021) eloquently describes the destructive impact of addiction and its sequelae on the personality and the salutary effects of psychodynamic therapy in healing the person when the patient is in recovery. Thus, we conceptualize addiction as a nondynamic factor that is highly relevant to understanding and conceptualizing patients' psychodynamic conflicts, but not a psychodynamic problem. The same is true for bipolar disorder, where affective intensity often overwhelms the individual's regulatory capacity and results in psychological stress from the attempt

to contain and manage it. For schizophrenia, the positive symptoms of paranoia and hallucinations likewise impact the patient's psychodynamics and are important nondynamic factors in the formulation.

The row entitled *psychodynamic themes* (see Figure 7.1) allows the clinician to note emerging areas of dynamic conflict. These notations are a first take at describing the problems and conflicts as they show themselves. Examples include loss, dependency, competition, guilt, conflict with women or men, authority problems, separation, self-esteem problems, rigidity, anger and impulsivity, or fear of bodily damage. Although these themes do not map directly onto the six core problems—depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma—these mini-inferences will help you decide which of the core psychodynamic problems best describes your patient. This row is also the place to make notations of repetitive patterns using the CCRT format, for example.

Previous treatments and the responses to them are noted in the last row of the worksheet, and this includes both psychotherapy and psychopharmacology. Arraying these treatment responses in the worksheet reminds us that treatment takes place over the life cycle. Much can be learned from what worked and did not work before, and transferential patterns are a window into the psychodynamic problems.

WRITING THE FORMULATION

The data you gather and jot down on the formulation worksheet needs to be synthesized. You may be able to connect the dots and see the core psychodynamic problem and how it runs through the patient's life, or it may still be obscure.

An optimal formulation would include 750–1,000 words. It should be written simply and clearly, with as little jargon as possible. Specific examples can illustrate the points made. The formulation is not a history, and you should resist the urge to write up all of the information you gather. A good formulation is at a higher level of inference than a history. We describe the four parts of the written formulation, based on Perry et al. (1987) and Summers (2002), with several updates and modifications, and this is summarized in Table 7.1. The example formulation at the beginning of this chapter follows this format.

Overview

Part 1 summarizes the patient's identifying information, including gender, events precipitating the illness, and salient predisposing factors. This

TABLE 7.1. Elements in Comprehensive Psychodynamic Formulation

Part 1: Summarizing statement

- Patient identification
- Very brief summary of:
  - Precipitating events
  - Most salient predisposing factors in the history
  - Major historical events
  - Extent and quality of interpersonal relationships
  - Important aspects of neurobiology
  - Behaviors that the formulation will attempt to explain

Part 2: Description of nondynamic factors

- Current syndromal diagnosis
- Race, culture, experiences of discrimination, deprivation
- Family history of psychiatric illness
- Brief summary of relevant information about:
  - Syndromal psychiatric illness
  - Temperamental factors
  - Childhood psychopathology
  - Subsyndromal illness
  - Psychopharmacology experiences
  - Other factors, including medical illness, mental disability, drugs/physical factors affecting the brain
  - Traumatic experiences

Part 3: Psychodynamic explanation of central conflicts

- Core psychodynamic problem
- Tracing of core problem and associated conflicts through personal history
- Include childhood example, major life event, recent example
- Explanation of patient's attempts to resolve this problem that have been maladaptive and adaptive
- Explain how the patient's racial/cultural/gender/sexual identity is intertwined with the core problem in at least one of the examples
- Formulation of core problems and central conflicts using the psychodynamic models most useful for the problem, including important conscious and unconscious wishes, motives, behavior, defenses
- Derive a recurrent CCRT (optional)
- Key strengths and how they have interacted with problems
- Effect of nondynamic factors in shaping psychodynamic problem via their effects on experience of self, other, and relationships
- Effect of dynamic factors on development and maintenance of syndromal illness

Part 4: Predicting responses to the therapeutic situation

- Prognosis, focusing on patient's experience of treatment
- Probable transference manifestations, expected resistances
- Strengths likely to be employed over course of treatment
- Probable reactions to psychopharmacological treatment

Note. From Summers (2002). Adapted with permission of the American Psychiatric Association.

section sets the scene for the rest of the formulation, so it should summarize critical information such as major historical events, the extent and quality of interpersonal relationships, and a summary of important neurobiological factors. Part 1 concludes with a review of the behavior that will be explained by the formulation. This section gives the reader an overview of the patient and a summary of the core problem, symptoms, vulnerabilities, strengths, and life events that the rest of the formulation will attempt to explain.

Nondynamic Factors

Part 2 details the nondynamic factors relevant to the formulation. This begins with any concurrent syndromal diagnoses, such as major depression or bipolar disorder. This is followed by a statement about the patient's race and culture and the important elements of race and culture in the patient's family. Next is a summary of neurobiological vulnerability in the style of a "review of systems": family psychiatric history, temperament, childhood psychopathology from the syndromal perspective, history of subsyndromal or prodromal illness, responsiveness to psychopharmacology, and identifiable traumatic experiences. These factors are described with their essential supporting evidence. Of course, there will be variation in the degree of certainty about these factors, ranging from clearly supported diagnoses with good data to inference and hypothesis. Because the formulation is always a work in progress, which we hope will be modified and refined, inferences are not only permissible but also necessary to create a comprehensive picture of the patient.

Psychodynamic Synthesis

The psychodynamic synthesis is presented in *Part 3*. This is the hardest section to write, but the most important. It begins with a statement about which of the six psychodynamic problems the patient is struggling with, and the rest of the section supports and illustrates this. The central conflicts associated with this particular psychodynamic problem should be illustrated. Three examples, including a childhood experience, an important life event, and an event in recent history should be described and related to the psychodynamic problem and associated conflicts. You must show how each of these three events reflects the patient's core problem and their typical solution to it. The psychoanalytic model that best explains that psychodynamic problem—ego psychology, object relations, self psychology, mentalization, or relational psychoanalysis (see Chapter 3, Table 3.1)—will supply the language for describing the psychodynamics. How the patient's race, culture, gender, and sexuality

impact these life events, and are intertwined with the psychodynamics, should be discussed with at least one of the three examples.

It is a challenge to pick three very specific events in this section of the formulation. Early learners often choose a generic observation about the patient, instead of a particular event, but this makes writing the formulation more difficult. If the events are specific, it is easier to describe the patient's feelings, thoughts, and behavior in relation to the event, and then use the essential psychodynamics to (1) explain why the patient felt as they did and why they responded as they did and (2) show more evidence to support the choice of a core psychodynamic problem as a meaningful framework for understanding the patient.

Peter's therapist chose depression as the core problem because of his painful and very present symptoms of depression, the patient's resonance with experiences of loss in the past and present, his prominent self-criticism, and very limited use of primitive defenses.

But, of course, there are ample data to suggest that attachment concerns are important and fear of abandonment would be an alternative problem to organize the formulation around. Then the core conflict would focus on separation and anger; these conflicted feelings will be noted in important relationships and emerge at crucial life events. As discussed in Chapter 6, object relations, mentalization, and relational psychoanalytic theory supply the most useful language for fear of abandonment. The typical problems with object constancy and split self- and object representations could be illustrated with a childhood experience with a parent, a crucial life event, and something from the recent history. The examples would use historical data to flesh out the description of the conflict or the impaired mentalization or particular relational entanglements. Viewing Peter's core problem as fear of abandonment, the CCRT is a wish for closeness, the response of other is distancing, and the response of self is anger.

The formulation explains how the patient has attempted to manage these painful conflicts, as well as their important defenses, wishes, and identifications. Like a recurring theme, or a "red thread" that runs through the history, a good formulation shows the essential problems, how they have been expressed throughout the patient's life, and how the patient managed them (e.g., defenses). Personality strengths provide resilience and ballast to these problems and their impact, and they should be described here, too.

Because development is driven by many nondynamic factors as well, a modern psychodynamic formulation attempts to integrate dynamic with nondynamic factors in understanding a patient's life. Thus, there are two additional tasks you must accomplish in Part 3 of the formulation.

First, you should address the impact of the patient's neurobiology on the form and content of the psychodynamic conflicts. Just as the experiences of self and other are shaped by events, so are they shaped by the individual's neurobiology. For example, the temperamentally active and aggressive child will address the developmental challenges of separation–individuation, the oedipal period, adolescence, and adult life cycle stages differently from the more placid person. The child with a bipolar vulnerability, who develops syndromal illness in the late teenage years, and whose subclinical symptoms were retrospectively present in the preteen years, likely had subtle deficits in affect regulation that made maturation more difficult. The child with symptoms of attention-deficit/hyperactivity disorder (ADHD) who experienced profound self-esteem injury associated with difficulties in rule-bound behavior may have particular challenges in developing a sense of mastery. Childhood obsessive–compulsive disorder may intensify separation difficulties because of a profound need for reassurance along with a sense of premature autonomy and aloneness. While childhood experiences have particular impact on development, these neurobiological factors undoubtedly affect all of the subsequent development.

Second, you should hypothesize about how the dynamics affected the neurobiology—that is, how have the psychodynamic issues contributed to the development, recurrence, maintenance, or resolution of syndromal illness? Typical examples here would include the triggering of panic attacks and panic disorder by the activation of conflict over aggression in a work setting in a patient with a three-generation history of panic, or the recurrence of major depression precipitated by increased marital tension in a patient with a history of early separation and loss.

The hypotheses about the relationship between dynamics and neurobiology are often more speculative than other elements of the formulation. Some think this is impossible to do. We recognize the difficulty, but feel that developing a formulation is a process of using limited data to develop an overarching explanation, in this area and others. There is an ongoing process of refining, changing, and improving the accuracy of the formulation. If you do not explicitly hypothesize about the neurobiology–dynamic relationship, you (and the patient) will make assumptions about it; then it will be implicit and not discussed and considered. In the end, you are allowed to be wrong!

In summary, Part 3 sets out the core psychodynamic problem, this patient's specific conflicts and defenses, at least three vignettes (childhood, major life event, recent history) that illustrate and support these ideas, and reflections on how the nondynamic factors influenced the patient's dynamics and vice versa.

Response to Therapeutic Situation

Part 4 focuses on predicting the patient's response to the therapeutic situation, drawing on the synthesis of Part 3. This includes how the patient may experience treatment and probable transference manifestations. You may also hypothesize about those strengths upon which the patient will particularly rely during the treatment, as this will help to plan the strategy for change. Because the defensive style and transference paradigm inevitably affect a patient's attitude toward medication, the formulation should hypothesize about the anticipated reactions to psychopharmacology, as well as the emerging treatment relationship. Here you may also comment on the match between patient and therapist race, gender, culture, and sexual identity and note the likely issues that may come up and the potential pitfalls if these factors are not addressed in a thoughtful and open manner.

The prognosis should include conjectures about the phases of therapy. For example, the treatment of a patient with depression who has been refractory to previous psychopharmacology and psychotherapy may include a prolonged phase of psychopharmacology trials, along with attention to psychological factors that have contributed to treatment refractoriness. During this initial phase, the patient may periodically feel close to and taken care of by the therapist, and this reaction could allow for a better psychopharmacological response. The next phase of treatment might involve more intensive psychotherapeutic work, with a more conflicted transference reaction. The patient may be able to work more effectively in this mode because the depressive symptoms are less severe due to psychopharmacology.

PROBLEMS AND PITFALLS

There is often vagueness in the initial formulation—it is the picture as you see it after four to six sessions. Although there is a lot one cannot understand at this point, a useful formulation commits to a clear way of organizing the data. Then the therapist can focus on the areas of uncertainty and listen carefully to see whether the initial formulation is borne out. It should provide the basis for an engaged discussion with the patient; if not, then you should go back to the drawing board in the spirit of inquiry and collaboration. You should not think of your formulation as a private test of your understanding—rather, it is a work in progress to be discussed, reflected on, and modified.

It is important to commit to one core problem, recognizing that there may be other problems that are relevant, or that may become central later

in treatment. The purpose of the formulation is to guide your approach to the patient in therapy. If you cannot distinguish between two or three equally important problems, how will you be able to help the patient begin to understand themselves, and how will you decide what to comment on? Most patients cannot work on two or three problems at once, especially early in treatment. Sometimes, the therapist realizes that a different core problem might allow for more effective therapy, and there is a deepening of the rapport and a sense of new, fresh material (Summers, Xuan, & Tavakoli, 2013).

Writing a formulation will expose you (and, ultimately, the patient) to the limitations of current knowledge about development, psychopathology, social determinants, neurobiology, and how they fit together. In addition, it makes us confront what we do not or cannot know about the specific patient we are treating. It is not possible to know what the patient's childhood was really like, or how to most simply express the essential conflicts. Both patient and therapist have initial ideas, and they will certainly change over time.

In writing Peter's formulation, we speculated about the impact of the patient's social anxiety, and family history of depression and psychosis. How did this interact with the family culture of restraint and formality? We often cannot tell how much temperament or the genetics of personality contributed to the development of an illness, and how much was contributed by a patient's adverse environmental experiences. Although this type of understanding is evolving in our field through the study of populations, in any specific case we rarely know. Yet the formulation calls for an estimate of this. Of course, limited information has never stopped the curious dynamic therapist from hypothesizing about earlier relationships and developmental experiences, so it should not stop us from hypothesizing about the relationship between biology, society, and psychodynamics. Not only is it important for the therapist to conceptualize this connection but some patients want to understand these connections as well. Modern narratives of the self include an impression of one's neurobiological fingerprint, and many patients think about their genetic vulnerability, especially if they are struggling with emotional problems. Similarly, awareness of the impact of discrimination, oppression, racism, and trauma is part of an understanding of self.

Peter completed his treatment after 5 years of intensive psychotherapy and medication feeling much more content and stable. He continued to be vulnerable to loss and depression, but managed far better. He understood his acute sensitivity to feeling overwhelmed by women, his urge to connect with strong men, and his tendency to deal with his anger in a guilty and self-defeating manner. He worked through these feelings in the transference relationship with the therapist, and had increasingly

healthy positive intimate relationships. He was dating and had several satisfying and close relationships with women. The main themes identified in the initial formulation did turn out to be important and relevant. But his later problem with procrastination and uncertainty about his interests and talents was not so clear early on. It was obscured by his intense depressive symptoms and his attempt to simply survive. Subsequently, these problems became a focus in the treatment. Peter was ultimately able to apply and gain admission to a competitive graduate school and launch his career. He finished therapy feeling open and enthusiastic about the future.

We end this chapter on a note of caution in the description of the case. We hypothesize that the patient changed because of the treatment we describe, but our therapeutic humility reminds us that we cannot be sure. Psychotherapy, like life, is not a controlled experiment. We make choices, we take actions, we learn, and we change; we never know what would have happened without therapy.

SUMMARY

The psychodynamic formulation is a concise conceptualization of the patient's problem that begins with the core psychodynamic problem and illustrates the connections among the patient's symptoms, key childhood experiences, important life events, and current life issues. A comprehensive formulation combines psychodynamic with nondynamic factors in understanding the patient's life course. The formulation allows the therapist to anticipate the unfolding of the treatment, including the opportunities for change, obstacles and resistances, and emerging themes in the therapeutic relationship.

8

Defining a Focus and Setting Goals

A person who aims at nothing is sure to hit it.
—Anonymous

The formulation and data gathered in the initial sessions suggest a focus for treatment. The focus will help to jump-start the therapeutic process and build the therapeutic alliance at the same time. With a clearly defined focus, you may be able to shorten the treatment, work more consistently on what the patient offers, and strengthen the relationship. You should be cautious about jumping to conclusions in deriving a formulation, as well as rushing to define a focus. You may not yet have recognized an important aspect of the problem, and, of course, the patient may not yet feel comfortable discussing the whole story. But the advantages of an early focus outweigh the risks, and in our practices, no good day goes without an apology for getting something wrong, followed by a significant change in direction. We define a focus early and change it if needed.

Defining a *focus* means agreeing with the patient on how you will describe the problem, and therefore how you will attack it together. This can be done within the first two to six sessions, after you know the core problems and the formulation is developing. The focus provides the therapist with a way of thinking about what to explore, what to ask about, and how to frame and phrase interventions. It is something that is agreed upon with the patient, and it needs to be collaborative. It is different from a *goal*, which is an endpoint in therapy. The goal is what we hope will happen if the patient and therapist successfully focus.

These working definitions of focus and goal are how therapists tend to think about treatment, but not the intuitive way patients do. For the patient, the goal is everything. It is what they want, what they hope for,

and what they hope to achieve. Usually, the patient expresses ideas and feelings about the goal, and the therapist works backward to define a focus.

For example, a patient who came to therapy complaining that her husband was passive, depressed, and insensitive, and whose wish was for her husband to change and love her more, needed help to come up with a useful focus for her therapy. Needless to say, the therapy was not likely to help change her husband. The therapist focused on why she felt so rejected when her husband was introverted and quiet. Why did she feel so driven to take care of him and so angry about it? What impact did her anger and hurt have on how she treated him, and on their relationship? The focus of the therapy became her needs and conflicts—dependency, caretaking, sacrifice, resentment, fears of abandonment—and what she could do about them. The focus was on things inside her that she could do something about. The goal was to decrease the intrusion of old feelings, needs, and defenses into the current situation, to help her decide whether she should stay in the marriage and have the best relationship she could.

There is a particular feeling a therapist has when the focus of treatment is clear. There is a sense of clarity and purpose about the interaction, and it is like exercising a toned muscle. From the perspective of the therapeutic alliance, a defined focus reflects agreement on goals and tasks and probably helps to promote the bond between therapist and patient. However, defining a focus requires an effort on the part of the therapist, as it does not necessarily emerge on its own.

PATIENT GOALS

Although patients come for help because they want to feel better in some way, their goals for the treatment vary widely. Some want to change something about their internal state—to feel less anxiety, or feel more satisfaction or pleasure. Some want to change an aspect of their functioning—to improve the ability to concentrate, or the capacity to organize themselves in some particular area. They may want to make an important external life change, like marrying or separating, having children, changing careers, or changing relationships with parents or siblings. Some want to deal with life cycle developmental problems, such as adapting to aging or loss or a change in the family. Some want to change somebody else, a goal that needs to be reframed.

Some patients are very ambitious and aspire to marked and dramatic changes. Others have more incremental goals in mind. Some have a narrower focus, with one thing they want to change, and they are

disinclined to work on anything not related to that goal. Whether realistic or not, some want a major personality change.

Sometimes goals are expressed in the patient's "theory" of the problem. Every patient (and every person) has a theory for why they are the way they are. This theory is usually a mix of realistic, accurate perceptions, but it usually also contains rationalizations and attempts to explain things the patient does not understand, and it avoids acknowledging thorny and painful aspects of the problem. Patients' goals usually follow from their theories. Examples of this include "My anxiety comes from having bad, reprehensible thoughts, and I need to control these thoughts, and then I'll feel better." The patient's implicit goal might be avoidance of stimulating situations and distraction and suppression of thoughts. Or "I've behaved badly, and now I am guilty and deserve criticism and punishment." The patient goal associated with this theory is to prove oneself to be blameless and good, and not deserving of punishment. Another is, "There is something unlovable about me; I am angry and bad, and this causes others to leave me." The theory is that they are noxious and this is the cause of their loneliness, and the patient's goal is to not feel angry.

UNSTATED GOALS

You must ask the patient about their goals, and explore and discuss them. This helps the initial engagement, and it is a key foundation for the development of a therapeutic alliance. But the alert therapist will recognize that every patient comes with important unstated, private goals and unconscious wishes for the treatment. Examples include the wish for protection, the wish to engage in a power struggle and achieve victory, the wish to be admired or idealized, or the wish to be loved. The "theories" just discussed are often unconscious. Most patients are unaware of these goals, or have never thought about them seriously. Sometimes dynamic therapy helps clarify their unstated goals as they become more self-aware.

Some patients know very little about psychotherapy, and their initial comments about goals reflect lack of experience and lack of information, rather than important ideas about their conscious and unconscious goals. With more experience in the therapy, they are able to communicate their thoughts more cogently. Some patients are afraid to venture into a discussion of goals out of fear of not achieving them, or because doing so will touch on uncomfortable feelings about the therapist, such as dependency or affection. Sometimes, the very problems they came to therapy for make it hard to communicate clearly about this.

Danielle, a 22-year-old cisgender White woman, came for treatment after an overdose with over-the-counter medication. In the hospitalization that followed the overdose, she related her lonely and failure-filled history.

Attractive in a waif-like way and extraordinarily shy, the patient had marked social anxiety and a proneness to social avoidance from an early age. Danielle grew up in an upper-middle-class White family with seemingly attentive and involved parents. Her older brother struggled with significant learning disabilities and became a great focus of early attention in the family. Her affectionate and socially anxious mother responded to her anxiety with sympathy and a permissive attitude. When Danielle was disinclined to play with children in the neighborhood, the mother accepted this and helped arrange for enjoyable solo activities. When she wanted to stay home from school, this was allowed.

At times, the parents pushed Danielle to become more connected outside the family, but she was adamantly avoidant. She usually felt that she had the upper hand in what evolved into control battles about decisions related to school, summer camp, vacations, and so on. She and her parents often entirely avoided these conflicts with pleasant but superficial interaction. Ironically, she lost respect for her mother because she could control her so easily.

Danielle had a verbal learning disability and developed increasing perfectionism, obsessionality, and preoccupation with weight and appearance. She became more isolated as the years passed, and had virtually no social contacts outside of school during her high school years. She went to a small college far from home, and felt thrown into closer proximity to others her age than she had experienced ever before. Excited about her prospects yet intensely anxious, she struggled to be "normal," while feeling chronically confused and alienated. Secretly, she hoped to escape the demands of her peer relationships. At the end of her first year, she had the feeling that she had to either have "real relationships" with people or leave school. Unfortunately, she felt overwhelmed by getting close to other students and left.

Following a brief time at home with her parents, Danielle tried again to launch herself. She lived with a group of other young adults conducting an ecological study project in an isolated rural area. Repeating the pattern of wanting but running from social connections, she soon felt she needed to leave, and returned home. However, after this escape from the requirements and demands of peers, she became acutely depressed, suicidal, and took an overdose that resulted in her hospitalization.

Danielle's core psychodynamic problem was fear of abandonment. As she began treatment, her stated goals were to find something that she cared about and an activity or place of some kind that would inspire and motivate her. She felt hopeless and wanted to feel part of something and feel hope about the future. She asked for assessment, advice, direction, and support for doing something and sticking with it. Essentially, she said, "I want a life, and I want advice, support, and pushing to make it happen." Eventually, she commented, "You are supposed to give me a life."

Over time, as Danielle talked more about her thoughts, feelings, and fantasies in the therapy, it became clear that she had an intensely held fantasy about the therapy and the therapist. She saw herself as a small, defenseless baby, looking for protection by a large, powerful, and benign mother. She had fantasies about being a baby in the therapist's womb, about being a little bird standing on the therapist's shoulder following him around all day long, and about being a small child standing just behind the therapist "in his shadow."

This example shows a rather dramatic contrast between stated and unstated goals for this patient—Danielle came to therapy saying she wanted to find a sense of personal meaning and identity, but longed for an almost symbiotic relationship. Although there is always a difference between a patient's stated and unstated goals, eventually in treatment they must begin to converge. Her unstated goal reflects a transference fantasy, and as with all transference fantasies, the patient partly believes it and wants to live it out. The uncovering process facilitates awareness of the unconscious goals, and after a while Danielle was able to recognize her fantasies about being a baby. She mourned the difference between what she wanted and would always want, and what was more realistic and achievable.

It is not always easy for the therapist to elucidate the unstated goals, and even more difficult to have a patient recognize them. However, when this happens it leads to deeper and more powerful insight, as the patient sees how the unstated goal is usually applicable to other important figures in the patient's life and not just the therapist.

HOW IMPORTANT ARE THE PATIENT'S CONSCIOUS GOALS?

A good coach knows that you must respect a player's level of skill and competence, build confidence, support and encourage improvement, and set a high bar of expectations. Likewise, a good psychotherapist must accept the patient where they are, respecting their stated goals, listening

carefully for the unstated ones, and expect as much growth and change as possible.

Patients' stated goals must form the basis for the initial engagement until you are able to collaboratively change them. This is out of respect for their skills, strengths, accomplishments, and struggle with their problems, and the recognition that they have done their best with it, because they know themselves better than the therapist knows them. Also, to do otherwise would be to undermine an essential part of the therapeutic alliance.

If you think the goals should be changed, then it is certainly reasonable to suggest this. For example, you might say, "Would it be more realistic to adapt to the way your father is, and find a good accommodation, rather than try to change the whole tenor of the relationship?" or "Maybe the issue is to find a way to start a new relationship rather than rekindle the old one."

Successful therapy involves setting reasonable and achievable goals and accepting that some goals cannot be reached. Setting unreasonable goals for therapy may stem from a generous appreciation of the patient's potential, but it will likely result in disappointment, reexperiencing of failure, and frustration.

DEFINING A USEFUL FOCUS

It is not up to the therapist to make the ultimate decision about the goal for treatment, but it is a crucial responsibility to propose a reasonable and appropriate focus. We begin the process of defining a focus by taking inventory of the following five factors: formulation, wide versus narrow focus, ambition and motivation, perspective on the problem, and the patient's personality characteristics (see Table 8.1).

TABLE 8.1. Relevant Factors in Defining a Treatment Focus

- Formulation of the patient's problem
- Wide versus narrow focus
- Motivation
- Perspective
  - Intrapsychic
  - Relational/systemic
  - Life cycle/developmental
  - Adaptation to neurobiology
- Patient characteristics

Formulation of the Patient's Problem

The treatment must focus on the core psychodynamic problem and the patient's particular conflicts reflecting this problem. You should explain what you think the core problem is in plain language. This makes it easier to understand both cognitively and emotionally.

In the case of Peter (Chapters 5 and 7), the depression involved guilt, identity problems, low self-esteem, conflict about women, and a pattern of procrastination. The formulation ties these conflicts together, with historical antecedents, and identifies the important nondynamic factors involved. The gist of this formulation is Peter's need to be close, and the upsetting feelings that come up about this in close relationships. The focus of treatment must include this essential conflict.

Wide or Narrow Focus

How wide or narrow to focus the treatment depends on how global or how localized the problem is. Some patients present problems that are relatively circumscribed, although they may be severe, with less intrusion of these problems into other areas of their lives. Others relate a picture of more pervasive difficulty, where most or all important areas are involved.

One wants to be parsimonious in defining goals for psychotherapy, treating only what needs to be treated. This makes sense from an efficiency perspective, but it is also important because dysfunction in one area may cause fallout and difficulty in others, and if the primary area of difficulty is ameliorated, there may be improvement in other areas without specific therapeutic attention. For example, a person with difficulties in intimate relationships may have relatively less conflict and minimal symptoms in occupational function, but the misery and preoccupation that results from conflict in their personal life may spill over and affect work and work relationships. Attention and improvement in personal relationships would result in improvements at work even without specific therapeutic attention (Zilcha-Mano, Dinger, McCarthy, & Barber, 2014).

Some patients tend to stay focused on one area, talking only about their family life, or only about their somatic symptoms. The clinical judgment you must make is whether this is a manifestation of anxiety and resistance to looking more deeply, or whether it is simply a more focal problem. There are patients who intuitively connect disparate areas of thinking, feeling, and functioning; for them everything is related to everything else. Is this wide-ranging and probing, or inefficient, meandering, and nonproductive? It is frustrating to trainees that there is

no clear way of making this determination. But the guiding principle for evaluating the success of the focus you have defined is whether the patient's self-awareness is developing further and getting clearer. Knowing when progress is being made is sometimes only apparent later, and this validates the clinical judgments.

Motivation

This hard-to-define quality is essential in thinking about how ambitious the therapist should be. Some patients seem to be truly willing to go the distance in struggling, thinking, and collaborating to try to get better. Some are certainly suffering, but they have less perseverance and focus in enduring the rigors and difficulties of psychotherapy. Although therapists sometimes reduce the patient's degree of motivation to something about the patient's pathology (e.g., less motivated because of rigidity of defenses), most experienced practitioners would consider there to be a motivational factor that is independent of the patient's problems. This factor may be the same quality that allows people to delay gratification, to focus and persevere in work and sports, and overcome physical problems.

Which Perspective to Focus On?

Each patient, and their core problem, can be worked on from a variety of perspectives: individual, relational, developmental, and neurobiological. Defining a focus means choosing which perspective is most helpful. Things get too complicated for patients if you try to do too many things at once. There are four perspectives we usually focus on:

1. *Intrapsychic*. This is the traditional psychodynamic individual psychotherapy model in which the patient's problems are understood to be based on conflict within their own mind, with subsequent compromise formations and behaviors. The problem is seen as a consequence of dysfunctional adaptation to conflict, and the goal of therapy is to understand the constituent parts of the conflict in order to arrive at a better adaptation to it. The therapist recommends that the patient try to understand the intrapsychic conflict in order to bring about a change in experience, perception, and behavior.

2. *Relational/systemic*. Here the focus is on the relational aspect of the patient's problem. The focus is still on the patient's own psyche, but it is on how an important relationship affects them. What determines the patient's responses, and how does their behavior then affect

the relationship? Essentially, the therapist proposes to help the patient improve their adaptation to a relationship or system, and thereby improve their subjective state and behavior.

3. *Life cycle/developmental.* This perspective focuses on the usual life developmental stages, anticipated transitions and crises, and the ubiquitous life cycle events, such as loss of a parent, illness, children growing up, and relationship maturation and change. Here the patient's problem is seen as resulting from normal life cycle events and difficulties in adapting to these events. What makes this a psychodynamic perspective is the conviction that intrapsychic conflict and compromise can be obstacles to the effective management and resolution of these life cycle challenges. The impetus for psychotherapy is to allow the patient to deal most effectively with these normative developmental issues.

4. *Adaptation to neurobiology.* This fourth perspective is the patient's adaptation to neurobiological constraints. These constraints may include temperamental vulnerabilities, such as shyness and social sensitivity, or proneness toward temper and impulsiveness. It may also include adaptations to genetic vulnerability to psychiatric illness, such as mood disorders or anxiety disorders. This focus helps the patient understand the brain-based causal aspect of their experiences, the meanings they attribute to their way of responding, and attempts to find an improved adaptive response. For example, a patient may recognize their temperamental equanimity, low reactivity, tendency toward suspiciousness when stressed, or emotionality and tendency to feel intensely.

These four different perspectives—intrapsychic, relational/systemic, life cycle/developmental, and adaptation to neurobiology—are all present for everyone. The question, as with the rest of the factors in determining focus, is which will be accessible, revelatory, and potentially mutative for the patient?

The intrapsychic provides a clear focus for treatment and clear rationale for individual work, but it may be more anxiety provoking, more likely to induce resistance, and make the patient feel "pathologized." The relational/system level of explanation is likely to resonate well with the patient's complaints, but limits the focus of the treatment to that relationship or system. The life cycle/developmental level usefully supports and validates the ubiquitous problems of adolescent and adult development and helps the patient to see themselves in a larger context. However, by "normalizing" the problem, it can lessen the potential for exploration and understanding of the individual conflictual background for the patient's problem. Finally, the adaptation perspective is essential to help a patient with significant neurobiological vulnerability to illness,

yet the extent of the neurobiological and psychodynamic contributions is not always clear. This focus runs the risk of inadequately working on the dynamic issues or trying to modify biology, which may be rather difficult.

Patient Characteristics

Evaluating patient characteristics that predict good response to psychodynamic psychotherapy (and psychotherapy in general) has been the subject of exhaustive research. We do not discuss this in great detail here but summarize the findings. The following characteristics seem to be associated with the ability to respond to psychodynamic treatment: psychological mindedness, curiosity, introspection, ability to utilize metaphor and symbols, verbal ability, intelligence, and ease of or capacity for closeness in relationships (Beutel, Stern, & Silbersweig, 2003; Gabbard, 2000; Ursano, Sonnenberg, & Lazar, 1998). Recent reviews suggest that functional impairment, chronicity, and either very high or low symptom severity are associated with poorer outcomes, while an internalizing coping style is associated with better outcomes (Constantino, Vîslâ, Coyne, & Boswell, 2018). Positive expectations about therapy are associated with better outcomes (Constantino et al., 2018). However, we do not want to leave the impression that dynamic psychotherapy is a treatment only for the worried well. The patient characteristics discussed are associated with but not required for good outcome. For example, Milrod, Leon, Barber, and colleagues (2007) reported that the presence of Cluster C personality disorder (as opposed to no personality disorder) predicted a better response to psychodynamic treatment of panic.

In addition to the patient characteristics that traditionally predict psychotherapy responsiveness are the resources the patient has available to them in contemplating treatment. These include time for the treatment, emotional energy to give to the process, financial resources, and support by others for the process.

BRINGING THE FACTORS TOGETHER

The therapist attempts to synthesize all of the factors just discussed into a focus that combines the core problem/formulation, the patient's motivation and resources, the breadth or narrowness of the focus that would be useful, the patient characteristics, and the best perspective on the problem. The focus should offer the most parsimonious way of working with the patient's problems. The patient's conscious goals, impressions

about the unconscious goals, and a sense of the initial interaction between therapist and patient must also be synthesized into the focus.

Of course, we are describing a process that is, of necessity, highly individualized. By taking an inventory of all these factors, the therapist will be able to take charge of this essential part of beginning the treatment. Rather than wait passively for the patient to define a focus, you can take a more active approach. We will illustrate this synthetic process with two examples describing the patient and problems, the inventory of factors, and the proposed focus. One will be an example of a successfully defined focus, and one not so successful.

Carrie was a 53-year-old cisgender White woman who came for evaluation because of depression and concern about her college-age daughter's emotionality. She was worried that her daughter had a personality disorder and it was her fault. Carrie was a tall, attractive woman with a brunette ponytail and an easy smile. She was embarrassed about needing to be in therapy, and was polite, eager to please, and deferential.

Carrie's daughter was in therapy elsewhere and seemed to depend on her mother for advice and help with surprisingly basic life decisions, all the while successfully managing a demanding academic load. She was resentful of her mother and critical of her. Carrie felt burdened by looking after her daughter and guilty that somehow her daughter's problems must have to do with her mothering. She was quite insistent on this last point; after all, she argued, what other explanation could there be for her daughter's problems? There were two younger children, both of whom seemed to be quite well adjusted.

Carrie was the younger of two children born to the second marriage of a dashing but unfaithful lawyer and his beautiful but critical and insecure wife. Carrie's mother disliked her older brother, the product of the father's first marriage, and was overly attached to her older sister, an academically precocious and socially inept scholar. Her father died a year before Carrie came to treatment, and this was a great loss. Growing up, the father was engaging, lively, affectionate, and nonjudgmental, while Carrie felt her mother was insecure and angry. Later as an adult, she saw her mother as competitive and bitter.

Rather quickly, the flow of topics began to shift toward vignettes about the mother. Practically every phone call, visit, or interaction felt irritating and rejecting. Carrie's mother never said the right thing; she seemed to need to get the last word in, or she left longish pauses on the phone to indicate her disapproval. She talked endlessly about herself, her health, and her loneliness. But Carrie felt compelled to listen and be helpful.

By the third session, the therapist had begun to organize the formulation around the core problem of depression, noting the prominent self-criticism, guilt, and powerful ambivalence toward Carrie's mother and her daughter. It had also become clear that although the daughter had her difficulties, and perhaps there was some earlier disruption in the mother–daughter bond that had contributed to this, Carrie had certainly tried very hard and done quite a good job as a mother. The therapist's impression was that this worry about her daughter was symptomatic of the core problem of depression, rather than a realistic assessment of her responsibility.

Further exploration of Carrie's current life revealed that she had a loving relationship with her husband, who was fun loving and high-spirited but irresponsible. He did not seem to pull his weight in managing the kids, taking care of the finances, and working around the house. Carrie laughingly commented that it was really like having four children.

More childhood history came out, too. Carrie felt that she was an afterthought in the family. Her sister was the apple of her mother's eye because of her academic prowess, and the brother was sweet to her but older and involved in other things. Her mother expected her to be available and responsive to her demands for attention, and was critical of anything that was emotionally "messy" or complicated. Early on, Carrie developed a strong group of friends and felt that she lived much of her life with them. She tried her best to gain her mother's love and interest but usually felt the best she could do was avoid too much criticism.

By this time, the formulation was even clearer. Carrie's depression had to do with an early attachment problem with her mother, leading to anger, self-criticism, and guilt, and she dealt with this by taking care of others: her mother, her husband, her children, and especially her troubled daughter.

Carrie's therapeutic interest was in her daughter and her mother, and the problems there. She had issues with her husband, but mostly she felt pleased about their relationship. Her other two children were a source of great joy. She enjoyed and was very successful in her career. Her ambition was to feel better about herself and especially find a way to manage these two troublesome relationships. She had a relatively narrow focus on what she wanted to change, and a more global change in her functioning was not her goal. She was strongly motivated and made it clear that if she felt she was getting somewhere, she was very committed to the appointments and to working hard.

Carrie's difficulties were best conceptualized from the intrapsychic point of view. One could have worked with her problem at the relational/systemic level, but the issues were not confined to one relationship or even one generation, and seemed to be part of what Carrie brought with her to each relationship. In fact, she had chosen a career that combined public service and pleasing clients. Although the life cycle level of the problem was relevant—her children were growing up and leaving home, and her mother was ailing—approaching her problems from this angle did not seem like it would help her get a handle on the powerful internal dynamic that seemed to be affecting her quality of life.

This patient had the classic characteristics of someone who will do well in therapy. Carrie was verbal, bright, able to think in a flexible way, and naturally introspective. She had an internalizing coping style and her symptoms were neither mild nor severe. She also had the resources, time, and emotional support from her husband to do the work. It is an interesting, and perhaps unfortunate, observation that when it comes to psychotherapy, those with the most psychological health often get the greatest benefit from treatment. This idea that "the rich get richer" should not be understood to mean that those with fewer psychological resources will not benefit from treatment, but rather, that the treatment of those who bring fewer resources to treatment may require an approach that is especially well organized, focused, and effective.

> In the fourth session, the therapist described his impression of the core problem—depression, self-criticism, guilt—and the sense that these feelings were organized around Carrie's feelings about her mother. He proposed working out and understanding her ambivalence about her mother to allow her to find a better way to get the most she could in the relationship, and prepare for her ultimate death. This would give a clear and finite scope to the therapy, and the benefits of work would surely spill over into her other relationships. Carrie was tearful and upset in hearing this. It made her sad to realize how central the problem with her mother had always been, but she felt some relief at having it clearly spelled out. She was also relieved as it helped her see that her main struggle was with her mother, and that her guilt about her daughter was just a reflection of that—maybe she had had some problems as a mother, and if so, it was because of her own upbringing, not because she was so bad.

The focus was agreed on collaboratively and this allowed the therapist to encourage the patient to explore her feelings in a more vigorous and active manner. The patient felt like she knew what she was working

on and why. The treatment continued for slightly less than a year on a weekly basis. At the time of termination, Carrie was able to view her mother dispassionately, with more empathy and also more ability to assert and protect herself. She had pushed her husband to take on more responsibilities around the household, and had been able to let her daughter take greater distance and live independently after graduating from college.

But defining a focus does not always work out so well! When psychotherapeutic treatments are not very successful, there is a tendency to note the patient characteristics that prevented this, the intransigence of the problem, or the possibility that more time was needed to be able to make progress. But it is also possible that the treatment was not successful because there was not an appropriate focus. The next vignette illustrates this and involves some speculation about what might have been more helpful.

Margaret was a cisgender biracial lawyer in her late 30s who was referred for treatment because of depression and anxiety. She had previously been in an extended psychotherapy, which had not been terribly fruitful.

Successful in her chosen career, Margaret had unfortunately developed rheumatoid arthritis in her late 20s, and this had progressed recently, causing some physical limitations, especially in her exercise regimen. She had a long history of dating and conflicted relationships with men, including multiple experiences of feeling that men turned out to be dishonest, unreliable, and self-centered. She seemed to feel that she needed to be in a relationship.

After being encouraged to "shop around" and meet with several therapists, Margaret chose the one she liked most, a female therapist in her 50s. The early sessions involved much painful emotional detail about the multiple prior relationships with men, including the most recent experience of betrayal and hurt.

The crucial aspect of Margaret's earlier history was a feeling that her White mother and Black father were loving and supportive, but that her mother was unrealistically and indiscriminately positive about everything she did. She felt that her mother was afraid and upset when anything bad happened to her, and that she was supposed to live out her mother's "unborn wishes." She loved the unlimited support, but felt suffocated by it. The patient was uncomfortable talking about her biracial identity and how she thought about her mother's and father's race. Her responses were rather flat, and she brushed away a question about what it was like for her to be meeting with a White therapist.

The therapist proceeded with an inventory of factors in defining a focus. The core psychodynamic problem and formulation suggested problems with self-esteem. The conflicts revolved around dependency and independence, as well as the need to please others. Her chronic illness must have exacerbated this. Margaret's problems seemed confined to personal relationships, and she had many of the characteristics predictive of a good psychotherapeutic response. Since she had had so much difficulty with men, the relational/systemic perspective seemed helpful. The focus of the treatment would be a better understanding of the issues involved in intimate relationships. Her goal was to have a successful relationship with a man. Margaret hoped the therapy would improve her ability to choose a potential mate, decrease behaviors that might contribute to conflict and strife, and help her to communicate and resolve problems that might come up.

The suggested focus resulted in an initial bounce in the patient's mood, and more motivation to consider Margaret's issues. There was also a medication change at the same time, so it was unclear which accounted for her feeling better. There followed an extended discussion of the painful conflicted feelings involved in her disappointments with men. She tended to choose men who could be selfish, and then test and almost provoke them to express their limitations. As she described her painful experiences of hurt, rejection, and abandonment associated with this, she became angrier and more frustrated with the therapist. Attempts were made to understand her anger and interpret it as a transferential reaction—that is, noting that she felt the same kind of encouragement and support that her mother provided, which led to hopeful optimism and then disappointed rejection.

The patient experienced these interpretations as accurate but even more reason to feel depressed and rejected. Support and continued attempts to help Margaret see her frustration with the treatment in this context, along with medication changes, were to no avail. She told the therapist that the focus of working on intimate relationships made sense, and the goal of helping her get into a good relationship was certainly what she wanted. But she felt this implied there was something the matter with her, and this was very upsetting and undermining to her. It reminded her of her parents just wanting her to be happy, and their wish for her to find a solution to her unhappiness rather than be herself.

Margaret expressed tearful appreciation for the help she had received early on in the treatment, but made it clear that she felt that just talking about men made her feel bad. Why did therapists always think that all a woman needs is a relationship with a man? She announced she was going to end the therapy.

When Margaret ran into the therapist in a public setting approximately 3 years later, she volunteered that she was feeling much better, had met and recently married a man whom she felt relatively content with, and despite some progression in her physical illness, things were going pretty well.

Could more have been done? Were the limitations inherent in the technique of psychodynamic psychotherapy, the patient's history and the nature of her problems, aspects of her character, or the contribution of her neurobiology? What did the therapist fail to see? What did the patient feel about seeing a White therapist and why was this hard for her to talk about? Did her progressive illness affect the way she saw treatment? Were they working on the most helpful core problem? Was she really as happy as she said she was later on? Had the treatment helped? There are no clear answers to these questions, but the patient had a specific criticism at the time the treatment ended that had to do with the focus of treatment and the goal that had been mutually agreed upon. This needs to be taken seriously, and one wonders whether defining the goal as a relational one (finding a good mate), was most helpful. Did it promote a replication in the discussion, and in the treatment relationship, of her mother's need for her to be normal, happy, and healthy? She was very sensitive to criticism.

Should the focus have been more on the development of her capacity for independence, self-awareness, and self-acceptance?—that is, perhaps the therapist should have defined a focus related to the development of independence and self-sufficiency, related more to the life cycle/developmental perspective, rather than on improved capacity to manage an intimate relationship.

CONTRACTING FOR TREATMENT

Defining a focus and establishing goals fall under Bordin's (1979) concept of task and goal (discussed in Chapter 4). We see the identification of specific goals and recognition of specific tasks for patient and therapist as essential elements of the therapeutic alliance. Indeed, defining a focus constitutes a kind of therapeutic contract. The patient proposes what they would like to try to accomplish, and the therapist indicates what might be a good focus. Then they discuss this. Treatment can proceed if there is a measure of agreement. This agreement between therapist and patient becomes an essential building block in the alliance.

From a practical perspective, we recommend that you summarize the core problem and suggest a focus for the treatment by the third or fourth session. By then you are likely to know the core problem, although

the formulation may not yet be clear. This succinct presentation should be made with clarity, vigor, and confidence, but with openness and curiosity about the patient's reactions and ideas about how to proceed. Of course, you will likely modify this focus over time.

INEVITABLE TENSION

Just because a contract is struck, it does not mean that both parties will abide by it. For the patient, there is the inevitable tendency to employ characteristic defenses, play out old interpersonal scenarios, and not do as promised. For conscious and unconscious reasons, the patient may not work on the agreed-upon focus, or may propose and hold to a view of it that is not conducive to deeper understanding. They may throw up their hands in helpless frustration that progress has not been made. An alternative focus may be proposed.

This difficulty in getting to work on the problem is captured in the term *resistance*, which we discussed earlier in Chapter 4. If the patient could easily and comfortably think about their problem, it would have happened before coming to treatment. The pragmatic psychotherapist will listen to and reflect on the patient's feedback about the work, the focus, and the goal, and will constructively reassess the focus and goal that have been proposed. Is the difficulty in moving forward just the inevitable resistance, or is it a reflection of a goal set too high or not optimally defined? Is the focus too broad, or too narrow? Is the formulation accurate? Could it be reworked? Is the problem defined as intrapsychic when a life cycle focus would be more effective, for example? The therapeutic contract is not set in stone, and it needs reevaluation and affirmation or modification.

The therapist may also stray from the defined focus. Lack of attention, interference from personal issues, enactments with the patient, or practical matters may cause the therapist to lose the focus. A little loss of focus results in flexibility and sometimes creativity, but too much can result in sloppiness, disorganization, or boundary crossing.

TRANSPARENCY

Our approach involves directness and transparency about the therapeutic alliance-building process and defining the focus and goals of psychotherapy. These issues are best discussed directly with the patient, but only in as much detail as the therapist can be honest about. We cannot anticipate how much change will occur, because we cannot possibly

know. Patients know the uncertainties, too, and they generally appreciate trustworthy openness about the therapist's realistic ideas about the focus and goal. A balance between optimism and realistic recognition of how hard it is to change is difficult to maintain, especially in the highly charged emotional field of the psychotherapeutic relationship. But that is exactly what patients need.

SUMMARY

The patient's expressed goals for therapy initiates a discussion between therapist and patient about the focus of the treatment. Using awareness of the psychodynamic formulation, the patient's goals, both stated and unstated, and the patient's degree of ambition and capacity to effectively use treatment, the therapist proposes a focus of treatment that becomes the subject of discussion and compromise in the therapeutic relationship. The resulting treatment plan may define the problem as intrapsychic, relational, related to life cycle challenges, or adaptation to neurobiology.

PART III

MIDDLE PHASE

9

The Narrative

Building a Personal Story

> The narrative was too constricted; it was like a fetus strangling on its own umbilical cord.
>
> —John Gregory Dunne

The Freudian model of sifting through layers of history for deeply hidden archeological prizes that are priceless and demonstrably true has given way to an awareness that there are multiple truths about oneself, discovered at different points in the life cycle, with different therapists, using different models of psychotherapy. The concept of narrative offers a new way of studying the content and structure of psychotherapy stories, transforming the process from a scientific pursuit of verifiable personal history to a more subjective enterprise.

Narrative has traditionally been studied in the context of literature, the telling of stories, and the reading of texts. Application of these ideas to patients as texts, and psychotherapy as a shared reading of these texts, forms the essence of the study of narratives in psychotherapy. Indeed, developing new narratives that are more therapeutic is seen by some to be the essence of psychotherapy, and some psychotherapeutic approaches focus exclusively on the writing and rewriting of a personal or shared narrative (Josselson, 2004; Singer, 2004). Adler, Harmeling, and Walder-Biesanz (2013) found that narrative coherence and processing the narrative were associated with sudden gains in psychodynamic therapy.

Roy Schafer (1981), Donald Spence (1982), and others departed from the objectivist tradition of psychoanalysis in their emphasis on the co-created understanding that comes out of the psychoanalytic process.

These authors emphasize the presence of multiple narratives and the difference between objective and narrative truth. Lieblich, McAdams, and Josselson (2004) review the literature on narratives in psychotherapy in their edited collection. They conclude that the work in this field emphasizes the value of multiple explanatory frameworks beyond the psychological, the variety of types of narratives used in psychotherapy, and the special application of narration in psychotherapy to address issues of power, abuse, and gender.

From our perspective, a narrative is a life story that includes and summarizes crucial biographical information in a coherent way. It can be more comprehensive and global, including early childhood, all important relationships, major life events, important transitions and epiphanies, the cultural and racial context, individual biological factors, and major adult experiences and why they were perceived as they were. But narratives are not always so epic in scope; they may also be more focal, like a short story that illuminates an aspect of the patient's character and provides a brief sketch of the history and context. Usually, the more intensive and enduring the psychotherapy, the more comprehensive the newly developed narrative will be.

Patients begin therapy with self-constructed narratives and, with the help of the therapist, form new and (one hopes) more useful, complex, and self-aware narratives. This occurs across psychotherapies and behavioral therapists suggest that one of the goals of CBT for patients with PTSD is the construction of a more complete, detailed, and smooth narrative (Resick, Monson, & Chard, 2016).

We believe that new narratives are therapeutic when they are accurate enough to contain new understandings about the past and present, are built on the core psychodynamic problem and formulation, and lessen excessive blame and guilt. They are typically stories about self and others and include tensions and conflicts that arise and are then resolved.

In addition to describing others about whom we care deeply, narratives are propelled by internal logic. They are about how we manage disorder, conflict, and chaos in order to achieve greater mastery, self-sufficiency, freedom, and security in our lives. There is always an arc of tension and resolution that defines a helpful narrative. Although the constraints on the structure and content of psychotherapy narratives are not as strict as those of a good Hollywood movie, there do seem to be certain features that make for a good narrative. Without rich and interesting characters, complexity, and salient events, there is no tension and no resolution—thus there is no good story, and a good story helps make a narrative therapeutic.

Paul, a White Catholic priest, sought treatment after the outbreak of the church sexual abuse scandals awakened his own personal childhood experiences of sexual abuse. He knew these experiences were important, but he was unsure of how and why. Paul also struggled with spasms of intense and overwhelming guilt, feelings of inferiority despite his achievements, and a powerful need to be liked and respected by others.

Paul felt ashamed of his experience of abuse and could not look at photographs of himself, particularly recent ones, because he felt he was ugly. His initial narrative, the story that summarized and made sense of the troubled part of his life, was that he had always felt insecure, and this led him to seek out the abuse because he was so needy. He felt he had been wrong in letting a priest touch him inappropriately, and even worse when he let another man do the same thing shortly thereafter. He was deeply convinced that he had been evil, and continued to feel in adulthood that there was something bad about him. He was celibate, but his experiences made him doubt his sense that he was heterosexual; the thought that he might be homosexual frightened him. This was the narrative he had of his life when he started treatment.

As Paul began to talk in therapy, he started to see other, stronger connections between his early experiences and how he felt now. He felt guilty, blamed himself, felt ashamed, and was convinced his mother held him responsible for the abuse he had undergone. He thought about how he felt as a priest now, how the abuse had affected his life by causing him to be quiet, incapable of accepting compliments, and unable to interact socially with others because he felt loathsome and inferior. He was embarrassed to be a priest and felt horror that a priest could manipulate and seduce a boy.

Paul began to empathize with his former insecure and lonely self. He was the youngest boy in a large family where the mother was the dominant influence and the father worked long hours to support the family. As the youngest child (he was 9 at the time), he felt loved, despite the fact that his mother was not particularly affectionate. But after the abuse everything changed. He felt different from his older brothers, who were athletic, socially popular, and more at ease with themselves. He felt ashamed, lonely, and depressed, but did not know why.

As therapy unfolded, a new narrative began to emerge. As a boy, Paul was religious, served Mass daily as an altar boy, and looked up to the clergy in his parish. This made him vulnerable to the abusing priest who took advantage of his piety. He had responded to affectionate interest from the priest, but his goal had not been sexual,

although it was intriguing to him that someone was giving him attention, money, and other gifts and at the same time was ingratiating himself with his mother. Paul did not know how to handle the uncomfortable feelings and experiences that came with sexual contact. He secretly blamed himself and felt deeply ashamed. As Paul reflected further on what happened, he saw that the priest, the authority figure, was the person who had transgressed boundaries, who had been wrong. Why would the priest have done this?

Whereas the old narrative had emphasized the patient's evil intent, lifelong suffering, and attempt to never again lose control over his bad impulses, the new narrative was more complex and empathic in the picture it painted of Paul's childhood. He was lonely, struggling in competition with his siblings, longing for attention and affection, and looking for a mentor or teacher, as do so many early adolescents. He had the misfortune to find this attention in a priest who used it to his advantage, soliciting sex. Paul felt scared, ashamed, confused, and trapped in this—not wanting to lose the man's special interest in him, but feeling uncomfortable and degraded by continuing. His shame contributed to his withdrawal and distance from his family.

Paul felt increasingly comfortable talking about what had happened, and shared more details. Ultimately, he and the priest were caught; he was deeply ashamed when his family learned about his secret experiences. The priest was sent away. The second abusive sexual relationship, very brief, made Paul feel even more guilty, as he felt he could not explain it by coercion and manipulation. In the old narrative, this second experience cemented his sense of being bad and worthy of humiliation and punishment. In the new narrative, he saw this as the repetition of an overwhelming and frightening situation; he was unable to manage the feelings about the first time, not able to live with himself for what had happened, and he simply repeated what he could not manage emotionally.

The patient's new narrative about his early history allowed him to revise his view of his current life. Paul connected his present shame about his appearance, and constant need to being liked by others, to his childhood self-loathing. He saw his continuing insecurity and guilt about his successes as a result of this. With a more forgiving and understanding perspective on why he did what he did as a child, Paul saw these self-critical symptoms as a reflection of old feelings that were not realistic in the current context. He was able to see that he did not have anything to be ashamed of, that he was likable and lovable without having to work so hard for it, and that his successes were deserved.

The essence of psychodynamic psychotherapy is that the past is prologue, and early experiences shape later ones. A psychodynamic narrative is a story about early relationships, and a coexisting story about the current experiences of adult life—that is, a narrative is always a double story—what happened in the past and how it affects what is happening now, which leads to a clearer picture of the present. The tension between these two stories forms the arc of the therapy, commanding attention and helping the patient move forward in a healthy way.

The pretherapy life narrative usually has not worked well enough to help the patient live a well-adapted life. Because of the limitations, inaccurate views of self and others, and misperceptions implied in the narrative, the patient is prone to make poor choices. They may feel confused and uncertain about themselves, or work extremely hard to contain intense emotions, leading to loss of flexibility, freedom, and satisfaction. During therapy, a new narrative is constructed, which is neither rosier and more optimistic than the patient's genuine experience, nor unnecessarily bleak. As this new narrative takes shape, the patient begins to believe it. In this chapter we describe the essential elements in useful psychotherapy narratives, and the useful techniques for helping patients develop new narratives.

NARRATIVE AND INTERPRETATION

Interpretation is the traditional psychodynamic and psychoanalytic intervention for conveying more profound understanding to the patient, emphasizing deeper truths. Interpretations are the therapist's contribution to the new narrative. They should be focused on the core problem and formulation and help the patient see themselves in new ways. But the concept of interpretation is therapist-centric, while narrative is the patient's language for thinking about themselves and telling their story. Thus, we see the writing of narratives as a more parsimonious and useful concept for talking about new understanding because it stays close to the patient's experience, avoids distancing jargon, and uses our natural, inborn proclivity for telling stories.

NEW NARRATIVES AND SUCCESS

A patient's motivation to come to therapy is a result of natural curiosity and the wish to be rid of painful symptoms but this motivation wears thin pretty quickly. The real spur for doing narrative work is succeeding in feeling different or better. Self-understanding gives a feeling of

coherence to uncomfortable situations, which decreases anxiety and helps a patient feel more in control. Does the new narrative do this? Does it decrease confusion, correct misperceptions, and open the door to new behavioral solutions? This is crucial because if it does, the patient learns how psychodynamic psychotherapy can help and develops further motivation. If not, there seems to be no point to the therapy, and patients will request focal symptomatic treatment, whether that comes from psychotherapy or psychopharmacology.

WRITING A NEW LIFE NARRATIVE

Building a narrative is an iterative process. The new narrative will arise from the old, but the old version must first be confronted. The therapist's job, using the formulation that suggests deeper motivations, more pervasive themes, and attempted solutions to conflicts, is to challenge this initial narrative and provide a stimulus for change. If you help the patient see the implicit narrative they bring to therapy and point out ways that this explanation is limited, or limiting, there is an increased motivation to understand more and to change the narrative.

As it develops, the new narrative will include a more comprehensive and articulated view of the patient's developmental experiences and major conflicts, the way they experienced those developmental problems, and a more adaptive and multifaceted view of their contemporary experiences. Essentially, the patient will come to say, "This is what happened, this is how I experienced it, this is how it shaped my current experiences, and this is what is really happening now."

ESSENTIAL NARRATIVE ELEMENTS

Every life is different, but there are certain elements that are present in all helpful psychodynamic psychotherapy narratives (see Table 9.1). We describe those elements first and then discuss how to challenge the old narrative to get there.

"Why it happened" is always central to the patient's story; it is the glue that connects all of the elements. This central causal explanation is a reassuring kernel of sense that rests at the heart of a narrative and gives it its therapeutic value. It makes a coherent account of a complex life that feels accurate and sensible enough to help the patient organize themselves and function better. We have seen five types of explanations used in narratives; usually they are combined in some fashion. We do not elevate these explanations to the level of scientific causality; in therapy the goal is to come up with a useful narrative, not an objective truth.

TABLE 9.1. Essential Components to Narrative

- Explanation for one's life course (e.g., why life happened this way)
- Most important life events and experiences
- Multidimensional picture of important relationship
- Hope and compassion
- Cultural values, context, and struggles
- Narrative voice

These explanations fit our universal need to tell a story about ourselves to ourselves and answer the question of why life took the direction it did. They reflect positive views of the self, as opposed to negative ones, and this is part of what makes them therapeutic. There is little empirical study of the content of narratives and we looked at the central causal explanations in many patients' narratives and derived these explanations.

1. "External events affected my life." Here the focus is on events producing understandable results and effects. The patient's experience is "I am this way because of what happened to me. I see things this way because of what happened." This is probably the most frequently employed narrative device, especially early in psychotherapy, and implies the impact of difficult events and a patient's attempt to manage them. It makes clear that the patient's self is relatively untainted by negativity and blame. This narrative explanation can be employed in a defensive manner or as an evasion of responsibility, but we know that useful narratives help patients see themselves as basically good but struggling. Maintaining flexibility and an open mind about when we are responsible versus when an external situation has greater weight is a complex existential task, and this causal explanation stakes out a claim of less personal responsibility.

2. "Past experiences are repeated." Templates are laid down by early experiences, and we tend to repeat the past, ideally making it better, but often repeating our misperceptions and mistakes. The notion that past experiences are repeated is inextricably part of every psychodynamic narrative, and most patients find this intuitive. The narrative explanation takes the form "I had *X*, *Y*, and *Z* critical experiences in the past and since then I have been repeating those experiences and trying to change them."

3. "I am this way now because it was the best survival strategy I could come up with." The central explanation in the narrative is the persistence of an old coping mechanism that is now dysfunctional. This explanation is an attempt to create a synthesis between externalization

of responsibility and self-blame. It says, "Children do the best they can with the cognitive and emotional capacities they have available, and they often come up with strategies for dealing with upsetting feelings and insoluble conflicts that work in a limited way, and then these strategies get repeated forever."

4. "We are all fallible." People know and accept this in general, but not always about themselves. Sometimes this idea helps to build a coherent narrative. The patient sees what happened in their life, the potential causal factors, and sees that they might have made better decisions or enforced more impulse control. But people are fallible, and sometimes they just don't do the best thing. The sense of this narrative explanation is that attempts and failures are the essential dynamic of life, and acceptance of this explains and justifies why a life went in the direction it did. This is a healthy kind of self-blame, recognizing that we all make mistakes.

5. "Personal choice and freedom" is a narrative explanation that is just the opposite of those we have discussed. Here the patient is not the passive actor, the recipient of the effects of the past, or of limited coping skills, important relationships, and accidents. Rather, the patient is the protagonist, marshaling their resources, creatively surmounting their situation (perhaps with help), and evolving a new way of managing things, leading to new experiences. In this triumphant narrative, there are moments of personal freedom and transcendence of circumstance whose explanation cannot be further reduced.

If the explanation for why things worked out is the arc of the life story, then the patient's seminal life events, what they meant, and how they were experienced, are its contents. Who were the characters, what were the crucial moments, and when were the points in time when the individual's course in life changed drastically? Which were the important relationships, including those with parents and other early caregivers, what happened in those relationships, who was constant and available, who was disappointing, who died, and who left? Later relationships, loves gained and lost, family, friends, comrades, and coworkers are the substance of the story. How did society and culture impact and shape the patient and those relationships? Traumatic events and positive experiences are included. If a narrative is the story of who we are, and we are essentially social, then it is a story of our relationships, how they developed, changed, and were internalized.

In contrast to the unidimensional view of parenting figures described by many patients early in therapy, a multidimensional, articulated picture of the most important early relationships, usually with the parents, is essential for a mature (posttherapy) narrative. The parenting figures

can be viewed from a distance. They have strengths and weaknesses, motivations, and needs; they are givers and takers, nurturing and needy, independent and dependent, transcending their own circumstances and limited by them. This is hard-won territory in building the new narrative. It comes from the detailed, safe, and thorough exploration of childhood memories and the patient's own experiences as a parent, lover, or friend. This aspect of narrative involves enhancing the capacity for mentalization.

A sense of hope about the future is essential to a therapeutic narrative. But how does this happen in a genuine way? Usually it is tied to hope about relationships, or about the possibility of new relationships. So often, early in therapy, a patient's one-dimensional understanding of a spouse, partner, parent, or boss is suffused with painful feelings: hurt, anger, betrayal, or disappointment. The intensity of these feelings is usually proportionate to the fixity with which they view the other person.

Hope comes from the recognition that these painful relationships can be experienced differently. New understanding of others allows patients to realize that the situation is more complicated than initially recognized. In the face of a more complex picture of the other person, it is possible to feel more empathy and more affection. Sometimes hope comes from realizing that the relationship is beyond salvation, and divorce or estrangement is the best option. This, too, allows for new possibilities for better and more loving relationships.

In either situation, a narrative that has more hope and more compassion is more likely to bring out positive responses in others than one suffused with bitterness and anger. Hope is a self-fulfilling prophecy and more likely to bring about that which is hoped for.

Cultural values and struggles with them are important causal elements in the narrative. Many patients find that embracing the important historical and cultural context in their narratives lends verity and conviction to their stories. They know they are affected by larger forces—racism and discrimination, immigration, colonialism, injustice, and economic inequality—and explicitly connecting their unique individual experiences with these broader forces, and how they were affected by them, is empowering and clarifying. Important events in a group's history, issues of power, subjugation, discrimination, and alienation are irrevocably part of an individual patient's story and are an essential narrative element.

Using traditional literary concepts to analyze therapeutic narratives is the converse of humanities scholars using psychoanalytic principles to analyze works of art. In analyzing patient narratives, Alon and Omer (2004) describe "psychodemonic," "tragic," and "comic" narratives. We describe these here and suggest that most successful psychotherapy narratives are tragic narratives.

The psychodemonic narrative portrays the patient as fundamentally bad, evil, and negative, and describes the effects of these qualities on their life. The "bad seed" explanation could refer to the patient's genes, soul, or something more inchoate than that. The rest of the narrative, the relationships with others, life experiences, the why, all derive from this explanation. Mutability is limited, and hope and compassion are at a minimum.

This is in contrast to the "tragic" narrative, which emphasizes fatal flaws, accidents, limitations, and mistakes, and how they result in larger and larger impacts on the person's life as they play out. In the tragic narrative, current suffering is seen as the result of prior events. Pain and suffering are the patient's lot in life and have an understandable cause. The fundamental innocence implied in the tragic narrative allows for a rich and complex story of change and transcendence and, thus, hope. Most psychotherapy narratives take the tragic format, with many variations.

Comic narratives rely on accidental events, misunderstandings, and fundamentally good motivations that are misunderstood, with the triumph of love in the end. It is interesting to consider whether psychotherapy narratives ever follow this format. Our impression is that this type of narrative, as reasonable, accurate, and helpful as it might be for many people, is not uncommon in life, but less frequent in longer-term psychotherapy. Most therapeutic narratives involve loss and suffering, but often more successful treatments that have brought significant change cause patients to look back and see a change in fortune from bad to good with a triumph at the end.

TECHNIQUES FOR CREATING A NEW NARRATIVE

There can be no new narrative, and no relief, until the old version loses its power. There are always alternative perspectives, explanations, and dimensions of understanding that can add to or change the old narrative. So, we must challenge the patient's existing narrative and open the path for new ways of looking at themselves.

Empathy and support in therapy allows a patient to feel the security and freedom needed to verbalize unsettling thoughts and reflect on them. This security, along with the instillation of hope, is an essential prelude to changing the old narrative and creating the new narrative. There is a cyclical quality to the process of psychotherapy and the cycle begins by elucidating old perceptions and questioning them, then providing support, and then exploring more, then support, and so forth. With each cycle the patient moves deeper into their feelings and experiences.

Beginning with more surface concerns and explanations, they can start to acknowledge more complex feelings and fewer reasonable and realistic explanations.

After a patient has talked about an important experience in the past or present, the therapist's goal is to bring out the patient's initial narrative understanding of the event. Typical questions that allow patients to unpack their implicit narratives are:

"How were you feeling in that situation?"
"What were you most afraid of in that situation?"
"What did you think was going to happen?"
"Why do you think that happened to you?"
"What do you think caused the other person to react to you that way? Why do you think the other person did that?"
"What do you think it is about you that made the other person react or behave that way?"
"What did the situation remind you of?"
"If your fears had come true, what would you have felt, and how would you have reacted?"
"How did you feel about feeling that way?"
"What is your idea about why these kinds of things keep happening to you?"

When you ask these questions, patients often do not really know the answers, but they usually have some ideas or suggestions. You are suggesting that these are questions you and the patient can be curious about together. Working from the surface implies asking questions about matters that are close to the patient's awareness, not the deeper thoughts, feelings, motivations, or conflicts you as a therapist hypothesize about. Working from the surface means starting from what the patient already knows or thinks, pushing and exploring, suggesting alternatives, listening carefully, and wondering aloud for what else might be there.

Some patients find it helpful to work on their narrative by utilizing a more concrete format. Journal entries, brief autobiographies, poetry, artwork, and diagrams can all be useful. Some patients prefer text and actual written narrative and will come to appointments with new versions of their narrative, allowing for collaborative discussion and review.

Psychodynamic psychotherapy deals extensively with the past. Malan's (1979) triangle suggests that the patient's central conflicts can be expressed in past relationships, realistic present relationships, and in the relationship with the therapist—that is, transference. Likewise, a comprehensive narrative includes all of these elements. The story begins

in childhood, traces the important life events, twists and turns along the way to include important relationships, and ends up in the present. The transference expresses the same conflicts and can be included in the narrative.

Some patients are filled with memories and easily reflect on past events, while some are fully planted in the present and less inclined to look back. Some like talking about the therapeutic here and now and their feelings and thoughts about the therapist. It is best, if possible, to flesh out all three areas of Malan's (1979) triangle with patients, because they reinforce one another, and understanding in one area builds understanding in the others. Some patients ask whether talking about the past is essential in psychodynamic psychotherapy. We think that it is possible to do useful psychotherapy focusing primarily on the present or the transference and spending less time on the past, but it is probably harder and may be less effective for the patient. The greatest potential for change comes from a broader exploration and a more comprehensive narrative. For briefer treatment it is often more useful to have a present-centered focus, as the single domain of data will allow for greater clarity and consolidation of the narrative. In more extended treatment, with broader objectives, there will likely be work in all three areas. Because narratives fundamentally involve a time line, they are most powerful and convincing when they start in the past and come up to the present.

THE NARRATIVE AND THE THERAPIST

As we have elaborated earlier, transparency in the therapist's role helps strengthen the therapeutic alliance and educate the patient. The therapist should explain the value of elucidating the implicit narrative that the patient has been using and the potential benefit of developing a new life story. Although this will likely affect a patient on a more cognitive and intellectual level, it will resonate emotionally as well and serve as a reference for understanding the therapist's behavior and attitude.

So many of the typical questions and concerns that patients have about therapy can be answered using the framework of the life narrative:

"Why do we have to talk about the past?"
"Is this therapy going to end up blaming my parents; isn't that just complaining?"
"What difference does it make if I understand the past when my problems are in the present?"
"How can I ever know what really happened?"

"I feel this way about my family, but my sister [or brother] sees it so differently, how can I know which is right?"
"How do I know how much culture, race, gender, sexuality, and historical context have affected me?"
"Therapy seems so subjective. How do I know if what we are talking about is true?"

You can respond to each of these questions with an explanation of narrative development as the central task of psychotherapy, and the ideas behind narratives we have tried to convey in this chapter.

We tell our patients that our collaborative work on a new, clearer, and more complex narrative of their lives is the main task of therapy. The new understanding will need to feel right to them and incorporate awareness of things that have been hard and painful to think about. The narrative is their story of what and how things happened and may not be accurate for others, even other members of the family. The standard of truth is whether, with deep and sustained consideration and input from the therapist, the narrative seems true to them. A new narrative should also open up new possibilities for living a better life.

Because therapy is essentially a learning process, with a focus on changing the way one sees and experiences the self and others, repetition and review are very important. Many patients will express the feeling that something important happened in a previous session, but not remember what it was. Although this may reflect the power of repression and the avoidance of anxiety, it may also remind us of the difficulty of learning new things about oneself. People forget what they have not yet fully learned. It can often be anxiety reducing, stabilizing, and soothing for a therapist to repeat the narrative that has been constructed so far. This is especially useful at moments of upset and crisis. Summarizing the narrative has a powerful but different effect in moments of quiet, when gains may be consolidated.

SUMMARY

Creating a comprehensive narrative, built up through questions and hypotheses that start from the surface of the patient's awareness and move deeper, helps to increase the patient's self-awareness. The narrative, which is a collaborative effort, is verbalized frequently over the course of treatment as it becomes more complex.

10

Change

> Not everything that is faced can be changed, but nothing can be changed until it is faced.
>
> —James Baldwin

The ultimate purpose of psychotherapy is to help a person change—that is why patients come to us. This chapter presents an evidence-based model of change in psychodynamic therapy and describes how therapists tailor treatment for individual patients. Personalized psychodynamic therapy involves engaging one or more of the six mechanisms of change that are likely to be effective based on an assessment of the patient's strengths and weaknesses.

It is easy to question our performance as therapists. Is the therapy working? While stockbrokers and Olympic athletes get immediate, ruthless, and crystal-clear feedback about their work, teachers and artists and therapists do not. It is humbling to plan for, observe, and assess change. The therapist's and patient's observations about what has changed, and their subsequent view weeks, months, and years later, are usually somewhat fluid and hard to pin down.

Therapists make judgments (sometimes biased) about what can change, what should change, and ultimately what has changed. Objective behavioral outcome assessments are certainly the cleanest measure, but they may not be aligned with patients' goals or subjective experience—patients are looking for symptom reduction, but they often seek a fuller life.

The psychodynamic psychotherapy literature has been rich in its description of how patients can feel different, but it has been less explicit in describing how therapists facilitate these changes. We know that access to real-time outcome ratings over the course of treatment has been shown to improve outcomes (Boswell, Kraus, Miller, & Lambert,

2015), and while this is an important tool for monitoring change as it happens, it does not help us understand how changes occur and how to facilitate it. Many of our patients say, "I am understanding myself better, but how is this going to help me change?" Psychodynamic therapists have not always had a concise, commonsense answer for them!

The classical psychoanalytic view is that insight is the silver bullet, that, in and of itself, facilitates change. But clinical observation and the theoretical literature over the past 50 years have identified other equally important mechanisms of change: new emotional experiences with the therapist, new kinds of self-awareness, and the development of new skills and capacities. The last decade has seen a burgeoning scientific interest in the mechanisms of change in psychodynamic therapy, and we now have important data to shed light on our understanding.

This chapter begins with a discussion of targets of change in psychodynamic therapy and then elucidates six mechanisms of change derived from the empirical literature: mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experience, affect experiencing, fostering adaptive psychological defenses, and enhancing adaptive interpersonal patterns (Barber et al., 2021). We discuss how patients are assessed for psychological strengths and weaknesses that predict which of these mechanisms of change may be most effectively employed (Zilcha-Mano, 2021) and use clinical vignettes to demonstrate these mechanisms as they come into play in one patient's therapy.

Sanjay was a 24-year-old cisgender Bengali American who identified as bisexual. Thin, with tortoiseshell glasses, wavy unkempt hair, and an air of intensity, Sanjay came for therapy with depressive symptoms, intense guilt and shame, occasional cutting behavior, and a feeling that he wanted to live a more genuine and meaningful life. His voice was soft but emphatic. He was a graduate student in engineering, mostly excelling in his academic work, but burdened, anxious, sad, and "not really living." He had a romantic crush on a student in his program, and was preoccupied with fantasies about him but expecting shame and rejection.

Sanjay was the third of three children born to Bengali immigrants who settled in the Midwest. His father, also in a science, technology, engineering, and mathematics (STEM) field, was irritable and critical. His mother was more affectionate, but passive, and she did not push back against the father's domination of the household. Both his older brother and sister were excellent academic performers and seemed less troubled than Sanjay, and his brother was to be married shortly in a big celebration. Sanjay was regarded by his father as haram, or forbidden, reflecting his father's strict Islamic view of homosexuality.

Sanjay had some surprising lapses in functioning, including missed academic deadlines and poor follow-through on treatment for a serious and painful ankle injury. The self-cutting began in early high school when his father discovered gay pornography in his room, and after several subsequent fights where his father made clear his anger and disapproval. During his teenage years, Sanjay began to skip regular prayers and felt guilty and worthless.

WHAT CHANGES IN THE PATIENT?

What was Sanjay coming to therapy for? Effective psychotherapy changes patients' subjective experience, as well as their objective functioning. Mood, affect, cognition, life satisfaction, and capacity for pleasure can all be positively affected. Change in one or more of these areas can impact other areas. Is the patient functioning better at home, work, in relationships, cognitively, in the ability to organize and focus? Does the patient bring flexibility and creativity to problem solving? Do they feel greater satisfaction and capacity for attachment and closeness? Is there improvement in the capacity to observe, understand, and consider alternatives—is there internalization of the "psychotherapy function"? Do significant others notice changes that the patient might not be aware of?

Much of the contemporary debate about the efficacy of psychodynamic psychotherapy and its comparison to more symptom-based treatments hinges on the issue of whether the treatment should only remove symptoms. Reducing symptoms is clearly important and makes an individual feel better, but should the treatment also actively facilitate improved mental health and functioning? Should we simply take out the lesion and let the patient heal, or should we provide training and rehabilitation to promote thriving as well?

Sanjay's symptoms—depression, anxiety, sadness, and cutting—were obviously a problem for him, but he also had restricted emotional and interpersonal functioning, as expressed in his wish for a "real life." He wanted to find a way to be open and self-accepting about his sexual identity and preferences, more open and joyful in his experience of life, and less self-defeating in his patterns of behavior. How was he going to deal with his needs for intimacy and maintain his relationships with his family? Can (and should) psychotherapy seek to help him build emotional strength and consolidate his identity, even after his presenting symptoms have diminished?

We list below some of the traditional (and not-so-traditional) goals or "targets of change" in psychodynamic treatment (see also Sharpless & Barber, 2009):

- Less emotional distress and more ability to handle stressful and painful situations.
- Decrease in symptoms.
- Positive self-esteem, with a sense that one's life fits with one's expectations.
- Feeling one has made the best of one's opportunities, with the experience of mastery (and acceptance) that comes with this.
- More stable and sustaining relationships, with the connection, sharing, support, stimulation, and validation that comes with these relationships.
- Improved ability to function in the world in vocational and leisure activities, in ability to meet basic needs.
- Enhanced capacity to creatively adapt to new situations that arise. Ability to deal with life cycle demands and find good solutions.
- Greater ability to use contemporary and realistic thinking to make decisions and find pleasure, meaning, and value in life.
- Greater creativity.
- More positive experiences and positive affect, and less negative experiences and negative affect, with improvement in the skills necessary to promote positive experiences.
- Greater feeling of freedom in making decisions and taking actions, as opposed to feeling compelled by others or by internal needs.

Most of the entries on this list are probably familiar and noncontroversial. The last item deserves some additional explanation. A sad man in his 40s started his therapy by saying that his goal was to "get my smile back," quoting from the then-popular (1991) movie *City Slickers*, about three middle-aged men who go out West to have fun and solve their midlife crises. This seemed like an understandable therapeutic goal for this negative, demoralized patient. But it was vague and disconnected from the obvious family problems that brought him to treatment, and it seemed fanciful and simplistic.

Nevertheless, this patient put his finger on something that is important for almost everyone in therapy. The theory underlying positive psychology, with its focus on the enhancement of experience and positive emotion, is that positive experiences are both an end unto themselves and also a buffer against negative experiences. Studies suggest that the capacity to create and sustain positive experiences can be improved, yielding enhanced life satisfaction (Seligman et al., 2005).

Sanjay was able to more clearly articulate his goals a few months into therapy. He wanted to feel less shame, anxiety, and depression. But he also realized that if he did not figure out how to have pleasurable and

positive experiences with family, lovers, and friends, his life was going to be a lot of hard work and not very satisfying.

MECHANISMS OF CHANGE

Recent empirical research on mechanisms of change builds on and extends a hundred years of clinically derived theory about change in psychodynamic therapy and psychoanalysis. Reviewing these seminal theoretical ideas will help to understand the evidence-based model of change.

Early psychoanalysts, including Freud, believed that increased self-understanding and awareness of conflicts was responsible for change. Insight was both the goal and the mechanism of change. The emphasis in classical analysis on understanding the seemingly incomprehensible (e.g., dreams, hysterical symptoms) or picayune (e.g., slips of the tongue, jokes) demonstrates the premium placed on insight into one's self. How this insight brought about change was not so clearly described.

Strachey (1934) articulated this classical mechanism of therapeutic change in psychoanalysis. For him, accurate interpretations made by the analyst constitute a superego mitigating force, allowing the patient to see themselves in a less critical light, leading to greater intrapsychic flexibility and decreased conflict. Based on an ego psychology model, Strachey saw the patient's identification with the analyst's understanding as contributing to a less self-critical, punitive, and anxious experience of self. Understood from the patient's perspective, "I am OK because I understand myself by appreciating my analyst's well-tempered understanding of me."

Alexander and French (1946) radically departed from earlier psychoanalysts. They believed that a "corrective emotional experience" helps the patient to change—that is, the patient is able to reexperience old conflicts in a new way and have a new kind of experience with the therapist that does not follow the historical pattern (Sharpless & Barber, 2012). The patient's experience here is "I am OK because I feel accepted and known and appreciated by my analyst." This concept generated tremendous controversy in analytic circles because it privileged this experience over insight and recognized the real person of the analyst. This proved to be an important influence on subsequent thinking.

Winnicott (1965) and others of the object relations school emphasized the therapeutic relationship as the lever for change. The connection with the therapist, modeled on the mother–child bond, helps to contain the patient's noxious, disturbing, and unacceptable feelings and impulses. Through a process of projection and reintrojection, the therapist detoxifies these painful and disturbing feelings, like a mother bird that predigests food for her young. The experience of containing

painful feelings, and borrowing the therapist's strength to do so, leads the patient to be more tolerant of these feelings and live more in the present. "I am OK because my analyst has been able to tolerate and contain me, and I am now able to tolerate and contain myself."

Loewald (1960; see also Cooper, 1989) speaks to the importance of the therapeutic relationship in facilitating change but makes a different point. He describes the development of a new kind of connection, where the closeness with the analyst allows for new and creative solutions to conflicts. The real availability of the analyst and the unconscious attunement with the patient result in a new relational field that facilitates the patient's openness to their unconscious. This renewed connection with the unconscious restores a normal developmental path that had been previously blocked by the neurotic illness. Simply put, "I am OK because I can now be open to myself and to my analyst, and this experience allows me to accept myself and be open to other people, new experiences, and the creative process." These concepts are similar to the selfobject relationship the patient develops in Kohut's (1984) self psychology model.

The relational perspective, articulated by Greenberg and Mitchell (1983), Renik (1993), and others, builds on the work of these earlier object relations theorists. The relational school sees the therapeutic enterprise fundamentally as a two-person unit, breaking down the old distinction between an ill patient and a healthy therapist. The relational psychoanalyst recognizes that the therapist inevitably engages unconsciously with the patient, enacting scenarios from the patient's past, and also from the therapist's own past, and creates something new and unique between them. Healthy change comes out of understanding their inevitable entanglement, and this understanding is aided by the therapist's participant observation in the experience. Relative transparency about the therapist's role in the relationship is part of the therapeutic technique here. "I'm OK because we have created an experience together that is OK, and I can see how I contributed to it."

Bateman and Fonagy (2003) proposed that mentalization, the capacity to experience oneself and others as subjective entities, is a critical element of healthy psychological development. It is a developmental achievement that is linked to the caregiver's ability to give meaning to the infant's internal states, which in turn is communicated back to the infant. Because trauma overwhelms the individual's capacity to make meaning, it also interferes with the capacity for mentalization. The therapist's attitude of curiosity, openness, and "not knowing" promotes mentalization. "I am supported and encouraged to be curious about myself and others, knowing that this is not always clear or even possible. But it is grounding to feel that we are all subjective beings that can be understood."

Evidence-Based Model of Change

These theories of change in the psychoanalytic literature each seem to capture something important about psychodynamic therapy. They describe a wide range of effects and are the basis for the empirical studies that suggest the six mechanisms of change we discuss here.

We describe each mechanism—mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experience, affect experiencing, fostering adaptive psychological defenses, and enhancing adaptive interpersonal patterns—and include data that support the relevance of each (Barber et al., 2021). A mechanism of change is defined as a mental construct that has the potential to change during treatment, and its change is hypothesized to drive improvements in the patient's mental health (Kazdin, 2007).

The mechanisms of change have dynamic interrelationships with one another. Change that takes place through one mechanism has the potential to facilitate change via others. For example, mentalization seems to be a precondition for most of the other five mechanisms. The first four mechanisms of change—mentalization, fostering insight, therapeutic alliance, and affect experiencing—are elemental processes of change. The fifth and sixth mechanisms—better defenses and enhancing adaptive interpersonal patterns—build upon the first four to drive change in intrapsychic and relational functioning.

It is important to distinguish between mechanisms of change in the patient, the improvement-related mental constructs that change during treatment, and the treatment techniques employed by the therapist. Each of the mechanisms of change is engaged through the strategic and effective use of supportive–expressive techniques. Techniques refer to the range of supportive and expressive interventions that comprise psychodynamic therapy and that are implemented by the therapist. For example, therapeutic alliance and new relational experiences, as a mechanism of change, requires the use of supportive techniques to build rapport and connection, but interpretation to manage ruptures and their repair. Fostering better psychological defenses requires exploration and interpretation to better understand conflicts and support to try new coping strategies and evolve new defenses.

Mechanisms of Change in Psychodynamic Therapy

- Mentalization
- Fostering insight into unconscious conflict
- Therapeutic alliance and new relational experiences
- Affect experiencing
- Fostering adaptive psychological defenses
- Enhancing adaptive interpersonal patterns

Mentalization

Early in the therapy, Sanjay frequently talked about his father's contemptuous and bullying attitude. It was a frequent trigger for intense anxiety and dysphoria. His father demanded that Sanjay pray regularly, demonstrate respect, even obeisance, while he regularly commented derisively on Sanjay's appearance and one of his friends' nonbinary dress. The bullying was expressed verbally and there was no overt threat of violence.

The therapist began to see a pattern in Sanjay's associations about these experiences. When he talked about his father's angry episodes, he reported on what his father said, the cold, piercing look in his father's eyes, and his own physical agitation and urgency. Then, Sanjay usually stopped narrating about his father and shifted to self-deprecating and self-denigrating thoughts. "I'm a bad son, I'm a terrible man, I am sinful, I should suffer." His mood plummeted and he practically demanded that the therapist agree with these dreadful conclusions.

When the therapist empathized with how painful his father's derogatory comments were, Sanjay seemed to feel worse about himself. He was more self-denigrating. It was like a repeating loop. Sanjay was stuck in either his focus on his father's anger, or his self-punishment. It was hard to help him gain perspective on his own fluctuating mental state and on his father's traditional values and style of parenting—it was unempathetic, damaging, and frightening, but not so surprising given the father's experience with his own autocratic father and his traditional Muslim cultural background.

The therapist stopped trying to interpret Sanjay's conflicted reaction to the frightening, blaming conversations (i.e., his fear and conflicted aggression toward his father), and focused instead on wondering what the patient felt, how he made sense of these moments, and what he thought of his father.

Slowly, a different pattern emerged in the sessions. Instead of the abrupt shift from the father's anger to self-blame, Sanjay began to express feeling frightened, worried, sad, angry, and uncertain in the sessions. He started to see himself as a person who has painful feelings, is confused by them, and struggles to handle them. Sanjay realized his father also had feelings that he had difficulty managing.

Initially, Sanjay was not able to see himself as someone experiencing complex feelings, nor could he see his father that way, and instead had a fragmented and unintegrated sense of self—he went from a description of the father's behavior to a profound state of self-blame and castigation. Sanjay had no coherent narrative understanding of himself nor his

father. His capacity for mentalization was especially compromised in experiences related to his father because of the traumatic aspect of this relationship, and was more present in his reflections on other relationships.

Because of these observations, the therapist shifted to techniques employed in mentalization-based therapy, which focuses on the present, on the patient's subjective experience, and refrains from proposing new narratives and new interpretations, especially involving events in the past. The interventions are designed to help the patient develop a more full, present, and genuine sense of their subjective, emotional life, and the ability to observe that in others.

For this patient, a more classical psychodynamic focus on insight would likely lead to false and ungenuine self-awareness for Sanjay. He could take it in and repeat it but not really feel it and begin to change. Sanjay might even experience the therapist as aggressive and controlling. Fostering insight into unconscious conflict is often not available to the patient with impaired mentalization, because the patient does not yet have the capacity to see themselves as a conflicted subjective self.

In the empirical literature, mentalization is studied through the concept of reflective functioning (Katznelson, 2014; Luyten, Campbell, Allison, & Fonagy, 2020). A high degree of reflective functioning suggests that a person is able to contemplate their own and others' emotional and cognitive states, see the difference between implicit and explicit motives and how they manifest in behavior, and appreciate how the relationship between two people changes over time.

The concept of reflective functioning was originally developed to understand the experience of patients with borderline personality disorder, but was expanded to study other problems (Fonagy, Bateman, & Bateman, 2011). The Reflective Functioning Questionnaire (Fonagy, Target, Steele, & Steele, 1998) is applied to clinical interviews (Harpaz-Rotem & Blatt, 2005), as well as narratives articulated by patients in psychotherapy (Karlsson & Kermott, 2006).

Multiple studies find that reflective functioning increases over the course of psychodynamic therapy (De Meulemeester, Lowyck, Vermote, Verhaest, & Luyten, 2017; Katznelson, 2014) and change in reflective functioning over treatment is linked to change in symptoms (Fischer-Kern et al., 2015; Kivity, Levy, Kelly, & Clarkin, 2021; Rossouw & Fonagy, 2012).

Fostering Insight into Unconscious Conflict

While mentalization is a way of being and a way of experiencing oneself and others, insight is a unique and particular cognitive and emotional understanding of oneself and others. It is content, rather than process,

specific to the individual, rooted in history, and both known and felt. Insight is built upon the scaffolding of mentalization and thus the second mechanism, fostering insight into unconscious conflict and has mentalization as a precondition.

Feeling previously warded-off emotions, recalling disavowed thoughts, and remembering troubling earlier memories are all results of good uncovering and exploratory psychotherapy. They increase anxiety, but remarkably, they also help make patients more comfortable. Anxiety decreases because painful affects typically have a finite life span, and they diminish in intensity.

It is a big responsibility to dig deep and encourage patients to express what they feel. For the therapist it is an exciting sign of progress and intimacy, but also somewhat intimidating. New therapists seek this experience but may be afraid of it. There are moments when a patient begins to experience intense emotion, and you will recall that old adage, "Be careful what you wish for, because you just might get it." Newer therapists must learn to tolerate the anxiety they experience when patients feel and express intense emotions.

Some months into the therapy, Sanjay's capacity to hold in mind his feelings, thoughts, and behaviors regarding his father were substantially increased.

> Sanjay felt deeply humiliated and ashamed, and castigated himself for his disinclination to be a traditional Muslim boy. He assured himself that his father's anger and disapproval was right, and his sexual feelings and his antipathy toward religion were deep personal defects. At other times, he felt strongly that his father was a tyrant and a bully. Sanjay's mother quietly encouraged him behind the father's back, but took care to never cross his father directly.
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> The therapist supported Sanjay's feeling that he was entitled to his feelings, interests, and life choices, and that the world outside the family was mostly prepared to accept him as the young man he was. Sanjay began to contextualize his father's attitudes and behavior, and to distinguish between the challenge presented by his father's attitudes as a realistic life problem he needed to deal with—his father struggled with the losses and stresses of immigration and aging, and the disparity between the culture of his new country and that of the country he grew up in. Sanjay realized he had his own feelings of confusion, shame, and guilt about his sexuality and how he wanted to practice his religious and spiritual life. He was very angry at his father and anxious and guilty about this.
>
> These insights—Sanjay's own sexual and aggressive feelings and reactions to them, and the angry conflict with his father—and a greater capacity to see them as they played out, led to a sense of

separateness, freedom, and empowerment for him, and a relief of some of his self-criticism and self-defeating behavior. Sanjay felt he understood himself better and felt more accepting of himself.

This example from Sanjay's therapy demonstrates insight as a mechanism of change in psychodynamic therapy. New understanding and emotional awareness often arise from the exploration of the self that pushes the bounds of what the patient knows and can tolerate. Exploration helps the unknown become known and the therapist is both a goad and a guide in this process.

The therapist's choice to focus on insight as a mechanism of change at this point in the therapy led them to focus on traditional psychodynamic uncovering techniques, ranging from more supportive to more expressive. The specific techniques include the following:

- *Open-ended interviewing.* Open-ended questions—exploration of current, past, and transferential feelings, fantasies, memories, thoughts, and perceptions—allow the patient to experience these feelings as fully as possible. This more supportive psychodynamic technique aims to help the patient get in touch with affects previously unexpressed and amplify affects that are suppressed, disavowed, denied, or ignored.

- *Guided exploration of known areas of conflict.* As the areas of upset and the painful feelings become more known, regularly returning to these parts of the patient's experience allows for more and more full experience of disturbing affects. The metaphor of unpacking is often used to describe this technique (i.e., going deeper into the details of a memory, experience, feeling).

- *Encouraging the patient to maintain awareness of painful feelings.* This technique includes (1) direct encouragement, education, and support; (2) empathic validation; and (3) silence and space to experience and reexperience. The therapist may empathize and specifically encourage the patient to stay with the feeling for a minute, if possible.

- *Addressing anxiety.* Approaches to dealing with patient anxiety and disinclination to talk about painful matters include patience and support, attempts to understand and validate the nature of the patient's discomfort, and interpretations about the patient's discomfort in the session and how this may be similar to feelings about other relationships.

- *Clarification.* Collecting instances of a repetitive scenario adds weight and depth to a patient's awareness of their experience, causing greater recognition of the power of earlier experiences.

- *Interpretation*. Providing a full explanation of the upsetting feelings—identifying and describing the repetitive traumatic scenario that underlies the patient's problem—increases the patient's understanding, but it may increase the patient's anxiety and upset first. Interpretations bring out new, sometimes unconscious, aspects of feeling, and this causes anxiety; but soon enough accurate and helpful interpretations decrease anxiety, because the explanations are true to the patient's experience and tolerable. Confrontation is an intervention in which the therapist assertively asks the patient to reconsider their self-understanding and the value of a new interpretation.

Increases in insight have been found to occur over the course of psychodynamic therapy (e.g., Connolly et al., 1999; Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007; Gibbons et al., 2009) and have been shown to relate to subsequent symptomatic change (e.g., Kivlighan, Multon, & Patton, 2000). A recent meta-analysis suggests an association between insight and outcome across treatments (Jennissen, Huber, Ehrenthal, Schauenburg, & Dinger, 2018). Among the supportive–expressive interventions, several empirical studies have found interpretations to be beneficial interventions (e.g., Orlinsky, Ronnestad, & Willutzki, 2004).

Thus, fostering insight, using the traditional supportive–expressive psychodynamic techniques, is the second mechanism of change in psychodynamic therapy.

Therapeutic Alliance and New Relational Experiences

We discussed the therapeutic alliance in Chapter 4 as a critical element of psychotherapy, providing the safe, effective context for shared work that is a common factor across different types of therapy. The therapeutic alliance and the impact of new relational experiences is the third active and specific mechanism of change in psychodynamic therapy.

> Sanjay did a lot of work on his conflicted feelings of sexual attraction, guilt, and shame. He had more distance from his father's and his culture's particular values, recognizing that the conflict he felt about his sexual feelings toward both men and women resulted from his unique internalization of the views of his family and community, as well as from himself. As a result, Sanjay was freer with his feelings and dating behavior with both men and women, exploring his desires and trying to understand more about himself.
>
> There was an evolution of Sanjay's therapeutic alliance with his therapist toward greater comfort, safety, freedom from judgment and criticism, and a greater sense of being understood. This

accomplishment was the result of many sessions spent talking about these issues, and being specific and honest about his feelings and fantasies. Sanjay anticipated criticism, feeling shame about what he expressed, but he was ultimately surprised and pleased by the consistent interest, curiosity, and attention of the therapist.

There were several small ruptures in the alliance, but one major one. Sanjay insisted that the therapist, a cisgender heterosexual male, seemed especially positive and encouraging about a woman he had several dates with. He felt this revealed the therapist's true wish that Sanjay would identify as heterosexual, and he felt angry and betrayed. "You have been acting like you are so open and so accepting. You do that because you are a professional and it's politically correct. But, if I was your son, of course you would want me to date women."

Sanjay's deeply felt sense that he had been betrayed by the therapist was followed by several appointments where he was late, had an internet connectivity problem with a telepsychotherapy session, and a completely missed meeting.

When the therapist inquired further about how Sanjay felt about the rupture and perceived failure of empathy, they were eventually able to come to a shared understanding of the connection between Sanjay's disappointment and anger and his acting out about the appointments. He was detaching from the therapist to avoid being angry, avoiding the possibility that the therapist would retaliate for his anger, and hurting himself by missing the appointments and the therapeutic relationship. Sanjay could see that his conviction about the therapist's wish for him to be straight was a projection, and reflected the part of him that felt that way and wanted to be that way.

When Sanjay understood that it was his own sense of anger and betrayal that projected anger onto the therapist, and his own need to avoid and punish himself that was at work here, he felt a deeper sense of support, understanding, and empathy. He felt closer, more known, and more supported than he had ever felt before. The appointment irregularities stopped and did not return for the rest of the treatment. The therapist had seen the "worst" in Sanjay—his sexual feelings, his conflicts, his anger, his urge to end the relationship—and was still consistently present and empathetic.

Conceptualizing the therapeutic alliance as a mechanism of change captures the new relational experience Sanjay had with his therapist. Sanjay moved from a constrained, self-protective, shame-filled position to a new deep experience of safety and closeness with his therapist. This was the result of a strengthening of the alliance that occurred with

the successful repair of alliance rupture—the understanding of his projection about the therapist's heterosexual bias. It was also built upon insight Sanjay gleaned about himself—when he is angry, he detaches and engages in self-defeating behavior.

According to Safran and Muran (2000), useful alliance rupture repair includes direct strategies in which the therapist draws attention to the rupture, such as inviting the patient to express their thoughts and feelings about a rupture, and indirect strategies, in which the therapist resolves the rupture without explicitly acknowledging it—such as providing some socialization when the patient feels anxiety about a moment of silence. Examples of resolution strategies include (Eubanks et al., 2018):

- Therapist clarifies a misunderstanding.
- Therapist changes tasks or goals.
- Therapist illustrates tasks or provides a rationale for treatment.
- Therapist invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy.
- Therapist acknowledges their contribution to a rupture.
- Therapist discloses their internal experience of the patient–therapist interaction.
- Therapist links the rupture to larger interpersonal patterns between the patient and the therapist.
- Therapist links the rupture to larger interpersonal patterns in the patient's other relationships.
- Therapist validates the patient's defensive posture.
- Therapist responds to a rupture by redirecting or refocusing the patient.

The patient's and therapist's trait-like general capacities for developing the therapeutic alliance were the subject of the Chapter 4 discussion on forming an alliance. But here we focus on the state-like aspect of the therapeutic alliance—that is, the component that changes with the evolution of their relationship (Zilcha-Mano, 2017).

The trait-like component of the alliance refers to the general capacity of the patient (and the therapist) to form and maintain helpful intimate relationships with other people in their lives, which also affects their ability to form a satisfying therapeutic relationship. Empirical findings support the existence of a trait-like component of alliance, show its origins in the intrapersonal and interpersonal capacities of the patient, and demonstrate that those with better capacities for a strong trait-like alliance also benefit from a more successful treatment (Zilcha-Mano & Fisher, 2022).

The state-like second component of the alliance is most relevant here as a mechanism of change. State-like changes in the alliance can be situation driven. For example, if Sanjay is dating someone who seems to make him feel appreciated, this may make him feel more generally optimistic. If he brings that attitude to the therapy, it could increase the state-like alliance. But, of course, situation-driven changes are not likely to persist and do not bring about enduring change. By contrast, psychotherapy process-driven changes in the state-like alliance reflect therapeutic alliance as a mechanism of change. Sanjay's reaction to the alliance rupture, the therapist's empathic attunement, and their collaborative work resulting in repair of the rupture is an example of process-driven changes in the alliance (Elliott, 2010). When they are not transient, process-driven state-like changes become enduring and form the basis for successful treatment and a new trait-like characteristic (Zilcha-Mano, 2017). This is a new relational experience that results in therapeutic change. Empirical findings support these observations and suggest that episodes of state-like strengthening of the alliance are associated with better subsequent treatment outcomes (Zilcha-Mano & Fisher, 2022).

This conceptualization links to the notion of the "corrective emotional experience." Patients generalize from the therapeutic relationship and bring new relational experiences and skills from the therapeutic setting out into regular life. The literature on corrective experiences suggests that many patients seek treatment because of interpersonal problems and start treatment with negative expectations about the willingness and ability of others to provide care and help in times of need (Huang, Hill, Strauss, Heyman, & Hussain, 2016). Negative expectations and low motivation, combined with poor interpersonal skills, may result in poor trait-like alliance.

The therapist's empathic and kind response to Sanjay's anger when he experienced the therapist as biased in favor of his dating a woman, and the attunement to Sanjay's experience and attention paid to understanding the rupture and its repair, was a corrective emotional experience. It was a new relational experience and Sanjay not only felt more trusting of his therapist but also less defensive toward others.

This resulting state-like strengthening in alliance serves as a critical mechanism of change, especially for individuals with poor trait-like alliance. This is in contrast to the sixth mechanism of change, enhancing adaptive interpersonal patterns, where the focus is on processing maladaptive interpersonal patterns outside of the office. When the trait-like alliance is strong, this allows the therapist to engage other mechanisms of change (e.g., insight and affect experiencing). But when the trait-like alliance is poor, state-like alliance strengthening is necessary for change.

Affect Experiencing

Psychoanalysis was born out of Freud's excitement over catharsis, the release of previously hidden feelings, and his conviction that this was the road to cure. Although it turns out there is much more going on in therapy than catharsis, the fourth psychodynamic therapy mechanism of change, affect experiencing, which comprises identifying, feeling, and expressing emotion, is a more expansive version of that original idea.

> Avoiding eye contact, Sanjay haltingly described an awkward and disappointing sexual experience. He felt ugly and unlovable, and sure he had embarrassed himself. When the therapist simply commented that sometimes sex does not work out so well, Sanjay was so moved, he broke down and cried.
>
> The therapist was quite surprised. After a few minutes of shaking sobs and tears, followed by nose blowing and collecting himself, Sanjay said he felt relieved that he was able to honestly describe what happened. The experience was awful, but it was over, and maybe it was not really so awful after all.
>
> The disappointment in bed brought up all of the years Sanjay had felt ashamed, like his feelings were not normal, his body was not attractive, and there was something terribly wrong with him. Instead of feeling this same old way, now, in this moment, he felt like maybe he was just himself, a person with needs and fears and good intentions. Sanjay cried while thinking of all of that pain, alienation, and sadness he felt in his adolescence and romantic life, and how lonely it had been. It was the first time he had cried in several years.
>
> After a while, Sanjay said he felt lighter, less upset, and relieved. In the remainder of the session, he was calmer, quieter, and more present.

Affect experiencing aims to help the patient get in touch with feelings previously unexpressed, or amplifies affects that are suppressed, disavowed, denied, or ignored. The therapist's understanding of the core problem and the formulation helps to guide the use of this mechanism of change by suggesting what emotions, often unconscious, are likely unexpressed and avoided by the patient. (See Chapter 5, Table 5.1, for the typical conflicted emotions by core psychodynamic problem.) The formulation, which takes the understanding of the patient to a much more individual and specific level, provides an even more precise guide.

Often, the moment that triggers intense affect experiencing is not planned or expected, as in the example above. But sometimes the

therapist has a sense of what is painful and unexpressed, and is waiting for the right moment to bring it up and explore and encourage the patient. It might be an unmourned loss, a constant sense of rejection, a fear of losing control, or other sources of pain that the patient refers to but does not actually experience deeply in the present.

Some have suggested that repeated exposure to painful old emotions helps to diminish their intensity, and emotional exploration allows for "desensitization" (e.g., McCullough et al., 2002). The role of affect in the therapeutic process has been studied across a variety of manualized treatments (Aafjes-van Doorn & Barber, 2017; Diener, Hilsenroth, & Weinberger, 2007; Pos, Paolone, Smith, & Warwar, 2017), and in the psychotherapy of diverse mental disorders (Greenberg & Pascual-Leone, 2006). Studies of affect processes in psychotherapy have consistently found that they are related to treatment outcome, with a significant medium to large effect size (Pascual-Leone & Yeryomenko, 2017; Peluso & Freund, 2018). Findings suggest that more adaptive affect expression is associated with reduced symptomatology (Burum & Goldfried, 2007), and is an important predictor of treatment outcome (Aafjes-van Doorn & Barber, 2017; Pascual-Leone & Yeryomenko, 2017). Finally, exploration of the therapist's affect experiencing can contribute to the understanding of therapeutic processes (Chui, Hill, Kline, Kuo, & Mohr, 2016; Kivlighan, Marmarosh, & Hilsenroth, 2014).

Over time, experienced clinicians develop a sense of how much can and should be accomplished in a session. Every session can move toward a clearer picture and a more direct experience with painful emotion. Otto Kernberg said to two of us in a case conference when we were trainees: "I am impatient in every session, and very patient over time," referring to his attitude about progress in uncovering painful emotions in patients.

Sometimes, patients with overwhelming emotion reexperience but do not get relief. Instead, they are overwhelmed. Decreased session frequency, more cautious elicitation of painful affects and memories, and more focused exploration are all useful, but these techniques may not be enough. Instead, these patients can take advantage of specific behavioral approaches that are more immediately soothing and supportive, such as breathing and relaxation techniques, meditation, guided imagery, journal writing, and other cognitive-behavioral strategies involved in dialectical behavior therapy (Linehan, 1993). These very helpful techniques are outside the scope of this book. For those who are benefiting from the exploratory aspect of psychodynamic therapy, but who are emotionally overwhelmed, what else can we do to help them manage the demands of treatment?

Painful affects must be validated as normal human reactions. Beginning therapists confuse this attitude with just being nice and warm, but it is different. The therapist must understand enough about the painful emotions and their context for them to make sense. Almost anything the patient feels is understandable and can be seen as the best possible response in the moment, given the context for the emotion response. The therapist's intervention can take the form of verbalized empathy and understanding, or it can be the nonverbal silent communication that expresses understanding. Normalizing a painful experience was the initiator of intense affective experience for Sanjay in the example above because of his frequent experience of shame and guilt. But for many patients normalizing and validating helps to decrease anxiety and emotional intensity.

Connect the individual painful experience with a larger context of meaning. For example, getting in touch with a deep sense of loss can make a patient feel worse and more hopeless. If this is understood as part of a ubiquitous human experience, or the kind of tragic circumstance others have suffered, or part of a personal trial, there is a larger meaning to the individual experience. The purpose here is not to convince the patient to feel less through encouragement or optimism but rather to try to find a context for larger meaning that makes sense to the patient. For example, the therapist pointed out to Sanjay that there are many young men struggling with their sexual identities—having a traditional cultural background often makes this process especially harrowing and difficult.

Understand and empathize with the painful feeling in its historical context. The therapist can encourage the patient to understand their pain as the remembered upset that has remained, ready to be reexperienced when the traumatic scenario from the past is restimulated. Patients find solace in the recognition that their intense feelings are part of their past, not part of their present life experience. This is reassuring because it acknowledges that the feelings may be strong, and they may be immediate, but they are finite and limited and do not represent a current reality.

The intensity of upsetting feelings is decreased when their realistic basis is explored. Helping the patient consider alternative perceptions, which we discuss in more detail below, reminds the patient that they have, metaphorically speaking, a foot in the past with the intense and upsetting experiences, and a foot in the present, seeing the same situation in another way. Generating new and possibly more adult and realistic perceptions of current situations helps the patient

to see how much is truly in the present and how much historical baggage they are bringing to the situation.

Remind the patient of the feeling of tolerance and containment experienced in the therapist's office as this can provide buffering and support. Identification with the therapeutic situation, and with the therapist, allows for increased tolerance of painful affects. So often, a patient in an effective psychotherapy will have a difficult time and will contain the painful emotion through the reassurance that they will talk about it at the next psychotherapy appointment. Even after therapy ends, some patients find it helpful to continue to have an internal dialogue with their therapist (Geller & Farber, 1993). Experiences such as these are not necessarily signs of an unhealthy dependence but rather indicate a technique for managing, soothing and containing painful affect.

Fostering Adaptive Psychological Defenses

The fifth mechanism of change, fostering adaptive psychological defenses, targets the defense mechanisms developed long ago to manage painful affects. A defensive style that employs immature defenses or that uses more mature defenses too rigidly can impair the patient's ability to perceive and interact with the world. Increasing the flexible use of less dysfunctional and more adaptive psychological defenses, and the use of better coping styles, is a core component of psychodynamic therapies. Psychotherapy has been found to improve defensive functioning, and improved defensive functioning has been associated with symptom relief.

In the past, defenses were conceptualized as unconscious, while coping strategies were seen as conscious. We are not convinced there is such a clear distinction between the two, as patients often have a dim awareness of thoughts and feelings that are labeled as unconscious, and they may employ coping strategies without reflection and little conscious awareness. Thus, we use these terms flexibly.

Sanjay was expected to wear traditional garb at his brother's wedding, but he felt it was unattractive and constraining. During the fitting, he looked in the mirror and saw an unattractive, ungainly young man who looked miserable and out of place—a loser. The shape of the pants made Sanjay look short and overweight. The attention and scrutiny he would receive at the wedding made him feel intensely anxious.

Although it was hard to stop his mind from focusing on the appearance of the wedding suit and how unappealing he felt he looked, the therapist helped Sanjay consider that these perceptions were actually how he saw himself, rather than how others would.

Sanjay imagined that his extended family and friends would see him in the negative light he saw himself, and perhaps his distress about his appearance was a projection of his inner sense of ugliness, self-criticism, and shame.

The therapist noted that there would be a variety of potentially enjoyable opportunities at the wedding—spending time with two cousins Sanjay was close to, one of whom had a disability and needed some help; colluding with his sister in laughing at some qualities of their new sister-in-law, and their parents' pleasure in showing off to their son's new in-laws.

Sanjay was able to move some of his attention to these new more outward-looking and pleasant activities, and there was a shift in his level of defensive function from more primitive defenses—projection, all-or-nothing thinking, introjection—to more adaptive ones—humor, altruism, and suppression.

Painful affects are often kept at bay through the utilization of defense mechanisms (see Chapters 5 and 6). The analysis of defenses is a core component of psychodynamic therapies, and psychotherapy has been found to improve defensive functioning (Hersoug, Bøgwald, & Høglend, 2005; Hersoug, Sexton, & Høglend, 2002). Furthermore, improved defensive functioning has been associated with symptom relief (Coleman, 2005). Interestingly, though, there is some evidence that improvement in defenses may actually follow symptom change (e.g., Akkerman, Lewin, & Carr, 1999), instead of preceding it.

Studies have shown a decrease in the use of immature defenses and an increase in the use of mature defenses over the course of therapy (e.g., Roy, Perry, Luborsky, & Banon, 2009). These changes have been found to be associated with symptomatic change (e.g., Johansen, Krebs, Svartberg, Stiles, & Holen, 2011). A review of existing studies suggests that for patients with more severe psychopathology, this mechanism may be more important in bringing about therapeutic change than in other populations (Crits-Christoph & Gibbons, 2021).

There are several techniques for fostering adaptive psychological defenses. Identifying and interpreting the patient's underlying conflicts and their associated resistances helps to bring these feelings and thoughts into conscious awareness. Repeated reflection on the advantages and disadvantages of the defenses and coping strategies allows the patient to build their capacity for conscious control over the defenses chosen. Finally, the therapist encourages the patient to try out and then evaluate new, more mature defenses and coping strategies. Previous work done leveraging mentalization, insight, strengthening the therapeutic alliance, and greater tolerance for affects will facilitate this process.

Enhancing Adaptive Interpersonal Patterns

The sixth mechanism of change in psychodynamic therapy is enhancing adaptive interpersonal patterns. This means promoting a shift from rigid, dysfunctional, and maladaptive relational patterns to flexible, mutual, and emotionally satisfying ones. Such satisfying interpersonal relationships in the real world, and comforting memories of past relationships, promote life satisfaction and resilience. This mechanism involves reflecting on current relationships and considering new perceptions and new behaviors.

> Later in the therapy, Sanjay dated a promising young man who was quite clearly interested in him, but who was quiet and not demonstrative of his affection. The man always returned texts, showed enthusiasm about spending time together, and was sexually available. They spent a significant amount of time together and Sanjay began to stay over at his apartment. This was exciting for Sanjay, and he experienced affection and romantic love for the first time.
>
> But the relationship made Sanjay feel very vulnerable and he was certain it would end. Specifically, he often felt that his boyfriend was angry at him, disapproving of his behavior or the things he talked about. Sanjay was sure that the more open he was with his affection, the more repelled his boyfriend would be, and that this was a sign of weakness and was a shameful, disgusting revelation.
>
> The work in the therapy helped Sanjay see the replaying of his dysfunctional relationship with his angry, critical, and demeaning father, and his own vulnerability, withdrawal, fear, and self-blame. These insights allowed him to consider other ways of understanding his boyfriend's reticence—maybe he was shy, or uncertain himself, maybe he was just quiet. The therapist reminded Sanjay about how he had to work through his negative paternal transference in the therapeutic relationship to find a sense of comfort and support.
>
> This work emboldened Sanjay to have the patience and calm to wait to see what kinds of affectionate interaction developed with his boyfriend—he noted his fearful responses and urge to withdraw, but held off acting on it. He began to feel a quiet but deep sense of connection developing and was able to maintain an attitude of optimism and curiosity and keep his fears and dysfunctional responses at bay.

In this example, the therapist facilitated a decrease in the rigidity and dysfunction of the patient's interpersonal patterns in his regular life through interpretations of those maladaptive repetitive interpersonal patterns as they manifest in relationships outside of the therapy room.

We have seen how the mechanisms of change are interrelated, and this sixth mechanism, enhancement of interpersonal patterns, is built upon other mechanisms, especially mentalization, insight, and therapeutic alliance and new relational experiences.

There is evidence that patients become less rigid in their interpersonal patterns over the course of psychodynamic therapy (Atzil Slonim, Shefler, Dvir Gvirsman, & Tishby, 2011; Luborsky & Crits-Christoph, 1998; Tishby, Raitchick, & Shefler, 2007) and show less interpersonal distress and better interpersonal functioning (Zilcha-Mano et al., 2014).

CHANGE STRATEGY

Therapists are usually explicit in their intention to explore and understand patients but not so clear and deliberate in how they propose to help them change. Effective therapists evaluate patients' strengths and weaknesses, informed by the patient's core psychodynamic problem, and steer the therapeutic interaction toward engaging those mechanisms of change they judge most likely to be helpful. They test the impact of various mechanisms of change in the interaction with the patient, and then settle on a strategy that focuses on one or two mechanisms.

Assessing Strengths and Weaknesses and Planning a Strategy

Patient strengths and weaknesses, characterized in the literature as trait-like because they are relatively stable and enduring qualities, can be assessed in a variety of ways (Zilcha-Mano, 2021). Research studies use deep clinical interviews (Hoffman, 2020), self-report questionnaires assessing the patient's subjective experience, a diagnostic battery, or other assessment approaches. In typical clinical practice, this is done through the usual clinical assessment (i.e., trying to understand the general capabilities and modes of functioning of the individual).

Patients' strengths are required to address their weaknesses, and the clinical assessment looks at both. We summarize the six mechanisms of change, and the techniques for engaging them, in Table 10.1, along with the pattern of strengths and weaknesses that favor their use.

For example, a patient may present with a trait-like strength profile that includes the ability to form a strong alliance (measured by the Alliance Expectation Questionnaire; Barber et al., 2014); insightfulness (measured by the Self-Understanding of Interpersonal Patterns Scales—Interview [SUIP-I]; Gibbons & Crits-Christoph, 2017); and difficulty with affect experiencing, especially in tolerating sad emotions (evaluated in a clinical interview). Based on this picture, the

therapist could choose to focus on the therapeutic alliance and new relational experiences, and identifying and repairing alliance ruptures in particular (Safran & Muran, 2000). The therapist could also focus on fostering insight (Høglend, 2014; Luborsky, 1984) or affect experiencing techniques (Elliott, Watson, Goldman, & Greenberg, 2003). The strengths in alliance and insight could be used to address the weakness in affect tolerance, or affect experiencing could address this problem directly.

Because time in treatment is limited, it is important to choose a therapeutic strategy. The optimal strategy will be efficient for the patient but also cost-effective (Cohen & DeRubeis, 2018). In the above example, the

TABLE 10.1. Developing a Strategy for Change: Mechanisms, Techniques, and Predictors

Mechanism of change	Therapeutic methods	Relevant strengths and weaknesses
Mentalization	Curiosity, empathic attunement to subjective experiences, support for narrative of subjective experience, avoidance of interpretations	Motivated and able to attach, openness Inability to employ theory of mind in understanding self and others
Fostering insight into unconscious conflict	Traditional open-ended exploration with focus on interpretation and new narrative	Introspective, curious Limited insight
Therapeutic alliance and new relational experiences	Empathic attunement, attention to rupture, and repair of alliance	Motivated for help Low trait-like alliance
Affect experiencing	Promoting affective experience and catharsis	Flexible, insightful Affect intolerance
Fostering adaptive psychological defenses	Challenging immature defense mechanisms and encouraging more mature defense mechanisms	Good mentalization and insight Use of immature defenses
Enhancing adaptive interpersonal patterns	Combining insight, therapeutic alliance, and ability to tolerate affects to explore and test new interpersonal patterns	Good mentalization, insightful, able to tolerate affect Dysfunctional intimate and interpersonal relationships, poor trait-like alliance

therapist identified difficulty expressing sad feelings as the critical weakness, and chose emotion-focused approaches, relying on affect experiencing as a mechanism of change after testing each of these approaches and monitoring the response. The therapist built on the patient's insight to convey why a fuller affective experience is valuable and how problems in this area limit their well-being. The therapist also built on the patient's trait-like ability to form a strong alliance to collaborate effectively on affect experiencing.

The patient's strengths and weaknesses are connected. Difficulty expressing sad feelings may limit one's ability to be insightful about experiences of loss, and may make it difficult to be empathic with others, which leads to difficulty in interpersonal patterns. Because the ability to express sad emotions makes relationships more satisfying, difficulty in this area compromises the patient's ability to form a close relationship with the therapist. Emotion-focused therapeutic work will likely result in gains in alliance and greater insight as by-products of effective treatment rather than as the driving force of change.

Although the assessment is helped by understanding the patient's core psychodynamic problem, as this suggests a profile of strengths and weaknesses, each patient must be assessed individually. Table 10.2 describes the typical strengths and weaknesses associated with each core problem and the mechanisms that are frequently engaged in the treatment of that problem.

The psychodynamic techniques chosen by the therapist—that is, the therapeutic strategy—may be implemented in an integrative (Wachtel, 2014) or modular manner (Barlow et al., 2017), starting with the weakness that seems to have the most adverse effect on the patient's life. Guided by the assessment, therapists typically try engaging each of the mechanisms likely to be effective and monitor which seems to work best.

Sanjay's therapist did not use clinical or research scales but an impression of his strengths and weaknesses became clear over the first few appointments.

As previously discussed, Sanjay had a particular difficulty in thinking about his relationship with his father. It was hard for him to note the different kinds of feelings he had about his father, and hard for him to imagine what his father might possibly be thinking and feeling. This was a focal area of impaired mentalization. This is clearly a critical area for attention because this capacity is necessary to address Sanjay's issues with shame, guilt, and anger.

Because of the profound conflict he experienced between his feelings and the cultural taboos of his family and community, Sanjay ruminated a great deal about his situation, trying to understand his

TABLE 10.2. Core Psychodynamic Problem and Therapeutic Strategy

Core psychodynamic problem	Typical strengths	Typical weaknesses	Mechanisms of change frequently engaged
Depression	• Courageous • Humane • Emotionally available • Relatable/social	• Limited insight • Immature defenses • Dysfunctional relationships • Aloneness • Affect restriction	• Insight • Better defenses • Enhancing adaptive interpersonal patterns
Obsessionality	• Knowledgeable • Careful and prudent • Hardworking	• Introspective, with limited insight • Affect intolerance • Dysfunctional relationships • Perfectionistic • Ruminative	• Insight • Affect experiencing • Enhancing adaptive interpersonal patterns
Fear of abandonment	• Motivated for relationship • Action oriented	• Poor trait-like alliance • Immature defenses • Dysfunctional relationships	• Therapeutic alliance • Better defenses • Enhancing adaptive interpersonal patterns
Low self-esteem	• Insightful • Sensitive • Motivated to get help	• Poor trait-like alliance • Affect intolerance • Immature defenses	• Therapeutic alliance • Affect experiencing • Better defenses
Panic anxiety	• High trait-like alliance	• Limited insight • Affect intolerance • Immature defenses • Restriction of affect	• Insight • Affect experiencing • Better defenses
Trauma	• Resilience • Stoicism • Introspective • Insightful	• Areas of limited insight • Poor trait-like alliance • Affect intolerance • Immature defenses • Dysfunctional relationships • Ruminative	• Insight • Therapeutic alliance • Affect experiencing • Better defenses • Enhancing adaptive interpersonal patterns

sexual experiences, anger, shame, guilt, and fear. This characteristic made insight-oriented work possible, but difficult, at least initially, because his apparent self-reflectiveness was more rigid and ruminative than free and curious.

Sanjay felt unsafe and anxious in relationships, convinced that he would be judged harshly (as he judged himself), and yearned for a sense of closeness and safety. Although he was cautious and guarded initially in therapy, it became clear quickly that he had a readiness to enter into a new kind of relationship that would be supportive and meaningful. Thus, working on deepening the therapeutic alliance and helping Sanjay have a new relational experience seemed to be a natural fit.

There was a lot of affect in the early sessions, especially fear, shame, guilt, and loneliness. Sanjay tolerated a lot of emotion and it was not clear that encouraging him to feel these painful emotions more immediately and intensely would be helpful. The emotional experiences were already quite powerful and there would surely be more catharsis one way or another.

Sanjay's defenses were predominantly denial, projection, and identification with the aggressor. The self-defeating, and at times self-destructive, behavior was a major problem. He did not have a borderline-level personality organization and did have the capacity for enduring and close relationships. The therapist considered this combination of less mature defenses with underlying personality strength as a target for the fifth mechanism of change: fostering adaptive psychological defenses.

Finally, Sanjay's relationships with his father, his brother, and his romantic partners were conflicted and troublesome. The therapist's impression was that he was motivated for change, but not yet prepared to be able to work directly on the relationships without some preparatory work using one of the other mechanisms of change.

In summary, Sanjay's therapist's therapeutic strategy was to promote mentalizing about his relationship with his father, and focus on the therapeutic alliance, deepening the therapeutic relationship to allow Sanjay to have new experiences of closeness, safety, and validation. When this strategy showed some therapeutic benefit, the plan was to focus more on fostering adaptive psychological defenses and adaptive interpersonal patterns.

This chapter lays out a framework, summarized in Table 10.1, that gives the therapist the opportunity to be systematic in the assessment of strengths and weaknesses and develop a change strategy. But this

strategy is only the starting point, and the best therapist is the one who carefully scrutinizes what is working and what is not.

Sanjay's therapist turned out to be correct that focusing on mentalization and the therapeutic alliance was helpful. The early months of attention to mentalization bore fruit, and Sanjay was much more able to see himself and his father. As the alliance deepened, Sanjay's mood improved and he became less anxious. He struggled with how to deal with his father, and how to address his underperformance at school. There was a shift to fostering adaptive interpersonal relationships as the primary mechanism of change, and Sanjay had more and more honest conversations with his father. He tried to manage his intense shame and anger about his bisexual romantic feelings, telling his father that he needed to understand himself first. Sanjay would not allow himself to follow anyone else's wishes and needs. He asked his father more directly for support and was able to see his father's attitudes and behaviors as the unfortunate result of his background, culture, and time.

Leveraging the Mechanisms of Change

In every journey, there is a plan but obstacles, barriers, and new opportunities present themselves along the way, and persistence and flexibility are necessary to reach the destination. Likewise, the therapeutic strategy shows the way, but the therapist must leverage the mechanisms of change through repeated, persistent, and empathic engagement with the patient. What was traditionally referred to as "working through," we conceptualize as the effective implementation of the mechanisms of change through a flexible therapeutic strategy.

Psychotherapy is a form of emotional learning, and like other kinds of learning, requires repetition and approaching the new ways of feeling, thinking, and behaving from different points of view at different times and in different contexts. The patient must be encouraged and supported to do this work, and the therapist must be just as persistent as the patient in this focused, craftsman-like process.

Fostering adaptive psychological defenses and enhancing adaptive interpersonal patterns are built on the first four mechanisms of change, and are a central part of the therapeutic strategy for patients as they move further into therapy. The basic unit of work is the patient's associations and the reflection on a recent experience and what it meant to them and how they felt about it. We encourage the patient to develop new perceptions based on a here-and-now, more objective, multidimensional way of seeing things. We do not know, and our patients do not know,

exactly what the objective reality is, in comparison with their repetitive scenario-based perceptions.

Traditional psychodynamic psychotherapy is often unwavering in its focus on the patient and tends to eschew speculation about the motives and experiences of others, seeing this as often unknowable and distracting. In contrast, we regard this type of discussion as highly valuable. We think that talking about others in the patient's life improves the ability to perceive and understand interpersonal experiences.

As therapists, we do not set ourselves up as the arbiters of reality, because that is ultimately a capacity we want our patients to develop and improve. We obviously do not just want to replace one rigid way of viewing the world with another. However, we are often able to think of and suggest alternative ways of perceiving the situations our patients tell us about—what we think might "really be happening." Our role is to suggest alternatives, model flexibility (Borkovec & Sharpless, 2004), and help patients improve their own abilities to generate and evaluate these alternative ways of experiencing their lives.

We help patients change and find new ways of feeling, perceiving, and behaving. The old ways have a particular feel to them, and patients learn to recognize these feelings and put them in their place: in the past. New perceptions are based on current adult realities, and are often recognized by the fact that they feel different from the same old feelings. In the beginning, patients notice the difference between their old perceptions and new realities considerably later than the moment when the feelings are triggered. Further along in treatment, they come to recognize the disparity soon after the triggering experiences. Ultimately it becomes a more instantaneous process. This skill, like the ability to ride a bike or catch a ball, is something that can be developed with repetitive practice, and it requires discipline and focus. Initially it requires much conscious attention and a sense of hard work. With time, it becomes a part of the patient, a capacity that is present even when the patient is not aware of it.

With mentalizing abilities, greater insight, a stronger therapeutic relationship, and an increased ability to tolerate painful feelings, patients can try new behavioral responses, engaging more mature defenses and healthier interpersonal patterns. These new responses often call upon social skills and capacities that may be evident in the areas of the patient's life less pervaded by conflict. Patients often are able to come up with new strategies themselves, but we are not afraid to suggest new behaviors for patients to consider.

Traditional psychodynamic psychotherapy tended to let patients struggle with their difficulties and encourage new behaviors when patients tried them. In contrast, we encourage collaboratively hatching

new plans and guiding and encouraging patients to try them. Of course, there is a concern about stimulating a power struggle, infantilizing the patient, and reproducing earlier traumatic situations by "telling a patient what to do." New behaviors are considered, not forced, and attention is paid to the potential for deforming the treatment relationship in a way that will undermine the therapeutic alliance. Nonetheless, we believe the potential therapeutic impact of working actively to develop a new behavioral repertoire outweighs the risk of the therapist enacting old patterns.

> Sanjay had a deadline for completing his graduate thesis project. For most of his time in graduate school, he had experienced this deadline as a massive demand that was going to be difficult to meet, and he worried about punishment and expulsion from the program. He was anxious, angry at the pressure, and showed many signs of responding in his characteristic fashion—avoidance, withdrawal, passivity—which would surely bring out the feared result. By this point, Sanjay was feeling better, and had more confidence and a greater sense of self-worth. Using the opportunity created by a strong therapeutic alliance, the therapist suggested the need for new behaviors, pointing out that feeling differently takes a person only so far. What are some possible ways of handling the same old dilemma differently?

When the patient tries something new, then therapeutic attention is focused on how it felt, what was different, how the patient perceived things differently, and how the others in the scenario acted differently. This is empowering for the patient and often a moment of significant therapeutic change. It is the cart before the horse, in the sense that the patient has tried a new behavior that feels strange and foreign, and not natural to the situation. The patient can consider what was different from the usual response. Was there less distress, a different outcome from the interaction? Often trying one new behavior opens up the possibility of other approaches. An interpersonal situation that had seemed immutable and fixed starts to be a problem that can be solved—the patient is emboldened to bring attention to bear and improve it. Indeed, trying new behaviors often enhances patients' motivation in treatment.

A positive cycle develops when new behaviors succeed. They support and extend the patient's sense of self as capable of change, effective, and able to manage painful emotions. They validate the more adult and realistic aspects of the patient's perceptions and further reinforce the childhood origins of repeated upsetting experiences. Thus, better defenses and more adaptive interpersonal patterns help to secondarily improve mentalization, increase insight, enhance state-like alliance, and tolerate painful affects.

New and more realistic ideas about others in the past and the present develop under these circumstances. All of these trends give rise to increased flexibility in thought and feeling and a readiness to embrace the world in a more positive light. Sanjay felt much better when he realized he was able to break his thesis work down into more attainable pieces, and experienced his work more as something he owned than something foisted upon him.

A special circumstance of this type of learning occurs when a demoralized patient experiences a breakthrough in subjective experience. Sometimes this happens by design: A planned new behavior produces a surprising and positive result. Sometimes accidents occur. Either way, the new positive affect has the effect of shaking the patient, causing a kind of motivational tipping point, and creating a new openness to change. Martin Seligman (2002) has referred to this "break in the clouds" as an important element in the treatment of depression.

SUMMARY

The change patients want from psychotherapy starts with the trust they begin to feel in their relationship with the therapist, allowing them to uncover and explore painful feelings in a new context. There is a wide range of psychodynamic therapy goals, including symptom relief and extending to a greater sense of freedom and creativity.

A therapeutic strategy that relies on engaging one of six mechanisms of change—mentalization, fostering insight into unconscious conflict, therapeutic alliance and new relational experiences, affect experiencing, fostering adaptive psychological defenses, and enhancing adaptive interpersonal patterns—moves the therapy forward. Therapists plan the therapeutic strategy by assessing patient strengths and weaknesses, relying on the core psychodynamic problem, and closely monitoring their choices to see what works for individual patients. The inchoate process of "working through" involves leveraging these mechanisms through practice and repetition, resulting in new perceptions of self and others and new behavioral responses.

11

Therapeutic Moments

Emotions in Psychotherapy

We do not remember days, we remember moments.
—Cesare Pavese

Psychotherapy is a series of moments of attachment and engagement. It is a new kind of relationship for the patient (and the therapist). There are moments of particular intensity that stand out and have a great impact on the patient (and the therapist). The empirical literature speaks of the therapeutic alliance as the most robust predictor of outcome (Flückiger et al., 2018), and the bond component of the alliance in particular is built up through moments of contact. In this chapter, we describe some of the characteristic moments that occur and suggest how to facilitate them. Although every patient–therapist pair is different, there are some characteristic moments that occur when therapy is going well.

CLOSENESS

There are moments of closeness and understanding. The patient is open, expressing themselves, feeling engaged in the here and now, and the therapist is responding fully. There is a quality of immediacy. It feels good for both participants, and they feel that something important is going on. This closeness usually occurs because a patient is talking about themselves, in specifics, about something emotional and particular (not global and observational), and the therapist feels they understand what the patient is feeling (Luborsky, 1984). It is about particulars, not

generalities. Something mutual develops in the verbal and nonverbal interaction.

> Owen, a mistrustful young White cisgender man who felt constantly inferior, manipulated by women, and one-upped by men, had been in therapy for 2 years. He was tall and thin, with short, reddish hair and an intense gaze. He worked as a lab technician and wanted to be a research scientist. Owen began to recognize that his feelings of competition and manipulation were projections of his own insecurity and anger. As vignette after vignette was discussed, he began to catch himself and genuinely understand that his reactions to others were driven by his old feelings about his father, mother, older brother, and stepmother.
>
> One day, after Owen described a workplace intrigue, I commented that his coworkers certainly had their personal motives, but he was interpreting their behavior according to the old template. I agreed that the older man in the office did treat him like he was at the bottom of the pecking order, and there was a woman who seemed secretive and scheming. But he was doing a good job, I said, and it seemed that in reality he was safe from his coworkers. Maybe the problem was his own feelings about his work, his tendency to experience his work colleagues like his parents (and stepmother). I said I thought he was able to see this now, and in seeing this, he really had to acknowledge his dreams and aspirations, his anxiety about whether he could fulfill them, and how his complaining about others served as a defense against these anxieties.
>
> There was a long silence, during which Owen looked at me, and time slowed down. I thought maybe I had overreached, said too much, or made him feel criticized. Maybe he was hurt and had detached, or maybe he was just very moved. Finally, he said softly, "I'm scared because I don't know if I will be ever be able to do what I really want." This time, I left a long pause. I did not know what to say, and then realized that I did not have to say anything. It was Owen's moment, his facing his own fears, and I was there with him. I felt like I knew what he was feeling, and that I'd seen him more clearly than ever before. I felt an intense sense of connection and closeness. The room seemed to disappear, and for a moment, it was just the two of us contemplating what was before him.

Moments of intense closeness such as this are exciting and potentially anxiety provoking for both the patient and the therapist. One hopes they allow the patient to feel known, accepted, affirmed, and perhaps loved. The therapist, too, may experience something redeeming

and transformative about these moments, making them feel special and unique, yet humbled by the universality of people's struggles. These moments of increased rapport indicate that therapy is on the right track (Malan, 1979; Muran & Eubanks, 2020).

The positive feeling of closeness and understanding usually improves the mood and level of attention of both parties. Fredrickson's (2001) experimental studies suggest that positive mood is accompanied by an increased capacity to consider alternative strategies for problem solving, and this undoubtedly also contributes to the therapeutic effectiveness of these experiences.

Moments of closeness and understanding may seem ineffable and hard to reduce scientifically, but as Louis Pasteur said, "Chance favors the prepared mind." Ongoing attention to the patient's feelings, awareness of one's own, a consistent effort at understanding the patient's repetitive patterns, and enough flexibility and spontaneity allows the therapist to make the most of these moments when they occur, and perhaps make them more likely.

LOSS

One therapist described being with a patient who is experiencing loss as follows:

> "Much of the time in sessions (but certainly not always) I feel calm and emotion filled but not overwhelmed or confused. There is a sense of being a vessel that fills and empties—I listen, empathize, imagine, feeling but not reacting too much. If I am sad, I will be sad with the patient; if I feel loss, I think about things I feel I have lost. If irritated, I usually realize it is my limitation, though stirred up by something the patient is doing. Above all, I try to stay close, connected, feeling, engaged, but aware that what the patient is feeling is not me."

When a patient is contemplating feelings of sadness, loss, or limitation, the therapist has a poignant, sad feeling, too, prompting them to reflect on their own losses, separations, traumas, and the passage of time. These moments usually have a fresh feeling for the patient—until now, the sadness has been avoided, but the patient lets it in, realizing that it hurts but that it is not so bad. Most patients are frightened of feeling sadness and loss. Feelings of loss are no more and no less than that—they are feelings about something that has already happened.

A young man suddenly lost a father-like figure who was a steady source of support during his childhood and early adulthood; this was just a year after losing a favorite aunt. This patient's mother died when he was a young child, and he was alienated from his father. When he told me about the sudden death, I teared up, experiencing these losses with him. In this case, I did not say anything, I simply sat there with him for a few minutes quietly.

Patients will usually see a gradual diminution in the intensity of sadness and loss. The feelings will become more of a familiar companion, present but not as disruptive, less terrifying and overwhelming. The therapist often feels a sense of satisfaction and comfort in observing this trend in a patient, and it is usually a sign that the therapy is moving forward.

But sometimes the sadness is so intense, and so deep, that it does not get better after talking about it. This is often the case in patients with attachment problems, self-esteem problems, or those who are so mired in depression that there is no way out yet. The biggest challenge for the therapist here is tolerating the shared feeling of sadness. We are all vulnerable to feeling overwhelmed by loss, we all feel it, and it might be the hardest emotion to keep in perspective. There may be plenty of moments when those of us who are merely mortal therapists will have difficulty tolerating this, and we defensively avoid the feelings of loss.

Most patients do not want to be convinced out of their sadness too quickly—others have usually tried to encourage them before. Some degree of empathic mirroring and encouragement is necessary for them to get somewhere. Intense sadness gets either better or worse with therapeutic attention. If it is not getting better, likely it will get worse; affect-amplifying, empathic attention to feelings of sadness and loss may be stressing the patient's ability to cope, and the therapist must find another path. The strategies for change described in Chapter 10 include a range of alternative approaches for this. The therapist must make a strategic decision in moments of loss about how much to empathize and share the feeling, and how much to help the patient manage and mitigate it. These are not mutually exclusive but it can be confusing to do both at the same time.

TRAUMATIC LOSS

Sometimes the loss is very fresh and recent, or so profound and overwhelming, that the experience is a traumatic loss. The patient's shock,

disbelief, or dissociation makes the moment something more than mourning and grieving. In the discussion of the core psychodynamic problem of trauma in Chapter 6, we discuss the therapeutic approaches needed for trauma to create an atmosphere of safety, trust, and truth telling, and the potential resistances, transferences, and countertransferences that may evolve.

Patients experiencing trauma and traumatic loss will, sooner or later, need to express what happened and how they feel about it. This is usually very painful, frightening, and overwhelming for the patient and often for the therapist, as well. Both people need some preparation for this moment. Despite our best intentions, we are usually quite defended against hearing about our patient's traumatic experiences. Typically, it's terrifying, reminding us of our own vulnerability and inability to control our circumstances. It can bring up our own experiences of trauma, or traumatic events we have witnessed or may have helped to cause. Detachment and dissociation are typical responses, and it may take time and thoughtful self-reflection to see the secondary effects the patient's trauma has on us.

What is it like to be with the patient as they relive their trauma loss? It is raw and often has a feeling of being "out of time," in the sense that both patient and therapist are intently focused on something that feels very immediate but happened some time ago. There are intense feelings of anger, fear, shame, and disgust that must be processed for both parties. Ultimately, the patient often has a deep feeling of being known and accepted; they may feel validated and acknowledged in a new and more profound way than they have before. They are often saddened and wiser. Therapists may feel a sense of accomplishment—they have done something very hard and it has been worth it. They may feel tired and troubled by the badness in the world, or the unpredictability of life. They may feel especially close to the patient, feeling empathy and respect, and relief that the trauma has not happened to them. There can be a feeling of fragility and the wish to bolster and protect one's own life.

JOY

On the other side of the continuum are experiences of positive emotion: laughing together, sharing joy at a fortunate event in the patient's life, feeling intense admiration or respect for the patient, even a form of love. Sometimes these moments come in the context of closeness and intimacy, but they may occur because of the positive emotional tone of what is being discussed or because something positive has occurred between patient and therapist. One patient discussed some wonderful

career successes and moments of breakthrough positive feelings about his wife and family. His pride, joy, and love were palpable in the session and caused a similar response in the therapist. Another patient had a remarkable daughter, and news of her latest successes was always a shot in the arm.

Joy is open, inclusive, emotional, and arises from union, connection, serenity, and acceptance (Vaillant, 2008). Joy should increase with therapy.

> Ann was a cisgender White woman in her mid-50s whose mother had several bouts of depression during Ann's childhood. Over the course of therapy, she realized that she loved her mother and felt very close to her, yet she had tremendous buried anger toward her because of her unavailability during long stretches of her childhood. Ann was anxious about any angry or critical feelings in herself, fearing that such feelings were unacceptable and dangerous to others. She worked terribly hard to maintain an upbeat attitude toward her mother, and indeed toward everyone, and pushed herself to care for her now-aging mother despite her negative feelings. In fact, Ann was a model daughter. But she wondered whether she really loved her mother, or was just doing her duty.
>
> Ann was a warm and kind woman who maintained a careful distance in the therapy. After several sessions in which I confronted her directly about her ambivalence toward her mother and her fear of acknowledging any anger lest she feel like she would explode with rage, she unexpectedly saw her mother at a distance in the local supermarket. Ann's mother was at the far end of an aisle, and Ann watched her unobserved for a moment. As though seeing her anew, Ann felt a powerful surge of love and affection, seeing this older, stooped, gray-haired woman carefully choosing groceries. Gone were the burden and obligation. Instead she felt, and knew instantly, that she really did love her mother. Ann was deeply contented, indeed joyful, to realize with certainty how much she loved her mother, and how fortunate she was to have her. As she described this experience, her love emanated from her, and I was filled with a similar feeling. I simply commented that she seemed to love her mother very much.

Positive emotion can come from the patient or the therapist. It is almost always infectious and shared. We know that patients can have strong positive feelings toward therapists—that is, positive transference based on positive relationships from the past, or based on ambivalent relationships that are too painful to experience in their entirety. Positive transference is transient and unstable. Joy in the therapeutic relationship is irreducible, based in the here and now, and usually increases over time.

The culture of psychoanalysis, and its trickle-down into the culture and technique of psychodynamic psychotherapy, does not place great stock on the value of expressing positive emotion in treatment. It is seen as risky because the patient may misunderstand, the therapist may take license in expressing private countertransference feelings, and boundaries may be crossed. When it comes to positive emotion, the traditional view seems to be that less is more.

We question this view and wonder whether it cuts off the therapeutic lifeblood of positive affect. Positive experiences are often what patients remember, what they like, and what causes them to refer others for psychotherapy. We suggest that moments of positive emotion help to grease the wheels of change. This may be particularly powerful with a therapist who generally restricts expression of positive emotion, but perhaps it is just as effective when the therapist is frequently warm and positive. Certainly there are limits to appropriateness, and the mutual experience of positive feelings should respect the boundaries of the relationship, a professional one determined and limited by the goals of the patient feeling better. The warmth and affection of a good therapist is more like the love of a grandparent than the emotional intensity of a parent or partner.

The positive emotional experiences that occur in psychotherapy are just not written about much or talked about in professional venues. In fact, they are probably an essential staple of good psychotherapy (whether psychodynamic, cognitive, or behavioral). They are part of the art, not the written procedure.

DIFFICULT DECISIONS

The psychotherapy relationship is generally a collaborative one (e.g., Bordin, 1979), and optimally each partner does their part. The patient talks about feelings and thoughts, stepping back and reflecting, trying to consider alternatives and new behaviors; the therapist listens, focuses, and empathizes. But there are particular moments when the patient is at a fork in the road, with an important decision to make, or struggling with whether and how to approach a situation in a new way. The patient wonders whether to sleep with someone for the first time, to quit a job and pursue something new, or to take a stand against an old familial pattern. The therapist may or may not have an opinion but feels a great sense of responsibility. What we say might really matter.

There is a particular poignancy to this moment. The feeling that something very important is at stake, and a choice must be made, is powerful and even awe inspiring for the therapist. It is a moment of

potential change. Like other emotional moments, this one is so resonant because both participants feel the significance of time passing, directions chosen and forgone, and hope for the future tempered by sober respect for the unknown.

In the end, it is always the patient who makes the decision, yet what the therapist does is never entirely neutral or dispassionate, nor should it be. The more your patient is choosing among reasonable alternatives, the more hands off and facilitating of their independent decision-making process you can be. The more the choice the patient is leaning toward is unhealthy or unreasonable and the patient's perceptions and reasoning are distorted, the more important it will be to exercise your responsibility by offering perspective and guidance.

THE ABSURDITY OF LIFE

Life is not fair, and sometimes patients are served such a big helping of bad fortune that it triggers a powerful feeling of meaninglessness and sense of the absurdity of life. This is usually a therapeutic moment, too, because to experience absurdity means feeling that there is no dark and personal reason for unfortunate events (this kind of perception is usually the basis for a psychological problem).

The therapist's stance is to enthusiastically recognize and appreciate the patient's experience of absurdity; this is not usually difficult because it is so palpable. This moment does not require anything complicated from the therapist; it has a built-in therapeutic quality to it. The patient is feeling a release from the sadness and pain of whatever has happened, liberated by recognizing the absurdity of it, and the therapist need only be open to it to share it.

A more superficial version of this occurs when you and the patient smile together about something absurd in the therapy situation, such as an elevator in the building that breaks down, bad traffic, a tickle in the throat that won't go away, running out of Kleenex, or dealing with insurance companies.

ABOUT THE THERAPY

There is a wonderful moment that comes when you and the patient see their new life narrative together. Sometimes the narrative follows the therapist's interpretation of an event and its connection to the patient's larger developmental arc, and sometimes it follows from the patient's proposed synthesis. The feeling of seeing the same thing together and the

sense of satisfaction that results from beholding a deep, pervasive pattern come together in a moment of collaborative closeness—we did this together! This is not the deep emotional resonance of empathic communication; it has a different feel. It feels more like the satisfaction coworkers feel about a difficult job well done.

Sometimes patients are frustrated with therapy because it is slow, uncomfortable, expensive, and the results are uncertain. They may have transferential reactions that make the therapist seem rejecting, cold, or unhelpful. This leads the therapist to feel anxious, defensive, or frustrated in return. The therapist can respond with increased conviction, feeling the frustration is the patient's problem, certainly not the therapist's. This retreat to arrogance is, sadly, a common reaction. Learning not to engage in this automatic response is one of the most important interpersonal skills novice clinicians must develop. Alternatively, therapists can become anxious and uncertain and try to appease the patient by placating and minimizing the conflict.

TRANSFERENCE AND EMOTION ABOUT YOU

Telling another person how you feel about them is usually restricted to close, personal relationships. But our patients have feelings about us, and it is important to help them share these feelings. Therapy is an unusual opportunity for honesty and directness; you and your patients will talk about things that are present in ordinary conversation but unacknowledged. It is a privilege and a skill for a patient to be able to express their feelings about the therapist in therapy.

It can feel awkward for new therapists to inquire about patients' feelings about them. It seems presumptuous, like indulging in narcissism or fishing for compliments. But simple inquiries about how the patient is feeling, followed by encouragement that discussing such things is not weird or inappropriate, usually works. A patient's expression of emotion about you is a moment that is different from closeness, loss, or the other moments we have discussed. It is less mutual than some of these other moments. You are likely reacting and absorbing the patient's affect, or feeling detached and conceptualizing what is going on.

Patients' feelings about you are related to the here-and-now relationship, the therapeutic alliance, and to old feelings revived in the present. It is gratifying when the patient expresses trust, respect, and confidence in the therapy and in their relationship with you. But there may also be criticism, either direct or implied. Observations about your personal characteristics are as likely to be positive as negative. You will need to

listen carefully and accept what is said, with the assumption that it is true because it is how the patient feels.

Sometimes patients consciously withhold their feelings because they are embarrassed or frightened. Often, they unconsciously withhold because they fear rejection, dependency, vulnerability, or competition. When the patient's reaction to you is based on something painful they are feeling but not able to name, articulating the feelings often helps. It may be therapeutic to reflect back to a patient that they seem to feel rejected by you, or irritated with you, or misunderstood; your awareness of those feelings helps the patient to feel understood. This can help diminish the patient's fear about expressing themselves.

When a patient is talking about you, you need to step back, simultaneously feeling and observing. The best way to respond to a moment of emotion about you is to feel your response, know what it is, and not act on it right away. You will have your own personal emotional reaction: pride, pleasure, hurt, anxiety, sadness, anger. But feelings you have about the patient that are not based on admiration, respect, and empathy are best held in awareness and felt, rather than expressed or acted on. Of course, it is impossible, both theoretically and practically, to not act at all; we are human and have feelings, and these are inevitably communicated. But it is our responsibility to hold our reactions in check, to reflect and not to act out. It is our responsibility to make the patient comfortable exploring themselves, while we find ways of tolerating it.

MISTAKES

As therapists, we inevitably make mistakes, such as forgetting important information, mixing up the appointment schedule, and making insensitive comments. Mistakes can often be subtle, too, such as attending to one issue over another that might be important, or being distracted and not paying full attention for part of a session. Although these errors are inevitable, they often cause therapists much guilt and self-questioning. Therapy can look easy—you just sit and talk with someone—but it requires consistent focus that is hard to maintain. We therapists have moods, subjective responses, waxing and waning attention, personal interests, and sensitivities. It is valuable to examine a mistake to see whether there is any new information that it brings to your attention. Mistakes may reflect countertransference. For example, did you mix up the appointment because you had an urge to avoid the patient, and if so, why would you feel that way? Did the patient communicate disinterest in the therapy or dislike of you? Did you forget to charge a patient, hoping it would induce them to like you more?

A mistake and its discovery cause both therapist and patient to stop and pay attention. In fact, part of why attention to mistakes is so valuable is because immediately afterward you are both paying close attention to each other (Casement, 2002). We discussed alliance rupture and repair at greater length in Chapter 4. A mistake and its repair are therapeutic moments when the mistakes are rare. When mistakes are frequent, they are not therapeutic and there is a problem with the therapist.

It is almost always the best course to acknowledge a mistake. In the discourse of everyday life, when one makes a mistake, one apologizes. This signifies recognition of the impact the mistake has had on the other person and acknowledges responsibility. Apology usually helps to set the therapeutic relationship right, but only when you understand what it meant to the patient. You must ask the patient how they felt about the mistake and about your apology. If therapy is fundamentally about helping a patient develop a new, better, and more accurate narrative, truth telling and acknowledgment of responsibility are essential qualities. When the therapist cannot do this, the patient will be less emboldened to try. Of course, apologies should not be made for the therapist's sake, to decrease guilt or avoid thinking about what drove the error. You should think about what would comfort you if you were a patient, and what would repair the breach of confidence and safety. It is usually helpful to ask the patient how they felt about your apology.

A teenager with repeated self-defeating behaviors was so stuck in a cycle of depression, resentment, and rejection that I became frustrated. The patient was 17 years old, cisgender, Latina, and depressed. After she described yet again drinking too much, finding herself in a potentially dangerous situation, and seemingly not caring about protecting herself, I lost my composure and got critical. I really showed my irritation, and feelings of frustration and annoyance. Feeling guilty, I discussed my outburst with several supervisors, teachers, and colleagues. I knew it had been a mistake, and my degree of frustration indicated that I had lost my focus on empathy and let my personal feeling of ineffectiveness come to the fore.

I was ready to apologize at the next session when the patient showed up 15 minutes late. She looked depressed and disheveled. She had difficulty saying much. I expressed my regret and remorse at being short-tempered in the previous session, and the patient cheered up remarkably quickly. Later in the session, she said that my anger made her feel like I cared for her. No one else took her feelings that seriously. This was a turning point in the therapy and subsequently she began to speak more openly about her feelings and fears. With this increased connection, she commented on the racial and cultural

difference she experienced with her White male therapist. As we explored how this made her feel misunderstood and disappointed yet again in her life, I became more aware of how much I felt unhelpful and confused. This further opened the door of mutual positive regard, and the greater comfort in the patient allowed me to ask why she was so self-defeating.

Of course, we do not advocate that therapists yell at patients or make other therapeutic mistakes. Rather, we can see that a mistake has important implications for an individual patient when it is part of a consistent, understanding, and accepting treatment. It is our job to do our best to make the mistake into something positive and useful.

The old worry about apologizing is that it might preclude a deeper discussion of motives and reasons and make it harder to understand the patient's conflicts. But expressing something positive, like an apology, support, and validation of harm, does not preclude the exploration of something negative, such as the patient's hurt or anger.

SELF-DISCLOSURES, BEING PERSONAL

A favorite supervisor once said that a therapist should show a patient the same courtesy, respect, and interest you would show to someone you are seated next to at a dinner. Above all else, be normal! This advice extends to handling personal questions and self-disclosure. Of course, the therapy is for the patient and about the patient, but you cannot expect a patient to become comfortable talking openly and honestly if you do not show some signs of getting engaged.

Another way to say this is that any interaction is like a song, with words and music. The words are a literal part of the interaction, but the music is the part that is emotional, attached, and rhythmic; without the music, the song is just a bunch of words. The therapist must experience and express feelings to make the therapy more than a bunch of words. The therapist should say as much as is necessary, but as little as possible to avoid distraction. One therapist said:

> "When patients ask where I am going on vacation, I tell them. When they ask who is coming along, I will usually answer that, too. Leave-taking is part of life, and this topic is more likely to shut down if I don't provide the information than if I answer it. If a patient goes on to ask what I will be doing, what the place is like, and so on, then I will ask how they are feeling about the vacation, what they are wondering about me and my life. Telling the specifics about

my vacation is not likely to help the therapy much, and it might make for distraction; also, I've already answered some questions, so I have maintained a genuine engagement with the patient. When questions are pursued to this degree, it is usually based on the transference and fantasies about the therapist, and that is probably where the attention should then be focused."

Comments about here-and-now aspects of life, what neighborhood the therapist lives in, whether they've seen a recent movie, whether they have children, where education or training took place, are all part of "being normal." Furthermore, by answering some of these questions, the therapist can justifiably inquire about the meaning of the patient's curiosity.

Expressing sad, affectionate, joyful, and concerned feelings about the patient is appropriate when genuine. Positive emotions are almost always appropriate to express, while negative ones are rarely constructive. Irritation and resentment are usually problems of the therapist, not the patient. The therapist needs to work these uncomfortable feelings out, and one must be very judicious in expressing them. Sometimes it is constructive to express negative feelings about a patient's behavior, asking whether others may have reacted this way—for example, "I felt like you pushed me away after you broke down and cried; I wonder if others have felt this."

If your negative feelings are powerful and interfering, then consultation with a colleague is invariably the best course. We discuss ways therapists use their strengths to manage uncomfortable emotion at greater length in the next chapter, Chapter 12. Usually, discussion and understanding are enough to tame these negative emotions so that you will be able to use them constructively. If not, then the patient should probably be referred to someone who will like them more; at that point, it's just not a good match.

SUMMARY

The experiences of emotion and connection we have discussed here do not do justice to the many types of experiences you can have with your patients, but they are some of the most common and powerful ones. These therapeutic moments help to increase the bond between the patient and therapist, and they are central to several of the mechanisms of change in psychodynamic therapy.

12

Therapist Strengths, or Managing Your Countertransference

> People seem not to see that their opinion of the world is also a confession of their character.
>
> —Ralph Waldo Emerson

In the last few chapters we focused on the building blocks of therapy: formulation, goal setting, facilitating change, and therapeutic moments. But to be effective, a therapist must be able to move beyond these building blocks. It is the instantaneous reactions you have that will transform a conversation with the patient into therapy. The therapist's personality strengths and how they are applied will make for a "therapeutic" demeanor and will help to bring about therapeutic moments.

Marjorie was a 63-year-old White widow suffering from depression and anxiety. She called initially for medication advice and then began to call for reassurance approximately three times a day. She complained when phone calls were not returned promptly (i.e., within an hour or two). Marjorie repeatedly described her fear, aloneness, and terrible nausea, often like she was telling me about it for the first time. Sometimes she was irritable. She seemed to have a great deal of difficulty with self-sufficiency.

Marjorie had a weekly appointment, where we focused on her difficulty functioning while addressing her sadness and loss. She wanted multiple appointments over the week, feeling that this was the only thing that would help her. She also needed to know that I was there, and would be able very quickly to answer her calls. Often, Marjorie brought up the possibility of seeing a different therapist.

I could certainly see Marjorie's ongoing depression and anxiety, and her pattern of repetitively seeking encouragement. I understood that she was resentful about being denied constant comforting reassurance. I felt compassionate and concerned, and I returned her calls and responded to her worries, hoping this would reassure her and decrease her anxiety about starting treatment. I had the feeling that the calls would slow down as she felt that I was responsive. I met with her twice a week for a few weeks.

But the calls kept coming, sometimes three or four times per day. I was more and more annoyed by the number of calls and the complaints Marjorie made. Hers was a dependent transference, and at times even a hostile dependent transference (she was both dependent on and angry at me). After a while, it evoked an irritable and rejecting countertransference feeling in me.

Several times I tried to tactfully bring up the possibility that this pattern was similar to what happened in other relationships (Marjorie's grown children from whom she was estranged). She was very insulted and almost quit treatment. I was sure it was not going to be helpful to discuss my negative feelings about the interaction with her, and I realized that any continuing attempt to provide this insight to her was really just an outlet for my irritation.

Instead, I expressed support and reassurance and reminded Marjorie that the symptoms would probably get better, as they had in the past. I gave firm guidelines about how she should take her medication and answered most but not all of her calls. She seemed to feel better when I was warm and reassuring, and greatly appreciated the sense that I was trying to take care of her, despite the fact that she frequently felt upset that no one was helping her.

I reassured Marjorie that I thought she would feel better and suggested that the terrible loneliness and the physical symptoms of nausea were how she felt when she was dislocated, lonely, and worried about the future. I told her I would try to help her to feel better and find better ways of dealing with the loneliness and misery, and I tried to do so in a direct, calm, unpatronizing tone. I kept one foot in the relationship, feeling worried about her intense loneliness and anxiety, and one foot outside, regarding her as a patient who was going through something she would look back on in 6 months with a different perspective. I expressed optimism and hope about the future and said that she still had so many things to look forward to and enjoy. All the while, I encouraged Marjorie to engage in activity and have a social life and healthy time alone.

Marjorie took these comments in and continued to express her feelings of loneliness; she continued to call, but less frequently. She picked up her social activities a little and started playing golf again.

Majorie still felt just as badly and complained that I was not really helping her enough. But she also expressed her appreciation for the therapy, and said, "Thank God I've at least got this to come to each week."

In this vignette, the therapist's personal qualities—steadiness, knowledge, warmth, genuineness, optimal distance, and optimism—were used to stabilize, support, and "contain" the patient. The strengths were present in the therapist's tone of voice, body language, and informal comments. These qualities helped to provide Marjorie with a considerate response to her distress, unlike the frequent responses of others in her life. The therapist was able to resist becoming part of a destructive and rejecting enactment, and Marjorie had a new and more positive experience. Although this example involved a primarily supportive phase of therapy, these strengths are just as useful in more directly exploratory work.

EFFECTIVE THERAPISTS

Given how important the personal qualities of the therapist seem to be, it is striking how little is known about what makes for an effective psychotherapist. Demographic variables are not very predictive, nor are theoretical orientation, supervision, amount of professional training, and practice variables (Wampold & Owen, 2021). There is even conflicting evidence for the positive impact of therapist experience on outcome (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Hupert et al., 2001; Propst, Paris, & Rosberger, 1994).

There is, however, a therapist effect, meaning that therapists differ significantly in their patient treatment outcomes. Baldwin and Imel (2013) found a therapist effect on treatment outcomes of approximately 3.0% in their analysis of 29 clinical trials, while 17 naturalistic studies showed a therapist effect of 7.0%. Johns and colleagues (2019) found that the therapist effect averaged 8.2–17.4% in RCTs and 5.0% in naturalistic studies.

The therapist contribution to the therapeutic alliance is statistically significant after controlling for a variety of confounding variables, with the suggestion that some therapists are more effective at promoting stronger alliances (Del Re, Flückiger, Horvath, & Wampold, 2021) and early gains in therapy (Erekson, Clayson, Park, & Tass, 2020). Especially relevant to this chapter, therapist responses to difficult moments in therapy seem to relate to their effectiveness (Anderson, Finkelstein, & Horvath, 2020) and their capacity to work with culturally diverse clients (Hayes, McAleavey, Castonguay, & Locke, 2016).

Therapist cultural competence has been investigated through research on the relationship between therapist cultural sensitivity training and patient outcome. These studies found consistently high

effect sizes (Evans, Acosta, Yamamoto, & Skilbeck, 1984; Thompson, Worthington, & Atkinson, 1994; Wade & Bernstein, 1991), as reviewed by Beutler and colleagues (2003). Negative treatment outcomes may come about because of microaggressions, which are a form of alliance rupture (DeBlaere et al., 2023).

Therapist self-disclosure shows statistically significant but clinically weak positive effects on outcome (Barrett & Berman, 2001; Piper, Joyce, Azim, & McCallum, 1998; Piper, McCallum, Joyce, Azim, & Ogrodniczuk, 1999). More recently, Constantino, Boswell, and Coyne (2021) found therapists' self-disclosure and management of countertransference are associated with positive outcomes.

A recent meta-analysis suggests that therapists' use of interpretations is significantly associated with better treatment outcomes (Zilcha-Mano, Fisher, Dolev-Amit, Keefe, & Barber, 2023). There is also increasing evidence for the relationship between competent delivery of a treatment and good outcome (Barber, Crits-Christoph, & Luborsky, 1996; Barber, Sharpless, Klosterman, & McCarthy, 2007). A few studies report significant effects on treatment outcome of adherence to a treatment manual (Bein et al., 2000; Feeley, DeRubeis, & Gelfand, 1999; Kendall & Chu, 2000). But Webb, DeRubeis, and Barber (2010) conducted a meta-analysis and found no overall correlation between adherence and outcome or between competence and outcome. Barber and colleagues' (2006) report of a curvilinear relationship between adherence and outcome is a possible explanation for this. They found a better outcome with a medium degree of treatment manual adherence than a low or high degree of adherence.

This brief review suggests that there are important therapist qualities that show up in process studies of psychotherapy and relate to alliance formation and handling difficult moments in therapy. Our focus on therapist strengths provides a way of targeting these qualities to help therapists to learn a way of being, not simply learn a technique. In the remainder of the chapter, we look at how a therapist pays attention in therapy sessions and therapist personality strengths and specific approaches for using these strengths to manage the difficult emotions and challenging moments.

Effective Therapists: Empirical Data

- Therapist effect, the variability of outcome based on the therapist, averaged 8.2–17.4% in randomized control trials and 5.0% in naturalistic studies (Johns et al., 2019).
- Demographic variables, theoretical orientation, supervision, amount of professional training, and practice variables are not very predictive of effectiveness (Wampold & Owen, 2021).

- Therapist contribution to the therapeutic alliance is statistically significant (Del Re et al., 2021).
- Negative treatment outcomes may come about because of microaggressions, which are a form of alliance rupture (DeBlaere et al., 2023).
- Therapists' use of interpretations is significantly associated with better treatment outcomes (Zilcha-Mano et al., 2023).
- Therapists' self-disclosure and management of countertransference may be associated with better outcomes (Constantino et al., 2021).

PAYING ATTENTION

When the therapist's telephone rings or their cell phone chimes with an arriving text during a psychotherapy session, of course we should not pick it up. To do otherwise would pull the therapist's attention away from the patient, and this would likely be an upsetting interruption. But what else do we know about where the therapist should direct their attention in effective psychotherapy?

Freud (1912) spoke of the "evenly suspended attention" of the psychoanalyst, characterizing a kind of relaxed and flexible shifting of attention to what the patient says and does, and the internal feelings, thoughts, and fantasies of the analyst. The Freudian analyst is caricatured as a distant and unengaged presence, but this concept of listening to the patient and to oneself is actually quite strenuous and requires a lot of engagement.

The patient's emotional state is the most important thing to pay attention to. Emotions may be expressed verbally or nonverbally. There is usually one dominant emotion experienced at any point in time, and the therapist should focus on this—whether it is sadness, loss, anger, longing, anxiety, or pleasure. The therapist should be aware of it, observing it and watching for shifts and changes. Usually the patient is aware of the feeling the therapist senses but not always.

Like the faith healers who held their hands over the sick person's body, "feeling" for the illness, we metaphorically try to sense the emotional hot spot in the patient's experience. Learning to do this is learning to simplify one's perceptions; there is an overwhelming amount of detail to observe about a person, and there are momentary shifts in topic, attitude, and body language. Sensing the dominant affect is like squinting while looking, so that only the broad outlines are clear. Patients get lost in their own complexity, and it is up to us to help them simplify and focus. Close attention to emotions is important, because at a moment of readiness, the therapist will want to help the patient name the feeling and connect it with what they are thinking about.

Simultaneous with the empathic attention to emotions, the experienced therapist listens to what the patient says, keeping track of the story, the characters, and the facts. These data fit into patterns, and the therapist thinks logically, rationally, and sequentially about the clinical information, organizing it in different ways. This occupies a certain amount of the therapist's attention, generating hypotheses about the formulation, trying to fit the pieces together, and modifying and trying other ideas. The therapist's attention to patterns also includes considering various interventions and imagining the patient's response to them.

We are also tracking what is happening in the relationship with the patient and in the room and in the moment. What is the ebb and flow of verbal and nonverbal communication, what is being expressed and communicated by patient to therapist and from therapist to patient? What kinds of enactments are occurring?

Thus, there is an oscillation in attention between feelings and thoughts, between the patient's emotional experience and the words, facts, and ideas the patient is talking about, what is happening in the relationship, and how these phenomena are conceptualized. (Our minds enable us to keep track of multiple incoming feeds of information, so this attention is not a new or alien ability. It just takes practice to develop.) There are periods when the patient is speaking and the therapist is thinking hard about exactly what is being said and how it fits with the history. At other times one is looking "through" the words as they are spoken, focusing instead on the dominant feeling the patient is experiencing. At other times, the specific content is not the focus but rather something about the music of what is happening in the therapeutic relationship.

The intensity of attention that occurs for both patient and therapist fluctuates. There are times when the patient is deeply attending to themselves and looking in a new way, seeing new aspects of new meanings to thoughts and behaviors. There is a particular look of activation, a slight widening of the eyes, loss of focus, and a quality of distraction we can see in the patient who is paying especially close attention to their thoughts and feelings.

Often, the therapist zeros in on the patient's experience at a moment like this, trying to imagine exactly what the patient is feeling. This type of rapt attention, with a loss of a sense of time because of immersion in the moment, has been referred to as "flow" in the general psychology literature (Csikszentmihalyi, 1991). The state of flow involves such attention and engagement that nothing else exists for the moment. Such moments occur episodically in therapy, and when they occur, they are usually valued highly by patients, as well as therapists.

Just as we are looking for disparities in the patient's communication, we are also looking for evidence of our own unconscious at work

in how we listen. Our wandering attention may be due to an enactment in the relationship with the patient. An example of an enactment would be a patient who is very reserved and careful, and who reveals so little of themselves that it is uninteresting and hard to pay attention. Another would be a patient who overpowers the therapist with the intensity of their affect or the violence of their language. Sometimes the content of what a patient says is overwhelming—for example, hearing about abuse or acute psychological pain is often so upsetting that it is hard for a therapist to listen. Sometimes the patient's reaction to the therapist, the transference, is the source of wandering attention.

> A male, heterosexual, cisgender, Jewish, secular psychotherapist began psychotherapy with an anxious Orthodox teenage boy who revealed that he was anxious and fearful about exploring his sexual identity. The patient complimented the therapist's stylish blazer in an early session, and then later his expensive watch. Then with great discomfort, the patient commented that the therapist's shirts were often tightly fitting and he wondered if the therapist was gay and perhaps interested in him.
>
> This evolving erotic transference made the therapist quite uneasy, worrying he had been seductive in some way, and the patient's Orthodox prohibitions against homosexuality added a punishing and guilt-ridden tone to these thoughts. The therapist's self-reflections began to interfere with his attention to the patient. Instead of empathy and curiosity about the patient, and his projections and transference reactions, the therapist found himself thinking about what would happen if the patient mentioned his perception that the therapist was gay and interested in him to his family, or what if others in his professional and personal community somehow heard he was a therapist who might cross boundaries.
>
> When the therapist was able to refocus on understanding the patient's conflicted feelings, and the complexity of his wishful and critical transference reactions, the feelings of anxiety and self-critical rumination diminished. He was more open to exploring the patient's thoughts, emotions, and fears.

These problems with wandering attention can only be addressed by confronting and working out the issues themselves. The self-protective patient needs support, encouragement, and help expressing themselves; the aggressive patient needs tactful confrontation to understand why they need to be so aggressive and help them find a way of developing a collaborative relationship. The patient in the example above needed help expressing his fantasies about the therapist and owning them.

Sometimes the disparity in the patient's and therapist's culture, temperament, or language pose a challenge. It is harder to understand the patient, accurately empathize with what is going on, imagine what the patient is feeling, or grasp the context for why they are experiencing an event as they do. This calls for increased focus and attention on the part of the therapist and sometimes explicit discussion of these differences to help widen and expand the communication. Usually acknowledgment of the distance needs attention.

Of course, the difficulty in focusing attention may truly be the therapist's, and not the result of something about the patient. Too little sleep, hunger, preoccupation with personal problems, illness, depression, and imminent vacation are all common reasons for this. The therapist must try to address and manage these concerns. The suffering, sad, anxious, abandoned or abused patient must be heard, and the therapist needs to reflect on their personal emotional responses to the upsetting material to make sure they are able to be empathic.

THE THERAPIST'S INNER EXPERIENCE

One patient impishly inquired as the therapist was keeping notes during a session, "What are you writing down now, your shopping list for dinner?" The patient was being funny, but they expressed their worry (and, perhaps, their annoyance) about not being listened to. They were also acknowledging an obvious fact: Therapists have their own feelings and thoughts, they are human, and it is only natural that they will spend some of their time daydreaming and thinking about themselves. Most of us fantasize about a day in the sun when listening to a patient glowingly recall a beach vacation.

The psychoanalytic tradition has creatively mined the remarkable fact that the therapist's feelings and thoughts reveal much not only about themselves but also about the patient they are listening to. The therapist who feels comfortable and satisfied during their 8:00 patient appointment, anxious and insecure at 9:00, irritated and impatient at 10:00, and daydreaming of love at 11:00, may just be having a busy day, but more likely these feelings reflect something of the interaction with each of the patients. The therapist brings some consistent vulnerabilities, interests, and strengths to all interactions, and is the same person in each hour, but like a set of tuning forks that vibrate sympathetically with sounds in the environment, different feelings and thoughts in the therapist will be stimulated by different patients. The challenge is to use these feelings effectively; you do not want to suppress them, but you cannot be immersed in them.

The best and worst part of being a therapist is the constant emotional experience. You feel open and reactive, stretched in many directions by powerful feelings about the patient, about the therapy, or about yourself; or closed and struggling, wondering why you are closed, why you seem to want to be. These "in-your-face" emotional experiences are an essential part of therapy and usually enable therapists to sense early on whether this is their calling.

Maintaining perspective on your emotions while letting yourself go to feel whatever you feel is the challenge. If you try to control your emotions, you will be exhausted, irritable, and unempathetic. Ultimately, it will not work anyway. If you let yourself go and forget to observe and reflect on your feelings, you will lose the focus on the patient, and your responses might be spontaneous but not professional and helpful. Honest self-scrutiny is what we ask of our patients, and we try to do the same ourselves. It is endlessly challenging, and appreciating the difficulty of self-observation will help you to keep your empathy for patients' struggles in doing this.

It usually takes a few years of learning therapy and observing yourself before you recognize and clarify your individual and unique responses to patients: particular enjoyment when patients are affectionate, fear of upsetting an already upset person, or a tendency to criticize and chastise. Certainly these feelings arise because of something the patient feels toward you. But you have some tender areas and some old templates that are always ready to be stimulated by particular patients. This is fine, and to be expected, although most early-career therapists feel guilty and inexpert because of it. You will get better at doing therapy by knowing and accepting who you are, not by trying to change yourself to someone who does not feel and react this way.

The feelings stirred up in the therapist by the patient in the following example illustrate the shifting nature of these emotional reactions and the therapist's continuing challenge to stay aware of them.

> David was a 42-year-old White cisgender professor with dark, wavy hair, whose countenance darkened into worry and doubt or brightened into a broad smile depending on what he spoke about. He came for consultation because of depression and anger at his wife.
>
> David felt hurt, rejected, and resentful of his wife's behavior. She was brusque and cold at times, and not as tactful and gentle as he wanted and needed. Her casual comments cut him to the quick and left him angry and puzzled. David wondered why she didn't understand his need for kindness and special attention. Why didn't she recognize his hard work to support her and the family? A thoughtful, kind, intelligent, and reasonable man with a good sense of humor,

David was easy to identify with. It was easy to feel his hurt, and I asked myself the same question: Why was she so insensitive to him?

But as the therapy progressed, it was striking how hard it was for David to give up his feelings of resentment. He saw this, too. When there was an argument and an attempt to make up, it took days for him to "bury the hatchet." David's wife came in for a joint meeting, and she pointed this out quite clearly. He brought deep feelings of disappointment and hurt to the marriage and often perceived her behavior as more critical and dismissive than how she actually felt. Maybe he was not so easy to live with, I began to think. I found myself identifying with her—David treated her like she was difficult and troublesome. It's hard to feel that you are never doing the right thing to make your partner happy.

I felt David's wife was affectionate and loving, but her way of communicating was different from what David wanted. He wanted someone who went out of her way to be warm and to avoid hurting him. She loved him, but this was not her way. She was direct and a little brusque.

It turned out that David was particularly sensitive to criticism, having grown up with tremendous sibling rivalry and a lot of negative emotion expressed in the family. His experience with his wife was shaped by this early upbringing, and he was prone to read her as distant and unloving and often felt criticized. He could be prickly at times, and this did not make her feel open and affectionate toward him.

My initial feeling of irritation and criticism toward the wife was based on identifying with David and his hurt and anger. Only with some distance from these feelings—which were based on identifying with him, not on a full, accurate view of their interaction—did it become clear that he could be distancing and difficult to live with. Then the identification switched to her. Just because he was kind and interested and easygoing with me did not mean he was this way at home. David felt wronged, ready to see anything she said as hurtful, and he was openly derisive at times. His attitude was part of why she kept her distance.

Over time, my feelings switched back-and-forth, and soon enough settled into a kind of overarching identification with both and with their affection for each other, their needs, and their disappointments. Experiences from my personal life, present and past—rejection, resentment, affection, intimacy, forgiveness and making up, peaceful satisfaction, compromise, and accommodation—were stirred up by these experiences and formed a basis for the empathy and various identifications.

Later in the therapy, David began to more fully understand his needs and his wife's affectionate attempts to fulfill them. He was less angry, more loving himself, and more aware of the need to enjoy himself as much as possible. He was less worried about how much affection he would get in the future. I felt respect and admiration for David as well as his wife, optimistic about their future together, and a sense of both the satisfactions and compromises of close relationships.

A feeling is just that—it is a feeling, and it feels palpably true. Feelings often seem reasonable and accurate in the moment. There is an urge to simply react to them, thinking that they reflect "reality." Recognition of what part of the situation was David's, what part his wife's, and what part was the therapist's own life experience helped to determine how to respond to the patient and what to do in the therapy.

STRENGTHS

Each therapist comes to the work with personality strengths that will help in their therapeutic work. By developing your own personal strengths, you can increase your ability to help your patients develop theirs.

Hope, love, kindness, social intelligence, flexibility, and curiosity are probably chief among the character strengths you will call upon. Hope is essential because of the therapeutic value of optimism; we never know what therapy (and life) will bring, and a positive outlook makes a positive outcome more likely because you can stay open to new possibilities. Love and kindness are the active ingredients that allow a patient to feel safe, appreciated, and held. Social intelligence allows for the effective processing of complex psychological data; this helps to understand what is going on with the patient and in the therapeutic relationship, observing from multiple points of view. Because we never know all of the important data, and life throws curveballs at our patients and us, flexibility in conceptualization, perception, and behavior is important; otherwise we will be stuck in quickly outdated perceptions of our patients. Curiosity helps increase understanding and facilitates building a new narrative with the patient; because we spend so many hours hearing about others' lives, we had better be curious if we are to remain engaged.

In their taxonomy, Peterson and Seligman (2004) describe other personality virtues and strengths that are probably helpful as well: creativity, open-mindedness, and perspective, persistence, integrity, humility, and humor. Without discussing each one in detail, it is clear that each of these contribute to the flexible, emotional, open, reflective relationship that we seek with patients.

There is some reason to suggest that the personal practices of psychotherapists, which include psychotherapy and other kinds of self-reflection programs (Bennett-Levy, 2019) can help to enhance the personal qualities that psychotherapists bring to their work, although at this point, there are little data to demonstrate that personal therapy improves therapist outcome (Rønnestad & Skovholt, 2013). Many believe that education, social support, aging, maturation, and some degree of personal travail help to promote personality strengths, and positive psychology interventions, such as gratitude exercises and positive experience journals, may also help.

Therapists are sometimes drawn to helping others because of their own difficulties. Loneliness, fatigue, frustration, and depression sap therapists of their capacities, and social engagement, rest, satisfaction, and enjoyment increase them. It is important to take good care of yourself to be able to help others. The very work of doing therapy challenges character strengths and provokes self-reflection, and for many this results in further strength development. If every career and every life path cause a development of some personality strengths more than others, we suggest that those strengths listed above that help make therapists effective—hope, love, kindness, social intelligence, flexibility, and curiosity—are probably also increased as a result of our long hours of attention, concern, and facilitating optimism. Many of us hope that doing psychotherapy is a virtuous cycle of trying hard to manifest these qualities in ourselves that help others, all the while helping ourselves learn and develop further.

USING STRENGTHS TO MANAGE YOUR EMOTIONS

Moving beyond the scant available data, we have tried to describe some of the strengths that we see as important for therapists. But most important is how those strengths may be used to help you manage your emotions and react in healthy and helpful ways with your patients. The particular character strengths you have will likely be the basis for your best strategies for managing the emotional intensity of being a therapist.

Of course, the traditional mainstay technique for dealing with powerful emotions about patients is to understand (see Table 12.1) the situation. Making oneself think about the patient's situation from a variety of angles, trying to imagine how it would feel to be the patient's husband or wife, child, parent, friend, or lover helps to put the therapeutic relationship in a clear context. Using knowledge about the patient's history and typical psychodynamics and awareness of one's own personal concerns and vulnerabilities (learned through previous therapy and

TABLE 12.1. Therapists' Techniques for Managing Emotion

- Understanding
- Optimal distance
- Positive emotions
- Empathy
- Personal painful feelings

life experience) helps to fully understand the patient. It also helps the therapist contain the feelings experienced in the session. This technique helped the therapist in the vignette above place and conceptualize their confusing and disparate emotional responses to David's story.

Staying clearly focused on the therapist's role—listening, understanding, supporting, collaborating, and educating—helps to keep an optimal distance from the patient's experience. Being close enough to feel what is happening, but far enough to know that it is someone else's life and issues, helps to manage the emotional turmoil of being close to a patient going through a hard time. Optimal distance prevented the therapist from empathizing too much with David to the exclusion of his wife, and then when the therapist was identifying more with the wife, from taking too critical a perspective on David.

You will usually feel admiration and respect for your patients because you know what they are struggling with and how they have borne up and dealt with crises and challenges. Typically, these feelings are felt and expressed infrequently, and it seems like the business of the therapy is to deal with problems and upset. A focus on these positive emotions not only supports the patient but also reminds the therapist of the patient's strengths. This helps the therapist manage the intensity of the negative emotions they might be experiencing. In the example above, recognizing David's daily struggle with his problems, his frustration and loneliness, admiring his stoicism, sense of humor, affectionate parenting, and wise and thoughtful scholarly work helped the therapist weather the patient's frequent feelings of irritation and hopelessness.

Conversely, attention to the patient's pain, even a determined focus on it, helps to deal with negative feelings toward a patient. Someone who is critical, demanding, or very needy of the therapist can trigger resentment or various defensive maneuvers for dealing with resentment—detachment, passive–aggressive behavior, or reaction formation. Conscious attention to the patient's pain and an explicit focus on empathy can cut through some of these understandable therapist responses. Make yourself imagine what it feels like to be the patient, how difficult

it may be to go through just one day feeling that way. This will increase your ability to reflect on the meaning of the patient's behavior and delay the automatic responses we have to upsetting or annoying interpersonal behavior.

Finally, the therapist's own personal sources of sadness, distress, or anxiety for the therapist may be stirred up by a patient's difficulty. The therapist can use these personal feelings as a source of strength and wisdom. The humility, feeling of immediacy, and genuineness that come from experiencing painful feelings in therapy—in the privacy of the therapist's mind—can bring gravity and focus to the ongoing discussion. It is striking that what the therapist is feeling, even if unspoken, will affect the relationship with the patient. The facial expressions, body language, and speech give away the therapist's depth of emotion, and feeling and containing this effectively will often instantly calm a patient down—this helps the patient tolerate their feelings and therefore helps the therapist tolerate theirs.

SUMMARY

The therapist's personality strengths help to transform dialogue with the patient into therapy. These strengths are reflected in the therapist's way of paying attention to the patient and how they use their inner experience. Specific strengths are helpful for managing intense emotion in the therapeutic encounter: understanding, optimal distance, positive emotion, empathy, and personal painful feelings.

PART IV

TELEPSYCHOTHERAPY AND COMBINING TREATMENTS

13

Telepsychotherapy

> Movies are a fad. Audiences really want to see live actors on a stage.
>
> —Charlie Chaplin

Clean-cut and earnest looking, a White cisgender straight young man in his fifth month of weekly virtual psychotherapy talked while his image on my screen began to bounce up and down. At the same time, his camera tilted up from a view of his torso and head to just his head. This broke my attention to his rambling thoughts about how to navigate a job search. The bouncing continued and I wondered what was happening and whether to ask. He continued like nothing else was happening. I waited. Soon he interjected sheepishly, "It's kind of hot in here and I changed to shorts," and returned to his work concerns.

It felt like a norm-breaking moment for me, and I thought about it for a while. He took his pants off in a session. Was this "inappropriate"? Did he notice my presence at all? Did he experience me as a parent he was comfortable with?

I wondered whether this experience brought up new technique issues to think about. Or whether it was just a version of an older question about how to understand and respond to "acting in," or enactment, the expression of thoughts and feelings in a session through behavior. I was used to thinking about patients' behavior in my office, and used to feeling confused at times, but caught off guard by this new experience in virtual space.

This chapter reflects on telepsychotherapy and concludes that the psychodynamic meanings of virtual interaction are essentially no different from interaction in physical space. But there is a different experience of connection with the patient in telepsychotherapy that is dynamically

meaningful and requires awareness and some different techniques. The multiple meanings of the young man changing his pants in the middle of the session—self-preoccupation, wish to be taken care of and treated as a child, impulsiveness, perhaps an attempt at intimacy but an avoidance of it as well—were mostly inferred, as he was embarrassed when I ultimately asked him about the moment. But the teletherapy format certainly made this particular type of enactment possible—he surely wouldn't have changed his pants in my office—and his sense of insulation from me, his anchoring in his own personal space, and my confusion and surprise all reflect the uniqueness of the telepsychotherapy experience.

Virtual psychotherapy gained in popularity prepandemic and soared during the pandemic. It remains widespread in many settings, but there are global and regional differences. The most fundamental precondition for successful psychotherapeutic treatment is that the patient comes to appointments. Virtual treatment has expanded access, and literally made access possible during the pandemic years. The practical advantages for patients, mostly in the ease and efficiency of attending appointments, suggest that many patients will continue asking for teletherapy. In the United States, patients have in-person and online options depending on provider availability, while in Israel, for example, almost all psychotherapy is in person. Our impression is that we are now in a hybrid psychotherapy world and will almost certainly remain so (Swartz, 2021).

Of course, virtual therapy is the thin edge of the wedge of other developments in technology that promote well-being and provide mental health treatments. Venture capital investments in mental health, much of it in digital start-ups, is exploding and represented a third of all venture investments in digital health in 2021 (DeAngelis, 2022). There is a dramatic proliferation of apps promising improved mindfulness, meditation training, and well-being habits, as well as internet-based algorithmic therapy. Psychotherapy will soon take place in the metaverse (Benrimoh, Chheda, & Margolese, 2022).

As we went to press, ChatGPT came online. ChatGPT is an artificial intelligence (AI) chatbot that uses natural language processing to create humanlike conversational dialogue (*www.techtarget.com/whatis/definition/ChatGPT*). There is little doubt that this new technology will impact the future of psychotherapy. As a minimum, it will improve the quality of mental health–related apps and is likely to lead to the automatization of simple behavioral interventions in the short term. Some predict that we are not far from being able to conduct other psychotherapies, including psychodynamic therapy, through patient interface with large language models. Indeed, it is hard to predict, and underestimate, the impact of this technology on psychotherapy. Beyond these direct

applications of generative AI in the clinical setting, we believe that it will be helpful at improving the training of the next generation of mental health workers through AI-driven supervision, new inputs for assessing patients and modifying treatment interventions, and new opportunities for conducting psychotherapy research.

This chapter discusses telepsychotherapy because it is not clear yet how these other technological innovations will embrace psychodynamic therapy. Our discussion includes telephone-based and virtual or video psychotherapy, but we focus mostly on virtual therapy in this chapter because it is more widespread and probably will continue to be. We review the data about effectiveness and technical interventions in virtual therapy, explore the nature of the virtual psychotherapy space, and make recommendations about virtual technique.

EVIDENCE BASE FOR VIRTUAL THERAPY EFFECTIVENESS AND TECHNIQUE

There is an older and less rigorous literature on telephone psychotherapy that suggests effectiveness and improved access when compared to face-to-face psychotherapy (Mohr et al., 2012). Telemedicine for mental illness, including medication management and psychotherapy, was found to reduce barriers to care and be effective (Hilty et al., 2013). Before it was widely adopted, a systematic literature review of video psychotherapy by Backhaus (2012) concluded that it is associated with good user satisfaction and clinical outcomes similar to face-to-face psychotherapy. More recent studies found no significant difference in outcome between virtual psychotherapy and in-person treatment (Fernandez et al., 2021) in general, and in depression (Berryhill et al., 2019), panic and agoraphobia (Bouchard et al., 2020), and cognitive reprocessing therapy for PTSD (Liu et al., 2020). Studies suggest decreased dropout in telepsychotherapy, but Lippke, Gao, Keller, Becker, and Dahmen (2021) remind us that the practicality of remote treatment, and the resulting increase in access, may be offset by the difficulty clinicians have in noting important cues from patients who withdraw from treatment or do not respond.

Markowitz and colleagues (2021) reviewed the literature on remote psychotherapy and concluded that "Overall, the research presents a fragile foundation for the broad edifice of telepsychotherapy and naturally occurring public health experiment it must now support" (p. 241). They note that well-constructed studies of telephone CBT (Simon, Ludman, Tutty, Operskalski, & Von Korff, 2004) and interpersonal therapy (Heckman et al., 2017) found a significant reduction in depressive symptoms.

The distance between patient and therapist on the video platform, if a problem, should show in poor therapeutic alliance ratings. Indeed, the

Norwood, Moghaddam, Malins, and Sabin-Farrell (2018) meta-analysis found that the therapeutic alliance in video psychotherapy is inferior to face-to-face therapy, but there was no difference in target symptom response. In a small study using sophisticated modeling techniques, Norwood, Sabin-Farrell, Malins, and Moghaddam (2021) later concluded that the therapeutic alliance is a change process in video psychotherapy and reflects engagement with the medium and connection with the therapist. Leuchtenberg, Gromer, and Käthner (2022) found that patients in virtual treatment and in-person psychotherapy reported equivalent therapeutic alliance and empathy in a survey study, while their therapists thought the alliance and empathy were better in person. Finally, McCoyd, Curran, Candelario, and Findley (2022) found three important themes from interviews of therapists in the pandemic. They experienced the therapeutic relationship as more remote, but felt the alliance remained surprisingly strong, and they experienced the work as "energetically taxing" (p. 331). We suggest these results are difficult to interpret because they combine and average patients, some of whom are less comfortable in the virtual setting and some who find it easier and safer.

Fisher, Guralnik, Fonagy, and Zilcha-Mano (2021) dissected the transition from in-person to virtual therapy through the lens of epistemic trust (the ability to take in new knowledge as trustworthy and relevant). Their qualitative research found that patients with low epistemic trust benefited from explicit attention to facial expressions and direct reference to the virtual frame, while patients with higher epistemic trust relied on attention to their personal narratives and the virtual frame to make a successful transition.

Telepsychotherapy: Key Empirical Findings

- Telephone and virtual psychotherapy can decrease barriers to access and result in decreased dropout rates and increased compliance (Hilty et al., 2013; Lippke et al., 2021).
- Telepsychotherapy is regarded positively by patients (Backhaus, 2012) and the therapeutic alliance has the potential to be strong in virtual psychotherapy (Norwood et al., 2018, 2021).
- Telepsychotherapy has outcomes equivalent to face-to-face therapy in a variety of settings (Berryhill et al., 2019; Bouchard et al., 2020; Fernandez et al., 2021; Liu et al., 2020; Norwood, 2018).
- There is evidence that the efficacy of internet-based CBT and dynamic therapy are not different (Johansson et al., 2017; Lindegaard, Berg, & Andersson 2020).
- There are few data on optimal technique for virtual psychodynamic therapy.

THE VIRTUAL PSYCHOTHERAPY SPACE

The transition back to in-person appointments revealed, perhaps more than the dramatic switch into teletherapy, the differences between face-to-face and virtual therapy. We made the transition in a global crisis and there were so many emotional and practical factors for patients and therapists that relief at continuity of treatment was prominent, and any disadvantages were less salient. The return to the office has been calmer, more gradual and deliberate, and more quietly revelatory.

We were, like so many therapists, surprised at how easy the transition to virtual was. It was exciting, brave even, but there was a sense of something missing. Patients' faces could seem larger on our screens, there were fewer cancellations, and we got to see patients' apartments, houses, cars, and coffee shops. We met their dogs and cats and babies, and heard their family members in the background. We saw them in less composed presentations. We were more likely to wear sneakers than shoes. We arranged our backgrounds and worried about our own children or family members and what else was going on in the home.

Most surprisingly, we forgot about the video camera and screen. In a movie theater, while waiting for the feature to start, you notice who is sitting in front of you, the pitch of the seat back, and whether the floor is sticky from spilled soda. But a couple of minutes into the movie, this all goes away and you are in the film, captivated by the story. The same was true with the adaptation to virtual therapy.

> A straight White cisgender woman in her 50s who had been in therapy for several years came to her first in-person session after the pandemic, flopped down in the chair, let out a long sigh, and stared at me. "Oh, my God, this is so different." She missed the feeling of being in the same room, of feeling that her therapist, an older White male, was really paying attention to her.
>
> She became tearful, then grinned and laughed. "I've really missed this so much, and don't know if it's safe in terms of COVID to be here or not, but I'm glad I am." Later in the session, she connected her reaction, which was at least in part present centered, to the awareness she had achieved in the treatment of her powerful need for admiration, attention, and approval from older men. She longed for private time with her father, who always seemed busy and attending to others. Telepsychotherapy felt like a repetition of that rejection and face-to-face was a fulfillment of that need.

We said that the same psychodynamics are at play in telepsychotherapy as in face-to-face therapy and the patient in this example would

surely have had a similar transference response if there was a change in the therapist's schedule, or in the office, or in the therapist's mood. But what can we say about the virtual space of video psychotherapy to help us understand the new elements of that experience, for us and for our patients?

One young patient started treatment with significant depression in the midst of the pandemic—we had never met in person. After a few sessions, the therapist realized that he had no idea how tall the patient was and asked him. On the screen, he looked like an average height and build. The patient responded quickly that he was 6 feet 3 inches tall and weighed 220 pounds. This certainly gave context to his parents' placating attitude and sense of being intimidated, and his vaguely bullying manner toward the therapist, who commented spontaneously, "Well, you are a lot bigger than I am!"

The therapeutic relationship is an intimate human connection, albeit a special kind of one, and it manifests our evolutionary history and the attachment bandwidth we are capable of. It is like the parent–child relationship, relying on nonverbal cues, intuition, subtle facial expression, empathy, and reciprocal communication, both conscious and unconscious. The connection is a superhighway of interpersonal data.

Features of the Virtual Psychotherapy Space

- Loss of direct eye contact
- No direct patient/therapist physical interaction
- Impact on potential boundary violation
- Effect of seeing oneself
- Rationalization of choice of in person versus virtual
- Psychodynamics shape the experience
- Ennui or burnout
- Increased therapist self-disclosure
- Hybrid therapy probably state of the art in future

Unless both therapist and patient are quite sophisticated in the use of their web cameras, the loss of direct eye contact is a constant. The small but significant angle between the location of the camera and the image on the screen introduces a subtle divergence in eye contact even when the patient and therapist seem to be looking at each other. While we don't typically spend a lot of time looking directly at our patients, we do so sometimes, very briefly, at particularly emotional moments, painful moments, or conclusive moments.

Direct eye contact is fundamental to intimacy, in life and in the therapeutic relationship. Typically, its absence is registered but not immediately salient. Of course, the original analytic situation, with the patient on the couch, was designed to avoid eye contact, so that the patient did not have to see the analyst and felt freer from observation and from the therapist's reaction. It also helped the therapist feel less burdened by the scrutiny of patients all day long. But face-to-face treatment has supplanted the historical posture because psychodynamic therapy now aims to be less regressive, more supportive and comforting, and more committed to including the therapist's subjectivity in the observed relational field. Some patients are very sensitive to these elements of therapy that can seem in shorter supply in the virtual space. We may not even consciously notice what is missing.

Telepsychotherapy raises an old question in a new way: How much closeness and vulnerability is optimal for our patients? There is no possibility of patient–therapist physical interaction in a virtual session—no possibility of physical intimidation or violence, no possibility of being hugged or kissed. Boundary crossing of this type is not possible. While relieving for some, this absolute barrier lessens the experience of vulnerability and intimacy for some patients and therapists. Some patients like the protection and safety of being detached and being able to avoid eye contact that is too direct. The feeling of insulation for the therapist can feel reassuring, but may also contribute to feelings of distance or alienation. Despite the potential obstacles to closeness in the virtual therapy situation, many therapists feel they can continue to observe and work with the transference (Hickey, Schubmehl, & Beeber, 2022).

A less frequently discussed aspect of this question is how telepsychotherapy impacts the disturbingly high frequency of therapist–patient boundary violation. Some past self-report studies have suggested that major boundary violations occur in about 6% of treatments (Procci, 2007). These include waiving fees, touching, and sexual contact. Patients have another buffer of protection when they are not in the same physical space. However, Reamer (2021) pointed out that digital communication between patient and therapist opens up multiple avenues for boundary crossing and violation.

What is the effect of seeing oneself in the thumbnail image that most virtual platforms provide? For patients and therapists? Patients with self-esteem difficulties and body image concerns often find it quite distracting or even distressing to be confronted over and over with their appearance. Many therapists note feeling more self-conscious. Do we look at the small image in the corner of the screen to check our hair or facial expression?

If the intimacy of the psychotherapy relationship depends on reciprocal visual contact, what happens when visual contact with oneself interferes, for both therapist and patient? Our culture's pervasive attention to women's appearance, including negative attributions associated with aging, makes the constant confrontation with one's virtual self-image stressful and conducive to shame (Bailenson, 2021), and this may have a particularly negative impact on women patients and therapists (Ingraham, Cruet, Johnson, & Wisnicki, 2008).

Patients often spontaneously reflect on the virtual therapy experience, and these reflections are like any other piece of psychodynamic data—comprising conscious and unconscious material, with defenses, impulses, and realistic perceptions interwoven. They are an invitation to exploration rather than an answer to a question. Most patients are positive about the virtual therapy experience, but they often feel a need to rationalize their choice of convenience. They may like the convenience and feel some disappointment or loss, too.

So far, we have been discussing patients' experience of virtuality in general, but the core psychodynamic problem and their specific psychodynamics shape the experience. Depressed patients are likely to experience the distance as a loss. Patients who are obsessional use the mediation of the screen to aid in their interpersonal detachment and help to control their affects and the degree of interpersonal connection. Patients with fear of abandonment may be the group most negatively affected by the transition to virtual psychodynamic therapy. Their attachment needs demand the full bandwidth experience of being in person and virtual treatment can feel like an abandonment. This fear mobilizes defenses and coping strategies that can lead to disruption in the treatment and it may be difficult to manage this alliance rupture without being in person.

Patients with low self-esteem may obtain the mirroring they require through virtual interaction, and this helps them avoid relating to the therapist as another person who has needs and feelings. Patients with panic may appreciate the easy access, especially those with agoraphobia, though the absence of in-person interaction may interfere with the satisfaction of their dependency needs. Finally, patients with trauma may feel safer because of the protection the virtual relationship allows, and they may be more able to talk about frightening memories because they can control the environment more effectively. At the same time, they may miss the nurturance and sense of safety available in a good therapeutic relationship, and this will make it harder to do the frightening and painful work of confronting and reworking their experiences.

The discussion so far has focused on what video psychotherapy is like for patients—access, detachment, nonactivity, unique psychodynamics—but what about the therapist's experience? At this point in time, our impressions about this problem are inextricably linked to the

experience of the pandemic. Staying at home with less contact with colleagues and others can combine with the vaguely lonely and deprived sense of being not entirely present with patients, and contribute to ennui or burnout. Characterized by emotional exhaustion, depersonalization, and a decreased sense of efficacy, burnout has dramatically increased among health care workers during the pandemic (Shanafelt et al., 2022).

Many psychotherapists express a vague sense of emptiness and loneliness, even in the context of engaged and intimate psychotherapy sessions, perhaps reflecting the subtle and "unnatural" experience of being with people virtually. These experiences and the family stress that accompanied the pandemic may be partly responsible for burnout, but frontline health care workers doing face-to-face work experienced this as well. For therapists with young families, balancing the needs of children and patients is particularly challenging when therapist/parents are seeing patients virtually while at home. On the other hand, many therapists value the ease, convenience, and comfort of virtual practice, and this allows them to be more relaxed, open, and empathic. This can lead to a guilty sense of detachment from patients and their suffering. Most therapists have become aware of the positives and negatives of virtual treatment and adjusted their schedules and commitments accordingly.

Therapists self-disclose very differently. Some psychodynamic therapists maintain a relatively abstinent posture, while some reveal thoughts and feelings about the therapeutic relationship in the spirit of working relationally. This difference reflects theoretical orientation, the challenges of working with different types of patients, and therapist temperament. The virtual setting poses interesting opportunities and challenges in therapist self-disclosure and the personal/professional boundary can blur. For therapists who work from home, patients may see more of the therapist's personal space. Sometimes therapists find themselves saying more about themselves because there are family members' voices in the background, or someone comes into the room, or a pet is present. Or if video backgrounds are used, patients are confronted directly with therapists taking steps to maintain anonymity.

Is the impact of telepsychotherapy different for psychodynamic therapy than other forms of psychotherapy? There is little empirical research comparing differential impact among psychotherapists, although the common factor of therapeutic alliance cuts across all the therapies. We simply do not know whether the increased emphasis on enactments and transference–countertransference in psychodynamic therapy makes for any unique effects.

As little experience as we have with virtual psychodynamic therapy, even less is known about hybrid therapy—that is, mixing face-to-face with virtual sessions. Many anticipate this will be the state of the art in the future. We encourage face-to-face meetings initially as this may

be helpful as the therapeutic relationship is being established. Although the data do not tell us that the therapeutic alliance is impaired in virtual work, therapists frequently feel more comfortable and confident with initial face-to-face meetings. Periodic subsequent face-to-face meetings "keep it real," allowing for the intensity of being truly together with the patient, as well as encouraging reflection on the impact of virtuality. We are fully supportive of mostly virtual meetings, as this clearly meets many patients' need for convenience and access.

VIDEO PSYCHODYNAMIC THERAPY TECHNIQUE RECOMMENDATIONS

With a clearer sense of the data about telepsychotherapy and a feel for the virtual space, we have recommendations for optimizing virtual psychodynamic therapy.

Virtual Therapy Technique

- Some in-person sessions are helpful, at least initially, and then periodically.
- Make sure the patient has privacy and absence of interruptions in their setting.
- Provide a clear protocol for the virtual format and be curious about the patient's reaction to it.
- Minor technology glitches are expected; significant glitches on the therapist's end need to be addressed as a rupture in the therapeutic relationship.
- Respond to a few questions about your home/office environment, but use the questions as an opportunity to explore the therapeutic relationship and the virtual setting.
- Be deliberate and direct in holding silences and in explaining and acknowledging them.
- Ask about the patient's experience of eye contact in the sessions and validate the difference between virtual and in-person contact.
- Notice the tone and volume of your voice in virtual sessions and adjust to diminish any unconscious attempts to overcome the mediation of the technology.
- Make more frequent empathic comments with more deliberate emotional language and more explicit and specific statements.
- Use facial expressions and changes in body posture to express empathy in patients with low epistemic trust.
- Empower the patient in making the decision about in-person versus virtual therapy, balancing the benefits and limitations, especially for patients with prominent shame and trauma.

Who Decides Virtual or Face-to-Face?

Of course, patient preference about coming to the office or meeting online carries the day. Where geography was traditionally an important factor in choosing a therapist, now patients choose therapists who see patients in person or virtually based on their preferences. Unless there are compelling reasons for entirely virtual contact, such as significant distance, expense of traveling, incompatible schedules, or one of the therapeutic dyads is immunocompromised, we recommend some in-person sessions, at least initially. This adds dimension to the relationship, allows for a better awareness of the impact of virtuality, and, if for no other reason, helps reassure the therapist they are not missing important practical or relational information. However, it's important to note, there does not seem to be empirical data supporting this clinically driven suggestion.

We encourage a simple explanation for the in-person meetings: It helps to deepen the relationship and this can help the therapy. This recommendation, and its accompanying explanation, should be made in the same tone we use in educating patients about the process of psychodynamic therapy. We try to be clear but do not insist, and we are curious and encouraging about the patient's response. If the patient declines to meet in person, is this a manifestation of a resistance, a preference for the subtle detachment of virtual work, a pragmatic decision to save the effort of traveling to the appointment, or a reaction to the recommendation of an authority? What other meanings might there be?

For the same reason, and with the same attitude, we encourage periodic in-person appointments over time. This parallax view of treatment—experiencing being together in two different ways—gives an opportunity for more reflection on the therapy and the therapeutic relationship.

Location

We ask the patient about the space they are in and whether they feel comfortable and private. This is both a question and an implicit statement about the importance of addressing both of those requirements. When a young person leans toward the camera and talks more softly when speaking about a parent, we know they do not feel entirely safe saying what is on their mind. When they do not use names, they may be feeling someone is listening.

We have met with patients in their basements, cars, coffee shops, kitchens, yards, offices, conference rooms, and hallways. As long as the

patient has privacy, is not distracted by the setting, and is relaxed enough to let their mind go and associate and reflect, these settings are all fine. When the environment intrudes on the sense of timelessness, and the safe space of therapy is compromised, the therapist must raise the issue for discussion.

> One young Black straight cisgender woman could not find a place in her workplace to meet, so she sat in the stairwell holding her phone. Every few minutes, someone came along and she lowered her voice. She said she felt comfortable and private. But whenever she began to speak about something more intimate, or about her conflicted relationship with her supervisor, I could only think about all of the echoing, bare stairwells I have been in, and worried about her. What did it feel like for her?
>
> The coworkers in the stairwell seemed like such an interruption that I asked her whether she truly felt comfortable, or was adapting to the circumstance because she felt she did not have any better options. This was emblematic of how she felt in general and it turned out to be a window into her overly compliant nature and an opportunity for exploration and an impetus to leave the office for her appointments, as well as other ways she could assert herself.

It can be surprising when a patient's family or friends show up in the video frame without announcement. One man's girlfriend snuck by the camera, acting like she was not there. I wondered aloud if he could really talk about what was going on in his life if he never knew when she would pass through the open living/dining area he was seated in. A confused and anxious adolescent planned to meet on his laptop at the kitchen table while his mother was cooking behind him. I suggested that he find a separate space, aware that he was just beginning to understand what therapy was, and clearly struggling with the boundaries in his relationship with his mother. If a spouse pokes their head in to say hello, I might express curiosity about whether this is informality and friendliness or they are checking up on us.

> One mother, whose son with special needs was the subject of a lot of the therapy, said with a huge grin, "Oh, here's Kevin. Kevin, this is Dr. X. Say hi!" I greeted him with warmth and interest, and after he left, asked her what it was like for her for me to meet him after all of our conversations about him. It did help me get a better sense of the boy and it increased our rapport. My patient wanted me to know him, both her love and empathy for him, as well as her distress about how he could be difficult and irritating.

Therapist's Space

The usual considerations for therapist's offices—welcoming, comfortable, not so personally revealing as to be distracting—hold for the therapist's virtual presentation. But a therapist working from home is likely to reveal more than in a professional office. Is the room well cared for or not? What indicators of culture, affluence, background, and personal taste come through? What does it communicate to a patient when the therapist uses a virtual background or a blurred background instead of a real one? Does the patient experience this as professional and nondistracting, or as distancing and rejecting?

What about the interruptions that would be unlikely in a professional office (e.g., doorbell ringing, child crying)? My patients notice that sometimes my dog, that periodically attends sessions, jumps up and wags her tail by the door. I know this means that my wife has arrived home, but patients wonder what happened and why she got up and went to the door. Some patients inquire, some don't seem to care, and some seem to avoid dealing with it.

These moments are unique to virtual treatment, but the same principles that we employ in psychodynamic therapy in the office apply here. The open space in the relationship allows for fantasies and other transference material, but too much self-disclosure stimulates and distracts the patient and muddies the waters. I explain the noise in the background, if asked, with a smile, or enthuse about my kids or dog, or apologize for an interruption in the session. But each of these moments is also an opportunity for exploring the therapeutic relationship and I try to take advantage of that opportunity, too.

Technology and the Frame

We usually call the patient, rather than having the patient call us. It's like coming out to the waiting room and inviting the patient in. This also allows us some flexibility if we are running a few minutes late. Some more abstinent therapists like to have the patient call them—this is seen as part of the patient initiating the work of therapy and the therapist responding, rather than the therapist reaching out to the patient.

Some telemedicine platforms mimic the analog reality by creating a virtual waiting room where the patient waits for a couple of minutes before the scheduled appointment time if they are early. The video platforms may use a persisting link, and both patient and therapist come online independently, but the therapist has to let the patient in. There is also meaning to the ending of the session, including who leaves the video link first. Probably most important is to have a consistent protocol, to

support the experience of safety and predictability, and to be curious about the protocol and how it feels for the patient.

Some patients are late, some have been waiting for a while to begin the appointment, and not infrequently patients and therapists have problems with technology. There is a learning curve in using the platforms, and devices frequently change, so it is important to be understanding and supportive about that. But these experiences may also have important psychological meaning and can be explored as the treatment evolves. For example, one patient messages through Skype that he is ready at precisely the appointment time, even if I have not called him yet. He is very preoccupied with rules and procedures and following them and being the best. Another patient is consistently 6–7 minutes late to appointments, ostensibly because of his ADHD and difficulty awakening, but over time it has become clear that his avoidance and numbness reflect his ambivalence about assuming adult responsibilities and taking action in his life.

The platform must be secure and compliant with appropriate laws and regulations. Sometimes patients ask to record their sessions and we typically discourage this. The potential for self-consciousness on the part of either therapist or patient is a definite negative. But some patients have difficulty recalling the content of what is talked about, or want to hold onto the relationship. We have made special agreements occasionally for part of the session to be recorded when there has been a discussion and exploration of the meaning of the request. Of course, any recording is a privacy risk because of the potential for a patient or therapist data breach.

Technology glitches abound, whether this means someone is late because the video platform requires running updates, or there is an internet problem, or a switch from another platform to the one used for therapy. Sometimes the cause is on the patient's end and sometimes it is on the therapist's. It's often not clear, and it is interesting to see who takes responsibility. We often quickly say something apologetic, because an important therapy narrative is that things happen, including bad things, that are frequently not someone's fault, but the result of many factors and much history. Sometimes technology glitches become the focus of tension in the therapeutic relationship.

> A White transgender woman with significant separation anxiety and attachment insecurity was sad, tearful, and angry in a session when I had connectivity problems. I was pretty sure the problem was on my side. Because of the problem, I started the session late and then had to drop off for about 5 minutes and return. So, we lost close to a quarter of an hour in the appointment. By the time I was back and the technology problem was solved, the patient was tearful, hurt, and

angry. She felt derailed by my coming and going, and angry that she had a short session because of a problem on my end. Not only should I not charge her for the full time, I should give her the full session now, she insisted.

In my mind, I was aware of, and thinking about, how to connect this experience with multiple other instances in which she felt rejected, abandoned, angry, and a sense of unfairness and powerlessness. But at the same time, she was right that her session was short because of a problem on my end. If the door to my office was stuck and I couldn't come out to the waiting room for 15 minutes, it would be clear that she had lost her time because of something I was responsible for.

Small incursions on the patient's session time in face-to-face therapy are just part of the experience—the therapist is finishing up a phone call for a moment as the patient walks in, or a package delivery person knocks in the middle of the appointment, or the therapist spills a glass of water and wipes it up—and we see minor tech glitches in the same way. Some sessions will go over the time and it all "evens out in the end" and is part of the imperfection of life. Thus, a video platform update that causes the therapist to be a moment late requires an apology and maybe an explanation, but probably not a specific plan to make up the time or adjust the charge.

But when there is a technology problem clearly in the therapist's domain, that is a significant compromise of the patient's session and the time needs to be made up. It can be understood as a breach in the therapeutic relationship and dealt with by trying to understand the experience, apologize for it, and in this situation, make up the time. With the patient above, we added 15 minutes to a subsequent session. The acknowledgment of a genuine impact on the session might make it a little harder to understand the transference meaning, but probably not, and it is necessary to protect the equality, integrity, and transparency of the therapeutic relationship.

"Webside Manner"

The term *webside manner* (Ruble, Romanowicz, Bhatt-Mackin, Topor, & Murray, 2021) refers to the therapist's attitude and orientation toward the patient in the virtual space. We discuss four aspects of virtual psychodynamic technique: silences, eye contact, therapist emotional expression, and empathic communication.

It is often harder to hold a receptive, calm, reflective, silent moment online than in person. Face-to-face therapy provides a fuller sense of being together, two bodies in the same room, than online,

and that fuller nonverbal experience holds the patient and often makes the silence safer and less anxiety provoking. Other troubling meanings of silence—disapproval, rejection, unhelpfulness, demand—are more likely to emerge virtually. The therapist needs to resist the urge to jump in to say something or ask a question, when they would be better off waiting to see what happens next with the patient's associations.

The therapist should be deliberate in the use of silence. The first few times that you wait quietly and patiently, leaving room for what comes next, you might need to explain what you are doing, and ask what it's like for the patient. The next time, you may note that it seems uncomfortable, especially in a virtual setting. However much these explicit framing explanations and reassurance may be needed in person, they are more needed online. From then on, the therapist can be curious about what is happening and what it is like for the patient. The only mistake you can make is not letting the silences happen.

How should we deal with the subtle eye contact disruption in virtual communication? Eye contact is a delicate topic to bring up because discussing it usually makes the patient self-conscious or feel criticized. Avoidance of eye contact is common when engaging with painful memories and feelings, and being seen is often accompanied by shame. In a virtual session it is better to ask the patient how they feel about being looked at than to note how they direct their eye contact. Asking this question with empathy communicates interest, curiosity, and hopefully acceptance, and can lead to the patient's reflection on where they themselves look. You can say something about the difference, subtle though it may be, between looking at each other online and in person. Some patients may be consciously aware of this, while others may not even have noticed it. Probably the best way to help make this aspect of the virtual interaction a subject of reflection is through hybrid treatment, when you can ask the patient about how they feel about the in-person and virtual sessions, and what is different?

Some therapists note that they speak louder in virtual sessions, as though trying to make up for the mediating effect of the technology—as people do when trying to communicate with someone with whom they do not share a common language. Emotional expression by the therapist may need to be emphasized in the virtual setting. Fisher and colleagues (2021) recommend deliberate and intentional use of facial expressions and changes in body posture by the therapist to communicate understanding and empathy, especially associated with the transition from face-to-face to video psychotherapy. They note that this approach is especially helpful for patients who have "low epistemic trust"—that is, greater difficulty regarding the therapist as trustworthy. By contrast, patients with "high epistemic trust" may benefit more from references to

the continuity of the patient's personal narrative across the face-to-face and video settings, and a direct conversation about how the patient is experiencing the virtual setting.

Empathic comments, reflecting patients' feelings and acknowledging their sensitivity and struggles, including in the process of therapy, is even more important in virtual therapy than in person. We recommend that therapists make these comments more frequently and more explicitly, especially in the early phases of therapy, to help develop the therapeutic alliance.

A young cisgender heterosexual Lebanese American man often had an intent, motionless expression on his face when he was quiet. It felt like he was staring at me. There were frequent periods of silence after we analyzed an interaction with a family member or colleague where he had felt slighted and been verbally aggressive. It was becoming clear that his emotional reactivity, tendency to attribute malevolent motives, and defensiveness contributed to the interpersonal tension. At times, he was aware of this, but mostly he felt aggrieved and self-protective.

As we worked on this repeated theme, I wondered about the meaning of the silences—did he feel hurt and criticized by me, was he angry and passive–aggressively responding to my interpretations, or was he detached from his feelings and thinking about something completely different? In face-to-face therapy, I am sure the same enactment would have evolved, and we would have been exploring the same dynamic.

When asked, he typically explained that his attention had shifted to a work task he was behind on. In virtual therapy, I felt more out of touch than I think I would have if he were in the room, and I felt less sure about what to say. Leaving the silence, waiting to see what his next associations were, seemed overly depriving, and I worried that he saw it as an aggressive stance on my part. Asking him yet again what he was feeling and thinking felt like I was doing more work than was necessary.

This enactment was more difficult to address online because it was subtle and as yet unverbalized. The subtle sense of distance in the virtual space made it feel more confusing for the therapist and more fraught for the patient. We recommend the same principles for dealing with this situation as one would in person: patience, tact, curiosity, trial interpretations, and an encouraging and hopeful attitude.

The therapist did let the silences go on, commenting that this was happening, suggesting that it was difficult to hear the interpretations

about his hurt and anger, and wondering what it was like for the patient in the session. This empathic comment opened the door for subsequent inquiries of the patient about how he felt looking at the therapist, whether he was aware of the particularly intent look, and what he was hoping for from the therapist in that moment.

UNIQUE PROBLEMS

There are three unique technique problems that arise in virtual therapy: (1) managing the in-person versus virtual treatment decision for patients with significant shame and/or trauma, (2) therapist confusion and difficulty with empathic attunement, and (3) therapist preference for virtual care.

Patients struggling with profound shame may feel more comfortable in the virtual environment. The feeling of being seen and revealed, which is so acutely painful, is often mitigated by the distance created by the technology. There can be a greater sense of safety and protection in virtual therapy. The question here is whether the therapeutic relationship, as a mechanism of change, is as potent in the virtual setting as it is in person. While the preponderance of the data does not suggest that there is any diminution in the power of the therapeutic relationship in virtual therapy (Norwood et al., 2018, 2021), it is not clear whether the studies done have the specificity and power to address this question. It is certainly reasonable to wonder about it, and to consider testing this out with some in-person meetings to gauge their impact.

Jean, a cisgender lesbian woman in her early 50s, was in therapy for panic and problems in her marriage. She had experienced physical abuse in her relationship with her father and had been sexually assaulted as a young woman. Jean frequently felt profoundly rejected by her wife, taking small misunderstandings as major slights, struggling with intense anger and vindictive fantasies toward her spouse, which made her feel guilty and bad.

The therapy began in person prior to the pandemic and was switched to virtual therapy for a year and a half. Jean, despite her previous in-person attendance, schedule flexibility, and comfort with COVID risk, declined to return to in-person treatment. She had difficulty explaining why, noting that she was more comfortable being in her home. Jean did make a connection between this feeling and the physical safety fears she has when traumatic memories are triggered.

The therapist felt uncomfortable encouraging Jean too strongly to return to the office because the therapy seemed to be going well

overall—there was new material coming up, a feeling of immediacy and spontaneity in the sessions, and the patient was feeling better and less frequently triggered. Also, encouraging Jean to return to the office more actively seemed too prescriptive.

The therapist wondered whether the frequent thought that Jean might do better in the office was an enactment of some sort that was not clear yet, or whether the therapist was accurately perceiving the decision for virtual as a defensive detachment from the therapeutic relationship. Maybe it was a reasonable and pragmatic choice, especially given Jean's trauma history and preference for control over her environment.

In every therapy, the therapist joins with the patient in a conscious and unconscious enactment that reflects the patient's history and conflicts, as well as the therapist's. Every patient wants to be present and engage with the therapist while they also want to detach and protect themselves. For patients with trauma histories and prominent shame, the urge to detach is particularly strong, and if virtual treatments afford them the sense of safety and comfort to do the work they need to do, then this is a benefit, and truly an advantage over in-person treatment. But if the detachment of virtuality deprives them of the intense personal connection that could embolden them to feel and express their deeper memories and feelings, then virtual therapy limits their potential progress.

Because of the paucity of data, we do not have a blanket recommendation for patients with these issues—that is, which treatment format is better—but rather see this question as something therapist and patient must struggle with together. The therapist can bring up the question, and encourage the patient to reflect on the experience of virtual therapy, if that is the chosen format. If there is an occasional in-person session, this will allow them to reflect on the difference between in person and virtual. Because the treatment of traumatized individuals is focused on safety and empowerment, it is far better for the patient to make the decision themselves with support, encouragement, and insight than to follow a recommendation they may feel ambivalent about.

The second unique problem with virtual therapy is when the therapist feels confused about what is happening with the patient, and has difficulty empathizing with the patient's feelings. While this is a frequent occurrence in therapy, and therapists and patients must find the patience to tolerate this and work together until things become clearer, sometimes the virtual format feels like an obstacle to knowing the patient. And some of the time, it probably is.

We recommend several approaches here. Hybrid treatment, or at least virtual treatment with periodic in-person meetings, allows for a

view of the patient from "two different angles," and this might help the therapist develop a clearer sense of what the patient is feeling and what they are struggling with. There is some evidence that both patients and therapists prefer this (Leuchtenberg et al., 2022). Particular attention to indications of affect, closer attention to micro-gestures, and more attention to the here and now in the relationship with the therapist may all help.

In the third unique situation, the therapist has made a personal decision to do only virtual treatment. This could be for health considerations, personal convenience, or just preference. Many therapists gave up their offices during the pandemic and discovered they did not need them, and many found that virtual work fit their lifestyle more comfortably. They feel they do good work and it is a valid practitioner choice, like what type of therapy they offer or what kinds of hours they are available.

Many patients think virtual therapy will work well with them, either because of the convenience or psychodynamic issues, but they may not be fully aware of the implications of their decision. Some will start virtual therapy and wish they could switch to in person—perhaps they want the physical experience of being with the therapist, or they realize the convenience factor is not so important, or because this is their first experience of therapy and they had little basis for thinking about what they would prefer.

We see it as the therapist's responsibility, both clinically and ethically, to make sure that patients are able to make choices that are best for them. So, we recommend that the issue be kept open and the therapist make sure they allow the patient to explore their feelings, and the possible meanings of wanting to meet in person. If it seems that in-person therapy will likely truly facilitate that patient's progress, then it's important to support that conclusion and encourage the patient to find this, especially before the therapeutic relationship develops and it is especially difficult to leave.

SUMMARY

Telepsychotherapy is a valuable and practical format for psychodynamic therapy. It is dramatically more prevalent because of effective technology, the conditions during the pandemic, and patient and therapist preference. Recent empirical studies of the effectiveness of telepsychotherapy and supplementing older studies on telephone psychotherapy, suggest equivalent outcomes and reduced barriers to treatment. There are important questions about whether the patient or therapist decide

whether the treatment is in person or virtual, the locations of both parties, and the impact of technology. In this chapter, we offered recommendations about psychodynamic therapy technique in the virtual setting regarding silences, eye contact, therapist tone and volume, empathic attunement, and some of the unique technique questions that come up in virtual psychotherapy.

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Psychopharmacology and Psychotherapy

All roads lead to Rome, but our antagonists think we should choose different paths.

—Jean de la Fontaine, "Le Juge Arbitre"—*Fable XII*

Words are, of course, the most powerful drug used by mankind.

—Rudyard Kipling

Sometimes dynamic psychotherapy does not take root until the patient gets pharmacological relief from disabling symptoms, making it tolerable for them to discuss painful issues. The power of psychodynamic psychotherapy lies in its ability to isolate and focus on internal conflict, using the therapeutic setting to throw into relief feelings and patterns obscured in everyday life. But if the symptoms are too severe, constructive self-reflection may not be possible. Clinical wisdom and data suggest that many people will require more than one type of treatment to be at their best.

There was a sea change in perspective on combined psychotherapy and psychopharmacology in the late 1990s, questioning old notions like the concern that medication treatment will decrease symptoms and thus decrease motivation for therapy. The practice of combined treatment is remarkably common, even in the treatment of psychoanalytic trainees (Roose & Stern, 1995), and we discuss the outcome data on combined treatment below.

A psychodynamic understanding of the patient and the treatment relationship can enhance combined treatment in a variety of ways. There can be better communication between doctor and patient, and this leads to more genuine conversation about anxieties and concerns about the medication. The dynamically aware prescriber may be able

to elicit a better history because of the depth of understanding; the prescriber can grasp the meaning of the symptoms to the patient and get a clear picture of the actual symptoms as opposed to what the patient is trying to communicate through a description of the symptoms. For example, awareness of one patient's tendency to be stoic and underreport or another patient's history of having to make dramatic gestures in order to be heard allows the clinician to more accurately assess the severity of whatever symptom or side effect the patient is talking about. Clinicians will be able to explain the value of the medication, the target symptoms, and the rationale for taking it in the context of the patient's worries and fears. Psychodynamic clinicians can discuss the psychological significance of the medication along with its medical and biological significance.

There is a vast literature on the placebo effect (Harrington, 1997; Mayberg et al., 2002; Zilcha-Mano & Rutherford, 2023), which is another way of conceptualizing the impact of the doctor–patient relationship and the patient's psychological history on the nature of the drug response. More favorable medication response occurs in positive relationships than in negative ones. The dynamically oriented clinician is in a position to understand and affect the placebo response, improving the potential for medication response.

INTEGRATION OF MIND AND BRAIN

Patients tend to lump their problems into those that are personal, psychological, or arising from their environment, and those that reflect a "chemical imbalance." As therapists, we rather quickly fall into this perspective, as well. But as a field, we are searching for a unifying and integrative model of mind and brain to support the integration of a variety of treatments and suggest new areas of investigation.

From a conceptual perspective, some unifying theories have been proposed, such as Damasio's (2000) model of consciousness, but there is not a dominant model embraced by the field. Kendler's (2005) review of mind–body philosophy nicely elucidates the philosophical frameworks used to grapple with the problem of integrating mind and brain. He concludes that most clinicians use the philosophical framework of explanatory dualism to cope with this problem on a day-to-day basis. Explanatory dualism holds that mind and brain are best understood by using simultaneous psychological and biological explanations. Neither explanation is supraordinate, neither is secondary; mind and brain are not the same thing, but rather different ways of explaining and understanding the same thing. We tell patients something like:

> "How you feel has to do with both your feelings and the things that have been happening to you, and it also has to do with your brain and how it processes what is happening. Psychotherapy can make you experience things differently and see the world differently, and results in meaningful changes in the brain. Medication can help to reset circuits so that you will not have such extreme reactions. They can work separately or together, depending on what is going on with you."

As pragmatists and explanatory dualists, our perspective is that psychotherapy and psychopharmacology are different interventions based on parallel and equally important perspectives on the mind and brain. The important and pragmatic questions ask which patients should get which treatments, and how they should be delivered. The comments that follow reflect our clinical experience and observations; there are limited data about how treatments should be combined—that is, specifically how the interaction between psychotherapy and medication can be exploited to bring about the greatest possible benefit.

We start with a discussion about combining treatments when a psychiatrist is both therapist and prescriber. Then we discuss the more common situation in which the treatment is split between a therapist and a psychopharmacologist and provide a framework for facilitating an effective collaboration.

INDICATIONS FOR COMBINED TREATMENT

Research studies of the treatment of depression have shown synergistic effects of combined treatment. Data suggest improved outcome in a variety of clinical settings from combining psychotherapy with psychopharmacology (Bockting, Hollon, Jarrett, Kuyken, & Dobson, 2015; Fava, Ruini, & Sonino, 2003; Rush & Thase, 2018; Town et al., 2017) and even repetitive transcranial magnetic stimulation (rTMS; Donse, Padberg, Sack, Rush, & Arns, 2018). Barber and colleagues (2011, 2021) found that adding psychodynamic therapy to medication was more effective than medication alone for depression in a small meta-analysis. There are numerous studies showing that CBT is as effective as medication, but more effective at preventing relapse than medication alone (Hollon, 1996, 2020).

The situation is less clear for anxiety disorders. There is concern that psychopharmacological intervention interferes with the arousal necessary for successful exposure treatment (Barlow et al., 2000; Otto, McHugh, & Kantak, 2010). But other studies suggest psychotherapy

and psychopharmacology each provide independent benefits. Cuijpers and colleagues (2014) reported that combined treatment was superior for panic disorder and obsessive–compulsive disorder: The effects were twice as large as the difference between psychopharmacology and placebo, and were present at 2 years after treatment.

MEDICATION AND THE PERSON

Sandra was a 36-year-old married White cisgender professional woman who came to treatment because of low energy and depression. She described a stable but distant relationship with her husband, and complained of exhaustion in looking after their 2-year-old daughter. Sandra was thin and fragile appearing, and she gave a careful and halting history. There were several episodes of being beaten by her father in early adolescence and an experience of being raped while she was in college. She felt extraordinarily "jangled" and needed a lot of time alone to regain a feeling of safety and wholeness. Her feeling of safety and integrity was easily eroded by the demands, expectations, and interpersonal stimulation that she felt in virtually every area of her life: her daughter, her husband, and her coworkers.

Sandra described an intense attachment to her mother, whom she thought was committed and well intentioned. Her mother was often critical and needy, and Sandra felt pressure to please her mother, but was resentful of her demands. Her father was an affectionate but volatile man who drank too much. On several occasions, just after Sandra went through puberty, her father lost his temper at her for minor misbehavior and beat her. She could recall vividly the circumstances of each beating, including the smell of alcohol on her father's breath. She complained to her mother after the second beating, and her mother seemed to respond with understanding and promised to make it stop. But it occurred again, and Sandra was shocked that her mother had been so ineffective or uncaring. Her deep disappointment drifted into guilt and self-criticism, and she had occasional moments of cold fury toward her mother, when she would pull back and punish her by rejecting her.

The rape in college occurred when Sandra went to a frat party that got out of control. She drank too much and was cornered by a student. She felt it was her fault for having had so much to drink, and she felt ashamed and told only one friend. Sandra had subsequent boyfriends but felt best when she was independent.

Four years before Sandra came to the initial evaluation, she met and eventually married her husband, a somewhat detached and

mildly depressed but kind man. During their engagement, she realized that she was depressed and she sought treatment with a psychopharmacologist. She tried several antidepressants but experienced uncomfortable and unacceptable side effects with minimal benefits, and she decided to give up on medicine.

This time when Sandra came for evaluation, she felt anergic, depressed, and was worried about her daughter and her ability to be a good mother. She knew that she was depressed and wanted therapy but she wondered whether she needed medication, even though she was anxious and skeptical about it. She was worried about side effects and afraid the medication would be too powerful.

After a series of trials and dosage adjustments, Sandra ultimately found benefit from a very small dose of a benzodiazepine antianxiety medication and a nonsedating antidepressant. During the initial medication trials, she had exquisite sensitivity to a variety of side effects, including sedation, anxiety, appetite suppression, nausea, and a sense of derealization. Sandra was able to work quite collaboratively with the psychiatrist-therapist, giving feedback about the benefits and side effects of the medication. During this time, the psychotherapy was mostly supportive, as she was too upset and felt too fragile to do any exploratory work. She was frequently concerned that the medication would hurt her or it was too powerful and would damage her in some way. Ultimately, the medication doses for both the antidepressant and the antianxiety medication were stabilized to balance benefit and side effect. Sandra had a clear response that helped her to feel less depressed, more energetic, and more resilient.

Sandra felt less depressed within the time course expected for antidepressant response, and she was less anxious with the low dose of antianxiety medication. Reducing her acute symptoms allowed a shift in her psychotherapy from support and education to exploration and narrative development organized around the core psychodynamic problem of trauma.

Helping a patient construct a new narrative, reexperience old feelings, rework perceptions, and try new behaviors is action enough in the therapeutic relationship. But prescribing medication, a tangible object that the patient places inside the body that diffuses throughout all of the tissues with specific unseen effects at neurons and synapses in the brain, is likely to evoke transference and countertransference that are much harder to recognize because of the complexity of the situation. How did medications make Sandra feel—both positive and negative feelings—and how did that affect her subsequent treatment?

Was Sandra's sensitivity to medication related to her biology or to her interpersonal sensitivity and expectation of being hurt? Just as patients have transference to the therapist, they bring transference to the medication.

Medications can change a person's self-experience. Where psychotherapeutic change tends to be incremental and continuous with previous ways patients have felt about themselves, pharmacological response is sometimes discontinuous and more foreign. The patient feels changed and different, and feeling different can help them to begin to think differently about themselves. A patient who has been chronically irritable and becomes less so with medication starts to question the old assumption of being difficult and unlovable. A traumatized person who has felt frightened and anxious, and becomes less reactive and more confident, may see themselves as stronger and more in control.

New and more complex ideas about the self also begin to emerge, taking into account the newly evident sense that how one feels depends on one's brain and its biological workings, as well as one's mind, self, and history. In an intuitive and visceral way, patients start to factor their understanding of their biological vulnerabilities into their views of themselves—their neurobiological fingerprint. Sandra realized that if medication could be so helpful in decreasing anxiety, then perhaps her feeling so vulnerable was just a little bit less her fault and a little bit more just the way she was wired.

MEDICATION AND TREATMENT GOALS

Sandra complained of low energy, depression, fatigue, career dissatisfaction, and worries about her parenting. Which of these symptoms was likely to respond to psychotherapy and which to medication? It is tempting to simply define physical symptoms like fatigue, or sleep disturbance when it is present, as targets for medication, while attitudes, function, and relationship problems are the domain of psychotherapy. But often the correlate of a better relationship is sleeping better, and one certainly has more energy when one is satisfied with one's work. Likewise, improvement in fatigue makes one more fun to be with, and this increases the enjoyment of close relationships (Fried et al., 2017).

It is important to provide patients with a framework for understanding why you are offering combined treatment and what results might occur from the treatments, even though they can be difficult to predict. Generally, we regard psychotherapy as targeting the life narrative, changing and reworking it to make experience and perception different, which then leads to behavioral change. It is incremental, "top-down" in

the sense of higher thought affecting visceral experience, and focuses on contrasting new and old modes of experience. Medication, "bottom-up," affects experience too, but is more discrete and specific in its impact and changes subjective experience without the split-screen quality of feeling old reactions and new reactions at the same time.

Thus, we explain to patients that therapy will help them think about and change how they experience themselves and others. We hope they come to see themselves in a new light, leading to new ways of experiencing and new behavior. They will substitute the old and dysfunctional for the new and more adaptive. Psychopharmacology will decrease symptoms that are abnormal effects of vulnerable biology. We point out to them that having fewer symptoms will help them draw on their strengths and deal with stresses more adaptively. We note that combined treatment can offer two pathways to improvement. Medicine will help the syndrome, whether it is a mood disorder, anxiety disorder, or psychotic disorder, and psychotherapy will help the patient sort out and improve their capacity to perceive and adapt. Psychotherapy has the potential to bring about long-term change, but might require "booster" experiences along the way, while psychopharmacology might be required for maintenance. Medication might reduce the patient's sense of blame and responsibility for their difficulties, but it might also decrease the feeling of having personally overcome and mastered their problems.

Phasing psychotherapy and psychopharmacology is a clinical art at this point, with little empirical data to guide us. Our approach is usually to educate the patient about what we know about psychotherapy and medication treatment for the problem they are dealing with, and offer the range of treatments when there are acute symptoms, whether depression or anxiety. When the patient requests combined treatment, we begin with weekly appointments and initiate and monitor the medication. We educate the patient about the presenting problem and the medication treatment. Support, behavioral management for acute symptoms, and family education are the psychotherapeutic interventions initially, while we set the stage for beginning an exploratory psychotherapeutic treatment when the patient is ready. Family members need to know what the problem is, and what the treatment plan will be, especially when the symptoms are significant. They are often reassured when they meet the clinician.

If a patient is acutely agitated, it is unhelpful to explore and encourage even more intense affective experiences. When the patient starts to feel a little better, enough to be curious and to start to regain a sense of control, then the exploration can begin. Some patients are ready in the first session, some are not for a couple of months. Thus, Sandra began to talk more about her relationships, history, and feelings and fantasies

only when she was less depressed, more active, and a little more confident.

Just as one frequently waits for a psychopharmacology response to begin a more active psychotherapy, sometimes medication effects are limited by conflicts that get in the way. Some patients are so anxious and guilty about feeling better that they do not seem to get a full response until the therapy has helped them deal with this problem. Others are pleased with the relief of anxiety they may receive from medication, but worried that their decreased anxiety leaves them less vigilant about possible dangers, and this creates anxiety in response.

MEDICATION AND THE THERAPEUTIC RELATIONSHIP

Education, discussion, informed consent, and a dispassionate evaluation of the risks and benefits of the medication are an essential aspect of the therapeutic alliance in combined treatment. Informed consent decision making about medication is the rational ideal and must be pursued, but there are many emotional factors in taking medication that are driven by the patient's dynamics.

The patient's perspective on medication certainly has to do with specific factors in their own life, such as prior medication experience, medical history, experience of others, and media exposure. Riba and Tasman (2006) describe typical positive and negative medication transferences, and their thoughtful list categorizes these attitudes into good and bad reactions to medication. We have attempted to extend Riba and Tasman's ideas, identifying the positive and negative medication attitudes we observe that are associated with each of the six common psychodynamic problems (see Table 14.1). Mintz's (2022) thorough discussion of the notion of psychodynamic psychopharmacology provides a framework for thinking about a wide range of psychodynamic factors involved in prescribing for patients, including the doctor–patient relationship, ambivalence toward medications, the therapeutic alliance, patient attachment style, countertransference, and treatment resistance.

We organize this psychodynamic discussion of prescribing around the patient's core psychodynamic problem. We cannot adequately answer the question of when psychopharmacology should and should not be used for particular patients because there are so many specific clinical variables that are important, including nondynamic factors, such as family history, prior medication response, culture, and other belief systems. Instead, we address the meaning medications have to patients with each core problem.

TABLE 14.1. Common Medication Attitudes for Core Psychodynamic Problems

	Positive transference	Negative transferences	Techniques for managing
Depression	Nurturance, help, good food, love, support	Stigma, punishment, rejection, disappointment, poisoning	Caretaking, concern, carefulness, methodical attention
Obsessionality	Pleasure through compliance, pleasing the prescriber, resistance to transference	Controlled, intruded on, weak, shameful	Relinquish control, consultant/advisor to patient
Fear of abandonment	Love, interest, safety, security	Disinterest, don't care about person, inattention	Reassurance, attentiveness
Low self-esteem	Caring, admiration, enhancement, perfection, increased lovability	Defectiveness, inferiority, losing competition	Active, paternalistic stance
Panic	Gratitude, safe, caretaker	Abandonment, disappointment,	Active, advising, guiding
Trauma	Safety, protection, validation	Trauma, damage, invalidation, condoning trauma	Caretaking stance, active, respect for patient decisions

PRESCRIBING FOR PATIENTS WITH DEPRESSION

Patients with depression feel hopeless, negative, and unloved, and they yearn for a prescribing doctor who is like a good parent: helpful, nurturing, supportive, giving them the sustenance they need so badly. They may be enormously appreciative of medication, as though it were good food on an empty stomach, desperately needed and in all-too-short supply. However, the opposite side of the coin is that medication may increase the feeling of stigma, punishment, and rejection. Patients may feel that medication marks them as damaged, worthy of rejection, and unredeemable. Instead of good food, the medication can be seen as poisonous, hurtful, and destructive. It is punishment for their inner badness.

When there are substantial side effects, or when the response is slow or not robust, this can tilt the medication transference toward the

negative. When there is a rapid response, there is more likely a positive attitude. Because medication algorithms can take quite a while to work though, patience can be required to get to the point where the benefit begins to show. During this time, patients may feel more hopeless, rejected, and damaged.

> A handsome, stylish White heterosexual cisgender man in his early 40s came for treatment, accompanied by his wife, when his depression recurred. His business was struggling, and he felt frustrated and disappointed with himself because he was depressed again after a long period of wellness. He was ambivalent about medication, but felt from prior experience that it was necessary for him to get better. He was annoyed about having to restart medicine, and each dose and each side effect made him irritable.
>
> It took 3–4 months before he began to feel better, and this sorely tried both his and his wife's patience. He was angry with the doctor, feeling that the medications were making him ill because of the side effects. He felt that the seriousness of the medical treatment supported his fear that he would never be successful. He felt marked forever by his illness, and this resonated with earlier feelings that there was something deeply lacking about him. At times he was not only angry but hopelessly negative and profoundly helpless.

It is essential for the prescriber to maintain some distance and objectivity from the painful symptoms of depression. The patient may be crying out in distress, intent on getting rapid relief, but the doctor must prescribe systematically and thoughtfully and not respond excessively to the pain. Responding overly quickly to the patient's suffering can lead to poor medical practice, such as switching drugs too quickly, escalating doses that may lead to unnecessary side effects, or using too many medications.

Concern, care, and patience are the hallmarks of good medical management of depression. Attention and empathic validation are good substitutes for impulsive action for the doctor, and the attempt to be caretaking will be more likely to evoke the positive transference than overly reactive prescribing. The patient described above responded to the medication after quite a while, and the doctor did their best to maintain a demeanor of patience, concern, affection, and caretaking while feeling under sustained attack and criticism. But since the patient was depressed and hopeless, it was not helpful to point out that his irritable and critical feelings were based on old patterns of feeling misunderstood and hurt. Instead, the doctor attempted to minimize the negative reactions through careful attention and made every attempt to provide the best and most effective medical care.

In chronic depression, the prescriber may develop an exclusive focus on medication, working intensely on drug combinations and doses while tending to disregard the patient's active responsibility in managing the symptoms. The patient and doctor can start to see the treatment as a biological puzzle and forget about important psychotherapeutic issues that should be dealt with. The opposite problem is when there is so much focus on working through conflicts that the clinician and patient forget to treat a syndrome that is right in front of them. It is hard to keep focused on mind and brain at the same time.

PRESCRIBING FOR PATIENTS WHO ARE OBSESSIONAL

The associated depression, anxiety, or obsessional intrusive thoughts and feelings are the pharmacological target symptoms for patients who are obsessional. Because patients who are obsessional are preoccupied with control over inner thoughts and feelings, and therefore over relationships, the issue of control is paramount in the prescribing relationship. Taking medication can feel like a loss of control, being intruded upon and controlled internally by the doctor, and perhaps humiliating and shameful. On the positive side, the patient can take pleasure in being compliant, taking the medication just right, and eliciting the satisfaction of the doctor. Like a well-behaved child, the patient feels they have done well and will earn a reward. Taking medication may bolster the patient's feeling of strength and mastery.

Because patients who are obsessional need to keep distance from their feelings about others, especially powerful and potentially dangerous people like doctors, there is frequently a resistance to the transference. There is a defensive disavowal of having feelings about the medication and the treatment, whether the feelings are positive or negative. These patients often just do not want to think or talk about their feelings regarding the doctor, the prescribing, or the medication. They try to evaluate the medication from a purely rational perspective, one that does not take into account their ever-present emotions.

The prescriber will do best by using the traditional consultation model here—that is, the patient is coming to the doctor, inquiring about medication, and will use it or not based on the information learned, and it will be the patient's decision. Informed consent, patient autonomy, and respect for the patient's decision making are always important, but for these patients it is an absolute requirement. Any attempt to be paternalistic or manipulative in the service of symptom reduction will backfire sooner or later. The doctor should emphasize the patient's control and take the role of advisor. Inevitably, the patient will want the advice and

will react to it either positively or negatively, depending on the dynamics and the status of the therapy. But the patient is most likely to make the best medication decision when the transference distortions are minimized by the doctor's taking a noncontrolling consultant role.

PRESCRIBING FOR PATIENTS WITH FEAR OF ABANDONMENT

Insecure attachment is associated with depression and Cluster B personality disorder, and the pharmacological interventions target depressive symptoms and mood instability. Patients' positive reactions to medication include the feeling of being loved, cared for, or treated with special attention. Ingesting medication given to them by their doctor may promote a feeling of intimate attachment. On the negative side, psychopharmacology can stir up feelings of rejection, objectification, and stigma. The patient may feel disregarded, and just one of many patients, none of whom seem to be important to the doctor. Not infrequently the patient's attitudes can oscillate between these poles, needing and appreciating the medication and angry about the feeling of abandonment it stirs up.

The management approach here is to maintain clear boundaries, advocating for medication when it will really help the patient and expressing a consistent attitude of concern and attention to the patient's feelings. The need for continuing empathy and sensitive listening cannot be overemphasized, but the doctor must not overidentify with the patient's feelings and must maintain a consistent approach in the face of the patient's fluctuating reactions and feelings. Strengthening the experience of object constancy is the psychotherapeutic goal for those with insecure attachment, and the therapist's most powerful tool for this is maintaining a consistent demeanor. The prescribing doctor's stance attempts to strengthen this, as well.

PRESCRIBING FOR PATIENTS WITH SELF-ESTEEM PROBLEMS

The psychopharmacologic target symptom for patients with low self-esteem is rejection sensitivity. Patients with self-esteem problems respond to taking medication in terms of how it makes them feel about themselves. It can raise their self-esteem; positive reactions include the sense that medication reflects caring and admiration from the therapist. The patient feels special attention and regard in the discussions about alternatives, often feeling especially understood, supported, and attended to. The wishful feeling is that the medication may help the patient attain the perfection, desirability, and lovability they seek, and it feels like

enhancement that will surely make them even better and more lovable. The other side of this reaction is that medication reflects negatively on the patients and who they are. Some patients with self-esteem problems feel that taking medication is an acknowledgment of defectiveness and inferiority, and they are filled with shame. If they are competitive, they could feel that taking medication makes them less attractive, impressive, or intelligent than others (or whatever the fantasy may be).

Bo, a transgender woman college student, came for consultation because of depression and low self-esteem that did not seem to respond to psychotherapy. They were small, cute, and nicely groomed, appearing like a nonbinary young teenager with blonde bangs, preppie-style clothes, and multiple visible piercings. They came out as female during freshman year of college with some support from a couple of old friends now attending other colleges, and much support from several members of the trans community in their own institution. The parents said and did the "right thing," mostly, by their report, although the father was circumspect and kept a greater distance from his child than before.

Bo was careful to note in the initial session that they felt unlovable and unattractive. They had always felt that way, and being smaller than average with some feminine mannerisms had been difficult around boys, and they had been subject to bullying and rejection frequently. They felt they were not a good and likable person, not because they were trans—they felt better since coming out and better since beginning the transition to looking like a woman. The issue, it seemed to Bo, was something different and maybe deeper.

In taking the history, it was clear that Bo had a bipolar spectrum mood disorder, with depressions punctuated by mild hypomanias, where they felt very positive about themselves, had excess energy, needed less sleep, were unusually productive, and given to grand fantasies.

The antidepressant medication prescribed had probably not been the most effective option because of the bipolar nature of the mood disorder. When this was discussed, and education about bipolar versus unipolar mood disorders and their treatment was provided and processed, the patient was surprisingly positive. Upon further exploration, this optimism and feeling of encouragement was more than a sense that an accurate diagnosis and new medication might help them feel better. Bo felt listened to, understood, and seen as someone more complicated than their appearance. They also imagined the new treatment, lithium, might help to dissolve some of their feeling of unlovability and unlikability.

The management approach to medication for those with self-esteem problems is to keep an active advisory stance, letting suggestions and recommendations border on old-fashioned physicianly paternalism. The mood fluctuations and uncertainty these patients experience may make them uncertain about the value of medication and erode their motivation. If medication treatment is appropriate, then a strong stance is helpful, and the patient feels it is supportive and empathic, err on the side of pushing your opinion and do not keep distance out of fear of hurting the patient's feelings.

Another patient commented that medication made him smarter and better than he had been before. Beyond the improvement in symptoms, he commented that the pill was like high-octane fuel in his tank, and he had never been as on top of his game as he was now. Some months later, the same patient had several setbacks at work, and he felt he was not able to keep up as he had in the past. Now he felt that the medication made him lose his edge. It was difficult to discern from observing him, from hearing about his situation, and from his wife's report whether there was any objective change in the medication response, but clearly his attitude had shifted dramatically from a positive medication transference to a negative one.

An active stance is less likely to interfere with therapy for patients with self-esteem problems than for patients with obsessionality who are extremely sensitive to control, and for patients with trauma to whom autonomy and safety are so important. Patients with self-esteem issues are more likely to want to be taken care of, but care must be taken that medication is not perceived as a substitute for close empathic attention in the psychotherapy.

PRESCRIBING FOR PATIENTS WITH PANIC

Panic is so acutely uncomfortable that patients are often desperate for symptom relief; this tends to induce a powerful dependent reaction. Patients with panic long for help from the doctor, and they will quickly step into a subordinate and supplicating position. When the medication is helpful, the patient feels intense gratitude. Their safety is solely in the doctor's hands, and there is great confidence and conviction about the doctor's skills and power. The doctor is seen as a benign caretaker with powerful tools available. Alternatively, the medicine can be disappointing and ineffective, and the patient feels the negative aspect of dependency, which is abandonment and aloneness. The doctor's back is turned, and no one can help. Because patients with panic are so intently focused on internal sensations, they are particularly anxious about side

effects. They worry that side effects presage more side effects or represent some kind of serious damage to the body. They can become terribly worried and seek reassurance.

It is a rule of thumb with these patients that there can never be too much reassurance and support during the initial phases of pharmacotherapy. It is hard to think clearly when you are seized by panic with little or no warning, and if the clinical situation warrants psychopharmacology, then it is appropriate to recommend the treatment in a decisive way, emphasizing the advantages and committing to helping the patient with side effects or difficulties along the way. The consultative distance that works so well with patients who are obsessional will just make patients with panic anxious and abandoned. Because the symptoms have been awful and the patients feel so dependent, not providing reassurance is tantamount to confirming the patient's worst fears, so specific recommendations about medication, dosing, and management of side effects are helpful. One should err on the side of lower doses followed by gradual increases; the more incremental the change, the more minimal the side effect, and the more likely the patient will be able to attain full therapeutic doses of medication.

PRESCRIBING FOR PATIENTS WHO ARE TRAUMATIZED

Psychopharmacology for patients who are traumatized focuses on symptoms of acute agitation, sleep problems, hyperarousal and activation, and associated depression. The patient may see the medication as affording safety and protection, decreasing the painful symptoms, and attending to the need to take the symptoms seriously and help.

These patients have often felt ignored by others, and their trauma has not been taken seriously or validated. Because of this, medication directed at the symptoms can feel like a validation of the seriousness of what they have been through and what they are currently experiencing. But those with trauma are also acutely sensitive to feeling hurt again, whether it's through uncomfortable side effects, medical risks, or the prescriber's lack of attention to the process. They have been treated badly by those in more powerful positions than their own, and the context of the doctor–patient relationship and the perceived power differential can mirror this. Medication can feel like an attempt to silence the victim of abuse. These patients are already filled with shame and secrecy, and being given a pill may make them feel like their experience is being ignored. An attempt to "just treat symptoms" condones or at least inadequately recognizes the evil of the abuser and the unfairness of the trauma.

A caretaking stance that emphasizes respect for the patient's autonomy is the optimal approach. It is essential to respond appropriately to the severity of the patient's symptoms and try to intervene. The greatest damage of the trauma is to the patient's sense of integrity, autonomy, and empowerment, and healing this must be central to every aspect of the treatment. The patient is treated as the decision maker. Information is given and issues are discussed openly. But if the patient is so symptomatic as to make decision making difficult, the doctor should step in and actively guide the decision. Patient empowerment is essential, but compassionate care of the patient is also the doctor's responsibility.

PROBLEMS AND PITFALLS IN PRESCRIBING MEDICATION

Just as patients have a variety of transference reactions based on their psychodynamic problems and specific life experiences, clinicians also have personal attitudes and feelings that are not based in current reality. These are medication countertransferences. Rescue fantasies about depressed patients, maternal urges toward those with abandonment fears, and aggressive feelings toward patients who are obsessional are all examples of these countertransference reactions that can be expressed in prescribing. For example, does the depressed patient really need a second antidepressant added, and does the patient who is abandonment sensitive need more frequent sessions or more aggressive medication? It is incumbent on the physician-therapist to examine these questions with as much self-reflection as other treatment decisions, understanding the ubiquity of enactments and the inevitable interplay between transference and countertransference.

Because prescribing is more tangible than many psychologically framed actions the therapist takes in the treatment, it may slip outside the lens of self-reflection. Thus, unrecognized and unacceptable feelings may come out in prescribing. For example, an angry and frustrated physician may withhold medication or impulsively change recommendations, or the need to keep a patient's admiration and affection may drive the doctor to make decisions that are not medically optimal.

At some point in treatment, the emotional meaning to the patient of taking medication should be explored. Analyzing the meaning of the medication with a patient does not suggest that the medicine is not needed and appropriate. The goal of this exploration is to clarify and free up the patient's and the doctor's decision-making process, so they are both guided by current and realistic considerations, not dynamic, historical ones.

If the clinician is both prescriber and therapist it is confusing to keep track of two very different realms of data and action, and it requires a kind of compartmentalization. The interaction with the patient will tend to be in "therapy mode," or in "medication mode," and occasionally in the mode of reflecting on the meaning of medication decisions. The doctor must be able to move flexibly among these modes, responding to the patient's cues and the medical need for discussion.

For therapist/prescribers, we recommend discussing medication issues either at the beginning of the session or the end. Some patients report on the medication response or side effects at the beginning; other patients will not bring it up, or bring it up at the end. The advantage of discussion at the beginning is that it leaves the remainder of the session open and does not require awkwardly closing down an open-ended emotional exchange to talk about side effects and doses. But, medication talk at the beginning of the session can be a problem because the doctor has not yet gathered how the patient feels, and it may be hard to make recommendations about dosing and management without this information.

Discussion of medication at the end of the session is advantageous because it allows the patient to open the session with what is emotionally salient and get right into the important issues at hand without the sometimes distancing and rationalistic discussion about medication. The problem with a discussion at the end is that there may not be enough time, and the importance of the medication may be downplayed and avoided, treated as an afterthought. It may also be a sign that the medication is not being brought into the therapy and discussed in terms of its emotional meaning.

Many patients continue medication after the psychotherapy is over, and this causes a change in the doctor–patient relationship. Patients treated for recurrent depression with combined treatment may complete the therapy, but maintenance medication treatment continues. Thus, the patient will come back for a medication visit, and this makes for a very different feel in the appointment.

The appointment schedule is much less frequent for medication review—for example, every 3–6 months. Transference and countertransference feelings are likely to be present, less intense than previously, but active nonetheless. The transition in care also involves a departure from the traditional technique for handling termination. Before the advent of combined psychotherapy and psychopharmacology treatment, the end of the therapy was the end of the relationship. In combined treatment delivered by one psychiatrist, psychotherapy termination is the end of the frequent intense meetings, and the beginning of a new, more reality-oriented doctor–patient relationship. This new relationship may be helpful and consistent with the patient's improved outlook and functioning,

but it might also be a nagging restimulation of issues and conflicts that were helped to some extent by treatment, but remain open and distressing. Discussion of the feelings about the transition may help the patient address it in a healthy way.

DUAL-PROVIDER SPLIT TREATMENT

All of the discussion until now has been about combined treatment offered by one doctor–therapist. But much more common is split treatment, where two providers work with the patient. Gabbard and Kay (2001) have written about the advantages and disadvantages of split treatment and suggest that single-provider care is better in a number of clinical settings, including the presence of schizophrenia or schizoaffective disorder, bipolar disorder with denial of illness, patients who are borderline and use frequent splitting, and patients with medical problems and psychiatric illness. Mintz (2022) reviews the advantages and disadvantages of combined versus split treatment and the advantages and pitfalls of communication in each configuration. Treatment in managed-care settings, community mental health centers, U.S. Department of Veterans Affairs (VA) hospitals, and other health care centers is almost always split treatment. Single-provider treatment tends to be primarily available in private practice settings.

Therapists and psychiatrists may work together in a hierarchical or collaborative way. Hierarchical models, where the psychiatrist is the primary clinician and the therapist "reports" to the psychiatrist, are sometimes found in community mental health centers, inpatient services, or other complex institutions. On the other hand, psychotherapists are primary clinicians and psychiatrists serve as consultants in many group practice models. Both of these arrangements involve a hierarchical reporting relationship between the therapist and the prescriber.

We recommend whenever possible that the psychotherapist and prescriber work together in a collaborative model with clear roles (Moras & Summers, 2001). Collaborative arrangements involve shared responsibility, and they make use of the skills and expertise of each clinician more fully than the hierarchical arrangements. Making thoughtful clinical decisions about both the psychotherapy and psychopharmacology and how they interact requires the full input of both practitioners. All too often, the responsibilities and roles in the collaborative relationship are not clearly delineated, leading to disruption in the treatment when the patient is not doing well. Therefore, clear definitions of the respective roles and responsibilities are likely to be helpful (see Table 14.2).

TABLE 14.2. Psychotherapist–Psychiatrist Roles in Collaborative Care

Function	Psychotherapist	Psychiatrist	Communication
Data gathering	Gathers full historical and current database, including personal, family, and developmental history	Gathers full historical and current database, including medical history and complaints, medical database	Shared database
Diagnosis, formulation, and treatment goals	Makes clear diagnosis and formulation; identifies focal problems, treatment goals, and target symptoms	Makes clear diagnosis and formulation; identifies focal problems, treatment goals, and target symptoms	Consensus diagnosis and formulation; consensus regarding focal problems, treatment goals, and target symptoms; rationale for each component of treatment
Treatment selection	Selects appropriate form and frequency of psychotherapy	Selects appropriate psychopharmacology regimen	Agree on strategy with patient, interventions, potential pitfalls
Provision of treatment	Delivers psychotherapy	Delivers psychopharmacology	Coordination of therapeutic interventions
Evaluation of treatment	Assesses psychotherapy responses and inquires about psychopharmacology responses	Assesses psychopharmacology responses and inquires about psychotherapy response	Share observations about treatment responses and adjust ongoing treatment as needed
Crisis management	Shared primary responsibility, especially responsible for adjusting to acute psychosocial stressors, techniques for modulating affect and behavior (improve stability), support for and monitoring of basic safety issues	Shared primary responsibility, responsible for acute psychopharmacological interventions, support for and monitoring of basic safety issues	Rapid communication, shared information, coordinated intervention with clear division of responsibility

Note. From Moras and Summers (2001).

The collaborative model requires that each practitioner do everything within their domain of responsibility and that they communicate with each other to reach a consensus about a shared understanding of the patient. This means that both therapist and psychopharmacologist perform a full diagnostic evaluation; of course, the therapist will gather more extensive developmental, relationship, and functional data, and the psychiatrist's assessment will tend to focus more on symptoms, natural history of symptoms, genetic factors, and medical issues. But each must gather enough data to form an opinion about the diagnosis and treatment. Following the evaluation, both providers will communicate essential aspects of the clinical data and discuss the diagnosis (in most cases, this is brief and there is relatively easy agreement). When there is disagreement, it is important to share as much of the clinical data as possible, agree on what else needs to be learned, and discuss how the clinicians will resolve this disagreement. Nothing dooms a combined treatment more than significantly differing perspectives, as the patient will be confused about what is being treated and often tends to feel and function worse when this occurs. You cannot agree to disagree, because ultimately this will confuse the patient and undermine one or both clinicians. The consensus diagnosis and the therapist's formulation will lead the way to treatment goals for each component of the treatment.

The therapist and prescriber will emphasize what each will work on and what they hope to achieve. The greatest stress on the dual-provider relationship comes when the patient has a crisis. When there is an acute loss or personal crisis, or there is suicidality or homicidality, both clinicians typically become involved. Everyone is anxious about who has responsibility and for what. The psychotherapist has usually been meeting more frequently with the patient and has primary responsibility in a crisis for understanding and helping the patient deal with acute stressors and for improving techniques for behavioral stabilization. The psychopharmacologist's responsibility is to assess the degree of symptom severity and provide optimal pharmacology to promote stabilization. They are both responsible for decisions about hospitalization or emergency evaluation and will need to communicate, often on an urgent basis, until the crisis subsides. These dangerous situations are harrowing for the clinician practicing alone, and while the company of a colleague can sometimes add to the complexity, including finger-pointing and discontent, it can also be a source of support and validation in a difficult situation.

Of course, medical–legal anxieties develop when there is potential dangerousness. This is inevitably part of the clinicians' anxiety and may become more of a focus than when there are two clinicians treating a

patient in crisis—they can disagree about decisions or roles or become anxious about who is supposed to do what. But the best medical–legal approach is the one that brings about the best patient outcome, and clear role definition with maximal help from both clinicians makes for the best outcome. Indeed, both clinicians are at medical–legal risk if a serious situation develops.

DUAL-PROVIDER TREATMENT PITFALLS

Dual-provider treatment works best when the two clinicians know and respect each other, have the same understanding of their collaborative and nonhierarchical roles and relationship, and communicate regularly. But threesomes are more complicated than twosomes, and problems can develop. Spotting the potential pitfalls is easier with the framework for the role relationships we have described, because it puts the clinicians' reactions to each other in the context of their roles and functions in a collaborative relationship, rather than personal qualities and skills. You can remember what you are supposed to do and encourage your colleague to follow their role expectations, and this makes the interaction less personal.

Sometimes therapists and psychiatrists stray from their responsibilities. Incomplete sharing of the clinical information—for example, one clinician learns about continuing obsessive–compulsive symptoms that the other clinician is unaware of—makes it hard for a thorough consensus diagnosis of the patient. Subtle or overt undermining of the other clinician's skills, expertise, or behavior throws the entire treatment into question for the patient. Unilateral assertions about the diagnosis, the need for treatment modifications, or conflicting assessments of the degree of progress cast doubt on the other provider's skill and trustworthiness.

Some clinicians find themselves collaborating because the patient requests it, or they happen into the situation. They may believe collaborative care is a less effective treatment model, and their ambivalence and doubt will likely come out at important moments. More insidious are the problems that come up when the clinicians are resolved to work together and observe the role expectations, but the countertransference experiences make this difficult. For example, patients who tend to split will often regard one clinician as better and more helpful than the other, or one treatment modality better than the other. Specific countertransference experiences in the psychotherapy—rescue fantasies, control struggles, hopelessness—may affect the therapist's view of the medication. This can cause noise in the collaborative relationship.

The "real relationship" between two providers affects the treatment as well. Close colleagues tend to talk more frequently about their shared cases. Clinicians who do not get along for other reasons tend to have more difficulty respecting their role divisions. Beliefs about each other's professional training and biases about the profession—physicians, psychologists, social workers, counselors, clergy—may creep into the communication, distorting and decreasing its effectiveness. The practice context may also affect the provider relationship. Clinic-based collaboration may be part of the culture and supported with group norms and ideals. In private practice, clinicians tend to select those they feel comfortable with for collaboration, but there is more difficulty finding the time to communicate, and lack of reimbursement for phone time may provide a disincentive for frequent contact. Close proximity helps the collaboration, as a brief discussion in the hallway is usually easier than repeated phone calls, voice mails, and texts.

SUMMARY

Combining psychopharmacology with psychotherapy adds another potential route of intervention. An integrated perspective on mind and brain allows us to see that interpersonal and biological therapies target the synapses, as well as the soul. Prescribing evokes particular medication transferences and countertransferences that are best understood and addressed using awareness of the patient's core psychodynamic problem.

The overarching principles for combining treatments when there is a therapist and prescribing psychiatrist are delineating a clear diagnosis and formulation, targeting specific problems with specific treatments, and transparent communication among multiple clinicians and the patient. Clearly defined roles and functions make the collaborative relationship between psychotherapist and psychopharmacologist function better. Attitudes of openness, humility, and empiricism, as well as a willingness to change plans based on results, result in the kind of flexibility many patients need.

15

The Patient Is Part of a Family

with Ellen Berman

People change and forget to tell each other.
—Lillian Hellman

We are fundamentally social. All "individual" problems, such as depression, low self-esteem, and abandonment anxiety, and indeed, all individual strengths, exist in a relational context, and empirical work in social neuroscience reveals the complex neuroregulatory functions of relational attachments (Feldman, 2017; Siegel, 2006).

Most of the time, people enter therapy because of relationship issues, including intimate relationships and marriage, parents, family, friends, children, divorce, colleagues. This is true for most of the cases in this book. It is confounding, then, that most early psychotherapeutic techniques ignored the interconnections and influence of other people, and insisted that the only relationship that could promote change is between therapist and patient. Of course, intrapsychic issues inhere to the individual and occur consistently in their relationships. But not all intrapsychic problems are caused by or cause serious problems in important relationships. For many, the couple or family buffers and heals. The individual's mood and functioning are profoundly affected by the system of which they are a part. For example, highly successful second marriages that provide more positive support, or a better "match," than the previous one that ended in divorce, may cause a patient's symptoms to

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disappear, although their personality is unchanged. In this chapter, we discuss how and when to do a couples assessment and combine psychodynamic psychotherapy with couple or family therapy.

Individual therapy is necessary, helpful, and efficient the more the problem involves individual suffering and unconscious conflict in the midst of functional relationships, and the more the suffering seems discordant with the relationship system around it. Pragmatic psychodynamic psychotherapy (PPP) addresses the relationship problems from the individual perspective. Couple or family therapy is the place to start when the problem is manifested in relationship conflict, the suffering is defined as dissatisfaction with others rather than individual distress, and other people in the family are dysfunctional. It is common for a patient to start in individual therapy and then move to couple therapy later, or for couple therapy to become stalled until individual treatment begins. When used together, the treatments can be synergistic, leading to greater symptom relief, change, and patient empowerment. We use the terms *couple*, *family*, and *systems* interchangeably in this chapter, referring to adult family systems and all of the diverse forms they take.

Couple or family problems do not always signal psychopathology in one of the individuals, although individual problems may stress the family. Tension may develop in generally well-functioning people when differences in temperament or goals are too great, or when a relationship is stressed beyond its ability to cope. Stressors may include a chronic and life-threatening illness, a complex stepfamily situation, or sudden job loss and financial stress. It is possible to have a great deal of marital tension when each partner alone appears symptom-free. Or marital stress may provoke symptoms in the individuals. Each member of the couple may react differently to marital conflict; one spouse may become depressed while the other may blithely ignore the tension.

These insights are based on the application of systems theory, a major development in psychotherapy in the modern era (Becvar & Becvar, 2017; Glick et al., 2015). The recognition that dysfunction and pathology may reside in relations between people, and not simply inside people, resulted in the development of treatment approaches that focus on the interconnections and relationships within the family, such as reciprocal attachment styles (Johnson, 2017) and communications and feedback loops of behavior (Gottman, 2016a). These ideas offer a new and powerful set of tools that can be used as a primary treatment or in conjunction with individual psychotherapies. This includes the recognition that individuals live in systems in which culture, race, gender, and sexuality are critical elements. Paying closer attention to the larger system in which the patient is embedded allows for broader possibilities for collaborative and creative treatment.

GENOGRAMS AND COUPLE CONSULTATION

We start first with how the individual therapist can gather data about the patient's important relationships through completing a genogram. A genogram helps the individual therapist learn about and remember historical details and gives a good sense of the patient's supports and strengths (McGoldrick, Gerson, & Petry, 2020). A genogram is a family map of three or four generations of the patient's family, including grandparents, parents, siblings, and children. Aunts, uncles, and other kin are included when possible. Names, occupations, ages, marriages, and divorces are noted, along with mental or serious physical illness in family members. Completing a genogram also provides a good opportunity to ask about community, race, ethnicity, and culture.

Therapists must be aware that they cannot know the nuances of all cultures and need to be curious, interested, and careful about making any assumptions. We need to express humility and openness. Individuals and couples are usually very happy to answer direct questions about race and culture if they are asked with genuine interest and curiosity, as it is a nonpathological way of understanding who they are (Depauw, Van Hiel, De Clercq, Bracke, & Van de Putte, 2023). As more and more people marry out of their home culture, the issue of how to make a new family culture becomes salient. The couple may struggle over holidays, child-rearing beliefs, or gender roles. Biracial children may find difficulty in forming their identity. The information gathered in the genogram can open the door to these discussions. See Figure 15.1 for a sample genogram for Abby and Bob, discussed below.

The genogram illustrates conflicts that can be traced through several generations. For example, a patient with an unavailable father has an abusive and substance-abusing grandfather. The genogram strengthens the emerging narrative and also helps to see biological loading for psychiatric illness in the family. A simpler genogram can take about 10 minutes to complete, while a more thorough exploration of family dynamics takes considerably longer. The genogram can help the therapist consider how the individual patient's symptoms and concerns, especially relational problems, may reflect systemic issues in the family (DeMaria, Weeks, & Twist, 2017). For example:

- How was this problem managed in the family in previous generations? How was it managed differently by different people (mother's family vs. father's family)?
- What was the patient told about this type of problem? Were there secrets involved?
- Is there a family history of trauma or major cultural shift around this issue, or other related issues?

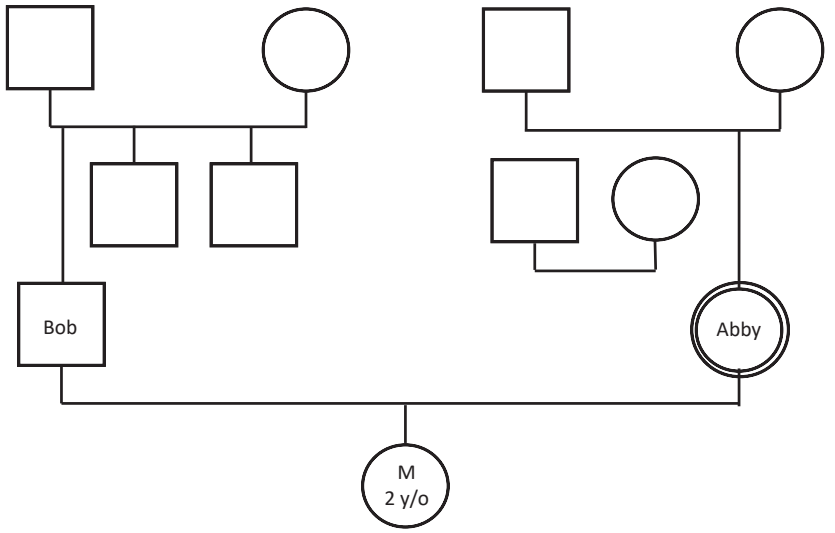

FIGURE 15.1. Sample genogram.

The genogram can be discussed with the individual patient or with the patient and family member present. Wachtel and Wachtel (1986) list several reasons for bringing other family members into the session: more accurate reconstruction of the patient's history, evaluating the current reality component of the patient's story, choosing a therapeutic direction (e.g., working with the patient toward changing a relationship vs. accepting it with greater equanimity), enabling the patient to see parents more positively, observing a sample of the patient's interactional style, and making the family more open to changes in the patient.

The traditional dynamic therapy model assumed that meeting with family members would complicate understanding of the patient's individual issues, confuse the transference relationship, and potentially compromise the therapeutic alliance by seeming to side with the partner or other members of the family. While each of these issues is genuine and has potential validity in particular cases, our view is that meeting a partner or family member is far more often valuable than it is hurtful.

Patients are just so different at home than they are in our offices. We forget the demand characteristics of the therapy situation (it is our home), including the virtual setting. Some patients are much more reasonable, reflective, and calm in the office than at home; some are less so. It is rare for family members to be aware of all of the communication that takes place, as so much is barely conscious or unconscious. We all miss important micro-level interaction. For example, when one spouse

looks grim and worried, then the other reacts by moving away an inch and sitting up. This reflects a dynamic that is an essential part of the relationship, and individuals are often unable to describe these subtle but fundamental patterns. Of course, it is difficult to work on this in individual therapy when a patient cannot describe it.

Not only is it hard to see important couple and family interactional behavior in individual sessions, it is also hard for the patient to practice new perceptions and behaviors. For example, encouraging a passive person to become more assertive when other family members are not prepared to welcome the new behavior will likely increase conflict and set up a possible failure. This is what the Hellman quote at the beginning of the chapter refers to. Practicing new patterns of communication with the therapist present can improve the chances of success.

We discuss the advantages and disadvantages in beginning individual and couple therapy, and then describe the typical clinical scenarios. The first scenario offers a detailed model for a couple assessment in individual therapy.

WHICH THERAPY FIRST?

The decision about whether to begin couple or individual therapy is often made by the couple as they begin to contemplate the possibility of treatment. Sometimes this occurs before the first contact with the therapist. If a coupled patient feels both individual upset and marital stress, a complex negotiation between the partners begins. Is the problem identified as the "fault" or "disease" of only one partner, or a problem for both? Who is most invested in change and willing to attempt therapy (which may be perceived as frightening or dangerous by either partner)? Who is willing to be identified as the patient? While it is common for both partners to have problems, often only one will be agreeable to therapy, usually the one who admits the most distress.

Sometimes one member is sent out to scout the therapist and report back about whether therapy is safe—that is, whether it will upset things too much. Gender is important in this determination. Women typically seek help from professionals earlier than men, who are more apt to insist they can "handle the problem on their own." Frequently, men see treatment as unwelcome and enter therapy as though it were an admission of failure, rather than an expression of hope and the possibility of change. The family member who presents for individual therapy is not necessarily the one who needs the most help but is often the one in the most pain. In some cultures, asking for help outside the community or extended family is not done. In those situations, often the

most culturally assimilated family member might enter first. Same-sex or nontraditional families may be appropriately concerned about the therapist's ability to understand them, and may take longer to develop a trusting relationship.

Because of these complex negotiations, stated and unstated, it is very important to explore how the decision was made to seek help. For some individuals, opting for individual therapy aids their secret goal of ending the relationship; the patient can convince the individual therapist, and themselves, that this is the only possible outcome, without ever giving the partner a chance to understand the gravity of the situation. In these cases, it is particularly important that the therapist see the spouse or send the couple for couple consultation.

Once therapy starts, either individual or couple, the treatment format may change. The therapist may recognize from the beginning that couple and individual dynamic therapy are both needed immediately, as in a situation where there is one very depressed partner who is on the verge of leaving the marriage. Sometimes it becomes clear after a while that one partner's individual symptoms fluctuate in response to the other's depression, and couple work is more appropriate.

Frequently, a patient begins individual therapy with the partner already in therapy with a different therapist. In these cases, it is particularly important to consider the state of the marriage, since the psychodynamic therapy draws attention and emotional communication from the dyad to their relationships with the two individual therapists, who may have very strong opinions about their patients' partners. The alternatives here include a referral for couple therapy, frequent communication between the two individual therapists, or a periodic meeting of the four principals. The couple may be at increased risk for splitting, confusion, and increased stress if one of these options is not chosen.

There is potential for couple therapy to increase the power of the individual dynamic therapy. For the therapist, combining treatments requires humility and flexibility—trust and regard for approaches other than the ones you are expert in, and the openness to look at each patient and each problem in a fresh way. The collaboration issues are similar to those discussed in Chapter 14 between a psychotherapist and psychopharmacologist. Offering both individual and couple therapy could also be confusing, diluting the power of each approach and reflecting uncertainty and insecurity on the part of the clinician.

In the end, whether the treatment takes the form of individual or family therapy, or both, is substantially a matter of patient choice and therapist–patient negotiation. The considerations above are important for us as therapists, but on this question the patient almost always carries the day in making the decision.

TYPICAL TREATMENT SCENARIOS

We use the story of one couple, Abby and Bob, to discuss the various therapeutic approaches and how they often play out. There are five typical scenarios—individual therapy leading to a couple assessment, individual therapy leading to couple therapy, couple therapy with a referral for individual therapy, concurrent couple and individual therapy, and both members of the couple engaging in individual treatment. Our conceptual scheme was adapted for adults from Josephson and Serrano (2001).

We envision and rewrite Abby and Bob's story according to each of these scenarios to illustrate the individual and marital factors involved and the advantages and disadvantages of each approach. We make specific management recommendations (summarized in Table 15.1) for each clinical scenario.

Begin Individual Therapy; Couple Assessment

Questions of identity, race, culture, gender, and sexuality are front and center in the evaluation of individuals and their intimate relationships. Therapists inevitably bring their own personal experiences and biases, and it is a crucial discipline to self-observe, question, and be curious about oneself and the patients' experiences. The first treatment scenario involves the woman in this heterosexual couple coming for individual treatment. In many cultural settings, women are more likely to flag relationship issues and address them more directly. They are often prone to accept responsibility and/or blame. We begin with this picture because it is so common in reality, knowing that it mirrors the biases of our culture.

> When Abby, a White cisgender woman in her late 30s, came for individual psychodynamic therapy as her sadness had progressed to the point of significant sleep, appetite, and energy disturbance. She was petite, with a sad, faraway look. She was passive, hopeless, and quietly angry. Abby felt her husband, Bob, a cisgender White man, did not listen to her and their attempts to work on their relationship seemed futile. She could not see how things could get better and felt lonely and disappointed.
>
> The initial phase of psychotherapy involved support and clarification of the situation, as well as pharmacotherapy. The individual therapist began to feel that he was siding with Abby in the frequent discussions of her interaction with Bob and requested that Bob come in for a consultation to see them together and hear his perspective.
>
> Bob was lean and square-jawed, with an intense stare. He explained that he felt Abby was often distant and unaffectionate,

TABLE 15.1. Combining Psychodynamic and Couple Therapy: Common Treatment Scenarios

Treatment sequence	Common clinical situations	Advantages	Pitfalls	Management strategies
Begin couple therapy; refer to individual therapy	Significant individual psychopathology that is an obstacle to couple/family work. Impasse in couple therapy.	Allows for more intensive focus of individual treatment when individual issues are compromising couple work.	Shame at being the "identified patient" unless both enter treatment. Emotional investment in individual therapy may decrease investment in relationship. If only one person changes, may increase possibility of divorce.	Concurrent vs. sequential therapy should be discussed. If sequential, a follow-up couple meeting should be arranged to determine when and if couple work should be resumed.
Begin individual therapy; refer to couple therapy	Problem turns out to be more relational than individual (e.g., questions of having a child, or possible divorce).	Allows for focus on relationship with both partners present. Decreases conflict that is undermining individual growth. Allows partner to acknowledge and participate in change.	Partners avoid dealing with internal issues or main secrets (e.g., affairs) in the couple work.	Individual therapist should not also be couple's therapist unless initial individual contact has been brief. Individual therapy can be continued concurrently if everyone is in agreement.
Concurrent couple and individual therapy	Urgent problem where both individual and couple issues need immediate attention. Not enough time in couple work to deal with individual issues, but couple wants to continue the work.	Allows for relationship support and exploration while allowing privacy for deeper individual work. If therapists work in concert, can be strongly synergistic.	Costly in time and money. Increased possibilities for splitting and therapist confusion. If only one person is in individual therapy, problem of "identified patient."	Essential that all therapists remain in contact, which is often difficult when you have three therapists involved. Can be done sequentially.

(*continued*)

TABLE 15.1. (*continued*)

Individual therapy with couple consultation	Problem is defined as individual, but in context of family relationships.	Practical and usually accepted by individual and couple. Provides very important data that can improve individual treatment. May facilitate beginning couple therapy if indicated.	May complicate alliance with individual patient by support for significant other. May solidify position of patient as "the problem" by not insisting on couple work. Sometimes difficult to recommend individual therapy for patient's partner even if clearly needed.	Couple consultation should be one to three sessions. Consultation is better done at the beginning of treatment. An occasional follow-up couple session may be scheduled later.
Two individual therapies	Each individual has long-standing personal issues, and relationship is basically functional.	Allows for intensive individual focus. Not as resource-intensive as concurrent individual therapies and couple therapy.	Therapists may unwittingly give directly contradictory advice to partners about handling situations. May direct couple's emotional commitments outward, decreasing potential for increased understanding and intimacy. Secrets are easier to keep.	Essential that therapists speak with each other to check that goals are similar and each has the same information about the relational problems.

Note. Adapted from Josephson and Serrano (2001). Copyright 2001 by Elsevier. Adapted by permission.

described her seemingly very provocative rejections of him, and his genuine attempt to make things better between them. Bob acknowledged his shame at having physically pushed her in the past when he was angry and he apologized for this impulsiveness. He was softer and more reasonable than the therapist anticipated. Both Abby and Bob had similar East Coast liberal backgrounds, and the cultural issues involved in their evaluation and treatment were secondary to gender issues.

Following the meeting with Bob present, the individual therapist began to confront Abby more directly about her own history and issues. Her difficult and critical relationship with her mother, lack of acknowledgment by her father, her sense that her brother was favored, along with the family history of depression, seemed central to the origins of her fragile self-esteem, sensitivity to criticism, and avoidance of direct conflict. Of course, Bob was contributing to their dysfunction, and his aggressive behavior was a significant problem, but what could Abby do to address it? It was easier and more effective to work on her problems using the psychodynamic therapy model with the additional data that came from Bob's visit. The issues with Bob could be peeled away more easily, allowing her to look at what she brought to the relationship.

Reality is fundamentally different from each partner's perspective. Where Abby felt ignored and victimized, resulting in withdrawal and anger, Bob felt set up and criticized, leading him to feel impotent frustration. The truth is that it is always easier to see the other person as the problem and see oneself as the victim, simply responding to unfairness. An intimate relationship can bolster individuals' defenses against dealing with their problems honestly and directly. Abby's early attachment issues surely prefigured her role in the marriage. The same would be true for Bob. If the therapist really sees what is going on from all sides, there is greater potential for holding individual patients accountable for the dynamics they bring to the relationship.

We recognize that bringing others into individual psychotherapy does complicate transference reactions, but these reactions are usually pretty apparent and can withstand this influx of reality. The benefit in observing the partner and the interactions, and cementing the family members' support for the treatment, usually outweighs this concern. Temperance and care in supporting both parties will prevent the patient (or the partner) from feeling ganged up on.

Careful preparation of the patient is required for a couple consultation in the setting of individual therapy. Confidentiality issues must be discussed in advance. When the patient is initially resistant, which is not

uncommon, a discussion of concerns and fantasies about the meeting is useful as it leads to further understanding the patient's feelings about the relationship.

We recommend a specific format (see Table 15.2) for couple consultation in the context of psychodynamic therapy. This requires slightly more time than the usual psychotherapy session. The implicit message of the consultation is that the family is important and the partner is an ally rather than the enemy. This model is easily modifiable for young adults meeting with parents or older patients in a consultation with their adult children.

The purpose is to learn about the patient from the perspective of the partner and to see whether there is a couple problem, or if there are resources within the couple that can help the individual. Change is not expected. We recommend the following:

- *Greet the partner*, reviewing the purpose of consultation, making it clear that this is not "therapy," but that you are interested in the partner's view of the situation. The partner is treated as a guest who has an interesting perspective rather than a problem.

- *Request a life history from the partner*, a description of the individual patient's strengths and vulnerabilities as the partner sees them, and an overview of their current work or life structure. Informally assess whether the partner has an Axis I diagnosis (do this as unobtrusively as possible, because you do not want this to look like a formal evaluation). A very brief history will facilitate an alliance and help develop some understanding of the partner's state of mind. We explain this is a "sound-bite" history and limit the time for this to 15 minutes.

- *Explore the partner's ideas and concerns* about themselves; the relationship; the patient's condition, strengths, and vulnerabilities, as the partner sees them; and an overview of their current work or life structure. What are the partner's hopes about the patient's therapy and how the relationship should change? This should be a three-way conversation, with the patient participating. The information gleaned should allow you and the patient to consider their behavior in a new way. A patient who has started therapy for depression and has trouble with self-assertion might look at themselves differently (as might the therapist) if the partner reports in a consultation that they are quite critical and demanding at home. If the patient already has a psychiatric diagnosis, ask what the partner knows about it. For example, the partner might know that the patient has attention-deficit/hyperactivity disorder (ADHD), but not understand that their inability to carry out promised tasks is a symptom of the problem rather than lack of love.

TABLE 15.2. Format for Couple Consultation in Individual Dynamic Psychotherapy

- Greet partner.
- Request a life history from the partner (approximately 15 minutes).
- Explore the partner's ideas and concerns about the patient's condition and the partner's hopes for the patient's therapy.
- Ask the couple to give you a marital history as a shared task.
- Ask each partner to comment on the other's family and history and on the strengths of the marriage.
- Assess the couple's strengths and vulnerabilities, and make note of their strengths and potential for greater satisfaction.
- Thank the partner for coming.

• *Ask the couple to give you a marital history as a shared task*. You will get two different versions of the history, which is to be expected. What is of interest is where the differences are. During this time, ask the couple to talk to each other about shared events in their past. Ask about how the children, if any, are doing. Ask specifically about strengths in the relationship.

• *Ask each partner to comment on the other's family and history.* This will usually pick up obvious past issues and current in-law problems and add to your understanding of each person. If you are not sure about the patient's family dynamics, the partner can usually tell you, and vice versa.

• *Assess the couple's strengths and vulnerabilities.* As the couple talks, consider their affective bonding, power relationships, boundaries, communication, and problem solving. How have they handled other stresses? How are they handling the current one? How do they understand the present problem? Does the relationship seem to be the cause of the problem, making it worse, or making it better? Ask specifically about what they see as current strengths in the marriage.

• *End the consultation* by thanking the partner for coming in. This might be the only time the partner is seen. Explain the individual treatment plan and highlight the couple's strengths and previous successes. If couple therapy is indicated, discuss it. If you believe the other partner could use therapy, consider whether it would be appropriate to gently suggest this.

Conducting a couple assessment or treatment requires the therapist to be more active than in individual sessions. The emotional energy is between members of the couple or family and the therapist is the

"conductor" of the joint session. Unless the therapist manages and controls the session, it is likely to devolve into arguing and little will be accomplished. It may be startling for the individual patient to see their therapist be more active, confrontational, or directive but they usually find this more interesting than upsetting.

It is complex and challenging to manage differences in culture, race, gender, and sexual preference with patients. These issues must be dealt with directly and with curiosity and humility by the therapist. With a heterosexual cisgender couple, only one member of the couple will be a different gender than the therapist and that person is in danger of feeling marginalized. This needs to be discussed and reevaluated over the course of the therapy, as there are usually considerable transference or countertransference issues regarding gender and connection, beliefs about gender roles, and unconscious bias toward or away from one's own gender. Differences in race, including experience with discrimination and oppression, requires awareness and curiosity on the part of the therapist to open up a conversation about ways of understanding the patient's experience that acknowledge systemic racism and racial trauma. A power differential between therapist and patient is important; a younger therapist with an older affluent couple may feel powerless. When a therapist and a patient come from different racial-ethnic backgrounds or different countries, there will be larger gaps in cultural understanding, and this requires particular effort to understand and communicate.

Begin Individual Therapy; Refer for Couple Therapy

Sometimes the couple consultation helps to facilitate individual therapeutic work, but then the couple reaches an impasse in their interaction at home that is tenacious and painful, and a referral for couple therapy is warranted.

> Abby's individual therapy helped her explore her early feelings of insecurity and loneliness, self-esteem vulnerability, and tendency to express her needs in an indirect way. She was no longer depressed, and she gained strength and insight from the experience and felt ready to try to make some changes in the marriage. Above all, Abby felt more able to be assertive.
>
> Despite her increased insight and greater strength, Abby and Bob seemed quite stuck in their dynamic. She experienced him as angry, critical, demanding, and bullying, and this did not seem to change when she asserted herself. Sometimes that escalated their tension. Abby reported that Bob continued to complain that he felt she

was detached and unloving. The therapist referred them for couple therapy so they could work more directly on their interaction.

Although occasionally an experienced therapist can fulfill all of the roles of the couple and individual work, we recommend referral to a couple therapist whom the clinician can trust and communicate with.

Begin Couple Therapy; Refer for Individual Therapy

The story of Abby and Bob might have played out differently if they had started their treatment as a couple.

Abby, a heterosexual married woman, set up a couple appointment for herself and her husband. She said her husband was willing to come, but he thought she was really the problem. Although Abby disagreed and was angry at this attitude, she was upset enough about the marriage to agree. Both members of the couple were White, cisgender, and in their late 30s. They had one young child.

The therapist took a history of the couple's relationship, including how they met, their backgrounds and genograms, their strengths and parenting of their child, and their disappointments and difficulties. In these initial sessions, the couple therapist discovered that Bob was already in individual therapy for anger issues, and did indeed blame most of the marital problems on Abby.

As with many couples, these young adults had begun their married life believing that their partner could meet their deepest needs. Abby was a shy, quiet, and lonely woman who was attracted to Bob because he appeared strong, powerful, helpful, and emotionally available. She believed he would protect her and give her love and liveliness.

Bob appeared to be a strong, confident man, but he had deep unmet longings for affection and approval, and he felt uncomfortable with these dependent feelings. He believed his job was to save, guide, and protect a woman who would then be grateful to him and make up for his insecurity.

But as time went on, their implicit emotional contract gave way to disappointment and resentment, as Abby felt overwhelmed and controlled by Bob's demands and responded by withdrawing. He experienced her wish to control her own life and her subsequent depression as a rejection, so he began increasingly coercive attempts to get her attention and love.

Bob's anger dominated the couple's sessions and made it hard for the therapist to focus on Abby's indirectness and her quietly

provocative behavior (e.g., simply not responding to appropriate questions from Bob). The therapist was able to communicate more easily with Abby, whom she saw as victimized by Bob's anger, and this made Bob feel even more unsafe and mistrustful of the treatment.

Over time, Bob became more able to acknowledge responsibility for his demandingness and his past episode of physical aggression. He had more genuine remorse. Abby talked much more clearly about herself and her tendency to express her upset by looking for opportunities to punish Bob for his anger by making him feel that he was a bad husband. She saw how this fit perfectly with Bob's aggressiveness; her indirectness was a way of dealing with his implacable demands and provoking him at the same time, making him look even more wrong.

Abby realized that it would help her to have individual sessions to discuss the interaction between them, including their interaction in the couple sessions. She owned her tendency to feel rejected, angry, and guilty, and the way she expressed this by taking the role of victim in the relationship. Abby began to see the friction between them as a reflection of her older childhood-based conflicts about closeness, criticism, anger, and emotional withdrawal.

Abby and Bob developed and practiced more effective ways of communicating and asserting their needs. With this improved interaction, Abby was left feeling her inner sense of loss and separation more directly, sometimes more acutely. She no longer had the distraction, and enactment with Bob, to manage it. She needed to find better ways of dealing with these feelings.

In her individual therapy, Abby worked on her feeling of rejection and detachment from her mother and the effect of this on her self-esteem. She was intensely self-critical and guilty and could begin to see that this had to do with the dynamics of her core problem of depression.

While the focus of individual dynamic therapy allows therapist and patient to look at the old unconscious patterns that may be less obvious in the couple setting than the more obvious legacies of family relationships and values, couple therapy maintains balanced attention to the role of the past of each partner, including the core psychodynamic problem, beliefs about marriage, and the old patterns of behavior contributing to the problem. The work can decrease the pain and tension in the interaction, allowing each partner to be more self-reflective. This is the goal and sometimes helps to define some important individual therapy goals for one of the members.

Concurrent Individual and Couple Therapy

The Abby–Bob story can also be understood as an example of concurrent individual and couple therapy. As they continued their couple work, focusing on their interaction and communication, each was working on their understanding of themselves in individual therapy. The integration of individual and couple treatments allows for more data—information about each person and how they are feeling, as well as the opportunity to see them together and understand how they interact. It allows the spotlight to be on the relationship in the couple therapy and on the individual psychodynamic problems in the individual therapy. Finally, concurrent individual and couple therapy gives each person a chance to try out new ways of experiencing the partner and new behavioral responses. This synergy can occur if the individual and couple therapy happen concurrently, or if one follows the other.

> Abby and Bob's couple therapist planned for a treatment where the couple's work would be integrated with each member's individual therapy. In her individual therapy, Abby worked on her feeling of rejection and detachment from her mother and the effect of this on her self-esteem. She was intensely self-critical and guilty and could begin to see that this had to do with the dynamics of her core problem of depression. Meanwhile, Bob's core psychodynamic problem, low self-esteem, became clearer and he was able to consider why he was so dependent on Abby's moods and responses, and why he got so angry and intimidating when he felt rejected or disappointed.
>
> There were periodic phone calls between the couple therapist and the two individual therapists, making sure the basic facts of the couple's life and interaction were consistent and shared. There was also clarity about the fundamental issues each individual was dealing with—depression and low self-esteem, allowing the couple therapist to identify manifestations of these problems as they came up in the couple sessions.
>
> Over time, Abby was more able to hold her own in the couple's meetings and began to give up the victim role and assert herself more effectively. Bob handled this with some ambivalence—glad she was more present, but struggling with giving up some of his control. He could reflect on this in individual sessions and process his ambivalence, and practice more adult and mutual communication in the couple sessions.

Abby's individual problems, primarily depression and low self-esteem, were intertwined with the marital problems—that is, they were

manifested in and to some extent caused by the relationship. Bob was the perfectly fitting puzzle piece for her, with issues of rejection sensitivity and anger when his needs were not met. But Abby's problems might have manifested differently if she had married a supportive and easygoing husband; then she might have presented with issues at work, or with her children. If she had married a quiet and passive man, she might have become the pursuer or emotionally demanding partner. Similarly, Bob's rejection sensitivity and need to pursue and dominate in order to feel safe met their match in Abby.

Another case example serves to illustrate the remarkable synergies of couple and individual therapy:

> Joan and Colleen, a cisgender same-sex married couple in their late 30s, came for treatment because of distress about their relationship. They have a 3-year-old son, the result of Colleen's pregnancy. Joan is a successful doctor, a second-generation Russian émigré, with an enormous need for admiration. She received attention in childhood for her appearance and academic performance. She works exceptionally long hours, even for a doctor, and receives many awards. Colleen is an adjunct faculty member at a nearby Catholic college. She was a parentified and somewhat neglected child and was praised for taking care of others. At work, Colleen was given little choice about the classes to which she was assigned and could not advance because she was not on the tenure track. Her income and work hours are much less than Joan's. Joan and Colleen came out as adults and had significant internalized stigma about being lesbian. Both are very circumspect about their relationship at work and not much involved in the lesbian community.
>
> Joan and Colleen's shared "contract" had been that Joan earned the money and Colleen took care of everything else regarding their shared home and emotional life. This worked for a few years since Joan craved attention and Colleen was used to being the caregiver and emotional support of others. But, in recent months, Colleen began to complain that she felt like a "50s housewife" and to request more help at home. Joan only begrudgingly complied. Their son was a flexible and easy child, but increasingly active and needing plenty of stimulation.
>
> Colleen recently discovered that Joan had been secretly meeting a coworker for drinks and they were on the brink of starting an affair. Colleen became deeply depressed, realizing that her long-term strategy of being the caregiver did not get her the love she craved. Joan was humiliated that this relationship had come to light and realized she did not want to lose the marriage.

Joan and Colleen came together for couple therapy to save their marriage. Joan was desperate to please and the initial months of couple therapy did nothing to alter Colleen's rage and deepening depression or Joan's confusion over her motives and fear of losing the marriage. The couple therapist insisted that both Joan and Colleen get individual treatment. Joan needed it to understand why she was seeking out the company of another woman, and Colleen was increasingly depressed and struggling to maintain her functioning.

They each began individual therapy and the couple therapist saw them every 2 weeks to stabilize the system and to support both individual therapists. In couples work, Joan was encouraged to become more generous at home and to understand her need for attention. Colleen worked on finding her voice and taking care of herself. It was clear that without the couple therapy, Colleen's therapist would have been tempted to encourage her to leave the marriage, and Joan's therapist would have been tired of hearing about the continuing depression and thinking that Colleen should be able to get past the near affair. After a year, the couple is still together and working actively on their relationship, as well as the individual conflicts that they bring to the relationship. Both are committed to the marriage in spite of the difficulties.

The two cases here contrast because Joan and Colleen came in a state of acute marital distress and both were referred for individual therapy, while Abby and Bob came to treatment together in the setting of Bob's individual treatment and their increasing distress. But, in both cases, the synergy of couple and individual therapy allowed both members of the couple to understand the needs, perceptions, distortions, and coping strategies they evolved in their own individual development and how this contributed to the interlocking puzzle of their relationship. They could bring that understanding into the couple sessions to promote greater empathy for their partner, more regulated emotional responses, an increased capacity for health communication, and they could practice new ways of feeling and behaving together.

Two Individual Therapies

Sometimes both members of a couple are in individual therapy with different therapists. When the couple is stable and communicating well, they can share their learning and use it to improve their relationship. If the therapists do not speak to each other, however, or do not share each other's view of the world or the partner, difficulties may ensue. If the individual therapist sees the patient as the victim, there is a tendency,

either by direct advice or by the way questions are posed, to encourage the patient to believe they have no responsibility for the problem. Frequently this leads to increased distance in the couple and sometimes even separation because the patient believes that the partner is hopeless and that there is no other way out.

Having two individual therapists is not the most effective way to track or alter marital communication. It does allow each of the partners time and space to work on their most troublesome problems. The two-therapist model works if the therapists communicate, and is most useful when each therapist meets the patient's partner at least once. In some cases, the two therapists and the patients meet periodically to make sure the relationship is being cared for. If the therapists are comfortable working with each other, this can be an effective way of dealing with relational and individual problems at the same time.

If Abby and Bob had both started individual therapy, they might have worked out their own issues—Abby becoming less reactive and withdrawn, Bob more self-sufficient and less demanding—and this could have tipped the balance into a cycle of decreased defensiveness. They could have expressed themselves, sought mutual understanding and compassion, and this would have brought them closer. But it's also possible that Bob would have complained about his wife's unavailability, minimizing what he brought to the marital conflict, engendering empathy and support from his therapist, and potentially locating the problem in Abby. Likewise, it is possible that when Abby related the history of Bob's physical aggression, her therapist would rally around her and focus on Bob's limitations. This might make each feel supported and understood, but result in less open and genuine communication between the members of the couple and a deepening of their distrust.

COLLABORATION BETWEEN THE INDIVIDUAL AND COUPLE THERAPISTS

The first principle of collaboration is open and frequent communication between the individual and couple therapist. This sounds obvious, but is often not done. The therapists may be concerned about the time involved, or about the possibility of altering the transference or sharing secrets. The couple therapist's feeling about the patient may be very different from the individual therapist's, or they may be frustrated that the individual therapy is not covering areas that are important to the couple. Openness moves both treatments along, with judgment on all sides about what is essential and important to communicate, and what will quell difficulty rather than incite it. It is striking how often this type of communication helps to calm the couple down. When one member of the couple tries to limit the communication, this is a warning sign and

must be dealt with carefully, but with an attempt to keep the lines of communication open.

The second principle of collaboration in combined couple and individual therapy is that the individual therapy should not become a forum for complaining about the partner. It is natural enough for this to occur, as the patient may believe that the partner is the main source of their symptoms, but it is quite unproductive. The couple therapy is the outlet for those resentful feelings and the best place to handle them. The individual therapy should focus on the individual, and the therapist must be firm and clear about this; otherwise, time will be wasted and the couple therapy will be undermined. This requires trust by the individual therapist that the couple's work is moving along and fairly balanced. Reinforcing these boundaries is an important focus of therapist communication.

Just as we have emphasized the importance of a clear formulation and treatment plan in individual treatment, this is true for combined treatment. The third principle is that the individual treatment plan should mesh with the couple plan. A coordinated plan orients the patient(s) and the therapists. Simply put, this means that the individual therapist works on a core psychodynamic problem and its manifestations in the patient's life, including in the relationship. The problem and the focus of that work should be communicated clearly to the couple therapist. When the couple therapist is aware of the central individual therapy focus and can refer to it, this will facilitate work on how this problem affects the couple's relationship.

PITFALLS IN COMBINING TREATMENTS

In contrast to the effective integration that occurs when the therapists communicate fully and regularly and keep the individual–couple treatment boundaries clear, there is much potential for confusion, disorganization, and damage when the coordination breaks down. Infrequent communication between the therapists is the mildest version of this problem. Patients may tell different stories to each therapist, promoting their own agendas differently in the two settings. For example, one patient insisted in couple therapy that they wanted to save the marriage, while discussing divorce with their individual therapist.

Perhaps one of the most difficult problems occurs when secrets are known to the individual therapist but not the couple's therapist, and the individual is not ready to allow these to be shared. An affair, strong sexual feelings for a different gender identity than the partner, or impending plans for divorce are some examples of this. While the individual therapist is ethically bound not to reveal secrets, they should make clear

to the patient that unless they are revealed, the couple's therapy may be compromised.

Therapists with different worldviews, values, therapeutic theories, or those who have specific disagreements create tremendous confusion and difficulty for their patients. For example, a therapist had seen a patient with fear of abandonment over a number of years, during which time the patient seemed to improve significantly. The couple's therapist thought the patient was still extremely disruptive within the marriage and requested that the individual therapist refer the patient back to the psychopharmacologist for a medication change. The individual therapist and the patient both saw this as an insult. The two therapists could not agree on a treatment plan, and the couple was faced with having to choose between plans themselves. The couple therapy nearly ended over this problem. This could have been avoided by a frank discussion between the two therapists where they resolved their differing perceptions and made a recommendation together.

It is hard enough for patients to sort out their problems and the complexity added by therapist–therapist conflict makes it much worse. While this situation is both frustrating and humbling to the therapists, it is also helpful to remember that well-trained therapists may differ enormously about the diagnosis and treatment of members of a system, depending on who in the family they are treating.

SUMMARY

Individual dynamic therapy and couple therapy can be synergistic, and there are a number of typical scenarios for how they are combined in clinical practice. Each scenario has particular advantages and pitfalls, and there are management approaches for each scenario. There are three principles for combining individual and couple work.

1. Communication and transparency between the two therapists is essential. Communication problems abound and it is the therapists' responsibility to manage this and come to effective consensus.
2. The individual sessions should focus on individual psychodynamic problems, and the therapist must be active in maintaining this boundary.
3. A clear focus for individual therapy and for the couple therapy increases treatment effectiveness and decreases confusion for all involved.

PART V

ENDING

16

Goals and Termination

> Freudian psychoanalysis is best for the young, Jungian analysis for the middle-aged, and when you are old, you need yoga.
>
> —Morris Schwartz, subject of the best seller *Tuesdays with Morrie*

Although less certain than death and taxes, the end of psychotherapy is inevitable. *Termination*, the term for the completion of therapy, sounds more like a death than a new beginning, but ending therapy is actually a transition to greater independence and maturity. Termination signals the end of a relationship and a graduation from a personal development program; it also offers a new kind of relationship experience.

Feelings about ending psychotherapy run high in both the patient and therapist. For the patient, it may be the loss of a benign and caretaking figure, and excitement and trepidation about flying solo. The special relationship and the undivided attention will be hard to replace, and there is often a powerful sense of sadness. The endings of earlier relationships will shape the emotional response to the end of this one.

Ending therapy means a return to traveling along life's developmental pathway without professional help. Ideally the patient will have greater self-awareness, new ways of perceiving experiences, and more adaptive behavior. There should be greater reflective capacity, use of more mature defenses, and greater strength. There will be future challenges and future conflict because maturation is never finished, and there will always be more adversity.

One hopes that termination occurs at a time when the patient wants it and is ready for it. The quotation at the beginning of the chapter reminds us that working out emotional conflicts is only part of maturity, and in some ways it is just the beginning. Knowing oneself and finding peace and acceptance is a lifelong task that requires various forms of

attention; working through emotional problems provides the platform for other growth opportunities.

For the therapist, ending the treatment is a loss, too. Patients figure prominently in our internal lives, and although the affective intensity for the therapist is usually less than for the patient, termination is a powerful emotional experience for us, as well. The satisfaction of termination results from a job well done, vicarious enjoyment of another person's hard work and good results, and an affirmation of the value of psychotherapy and sometimes of one's own values. Ending therapy does not have the satisfaction of personal change, more free time, and financial savings as it does for the patient.

There is surprisingly little empirical study of termination in psychodynamic psychotherapy (see Joyce, Piper, Ogrodniczuk, & Klein, 2007). Some of the research has focused on patients who were thought to have terminated treatment too soon; this is a common phenomenon, and across psychotherapies the dropout rate is close to 50% (Roe, 2007). While some authors suggest that early dropout reflects poor patient outcome, other studies suggest that some "dropout" patients benefited from therapy (e.g., Roe, 2007). Bhatia and Gelso (2017) found that therapists estimated they spent 17% of the treatment time focused on termination. Studies of patients who may have stayed too long in therapy are lacking. Our discussion of termination focuses mostly on treatments where there has been sufficient duration to identify problems, develop an alliance, work on a new narrative, and focus on making changes.

ENDING IS IN THE AIR: PLANNED AND UNPLANNED TERMINATION

There is an intangible feeling in the air in the session when termination is imminent. Sometimes this is present very early on, when the patient feels that therapy will not be helpful or the therapist is not helping them feel comfortable. This is an abortive treatment more than a termination proper.

Some patients want to end and consider their exit strategy well before they bring it up in a session. When a full treatment begins to move toward the phase of termination, the patient has often felt a sense of readiness (and the therapist, too) before it becomes conscious, and certainly well before the thought is articulated by either party.

When there is less new material, more working through of the same situations and interpretations, less distress for the patient, and more of a sense that the patient is reporting events and not breaking new ground, the treatment may be moving toward termination. The patient may try

to think of topics to discuss and seems pleased when there is a meaty or conflictual situation to bring up. There is less urgent need to get work done.

Sometimes the therapist becomes aware of the imminence of termination first. The patient is plowing forward, continuing to use the sessions in the same way, but the therapist senses that things are better for the patient, the goals have been accomplished, and the motivation for continuing is not clear. There is always something to talk about, always something to understand better or deal with in a better way. But the benefits of coming to treatment must be greater than the costs—of time, money, emotional involvement, distress—to justify it. If there is not genuine forward motion, the therapist will usually feel this and begin to wonder.

It is a challenge to determine whether the therapy is slowing down because the work has largely been done, or whether there is an impasse and the patient and therapist are stuck. There is always potential for transference and countertransference to interlock, with the patient and therapist enacting old scenarios. For example, a patient with fear of abandonment may handle this recurring issue by rejecting closeness and leaving relationships prematurely. The therapist could be prone to feeling guilty about confrontation, and this pair will be vulnerable to an impasse where the patient stops bringing in new material, and the therapist lets the patient go and supports an early termination. The therapist and patient may not be able to get on top of this interlocking mutual fulfillment of unconscious need and free up the interaction to be able to talk about what is going on and enact it less. This is an example of a psychotherapeutic impasse.

When termination occurs in a short-term psychotherapy with a planned number of sessions, the experiences of loss and separation typically show themselves clearly in the later sessions. Using the Core Conflictual Relationship Theme (CCRT) framework, a systematized psychodynamic model, Nof, Leibovich, and Zilcha-Mano (2017) observed a regression in the patient's "response of self"—that is, their characteristic response to perceptions of others' reactions to them. This temporary return to old interpersonal scenarios under the stress of termination and separation reverses the patient's movement toward more current, reality-oriented and adaptive responses. They recommend specific techniques for handling the final session, including summarizing a coherent narrative understanding (Adler, Skalina, & McAdams, 2008), promoting a balanced view of the patient's experience that they refer to as "combining the whole," empathic inquiry into the patient's experience of termination, and the use of statements or letters summarizing the work done during the treatment.

In Chapters 5 and 6, we described the potential resistances, enactments, transferences, and countertransferences that arise with each of the six core problems and could result in an impasse. The therapist is responsible for asking whether the feeling of termination "in the air" is a consequence of effective work done, or whether it reflects an impasse. You will use your understanding of the core problem, formulation, and defined goals to consider this, and you will discuss it directly with the patient.

Although it is important to understand whether the impending termination is appropriate or the result of an impasse, much of the discussion in the psychodynamic and psychoanalytic literature presumes that the therapist has more control over the process than is actually the case. If starting the treatment and identifying the core problems is like taking a ski lift to the top of the mountain, then rewriting the narrative and working on change are like skiing downhill. Termination is the last few minutes at the bottom of the hill when you have built up so much speed that getting to the base is inevitable. We can raise questions, help to clarify what is going on about ending, but mostly we need to get out of the way and let the patient do whatever is necessary.

The only exception to this approach is when there is an enactment where a patient abruptly and intensely wants to leave, and prior to this point there has been a good therapeutic alliance and good therapeutic work. The transference–countertransference may have built to a fever pitch, and the patient wants to leave because of it. The enactment may involve a negative transference with powerful feelings of anger or fear, or a positive transference, either of which the patient strives to contain by leaving. In these situations, the therapist must be clear and direct in interpreting the situation to the patient, supporting the reality, and explaining why it will help to stay and work this out.

Carrie was the twice-married woman in her early 50s previously described in Chapter 8. She had been treated with CBT for anxiety and mild depression. She was warm and friendly, with a very quick sense of humor that usually involved a rueful acknowledgment of her burdens in life.

> Carrie had lost her beloved father within the previous year and contended with an acrimonious relationship with her mother, a selfish and vain woman who felt increasingly alone and demanding as she aged. She had two college-age daughters, one of whom had depression and a lot of interpersonal drama. The older daughter was set to graduate from college, and Carrie was very worried about how she would do without the structure of college life. The daughter cried often and was alternately angry and needy. Carrie was glad that the

daughter's long-suffering boyfriend was there to manage a lot of her emotional lability.

The background, and ultimately the foreground, of the treatment was Carrie's worry that she was a bad mother, like her mother had been, and that's why her daughter was struggling so much. The psychotherapy took place on a weekly basis over a year and a half and was characterized by a strong alliance. We talked about her difficult early relationship with her mother, competitive older sister, and her fun-loving but intermittently unavailable father. Carrie reexperienced many old emotions, including fear and anger toward her mother, a need to manage her mother's moods, worry about her criticism, and a feeling of helplessness and loss about not seeing her father much after the parents' divorce.

Carrie returned numerous times to the painful feeling of disappointing her mother, and worrying about her mother's anger with her. This made her anxious and resulted in a characteristic compliant response. Over time, she learned to separate her feelings from her mother's and worry less about what her mother felt. Carrie could decide what was an appropriate degree of responsiveness to her mother, tolerate her mother's disappointment, and be freer from guilt and self-criticism. Needless to say, this helped her with her relationship with her daughter, as well as other relationships.

Carrie felt that generally she functioned well in life and had made significant progress in feeling freed up from worrying so much about her mother and her reactions. She thought she might be ready to stop therapy. But she was worried she would start to feel the old feelings again if she stopped. Carrie had felt well the last time she stopped therapy and later felt much worse.

My question about ending therapy was whether it was true that Carrie's treatment had gone well and she was ready to stop, or whether she had only gone so far. Did the pleasant working relationship with me avoid conflict in the therapeutic relationship? In other words, was the positive transference a defense against more conflicted feelings about me, either as a cold mother or the unavailable father?

We had defined low self-esteem as Carrie's core problem and worked on this intensively in her relationship with her mother and at various times in her relationship with her sister, husband, daughter, and colleagues at work. She did seem to feel much better, and was less upset when she spoke with or saw her mother. Carrie seemed more even-keeled and happier. When there were glitches, she seemed to recognize the old patterns and correct them with a more contemporary perspective and response. Carrie was appreciative about the therapy. But she was afraid to leave.

So I summarized all of the work we had done and wondered about how it felt to consider leaving. Carrie worried that I thought she was still "crazy," and felt sad that she would miss the sessions if she stopped because they had been so helpful. Mostly she wanted to know whether she could come back if she needed it. Would I be upset with her for leaving and not want to see her again? After probing further, I concluded that the dominant feeling about termination did seem to be a concern about losing support; this was likely connected to the old feeling of losing her close relationship with her father and her longing for a secure relationship with her mother. But I did not think these old feelings and the conflicts associated with them were resulting in an impasse—that is, it did not seem that there was a negative transference she was leaving treatment to defend against. There is always more to talk about, but Carrie seemed to have achieved the goals she had set out for herself: feeling freer in her relationship with her mother and less guilty about her daughter's difficulties.

I felt pleased at the progress, encouraged the termination, and asked Carrie how she would like to end. She wanted to switch to monthly appointments for a couple of months to be sure that she really did feel as well as she thought she did, and then stop from there. At the last appointment before moving to this monthly schedule, it was almost as though Carrie were holding her breath as she left the office, excited about whether she would make it, but worried. In fact, she came back for four monthly appointments, weathering one small crisis during that time, and then she decided she would stop and hope for the best.

This example of a typical termination experience illustrates the attention to the criteria for termination, questioning of the decision (skeptical but respectful), attention to the transference meaning, and the expectation that the decision to end or continue belongs with the patient.

REASONS FOR TERMINATION

The psychodynamic psychotherapy literature emphasizes a variety of criteria for ending, such as symptom resolution, attainment of goals, internalization of the psychotherapy function, and resolution of the transference (Weiner, 1998). It is clear what is meant by symptom resolution and attainment of goals. The patient is the best judge of this. The next criterion is interesting and important. It is variously referred to as *identification with the therapist*, *development of self-reflective capacity*, *insight*, and *improved relationship skills*. Each of these terms has

a slightly different meaning and different connotation, but all speak to the patient's ability to do for themselves what the therapy relationship helped them to do. Does the patient have the ability to continue questioning, analyzing, self-assessing, and self-correcting the work? This is essential because it is not possible (nor desirable, probably) to have a treatment that is so thorough that every possible issue is taken up and worked on. The patient should be able to function independently and manage problems as they come up.

The psychodynamic, and especially psychoanalytic, literature is focused on how termination can represent an acting out of unresolved transference (Greenson, 1967). Freud (1937), however, seems to have had a rather pragmatic perspective, wondering in his classic work on the topic, "Analysis Terminable and Interminable": "Is there such a thing as a natural end to an analysis?" (p. 219). His point was that there is always more to do, and the timing of ending has some degree of arbitrariness. Indeed, Roe (2007) found that 60% of private practice dynamically oriented psychotherapy patients thought their treatment lasted too long or ended too soon.

Our view is that there is almost always a transferential aspect of the decision to end therapy, and if enough of the criteria for termination have been met and the patient really feels ready to go, you will probably not achieve more by pushing the patient to stay. A lot of life involves the acting out of unresolved transference wishes, and our goal is to help the patient get some perspective on this, and determine how much is too much.

Some authors distinguish between forced and unforced terminations (Glick, 1987). Forced terminations come because the patient is leaving the area, there are financial or schedule limitations, or the therapist is no longer available. The determining event is something outside the treatment and outside the dynamic of the therapy. Unforced terminations occur when the internal logic of the treatment results in a decision to end, either because of effective resolution of the problems or an enactment. In our experience, it is much more common for patients to begin to consider ending than for therapists to propose it. Therapists tend to get involved and want to stay involved, and we experience less pressure to end than the patient does—after all, it's what we do, and for the patient therapy is an add-on to their lives.

Financial limitations and constraints imposed by third-party payors frequently limit the duration of therapy. Therapists must, of course, respect the financial decision making of their patients, while making sure the emotional determinants of financially driven termination are explored. When an insurance company cuts off reimbursement, this shared external "enemy" can be a source of bonding between the patient

and therapist. Acknowledging the sad limitations of our health care system supports the patient's sense of reality, but vilifying payors can limit the exploration and acceptance of the inevitable limits of therapy by distracting and projecting these issues outside the therapeutic relationship.

BEYOND PATHOLOGY: ACHIEVING POSITIVE GOALS AS THE CRITERION FOR TERMINATION

So far, we have discussed reduction in pathology as a marker for considering termination, but positive criteria may be even more important. If the goal of treatment is better adaptation, and not just symptom reduction, then perhaps the most important question is whether the patient's adaptation has improved and whether it could improve more. If each patient comes to the therapy with a set of characteristic defenses and usual coping strategies, by the end of the treatment the defenses should be healthier, employed more flexibly and smoothly, and there should be a greater inner sense of freedom. Is the patient who is obsessional using higher-level defenses and employing them more effectively? Is the patient who is traumatized more empowered and more sure of themselves? From this perspective, the termination question is "Has the mental health of the patient improved?" and not "Has the psychopathology diminished?"

> Andrew was a 49-year-old divorced graphic artist who came for therapy because of confusion about his bisexual interests. He was deeply attached to and even obsessed with a male friend who was an athletic companion. Andrew's marriage had been short-lived; he felt very inadequate because his wife had left him, complaining that he was cold and unsympathetic. The divorce was 15 years ago, and she had remarried and now had three children. Andrew had had two enjoyable relationships with women since then, but when the possibility of marriage came up, he felt sure he would be rejected and humiliated and ended the relationships. He had a number of liaisons with men, but none became stable and intimate. Andrew was depressed and thought constantly about how much he wanted a sexual relationship with his friend, how dishonest he was because he never expressed this, and how his friend would be upset and distance himself if he knew.
>
> In the therapy, there was a rich and thorough exploration of Andrew's early life, his relationships with his parents and brother, and his many friends. He understood a lot about his problems with self-esteem and his strategies for managing this. Andrew's male friend got married, and they saw each other less. He was less troubled because

there was less contact. Andrew began to like himself more, and felt that his bisexuality was just the way he was—he was not sick and damaged. He wished he were simply straight, and wanted to find the right woman, but he somehow never felt as comfortable with women as with men.

There was no epiphany about Andrew's sexuality and no clear solution to his problem. But he began to have a feeling of starting life anew. He changed jobs, moving to a smaller company where he took a leading creative role, and took a long vacation with some money he unexpectedly earned. Andrew began to think about his future in a new way. He pondered the kinds of experiences and challenges he wanted to have. He was sad that he probably would not have the kind of relationship with a woman that he would have liked. Maybe he would find a man to be with, maybe the right kind of relationship with a woman. Andrew's dry sense of humor became more evident, and he was more playful. He had a number of excellent ideas at work that were recognized. His social life was more active.

Andrew ended the therapy about 6 months after the vacation and move to the new job. He wrote a note a year later to say that he was feeling well and was enjoying himself. Andrew expressed his thanks for the therapy and wished the therapist well.

This ending made sense from the perspective of symptom reduction, but it made even more sense in terms of the patient's return to a healthy life cycle progression. Andrew certainly felt better, he was taking on the challenges of aging, and was using his characteristic strengths—creativity, persistence, vitality, social intelligence, and gratitude—to find fulfillment and closeness in the next phase of his life. He had learned a lot from the painful entanglement with his friend, and he found renewed engagement with his work. He was better adapted to his bisexual feelings and had more comfort with this, and more awareness of what relationships worked and didn't work. Andrew was more comfortably self-reflective, and from the defense perspective, he began to use less reaction formation and doing and undoing, and also less repression. There was more sublimation and humor.

LOSS OF THE THERAPY AND THE THERAPIST

So far, the picture we have painted of termination has a decidedly positive cast, and indeed positive feelings are often prominent at termination in longer-term dynamic psychotherapy (Roe, Dekel, Harel, & Fennig, 2006). Work has been done, goals are mostly met, and the patient is

more or less ready to go. Both therapist and patient feel some degree of satisfaction. But ending will also stir up painful feelings of sadness and frustration. Patients may feel loss of the closeness with the therapist, disappointment about the extent of changes made, feelings of rejection, and reexperienced loss from long ago. These feelings will occur when there is an interruption in the natural progression of the treatment causing early termination, but they may be significant even when the termination is planned.

Psychodynamic psychotherapy allows the patient to experience these feelings of limitation, disappointment, and sadness, and explore them as fully as possible. Patients may be reluctant to discuss their negative feelings; after all, the treatment has to end sometime. They may be afraid to hurt the therapist's feelings and discuss how the relationship did not meet some of their expectations.

We have all had profound attachments, and loss or disappointment in those attachments is ubiquitous; it is part of normal and abnormal growing up. Because traumatic experiences repeat, childhood feelings of sadness, rejection, or abandonment will be triggered by the ending of the therapy. For example, a man whose father had died several years before, with whom he was especially close, was surprised at how much sadness and longing he felt in the last couple of appointments before ending. A woman who evolved a caretaking role with her mother to prevent fears of her mother's death wanted to avoid any sense of loss of the therapist; she was cheerful and focused on discussing her plans and the therapist's for the summer. Another woman whose father had died when she was a girl wanted to hold on to the therapy relationship and never finish, as she had always held on to her memories of her father.

Even if the patient wants to stop and is ready to stop, the end may be experienced as a rejection or disappointment. Transferential reactions are driven by timeless templates that do not obey the demands of current reality. That is why these feelings are so confusing to patients, and why exploring them and connecting them to the ongoing themes of the treatment (and the core psychodynamic problem) will help to complete the work. In termination, patients experience a "disactualization" of important wishes, realizing they will not come to pass, including powerful transference wishes, and this is a special type of alliance rupture that requires attention and repair (Ben David-Sela, Nof, & Zilcha-Mano, 2020).

Because the core psychodynamic problem is reflected in all areas of the patient's functioning, including endings, the patient's termination reaction can be anticipated. Depressed patients will likely be ambivalent about losing the relationship, and this will be intermixed with guilt and self-criticism. Patients who are obsessional will feel the loss and tend to

feel controlled by the therapist in the way the ending occurs; they will be angry and need to inhibit this aggression through the use of obsessional defenses. Patients with fears of abandonment will feel frankly bereft, and the loss will seem to them as real as the loss of a parent by a child. Patients with low self-esteem will commonly feel that the end of treatment, and the therapist's letting them go, means they were not so loved in the first place. It is a rejection, even if they initiated the ending. Patients with panic share the dependency and fear of separation that patients with fear of abandonment have, but they will likely anticipate and experience a recurrence of panic and want to remain as dependent as possible. Patients who are traumatized will see the therapist as punitive, or as the bystander who stood by and did not help.

Thus, the last task of psychodynamic psychotherapy is to help the patient see the connection between the negative feelings stirred up by termination and the main theme of the work. Carrie was able to connect her worry that she would alienate the therapist by leaving with her feeling that being independent made her mother feel abandoned and angry. She was worried about leaving because something bad might happen and she would not be able to come back to therapy because she had burned her bridges. Once Carrie saw this as a transference reaction based on her relationship with her mother and connected it to her main psychodynamic problem, she felt freer to leave. Andrew felt vaguely rejected by the therapist when he ended, although of course it was his decision. The therapist was male, and he felt such longing for and rejection by men.

Not all negative feelings at the end of treatment are based on transference. It is sad and disappointing for patients to realize that they are only able to change so much. They often had hoped for more. Maybe the treatment could have been more effective and the therapist could have done more, or the patient could have contributed more. Maybe it was all that could be accomplished. These are issues that most patients (and most therapists) ponder. It is necessary to validate the patient's feelings in this area and accept our own limitations as therapists, as well.

TERMINATION AND THE THERAPIST

Although it is supposed to be the patient who regresses and gets in touch with old powerful feelings in the therapy, the therapist also gets deeply attached and feels the loss. It is painful and uncomfortable to say goodbye to patients at termination. It is worse because we feel we have no control over the process—it is supposed to happen when it does and how it does for the patient's greater good, not ours. Gabbard (2005) notes

that, as therapists, we must get used to a "professional life of constant loss" (p. 112).

We can become so set in our role that we ourselves might not notice how important the attachment to a particular patient has become. This attachment might reflect a powerful countertransference reaction or may just reflect the duration and intensity of a long-term relationship. You have spent more time in the last year with certain patients than you have with a lot of your good friends or relatives.

Therapists need to feel the end of the treatment relationship and in some way mourn the loss. If the end of a treatment fills you with emotion, then it will be important to sort out how much this has to do with losses and endings in your own life, or life cycle issues you are personally engaged with. Perhaps the patient's experience reminds you of some specific losses in your history. Just because you can interpret what is happening based on the patient's transference and conflicts does not mean it does not reflect your concerns, as well. For example, patients with trauma often stir up guilt and anxiety in the therapist at the end of treatment because the therapist is no longer able to protect them. Patients with panic can be so dramatic and anxious at termination that therapists are relieved the treatment is over, and this leads to feelings of guilt. Like any mourning process, there is not much to do about it other than to know the meaning of what you are experiencing and try to let the feelings take their natural course.

If the problem is that you do not feel much about a termination, then it will be important to think more about the patient, the work together, the moments of emotional intensity, and imagine the next chapter of the patient's life. This will likely bring up some of the unrecognized emotion you may have.

One of our trainees was excited about her graduation and beginning of a prestigious postgraduate fellowship. She had to refer several of her psychotherapy patients to new trainees. She felt guilty about how well her life was going and how her patients were still struggling. This guilt caused her to delay telling her patients about her graduation—she thought they would be angry with her. One of the patients being transferred was a young woman who had been abused and was angry with women in general. The combination of the resident's guilty feelings and the patient's dynamics resulted in the resident's being especially avoidant. Not surprisingly, this made the patient especially hurt and angry when she learned without much notice that she would need to stop. The trainee then felt, of course, even more guilty.

We have become more interested in termination as the years go by, and see ending as more filled with emotion than in our years of training and early practice. Perhaps this has to do with aging, maturation, and

awareness of loss, as younger people tend to focus more on the beginnings and the future and less on endings. Perhaps it just takes more experience to see these clinical phenomena at a moment in the relationship when there is so much going on. But the earlier you begin to attend to the feelings about termination, the sooner you will see it.

MODELS OF TERMINATION

There are two different ways of conceptualizing the end of therapy: one based on the traditional techniques of psychodynamic psychotherapy, and one based on the primary care model of medicine and adapted for use in dynamic psychotherapy.

The traditional dynamic psychotherapy model sees treatment as a finite experience with a beginning, middle, and end, and regards the task of termination as the successful ending of the treatment, with the notion that the end of treatment should have a sense of finality. Treatment should be definitive, identify the key problems, and work them through to a successful conclusion. Maximal use should be made of the transference and what the patient can learn for themselves from the transference experience of loss at the ending of treatment. Although the patient may have difficulty understanding the progress that has been made and have an intense transference experience while ending, the working through of this experience is held to be highly therapeutic. The traditional model of termination is based on the idea that the patient will develop self-reflective functioning more fully when pushed to confront these transferential feelings and work on them. There will be subsequent life problems and life cycle issues to deal with, and patients will need to use the insight and changes they made during their finite course of therapy to manage these future challenges. This may explain the observation that patients continue to improve in the months after therapy (e.g., Blomberg, Lazar, & Sandell, 2001)—that is, patients become increasingly adept at using the knowledge and self-awareness gained during treatment.

By contrast, the primary care model presumes that the work of therapy is never done and does not try to push it to a conclusion in the middle of the game, so to speak. In this model, patients come for bursts of treatment when they are experiencing symptoms, having difficulty functioning, or are lagging in their ability to manage some aspect of their life demands. This occurs at multiple points along the life cycle. Treatment is offered when needed, and as patients begin to feel better (whether this is in the symptom, subjective freedom, internalization of psychotherapy function, or mental health sense), they pull away from

the therapy, aware that they may come back at some point in the future. This has also been referred to as the termination as consolidation perspective (Maples & Walker, 2014).

The benefit of this model is that it may be more parsimonious in terms of therapy sessions because there is less pressure to make the treatment definitive and final (which may be unrealistic), it has a natural feel to it, and there is less concern about iatrogenically stirring the patient up to deal with transference feelings about ending that might not otherwise need much attention. The problem with this model is that issues can easily be left on the table and partially resolved, and it is easy to avoid confronting limitations and losses. This model presumes that the future is not knowable, and if there are problems later, they can be dealt with then.

As you consider these two perspectives, you will see that they reflect two different ways of conceptualizing psychopathology. The traditional model is more consistent with treatment of a discrete and acute disease, while the primary care model presumes a chronic view of the problem and an appreciation of the need to develop strengths. It has become clear that depressive and anxiety syndromes infrequently disappear, but tend to wax and wane during the life span. More important, though, when one sees a patient early in the development of their illness, one cannot know whether the problem will become chronic except in the cases of certain syndromal illnesses. We have some knowledge that helps us prognosticate about who will have what course of illness, but unfortunately we are not yet very good at predicting the course of illness for a specific individual. This may be especially true for patients with troubling but less severe problems.

Because there is little empirical research to guide us about whether to employ the traditional psychodynamic model for termination or the primary care model, a few orienting principles are useful. We consider how likely it is that the patient will need and want more treatment in the future. Patients with more chronic conditions are more likely to have future episodes of illness or difficulty than those who have more circumscribed emotional conflicts that can be more definitively worked on. Those more likely to return may not be best served by an attempt to make the treatment definitive. Those patients who have done more extensive and deeper work in therapy, especially using the treatment relationship, will benefit from an ending that takes full advantage of working with transferential feeling about ending, and will probably be left in some confusion and disarray if the transference feelings are not worked on. Patients who have a benign positive transference, and whose relationship with the therapist is more based on the actual relationship (or the therapeutic alliance) than on the transferential relationship, will probably be able to end more easily when treated in the primary care

model because conflictual aspects of the transference have not been prominent.

Patients have their own feelings about how they would like to end. Some want to end precipitously; having thought about it themselves, they will announce the decision and want that session to be the last. Others are very anxious about ending therapy and want to slowly titrate down the frequency, trying to minimize the impact and desensitize themselves to their feelings about stopping. These requests must be respected but questioned. Is the patient who wants to stop quickly defending against powerful feelings about ending that will plague them after the treatment and that would be better off being talked about? Or are they really ready to end and move on? Is the patient who is worried about leaving therapy quite able to stop but overly anxious about termination? Do they need encouragement to be more independent? These questions are best answered in the context of the issues you have worked on with the patient and can be fleshed out with direct discussion with the patient. Your job is to raise questions, slow down action, and encourage maximal reflection. This is the essence of therapy at any stage of treatment. Nevertheless, most of the time, the patient (and the momentum of the treatment relationship) will determine how the ending is played out.

Nicholas is the businessman discussed in Chapter 2 whose wife was planning to divorce him. He came for therapy to figure out how to win her back, and much of his thinking consisted of his using "chess-playing" logical strategic thinking to figure out what his wife wanted and give it to her. The work of therapy was in helping Nicholas to get in touch with the many feelings he had about being a husband and father so that he understood what he really felt and what kind of relationship he wanted to have.

Nicholas's parents divorced when he was 7 years old, and his mother became depressed and helpless. He remembers day after day coming home from school to find her crying at the kitchen table. His father was living a bachelor's life, dating and driving a fancy car. Nicholas's younger sister was too young to really understand what was going on. He felt a tremendous amount of responsibility toward his mother, and a lot of resentment about having to worry about her and take care of her (although he was not very aware of these latter feelings until the therapy because they made him feel quite guilty).

Nicholas's first round of therapy lasted 7 months, and he worked on understanding his relationship with his wife, why he experienced her as so demanding and difficult, and why he was so controlling and irritable with her. He realized that his superficially supportive demeanor hid his demands and frustration with her. In time, Nicholas

understood more about his needs and was better at expressing them in a constructive way. As he became better able to do this, she was pleased and felt that he was easier to live with. Nicholas, in turn, was less angry because he felt less compelled to do whatever she wanted, and he felt he was getting more of her attention.

Nicholas felt very pleased with his work in therapy, and the marriage seemed patched up. He mentioned ending in a session, and then skipped the next appointment and did not call to reschedule. Nicholas did not return my phone calls asking him if he would like to come for a final appointment. I understood this as a return to business as usual for him and an avoidance of saying good-bye. Perhaps it was connected to his early loss of his father, or maybe he was busy, not a natural communicator, and was finished with therapy.

A year and a half later, Nicholas called again and wanted to come back for some appointments. His wife had breast cancer and he was afraid he would lose her, and was also afraid for his two young children. This time he came for about 4 months on a weekly basis. His prior understanding that he related to his wife as though she were his unavailable childhood mother became even clearer this time. To Nicholas, his wife's breast cancer, emotional anguish, and the physical sequelae of her treatment were like his mother's depression. His wife was also drinking excessively at this point, and she wanted to spend time with a couple of friends who also enjoyed drinking. This made Nicholas feel rejected and angry. Despite understanding that this was her attempt to deal with her feelings about the cancer, it was a tremendously sore spot in the marriage during this time. Nicholas could hardly stand all of the feelings of rejection, fear of loss, and resentment about being compelled to help her feel better. In addition, there seemed to be little he could really do to change things. But Nicholas's ability to separate out the old template of his depressed mother from the current reality helped him ground himself.

The termination of this second round of treatment was different. This time, Nicholas did not disappear. He began to feel better and clearly was handling a tough situation better. He realized that his wife needed psychological help and needed treatment. Nicholas was able to step back and give her some space, and at the same time he continued to appropriately express concern about her emotional state and her drinking. He asked to stop therapy but left open the possibility of coming back. Nicholas planned a few final sessions and left with a sense of clarity about what was ahead of him.

This vignette illustrates an intermittent course of treatment that is consistent with the primary care model. This was not the intended

treatment, but it became the model de facto. The therapist did not push Nicholas to consider all of the transference implications of his decisions. While it is likely that there were conflictual roots to this decision—avoidance of feelings of dependency and loss of the treatment, controlling the relationship with the therapist—this was mentioned with the patient but not with a recommendation to stay in treatment and work on this until there was finality.

Despite the fact that there is no definitive termination in the primary care model, ending is a moment to tie up loose ends and help the patient summarize the work done together. A new narrative has coalesced and the therapist can reflect it back to the patient. A summary will pull both therapist and patient out of the emotion of ending, and so it should not be done at the same moment as when the patient is talking about sad feelings.

The ending of treatment for Peter, the young man with depression discussed in Chapters 5 and 7, proceeded according to the traditional psychodynamic psychotherapy model. The goal was to definitively deal with his problems, so that he could try to manage psychological issues independently. The termination was planned several months in advance after an extended period of wellness. The feelings and conflicts around intimacy, loss, and self-esteem were well worked out, and the transference had long been a focus. With the end of the therapy looming, Peter felt a strong sense of loss, but he was pleased with his level of self-reflectiveness and self-sufficiency. Some of the old feelings of self-criticism, anger, guilt, and low self-esteem did crop up toward the end of the appointments, but they were understandable and interpreted as transferential reactions to the loss of the therapist. Because Peter had found his new career interest, and he considered it to be similar in seriousness and status to the therapist's, he seemed to be managing the loss through a healthy identification. After the end of the treatment, Peter communicated every couple of years with his therapist, reporting on his progress and successes and frustrations.

This type of ending feels more rigorous and difficult for both patient and therapist. The worry about the patient's ability to do it all without help is paramount in both people's minds. But a great degree of respect of the patient's strength and resilience is implied in trying to end the relationship in a definitive way.

Although a full discussion of the medical–legal issues surrounding psychotherapy, including informed consent, ethical requirements regarding boundaries, collaboration, coverage, and privacy, is beyond the scope of this book, it is important to recognize that the end of treatment requires particular attention to these issues (see, e.g., Barnett, 1998). The problem of abandonment, in the legal not the emotional

sense, is an area of vulnerability for therapists. Clinicians have a responsibility to treat those in their care, and they cannot dismiss patients from their practices willy-nilly. Terminations must be well documented, and patients who drop out of treatment without discussion need to be contacted, and alternatives to returning to you should be reviewed and then spelled out in a letter.

TERMINATION FOR TRAINEES

Ending therapy is often a particularly emotional experience for trainees. They have never done it before, and it is often forced by circumstances. A common problem is that patients in training clinics are passed on from trainee to trainee as people graduate or change location. This puts young therapists in the difficult position of beginning treatment with patients who were treated by older trainees whom the new therapist may know and have great respect for. Also, this system confronts a new therapist with a patient who is sometimes more experienced than they are. This is certainly a stressful undertaking, and understanding what is going on and doing the best job possible is the best antidote to these anxieties.

A forced termination, where the therapist leaves, is particularly likely to stir up feelings of loss and rejection in the patient and guilt in the therapist. When this has happened before to the patient (some patients work with several trainees over the course of their treatment), it is harder to elicit a fresh reaction to what is going on. The patient becomes a "professional" in dealing with transfers, and the issues are harder to discuss. This makes it harder for the therapist to learn about the situation and to focus on the patient's feelings and needs. When the patient becomes inured to the loss of multiple therapists but remains connected to the clinic, the concept of "institutional transference" is invoked. This is the notion that the patient forms an attachment to something larger than the individuals, to the organization itself. More likely, this "institutional transference" reflects a quasi-adaptive detachment from the losses and disappointments about multiple individuals.

Training clinics tend to promote the traditional psychodynamic model of termination because they want to teach the time-honored concept—this is seen as the "real thing." That is well and good, but the actual practice is likely closer to the primary care model. This disparity between ideals and practice can make therapists-in-training feel they are not living up to the expectations of their supervisors and mentors. Honest self-reflective attention to the experience of termination is useful, but overdramatizing the experience is not. In this regard, Nof and colleagues (2017) remind us, "Successful therapy does not need a show of fireworks

at its end, and unsuccessful therapy most of the time cannot be saved by termination maneuvers in the last minute" (p. 34).

However, a wonderful benefit of being in a training clinic is that you are made to think about termination. We are all somewhat avoidant of the pain of loss, and when the treatment is going to be over soon there is a tendency to move one's attention on to something else. In clinical practice there is very little stimulus to think about termination except when the patient is upset. So the training clinic facilitates learning about termination, but the excessive application of the traditional psychodynamic model for patients makes for confusion at times.

Bostic, Shadid, and Blotchy (1996) make excellent practical suggestions about forced terminations in training, including giving patients 3- to 6-months' notice, not divulging the specifics of the reasons for the termination too quickly in order to facilitate discussion, active collaboration about plans for transfer, support and encouragement for the patient, erring on the side of accepting gifts that are offered, and frequent discussion in supervision about termination.

SUMMARY

Termination provides the patient and the therapist with closure on an important experience. We know more about beginning treatments than ending them, and the two main ways of conceptualizing termination, the traditional psychodynamic model and the primary care model, both offer meaningful approaches to a successful ending. Opening up the decision to end, and exploration of the feelings involved, allows for a last piece of work on the therapeutic relationship, sorting out the transferential and alliance components, and lets the patient include this in the final psychotherapy narrative. Personal emotional reactions are frequent during the end of treatment, and therapists, like patients, need to reflect on the ending of the relationship.

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