Psychodynamic Psychotherapy

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with the ''Listening Exercise'' for Chapter 16 (Learning to Listen).

This is a short recording that will help the reader to learn about different ways we listen. It is designed to accompany a listening exercise which is found on the second page of Chapter 16 (p 144).

Psychodynamic Psychotherapy

A Clinical Manual

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For our families:

Thomas, William and Daniel

Marc, Rebecca and Ruth

Jon, William and Ben

Eric, Lena and Maia

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Acknowledgments

As we write the last words of the book, the notion that ''supporting and uncovering'' go together feels so natural that it's hard to believe that we ever thought otherwise. But even when we started our course on psychodynamic psychotherapy for psychiatry residents at the New York State Psychiatric Institute/Columbia University several years ago, that wasn't necessarily the case. As we began to plan the course, I got an early e-mail from Carolyn. ''So you're calling your course psychodynamic psychotherapy,'' she asked, ''What about supportive psychotherapy – isn't that psychodynamic, too?'' I began to think – what was it that we were actually trying to teach? Sabrina reminded me of all the supervisees who hide their supportive comments from their supervisors, and wondered if our course could address this in a new way. Anna was on board. Thus began our journey toward a truly integrated way of looking at the technique of psychodynamic psychotherapy – and a method for teaching it to trainees.

Since this book was born as a syllabus for our wonderful Columbia residents, our biggest thanks go to them. They were our first readers and critics; they were the first people who encouraged us to publish this as a book. In particular, Allison Baker, Alexandra Martins, Catherine Roberts, and Alicia Rojas spent many hours over the last few years giving us the ''residents' perspective'' and helping us to make our material as clear and understandable as possible.

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William and Daniel put up with a mom who sometimes seemed glued to her computer screen. They listened as I read whole chapters out loud and are genuinely proud, which means the world.

I can hardly find the words to thank Thomas Cabaniss. He first told me that I should write a book in 1986. Here it is, and it would never have happened without him. He read each word, was supportive at every moment of the process and is my best editor. Here's to the next one.

Deborah L. Cabaniss, m.d.,
February 2010

Introduction

''Why can't I find a good relationship?''

''Why do I keep bombing out at work?''

''Why can't I have more patience with my children?''

''Why can't I feel good about myself?''

Feeling good about ourselves, having loving relationships with others, and doing satisfying work – these are the goals of most of our lives. We all have certain patterns that guide the way we try to achieve these goals. By the time we're adults, our patterns are fairly fixed, and changing them is not so easy. The habitual nature of these patterns is akin to the way water runs down a hill – after a while, a certain groove gets carved out and the water always flows down that channel. If you want the water to flow another way, you're going to have to do some hard work to alter the path. It's the same with us – after a certain age, we're pretty consistent about the way we think and behave. But for a lot of people, their characteristic ways of thinking about themselves and dealing with others are maladaptive and they need a way to change.

The problem is that although they know they *want* to change, they don't know *what* they want to change. That's because habitual patterns, more often than not, are motivated by wishes, thoughts, fears, and conflicts that are out of awareness. For example, take a person who never advocates for herself and doesn't know why – but who deep down feels that she deserves to be punished. Or a person who is lonely but is unaware that his fear of rejection is actually causing him to avoid others. For these people, learning about their deep-seated thoughts and fears can be unbelievably powerful. The insecure woman can understand that her self-sabotage has been a lifelong form of self-punishment, and the lonely man can begin to understand that he produces his own isolation by denying his need for others. They can start to develop new patterns of behavior. They can change their lives.

This is what psychodynamic psychotherapy is all about. It offers people a chance to create new ways of thinking and behaving in order to improve the quality of their lives. Since most of the ways that we think about ourselves and deal with our environment evolved as we grew up, we can think of this process as reactivating development. One thing that's incredibly exciting about this view of psychodynamic psychotherapy is that it fits so well with advances in neural science [1–4]. For example, we now hypothesize that all learning comes with changes in neural circuitry – so adult

brains change all the time. In the words of Eric Kandel, ''Insofar as psychotherapy works, it works by acting on brain functions, not on single synapses, but on synapses nevertheless'' [5]. New growth – new connections – new patterns.

In this model, not all environments foster new growth – you need a particular set of circumstances in which the person feels safe enough to allow this to happen. If you've ever worked on changing anything that had become habitual, it's likely that the process involved another person, like a coach, a teacher, or a parent. In psychodynamic psychotherapy, that person is the therapist. Change happens not only because people learn new things about themselves, but also because they feel safe enough to try out new ways of thinking and behaving in the context of this new relationship.

This manual will teach you to conduct psychodynamic psychotherapy. Because it was first developed as a syllabus for teaching psychiatric residents, it has been classroom tested for several years. It will systematically take you from evaluation to termination using straightforward language and carefully annotated examples. Psychodynamic psychotherapy is a specific type of therapy that requires the therapist to carefully and deliberately make a thorough assessment, establish a therapeutic framework, interact with the patient in particular ways, and make choices about therapeutic strategies. As you journey through this book, you will learn all of these essential skills. Here's the basic roadmap: Part One (What is Psychodynamic Psychotherapy?) will introduce you to psychodynamic psychotherapy and to some of the ways we hypothesize that it works. Part Two (The Evaluation) will teach you how to evaluate patients for psychodynamic psychotherapy, including assessment of ego function and defenses. In Part Three (Beginning the Treatment) you'll learn the essentials for beginning the treatment, including fostering the therapeutic alliance, setting the frame, and setting goals. Part Four (Listen/Reflect/Intervene) will teach you a systematic way of listening to patients, reflecting on what you've heard, and making choices about how and what to say. Part Five (Conducting a Psychodynamic Psychotherapy: Technique) will teach you to apply the listen/reflect/intervene method to the essential elements of psychodynamic technique – affect, resistance, transference, countertransference, unconscious fantasy, conflict, and dreams. By then you'll be ready to use these methods to meet therapeutic goals, and in Part Six (Meeting Therapeutic Goals) you'll see how these techniques are used to address problems with self-esteem, relationships with others, characteristic ways of adapting, and other ego functions. Finally, Part Seven (Working Through and Ending) will take you to the end of the treatment, addressing ways in which our technique shifts over time.

Learning is best when it's active – and thus we've included suggested activities at the end of many of the chapters. These are designed to allow you to try out the skills and techniques that you will learn in this book. They can be done alone, with a partner, or as part of a classroom activity. ''Comments'' are included to guide reflection and discussion; they are not meant to be definitive or ''correct'' answers.

We have made many deliberate choices about the use of jargon. For example, we do not extensively use terms like ''transference'' and ''resistance'' until we formally introduce them in Part Five, both because we want to carefully define our terms and because we want you to think as openly as possible as you begin learning about this treatment. We all have preconceived ideas about these concepts and, as

much as possible, we are trying to reduce the impact of previously held notions. We have also consciously decided to avoid discussion of particular theoretical schools of psychodynamic psychotherapy, such as object relations theory and self-psychology. Again this decision reflects our intention to teach the technique of psychodynamic psychotherapy in the most ecumenical way possible.

So, let's begin at the beginning – on to Part One and ''What is Psychodynamic Psychotherapy?''

PART ONE: What Is Psychodynamic Psychotherapy?

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1 The Treatment for a Mind in Motion

Key concepts

Psychodynamics means *mind in motion*.

A psychodynamic frame of reference postulates that dynamic (moving) elements in the unconscious affect conscious thoughts, feelings, and behavior.

A psychotherapy that is based on the psychodynamic frame of reference is a psychodynamic psychotherapy.

Both uncovering and supporting techniques are used in almost every psychodynamic psychotherapy.

The basic goals of psychodynamic psychotherapy are to:

1. understand elements of the patient's unconscious that are affecting his/her conscious thoughts, feelings, and behavior
2. decide whether uncovering or supporting will help most at that moment
3. uncover unconscious material or support mental functioning in the way that will best help the patient

What is psychodynamic psychotherapy?

Literally, **psychotherapy** means *treatment for the mind*. Psychotherapy has its origins in psychoanalysis – the ''talking cure'' that was first developed by Sigmund Freud [6]. Consequently, the word psychotherapy has come to refer to a treatment that involves talking. But it's not just any talking – in order to be psychotherapy, the talking has to be:

- a treatment
- conducted by a trained professional
- within a set framework
- in order to improve the mental and emotional health of a patient

And what about **psychodynamic**? You've probably heard this word many times – but what does it mean? Psycho comes from the Greek word *psyche*, which meant *soul* but has come to mean *mind*, and dynamic comes from the Greek word *dynamis*, which meant power but has come to mean *physical force in motion*. Simply

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stated, the word psychodynamics refers to the forces of the mind that are in motion. Freud coined this word when he realized that, as opposed to earlier conceptualizations of a static psyche, the mind was an ever-changing system, roiling with perpetually moving energized elements. These unconscious elements could explode into consciousness and vice versa, while powerful wishes and prohibitions could barrel into one another, releasing the psychic equivalent of colliding subatomic particles [7].

Freud realized not only that elements of the mind were in motion but also that most of this frenzied mental activity was going on outside of awareness. He described this mental activity as **unconscious** and hypothesized that it could affect conscious thoughts, feelings, and behavior. Thus, we arrive at the two definitions that provide the foundation for this manual:

1. A psychodynamic frame of reference is one that postulates that unconscious mental activity affects our conscious thoughts, feelings, and behavior.
2. A psychodynamic psychotherapy is any therapy based on a psychodynamic frame of reference.

The unconscious

We often refer to our unconscious mental activity as *the unconscious*. Feelings, memories, conflicts, ways of relating to others, self-perceptions – all of these can be unconscious and can cause problems with thoughts and behavior. Unconscious thoughts and feelings develop in the person from childhood, and are a unique mix of early experiences and temperamental/genetic factors. We keep thoughts, feelings, and fantasies out of awareness because they threaten to overwhelm us if we are aware of them. They might be too frightening, or stimulating; they might fill us with shame or disgust. Because of this, we make them unconscious but they do not disappear – they remain full of energy and constantly push to reach awareness. Their energy affects us from their unconscious hiding places, and they exert their influence on the way we think, feel, and behave. A good analogy comes from Greek mythology:

> *Zeus, the young god, was tired of being ruled by the patriarchal Titans, so he buried them in a big pit called Tartarus. Deep beneath the earth, they no longer posed a threat to Zeus' dominance. Or did they? Though out of sight, they had not disappeared, and their rumblings were thought to cause earthquakes and tidal waves.*

So too, unconscious thoughts and feelings are hidden from view but continue to rumble in their own way, causing unhappiness and suffering in the form of maladaptive thoughts and behaviors.

Psychodynamic psychotherapy and the unconscious

In many ways, the psychodynamic psychotherapist is like the plumber you call to fix your leaky ceiling. You see the dripping but you can't see the source; you

can catch the drops in a pail, but that doesn't stop the flow. The plumber knows that the rupture lies behind the plaster, somewhere in pipes that as yet cannot be seen. Here, though, the plumber has an advantage over the psychodynamic psychotherapist – he can use a sledgehammer to break through the plaster, reveal the underlying pipes, find and fix the offending leak, and patch the ceiling. But the psychodynamic psychotherapist is working with a human psyche, not a plaster ceiling, and thus requires more subtle tools to seek and mend what's beneath the surface.

Uncovering and supporting

Like the plumber, the psychodynamic psychotherapist's first goal is to understand what lies beneath the surface – that is, to understand what's going on in the patient's unconscious. Many of the techniques of psychodynamic psychotherapy are designed to do just that. Once we think that patients are motivated by thoughts and feelings that are out of their awareness, we then have to decide how to use what we have learned in order to best help them. Sometimes we decide that making patients aware of what's going on in their unconscious will help. We call this **uncovering** – Freud called it ''making conscious what has so far been unconscious'' [8]. We have many techniques for helping patients to uncover – or become aware of – unconscious material. What we're uncovering are inner thoughts and feelings that they keep hidden from themselves but which nevertheless affect their self-perceptions, relationships with others, ways of adapting, and behavior.

Sometimes, however, we decide that making patients aware of unconscious material will *not* be helpful. We generally make this decision when we judge that the unconscious material could be potentially overwhelming. Then we use what we have learned about the unconscious to **support** mental activity without uncovering thoughts and feelings. (See Chapter 18 for discussion of uncovering and supporting techniques.)

Here are two examples – one in which we would choose to *uncover* and one in which we would choose to *support*:

> *Ms A is a 32-year-old woman who has a trusting relationship with her husband, many close friends, and a satisfying personal career. In the past, she has used journaling, cooking, and athletics to work through short periods of anxiety. She presents to you complaining of insomnia that she believes has been triggered by a fight she is having with her younger sister, B. Ms A says that she's ''mystified'' by B's hostile behavior, which began about a month ago in the context of B's impending graduation from medical school. Further exploration reveals that although B wanted to become a dermatologist, she was not offered a position in this field and will have to do an interim year of internal medicine and then reapply. Ms A says that she has been very sympathetic about this setback and does not know why B is so hostile toward her. When you ask about their earlier relationship, you discover that Ms A has cruised effortlessly from one Ivy League institution to another, while B has struggled academically. You hypothesize that B's hostility towards Ms A may be fueled by envy, and that Ms A has been unconsciously keeping herself from becoming aware of this out of guilt. You think that Ms A will be helped by learning about her unconscious guilt and decide to help her* ***uncover*** *it. Once she grapples with her guilty feelings, she is able to recognize her sister's hostility and envy. This awareness helps her to understand their recent interpersonal difficulties and resolves the insomnia.*

Ms C is a 32-year-old woman who is isolated, moves frequently from job to job, and often reacts to stress by binging and purging. She presents to you complaining of insomnia that she believes has been triggered by a fight with her younger sister, D. She says that their mother has recently become ill, and that she, Ms C, is shouldering the entire burden of caring for her while D ''just sits in her suburban home with the other soccer moms and sends checks.'' Ms C, who is struggling to make ends meet, tells you that she thinks that her sister, who is married to a very wealthy man, is ''shallow and materialistic'' and that she ''wouldn't switch lives with her if you paid me.'' She says that she is ''enraged'' at D for not doing more to help their mother and that ruminations about this are causing her to stay awake at night. You hypothesize that Ms C's rage is fueled by envy of D, but you decide that learning about the way in which this might be contributing to the insomnia will not help her at this time. Instead, you decide to ***support*** *Ms C's functioning by empathizing with the amount of work she is doing to care for her ailing mother, and by suggesting that she use her mother's Medicare benefits to get some help with the eldercare. Once she feels validated, Ms C relaxes, her insomnia resolves, and she is better able to understand many aspects of her current situation.*

In both cases, the first thing that the psychodynamic psychotherapist needed to do was to understand the way in which unconscious thoughts and feelings were affecting the patient's conscious behavior. However, in one situation the therapist decided to *uncover* while in the other the therapist decided to *support*. Thus, we can say that the goals of psychodynamic psychotherapy are to:

1. understand the ways in which the patient is affected by thoughts and feelings that are out of awareness;
2. decide whether uncovering or supporting will help most at that moment;
3. uncover unconscious material and/or support mental functioning in the way that best helps the patient.

Making the decision in step #2 depends on careful assessment of the patient, both at the beginning and throughout the treatment, to determine what will be most helpful at any given point in time (see Part Two). Psychodynamic psychotherapies that primarily use uncovering techniques are often called insight oriented, expressive, interpretive, exploratory, or psychoanalytic psychotherapies, while those that primarily use supporting techniques are often called supportive psychotherapies [9]. Unfortunately, these are often seen as completely separate from one another. On the contrary, *uncovering and supporting do not constitute separate therapies but rather they are two types of techniques that are used in an oscillating manner in* ***all*** *psychodynamic psychotherapies*. One patient may benefit from a therapy in which a preponderance of uncovering techniques is used, while another may benefit from a therapy in which supporting techniques predominate, but all treatments use some of each at different points.

The optimal mix of supporting and uncovering techniques will vary from patient to patient, and sometimes from moment to moment, depending on the individual person's strengths, problems, and needs. Some patients only require the implicit support conveyed in the therapist's attitude of empathy, understanding, and interest. Other patients need more explicit support throughout the therapy. Whatever the overarching goals we choose at the start of treatment, we are prepared to shift our approach flexibly depending on the patient's changing needs.

The importance of the therapeutic relationship

Uncovering and supporting do not happen in a vacuum – they happen in the context of the relationship between the therapist and the patient. This relationship is central to what defines psychodynamic psychotherapy. It not only provides a safe environment in which patients can talk about their problems, but it also allows them to learn about themselves and their relationships to others through their interaction with the therapist. The relationship itself is likely to be an agent of change in psychodynamic psychotherapy, both as a ''relationship laboratory'' that the patient can learn from, and as a direct source of support that can foster growth and change. Talking about and learning from the therapeutic relationship is called discussion of the **transference** (see Chapters 12 and 21) and is often a major focus of psychodynamic psychotherapy.

With this addition, we can round out our definition of psychodynamic psychotherapy in this way:

> *Psychodynamic psychotherapy is a talk therapy based on the idea that people are affected and motivated by thoughts and feelings that are out of their awareness. Its goals are to help people to change habitual ways of thinking and behaving by helping them to learn more about how their minds work, and/or directly supporting their functioning, in the context of the relationship with the therapist.*

But how does this happen? Let's move on to Chapter 2 to explore some of the theories behind the technique.

2 How Does Psychodynamic Psychotherapy Work?

Key concepts

A theory of therapeutic action is a theory that tries to explain how a psychotherapy works. Basic theories of therapeutic action for psychodynamic psychotherapy include:

- making the unconscious conscious
- supporting weakened ego function
- reactivating development

Psychodynamic psychotherapy can be thought of as a remedial process in which development can be reactivated and new growth can occur in the context of the relationship with the therapist.

Theories of therapeutic action

In order to choose what to say to patients, we have to have some idea about why what we're saying will help them. This means that we have to have theories about how we think therapy works. A theory that tries to explain how a psychotherapy works is called a **theory of therapeutic action** [10]. In psychodynamic psychotherapy, we have several theories of therapeutic action that help guide our work.

Making the unconscious conscious

In psychodynamic psychotherapy, one of the things that we think helps our patients is making the unconscious conscious. This idea was the basis for Freud's first theory of therapeutic action [11]. Drawing on his clinical work, Freud hypothesized that some patients developed symptoms because thoughts and feelings that were not accessible to consciousness nevertheless exerted a pathological effect on their conscious functioning. Freud's idea was that many of these thoughts were memories, and thus he famously said that these patients ''suffer mainly from reminiscences'' [12]. Although Freud first used hypnosis to bring the sequestered memories into consciousness, he and his patients soon realized that simply talking freely brought

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unconscious thoughts and feelings to the surface. Since that time, ideas about therapeutic action have become more complex. However, the basic ideas that:

- thoughts and feelings that are out of awareness can affect and motivate people, often leading to habitual but maladaptive ways of thinking and behaving; and
- becoming aware of these thoughts and feelings can be therapeutic

are still central tenets of psychodynamic psychotherapy.

Why should becoming aware of unconscious thoughts and feelings be therapeutic?

There are many ways to think about this:

- **Lancing the abscess –** One idea is that cloistered off thoughts and feelings can be harmful and releasing them can be cathartic. The analogy in physical medicine is the pus-filled abscess that causes pain even if it is hidden beneath the skin. Just as the abscess needs to be lanced and debrided, this theory says that sequestered feelings need to be released. This is often called **abreaction** and remains an important idea in psychodynamic psychotherapy [13].
- **Preventing proliferation in the dark –** Freud said an element from the unconscious ''proliferates in the dark'' if it is not brought into consciousness through speaking, meaning that it will grow to enormous, inappropriate dimensions [14]. Again, we have all had the experience of being less afraid of something once we've talked about it. In this model, talking about something is like turning on the light in your bedroom to find that the giant monster in the corner is really a hat on a chair.
- **Knowing ourselves better helps us to make better decisions –** If the forces that govern our thoughts, feelings, and behavior are unconscious, we cannot control them. They guide our decision-making, provoke anxiety, and produce feelings. It makes sense, then, that increasing awareness of these forces can help people by giving them more conscious control over how they run their lives, for example how they make decisions, think about themselves, and have relationships with others. Explaining this concept to patients can be a very effective and powerful way to help them understand this treatment and its therapeutic potential.

How do we help people to become aware of things that are out of awareness?

If we think that unconscious thoughts and feelings cause conscious suffering, we have to access them – but the question is *how*. It's like getting to uncharted territory without a map. Even if we had a map, we might not understand what we found there because the unconscious mind and the conscious mind are characterized by different types of thought processes. The unconscious mind is governed by what we call **primary process**, which is non-linear and non-verbal (like dreams), while the conscious mind is governed by **secondary process**, which is linear and verbal (like conscious thought) [15]. Thus, in order to understand unconscious thoughts

and feelings, we have to translate them into a form that the conscious mind can understand. We do this with *words*. Words are the transporters from the unconscious to the conscious mind. You can think of words as boats that ferry ideas between the unconscious and conscious parts of the mind. We've all had this experience – when we use a word to shape an inchoate thought, we often have an ''a-ha'' moment. This is enormously helpful, and can reduce anxiety. Once we have words for a thought or feeling, we can talk about it, subject it to conscious scrutiny, and use it to understand ourselves more fully.

You will learn specific techniques for helping patients to uncover unconscious thoughts and feelings in Parts Four and Five of this manual.

Supporting weakened ego functions

A second theory of therapeutic action is that psychodynamic psychotherapy works by helping patients to *strengthen their ego function*. In order to understand this theory, let's first define the term **ego function**. We can divide the mind into three basic parts – the **id**, the **ego**, and the **super-ego**. These are not actual structures that can be located anatomically, rather they are best thought of as clusters of functions. The id consists of wishes and desires, the super-ego contains conscience and personal ideals, and the ego manages the person's inner mental life and relationship to the world. In order to do this, the ego relies on many essential functions, such as impulse control, internal and external stimulus regulation, the capacity for tolerating anxiety and strong feelings, and mobilization of defense mechanisms (see Chapter 4 for more detail). If these ego functions are weak, people can suffer in many ways. Ego function can be chronically weak, or can wax and wane in response to intermittent stress, trauma, or physical illness. Some patients have global problems with ego function, while others have difficulty in only one or two areas.

Psychodynamic psychotherapy can help patients by *supporting* weakened ego function. This can be explicit, for example when we teach patients new ways of dealing with strong feelings. It can be also be implicit, for example when the sheer act of meeting to discuss feelings with the therapist helps to decrease a patient's anxiety. This theory of therapeutic action suggests not only that patients derive temporary benefit by ''borrowing'' ego function from their therapists during times of ego weakness, but also that they can internalize new ways of thinking and behaving in order to strengthen ego function on a more permanent basis.

Psychodynamic psychotherapy as the reactivation of development

Another theory of therapeutic action in psychodynamic psychotherapy is that this treatment can reactivate mental and emotional development in order to foster new, healthier growth. A good analogy for this model is what happens when a tennis player stops improving because she is hampered by a weak serve. A new coach diagnoses the problem, helps her to ''unlearn'' her old serve, and teaches her a new technique. Fortified with a new, stronger serve, her game improves. In a similar way, things happen in peoples' lives that may lead to problematic development

in one or more areas. For example, lack of praise as a child could stunt creative development. There are myriad ways in which aspects of mental and emotional development can be arrested or stunted, rendering people unable to move forward as adults. This can lead to a variety of problems, such as maladaptive coping mechanisms, impaired relationships with other people, and problems in maintaining self-esteem. The reason for the developmental problem is usually something very painful, such as abuse, neglect, emotional deprivation, lack of parental attunement, or over-stimulation. Advances in neuroscience are teaching us that early experiences like this can result in lasting biological changes that may be reversible in certain circumstances [16].

It's also important to remember that these early experiences occur in the context of the person's unique temperamental and genetic milieu, which can impact his/her development [17]. In the psychodynamic frame of reference we are very interested in these early experiences and the way in which the need to put them out of awareness can lead to diverse developmental problems. We have many theories about how this happens and how development is affected – but all of our theories postulate that *psychodynamic psychotherapy helps to reactivate development in the context of the new relationship with the therapist*. Areas in which new growth can occur include:

- development of new ways of thinking about oneself and of regulating self-esteem
- development of new ways of relating to others
- development of more flexible, adaptive coping mechanisms.

For example, if a person who believes that no one will take care of him realizes that his therapist does, we hypothesize that this reactivates the development of his self-esteem regulation and capacity for relationships with others, allowing for new, healthier growth. For some patients, putting this experience into words can help them become aware not only of the problem and the potential reasons for it, but also of the ways in which the therapeutic relationship is helping them to develop new patterns of thinking and feeling. With other patients, this process may be more experiential and less verbally explicit. Determining which patients will benefit from each type of technique depends on making a careful assessment, which is the topic of the next part of this manual.

Now that you have an idea of what psychodynamic psychotherapy is and how we think it works, let's move on to thinking about how we evaluate patients for this treatment and for whom it is most helpful.

Theories of therapeutic action

- Making the unconscious conscious
- Supporting weakened ego function
- Reactivating development

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PART TWO: The Evaluation

Introduction

Key concepts

There are four basic phases of psychodynamic psychotherapy:

- evaluation
- induction (beginning)
- midphase (main work time of the therapy)
- termination (ending)

There are two major goals of the evaluation phase of psychodynamic psychotherapy:

- To gather information about the patient in order to formulate the case and make a recommendation
- To make a connection with the patient, and set the tone for the treatment

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Psychodynamic psychotherapy has four basic phases:

Phase	Goals
Evaluation	Making an assessment
Induction	Beginning the treatment: includes establishing the treatment, making an alliance with the patient, setting goals, and helping the patient to learn to use the therapy.
Mid-phase	The main work time of the treatment: the patient and therapist are working well together on achieving therapeutic goals.
Termination	Ending the treatment: includes consolidating goals, reviewing the treatment, realistic appraisal of change and possibility for future change, planning for future treatment if necessary, and leave taking.

In this manual, we will review all of the phases of treatment. In this section we will begin with the **evaluation phase**.

In order to best help our patients, we need to understand as much as we can about the problems that have brought them for help and the way in which their minds characteristically work. This is the task of the evaluation phase. Chapter 3 will teach you how to take a full history while creating conditions of comfort and emotional safety designed to encourage your patients to talk freely and openly. Chapter 4 focuses specifically on the assessment of ego functions, including defense mechanisms. In Chapter 5, we will describe a particular way of thinking about and organizing clinical data – the **Problem → Person → Goals → Resources model** – that will help you formulate specific goals for a psychodynamic psychotherapy. Finally, Chapter 6 describes the general indications for psychodynamic psychotherapy so that you can have a clear idea of who will benefit most from this type of treatment.

3 Creating a Safe Place and Beginning the Evaluation

Key concepts

Every psychodynamic psychotherapy begins with an evaluation phase. Depending on the type of treatment and setting, this may last from one to four sessions. During this phase, the therapist should:

- create a safe environment for the patient to begin to talk
- start by asking open-ended questions in order to discover the patient's chief complaint
- take a thorough history of the present and past psychiatric illness, as well as the developmental history
- assess
  - multiaxial diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - ego function, including characteristic defenses
  - super-ego function
  - strengths and weaknesses

Dr Z, an interventional cardiologist at a tertiary medical center readies himself for his first angiogram of the day. Mr A, his first patient, was sent by a local internist for assessment of ''classic angina.'' ''Good morning, Mr A,'' says Dr Z, ''How are you?'' ''Fine,'' says Mr A, ''Except that I continue to have that pain in my stomach all the time.'' ''All the time?'' asks Dr Z, ''Let's have a listen.'' This patient has been ''sent'' for an angiogram, but Dr Z is skeptical about the diagnosis and makes his own assessment before embarking on the ''intervention'' that he was asked to perform.

As psychodynamic psychotherapists, we have to do the same thing. There's an old saying that ''if you're a carpenter, everything looks like a nail.'' Just because we're psychodynamic psychotherapists doesn't mean that psychodynamic psychotherapy is always the right treatment. The first thing we need to do with every patient we see is to make a full assessment in order to determine the right treatment for that person. Even if you're a trainee who is ''sent'' a patient for psychodynamic psychotherapy, you still have to conduct an assessment in order to make an informed recommendation.

Decades of *New Yorker* cartoons portrayed psychotherapists as passive, waiting for their patients to begin. Nothing could be farther from the truth. When we begin the evaluation phase, we have two major jobs. The first is to create a situation in which

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the patient feels comfortable enough to talk about extremely personal things. The second is to try to discover:

- who this person is, and
- why he/she is coming for help now

Creating a safe place for talking

Helping the patient to feel safe, heard, and understood in a non-judgmental atmosphere has been referred to as providing a **holding environment** [1, 2]. In the therapeutic relationship, providing a holding environment means establishing conditions that help the patient to feel secure, safe, and trusting. It is the basic groundwork for the alliance between the patient and therapist (also called the **therapeutic alliance** – see Chapter 9).

We try to create this environment of safety in several ways:

Taking an empathic, non-judgmental stance

As we'll discuss more in Part Three, approaching each patient with empathy and a non-judgmental stance is key to creating a safe place. Part of this involves starting with open-ended questions, designed to encourage patients to talk about the problem that brought them to treatment. Even though you have myriad things that you want to know about the patient, try to start the evaluation by following the patient's lead for a while (about 5–10 minutes in a 45–50 minute session) in order to really understand the chief complaint. No topic is too personal for this venue. Some patients will talk freely about everything from their sexual relationships to their deepest fears. Other patients may have more difficulty talking because of shame, fear of judgment, or difficulty trusting other people. Be prepared for this, listen attentively, and ask appropriate questions in your most non-judgmental tone. Some patients will remain tense and uncomfortable despite all of your best efforts. Try to address and lessen their discomfort, while remembering that their anxiety may offer you important information about who they are.

Example

Therapist	*So I heard from Dr T that you'd be coming into the clinic, but I don't know much more about what brings you here at this time. Can you tell me about that?*
Ms B	*Well, it's about my boyfriend. We were going to get married but the plans are off. I've been crying for days. I think that I've ruined my life. I can barely talk about it.*
Therapist	*I can see that you're very upset – can you tell me more about what happened?*
Ms B	*It's too embarrassing – I'm such a terrible person – I had too much to drink about three weeks ago and slept with someone else and he found out – I've been distraught since then. You must think that I'm a terrible person.*

Therapist *This is clearly very hard for you to talk about, but the fact that it has made you so upset is why you've come to talk to me today. I just want to hear about what's happened so that I can best help you to feel better and to understand the situation. Let's start from the beginning. When was the wedding supposed to be?*

Warmth and interest will carry the day. Getting the whole story will convey your interest to the patient and will make him or her feel safe enough to tell you even the most difficult stories.

Attending to the person's physical comfort

It is very important to offer the patient a clean, quiet place in which to talk to you. Comfortable chairs that are close enough to encourage conversation but not so close that the therapist and patient touch in any way are essential. Turning your phone off during sessions or offering to adjust the thermostat if a patient feels cold are small gestures that can go a long way towards helping the patient feel safe and comfortable.

Assuring confidentiality

Making sure that patients know that their conversation with you is confidential is key to making them feel safe. You can convey this explicitly, as well as preventing interruptions during the session.

Demonstrating understanding

Simply conveying your initial impressions to the patient in a way that makes him/her feel heard, validated, and understood can be immensely therapeutic.

Example

Mr C *So these last two months have been terrible – it's hard to put into words exactly what's been happening – but I've just felt awful since my wife died – not eating, not sleeping – and just dragging around. I don't know why I haven't been able to get back to work.*

Therapist *It sounds like you've been really depressed. It's really hard to work when you feel that bad.*

Mr C *Yes – I have been depressed – that's right – my sister keeps telling me to just go back to the office but you're right – it isn't that easy.*

Setting the frame and boundaries

It is said that ''good fences make good neighbors,'' and a good framework makes for a safe evaluation. Opacity and guessing make people anxious; openness and transparency help to make people feel secure. Letting the patient know who

you are, for how long you'll be speaking, and that this is an evaluation for psychotherapy gives the patient the context for the interview. We'll discuss this more in Chapter 8.

Being professional and thorough

Conveying a professional tone will also help your patients feel safe. This means being warm without being familiar. Remember that this is a one-way relationship – the art is to keep it that way without being wooden.

Example

Mr D *Yeah, I grew up right outside of Rochester.*

Therapist *Oh really, me too! Where did you go to high school?*

This response is too familiar – the patient doesn't need to know where you're from.

Mr D *Yeah, I grew up right outside of Rochester.*

Therapist *So how long did you live there? When did you move to Minneapolis?*

This response conveys interest without being familiar.

Making an assessment

While you're creating a safe place, you're also making an assessment. Although you don't want to shoot rapid-fire questions at the patient, in the first few sessions you do want to get the details of the present illness, past illness, and personal/developmental history. Prescribing psychotherapy is just like prescribing anything else – you can't decide what to prescribe before you take a history and make a diagnosis. Making an assessment is actually a very good way to begin fostering the therapeutic alliance (see Chapter 9) because it will assure your patients that you are a careful clinician who wants to thoroughly understand them and the nature of their problems.

In the first session with the patient you can be very explicit about the way you're going to begin the evaluation. Usually, it's the first thing you say to the patient:

Can you tell me what brings you here to see me today?

That tells the patient that you want to work with him/her to learn about the history. If the patient is in distress at the beginning of the session, you can leave it at that for the moment in order to explore the pressing problem. If things are less urgent, you can choose to say a bit more at the beginning to set up the framework for the evaluation phase:

Mr E, why don't we start today by talking about what's brought you to see me at this time. We'll spend a few sessions talking about that and about things that will help me to learn more about you. Once we've done that, we'll try to pull things together to get a sense of what the main problems are, and then we can talk about the treatment options.

This framework will help the patient to know how the first few sessions will proceed, how best to participate, and when to expect your recommendation. Notice that it does not promise that you will treat the patient. Since you have not yet completed your evaluation, you should not promise any sort of treatment at this point.

When we evaluate a patient for psychotherapy we have to look at many things:

DSM diagnosis

The first thing to do is to establish a DSM diagnosis. Mood and anxiety disorders are very common among patients seeking psychotherapy. Don't forget to ask about substance abuse, as well as medical problems that might be contributing to their difficulties. Your diagnosis will help you to decide whether psychodynamic psychotherapy or any other type of treatment is indicated. The presence of mood disturbances, anxiety disorders, or other Axis I pathology does not necessary preclude psychodynamic psychotherapy, but it might mean that another treatment, such as medication, might be indicated as well. Severe symptoms that impact a person's capacity to function adaptively might also suggest the need for a more supportive stance, at least at first [3].

The history

This includes:

- **the history of the present illness** – which begins with the last time the person was at his/her usual state of mental and emotional functioning
- **the past history of symptoms** – which details past episodes of symptomatology
- **the developmental/personal history** – which includes: assessment of early temperament; childhood symptoms; the quality of early relationships and attachments; and the person's educational, vocational, and relational history to the present day. Note: The developmental history is traditionally called the **genetic history** – not because it's literally about the person's genes, but because it's about his/her early life.

In order to make the best formulation and recommendation possible, you should ask explicitly about the history at the beginning of the treatment. Of course, you should be alert to the fact that material about the history will continue to emerge throughout the treatment, and you should allow yourself to let new findings impact on and alter your initial impressions.

Ego function

As we'll discuss more extensively in Chapter 4, assessing the patient's ego function is also essential for making decisions about treatment. We have to know whether the patient can make a relationship with the therapist, tolerate strong feelings and

anxiety, accurately perceive reality, control impulses, and delay gratification. This will also include an assessment of **super-ego function** (see Chapter 4). If psychodynamic psychotherapy is indicated, assessment of ego function will guide our decisions about whether we want to take a predominantly uncovering or supporting stance.

Psychological mindedness

Some people conceptualize their minds as having unconscious elements and some don't. Some people can learn to think this way and some can't. Assessing the way in which patients think about their mental functioning is essential for deciding what type of psychotherapy is most appropriate. Making **trial interpretations** during the assessment phase can be very helpful in assessing this:

Example

A 34-year-old man presents with difficulties committing to a relationship with a woman. In the course of the evaluation, he reveals that his parents divorced when he was eight. After more discussion of this, the therapist asks the patient whether he thinks that what happened in his family has affected his own adult relationships.

- A psychologically minded person might say something like:

  Oh yes, I've always known that though I don't know what to do about it.

  or

  Huh – I've never put the two together, but that's interesting.

  or even

  I could see how that might be true for someone, but I don't think that it's true for me.

  Uncovering techniques are likely to help this patient further understand the way his feelings about his parents' relationship are affecting his capacity to commit to a relationship of his own.
- A non-psychologically minded person might say:

  Why would their problems contribute to mine? I just can't find the right woman.

  or

  They just had a bad relationship. I don't think that that's relevant to my situation.

Ego supportive techniques may help this person understand his frustration with his situation in order to use new methods for meeting people.

Assessing psychological mindedness during the evaluation is essential for determining what type of treatment will be most useful to the patient.

Capacity for self-reflection

In order to begin to think about their behaviors, fantasies, and relationships with others, people have to be able to ''step outside'' their immediate thoughts to look at them critically. This capacity for self-reflection is also important to assess during the evaluation phase. Questions that ask patients to think critically about themselves and their behavior will help you to gauge their capacity for self-reflection. Here are some examples:

How would you describe yourself to another person?

How do you think that your partner would describe you?

What kinds of things do you think are the easiest/most difficult for you in your relationships with other people?

If this follows organically from something that the person is telling you, all the better. Consider this example:

Ms F presents for psychotherapy saying that she has been fighting with her husband. She says that he is unemotional and unsupportive; for example, he did not come to a recent amateur concert that she gave that was very important to her. As you listen, you wonder whether she is doing anything that is contributing to the couple's difficulties. You decide to ask about this to assess Ms F's capacity for self-reflection. You say:

It really does sound like you and your husband are having a difficult time and that you are very upset about his lack of support. In order to best understand your relationship, I wonder if you could reflect on any possible ways that you might be contributing to the difficulties that you're having.

A person with limited capacity for self-reflection might say:

No way, it's all him. He's a jerk.

While a person with some capacity for self-reflection might say:

Let me think about that . . . I suppose that I'm so angry that I'm pulling back and being very cold. I think that that's definitely making him even less supportive.

The capacity to reflect is also critical for the ability to think about the treatment and the relationship with the therapist. This is important to know when making a treatment recommendation, since discussion of the therapeutic relationship is an important part of many uncovering techniques. You can begin to assess this from the beginning by asking simple, straightforward questions like:

What was your experience of being here today?

Did you have any thoughts or expectations about what I'd be like before you came?

How did your experience compare to what you thought it might be like?

If a patient was previously in psychotherapy, don't hesitate to ask about the former therapist(s) and about how talking to you is similar or different from what he/she has experienced before.

Prioritization of problems

Like a triage nurse in an emergency room, the therapist has to know not only what the patient's problems are, but in what order to deal with them. For example, a patient might have panic disorder, but if he is suicidal, the safety issue takes priority. In general, potential violence (towards self or others) trumps all other problems. It's also critical to assess what the patient feels is his or her most important or pressing problem. We'll discuss goal setting more extensively in Chapter 7.

Motivation

We might think that psychodynamic psychotherapy is the best treatment for a given patient, but if he/she has another idea, it won't fly. We can assess motivation for treatment by asking patients questions that are designed to give us a sense of their ideas about therapy:

What did you imagine psychotherapy would be like?

Did you have any idea about how often you'd be coming?

Do you have the feeling that psychotherapy could be helpful to you?

Resources and social matrix

The therapist must assess not only the patient's problems and inner resources, but also his/her outside resources and social context. For example, a patient who is only in the country for two more months is not a good candidate for a long-term psychodynamic psychotherapy, while a student on a work/study stipend should probably be seen in a sliding scale clinic.

More than one treatment might be appropriate for any given patient, for example a patient might need psychodynamic psychotherapy *and* medication. Sometimes these treatments are conducted one after another and sometimes they are conducted concomitantly. We will review these options in Chapter 15.

Now that we've set the stage for the evaluation, let's move on to assessment of ego function in Chapter 4.

The assessment

- DSM diagnosis
- The history
- Ego function/super-ego function
- Psychological mindedness
- Capacity for self-reflection
- Prioritization of problems
- Motivation
- Resources and social matrix

4 Assessment of Ego Function

Key concepts

Ego function can be conceptualized as the way people manage their inner mental life and relationship to the world.

Ego functions include reality testing, judgment, capacity for relationships, stimulus regulation, affect/anxiety tolerance, impulse control, capacity for play, self-awareness, self-esteem regulation, cognitive functions, and defenses.

Defenses are unconscious mechanisms that people use to shield themselves from thoughts and feelings that might otherwise overwhelm them or cause intolerable anxiety.

Super-ego function regulates generation of guilt and is also important to assess.

Evaluating ego function is essential for determining:

- what kind of psychotherapy will be most beneficial
- whether patients can benefit from uncovering unconscious material
- whether patients can benefit from support of ego function

In order to benefit from uncovering unconscious material, patients must have adequate ego strength to buoy them during the treatment, limit regression, support reality testing, and allow them to function in their outside lives. The discovery of weakened ego function is an indication for ego supportive techniques.

As we discussed in Chapter 2, we can think of the mind as divided into three parts: the **id**, the **ego**, and the **super-ego**. These are not literally parts of the mind, nor are they located in any particular area of the brain; rather, they are best conceptualized as clusters of functions that may have some neurobiological correlates. For example, there are similarities between the id, as Freud described it, and the limbic system of the brain. Higher level neocortical structures, particularly in the frontal lobe, are involved in coordinating and regulating a number of mental activities that roughly correspond to what we call ego functions [4].

We can conceptualize ego functions as the way in which people *manage their inner mental life and their relationship to the world*. Another way to think of them is as the way people *modulate their responses to internal and external stimuli*. Either way you look at it, the capacity to perform these functions is clearly linked to mental and emotional health [5–10].

What is "ego strength?"

It is easy for people to maintain their equilibrium when everything is calm – the trick is to stay in control when buffeted by internal and external stimulation. The person

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with good ego strength is able to do this, while the person with weak ego function cannot.

Ego functions are the tools of mental functioning that a person uses to accomplish this. Exactly how ego functions come into being is not known. Are they hard wired? Are they learned? We can hypothesize that the answer involves some combination of nature and nurture, but regardless of its etiology, ego function is an essential part of how someone functions in the world [11].

Some ego functions deal primarily with our relationship to the world around us and protect us from being overwhelmed by environmental stimuli. These include reality testing/sense of reality, stimulus regulation, relationships with others, and judgment.

Other ego functions deal primarily with the internal environment and protect us from being overwhelmed by internal stimuli. These include affect/anxiety tolerance, impulse control, defenses, self-esteem regulation, and cognitive functions.

The condition of feeling that there is too much stimulation can arise in one of two situations:

1. **there is actually too much stimulation –** this can be caused by:
   (a) too much external stimulation – trauma, neglect, lack of containment
   (b) too much internal stimulation – anxiety or affect, either related to a mood or anxiety disorder or to unconscious thoughts and feelings
2. **the person has difficulty dealing with stimulation –** this can be caused by:
   (a) poor anxiety/affect tolerance
   (b) poor impulse control
   (c) impaired cognitive capacity

Both have to be considered in the assessment of ego function.

What are the individual ego functions?

We can divide ego function into 11 basic capacities (list adapted from Bellack and Goldsmith [5]).

1. **Reality testing and sense of reality –** Reality testing refers to the ability to discriminate between perceptions that are real and those that are not (as opposed to having hallucinations, delusions, illusions, or grossly distorted perceptions of events). Having an intact sense of reality means that external events as well as one's own body are experienced as real and familiar (as opposed to having feelings of derealization and depersonalization, *déjà vu* experiences, dream-like states, out-of-body experiences, feelings of merger with others, or a grossly distorted body image).
2. **Judgment –** Having intact judgment means that the person:
   (a) is aware of the appropriateness and likely consequences of an intended behavior (including the probable dangers, social consequences, and legal ramifications); and
   (b) behaves in a way that reflects this awareness.

Thus, knowledge of consequences does not in itself constitute good judgment. For example, patients may know that having unprotected sex is dangerous, but if they don't also practice safe sex their judgment is impaired.

3. **Relationships with others (also called ''object relations'') –** This function encompasses the perceptions and expectations we have of other people and, more broadly, the quality of our lifelong pattern of relationships. It is more than just the ability to form and sustain relationships. Rather, it is the ability to sustain relationships that are stable, intimate, loving, sharing, and empathic, and in which the other person is viewed as whole and separate. Examples of people with impairment in this area include the person who lives as a recluse who needs a great deal of interpersonal distance, the person who is unable to tolerate separation and needs constant reassurance, and the person who lacks empathy and manipulates others without regard for their feelings.
4. **Sensory stimulus regulation –** In order to function effectively in the world, people need to be able to actively ward off excessive *sensory* stimulation. These ''stimuli'' are both **external** stimuli (like noise) and **internal** stimuli/bodily sensations (like pain). With intact stimulus regulation, insignificant stimuli (such as traffic noise outside a classroom) are automatically tuned out so they do not divert attention from other important aspects of the environment (such as the teacher's lecture). Without this function, people can feel flooded by noises, smells, and visual stimuli. For example, some people with impaired stimulus regulation cannot tolerate crowds because of the heat/noise/smells; others are bothered if they are not in a perfectly quiet room. Too much environmental stimulation makes them shrink away, withdraw, or feel overwhelmed.
5. **Affect/anxiety tolerance –** This refers to the ability to tolerate and regulate anxiety and other intense positive and negative emotions (such as anger, envy, despair, longing, or love). People with poor anxiety/affect tolerance feel easily disorganized and unmoored by their own feelings or may have rapid and dramatic swings from one mood state to another. We can think of this function as another type of *internal stimulus regulation*.
6. **Impulse control –** Good impulse control refers to a person's ability to act on or channel his/her feelings, urges, or wishes in a controlled way. People with poor impulse control act on feelings and urges in uncontrolled and maladaptive ways such as constantly needing to be in motion, throwing temper tantrums, binging on food, over-using alcohol and other substances, engaging in impulsive sexual activity, and self-mutilating. Closely related to this are frustration tolerance and the capacity to delay gratification.
7. **Capacity for play (also called ''regression in the service of the ego'') –** This refers to the ability to relax, to drift into fantasies and daydreams, and to experience unconscious feelings and urges without feeling anxious or over-stimulated. People with the capacity for play are able to channel their fantasies and daydreams into productive creativity. It also helps them to connect to deeply seated emotions. The capacity for play is also important for psychotherapy – both for patients

and for therapists. It allows patients to retrieve and experience unconscious thoughts and feelings, and it facilitates empathy in therapists. If people feel confused, overwhelmed, or disabled by fantasies, or if they regress easily but have trouble reversing the process, the regression is not ''adaptive'' and can be disorganizing.

8. **Self-awareness/psychological mindedness –** Being self-aware or psychologically minded means having curiosity about one's own internal state, having the ability to recognize and identify one's feelings accurately, and having the capacity to understand people and their unconscious motivations. People who lack self-awareness show little interest in exploring their behavior, cannot give reasons for their actions, give the therapist a lot of ''I don't know'' responses, and have little awareness of feelings.
9. **Self-esteem regulation/accurate self-appraisal –** Self-esteem regulation refers to one's ability to regulate oneself in response to a blow to the ego. Accurate self-appraisal reflects the degree to which one's *subjective* sense of one's capacities correlates with one's *actual or objective* competence. It is also related to one's ability to believe in one's own capacities, or sense of self-reliance (see Chapter 25 for more detail).
10. **Cognitive functions –** refers to the built-in cognitive apparatus a person is equipped with (intelligence, memory, attention, linear thinking, etc.). It also encompasses the ability to use this innate equipment to connect different aspects of experience, to recognize patterns, to reconcile inconsistent attitudes and feelings, to solve problems, and to think abstractly.
11. **Defenses –** Defenses are the *unconscious* and *automatic* ways the mind responds to internal and external stress and emotional conflict [12]. They are coping mechanisms that limit a person's awareness of painful affects like anxiety, depression, or envy, and resolve internal emotional conflicts. Defenses can be usefully divided into groups depending on how adaptive they are [8, 13–18]. For example, it is more adaptive to read a book about one's problems than to ignore them. More adaptive defenses are generally based on **repression**; less adaptive defenses are generally based on **splitting**. Whether a person's defenses are based primarily on repression or splitting is related to whether the person has achieved **object constancy**. (Note: *Object permanence* is knowing that something that is out of sight is still there; *object constancy* is knowing that bad and good can exist in the same person) [19]. If a person can tolerate the idea that bad and good feelings can co-exist in themselves or others, they can deal with painful or anxiety-provoking thoughts and affects by keeping them within themselves but making them unconscious (repression). However, if a person cannot tolerate the idea that anything bad exists in a good person, or vice versa, they need to separate the bad from the good. In order to do this, they have to experience some of their feelings as if they are coming from outside the self (splitting). Developmentally, splitting is normal in small children, but may persist (leading to lack of object constancy) when the person needs to protect their good image of an abusive or neglectful parent. A list of the major defenses follows, grouped according to how adaptive they are:

Less adaptive defenses

As above, splitting-based defenses tend to be less adaptive because they protect people from negative feelings and thoughts at a very high cost [20]. Splitting-based defenses predominate when object constancy has not been achieved. While they help to preserve good feelings, this comes at the cost of consolidating a three-dimensional view of the self and of others. A predominance of splitting-based defenses is a good indicator of ego weakness and leaves the individual handicapped in terms of having healthy relationships with others. Splitting-based defenses are sometimes called immature, primitive, or borderline. They are:

- **Splitting –** Splitting is a defense in which the ego preserves good feelings and avoids bad feelings by separating them into different people [15].

  Example

  Ms A's mother never kept food in the house and was harshly critical. Nevertheless, Ms A idealizes her mother and vilifies her father. As an adult, Ms A is unable to see men as having any good qualities despite her desperate wish to be in a heterosexual relationship.

  In this way, Ms A preserves her good feelings about her mother at the expense of having any good thoughts about men.
- **Projection –** In projection, the ego protects itself by perceiving unacceptable thoughts, feelings, and fantasies as originating outside of the self.

  Example

  Mr B's girlfriend cheated on him. He did not experience any anger at her, but became paranoid that she was spreading unflattering rumors about him.

  Note that in projection, Mr B experiences the anger as coming from the girlfriend, but she might have no awareness of this.
- **Projective identification –** Projective identification occurs when one person (A) projects a thought or feeling into another person (B) and then interacts with B to make B experience the projected feeling. We say that in this way, person A maintains an **identification** with the projected feeling.

  Example

  Mr C is passed over for a promotion by his boss. Although he says that this is fine with him, his unconscious rage is so overwhelming that he projects it onto his boss, and comes in 2 hours late for a week until his boss is so enraged that he fires him.

  Mr C projects the rage onto his boss; the boss unconsciously identifies with it and then fires Mr C. In this way, Mr C keeps his rage out of awareness – but at an incredibly high price.
- **Pathological idealization and devaluation –** Idealization and devaluation are natural results of splitting. Remember that the person who is idealized today may easily be devalued tomorrow.

Example

One week, Ms D thought that her therapist completely understood her while her husband was an idiot; the next week it was the reverse.

The following are less adaptive defenses although they are not linked as clearly to splitting. As with splitting, though, they ''work'' but at great cost to the functioning of the ego:

- **Denial –** In denial, the ego protects itself from unacceptable feelings by disavowing their existence. Note that denial can be a lower- or higher-level defense based on level of disavowal of reality.

  Example

  Mr E presented to the dermatologist complaining of acne and was found to have an enormous tumor protruding from his cheek.

  Mr E was so unable to process the unacceptable fact that he had a tumor that he denied its existence, calling it a ''pimple.''

- **Dissociation –** Dissociation allows the ego to avoid unacceptable thoughts and affects by disconnecting the self from aspects of one's current reality. This can involve losing one's consistent sense of identity, memory, and ability to perceive sensations or current sense of reality.

  Example

  When her mother was hitting her, Ms F retreated into a state in which she did not feel pain. This happened to her later in her life whenever her husband yelled at her.

  This is the quintessential ''high cost'' defense, since major cognitive functions are sacrificed to avoid the experience or memory of massive trauma.

- **Acting out –** One way to avoid a painful or uncomfortable feeling is to *do* something that enacts the feeling without becoming consciously aware of it.

  Example

  Ms G was so upset after she failed her French final that she went out drinking with her friend and ended up blacking out in the apartment of a man she did not know.

  Classically, acting out referred to enacting feelings that are generated within the therapy:

  Example

  Although Ms H said that she did not have any feelings about her therapist going on maternity leave, she signed up for several yoga classes during that time that prevented her from being able to return to her regular session times.

- **Regression –** When people regress, they go back to an earlier way of functioning in order to avoid the anxiety-provoking feelings prompted by a later developmental period.

  Example

  Up against four medical school exams, Ms I retreated to her parents' home, where they made her meals and did her laundry.

  Ms B retreats to her parents' home in order to feel protected as she did as a child because she is faced with having to perform at a more advanced level. Note that this defense is commonly used during periods of stress by people who generally function at a very high level.

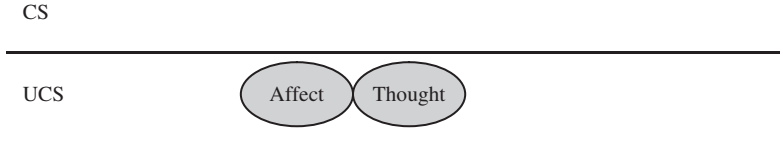
More adaptive defenses

The more adaptive defenses tend to be based on repression. In repression-based defenses, all or part of the unacceptable thought or feeling is made or kept unconscious. We can think of thoughts and feelings as being linked in one unit (thought-feeling), as in the following example:

Mr J felt sad (affect) when he thought about his mother's death (thought, memory).

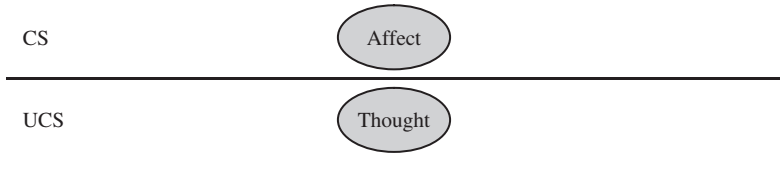
Here, sadness is linked to the memory of the mother's death. If this is unacceptable to Mr J, his ego will try to keep it unconscious. There are three options for repression here:

1. The ego can repress both the affect and the thought – then Mr J will never think about his mother's death.



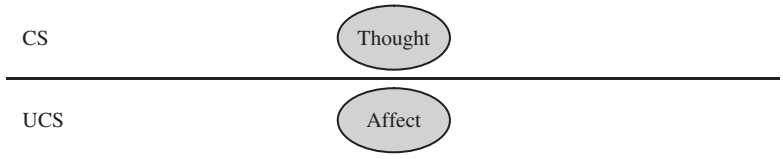
Both affect and thought are repressed

2. The ego can repress the thought and leave the affect conscious – then Mr J will feel sad but won't know why.



Affect remains conscious; thought is repressed

3. The ego can repress the affect and leave the thought conscious – then Mr J will remember his mother's death but have no feelings about it.



Thought remains conscious – affect is repressed

Different defenses repress different elements. The ego can also transform unacceptable unconscious elements by changing their object and reversing their affect.

Here are some repression-based defenses:

- **Isolation of affect –** Here, the ego represses the affect but the thought remains conscious. In the above example, #3 is isolation of affect. When this defense predominates, the person seems devoid of feeling.

  Example

  Mr K said that he had no feelings about having just been left by his wife.

- **Intellectualization –** Related to isolation of affect, this defense uses substitution of excessive thinking to take the place of painful or uncomfortable feelings.

  Example

  Unable to process feelings of anxiety about beginning therapy, Mr L read ten books about psychotherapy and began by engaging his new therapist in a discussion of the neurobiology of transference.

- **Rationalization –** Here the ego deals with unacceptable feelings by coming up with good reasons or justifications for problematic situations/feelings.

  Example

  Mr M is fired but tells his wife that it is for the best because he'd been unhappy at work for years.

  Mr M protects himself from overwhelming feelings by repressing them and allowing an understandable or sensible explanation to come into consciousness.

- **Displacement –** In this defense, the object of a wish or feeling is exchanged for one that feels more comfortable.

  Example

  Timmy is afraid of his father, but instead feels afraid of the school principal.

The idea of being afraid of his father is repressed, and the affect is linked to a new object.
Note that this is *not* a splitting-based defense because the affect is still perceived as originating in the self.

- **Somatization –** Here a thought or affect is repressed and is experienced as a bodily sensation.

  Example

  Mr N began to experience stomach cramps in October. When his therapist wondered if this could be related to the upcoming second anniversary of his wife's death, he realized that he had completely forgotten that this was coming up.

- **Undoing –** This is the ego's chance at a ''do-over'' – the ego gets to reverse something it feels is unacceptable or uncomfortable.

  Example

  Ms O cheated people all day long in her work and then gave a dollar to a beggar on the street.

- **Reaction formation –** In reaction formation, the unacceptable affect is reversed and experienced consciously *only* as its opposite.

  Example

  Ms P was excessively overprotective of her infant son in an effort to protect herself from her rage at his inability to sleep through the night.

  This is different from undoing because the original (non-reversed) affect was never consciously experienced – it becomes the opposite before it becomes conscious, and thus doesn't have to be undone.

- **Identification –** This is the ''if you can't beat 'em, join 'em'' defense. Feelings such as jealousy and competitiveness are dealt with by internalizing aspects of the other person.

  Examples

  After her older sister and her friends rejected Anne, she began listening to the same music that they did.

  Dr S noticed that Ms Q, a patient whom she had been seeing for two months, was starting to wear clothing that resembled her own.

  In many cases, identification can be quite adaptive, for example when someone works in a productive way with a mentor. It is a normal and important part of development during adolescence.

- **Excessive emotionality –** Here, thought content is repressed while affect remains conscious. In some ways, this is the opposite of defenses such as intellectualization and isolation of affect. Sometimes the high affect can substitute for a repressed

thought, and sometimes it can substitute for another more anxiety-provoking affect.

Example

Ms R seemed unaffected by the fact that her divorce became final today but became hysterical when she was told that her grocery order was delayed.

- **Externalization –** Using externalization, people perceive internal conflicts as if they were external conflicts.

Example

Ms S consulted a therapist to talk about whether she should stay with her fiancé or begin to date an old boyfriend who had contacted her. Months into therapy, she realized that she was ambivalent about getting married at all.

Ms S externalized her ambivalence about getting married, experiencing it as if it were about whether to date one man or another. Note that this is *not* a splitting-based defense mechanism because the feelings are still perceived as coming from within the self.

- **Sexualization –** When people sexualize, they take issues that are not sexual and make them sexual to avoid deeper uncomfortable feelings.

Example

Adrift during her mother's depression, 14-year-old Monique began to flirt with her male gym teacher.

Monique is sexualizing her need for maternal affection. Sexualization can replace a range of feelings and fantasies, including ones with rageful and competitive themes.

- **Repression –** Don't forget repression itself. Repression hides thoughts, feelings, and fantasies from consciousness, leading to forgetting, denial, and inhibited sexuality.

Example

After her divorce, Ms T was so anxious about paying taxes herself for the first time in 20 years that she completely forgot the tax deadline.

- **Turning against the self –** This defense substitutes the self for the object, particularly when it comes to negative affects.

Example

Mr U was angry with his father for buying a new house rather than paying for a year of his college education; however, he experienced this rage as self-criticism for not doing as well as he could have during his first semester.

Note that well-functioning people use the above ''repression-based'' defense mechanisms *every day*, and, when under stress, they may regress and transiently use splitting-based defense mechanisms. Thus, it's not the presence of splitting based defenses, but rather the predominance of them, that really makes it difficult for people to function well in love, work, and play.

Most adaptive defenses

The ego has several other mechanisms at its disposal to help allay painful affects, thoughts, and fantasies. Classically, defense mechanisms are mediated unconsciously – that is, they are deployed without the person knowing about it. Thus, the person does not say, ''I don't want to be angry with my father so I'll reverse that and feel really close to him'' – the anger never registers, and the ''flip'' is made unconsciously so that the affect that reaches consciousness is always the reverse of the rage. However, mature egos have various other maneuvers that they can use to help buoy self-esteem and contain painful affects [1, 21, 22]. These may or may not be conscious and thus are not all classically defense mechanisms.

- **Humor –** Many people use humor to allay uncomfortable thoughts or affect. When this is conscious, it is quite adaptive, however the chronic use of humor to avoid painful affects can be problematic.

  Examples

  Mr V made an uncomfortable slip during a sales pitch and then made a joke about it to his clients.

  Here, humor is used very adaptively to moderate anxiety. This is a conscious choice.

  Ms W complains that her boyfriend can never talk seriously about anything regarding their relationship and makes a joke of everything.

  Here, humor is used as a true defense mechanism and is much less mature and adaptive – it impedes intimacy in order to allay uncomfortable affects and thoughts.

- **Altruism –** This involves doing things for others as a way of dealing with painful affects.
  Again, when this mechanism is conscious or close to consciousness, this can be very mature, but when it is more unconsciously mediated it can be self-defeating.

  Examples

  After his father died of cancer, Mr X started a foundation to raise money for cancer research.

  Here the altruism helps to work through the grief and difficult feelings.

  Rather than care for herself, Ms Y spends all of her time caring for wounded animals.

  While caring for wounded animals is better than doing dangerous or malicious things to herself or others, the extent to which this impedes her ability to care for herself makes this less mature and less adaptive.

- **Sublimation –** In physical science, sublimation occurs when an element goes directly from a solid to a gas without going through the liquid form. In psychodynamics, sublimation occurs when an uncomfortable thought or affect goes straight from the unconscious to consciousness in a useful form – without having to be transformed. Thus, when a person can discharge his/her feelings of rage by writing a poem about anger or going to the gym to punch a punching bag, the affect is completely discharged without having to launch a frank ''defense.'' Sublimation often implies that the result is something that is useful or positive.

  Example

  Ms Z made sure that whenever she was frustrated with work she had time for a long run after she got home.

  Here, Ms Z is aware of her emotions and discharges them directly through exercise, a positive activity that benefits her.

- **Suppression –** ''I won't think of that now,'' says Scarlett O'Hara in *Gone with the Wind*, ''If I think of it now it will upset me'' [23]. That's a classic example of suppression. Unlike repression, suppression involves a conscious decision to put a thought or affect out of one's mind. Once again, suppression can be adaptive or non-adaptive. If the person puts one's bills out of his/her mind for too many months, debt grows; however, the ability to put one's worries on the ''back burner'' is essential for mental health.

  Example

  Mr AA was worried about his mother who was developing Alzheimer's disease, but he was able to put this out of his mind while he was enjoying time with his friends. (adaptive suppression)

Ego functions

- Reality testing
- Judgment
- Relationships with others
- Stimulus regulation
- Anxiety/affect tolerance
- Impulse control
- Capacity for play
- Self-awareness/psychological mindedness
- Self-esteem regulation
- Cognitive functions
- Defenses

Adapted from Bellak and Goldsmith [5].

Defense mechanisms

Less adaptive

- Splitting
- Projection
- Pathological idealization and devaluation
- Projective identification
- Denial
- Dissociation
- Acting out
- Regression

More adaptive

- Isolation of affect
- Intellectualization
- Rationalization
- Displacement
- Somatization
- Undoing
- Reaction formation
- Identification
- Excessive emotionality
- Externalization
- Sexualization
- Repression
- Turning against the self

Most adaptive

- Humor
- Altruism
- Sublimation
- Suppression

Adapted from Gabbard [16]

Super-ego function

Super-ego function, which includes both the person's conscience and their ideals for themselves, is also essential to assess. As we will explore more fully in Chapter 25, overly harsh super-ego function can make someone feel inappropriately guilty, while underdeveloped super-ego function will leave someone without a good sense of right and wrong. Harsh super-ego function can lead someone to feel overly guilty about something very minor, as in this example:

> *Mr BB, who was caring for his elderly mother, thought that he was a terrible person for occasionally having the wish that his mother would die.*

Mr BB has done nothing wrong – he has just had a thought. Nevertheless, he is quite self-punishing. This kind of self-punishment can lead people to have symptoms of anxiety and depression. It can also affect the way they think about themselves and have relationships with others. On the other hand, some people have under-developed super-ego function and do not feel guilty when they do things to hurt others:

> *Ms CC routinely hits her children with a brush when they misbehave. When asked about this, she says, ''Feel bad about it? Are you kidding? They had it coming and will get more if they don't listen.''*

Here, Ms CC has no remorse for actions that most people would feel bad about. Healthy super-ego function allows someone to have a sense of right and wrong and to experience enough guilt to be kind to themselves and others. Remember that people can feel guilty about thoughts, feelings, and fantasies, as well as about actions and omissions. It's important to assess patients for this kind of guilt regulation in order to learn about their mental and emotional functioning. Questions that are designed to assess guilt regulation include the following:

> *How did you feel after you did/thought that?*
>
> *Did you think that you had done something wrong?*
>
> *Did you think that you should be punished for that?*
>
> *How did doing that/thinking that make you feel about yourself?*

As with the assessment of ego function, any story can help you to assess super-ego function – whenever you hear something related to guilt or absence of guilt, you can use the opportunity to learn about this important aspect of the person's emotional functioning. Note that although super-ego functioning has been classically separated from the ego functions, guilt regulation operates alongside and in concert with the ego functions and thus when we discuss ego functions in general we are including this as well.

Why is the assessment of ego function important when we evaluate people for psychodynamic psychotherapy?

People with good ego strength can tolerate internal and external stimuli well without being overwhelmed by them. Since they don't have to expend a tremendous amount of energy simply staving off stimulation, they can spend energy on other things, such as thinking, loving, and playing. Conversely, people with lower level ego function spend much of their energy just dealing with what feels like overwhelming levels of internal and external stimulation. How much energy can be left for other things? A good analogy would be a town lying next to a river that constantly floods compared with a town that is well positioned on a hill. The town near the river has to spend most of its resources just dealing with the river – anticipating the flood, dealing with the flood, and cleaning up after the flood, while the town on the hill can relax, play, and develop cultural activities.

If you want to help the town by the river, you have to help them with flood issues. Trying to help them with anything else won't work for a few reasons:

- Their problems are related to the flood – so that's where your help should be focused;
- They are so preoccupied with flood issues that they are unable to deal with anything else.

On the other hand, helping the town on the hill can take other forms, since they are not only preoccupied with survival. Using this analogy, people who grapple on a daily basis with problems like impulse control and anxiety tolerance need a therapy that regularly and directly helps them to build up their problematic ego function, while people who do not have to struggle with basic ego functions can concentrate on difficulties that relate to unconscious thoughts, feelings, and fantasies.

Assessment of ego function can also help us to determine which patients can tolerate uncovering techniques. Uncovering unconscious material can be difficult and painful and thus is best undertaken with patients who have a certain level of ego function. For example, as we discussed in Chapter 1, uncovering psychodynamic psychotherapy often uses discussion of the therapeutic relationship (**transference**) in order to understand aspects of the patient's defenses, relationships with others, and self-perceptions (see Chapters 12 and 21). In order to effectively utilize this technique, patients have to understand that discussion of their feelings about the therapist *will not lead* to a relationship with the therapist outside of the therapeutic situation. This requires the capacity to think abstractly, control impulses, test reality, have a developed sense of right and wrong, and tolerate strong affects. Other ego functions, such as the capacity for play (in order to make connections and to associate to dreams and fantasies) and to delay gratification (in order to stay with what can be a lengthy treatment), are also helpful for the uncovering process.

For all of these reasons, *people with problematic ego function generally need support for their ego functions, while people with better ego function can tolerate and benefit from uncovering of unconscious thoughts and fantasies*.

Strengths and weaknesses

When we assess someone's ego function, it's important to remember that we are looking for points of strength as well as points of weakness. This is essential not only for our evaluation, but also for the treatment, since we will utilize areas of strength throughout the work.

Example:

Mr DD avoids socializing in order to deal with his extreme anxiety. In his isolation, he has become an excellent carpenter, spending many hours carefully constructing beautiful furniture.

Although Mr DD's difficulty with relationships is a weakness, his talent for and love of his craft are strengths. His ability to concentrate and persevere could become important to his capacity to work in therapy.

Ever-changing ego function

It is also important to remember that ego function is not static, and thus a person's need to have support supplied from the outside waxes and wanes. Stress caused by medical and psychiatric illness, bereavement, role transitions, and blows to self-esteem can temporarily weaken ego function. Ego function can also be weakened in a moment-to-moment way, for example when a patient feels misunderstood or criticized by the therapist. Drugs and alcohol can also alter both ego and super-ego function. These changes require us to be flexible in the use of uncovering and supporting techniques and to constantly ask ourselves:

- What are the goals at this moment in the treatment?
- What is the level of ego function at this moment in the treatment?

Now that you've done a thorough assessment of the patient, let's move on to Chapter 5 to consider how to use the information you've collected to generate a formulation and to make an informed recommendation.

Suggested activities

Here are some exercises that will help you to practice thinking about ego functions and defenses.

Activity 1: Ego Functions

What ego functions are impaired in these patients?

1. *Ms A only feels good about herself on days that she gets a call or text from her boyfriend.*
2. *Mr B drinks excessively after he fights with his wife.*

3. *Ms C can't help herself from going home with random men she meets at bars.*
4. *Ms D says that she has many friends but is unable to name one whom she could call if she had an emergency situation.*
5. *Mr E thinks that his therapist is trying to get rid of him as a patient because the therapist charges for missed sessions.*
6. *After a hard day at work, Ms F comes home and yells at her children.*

Comment

1. Ms A has a tenuous ability to regulate her self-esteem.
2. Mr B has poor affect tolerance – he can only calm himself down by drinking.
3. Ms C has poor impulse control and impaired judgment.
4. Ms D has poor relationships with others – all of her friendships are superficial.
5. Mr E has poor reality testing.
6. Ms F has poor anxiety tolerance.

Activity 2: Defenses

What defenses do you think that these people are using? Are they repression-based or splitting-based?

1. *Ms A has a three-month-old baby boy who cries day and night. Her husband never gets up to help her during the night. She has dark circles under her eyes and is exhausted. She will not leave the baby with anyone, including her mother, for fear that something will happen to him.*
2. *While studying for his bar exam, Mr B, a healthy, 25-year-old law student, becomes panicked that he is going to have a heart attack. He begins to feel odd sensations in his chest and worries that he is winded when he walks up the stairs.*
3. *After failing his orals, Mr C tells his roommate that it's all for the best because it will force him to bone up on his ancient Chinese history.*
4. *When Ms D's roommate begins dating their mutual friend, she becomes convinced that her roommate hates her and is trying to steal all of their other friends.*
5. *Mr E completely forgot that he had to pay his taxes until he received a warning note from the Internal Revenue Service.*
6. *When Ms F was late for her session, she berated her therapist for not giving her extra time at the end of the session. The therapist left feeling guilty.*
7. *Mr .G consulted a therapist after he was fired from his job, but in the first session he explained the situation in a near monotone. When the therapist asked him if he was upset about this, he said, ''Why should I be? It's all part of the job.''*

Comment

1. **Reaction formation –** it is likely that Ms A's over-protectiveness is covering repressed aggression toward her inconsolable child. This is repression-based

because the aggression remains within Ms A but is experienced consciously as its opposite.

2. **Somatization –** Mr B is experiencing his anxiety as if it is originating in physical symptoms. This is repression-based because the anxiety remains within Mr B but is experienced as physical symptoms.
3. **Rationalization –** Mr C deals with his disappointment by finding a good reason for his failure. This is repression-based because the disappointment of the failure remains within Mr C but is experienced without the affect.
4. **Projection –** Ms D deals with her rage at her roommate by experiencing it as originating in her roommate. This is splitting-based since she cannot deal with the affect by keeping it within herself.
5. **Repression –** Mr E deals with the anxiety of paying taxes by completely putting it out of his mind. This is repression-based because it remains within him but is not conscious.
6. **Projective identification –** Ms F deals with her feelings by projecting them into the therapist and then behaving toward the therapist in such a way that the therapist experiences those feelings herself. This is splitting-based because Ms F cannot keep the feelings contained within herself.
7. **Isolation of affect and rationalization –** Mr G knows what happened but has repressed the affect. This is repression-based because the affect remains within Mr G and is just out of his awareness. He also uses rationalization because he gives a justification for being fired – this is also repression-based.

Activity 3: Strengths and Weaknesses

Think about both the ego strengths and the ego weaknesses in these patients:

1. *Mr H is a 45-year-old man who presents for therapy saying that he is conflicted about an extra-marital affair that he is having. He worked for many years as a contractor until he was recently laid off. When he meets his union buddies each evening at the local bar, he confides to them that he is bickering daily with his wife. He is listless during the day and is having difficulty curbing his appetite for internet pornography. He says that the only thing that has made him feel like a ''man'' recently is that he has ''hooked up'' a few times with the waitress from the bar – she is ''young and pretty'' but he's sure that she'll ''dump him'' soon.*
2. *Ms I is a 65-year-old woman whose husband of 40 years has just died. She feels lonely and isolated – many of her friends no longer live in her neighborhood and her children live in far-away states. She has kept up her daily schedule of swimming, reading, gardening, and cleaning the house, but she says that it feels ''empty.'' She says that she has always been shy and that her husband was the one who helped them to have an active social life. She is wondering what the next phase of her life will be like and is asking for your help.*

Comment

1. During this period of his life, Mr H is having difficulty with self-esteem management, impulse control, and affect regulation. He is aided by having friends and a long-term

relationship. He has some capacity for self-reflection, as evidenced by his decision to seek out psychotherapy.

2. Ms I is using her tried and true interests to get her through this period of mourning. She is hindered by lifelong shyness and difficulty meeting others and her isolation. However, she is self-reflective and interested in collaborating with you to learn new ways of being in the world.

5 Formulation: The Problem → Person → Goals → Resources Model

Key concepts

Once we've assessed the patient, we can formulate the case in order to recommend treatment using the Problem → Person → Goals → Resources model:

- Problem(s) – What is/are the problem(s)? How do we prioritize them?
- Person – What is this person's general level of functioning? What is his/her level of ego function? What are his/her characteristic defenses? Super-ego function? What are his/her strengths and weaknesses?
- Goals – What does the person want help with? What do you think that he/she needs help with?
- Resources – What are the available resources that can be used to try to achieve the goals?

Once we take a history and do a thorough evaluation of the patient, we are ready to formulate the case in order to decide what type of treatment, if any, would be most helpful at this time. The initial formulation can be thought of as bringing together these four elements:

- the problem
- the person
- the goals
- the resources

We call this method of formulation the **Problem → Person → Goals → Resources model**. In this chapter, you will learn how to use this model to make the best treatment recommendation for your patient. It will help you to:

- decide whether psychodynamic psychotherapy is indicated
- decide whether a more uncovering or supporting stance will be most helpful

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Assessment of the problem vs. assessment of the person

First let's consider the difference between understanding the **problem** and understanding the **person**. In this model, the **problem** refers to the difficulty that is bringing the patient to treatment *now*, while the **person** refers to general aspects of the patient's baseline functioning (such as strengths and weaknesses, temperament, characteristic defenses, and typical ways of responding to others). We need to know both in order to prescribe the appropriate treatment. Two people might present with similar problems; however if they have different levels of ego function they will benefit from different types of therapy. Consider the following:

> *A 35-year-old woman presents to a therapist with the chief complaint that she is confused about her career. She states that she has been at her job for six months, but feels dissatisfied, stating that it ''isn't a career like my friends have.'' She is conflicted about staying at her job, which offers her stability, and leaving her job to pursue a PhD in art history.*

This is a fairly typical chief complaint for someone to bring to a psychotherapist. She is confused about life choices – we hypothesize that she has a conflict. But let's consider two different people who both present with the same chief complaint:

> *Ms A is a 35-year-old woman who presents to a therapist with the chief complaint that she is confused about her career. She states that she has been at her job for six months, but feels dissatisfied, stating that it ''isn't a career like my friends have.'' She is conflicted about staying at her job, which offers her stability, and leaving her job to pursue a PhD in art history. Ms A states that she has had eight jobs in the last five years. She initially states that she left each job because the people were ''so stupid'' but further discussion reveals that she might have been fired for clashes with superiors. The ''friends'' that she mentioned are a group of people she met three months ago at a self-realization retreat. The anxiety produced by her current job situation has prompted her to binge drink on the weekends. When you ask her why she'd like to pursue a PhD in art history, she has only a vague idea of what it would entail and confesses that she knows very little about art. ''One of my friends is doing it and it seems really cool,'' she says. ''I went to a party at her house with a lot of the people from her program and they were really smart – that's where I should be.''*

> *Ms B is a 35-year-old woman who presents to a therapist with the chief complaint that she is confused about her career. She states that she has been at her job for six months, but feels dissatisfied, stating that it ''isn't a career like my friends have.'' She is conflicted about staying at her job, which offers her stability, and leaving her job to pursue a PhD in art history. In college, Ms B loved Italian renaissance art, but was told by her parents, who are both very successful attorneys, that anything less than a ''profession'' (medicine or law) was a waste of time. At the end of college, she and several of her close friends studied for their law school entrance exams. She was accepted to several good law schools, but she developed a ''mono-like'' illness prior to matriculation and never began. She is still very close to most of her college friends, many of whom are now unhappy lawyers. Ms B floundered around for a while and found success working for a non-profit company. She was just hired to a high-level administrative position at another non-profit company but realizes that it's ''now-or-never'' for her dream of becoming an art history professor. She has been dealing with her frustration by immersing herself in the art world again, attending lectures at a local museum and reading new books about renaissance art.*

Although both Ms A and Ms B present with a similar chief complaint, they have vastly different:

- histories
- ways of dealing with anxiety
- quality of relationships with others

Thus, although the *problems* sound similar, Ms A and Ms B are very different *people*. Ms A is conflicted, but she has great difficulty containing her anxiety without acting out in a variety of self-destructive ways. Her conflict about her job status is the latest manifestation of a chaotic work history and her quest for a PhD seems superficial. In contrast, Ms B has a longstanding interest in art history which she inhibited secondary to the wishes of her parents. She has dealt with her frustration by satisfying her hunger for immersion in the art world.

Undergoing psychodynamic psychotherapy is often very difficult. When we use a more uncovering mode, we try to unearth feelings, conflicts, and fantasies that are experienced as terrifying or shameful, change automatic defenses that have become habitual, and alter behaviors that ''protect'' people from overwhelming anxiety. In order to do this, a person needs strengths that help them. As we discussed in Chapter 4, these are often referred to as **ego strengths**. Thus, having a full understanding of a person's underlying strengths and weaknesses – apart from the presenting problem – is essential to deciding what type of psychotherapy or technical stance will be most helpful to a given person at a given time. In sum, understanding who the *person* is involves understanding not just his/her observable symptoms and behaviors, but also his/her inner mental functioning, including their ego function, dominant defense mechanisms, super-ego function, and characteristic ways of responding to others.

Problem

So let's begin with the *problem*. Defining the patient's problem often sounds easier than it is. The patient might not be aware of what his or her problem is, or the most pressing problem might not be the patient's chief complaint. During the assessment phase, one of our main jobs is to determine what we think the patient's problem is – and if there are numerous problems, to prioritize them.

Example:

Ms C presents for psychotherapy saying that she is lonely and that she heard that psychotherapy could be helpful with commitment problems. In the course of the evaluation, you learn that Ms C has been drinking a bottle of wine per night.

In this example, Ms C says that she has a problem with relationships, but it becomes rapidly evident that she has a problem with alcohol. Thus, her chief complaint may

not be her most pressing problem. The important thing is to prioritize the patient's problems without dismissing the patient's subjective experience of what he or she thinks is most important. Continuing with Ms C, let's fast forward to the therapist's formulation:

> *Therapist – Ms C, I'm so glad that you learned about this treatment and that you are interested in exploring it. You've really been unhappy about your relationships and I think that I can help you with that. It also sounds like you're drinking more than you had been and that this might be exacerbating some of your difficulties. Let's see if we can create a plan that addresses both of these issues.*

We have to remember that just because we're assessing the patient for psychotherapy doesn't mean that some other form of treatment might not be indicated. Patients who present for psychotherapy may have many different types of problems, including mood disorders, anxiety disorders, eating disorders, and substance abuse disorders. The presence of a disorder requiring medication doesn't preclude the use of psychotherapy, including psychodynamic psychotherapy. Depending on the situation, the patient might need to be stabilized with medication before beginning psychotherapy. For example, a very depressed patient with psychomotor retardation might have difficulty speaking in sessions, but once her symptoms improve she might benefit from psychotherapy. On the other hand, a patient with dysthymia and relationship issues might begin medication and psychotherapy at the same time. (See Chapter 15 for further discussion of medication and psychotherapy.)

Person

As we discussed in Chapter 4, people have characteristic ways of dealing with their environment that we call ego functions. These develop throughout the person's life and form the basis of the person's characteristic way of functioning. In formulating the case, we need to not only consider the symptoms that are bringing the person to treatment at this time, but also the person's underlying ways of responding to stress, relationships, and all of the other internal and external stimuli that they face every day. This is the part of the formulation that we call the *person*. Most importantly, this will include the assessment of ego functions, defense mechanisms, super-ego function, strengths, and weaknesses.

Goals

During the assessment, we need to talk to our patients about goals. Understanding the goals of the treatment is essential for making an informed treatment recommendation. Setting goals involves considering both the patient's hopes and wishes for treatment as well as the therapist's assessment about what is needed and realistically achievable. The goals of the patient and the therapist are not always the same. Sometimes patients are consciously aware of their goals and sometimes they are not. Sometimes they state

them outright and sometimes you have to ask for them. As much as possible, always try to make goal setting a collaborative process. Regardless, determining the patient's goals is a critical factor in deciding whether psychodynamic psychotherapy is indicated. (See Chapter 6 for more on indications for psychodynamic psychotherapy, and Chapter 7 for more on setting goals.)

Resources

Sometimes, psychodynamic psychotherapy is the treatment of choice but the resources are not available. Resources include both:

- factors related to the system, including availability of therapists, types of treatment, and treatment hours
- factors related to the patient's resources, including financial situation, health insurance, family support, and time

Consider these situations:

> *Ms D is interested in undergoing psychodynamic psychotherapy but there isn't a therapist in her part of the state who is familiar with this type of treatment.*
>
> *Mr E has an evaluation for psychotherapy but decides that he can't afford it.*
>
> *Mr F is on a waiting list for an appointment for a psychotherapy intake.*
>
> *Eight-year-old Gaby would benefit from psychotherapy but both parents work two jobs and aren't available to take her to appointments after school.*

In a perfect world these things wouldn't matter – but in the real world they do. If we don't take them into consideration, we suggest treatment plans that are potentially unrealistic for our patients. Thus, thinking about resources is essential to the assessment of patients for psychotherapy.

A sample formulation

Once you have all of these elements, you can construct your initial formulation. Here is an example:

> *Mr H is a 45-year-old man who presents with the chief complaint: ''I'm not getting along with my wife.''*

- **Problem – marital discord**

  > *Mr H says that for the past six months, he and his wife have been arguing more than they were before. This is in the context of Mr H's mother-in-law coming to live with them during her recovery from a major illness. Mr H says that he loves his wife and that he would like to understand why he is so angry with her. There is no evidence of mood or anxiety disorder.*

- **Person**
  - **Ego function**

    Throughout life, Mr H has exhibited excellent ego function. He has very good judgment, many close long-term relationships, and a generally good ability to tolerate anxiety and strong affects. This is part of why his recent anger stands out as a problem. His mother died when he was seven years old and he has a vague idea that this could be related to the current problem (psychological mindedness).

  - **Characteristic defenses**

    Mr H has a nuanced view of others and can perceive them as having both good and bad qualities. He has many adaptive defenses that are generally repression-based. He sublimates anxiety and aggression by excelling in athletics and pursuing hobbies such as woodworking. He has many close personal relationships that he uses to cope with anxiety and stress. He habitually keeps strong feelings out of awareness, suggesting a prominent reliance on isolation of affect as a defense. He has been reading books about marriage in mid-life to learn more about this problem (intellectualization).

  - **Strengths**

    He has kept a job for many years and has many close long-term relationships. He is motivated for treatment and seems to love his wife very much. He derives a great deal of satisfaction from his work.

  - **Weaknesses**

    He occasionally has more than three drinks on a weekend night. Over 10 years ago, he was drinking on a more regular basis. He is somewhat disconnected from his feelings.

  - **Super-ego function**

    Mr H has a developed sense of right and wrong. His guilt regulation tends to be appropriate, as evidenced by his consultation for this problem.

- **Goals**

  Mr H would like to improve his relationship with his wife and to understand why this situation has made him so irritable. The therapist agrees with this short-term goal and adds the long-term goal of helping Mr H to understand more about the way in which his mother's death continues to affect his relationships.

- **Resources**

  Mr H has insurance that will cover 50% of the clinic fees, and he is able to pay the rest out of pocket. He will be able to take time at lunch to come to sessions.

In this example, the ''person'' section tells us that Mr H has generally good ego function and is relatively psychologically minded. His interpersonal problem seems to stem from conflicting feelings about his mother that are coming to the fore in the context of his mother-in-law's illness and presence in his household. These suggest that Mr X will be helped by a psychodynamic psychotherapy with a primarily uncovering stance designed to help him to learn more about feelings that are out of awareness. He agrees with these goals and has the resources to begin the therapy.

The formulation brings together what we've learned so that we can make a recommendation. In the next chapter, we'll review the indications for psychodynamic psychotherapy so that you can use your formulation to make the best treatment plan with your patient.

Suggested activity

For each patient, name two things that are *problems* and two things that characterize the *person*.

1. *Mr A is a 45-year-old man who presents with new-onset anxiety related to problems with his 16-year-old daughter. A single parent since his wife died five years ago, he says that he doesn't know how to deal with his daughter's promiscuity and marijuana use. ''I just can't talk to her like my wife did,'' he laments, telling you that he often withdraws and doesn't confront her about her behavior. He says that this pattern of behavior reminds him of how he dealt with his ''spirited'' wife as well. His worry that she is on the ''wrong track'' has led him to have insomnia, daily ruminations, and ''one too many'' beers at night.*
2. *Ms B is a 35-year-old woman who presents because her boyfriend has broken up with her. She says that she is tearful at work and that for the last week it has been difficult to concentrate. She explains that although her boyfriend is married, she knows that he was closer to her than he was to his wife and she can't understand why he has made this choice. She says that she has dated married men before but that this was ''different'' because she was ''sure'' that he was going to leave his wife.*

Comment

1. Mr A

Problem:

- Anxiety symptoms
- Difficulty communicating with his daughter
- Increased drinking

Person:

- Tends to withdraw rather than confront
- Single parent
- Somewhat self-aware

2. Ms B

Problem:

- Depressive symptoms
- Recent break-up

Person:

- Pattern of dating unavailable men
- Tends to use denial to deal with difficulties
- Limited self-awareness

6 Indications for Psychodynamic Psychotherapy

Key concepts

The last part of the evaluation phase is making a recommendation for treatment.

We use the Problem → Person → Goals → Resources model to make an initial formulation and to guide our recommendation for treatment.

- Problem – Psychodynamic psychotherapy is particularly indicated for:
  - problems that seem to be caused by unconscious factors
  - weak or faltering ego functioning
- Person – Baseline level of ego functioning helps us to decide whether uncovering or supporting should be our predominant technical mode.
- Goals – Both long-term and short-term goals can be indications for psychodynamic psychotherapy.
- Resources – Necessary resources include time and money, as well as availability of appropriately trained mental health professionals.

Empirical studies have demonstrated that psychodynamic psychotherapy is efficacious for many types of psychopathology.

You're in your office conducting the evaluation of a patient. What is it that would make you say, ''I think that psychodynamic psychotherapy would really help this patient''? This chapter will address that question in order to help you know when to recommend this type of psychotherapy.

When is psychodynamic psychotherapy likely to help a patient?

We can use the Problem → Person → Goals → Resources model to decide whether to recommend psychodynamic psychotherapy. Remember that a *problem* refers to the difficulty that is bringing the patient to treatment *now*, while the *person* refers to general aspects of the person's baseline way of dealing with the world. Although we will address each of these elements separately, we ultimately have to consider them all together in order to determine whether psychodynamic psychotherapy is likely to help the patient. For example, a patient could have a problem that we think

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might be helped by uncovering unconscious material, but might lack the motivation or resources to make this treatment feasible. Here's an example:

> *Mr A consults a therapist because he is having difficulty with his 16-year-old son. A generally patient and thoughtful man, he cannot understand why they are constantly yelling at each other. When you take a history, you find that Mr A's father is a volatile, abusive man from whom Mr A has been estranged for many years. You think that Mr A might be unconsciously identifying with his father in his dealings with his son, and that uncovering this could be helpful to this relationship. However, when you begin to explore this with Mr A, he becomes upset and says that*:
>
> 1. *he's nothing like his father, and*
> 2. *he wants to clear up the whole situation in three weeks.*

Despite your hypothesis that Mr A has a problem that is caused by something in his unconscious, he is not motivated for this type of treatment and he is not interested in committing the resources needed for an in-depth, uncovering treatment.

In the following sections, we will use the Problem → Person → Goals → Resources model to think about when to recommend psychodynamic psychotherapy.

Problem

Although many problems have been treated by psychodynamic psychotherapy[1], there are two basic kinds of problems for which it is particularly indicated:

Problem #1 – Clinical situations caused by unconscious factors

Problems such as interpersonal difficulties, distorted self-perceptions, and maladaptive ways of dealing with stress are undoubtedly the complicated end products of myriad factors, including inborn temperamental factors, the impact of early attachments, traumatic experiences, mood and anxiety disorders, and cognitive strengths and weaknesses. However, based on our clinical experience, there are certain kinds of problems that improve when unconscious elements are brought into conscious awareness. Given this, we can infer that unconscious elements may be causative factors.

As we discussed in Chapter 2, we can think about this kind of causation using a developmental model. As we develop, certain affects, wishes, fantasies, fears,

[1] *Although further empirical outcome research is needed for psychodynamic psychotherapy, the results of more than 30 randomized control trials (RCTs) are currently available that provide ample evidence for the efficacy of psychodynamic psychotherapy in specific mental disorders. Conditions for which psychodynamic psychotherapy has proved at least as effective as cognitive behavioral therapy (CBT) in RCTs include depressive disorders (major depressive disorder(MDD)), anxiety disorders (generalized anxiety disorder (GAD), social phobia) eating disorders (bulimia nervosa), substance-related disorders (opiate dependence, cocaine dependence, alcohol abuse), borderline personality disorder, and Cluster C personality disorders. There is also evidence from RCTs that psychodynamic psychotherapy is effective for somatoform disorders and panic disorder. Similarly, available data for supportive psychodynamic psychotherapy suggests it is effective for a wide variety of problems, including personality disorders, medical illness, schizophrenia, generalized anxiety disorders, social anxiety, depression, adjustment disorders, opiate addiction, and cocaine abuse* [24–31].

and conflicts threaten to cause us intolerable anxiety. According to this model, we keep these affects, fears, and wishes out of awareness to protect us from intolerable anxiety, but we do so *at the expense of continued normal development*. Depending on what we repress, development is affected to a greater or lesser degree. Here are two examples:

> *Ms B is chronically abused by her mother. Keeping negative feelings about her mother out of awareness leads to global problems in the development of trust, self-esteem management, the capacity for attachment, and a host of other critical functions.*
>
> *Mr C has loving parents but competes with his younger brother for his mother's attention. Keeping his aggressive feelings toward his brother out of awareness impedes his ability to compete in a healthy way with male peers, affecting some aspects of his adult career advancement.*

Because of the extent of her abuse, Ms B's repression impacts her functioning to a greater degree than Mr C's does.

When we assess patients for psychodynamic psychotherapy, we are looking for indicators that suggest that the problems we're seeing are caused, at least in part, by hidden, unconscious factors. But, once again, how can we find factors that are out of awareness? Sometimes, we can determine this from the history – in other words, the patient gives us a clue at the outset that the problem is *related to something in his/her past that is now inappropriately transposed onto a current situation*. Here's an example:

> *Mr D is a 34-year-old heterosexual man who describes becoming anxious every time he is in a relationship with a woman that starts to become serious. You do a thorough evaluation and assessment of ego function and you find that the man does not have an anxiety or mood disorder. He also has generally good ego functioning – he has good friends, is intelligent, functions well at work, and has good anxiety and affect tolerance. According to the DSM he's healthy – no problems at all. But he's come to you because he's very upset – he wants to have a long-term relationship and his inability to do so is greatly affecting his quality of life. When you take a* ***genetic history*** *you discover that his father had to forego his wish to be a writer in order to support his wife and son. The patient says that his father became chronically withdrawn from the family and that his mother relied on the patient for emotional sustenance.*

Once you hear this, you hypothesize that the patient's fears about long-term relationships have more to do with his thoughts, feelings, and fantasies about his parents than with the actual women in his current life. Uncovering psychodynamic psychotherapy can help to make the patient aware of this and can help him to move forward with his life.

But what if we don't explicitly hear this link to the person's past? How can we tell if the person's problem is related to unconscious factors? In these cases, we're like geologists who need to rely on surface indicators when looking for subterranean formations. What kinds of clues can we use to help us know whether a person's problem may be linked to unconscious factors? Here are a few chief complaints that often signal that unconscious elements are at play:

- **"I'm stuck"** – One of the most common chief complaints that psychodynamic psychotherapists hear from their patients is that, in some way, they feel stuck.

Some are stuck in their careers, others are stuck in their romantic relationships – but whatever it is, they don't know how to move forward. Generally, patients presume that this indicates that things are not moving, but we know better. We know that the feeling of being stuck is usually caused by *conflict* that is out of awareness. If two horses are pulling a cart, and one is going due east and one is going due west, there's plenty of force but the cart isn't going anywhere. It's stuck. There could be two horses, four horses, eight horses – if they're all pulling in equal and opposite directions, the result looks like stasis. That's what our patients feel. Here's an example:

> *Mr E is a 30-year-old writer who has published one book who presents saying that he can't seem to start his second novel. He has hundreds of pages of notes but freezes when he starts to write. He says that he wants to write it; however, as you discuss this with him, it becomes clear that he is desperately afraid that he will get a bad review and that his earlier success will be seen as a ''fluke.''*

Mr E is stuck, but it's because he has two equal and opposite forces going on in his unconscious. One wish is to move ahead and to write his second novel. But an equal and opposite force is the fear and shame involved in exposing himself to scrutiny. If he never writes, he can never be judged. If we can help him to understand this, we can help him to resolve this conflict and to move forward in his life.

- **''My life is great except for . . .''** – A good indicator that some developmental trajectory has arrested is the situation that occurs when only one aspect of a person's life is problematic. Very often, people present who are moving ahead with their careers and have many friends but who have persistent difficulties with intimate, romantic relationships. Conversely, some people have no problems with relationships but have difficulty with competitiveness that translates into career dissatisfaction. Of course, further investigation may reveal that there is more to the story, but this type of presentation is often a good clue to the presence of an unconscious determinant.
- **''I don't know why I keep doing . . .''** – Persistent patterns of maladaptive choices, particularly in someone who seems to have the capacity to make better choices, is often a good indicator that something in the unconscious is perpetuating the situation. Consider an attractive, intelligent young woman with very close female friends who consistently dates married men, or an earnest young father who keeps getting into dead-end business situations.

As we listen to our patients, we will begin to hear these clues. They signal to us that unconscious factors are keeping our patients from moving forward in their adult lives.

Problem #2 – Weakened ego function

The other major set of problems that indicate that patients would benefit from psychodynamic psychotherapy is the presence of weakened or faltering ego function. This problem can be acute (temporary) or chronic. In either case, patients with this

problem may benefit from psychodynamic psychotherapy with a supporting stance. Here is an example:

> *A seemingly healthy and previously well-adjusted 21-year-old college senior presents to his student health center at a large university a few months before graduation. He says that he has just been dumped by the love of his life, feels depressed, and overwhelmed, can't study, and feels panicked and suicidal because he is in danger of flunking his midterms. He admits he is also drinking more than he should but can't find any other way to calm himself down. He has always considered himself a ''strong'' person and is appalled and ashamed by his ''total collapse.'' If he manages to graduate, he plans to go to medical school in the Caribbean, but he is beginning to doubt whether he has made the right career choice. His own dream was to study philosophy but his parents, who are recent immigrants, thought this was ''too impractical'' and urged him to pursue medicine, despite his lack of aptitude in the pre-med courses and middling performance in his medical school entrance exams.*

The therapist thinks that, in addition to his acute grief over losing his girlfriend, this young man may be unconsciously ''shooting himself in the foot'' as a way of defying his parents' expectations, and might benefit from an uncovering psychodynamic psychotherapy. However, the fact of the matter is that at this moment he is less interested in a deeper understanding of his difficulties than he is in rapid relief of his symptoms and a concrete plan for getting through his exams. His life circumstances (and perhaps the health center's policies) also dictate that the treatment will be brief. Is psychodynamic psychotherapy contraindicated? Not necessarily, but the patient's acute needs may dictate a supportive approach that takes into account – without necessarily exploring – some of the unconscious thoughts and feelings fueling his behavior.

Psychodynamic psychotherapy with a supporting stance may be indicated for:

- People with generally good ego functioning who are experiencing *temporary* weakness in certain areas of ego functioning in the face of stress, such as:
  - **Newly diagnosed medical illnesses**: Blows to our physical functioning often affect our emotional functioning. Ego support can often help patients who are newly physically ill to manage feelings such as rage and loss, and to develop coping mechanisms to deal with their altered level of physical functioning.
  - **Social upheavals**: Events that acutely alter the way we relate to the people in our environment can often dramatically affect ego function. Examples include divorce, death of a parent or spouse, breakups and relationship loss, leaving home, getting married, becoming a parent, losing a job, and retiring.
  - **Other crises**: Anything that acutely overwhelms our capacity to function at baseline has the potential to temporarily weaken ego function. This could include business reversals, financial problems, natural disasters, physical threats/trauma, and legal problems.
  - **Stressful periods during an uncovering psychotherapy**: Sometimes the emotional work of psychodynamic psychotherapy can temporarily overwhelm a person's ego function. This may require a period of ego support to deal with very strong affects or anxiety.

- People with *chronic* ego weakness, such as:
  - **Lack of psychological mindedness and/or motivation for understanding**: People who chronically lack the ability and/or motivation for thinking about the way that unconscious factors affect their lives will often benefit from therapy that directly addresses their manifest functioning.
  - **Poor anxiety tolerance, low frustration tolerance, difficulties regulating affects, overwhelming anxiety around separations**: Some people have a harder time than others tolerating their distress and may always need immediate relief from their symptoms. Support for ego functions can provide this.
  - **Lack of trust and/or a history of problematic relationships**: People with seriously impaired relationships and a tenuous ability to trust others often benefit from ongoing ego support to help them to improve their relationships with others.
  - **Poor impulse control**: People with poor impulse control are generally best treated, at least initially, with supporting techniques that help them to control their feelings and impulses long enough to talk about them. Such patients may suffer from affect storms or tantrums; may binge on food, alcohol or drugs; may self-mutilate; may engage in risky or dangerous sexual activity; or may generally act on feelings in an uncontrolled and maladaptive way.
  - **Chronic psychotic, mood, or anxiety disorders**: People with chronic major psychiatric disorders may have persistently impaired reality-testing, poor impulse control, and poor anxiety tolerance. They can benefit from psychodynamic psychotherapy that focuses on actively supporting weakened ego function.
  - **Chronic physical illness**: Ongoing physical illness can chronically weaken ego function. Reasons for this include the stress of treatments, permanent loss of mental and physical functioning, and ensuing changes in a person's ability to work, play, and have relationships. Ego support is often an essential component of the maintenance treatment of myriad illnesses such as cancer, diabetes, neurodegenerative disorders, and HIV-related conditions.

Person

The patient's baseline functioning in several areas will help to determine whether a predominantly uncovering or supporting stance will be most helpful. As we have discussed in previous chapters (and above), weakened ego function is generally best helped by techniques designed to support these functions, while patients with stronger ego functioning can better tolerate uncovering techniques.

We also have to assess our patients' *motivation* and *psychological mindedness*. Although most people have unconscious factors that impede their adult function in some way, not everyone is interested in exploring these unconscious factors, and not everyone thinks that they could be related to their current-day problems. This is not to say that patients cannot gain understanding and motivation over time. *Patients for psychodynamic psychotherapy are made, not born* – that is, we can teach our patients

about psychodynamic principles, demonstrate to them that they work, and in this way help our patient to develop the ability to benefit from this type of treatment.

Goals

Both long-term and short-term goals can be addressed by psychodynamic psychotherapy. When most people present for treatment, they are in some sort of crisis – and thus short-term goals are primary. Generally, we can help them with these fairly rapidly, either with psychotherapy alone or with some combination of medication and therapy. However, many of these people may realize that their acute problem is part of a much longer pattern that will continue to trip them up if they don't understand it. We can help our patients to recognize this and to reframe their short-term goals into long-term goals. Here are two examples:

Short-term goal *I just want to be able to get married next month without calling it off.*
Long-term goal *I need to figure out why I keep doubting my relationships.*

Short-term goal *I need to get my father off my back.*
Long-term goal *I need to figure out how to have a more adult relationship with my parents.*

In general, appropriate goals for psychodynamic psychotherapy relate to improving:

- self perceptions and self-esteem management
- relationships with others
- characteristic ways of adapting to external and internal stimulation (stress)
- ego functioning

(See Chapter 7 for more discussion of goal setting.)

Resources

It takes years to develop our characteristic ways of thinking about ourselves, relating to others, and adapting to internal and external stressors. Our ego functions develop early and are firmly fixed by the time we're adults. Thus, changing these aspects of ourselves can take quite a while. If our patients have long-term goals, they need to have time to commit to the treatment. Money is also a factor, although clinics exist that offer psychodynamic psychotherapy at reduced fees. Finally, psychodynamic psychotherapy requires an appropriately trained mental health professional who can conduct the treatment.

Once we have conducted a full assessment and recommended psychodynamic psychotherapy, we are ready to begin the treatment. This is the topic of Part Three of this manual.

Suggested activity

For each of these patients, would you begin psychodynamic psychotherapy with a predominantly uncovering or supporting stance? Give two reasons for your answer.

1. *Ms A is 29-year-old graduate student who presents with difficulty finishing her dissertation. She describes thinking obsessively about her topic all day long but being unable to sit down to write. ''The dissertation seems like an enormous blob,'' she tells you, ''I don't know where to begin.'' She lives with roommates with whom she eats meals but does not socialize, and she says that there's ''no one around who I can count on.'' She says that her advisor ''hates'' her and may even be actively thwarting her academic efforts in order to kick her out of the program. She tells you that her father was a fairly prominent professor at a rival institution who has ''very high expectations'' of his children but who ''favors'' her older brother. She denies symptoms of depression and, aside from obsessing, does not have other symptoms of anxiety. She says that ''some teachers'' thought that she might have had attention deficit disorder (ADD) as a child, and that despite her good performance in college, distraction did cause her to have problems in ''less structured'' courses.*
2. *Mr B is a 32-year-old man who is contemplating proposing to his girlfriend Z. After dating different women for many years, he says that he ''really loves'' Z and that she's the first woman he could imagine ''sharing his life with.'' His friends – many of whom have known him since college, really like Z and are encouraging him to ''seal the deal.'' However, he is hesitating and this is causing him anxiety. He does not report any symptoms of depression or anxiety. The one person who is ''not so hot'' about Z is his mother, who worries that she's ''not good enough'' for him because she ''doesn't have the graduate degrees'' that he has. In the last few weeks he has found himself calling his mother more often, which feels a little ''automatic'' and he has ''wondered why'' he's doing it. Since his father died 10 years ago, he says that he has felt ''responsible'' for his mother, which makes him both ''proud'' and ''resentful.''*

Comment

1. **Begin with a supportive stance** – Ms A's isolation (problems with relationships with others), her inability to create a plan for writing her dissertation (cognitive problem), and perhaps some paranoia (problems with reality testing) suggest that she requires ego support at this point in her treatment. She seems to be intelligent (a strength) and there may be some unconscious factors at play (competition with father, superego pressures), but she needs help with her weakened ego functions first in order to improve her current ego functioning.
2. **Begin with an uncovering stance** – Mr B is in the classic ''stuck'' position of someone who has an unconscious conflict. It is likely that two conflicting unconscious fantasies, ''I love my girlfriend'' and ''I need to take care of my mother,'' are colliding and leading him to feel that he can't move in any direction. The fact that his calls to his mother feel ''automatic'' and that he has ''wondered'' about this suggests that he is somewhat aware that unconscious factors are involved. There is no indication of ego weakness at this time – on the contrary, it sounds like he has very good friends in whom he is confiding. An uncovering approach is likely to help him to understand how these unconscious factors affect him, and to allow him more freedom to make decisions.

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PART THREE: Beginning the Treatment

Introduction

Key concepts

The beginning of a psychodynamic psychotherapy is also called the induction phase. The important goals of this phase are:

- discussing treatment recommendations and alternatives in order to obtain informed consent
- setting goals for the treatment
- setting the frame
- establishing boundaries
- developing a therapeutic alliance

During this phase, and throughout the treatment, empathic listening and attention to the patient's feelings about the therapist and the therapist's feelings about the patient are essential tools for understanding the patient.

The beginning of a psychodynamic psychotherapy may also involve pharmacotherapy.

Understanding the way in which the two treatments work together is important at the beginning and throughout the treatment.

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Setting things up clearly from the beginning

With most things in life, a good beginning is critical for the rest of the project. Think about . . .

- writing an outline for a paper
- gathering the best ingredients for a recipe
- planning an itinerary for a trip
- digging a foundation for a building

. . . in all of these cases, a solid beginning and good planning are often the keys to success.

The same is true with beginning a psychodynamic psychotherapy. Establishing a framework for the therapy, engaging with the patient, and setting goals are crucial to the potential success of the treatment. In the next chapters, we will discuss the factors that are essential for beginning a psychodynamic psychotherapy.

7 Informed Consent and Setting Goals

Key concepts

Before beginning a psychodynamic psychotherapy, the therapist and patient should:

- discuss treatment recommendations and alternatives in order to obtain informed consent;
- discuss and set realistic goals for the treatment.

Once you have completed your evaluation, you need to discuss your recommendation with the patient and set goals. Even though psychodynamic psychotherapy can be an open-ended treatment, you and your patient still need to have some agreement about what the treatment will be like and what you're aiming to achieve. These discussions can be conducted in an open, collaborative way that helps to engage the patient in the treatment and that demonstrates the need for the patient's active participation.

Informed consent in psychodynamic psychotherapy

Talking to patients about why you're recommending psychodynamic psychotherapy but also discussing potential alternatives enables them to give their **informed consent** for beginning the treatment. We often think about informed consent as something surgeons or anesthesiologists need to get before doing procedures, but psychotherapy is a procedure, and we should treat it as such. There are different opinions about what should be included in informed consent. Rutherford *et al*. outline a ''minimum'' informed consent and a more ''comprehensive'' informed consent [1]. The minimum informed consent includes:

- statement of the problem
- description of the recommended treatment
- likely course with and without treatment
- common and serious side effects
- cost
- supervision (if applicable, as in for a case conducted by a trainee)

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The more comprehensive informed consent includes:

- more extensive discussion of differential diagnostic possibilities and treatment options
- the expected duration of the treatment
- confidentiality issues
- information about the clinician's qualifications

Learning to talk about these elements in a clear, non-jargon filled way will not only help the patient to understand the treatment, but will also help you to clarify your thinking about the recommendation.

As an example, let's think about Mr A and how we'd discuss informed consent with him at the beginning of his treatment. First, some information from Mr A's evaluation:

> *Mr A is a 45-year-old man who presents with vague feelings of dissatisfaction with his career and relationships. Your assessment reveals that he does not have an Axis I diagnosis, but that he has low self-esteem and that he frequently makes self-defeating decisions. You also determine that his level of ego function is good – he has many friends, tolerates anxiety and affect, and has good impulse control. You decide that psychodynamic psychotherapy is the treatment of choice.*

Now, here's a conversation from Mr A's third session:

Therapist	*As we discussed in the first session, after talking about some of the things that have been troubling you it makes sense to try to pull things together so that we can talk about what might help you most.*
Mr A	*So what do you think is wrong?*
Therapist	*Well, many of the things we've discussed point to the idea that you've been having trouble keeping up your self-esteem, particularly when things get rough. On the surface, though, it doesn't seem like you should have a low sense of yourself – you have friends, you're smart, you've been complimented many times at your job – so I wonder why you're continuing to have such difficulty. Often, when people feel bad about themselves despite the fact that it looks to the outside that they have little reason to feel that way, it means that they are conflicted about their self-perception. I have a feeling that you might have a conflict like that that's affecting your ability to feel good about yourself.* (**statement of problem)**
Mr A	*Yeah – sometimes I feel good about myself but sometimes it all falls apart. But what can I do about that?*
Therapist	*This kind of problem is often very well treated with a psychotherapy that helps you to look into yourself to learn about things that might be affecting your self-esteem even though you're not aware of them.* (**description of the recommended treatment)**
Mr A	*That sounds hard. Is that the only choice?*

Therapist *Some people might also recommend other forms of psychotherapy for this, such as cognitive-behavioral therapy and interpersonal therapy, but my feeling is that your long-standing difficulty with this problem is best treated by trying to look at what's under the surface.* (**differential discussion of therapeutics)**

Mr A *How long will that take?*

Therapist *This type of treatment typically takes a while – it's taken 45 years for these patterns to develop, so it makes sense that it will take months or possibly even a few years to help change them.* (**expected duration of treatment**) *It's great that you're coming in for this treatment now, because my sense is that this has been a problem for you in the past and will likely continue to be in the future.* (**likely course without treatment**)

Mr A *That makes sense. I hate to think that it will take a long time, but I understand what you're saying. One thing that's worrying me is the cost.*

Therapist *We can offer this treatment to you at a sliding scale at our clinic.* (**cost**) *I will be your therapist. I'm a third year resident in psychiatry – that means that I'm a physician who is in my psychiatry residency. I will only discuss this case with my supervisor, who is a senior psychiatrist here.* (**confidentiality and supervision**)

Honesty, as usual, is the best policy. If you're a trainee, you have to let your patients know. Understandably, people may be wary about putting themselves in the hands of someone who seems inexperienced, but your willingness to discuss their concerns in an open and non-defensive way will generally be enough to allay their worries. As you can see from the example, there are ways to do this that make the patient feel comfortable and well taken care of.

Although some therapists have patients sign an informed consent form, documenting this process in your notes will usually suffice.

Setting goals

Once patients give their informed consent to begin treatment, the next step is to set goals. The ability to set goals for any given treatment is as important for the therapist as it is for the patient. Sometimes the goals are very clear. The depressed patient needs relief from symptoms and the suicidal patient needs to be kept safe. When a patient presents with depression, we know to say, ''Mr B, it seems to me that you are having a major depression. What we need to do is to make you feel better. With medication, your sleep and appetite should be back to normal, and you should regain the energy and concentration to go back to work.'' But what about goals for the person who comes in with an interpersonal difficulty, self-esteem issues, or a work inhibition? Even with these problems, it is still possible to outline goals. In doing so, we can think about the following:

- **The urgency of the complaint:** Does something have to be done right now? This is true when patients are in danger of hurting themselves or others. You can set layered goals, prioritizing urgent goals while also discussing goals that you will get to later.

- **The nature of the setting:** You and your patient will have to set goals that make sense for the setting in which the treatment is occurring. For example, if you're a resident who can only treat the patient for a year, you will have to set goals that are different from those that you'd set if the treatment were completely open-ended. The same is true if the patient knows that he/she is going to move away after some period of time.
- **What does the patient think is wrong?** When setting goals, you have to work with what the patient brings to the table. Even if you have an idea of what the goals should be, the best way to join with the patient is to *listen* to what he/she wants to work on *right now*. Start there. Help the patient to set realistic goals for that treatment setting. This is not copping out or scratching the surface – it's helping the patient, establishing a therapeutic alliance, and working with the patient at his/her level.

Let's look at a few examples to think about how to set realistic goals for the beginning of psychodynamic psychotherapy.

> *Ms C is a 34-year-old single, heterosexual woman who presents with the chief complaint that she's been ''feeling bad'' about herself. She explains that she's upset that all of her friends are already married and having children. She says that she keeps getting involved with men who initially seem interested in her and but who ''turn out'' not to be interested in commitment. This pattern has made her confused and frustrated. She has no symptoms of a mood or anxiety disorder. She says that her parents divorced when she was seven and that her father has now been married and divorced three times. When you ask whether she thinks that her parents' marital history could be related to some of her difficulties, she seems interested in this possibility and it evokes further memories.*

Ms C does not have an immediate, urgent problem. There isn't something to fix right now; rather, she wants help with long-term problems. You hypothesize that her difficulty is related to an unconscious process and she seems interested in this idea. She has the resources to engage in an open-ended treatment. She seems psychologically minded and motivated to learn about herself. You recommend psychodynamic psychotherapy, twice a week, with the goals of:

- improving her sense of self and self-esteem
- improving her relationships with men

and you say,

> *Struggling with your feelings about being single has made you think about how your relationships with people from your childhood – for example, your mother and father – might be affecting your current life. That's the silver lining of this tough period – you've started thinking about things and it has motivated you to come here to talk about them. I think that there may be thoughts and feelings that you're not aware of – that are unconscious – that are affecting the kinds of choices you've been making about relationships. My sense is that the best goal for us would be to try to understand why you've been making choices about relationships that haven't felt satisfying to*

you – and that the best way to do this would be in a psychodynamic psychotherapy. I think that learning about this will help the way you feel about yourself, too. Does that sound like what you're aiming at?

These goals are broad and open-ended. They will not be accomplished overnight. In order to make goals like this, your patient has to be able to tolerate delayed gratification. Note that the therapist offered the patient the chance to discuss her feelings about the goals and to add her input.

When the patient does not have this degree of good ego function, goal setting will be quite different. Goals with this kind of patient may have to be shorter term and more concrete. It also may be necessary for the therapist to be very active in the discussion of goals with these patients. It's important to remember that goal setting may be very therapeutic for the patient because it offers a structure to the psychotherapy, instills hope, and can be personally organizing. Even if the person is having trouble defining his/her own goals, you can make this process collaborative by asking questions such as, ''What would you like to accomplish here?'' and offering suggestions about possible specific and realistic objectives. Of course, always ask for feedback, for example ''Does that sound right to you?'' While the *general* goals in a more supportive psychodynamic treatment are to reduce symptoms, change behavior, and improve functioning, the *specific* goals for any individual can vary widely depending on the particular patient's array of strengths, vulnerabilities, and needs. Here are two examples of goal setting in a treatment that uses a predominantly supporting stance.

Mr D is a 47-year-old man with bipolar disorder. He has just been readmitted to the inpatient service for a depression that occurred after he decided to stop his medication. When you first meet him, he is anxious and depressed and eager to get better quickly so that he can be discharged. After taking a history, you have this conversation with him:

Mr D	*I just want to feel better, doc. I'm jumping out of my skin. I feel terrible.*
Therapist	*I can only imagine how bad you feel – the first thing we have to do is to get you back on a good dose of medication so that you can feel better.*
Mr D	*That's my goal – I just want to get home as fast as possible so that I can get back to work.*
Therapist	*We're definitely in agreement about that. But I wonder if it would also be helpful to figure out what led you to stop taking the medication to begin with?*
Mr D	*I don't know – I just get it into my head to stop and I do and then I get into this mess.*
Therapist	*So that sounds like something we should work on, too – figuring out what it is about taking medication that makes you want to stop, and thinking about what you might be able to do to keep yourself from stopping in the future.*

In this example, there are several short-term goals:

- symptom relief
- understanding why the patient wants to discontinue the medication
- improving impulse control when he wants to discontinue his medication

Let's also think about the goals for Ms E:

> *Ms E is a 40-year-old woman whose generally good ego function has temporarily regressed in the setting of depression following a particularly bitter divorce.*

Here's a goal setting conversation that she had with her therapist:

Ms E	*I feel like I used to be a normal person – now I'm just decked by this divorce. What's happened to me? Will I ever feel better?*
Therapist	*Of course you will – we're just going to have to work during this period to help you to remember all the things you're capable of doing.*
Ms E	*But you know, the thing that terrifies me the most is that I picked him to begin with. After all this, will I just pick another jerk?*
Therapist	*That's a great thing for us to work on – it sounds like you're really ready to figure out why you've tended to choose men who aren't really available. Does that sound right?*

Here, there are two goals:

- helping to urgently buoy self-esteem
- working collaboratively to learn about her maladaptive choice of partners.

All psychodynamic psychotherapies – whether predominantly uncovering or supporting, time-limited or open-ended – have goals that you can set and discuss with your patients. Remember that goals change as the therapy goes on, so that you will have to have goal setting conversations with your patients that change as the therapy progresses. Note that these goal setting conversations are not formal – they are part of the natural dialogue of the therapy. Nevertheless, they can and should be explicit.

Once you've done that, the next step is setting the frame. We turn to this topic in the next chapter.

Suggested activities

Activity 1: Informed consent

Here is one therapist's effort to give informed consent to her patient. Can you name the elements that are included? What is left out?

> *Ms A, let me try to sum up what you've told me so far. It sounds like you've had real difficulties with work recently, which could be related to the fact that you're not really interested in your field. It also sounds like there are other things in your life that you continue despite the fact that you're not 100% interested in them, like your relationship with some of your friends. These problems suggest that psychodynamic psychotherapy might be helpful. This is a kind of*

treatment that will allow us to learn more about you – even about things that might be out of your awareness – so that you can make choices that feel more fulfilling to you. I'd suggest that we begin twice a week – we can talk about a schedule that's convenient for you. My fee is $150 per session. How does that sound?

Comment

The therapist does a fine job of *stating the problem*. She begins to *describe the recommended treatment*, although she does not explain why she recommends the frequency of two times per week. She also gives information about the *cost*. She does not, however, include the *likely course with and without treatment*, *side effects*, *other therapeutic options*, *likely duration*, and *confidentiality issues*. These additions might sound like this:

I'm recommending that we meet more than once a week because really understanding what's below the surface takes some time, and if we meet once a week it's likely to just give us time to hear what's been happening during that week. There are other types of psychotherapy available, and we could talk more about these, but my sense is that the kind of longstanding patterns that you're describing are best dealt with psychodynamic psychotherapy. Depending on our goals, this therapy can take a while – sometimes months to years – in order to really help you to understand yourself as fully as possible. What you've been describing to me is that this pattern of sticking with things that are unsatisfying to you goes on in every aspect of your life, so my guess is that until you understand what's causing this, it will continue. A few other things that you should be aware of – we'll always meet here, we'll have a regular schedule, and of course the treatment is completely confidential. Let's spend some more time talking about these things to make sure that you understand them and to address any questions you might have.

Activity 2: Setting goals

For each of the following patients, write two goals and a few sentences about how you would present this to the patient.

Patient #1

A 54-year-old man presents for psychotherapy saying that he and his wife are fighting bitterly. As you talk to him, it becomes clear that he has major depression for which he is not receiving any treatment.

What are the goals?
How do you present them?

Patient #2

A 25-year-old woman presents saying that she feels lonely and depressed after breaking up with her boyfriend. Over the course of the evaluation, you learn that she regularly blacks out after drinking on the weekends with friends. She has a long history of difficult relationships although she is a very successful student.

What are the goals?
How do you present them?

Patient #3

A 50-year-old man presents saying that ever since dropping his son off at college he's feeling old. He has aches and pains but his doctor says that he is in perfect health. His father died young – at 56 – and he knows that this has something to do with the way he's feeling. He is happy with his wife but has started to think about a woman who works with him. He's not sure if he needs therapy but just isn't feeling like himself. He has no symptoms of depression and denies substance abuse.

What are the goals?
How do you present them?

Comment

Patient #1

Goal #1 – decrease symptoms of depression

Goal #2 – help patient understand what is causing difficulties in his relationship with his wife.

Since the patient is in the middle of an acute depression, it's not clear whether the trouble that he's having with his wife is chronic or related to his depression. Therefore, your first goal is to help him with his depression, while beginning to engage him in a discussion of his relationship. You might say:

It seems clear that you and your wife are having some real difficulties in your marriage and that you've been pretty depressed recently. Sometimes, when you're that depressed, it's really challenging to even begin to deal with what's going on in a relationship so I think that our first order of business is to help you feel better.

Patient #2

Goal #1 – decrease binge drinking

Goal #2 – help patient to understand her pattern of unsatisfactory relationships with men.

This patient has both short-term and long-term goals. The breakup with her boyfriend prompted her to come to psychotherapy – if she is able to self-reflect, she could use the treatment to begin to examine her unsatisfactory pattern of relationships. However, an important short-term goal is to help her to understand that her binge drinking on weekends is a form of alcoholism for which she needs help. You might say:

I think that taking a look at your relationships will be very helpful to you. The first step is to notice a pattern, which you've done – this will help us to learn more about the kinds of choices you make when you begin relationships, and will help you to understand why the relationships you've had have been less than satisfying for you. I'm also glad that you told me about blacking out on weekends – it sounds like that's been a real problem during this time and that getting your drinking under control will help you in all aspects of your life. I'd suggest that we make that a goal of this therapy as well.

Patient #3

Goal #1 – decrease his transient symptoms of somatization and obsessing about other women

Goal #2 – help patient to make the transition into a new phase of life.

As with Patient #2, this patient has both short- and long-term goals. The short-term goals involve symptom relief, but we see that his symptoms are just the symptoms of a deeper problem. We suspect that dropping off his son feels like a symbol of the beginning of old age and, given his father's early death, may even feel like the prelude to the end of his life. Helping him to make this transition and to explore his fantasies about growing old will be very helpful to him. You might say:

> *Dropping a child off at college is definitely a big milestone. You must be very proud of him. But I think that, whether you're aware of it or not, dropping him off means something else to you, too – something like, ''well, now I'm old.'' I wonder if this is why you're suddenly so worried about your health and are looking around for diversions. Given this, I think that we've got a few goals – we need to help you feel better about your health and to understand what's getting you preoccupied with your co-worker – but I suspect that these are connected with another goal which is helping you to figure out where you are in your life and making you more able to see how much of life you still have ahead of you.*

8 Setting the Frame and Establishing Boundaries

Key concepts

Setting the frame is essential to any type of psychotherapy – it establishes boundaries and sets up a safe relationship in which the patient can work. It also establishes the contract of the treatment and the rules for interaction between therapist and patient during the treatment.

Setting the frame must be done actively at the beginning of the treatment.

The frame of psychotherapy involves:

- roles – establishing the roles, responsibilities, and appropriate behavior of both patient and therapist
- time – when the therapy will take place, how long sessions will be, and how long the treatment will last
- setting – where the treatment will take place
- money – how much the treatment will cost and how the patient will pay
- contact information – how the therapist can be reached in an emergency or to make logistical arrangements
- what to do in the event of an emergency
- rules of confidentiality
- supervision and other issues relating to being a trainee

A **boundary** can be defined as the edge of appropriate behavior.

A boundary ''crossing'' is a benign deviation from the frame that may advance the treatment and does not harm the patient.

A boundary ''violation'' is a deviation from the frame that is clearly harmful or exploitative of the patient.

The best ways to avoid boundary violations are to:

- actively establish the frame with the patient
- establish a usual way of conducting treatments that does not vary from patient to patient
- seek out supervision from a supervisor or peer whenever you have doubt about a boundary

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Setting the frame

Setting the frame is essential to beginning a psychodynamic psychotherapy and should be done thoughtfully and explicitly at the beginning of the treatment. This chapter will outline the elements of the treatment frame and suggest methods for establishing it in different treatment situations.

Why do we need a frame?

Of all the elements of psychodynamic psychotherapy, the frame is among the most caricatured. The ''50-minute hour,'' ''our time's up'' and the two chairs facing each other show up in everything from cartoons to movie spoofs. This may be because the therapeutic relationship *is* different from regular social relationships – and for good reason. We want to separate what goes on in the therapy from what goes on outside. We know that psychotherapy is difficult – it reveals vulnerabilities, strong affects, and shame – and we know that in order to tolerate this, our patients need to be assured of the safety of the therapeutic setting. We set up certain things *before* the patient ever enters the office, such as maintaining a clean, quiet office, free of distraction, with discrete places to sit. We set up other things *with* the patient – for example, the schedule and the boundaries. Our personal styles will affect the way in which we set up these things. For example, some therapists carry pagers while some use an answering service; some allow patients to contact them at home on weekends while others do not. But whatever we choose to do, we try to do it in a standard way for all patients and in a way that our patients know about. Try to imagine the anxiety a patient would have who never knew if her therapist was going to show up at the same time. *The therapist should never imagine that the patient knows the frame without being told* – even the most experienced patient might have had a different frame with his/her last therapist. One way to think about the frame is that the elements of the frame are the ''ground rules.'' If you're playing a game with one or more people, you need to use the same set of rules or you can't play together. Imagine four people on a tennis court, two of whom are using one set of lines and two of whom are using another set of lines – that's a recipe for chaos and fighting. Or two kids playing a board game – one who says that the first roll of the dice is final and another who allows for ''do-overs.'' Stay tuned for many tears!

The elements of the frame

There are many parts of the frame – some are concrete and some are more abstract, but they are all important. They are:

- role
- time
- setting

- money
- contact information
- what to do in the event of an emergency
- confidentiality
- issues relating to traineeship – such as supervision, use of material for conferences, and so on

Adapted from Gutheil and Gabbard (1993) [2].

Role

As Gutheil and Gabbard note, defining and communicating the **roles** of the therapist and patient is an important part of the treatment frame [2]. A role is a part or function that we play in a particular situation. We play roles in every aspect of our lives. Sometimes we're daughters and sons, sometimes we're weekend guests, and sometimes we're patients. All of these situations go better when roles are defined and the definitions are accepted by all of the participants. The same is true for psychotherapy. You might think that the roles played by therapist and patient in psychotherapy are obvious, but that's not necessarily true. First of all, different psychotherapists play different kinds of roles. A resident psychiatrist might have to draw blood from a patient with whom they conducted a psychotherapy session earlier that day. A behavioral therapist might drive with a patient to an airport to treat a flying phobia. A cognitive therapist might give directives about homework. Each of these therapists has a slightly different role.

The concept of role has many different parts. There's **function** – that is, what we do. You can think about the many functions that the psychodynamic therapist has – some of which we've already discussed. Making an assessment, listening, and trying to empathize and understand in a non-judgmental way are all functions related to the psychodynamic therapist's role. In some therapies, the therapist's role might also include other functions, including prescribing medication, assessing medication side effects, speaking to other doctors or school personnel, and so on. Some of these overlap with **responsibilities**. A responsibility is literally a duty – thus, it's something that another person can count on you doing. Some of these are so obvious that they might seem ridiculous to mention, but they are among the most important. They include showing up when and where you say you will, giving adequate notice of vacations, staying awake during sessions, paying attention, remembering things that the patient tells you, and adhering to the frame of the treatment without crossing boundaries. The fact that you will do these things will mean an enormous amount to patients – particularly those who never had people in their lives who took these kinds of responsibilities to heart. Keep in mind that you have to do these things in an average expectable way – circumstances may sometimes make you late, tired, or forgetful. That's fine and human – it happens to all therapists. The idea here is that if you take these responsibilities and functions seriously, when you deviate from them in benign ways you can learn from them – about yourself and about your patient.

Example

A therapist who is always on time comes 5 minutes late to a session:

Patient #1 *I can't believe you're late! Now I'll only get 40 minutes instead of 45.*

Therapist *Why do you assume that?*

Patient #1 *That's the way it is in this world – everybody's always trying to cheat you.*

Since the therapist has already set the frame and is generally on time, he can use this benign deviation to learn about this patient's underlying assumptions of being exploited. The therapist also learns about the patient's rigidity and inability to hold onto an experience of him as generally trustworthy to offset the blow of being ''forgotten'' for 5 minutes.

Patient #2 doesn't mention the lateness until the therapist asks about it.

Therapist *You didn't mention that I got to the session 5 minutes late.*

Patient #2 *Oh that – that's fine – you're always on time – and I'm sure that it's because you had an emergency on the inpatient unit.*

Here the therapist learns that the patient can use information about the relationship in general to deal with the therapist's lateness, but also gives potential information about a patient who tends to put his/her own needs last.

If the therapist's role and responsibilities include listening, understanding, and reliability, the patient's role and responsibilities include attendance, punctuality, payment, speaking, and participating in the psychotherapy. Part of the role of each member of the therapeutic dyad includes acknowledgment of what is and what is not appropriate behavior. For example, psychodynamic psychotherapy is a talking therapy – *thus physical contact is not part of the role for either party*. It is the role of the patient to say whatever comes to mind, but it is not the role of the therapist to say whatever comes to mind. The patient can tell the therapist that he/she is angry at the therapist, but it is not appropriate for the patient – regardless of the degree of rage – to be cruel to the therapist, to make racially or ethnically derogatory remarks, or to sexually harass the therapist. We will discuss this further in the section ''Boundaries, boundary crossings, and boundary violations.''

Communicating role

Part of setting the frame involves communicating roles and role expectations. What is communicated will often depend on the type of treatment, but this should be done in all psychotherapies. Here is an example of how you might communicate roles in an early session of an uncovering treatment:

Example

The basic idea here is to say whatever comes to mind, without holding back or editing, as much as possible. Things that you might pay particular attention to are thoughts and feelings about the therapy, and dreams – but talk about whatever comes to mind. I'll listen and chime in with questions and comments. Since we're trying to get to material that's out of awareness, and to do that we rely on your ability to follow your train of thought, I might be quiet even when you're quiet in order to let you just get to the next thought.

With a patient who needs more support from the therapist, at least early in the treatment, the *content* of what you say about roles might be somewhat different – for example, the patient might need you to suggest a general structure for sessions and/or would feel more disorganized if you suggested he/she pays attention to his/her dreams, fantasies, or transference feelings – but it is still important to provide some explanation about roles.

Example

You should feel free to talk about whatever's on your mind – how you've been doing since our last meeting, any difficulties that may have cropped up with the medication, or problems you're having at home. I'll listen, ask questions, make comments, and try to keep us on track so we'll be sure to leave time for other issues you'd like to talk about.

Sometimes, patients have questions about role that come up in the treatment. For example, patients frequently ask us personal questions. When this happens, we can explain our role with comments like this:

Patient *How come I have to tell you all of these things about myself and I never get to find out about you?*

Therapist *You're right – this kind of conversation is different from other conversations that you have with people outside this room – like with friends and co-workers. It may seem strange but there's a reason for that – this conversation is about you and about helping us to understand more about you. Is there something that we've been talking about that made you particularly interested to know about me just then?*

Acknowledging that the therapeutic roles are different from normal social roles helps to induct the patient into the therapeutic situation and generally diffuses anxiety.

Time

Time is one of the most important aspects of the frame. When we set up a psychotherapeutic situation, we set aside some specific, consistent period of time during which our attention will be focused exclusively on the patient or patients. When you think about that, it's amazing – who else sits and listens to another person for 45 minutes straight? Nevertheless, patients may have underlying wishes for unconditional or unlimited caretaking by the therapist, which can make the formality of the ''set time'' or time limit seem restrictive. Your conviction (or your developing conviction) that time limits and predetermined, consistent schedules are protective of the patient will help you to convey the importance of the ''time'' aspect of the therapeutic frame. What if one day a therapist decided that the session was boring and cut it short? What if the therapist decided to take the day off and didn't tell the patient? What if the patient decides not to come and doesn't tell the therapist? What message is sent to the patient if the therapist decides to extend the session for another hour? Going back to the analogy of the game, time limitations are part of the rules – not because we wish to be arbitrary and withholding, but rather because we want to protect our patients.

Aspects of the time frame that we need to convey include the times of the individual sessions, the schedule of sessions (when the sessions will be held) and some idea of the duration of the therapy. For time-limited treatments, the therapist can convey the duration at the outset (''we'll be meeting for 24 sessions''); for more open-ended treatments this is harder, but not impossible (''psychodynamic psychotherapy usually lasts for more than a year'') (see Chapter 11 for further discussion of frequency and duration of sessions).

When setting a schedule, try to be flexible, but know your limitations. Only offering one or two possible hours per week may be too restrictive, but on the other hand, you should know what your ''hours'' are even if you're a trainee. You might say that you work 9 a.m. – 7 p.m. or 8 a.m. – 6 p.m. – then you shouldn't offer anything after or before those hours. You set your schedule for reasons that relate to your own life, and if you deviate from that schedule to suit a particular patient you will undoubtedly become resentful. You also know when you work best; if you're not a morning person, don't agree to the 7 a.m. session just because your patient is being demanding. Furthermore, you may have limitations that relate to other work responsibilities. If you have questions about setting schedules, discuss this with a peer or a supervisor. Too often, trainees get ''bullied'' into meeting with patients at hours that are unreasonable – you can consider this to be a deviation from the frame if you know your limitations. Similarly, the schedule should be fairly reasonable for the patient. Demanding that the patient come to sessions during classes or work time is usually not viable. If your schedule and your patient's schedule really don't seem to have any points of intersection, you may need to make a referral to another therapist.

Beginning on time and ending on time are also part of the frame that you should discuss with your patient. When you say, ''We'll begin at 11 a.m. and end at 11:45 a.m.,'' you mean it – when the patient comes at 11:15 a.m. you should still end at 11:45 a.m. even if the train was late. This conveys the primacy of the frame. If patients protest about this, you can say that you're sorry about the train but that's the time that you have for the session. Again, you'll learn about your patients this way. Higher functioning patients will understand even if they're disappointed; more demanding patients will think that you should adjust your schedule around their lives. This does not mean that you need to be rigid – the patient who is weeping copiously at the end of the session should get a few extra minutes to compose him/herself. On the other hand, you can help to choreograph the session so that the patient is ready to go by the end of the allotted time (see Chapter 11).

Setting

Where the therapy occurs is a critical part of the frame. You don't meet in the park, in a coffee shop, or at a bar – you meet in a place that's particularly designed for psychotherapy. This might be a clinic room or a private practice office but it's your psychotherapy ''space.'' This conveys that the therapy is a professional arrangement, not a social interaction. Again, this is vital for the protection and safety of the psychotherapy, the patient, and the therapist. Even on the most beautiful day of the year, it is not appropriate to say, ''why don't we have our session out on the front patio?'' The patient can expect the setting to be reasonably comfortable and private.

Most therapists who have their own offices like to decorate them in a way that feels comfortable for them – with furniture, lighting, and pictures that reflect their own taste – but a ''comfortable'' setting generally means that the patient is not bombarded with personal information about the therapist. Thus, pictures of friends and family and overly personal memorabilia are generally over-stimulating for patients. For example, while it's appropriate and essential to hang up one's professional license, and would be fine to display professional certificates or even commendations, displaying one's bowling trophies or scuba certification would not be appropriate.

Money

Ah, money. Psychodynamic lore has it that many people find it more comfortable to talk about sex than to talk about money! People are often ashamed about how little or how much money they have, they have wishes that their therapists would treat them for free, and they guard their money carefully – these are but a few of the reasons that make it difficult for patients to talk about the fee. Nevertheless, it is another essential element of the frame [3–6]. Once again, it is a reality of the psychotherapeutic situation – it is usually a fee-for-service professional arrangement. Sometime in your career, you will probably have a patient say to you, ''If you really cared about me, I wouldn't have to pay for this'' – the fact is, nothing could be further from the truth. It is because we care about our patients and about treating them in the most professional way possible that we insist on payment. Plus, it pays our bills – being a psychotherapist is a profession.

Some fees are set and some need to be set with patients. When there is a sliding scale, the therapist should find out how much money patients make and how much they can budget for psychotherapy per week. Yes, this means asking patients how much money they make and whether they have other income streams (trust funds, parents who can help pay for treatment, insurance, etc.). Some patients have no idea – this is a good time to encourage them to find out and to make a budget so that they can negotiate the fee. When we discuss this in an open and straightforward way, it is actually very helpful for our patients. Sometimes, the discussion of the fee ends with the fact that the patient cannot afford to be seen by that therapist – in this situation, the therapist can help the patient to find a therapeutic situation that he/she can afford. This is a good outcome. As with the schedule, psychotherapists usually do best when they are somewhat flexible while knowing their limits. And as with the schedule, therapists who deviate from those limits will find themselves quite angry with their patients in short order.

Once the fee is set, the therapist should communicate to the patient about when and how payment should be made. Some therapists are paid by third party payers, while others operate on a self-pay basis – this should be clear:

> *I'll give you a bill on the first of the month and I'll ask you to give me a check by the middle of the month. If you're submitting to insurance, everything you need will be on the bill.*

Once the frame is communicated, deviations can be dealt with in the therapy. Non-payment of bills should not be allowed – it should always be dealt with as soon as possible. It might mean any number of things – the patient might be angry with

the therapist, the patient might have antisocial traits, the patient might have gotten him/herself into a psychotherapeutic situation that he/she really can't afford – but each of these should be explored and dealt with to preserve the frame of the treatment.

Contact information

Although the therapist should make it clear that the therapy is contained within the therapy sessions, there are two major reasons why the patient might need to contact the therapist outside of session time: (i) in the event of an emergency and (ii) to convey logistical information such as the need to miss or change the time of a session. The therapist should tell the patient this in a very straightforward way:

> *Although the therapy will take place here during our scheduled session times, in the event of an emergency, or if you need to let me know that you have to cancel or change a session time, you can reach me in the following way . . .*

This conveys both how to reach you and the appropriate reasons for trying to reach you. Thus, the patient should not call just to ''touch base'' with you unless that is specifically part of the frame. More fragile patients may call frequently between sessions, particularly early in the treatment. This may be because their capacity for self-soothing is so limited that any emotional upset feels like a four-alarm fire, or because their ability to maintain a sense of connection with you between sessions is tenuous. Under certain circumstances, it may be appropriate to provide additional support by making yourself more available between sessions or to offer the patient additional time. At the same time, your ultimate goal is to help the person develop the capacity to contain his/her feelings and hold on until he/she can talk it over with you in person. These are not easy decisions for the therapist, so when in doubt, don't hesitate to seek advice from your supervisor.

This is the age of e-mail, texting, and cell-phones – none of which is particularly appropriate for therapist/patient contact. E-mail has confidentiality limitations and texting and cell-phone calls are more appropriate for social interactions. Once again, the professional frame calls for limits. If the patient e-mails you a request for a schedule change, what's to stop him/her from e-mailing you an interesting article from a newspaper or a link to his/her favorite blog? If patients discover your e-mail address and e-mail you (not very difficult, particularly for students) don't respond by e-mail – if it's an emergency, call them, otherwise, discuss the e-mail in the next session. Early on in treatment, you can reiterate the frame – if this kind of acting out occurs later, you can find out why they felt the need to e-mail and thus learn about how they operate. You should have a phone line for your practice that is separate from your personal phone line, and you should record a voice mailbox message for your patients that will convey who you are and what to do in the event of an emergency. Here is an example:

> *You have reached the voice mailbox of Dr John Doe. Please leave your name, the date and time of this call, and your telephone number – even if you think I have it – and I will get back to you as soon as possible. If this is an emergency, please hang up and call 911 or proceed to your nearest emergency room and have the doctors there contact me.*

Individual psychotherapists who know the scope of their practice may ultimately feel that they do not have to include the last sentence of this message, however it is generally useful for trainees working in an institutional setting. You can discuss this issue with your peers and supervisors.

What to do in the event of an emergency

As alluded to above, discussing what to do in an emergency is often an important part of setting the frame – particularly with patients who are at high risk for self-injurious behavior. You can only function as a therapist if you and your patients agree at the outset on what they should do in the event of an emergency. The best plan is likely to be that patients either call 911 or, if they are able, take themselves to the nearest emergency room. They can call you from there. Do not try to handle emergencies yourself over the phone.

Confidentiality

Part of the frame is that you provide the patient with confidential treatment. This may be somewhat modified if you are in supervision (see below) but those modifications are only for training purposes. You should tell your patient that the treatment is confidential as part of setting the frame, and you must hold to your end of the bargain. You will hear some very interesting things in your psychotherapy offices – stories that would mesmerize many a dinner party guest – but resist the temptation! They say that there are six degrees of separation, but it sometimes feels as if there are two. Presume that the person you tell could be your patient's long-lost sister – it's definitely a frame violation. Your patient can talk about the treatment with whomever he/she wishes – but you cannot. That said, you might need to talk about the case with your supervisor (see below) and occasionally with peers. Peer supervision can be a vital part of your professional life, particularly after your training. As a peer supervisor, take your role seriously and professionally – and there's usually little use for names. When writing up cases for publication, Gabbard's dictum of ''disguise or consent'' is the way to go [7]. The same goes for professional presentations.

Supervision and issues relating to traineeship

If you're a trainee, the patient should be aware of your trainee status. The fact that you will discuss the case with a supervisor is part of the frame. There's no reason to hide this. If you were a patient and your therapist was a trainee, you'd probably be glad that he/she had a supervisor. It does mean, however, that the case will be regularly discussed with another person. As a trainee, you also may be asked to videotape the treatment, which then becomes another part of the frame, which you should discuss and for which you should obtain consent. Trainees often worry that these frame issues will upset the patient; however most patients are relieved to

discuss them up front and are more upset when they are surprised by these issues midstream. Here is an example of how to discuss these issues with a patient:

> *As you know, all treatment in our resident clinic is free. All the therapists in the clinic are psychology interns – that is, we have finished graduate school and are becoming clinical psychologists. As part of our training, we discuss our work treating patients with senior supervisors. You and I will meet with a supervisor sometime in the coming weeks. This is a helpful consultation for the treatment that also helps me to learn about interviewing and psychotherapy.*

As we discussed in the chapter on informed consent, do not be afraid of your status as a trainee. It's what you are and you should let the patient know. Your transparency about this will help to build the therapeutic relationship.

Here is an example of a frame-setting conversation:

Therapist	*So now that we know that we're going to be working together, let's talk about how and when we're going to meet. As we discussed, it seems to me that meeting twice a week makes sense for the goals we've outlined, and I've got time available either on Wednesday morning at 9 or 10 or on Thursday afternoon at 2 or 3.*
Patient	*The earlier times would work well for me.*
Therapist	*Great – our sessions will be 45 minutes and they'll be here in this office. If you need to talk to me between sessions, you can always call my office line – I generally don't pick up when I'm seeing patients, but I'll get back to you as soon as I can. On weekends, I generally check my machine in the morning and in the afternoon. The clinic fee is $90 per session, and once we set up a schedule, we will charge you for sessions even if you miss them.*
Patient	*Why is that?*
Therapist	*Well, I'm going to keep this time open for you so that you always know that you can be here for a session. It's like you're renting it. If you choose not to come to a session, that's your choice – it's not for me to say that your reason for not coming is or is not a good reason. If you know in advance that you're going to miss a session, I will try to fill your time – and if I do, you won't be charged.*
Patient	*OK – I get it. Do I pay you each time?*
Therapist	*Yes – you can pay the clinic receptionist before you come in each week.*
Patient	*Are you going to talk in the sessions? My friend goes to a therapist who never talks.*
Therapist	*Of course – we'll both talk. But this time is really yours, to talk about whatever feels important to you. I'll listen, and I'll talk in order to help you to talk more, to ask questions, and to help to understand what you're thinking and feeling.*

Note – the therapist who is taking a predominantly uncovering stance may want to add:

> *Since our goal is to get to thoughts and feelings that are out of your awareness, the best way we know how to do this is to say whatever comes to mind. You should try to do that to the best of your ability – paying special attention to your feelings, dreams, and things that relate to the therapy.*

In this way, the therapist addresses many aspects of the frame – time, meeting place, and money.

Patients will often have questions about these elements, so it makes sense to think ahead of time about how you will address them. If you understand the rationale behind the frame, you'll have an easier time explaining it to others.

Boundaries, boundary crossings, and boundary violations

As you can see, all treatments have frames, and all good treatments start out with a careful delineation of the frame. Once the frame is set, deviations from the frame are clear. A **boundary** can be defined as the edge of appropriate behavior [8]; thus deviations from the frame cross boundaries. Some boundary crossings are benign while others are not. A **benign boundary crossing** is defined by Gutheil and Gabbard as a boundary transgression ''where the ultimate effect of the deviation from the usual verbal behavior may be to advance the therapy in a constructive way that does not harm the patient'' [8]. They cite examples such as touching a patient in order to help him/her up after a fall on the way out of the office or hugging the patient who reaches out for an embrace after getting news of the death of a child. A study of the behavior of psychoanalysts following the events of September 11 found that the majority of analysts surveyed engaged in some type of benign boundary crossings such as a modicum of self-disclosure and advice-giving to help to deal with the traumatic nature of the event [9].

Sometimes we consciously engage in a benign boundary crossing (keeping the patient a few extra minutes as he/she composes him/herself, rescheduling in a way that's a bit inconvenient for you because the patient is in some distress) and sometimes we realize this later (for example, in supervision) – either way, it's good to discuss this with the patient. For example, after realizing that you forgot to tell the patient that you were going on vacation until two days before you left you might say to the patient, ''you're right, I usually tell you with more notice. That was my mistake. What thoughts did you have about that?'' You can acknowledge the error, but also allow the patient to express his/her feelings about it.

On the other hand, Gutheil and Gabbard define **boundary violations** as a transgression ''that is clearly harmful to or exploitative of the patient'' [8]. Examples of this are socializing with patients, physical contact (other than handshakes) with patients, taking gifts from patients or giving gifts to them, and meeting with patients at odd hours (9:00 p.m. on Saturday, for example) or in inappropriate settings (coffee shops, restaurants, etc.). Most investigators in this area agree that there is a ''slippery slope'' between frequent boundary crossings and boundary violations. Thus, while boundary crossings are generally benign, human, and can even be therapeutic, finding that you are making frequent boundary crossings with particular patients warrants reflection – on your own and with a supervisor.

Your initial frame is absolutely essential – for the health of the treatment, and for the safety of therapist and patient. If you begin ''setting the frame'' as a trainee this will become a natural part of your practice for the rest of your career.

Suggested activity

Boundary crossing, violation, or neither?

1. A therapist who has expertise in an academic area that a patient is struggling with offers to give the patient 15 minutes extra per session to tutor her.
2. A therapist says to his patient, ''I think that it might help to bring your husband in next time so that he can learn more about your difficulties with alcohol.''
3. A therapist says to her patient, ''We've got a job in my lab that I think would be perfect for you. Let me give you the name of the human resources person.''
4. A therapist says to his patient, ''I can definitely remember feeling that way when I was about to graduate from high school. It's definitely a scary time.''
5. A therapist receives a gift of a book from a patient at their last session. He opens it, comments on it, and says thank you.
6. A therapist sees that a storm begins during a session with a patient. At the end of the session, he lends the patient an umbrella.
7. A therapist allows a patient to pay the fee two weeks late because the patient has to pay his taxes.

Comment

1. **Boundary violation** – tutoring is clearly outside of the therapeutic frame. The clue is the ''extra'' 15 minutes, which is clearly a frame violation.
2. **Neither** – including family members in sessions can be an important part of the therapeutic work and can be essential for psychoeducation.
3. **Boundary violation** – offering to employ the patient may seem friendly, but is a clear boundary violation.
4. **Neither** – although the therapist is disclosing something about herself, it is generic and designed to help the patient learn about an important moment in his life.
5. **Neither** – patients often give small tokens of their gratitude at the end of the treatment.
6. **Boundary crossing** – while it is technically not within the frame to lend something to a patient, helping the patient to stay dry will not threaten the treatment. If lending continues, however, it could lead to boundary violations.
7. **Boundary crossing** – as a one time allowance, this would be a boundary crossing. Again, if it persisted, it could threaten the treatment.

9 Developing a Therapeutic Alliance

Key concepts

Therapeutic alliance is the trust between patient and therapist that allows them to work effectively together.

It is sometimes called the working alliance.

Studies suggest that the state of the therapeutic alliance is the best predictor of outcome in psychotherapy.

The therapist must actively foster the therapeutic alliance by demonstrating:

- interest
- empathy
- understanding

What is the therapeutic alliance?

Have you ever tried to change the way you do something? It could be anything – the way you hold your tennis racket, blow into a flute, meditate – you name it. If so, think about that experience. No matter how motivated you were to change, and no matter how much you knew that it would help your serve, musicality, or sense of inner peace, it can be difficult and scary to change even the smallest thing. In order to change, you have to give up your old way of doing something first and then try the new way. That means that for a while you're in a free fall – you no longer have your old habit to rely on and you don't yet have the new one. Now, take the anxiety of trying to change that one thing and multiply it by about a million and you may be close to the terror involved in trying to change something as complex and entrenched as characteristic ways of adapting to stress and relating to other people. Who would do such a thing? Well, that's just what we ask our psychodynamic psychotherapy patients to do. Just as you had to trust your coaches and teachers, your patients in psychodynamic psychotherapy need to believe that you will help them through this potentially harrowing adventure. That trust is called the **therapeutic alliance** [10, 11]. If it's there, the patient knows that you will help him or her even when the going gets rough.

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Establishing a therapeutic alliance

Establishing the therapeutic alliance might be the most important part of beginning the treatment. Many studies suggest that the therapeutic alliance is the best predictor of outcome [12–14]. So what is the therapeutic alliance? Sometimes called the working alliance, the therapeutic alliance is the *trust between the patient and therapist that allows them to work together effectively*. Trust is the basic ingredient. The patient believes that the therapist is trustworthy and has the patient's best interest at heart – so even if the patient is temporarily angry with the therapist, the patient understands that he/she can continue to work together productively.

This type of trust takes time to develop – and in a long-term psychodynamic psychotherapy this can take months – but you can begin to establish a therapeutic alliance during the first meeting. How do you begin to establish a therapeutic alliance? We can consider the ''triad of the therapeutic alliance'' to be demonstrating *interest*, *empathy*, and *understanding*:

- **Demonstrate interest:** Think about the last time you were seated next to someone you didn't know at a dinner party. Did that person ask you questions about yourself or did he/she talk about him/herself? A person who is genuinely interested in you makes you want to talk to him/her – and makes you feel that he/she cares about what you are saying. We demonstrate interest in many ways – by being attentive (not answering the phone, pagers, or checking e-mail), by asking relevant questions (not just ''name, age, serial number'' type questions), by demonstrating that we're listening (following up on things that were said a few minutes ago, remembering details) and by making eye contact. You'd be surprised how far remembering a detail goes in developing the therapeutic alliance. For example, if a patient says, ''I was going to go out with Alice last night. She's a woman I work with,'' and you've heard about Alice before, you might say, ''Oh yes, the colleague from the conference in Atlanta.'' At the beginning of a treatment, this helps the patient to know that you've been listening and that you're interested enough to commit brain cells to storing vital information about the details of his/her life.
- **Demonstrate empathy:** Our patients are usually in some sort of pain. They're depressed, getting divorced, recently unemployed, worried – and we have to let them know that we understand this. Sometimes we can show empathy in our facial expression, but actively making empathic remarks is essential to building the therapeutic alliance. If you went to tell someone your troubles and all he/she did was nod his/her head, you probably wouldn't feel well understood. Here are some examples:

Example #1

Patient *And then, right in front of Brian, my mother told me that she was sick of the whole wedding thing and she wasn't going to pay for any of it. I was mortified. I thought I was going to go through the floor.*

Therapist *That sounds awful. What happened then?*

Example #2

Patient *So then I walked in and there they were – in our bed – Carol and her trainer. I couldn't believe it!*

Therapist *Oh my goodness! What did you do?*

Example #3

Patient *It's getting so that whenever I see Dee at work, I feel a little sick to my stomach.*

Therapist *That's been going on for a few weeks. Can you tell me more about the last time it happened?*

The type of empathic statement we choose should mirror what the patient is saying. The man who walked in on his wife having sex surprised even the therapist – it's so dramatic that a dramatic empathic statement is called for. The patient's feeling about her colleague, on the other hand, calls for a quieter but equally understanding remark. Being an empathic therapist is a lot like being an attuned mother – you listen to your patient and reflect his/her feelings back to him/her in a slightly modified way. Don't be afraid to show some feeling – wooden Indians are for tobacco stores, not for therapy offices. The bottom line is that when the patient tells you something that calls for a human response – say *something*. Remember that silence is also a communication – and early in the treatment, it can communicate lack of empathy and interest.

- **Demonstrate understanding:** You may ask, ''How can I demonstrate understanding when it's the beginning of the treatment? I thought that I was supposed to develop my formulation as I go?'' This is true, but you have to be able to understand *something* – even from the get-go. You may not understand *why* someone has long-standing relationship problems or behaves in a self-defeating way, but you may understand *that* they do. Saying something that conveys understanding, even in your very first meeting with the patient, is one of the best ways to get someone to join with you in the therapeutic endeavor. Here are some examples of ''understanding comments'' that would be appropriate for a first (or early) session. In this first example, the therapist conveys understanding of the current state of affairs, not the etiology of the problem:

  It sounds like this last break-up has made you feel that there's something going on in you that's making it hard to have a long-term relationship.

  In the next example, the therapist conveys understanding of the chronicity of the problem:

  It seems to me that having this recurrence of depression has made you feel that this is going to be a chronic problem, and that's been hard for you to wrap your mind around.

  Finally, the next therapist demonstrates understanding of the way in which the patient's defensive rigidity is impacting a relationship:

  For one reason or another, you've found it difficult to respond to your mother in any way other than withdrawing – and that's really straining your relationship with her.

Note that these comments share many elements – they are stated as hypotheses, rather than as definitive statements, and they convey understanding of the current state of events, rather than about the etiology of the problem. Learning to formulate comments like this is key to ''seeding'' the therapeutic alliance.

How do you know when you and the patient have a good therapeutic alliance? One good indicator of a good alliance is the patient's ability to work actively and productively in the treatment. Another very important sign is low anxiety on the part of the therapist; conversely, substantial anxiety in the therapist can be a very good indicator of a tenuous alliance. Remember that you are making the therapeutic alliance with the healthy part of the patient. You will need to find that part and to make a connection with it in order to forge a strong alliance.

When trust is a problem

How do we foster a therapeutic alliance with a patient who has difficulty with trust? Patients who:

- are paranoid
- have difficulty believing that others are interested in them
- have difficulty believing that others care about them
- find it deeply humiliating to admit that they need help
- expect to be judged harshly by others

will have difficulty believing that the therapist is on their side. With these patients, we may have to work more actively, both at the beginning and throughout the treatment, to build the alliance and enhance the patient's sense of safety. For example, let's take the following remark made by a patient in an early psychodynamic psychotherapy session:

> *When I was in the waiting area, I noticed that you were talking to that other doctor down the hall. I wondered what you were talking about.*

If the patient generally trusts other people, you might answer by showing interest in the patient's thoughts by saying:

> *Can you tell me more about those thoughts?*

On the other hand, if the person generally has trouble trusting others, you might need to pre-emptively address potential paranoia by saying:

> *I wonder if you're mentioning that because you're wondering whether I share what we talk about with anyone else – remember that everything that we talk about here is completely confidential. If you ever have concerns about that, we can talk about it some more.*

For all patients, *actively fostering the alliance is an essential part of beginning the therapy*. You can practice formulating comments that are designed to foster the alliance in the following exercises.

Suggested activity

Read each vignette and write one or two lines about what you might say next in order to convey understanding and enhance the therapeutic alliance.

Patient 1

A 62-year-old woman presents to a clinic complaining that her daughter-in-law, with whom she lives, hates her and is making her life miserable. The patient's internist recommended the visit after the patient presented with increased blood pressure after a particularly bad fight with the daughter-in-law. In your evaluation, you find that the patient has no Axis I pathology. You also find that the patient has few friends, ''They're all out for themselves,'' she tells you. During the session, you start to feel like the session is dragging on and the patient is just complaining – externalizing all of her difficulties. Your only attempt to see if the patient sees any of this as ego-dystonic, ''Do you think that you might have done anything that has upset your daughter-in-law?'' is shot down in short order. You begin to realize that this woman's problem with her daughter-in-law is just the latest in a long line of interpersonal difficulties. The patient is not particularly happy to be at a psychiatrist's office and says, ''So – what do you think you can help me with?'' You say . . .

Comment

This is very early in the treatment – in fact, it's the first meeting. The surface material is that this woman is suffering – she feels victimized, angry, and misunderstood. Even if you think that underlying characterologic problems are at play, you want her to know that you understand what *she* thinks are her main problems, so you could say,

You have really been suffering – I think that the first thing we need to do is to understand what exactly has been happening at home because it's troubling you so much it's affecting your physical health. I think that if we know more about that, we might be able to figure out ways to make the situation better.

Patient 2

A 29-year-old man presents to you with symptoms of major depression – hypersomnia, hyperphagia, lack of initiative, difficulty concentrating, and low self-esteem. His work functioning is negatively affected. He also complains that he is isolated and that he is frustrated with his romantic life. You tell him that he has major depression and you recommend initiating medication therapy with sertraline. After six weeks at 150 mg per day, his symptoms are significantly improved – he is eating and sleeping normally, concentrating better and his work function is back on track. He's aware that his depression is better and is happy about that. Yet his interpersonal difficulties persist. He begins to date a woman, C, whom he has met online – gets very excited about her, then drops her when it is clear that she has some tastes that are not as ''cultured'' as his. Although always on time when he was depressed, he begins to come a bit late and sometimes asks if you have extra time after the sessions. He says, ''I don't know if this is working – I'm still having the same problems with women!'' You say . . .

Comment

This is a bit later in the treatment, although it's at a point when the goals of the treatment might be shifting. What's on the surface is that the patient is frustrated, and you want to convey your understanding of this. You might say,

> *I think that you're really feeling frustrated that your problems with women didn't clear up as quickly as your problems with your mood. But this is exactly what happens in therapy. People come for therapy when they're in crisis, their symptoms go away pretty quickly, and then they're able to look more analytically at some of the other issues in their lives. So we're right on track. Let's talk more about what happened with C . . .*

Patient 3

A 34-year-old woman has been working with you for six months in 2x/week psychoanalytic psychotherapy. She sought therapy for interpersonal difficulties resulting from her intolerance of other people's incompetence. Though she recognizes that this is problematic, she still becomes enraged when she is not properly supported at work. She thinks that you are very smart, and is pleased with the work that you are doing together in psychotherapy. Through your work, she has realized that her standards for herself and others are often too high, and she is getting along better with co-workers. One day, in a session, you misremember something about her history, confusing it with the history of another patient. ''I don't have an Aunt Ilene,'' she roars. ''Are you paying attention? I'm surprised . . . I thought that you were different.'' You say . . .

Comment

This is well into the treatment. The patient has had a good alliance with you. You want to convey understanding about her disappointment in you while helping her to see that this is exactly what she experiences with others. You might say,

> *You're very disappointed/angry that I misremembered something about you and it makes you feel as if I never pay attention.*

10 Therapeutic Neutrality

Key concepts

Therapeutic neutrality is the therapist's ability to listen and to respond to patients without imposing judgment or partiality.

Classically, the concept of therapeutic neutrality referred to the therapist's ability to remain equidistant from the patient's id, ego, and super-ego.

Therapeutic neutrality is not always the proper stance for a therapist. When the patient

- has the potential to harm him/herself or others
- is abusing substances
- is engaged in high risk sexual behavior
- is denying a medical illness, or
- is violating the frame of the psychotherapy

the therapist needs to take a non-neutral stance.

Therapeutic abstinence is the therapist's ability to conduct the treatment without gratifying his/her own needs.

Neither therapeutic neutrality nor therapeutic abstinence connotes the need to squelch one's own personality or to affect a wooden stance as a therapist.

Psychotherapists hear it all. Fantasies of every flavor, tales of petty and not so petty crimes, lust, rage, envy – you name it. It's all part of a day's work. Some is easy to listen to, some is titillating, some is seductive, some is revolting, and some is dull. Unless we hear something that makes us think that either the patient or someone else is in danger, we just listen, try to understand, and attempt to make appropriate and helpful interventions. That's our job. It's not our job to cast aspersions, punish, admonish, convert, or otherwise judge what our patients tell us. That stance, in which we listen impartially and use what we hear to understand rather than to judge, is called **technical neutrality** [15, 16].

Technical neutrality

No therapist, no matter how experienced, is ever perfectly neutral. Achieving neutrality, like trying to free associate, is an asymptotic task – we may strive for it but we never quite get there. Over time, we learn which patients and what types of material make this task particularly difficult for each of us. This often has to do with

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our own values, beliefs, backgrounds, and histories. For example, a therapist whose family was involved in the Armenian genocide might find it hard to remain neutral when listening to an anti-Semitic patient, while a therapist who had lost a sibling might find it difficult to listen to a mother whose child had just died. Supervision and personal therapy can be very helpful in these situations.

It was Anna Freud (Sigmund's daughter) who first defined technical neutrality as the therapist's stance that is equidistant from the id, ego, and super-ego [17]. Although this may seem quite abstract, it has great clinical wisdom. The idea is that the parts of the mind are in constant conflict with one another, and the therapist has to strive not to ''side'' with any one of them.

Example

Mr A is a 60-year-old man who has been married for 30 years. His wife, while kind, has never been particularly sexual and Mr A has felt sexually dissatisfied for much of his life. His wife is now suffering from Alzheimer's disease and is being cared for by a live-in female nurse, B, who is about ten years younger than Mr A. Mr A and B have become quite close and have recently started a sexual relationship. While this has been exciting and gratifying for Mr A, he is racked with guilt. He seeks out therapy because his anxiety and guilt are making it difficult for him to sleep.

Here is the way that three therapists approach Mr. A's situation:

Therapist #1 thinks that Mr A has been unfairly sexually repressed during his adult life and feels happy for him that he has finally found a sexually satisfying partner. He tells Mr A not to feel guilty but to enjoy his new relationship.

Therapist #2 thinks that Mr A is anxious because he knows that he is doing something wrong. He tells Mr A that, as sick as his wife is, he is committing adultery, and that as long as he is doing that he will continue to be anxious.

Therapist #3 thinks that Mr A has a conflict – one part of him wants to gratify long-denied sexual needs, while the other part wants to be faithful to his wife and feels guilty about the adultery. He explains this to Mr A and says that the anxiety he is experiencing is probably the manifestation of this conflict. He suggests to Mr A that talking about this conflict in therapy will help him to understand the choices he is making and will ultimately decrease his anxiety.

Of the three therapists, only Therapist #3 has a technically neutral stance. Therapist #1 is siding with Mr A's sexual wishes, while Therapist #2 is too close to his prohibitions. Therapist #3 parks himself squarely in the middle – he sees the conflict, outlines it for the patient, but does not take sides.

Taking sides

Sometimes, taking sides is the right thing for a psychodynamic psychotherapist to do. Here are some examples of situations in which technical neutrality is not the right stance:

- **When the patient has the potential to harm him/herself or others:** As mentioned before, when the patient places him/herself or someone else in danger, technical

neutrality is trumped by the need to protect the patient or the other person. For example, if a patient is hurting a child or partner, the therapist needs to:

– tell him/her to stop, and

– help him/her to do so.

This could involve different kinds of interventions, such as referrals to social service agencies or hospitalization.

- **Substance abuse:** If you hear from patients that they are abusing substances, it behooves you to temporarily abandon your technically neutral stance in order to try to get them into treatment.

  Example

  A 35-year-old lawyer comes to her psychodynamic psychotherapy session with a broken nose. You notice this and ask her what happened. She says that she's not sure. Upon exploration, she tells you that she blacked out during a party and woke up in a strange man's apartment. She thinks that she might have fallen on her face. She reveals that she frequently has 8–10 drinks on a weekend night and has blacked out several times before. You help her to understand that binge drinking is a form of alcoholism and you tell her that in order for the treatment to continue, she needs to go to Alcoholics Anonymous (AA).

  This non-neutral intervention could save her life.

- **High-risk sexual behavior:** All patients need to be asked about safe sex practices. If patients reveal to you that they are not practicing safe sex, you need to tell them that they need to do so. Subsequently, you can explore the meanings of this behavior, as well as their feelings about your taking a directive stance, but this exploration cannot take the place of telling patients that they need to protect themselves. Again, this is not technically neutral but it is potentially life saving.

- **Denial of illness:** If patients are avoiding medical attention that could put their health in jeopardy, you need to let them know in a non-technically neutral way.

  Example

  A 34-year-old woman whose mother died of breast cancer and who has never had a mammogram tells you that her breast self-examination revealed a small lump in her left breast. She says that, because it was painful to touch, she is sure that it is a cyst. You try to explore her fear of breast cancer and of what mammography could reveal, but she still says that she's sure that it's a cyst. You then tell her that she has to go for a mammogram, and that you'd be happy to help her find a referral.

  You tried the exploratory route and failed – time to temporarily abandon technical neutrality.

- **Violations of the frame:** If your patient tries to cross a boundary or to deviate from the frame, it's not the time to be technically neutral. For example, if a patient suggests meeting outside of the session or engaging in physical contact, you need to say ''no, that's not part of what we do in psychotherapy.'' That's not technically neutral

but it's necessary for maintaining the treatment. Similarly, when a patient doesn't pay, you need to explore the reasons for the non-payment – but if it continues you may need to set a payment deadline in order to preserve the frame of the treatment.

Therapeutic abstinence

In psychodynamic psychotherapy, the patient and the therapist have a one-way relationship. That means that the therapist is there to help the patient and not vice versa. There are many moments in psychotherapy when it would be very easy for the therapist to satisfy personal needs – but then it would no longer be psychotherapy [3, 18–21].

Examples

1. *A therapist in a small town is treating the Dean of the local law school. The patient has been substantially helped by the psychotherapy and is very grateful. In addition, because his daughter went to high school with the therapist's son, he knows that the therapist has a son in college who is eager to go to law school. He tells the therapist that he would be happy to do whatever he can to help her son gain acceptance to his law school. The therapist knows that her child is bright but that his law school entrance examination scores were a bit sub-par. This help could be invaluable to his chances for acceptance. Nevertheless, she thanks the patient for his offer, says ''no thank-you'' and explores this offer with him. They uncover his discomfort with gratitude and his wish to ''level the playing field''.*
2. *A recently widowed therapist is treating a young artist. The therapist's wife was a prominent scientist and her obituary was in the newspaper – thus, the patient is aware of her recent death. The young artist is invited to many art openings and invites the therapist to one of them. The therapist, who has been painfully lonely, longs to join his young, vibrant patient, but knows that this is not part of the treatment. He thanks his patient, declines, then explores the offer. The conversation turns to the patient's feelings about his lonely grandfather.*
3. *A third-year psychiatry resident is treating his second patient in psychodynamic psychotherapy. The only time that the two could find to meet was on Thursday at 7:00 p.m – after the resident's shift in the Emergency Room (ER). The patient notices the bags under the resident's eyes and brings him a cup of coffee during one session. He is so tired that he accepts. In order to get to the session, the resident must literally run from the ER, leaving no time to have a cup of coffee. The patient brings coffee to the next session as well. The resident realizes that this is gratifying his needs and tells the patient that although it is a nice thought, she does not have to bring him coffee. They explore the interaction, and learn about the patient's generally masochistic relationship with her mother.*
4. *A research psychologist with a private practice is treating a very wealthy philanthropist. The researcher is in need of $500,000 in order to start a new and very important research center. The philanthropist gives that kind of money and more to worthy causes – including other parts of the university – all the time. The patient has done well in psychotherapy and is very grateful. After the patient gives $1,000,000 to another research venture, the therapist becomes agitated and upset. In the next session, the therapist almost asks the patient for a donation – but stops herself.*

In each of these examples, the pull to violate therapeutic abstinence is intense – but in order to preserve the treatment the therapist must refrain from gratifying his/her own needs. One might think that in some cases, no harm would be done – for example, in the case of the research psychologist – but the balance of the therapeutic relationship would be forever changed. In order for the therapy to work, the patient needs to feel that he/she is the only one who is being helped by the psychotherapy.

That said, there are many complications. For example, if you are a trainee, your patients will know that their psychotherapy helps you to learn. This is a reality of the situation. Patients pay their therapists – thus the therapy helps the therapist to make a living. While gaining an educational benefit and receiving a fee do represent gratification of the therapist's needs, this type of gratification is *part of the frame* – the patients choose to come to a clinic staffed by trainees, and psychotherapy is generally rendered on a fee for service basis. Apart from this, therapists are gratified by knowing that they are helping people, doing interesting work, learning about new things from their patients – but these are average expectable gratifications of any mental health or medical professional.

Clues that we are experiencing more than ''average expectable'' gratification include:

- getting very excited about seeing the patient
- thinking a great deal about the patient outside of sessions or supervision
- choosing special clothes to wear on the day of a patient's session
- engaging in boundary crossings or violations (see Chapter 8)

Again, supervision and personal therapy is generally very helpful in these situations. Therapists sometimes become ashamed of having strong feelings about patients and try to suppress them – this is a sure way to have them lead to trouble. Rather, discussing such feelings in therapy and/or supervision can help to uncover the roots of the feelings and can help you to understand more about the patient as well.

Neutrality, abstinence, and ''woodenness''

''Are you going to talk in this therapy?'' the first-time psychotherapy patient asks you, her therapist. You know that you will talk, but the patient's question didn't come out of thin air. Scores of movies, TV shows, and cartoons portray therapists as bizarrely wooden creatures with stone faces and pursed lips who say next to nothing. Unfortunately, for many years, Freud's early ideas about neutrality were misunderstood to mean that therapists should be robotic. On the contrary, as a therapist, you can smile, furrow your brow, ask questions and yes, even laugh, while remaining technically neutral. Consider this example:

Patient *I wasn't spying on you, but I saw you coming in today and I noticed that you had the most beat up umbrella. I hate to say it, but it looked a little weird.*

Therapist *(laughs and points to her wet shoes) Yeah – and it didn't do me much good today! Did you have any other thoughts about the fact that I had such a crummy umbrella?*

Patient *Yeah – I thought, ''Your kids must take the good ones in the morning too.'' So may be my kids aren't as selfish as I think they are.*

No ''emotional coldness'' is required. In fact, natural moments like this one help patients to remember that their therapists are first and foremost human beings. Expect that it will take you some time to find your way to a technically neutral but natural stance as a psychodynamic psychotherapist.

Some patients with weaker ego function are especially vulnerable to feeling anxious, demeaned, or mistrustful if the therapist is too silent, wooden, and opaque – especially at the beginning of treatment and at the beginning of each session. Creating a holding environment for these patients may involve being more personal, active, responsive, and conversational than you might be for other patients. Particularly if your natural style is to be reflective and reserved, you may need to demonstrate your ''presence'' for these patients with a more animated demeanor, a warmer tone, or a little more facial expressiveness. Sometimes, it might even help to make a joke, share an opinion, offer anecdotes from your own experience, or reveal a little more about yourself in response to questions.

Example

A very inhibited patient with whom you are using a predominantly supporting stance is terrified about giving an important presentation at work. She asks you if you have ever been nervous when speaking in public. She has come a long way from the beginning of treatment when she would barely look at her colleagues, and you want to support her freshly minted bravery. You say, ''You bet – it's always hardest to speak in front of your closest colleagues.''

Note, however, that adopting a more supportive stance does not give you free rein to talk about yourself without carefully considering what's best for the patient. As always, use what you know about the patient's particular needs, problems, and vulnerabilities to decide whether the patient would be best helped by having this information about you at this time. When in doubt about how open to be or whether to answer a specific question, you can always hold off until you get more information or seek supervision. Here are some graceful phrases that might help you to deal with requests for personal information:

What brought that to mind just now?

I could answer that, but what would it mean to you, one way or the other?

What got you thinking about that?

Can you tell me what is behind your question?

Very often, thinking about what you might like to hear from a therapist if you were in the patient's seat can help you to make technically neutral but *human* choices.

Suggested activity

To answer or not to answer?

What do you say when the patient says:

1. *I really like your haircut – can I get the name of your stylist?*
2. *Are you divorced? I'm not sure that you could really understand me if you aren't divorced.*
3. *Where did you get your PhD? Is that a good school? Did you do clinical work or just research?*
4. *Why do you have your office in this complex? The parking is terrible.*
5. *Why do you think that that's what my dream means? That doesn't make sense to me.*
6. *Can you recommend a good book about how psychotherapy works?*
7. *Do you think that I might need medication?*

Comment

1. **Don't answer** – This kind of question is clearly outside of the frame of the therapy. The therapist deserves his or her privacy and boundaries. This kind of question, though, is often helpful because it guides the therapist towards thoughts and feelings that the patient may have about the therapy and the therapist. You might say,

   > *Thank you. I know that your question was about the haircut itself, but I wonder if your asking might mean that you have some feelings about me or the way I look?*

   This kind of answer is implicitly psychoeducational since it helps to promote self-awareness and interest in feelings about the therapist.
2. **Don't answer** – As in the first situation, this information is private and does not have to be revealed by the therapist. Again, though, it indicates that the patient has a worry about whether the therapist can understand him/her – and this can be addressed by the therapist:

   > *It sounds like you have some worries about whether I will be able to understand you and what you're going through. Let's talk more about that*.

3. **Answer** – This is a valid question and part of the process of informed consent. It's reasonable for a patient to want to know where and how the therapist was trained. Patients don't always know how therapists are trained, and it's good to inform them.
4. **Answer** – Particularly if this is at the beginning of the treatment, it's reasonable to say something about the location of your office. As with the previous questions, though, the fact that the patient has asked probably indicates that the patient has feelings about the therapist or the therapy. A comment like, ''I'm sorry that you're having difficulty with parking – but I wonder if you're having other feelings about beginning the treatment that we should talk about'' is likely to deepen your understanding of the way that the patient is feeling.

5. **Answer** – Again, particularly at the beginning of the treatment, it's good to be transparent about the comments you're making – no harm in (i) explaining your idea and (ii) asking why it doesn't seem to resonate.
6. **Answer** – The problem with this answer is that there's no simple answer. There's no reason why a patient in psychotherapy shouldn't read about it, but sometimes the wish to read about it covers other concerns that you should ask about. You might say, ''There are many books about psychotherapy, but it sounds to me like you have some questions about how this process works that we could talk about. Do you have any specific questions that could start us off?''
7. **Answer** – This is a direct question about the treatment. Even if the patient could potentially be using the question in the service of not looking at deeper issues, it's possible that it's the patient's way of saying that there are more severe symptoms that he/she hasn't discussed or that he/she doesn't feel better yet. Our patients often give us our best supervision, so questions like this can very often be helpful guideposts.

11 Conducting a Psychotherapy Session: Decisions about Length and Frequency

Key concepts

Every session has a beginning, a middle, and an end.

Each part of the session has particular characteristics and goals that guide what we do and say.

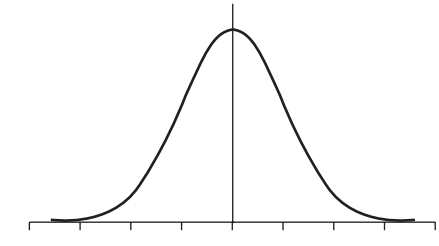
The therapist's job is to gently guide the session to give it form and to develop themes.

The session begins from first contact, which could be in the waiting room, and ends when the patient leaves the room – comings and goings are part of the process.

We make decisions about length and frequency of sessions based on our evaluation and formulation of the patient.

Sonatas have an exposition, a development, and a recapitulation. Exercise classes have stretching, the workout and the cool down. The same is true for a psychotherapy session. Like a sonata or a class, psychotherapy sessions have a form. Each part of the session is different, with distinct goals and techniques. Thinking about these can help us decide what we do and say in sessions.

Once you have conducted whole psychotherapies you will see that the topography of each session is a microcosm of the psychotherapy as a whole – there is an opening, a time of deep work, and a termination. The phases of the therapy are called the **induction**, the **midphase**, and the **termination**. The phases of the session are the **beginning**, the **middle**, and the **end**.



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The beginning – opening

People come into therapy from the outside world. They have been dealing with their external lives – work, family, stresses – and when they come into our offices for psychotherapy, something changes. They are now in a place where they are going to think and talk about their internal lives. This is not necessarily an easy transition to make. We need to be respectful of this potential difficulty and help it to happen gently. We can think about it as a gradual opening. Whether the patient comes once, twice, or three times a week, there is the need for a transition at the beginning of the session. This transition doesn't just begin when the patient starts to talk – it starts the moment you open the door or even when the patient is sitting in the waiting area.

Introductions/greeting

Every session has a beginning. This usually involves some sort of greeting. In the very first session, you will need to introduce yourself to the patient. For adult patients, it generally makes sense to use formal titles for your patient and for yourself. The relationship begins immediately, from the first interaction, and if you call your patient ''Jane'' and introduce yourself as ''Dr Smith,'' you're setting up a power differential from the get-go. A handshake is often in order for this first meeting. A smile conveys interest and warmth. No need for extensive chitchat, although it is sometimes good to have something to say as you walk the patient to your office. Remember, this is the beginning of an important relationship, and you're forging the alliance from the very start.

Examples

Hi, you must be Mrs Jones. I'm Mr Anderson (handshake). Why don't you come this way – we'll be meeting just down the hall. Did you have any trouble finding the clinic (as you walk there)?

(approaching a busy waiting room) Excuse me, is anyone waiting to see Dr Brown? (patient stands up and approaches). Hi, you must be Mr Wilson, I'm Dr Brown. Nice to meet you. We'll be meeting here in Room B. Did you have to wait long?

You are a person, as is the patient, so when you meet, it's a human interaction. You can be welcoming without being overly familiar as you set up the psychotherapy situation. (Note that Dr Brown respected Mr Wilson's privacy by not calling out his name in the clinic waiting room.)

In subsequent sessions, you needn't greet the patient in the same way – you can forego the handshake (although some continue this) and the initial introductions. However, the smile and welcome are always important.

The therapist's opening

Therapy is a little like chess; someone has to make the first move – and it should be you. The silent therapist who comes in, sits down, and says nothing is a caricature. Your job is to subtly shape the session, and this happens from the very beginning.

Patients – particularly ones who are very upset, disorganized, or pressured – may start the session, and if they do you can let them talk for a little while. However, after a minute or two, it's time to begin the choreography. An effective therapist will control the flow of the session without seeming to, gently nudging the patient like a parent who is guiding a child as they learn how to walk. Openings should be just that – open – and should generally consist of open-ended questions. The beginning of the session is a time for the patient to speak freely and your opening should encourage this. Let the patient speak in his/her own way for a little while – perhaps 5 minutes or so. This will help you to hear the patient's speech pattern and thought process. It will also let you see where the patient begins and what he/she prioritizes.

Examples

I heard from Dr Z that you were going to call, but he really didn't tell me much about the problem – so why don't we start from the beginning. What brings you here today?

On the phone, you mentioned that you wanted to have a consultation for psychotherapy – maybe we could start with why you thought that would be a good idea now?

In subsequent sessions, you won't have to start with the history, but it's still good to say *something* to open the session. What you say will depend on who the patient is, the kind of therapy that you're doing, the current issues and problems, and your own style. If you're doing a predominantly uncovering psychotherapy that stresses free association, you might start with, ''What's been on your mind?'' If you're mostly using supporting interventions, you might say, ''How has your week been?'' or ''Tell me how things have been going.'' Again, you're a person and your patient is a person and sitting down to talk to a person who says nothing at all is quite bizarre. You can experiment with using different openings with different patients.

The opening part of the session gives you information about how the patient is feeling and what he/she is thinking about. From this you will begin to pick up themes that you can develop in the middle portion of the session.

The middle – deepening

The middle of the session is a time for deepening of issues that emerged in the opening. During this part of the session, you will choose from among the things that you have heard in the opening that you want to ask more about. In terms of the topography of the session, this is where the ''peak'' of the session occurs, as it might in a short story. One important thing to remember is that *when* the ''middle'' happens might not be at the middle of the time period – it could be after 10 minutes or after 40 minutes. The ''peak'' does not have to be dramatic – it's just the part of the session in which the most work happens. This could mean many things, but it often occurs when patients connect to new affects or realize something new about themselves. Timing it in this way allows for closing during the end part of the session – you do not want the patient to leave the session in a raw state, and you want to give the patient time to respond to your comments. Thus, the middle of the session is the time to make comments designed to move the patient forward in the therapeutic work.

Examples

During the opening phase of the session, Mr A spoke about being very angry with his boss for passing him up for a promotion. He also said that he didn't feel like cooking although this is something that often is enjoyable for him. The therapist wondered to himself whether these two things were related and in the middle portion of the session asked Mr A, ''I wonder if one of the reasons that you didn't feel like cooking had to do with your feelings about what happened at work.'' This allowed Mr A to talk more deeply about his feelings about work and how they were affecting him.

Ms B began the session by saying that she was feeling anxious but didn't know why. The therapist noted to herself that Ms B had been about five minutes late to the session. During the middle of the session, the therapist asked Ms B, ''I wonder if you have any thoughts about coming a little late today.'' After a brief pause, Ms B was able to begin to think about having been very upset after the last session. They then discussed whether this might have made Ms B ambivalent about coming to the session today.

In both of these examples, the therapist had thoughts early on about what to explore with the patient, but waited until the middle of the session to deepen the material.

The end – closing

Just as the beginning of the session is the transition into internal reflection, the end of the session is the transition back to the outside world. We have to give the patient enough time to ''close'' a bit before returning to his or her life. Some of this involves timing – we don't want to introduce new topics or probing questions too near the end because the patient will not have enough time to reflect on them or to respond. Even if we have things to say, we will often hold them for another time, rather than introducing them too late in the session. Sometimes, we need to be explicit about the closing. For example, if a patient brings up an important topic near the end of the session we can say,

That's a very interesting and important topic, and we should bring that up again next week, when we have more time.

We can also help the patient to close by making consolidating comments like,

We've really been able to explore many things about your relationship with your mother today.

This will help the patient to frame the session and will signal that the ending of the session is near. The patient's session may just be another 45 minutes in your day, but you have to remember that this may be a very important and cherished time in your patient's day or week – if this is true, the ending may be a time of strong feeling, whether this is communicated and/or conscious or not. Thus, the gentleness and respectfulness of the opening also holds true for this part of the session. Abruptness is jarring and not necessary – there are many ways to say that it's time to end. For example, ''OK – why don't we stop here for today'' is much less abrupt than, ''Time's up'' or ''We have to stop.''

Saying good-bye

Just as we greeted the patient when he/she came in, we have to say good-bye. ''See you next week'' or ''See you next time'' are perfectly fine things to say to your patient as he/she walks out the door. As with the opening, there's no need for extensive chitchat – your closing should be a respectful end for work done together.

Sessions – how long, how often, and how many?

Along with learning how to choreograph a session, we also have to make other decisions about the sessions in a psychodynamic psychotherapy [22, 23].

- **How long should sessions be?** Freud originated the ''50-minute hour'' – he saw his patients for 50 minutes and then used the remaining 10 minutes for note taking and formulation. Many psychotherapists continue this schedule. The session has to be long enough to allow the patient to open up and for themes to develop, but not so long that the patient becomes overwhelmed or unfocused. When using primarily uncovering techniques, most therapists feel that they need at least 45 minutes for this to happen. A 45-minute session is also often used for more supporting techniques, although patients with limited capacity for affect/anxiety tolerance and attention may do better with shorter sessions. If you decide to use shorter sessions with a patient, be consistent and set this up at the beginning of the therapy as part of the frame.

  Some therapists may decide to make their first evaluation session longer, usually 1–1.5 hours, in order to have time to take a full history. If you decide to do this, make sure to explain to your patients that the length of the evaluation session is different from the length of your weekly sessions so that they know what to expect.
- **How often should I meet with my patient?** The frequency of sessions in psychodynamic psychotherapy depends on the goals and needs of the patient. Because psychodynamic psychotherapy requires self-reflection, meeting less than once a week makes continuity difficult. There are two indications, however, for even more frequent sessions:
  - **To enhance in-depth uncovering work** – When the patient is able and motivated to do in-depth uncovering work, and you feel that the goals include major shifts in adaptive functioning, self-esteem management, or relationships with others, psychodynamic psychotherapy is often optimized by two or even three times per week sessions. The increased frequency of sessions can promote free association, decrease resistance, and enhance discussion of the therapeutic relationship. The increased frequency increases the intensity of the work, and thus can increase anxiety and painful affects as well. Note that if you decide to increase the frequency of the sessions and the patient worsens, this could mean that the patient cannot tolerate the heightened level of intensity. Nothing is written in stone – you can always go back to once a week and either remain there or decide to increase again when the patient's ego function improves.

  - **To add greater support during a crisis** – A patient with weakened ego function may need multiple meetings per week to help him/her cope with the vagaries of everyday life. This could include a brief period of increased suicidal feelings, the weeks after a major loss, or any other crisis situation. Again, whenever you change the frame, discuss both the alteration and the return with the patient.

- **How long should the treatment be?** Sometimes psychodynamic psychotherapy lasts a few weeks and sometimes it lasts a few years. Discrete goals, such as relief of a single symptom, or sorting out a specific interpersonal situation, may be accomplished in a few weeks or months. The uncovering and supporting techniques described in this manual can be used in a short-term treatment if the goals are well defined. Long-term psychodynamic psychotherapy, which can last months or years, is indicated for the following goals:
  - substantial character change – defined by major changes in defensive operations, self-esteem management, and relationships with others
  - ongoing need for support of ego functions.

  As we discussed in Chapter 8, the length and frequency is part of the frame and needs to be discussed explicitly at the beginning of the treatment.

Suggested activities

Here are some exercises to practice openings and closings of sessions:

Activity 1: Greetings and openings

1. *Mr A is a 55-year-old man who has had paranoid schizophrenia for 30 years. He was admitted to an inpatient unit by the doctor on call last night. At rounds, the admission note is summarized and you learn that he will be your patient. After rounds, you start to read the chart when you notice that he's pacing around the nursing station. A nurse approaches you and says, ''You need to meet with Mr A.''*

   What do you do next? What do you say?

Comment

Suggestion

> *Good morning, Mr A, I'm Dr Z. I'll be your doctor while you're here in the hospital. Do you feel up to speaking for a while now? If so, let's take a few minutes right here near the nurses' station and talk, and then we can talk some more a little bit later.*

No need to be rigid about your intakes – always gauge how appropriate it is to begin talking to the patient at that moment.

2. *Ms B is a 43-year-old woman who was recently hospitalized for a suicide attempt and who was referred to the Day Treatment Program after discharge. She is your Wednesday morning intake. It's time for the session. You go to the waiting area where several people are seated.*

   What do you do next? What do you say?

Comment

Suggestion

> *Hi – I'm Mr Y – does anyone have an appointment with me this morning?*

You can protect your patient's privacy in a waiting area by using your own name rather than his or hers.

3. *Mr C is a 62-year-old man who is having his first appointment at an outpatient clinic. The patient called to schedule an appointment and told the administrative assistant that it was ''for help with depression.'' All you have is that note. When Mr C comes into your office, he looks older than his stated age and is using crutches.*

   What do you do next? What do you say?

Comment

Suggestion

> *Good morning – I'm Ms X, one of the therapists here in the clinic. Can I help you with those? Why don't you have a seat? I'm glad that you were able to make it in today. I heard from the clinic staff that you wanted to make an appointment but I don't have any other information – so let's start from the beginning. What brings you to see me today?*

Your introduction is designed to help make the patient feel comfortable and to begin to talk.

4. *Ms D is a 45-year-old woman who has made an appointment with you in your private office. On the phone she said that she was having difficulties with her husband that she wanted to discuss. She comes at the appointed time.*

   What do you do next? What do you say?

Comment

Suggestion

> *Hi – I'm Ms W. Nice to meet you. We just spoke briefly on the phone – but why don't we start now with what's brought you to see me today?*

A friendly, open-ended, clear opening will help your patient begin. Perhaps the problem is with the husband or perhaps that's what she felt most comfortable saying over the phone – this opening gives her the greatest latitude to tell her story.

Activity 2: Closings

1. *You have spent 10 minutes talking to Mr A when you notice that he is starting to fidget in his chair. You have barely scratched the surface of the story of why he came into the hospital. At one point he starts to stand up.*

What do you do next? What do you say?

Comment

Suggestion

> *I'm glad that we had a chance to begin to talk. Why don't we finish up for now and we'll talk more in a little while.*

An agitated patient may not be able to sit through a full intake. Attending to the patient's comfort and ability to sustain the interview can be as important as making sure that you get all the information.

2. *You have spent 45 minutes with Ms B. She was extremely tearful and repeatedly said that she was having obsessive thoughts of driving her car into a wall. Although she says that she thinks that she won't do it, you are very nervous and not sure what to do but time is almost up.*

   What do you do next? What do you say?

Comment

Suggestion

> *Even though you were just discharged, it sounds like things are still pretty rough for you. The time for our session is up, but I think that we still have some things to think about in terms of how best to help you now. Why don't you come with me to speak to Dr A, my supervisor, a bit more.*

You never know what you will learn in an intake. Be prepared to extend the evaluation in case of emergency.

3. *You have spent 45 minutes with Mr C, who is recently widowed and is recovering from knee surgery. He has dutifully told you much of his history and has told you that he is depressed and lonely. Despite this, he seems to be getting out, eating and sleeping well, and has recently enjoyed a trip to see his grandchildren. He has no suicidal ideation. You are not sure whether he has a major depression and needs medication. The session is almost over.*

   What do you do next? What do you say?

Comment

Suggestion

> *It's clear to me from what you've told me that you've been depressed in the last few weeks. Before we decide what the best treatment is, I think that it makes sense to meet again to see how you're feeling in a few days and to hear more about you. Can we try to find a time early next week?*

The evaluation phase can last several sessions – as long as there's no emergency, you should not feel pressured to make a decision about the treatment after one session.

4. *You have spent 45 minutes with Ms D, who has told you that her marriage of 15 years is ''on the rocks'' and that she has been having an affair. The session is almost over and you know that you only have 10 minutes before your next session. There is no emergency, although Ms D has much more history to tell.*

   What do you do next? What do you say?

Comment

Suggestion

> *You know, we're almost out of time today. I'm glad that we were able to begin talking about the difficulties you're having, but it's clear that you have much more to tell me. That's the way this usually works – it generally takes a few sessions to get the whole story. Let's figure out when we can meet again to continue talking.*

As above, conveying understanding while also communicating that this is the beginning of a longer process is an important function of the first closing.

12 Our Patients' Feelings about Us and Our Feelings about Our Patients

Key concepts

In psychodynamic psychotherapy we are interested in knowing about and understanding:

- our patients' feelings about us, and
- our feelings about our patients

These feelings are ubiquitous and are important to the treatment.

As we begin a psychodynamic psychotherapy, it is important to recognize both sets of feelings so that we can use them in our work with our patients.

The process of recognizing and managing feelings we have about our patients is called self reflection.

The heart of psychodynamic psychotherapy lies in the relationship between the patient and the therapist. Whether the technical mode is primarily uncovering or supporting, the relationship is key. It makes sense, then, that the feelings the patient and therapist have about each other are an integral part of the treatment itself, and that starting to recognize them is an essential part of beginning a psychodynamic psychotherapy.

Our patients' feelings about us

The fact that patients may have strong and complex feelings toward their therapists is not unique to the psychotherapeutic encounter. Relationships with doctors, bosses, teachers, even spouses, are all examples of situations in which expectations, wishes, and fears are heightened. In psychodynamic psychotherapy, our patients' feelings about us, their therapists, give us important clues about their emotional lives. Our aim is to recognize these feelings and to encourage our patients to take interest in them as well.

Psychodynamic Psychotherapy: A Clinical Manual Deborah L. Cabaniss, Sabrina Cherry, Carolyn J. Douglas and Anna Schwartz
 ISBN: 978-0-470-68471-9

Our patients have feelings about us even before they meet us

It's never too early to listen for a patient's emotional response to us – it is present even in the first phone contact prior to the initial meeting. Does the patient sound excited, nervous, condescending, or eager to please? Your patient may talk about his/her initial impression in the first appointment.

Example

Mr A has been referred for an evaluation by his internist. Within the first five minutes of the interview, he tells the therapist, ''I have to say, you're not at all like what I expected. From what Dr Z said about you, and because of your last name, I expected you to be old, stern and European. I was a bit nervous coming here today.''

Encourage your patients to talk about these feelings

Encouraging our patients to take interest in and talk about their feelings toward us is an important part of beginning treatment. Patients who have never been in psychotherapy before may not know that we are interested in hearing about these feelings, or that they are useful to the treatment. Psychoeducation is key – here's an example:

Patient	*I wasn't sure that I wanted to come to this second appointment.*
Therapist	*I'm glad that you mentioned that – I wonder if it had anything to do with your experience here last time or about any feelings you had about me?*
Patient	*I feel funny saying this, but I thought that you probably have much sicker patients to deal with and that you would be bored with my silly problems. You have that big diploma on the wall – I thought that you should be doing more important things.*
Therapist	*No one person's problems are more important than the next. But it's important that you told me about those feelings. As we continue, you should try as much as possible to talk about any thoughts or feelings that you have about me or your experience of the therapy. Those feelings will not only help us in our work together, but they'll help us to learn about you.*

It is important to state this explicitly, since many patients need a certain amount of permission to talk about their feelings about you in the sessions. As you continue, you can ask questions such as:

What were your feelings about our last session?

What has your experience been of this conversation?

You were very upset last time – what did you feel about what I said?

This will encourage your patients to talk about these feelings in an ongoing way.

Strong early reactions to us can tell us about the patient

How a patient reacts to us emotionally at the beginning of treatment can help us to learn about how they react to stress and to others. Consider the following examples:

> *Ms B is a young woman who is hospitalized on an inpatient unit. When she first meets the resident assigned to treat her, she says, ''How old are you anyway, like 23? Dr Y is much more experienced than you are. I'm not sure I'm going to be able to work with you. And by the way, no offense, but that's a really ugly shirt.''*
>
> *Ms C, a middle-aged woman who is at the end of her initial consultation with a new therapist, says, ''I can tell you're different than the other therapists I've had. No one else understands how awful my husband is. You really picked up on that, like it's intuitive. I already feel such a connection, it's fantastic!''*
>
> *Mr D is a man in his 30's who has come for treatment of mild depression and panic attacks. At his second appointment, he says, ''I felt better after meeting with you the other day. It was reassuring to hear that you think I have symptoms of panic, and that medication will help. I also thought that what you said about why this is happening to me now made a lot of sense.''*

Ms B is overly aggressive, devaluing, and insulting to the therapist. We could expect that she relies on splitting-based defenses to help her to cope with stressful situations. When she feels insecure, powerless, or envious, she resorts to belittling and attacking – in this case, the therapist.

Ms C is too complimentary of her new therapist. We could suspect that she tends to idealize or devalue people. In order to shore up her self-esteem, she yearns for special feelings of connection with individuals she sees as very intelligent, talented, or powerful.

Mr D responds in a generally positive, but not idealized, way to the therapist. We could imagine that he has fairly healthy responses to stresses and that his relationships with others are deep and nuanced.

In all of these examples, the patients' early reactions to the therapist give interesting information about the patients' characteristic ways of dealing with stress and relating to others.

Patients convey their feelings about us verbally and non-verbally

The patients in these examples expressed their feelings about the therapists verbally and without prompting. In contrast, many patients' feelings about the therapist are more indirectly expressed. This kind of communication can be non-verbal, for example through affect, demeanor, attitude, or body language. Or it can be expressed via displacement, for example when a patient describes feelings about another person. It is helpful when listening to patients to frequently ask oneself the following questions:

- What is the patient feeling and thinking about me, or about our relationship, at this moment?

- How is he/she expressing this?
- Are the thoughts and feelings in the foreground, or the background?

Even the seeming absence of any feelings toward or about the therapist is an emotional response, and something to be noted.

Examples

A 19-year-old man comes for psychotherapy with a chief complaint of difficulty in romantic relationships. He has a general attitude of mild entitlement and contempt or disdain of others. He doesn't explicitly say anything about his feelings for his female therapist. However, the therapist observes the following behaviors. The young man blows his nose and strews the used tissues all over the table next to his chair, rather than placing them in the nearby wastebasket. He frequently pulls out his cell phone to send or receive text messages. Occasionally, he stands up to stretch, turning his back on the therapist. He interrupts and talks over the therapist.

A 28-year-old woman in therapy for anxiety and low self-esteem has a history of a very close but highly ambivalent relationship with her mother, whom she experiences as extremely critical, intrusive and controlling. She tends to respond to her therapist's observations as criticisms. She appears eager to please the therapist, to be a ''good patient,'' but is easily wounded by all but the most overtly supportive statements.

A 40-year-old married woman who has recently begun psychotherapy with a male therapist starts talking about a man at work she finds attractive. She spends increasing time in her sessions discussing her flirtation and deepening intimacy with this colleague, and also her guilt and conflict about ''emotionally cheating'' on her husband.

The therapist who can pick up on verbal and non-verbal communications will learn a great deal about these patients.

Challenges for the beginning therapist – how could I be that important to the patient?

One of the biggest challenges for beginning therapists is to become comfortable with hearing and acknowledging patients' feelings about them. It can be very difficult to convey an attitude of openness, interest, and acceptance when faced with a patient's aggressive or sexual feelings toward you. But such an attitude is usually the most helpful stance.

Example

Patient *I don't think I can work with you, you're just too young. I don't mean to offend you, but I don't see how someone your age can possibly be helpful to someone my age.*

Therapist *I understand that you have some concerns about working with a resident, someone who is still in training. Can you tell me more about how you feel about my age and level of training? What about you, more specifically, are you worried that I won't understand?*

In this example, the therapist both validates the ''realistic'' aspect of the patient's complaint, while staying non-judgmental, interested and probing for more detail.

As therapists, we may become highly important figures in our patients' lives. It may take some time for beginning therapists to appreciate and become comfortable with this role. Events such as interruptions in treatment for vacations, illness, or other reasons can have tremendous significance. Listen for patients' responses when there is an alteration in the usual therapeutic frame, and don't be afraid to ask questions about it.

Example

A fourth-year psychiatry resident had to cancel a therapy appointment with his patient at the last minute, because of an emergency on the inpatient unit. When he phones the patient to tell him, the patient says, ''Oh, that's OK, I'll see you next week.'' At the next session, his patient doesn't mention it. The resident brings it up about mid-way through the session:

Therapist	*You haven't said anything about my canceling our last appointment. That's never happened before, and I wonder how you felt about it?*
Patient	*Well, I know that you work in the hospital, and that emergencies happen. That's OK. But I did feel disappointed; I was really looking forward to the session and to telling you about that job interview.*
Therapist	*You didn't mention that until I asked.*
Patient	*Yeah, I have a hard time telling people that I'm upset with them, especially when I feel rejected. I'm always afraid they'll get angry with me, especially if it's something like this, where it wasn't really your fault.*

Another therapist might not have mentioned the canceled session if the patient didn't bring it up. He may have felt anxious or guilty himself about having cancelled and might not have wanted to face the patient's reaction. But by introducing the topic and expressing an attitude of curiosity about the patient's response, this therapist invited the patient to reveal feelings of rejection, which may have remained hidden under the guise of a ''reasonable'' response to the cancelled session.

Our feelings about our patients

Just as our patients develop a wide array of feelings towards us, we respond emotionally to our patients. Being able to recognize and manage such feelings is an important component of therapeutic competence. These feelings can help us to understand what our patient is experiencing, both consciously and unconsciously. We can think of this process of **self-reflection** as the counterpart to empathic listening.

At times our reactions to patients may be dramatic and in the forefront of our attention. At other times, they may be subtle and out of our awareness, forming the general backdrop of our interactions with patients. It can be helpful to ask oneself these questions periodically:

- What am I feeling towards this patient now?
- What do I think the patient is feeling about me? How does that make me feel?

- What in the patient's communications (verbal or non-verbal) might I be responding to?
- Does the patient seem to be casting me in a particular ''role?''
- What might I be bringing to this situation (such as attitudes, memories, or biases) that is specific or unique to me?
- Is my response to this patient within the range of average, expectable responses a therapist might have to this patient?
- Do I feel compelled to say or to do something in response to the patient now?

All therapists have all kinds of feelings about their patients

In thinking about our reactions to patients, it is important to remember that, just as we expect our patients to have the full gamut of feelings about us, it is normal for us to have all kinds of feelings about our patients. These can include affection, love, anger, protectiveness, dislike, attraction, disgust, boredom, and excitement. Recognizing and accepting such feelings in oneself is important, as is having the opportunity to talk about them with others, such as colleagues, supervisors, or one's own therapist.

Self-reflection is key

Allowing ourselves to accept and recognize our feelings about our patients will give us some of the most important information that we can get about who they are, what they are feeling, and how they experience the world. Sometimes, our emotional response may be very similar to what the patient is feeling.

Examples

You have just admitted a 23-year-old man to the inpatient unit, and are conducting your initial interview. He appears to be in an exuberant mood, talking very animatedly, laughing often, and leaping up from his chair at times. He describes his recent work on an important artistic project, which he feels may be a work of genius. He hasn't slept in several days, but feels full of energy.As you listen, you notice yourself feeling energized, despite the late hour. Although you have some trouble following the thread of his story, you find him fascinating. When he laughs, it feels contagious, and you find yourself smiling.

A 59-year-old woman is in psychotherapy for mild generalized anxiety and an adjustment disorder. She is somewhat obsessional, and is a self-described ''worrier.'' She is talking about her husband's recent retirement, and her anxiety about their finances. ''The stock market is tanking,'' she says, ''and the rest of the global economy will follow suit.'' She's not sure it was a good idea for her husband to retire, and she's especially worried about her adult daughter, with her three young children and large mortgage to pay. As you listen, you find yourself feeling a bit anxious and uneasy. At one point, you realize your mind has wandered and you're worrying about your own finances. You think to yourself, ''Maybe she's right and we should all feel as nervous as she does.''

The first thing therapists need to do when they self-reflect is to note their affect. For example, the first therapist is happy and energized, while the second therapist is

anxious. Therapists may see that their affect resonates with the patient's. Then they can proceed to ask themselves the series of questions outlined above.

Our emotional responses to patients will often be more complex than a single affect; they may become organized into a set of attitudes, or a role or variety of roles that we feel cast in by a patient. Of course, the role of doctor or therapist is one we expect, and usually take for granted. But beyond that, we may feel that our patients respond to us as if we were their parents, siblings, colleagues, friends, lovers, or adversaries. Again, the process of self-reflection can help sort this out.

Example 1

A new patient walks into your office for the first time. He greets you in a friendly and casual manner, calling you by your first name, ''Hey, Joe, how's it going?'' He throws a leg over the side of his chair as he sits down. He proceeds to chat about the trouble he had with the subway on his way to your office.

Here are two potential responses:

You feel a bit taken aback at first, and unsure of yourself. It feels as though you're meeting someone at a party, and are expected to make small talk. Then you feel yourself relax, and you make a joking comment about the subways.

or

You feel a bit taken aback at first, and then you feel irritated. It feels as though you and the patient are in some sort of competition. You think about asking him to put his leg down, and wish that he would refer to you as ''Doctor.''

Example 2

A patient you've been treating in psychotherapy often asks for advice and reassurance. She has difficulty making decisions on her own without a great deal of support and input from you or others. She now is asking you, for the tenth time, whether or not you think she should take the new job she's been offered.

And two responses:

You feel affectionate towards, and protective of, this patient. You are tempted to tell her that she should take the job, and to praise her for having landed such a good opportunity.

or

You feel a mix of warmth and irritation toward this patient. You are exasperated at being asked, yet again, what you think she should do. You feel tempted to tell her to just make up her mind and stop obsessing!

In the first example, the therapist may experience him or herself as cast either in the role of friendly peer or in the role of a competitor. In the second, the therapist may feel cast in the role of a loving and approving parent or in the role of frustrated and impatient parent.

These brief vignettes also illustrate that each therapist has his/her unique response to every patient, determined by his/her own personality, life experiences, and history with the patient. There is no one ''standard'' or correct emotional response to a patient.

Preview – transference and countertransference

In psychodynamic psychotherapy, our patients' reactions to us are often referred to as the **transference** and our reactions to our patients are often referred to as the **countertransference**. Both are central to many of the techniques that we use in conducting this kind of treatment. You will learn much more about this in Chapters 17, 21 and 22. For now, let's move on to two chapters in which you will see the ways in which self-reflection can help the psychodynamic psychotherapist listen empathically and explore unconscious meanings.

Suggested activity

Read the following vignettes and consider the questions at the end:

1. Mr A

You are a trainee on the psychiatric inpatient unit, admitting a new patient. The information you have been given from the emergency room resident is that the patient, Mr A, is a 35-year-old man with a history of bipolar disorder who stopped his mood-stabilizing medication a month ago, and now presents with manic symptoms. You knock on the door of the interview room and say, ''Hello Mr A, I'm Dr Z. I will be working with you here on the unit. I'd like to talk to you now about what brought you to the hospital.'' Mr A is sitting in a chair with his arms crossed, with a faintly contemptuous smile on his face. He looks mildly disheveled. In a scornful tone of voice, he says, ''I don't care who you are, and I'm not interested in talking to you. Do us both a favor and go back to wherever you came from, and let me relax. I'm not planning on staying here for long.''

- How would you describe what Mr A might feel toward Dr Z?
- What are you feeling as you imagine yourself in Dr Z's place?
- What would you say to Mr A?

Comment

Mr A is probably exhibiting symptoms of a manic episode. You don't know exactly what he's feeling, but his response to you suggests that he may be feeling irritable, angry, suspicious, or grandiose. He also might be feeling anxious, frightened, tired, or vulnerable. Whatever his combination of feelings may be, he is directly and indirectly (body language, tone of voice) expressing strong feelings about you. Since you've just met him, these feelings are not based on anything specific or personal about you, but rather on your role and the situation you and he are in. In such a situation, it is important to take your own emotional pulse before proceeding. If you feel frightened or threatened by Mr A, you shouldn't stay alone in a room with him. You might say:

> *If you'd like to rest a while before we meet, that's fine. I'll be at the nurses' station – why don't you come by there a little later? We don't have to talk for more than a few minutes today.*

Even if you don't feel frightened, chances are that you have some kind of emotional response to Mr A. Remember, there is no one ''right'' emotional response to a patient. The range of emotional reactions to him might include anxiety, irritation, frustration (you were hoping to finish your admission before dinner time), excitement (you've never treated a manic patient before, this will be a challenge), or feeling intimidated or insecure. If you feel comfortable enough to continue the interview, you might say something like:

> *I'm sorry that you don't feel like talking now. We will have to meet at some point so that I can learn about you and we can make a plan about your time here in the hospital. Could we spend a few minutes doing that now?*

2. Ms B

You are treating a 28-year-old woman, Ms B, in twice-weekly psychotherapy. She is a teacher at a local head-start program; you and she have used primarily uncovering techniques to help her understand and solve her difficulties. It is now a year into treatment and she is feeling considerably better. You feel that Ms B has a strong therapeutic alliance with you, and that she genuinely likes and trusts you. You like her very much, and feel that the two of you have done good work together. During a session in which Ms B has talked about trying to meet new friends, she says, ''I was at a fun party Saturday night. I met some people who were really great. I'll bet you would have had a good time if you were there. Do you think that if you weren't my therapist and we met at a party, that we would become friends?''

- What might Ms B feel about you at this moment?
- What are you feeling about Ms B?
- What would you say to Ms B?

Comment

Ms B is talking about her positive feelings towards her therapist. These might include fondness, affection, gratitude, respect, and longings for closeness. They might also include loving or erotic feelings. She is also expressing curiosity about her therapist – what is he or she like outside of the therapy setting, what does he or she feel towards her?

As Ms B's therapist, you might have similar feelings of fondness, affection and a wish to be close to her. In addition, you might have feelings of pride in her and in yourself for successful work together. Since this treatment has been predominantly an uncovering one, you would want to continue to uncover the thoughts and feelings Ms B has about you now. You might say to her:

> *You're wondering what I would have felt at that party, and what it would be like to know me outside of this setting. Tell me more about these thoughts and feelings.*

13 Empathic Listening

Key concepts

Empathy is the capacity to recognize and understand another's mental and emotional state. Sometimes we say that it is the ability to ''put oneself in another person's shoes.''

Empathic listening is listening to another person in order to understand how he/she is experiencing him/herself and his/her world.

Paying attention to our emotional responses to our patients is essential to listening empathically.

In psychodynamic psychotherapy, we oscillate between listening from the perspective of the patient and listening from our own perspective in order to best understand our patients.

More than anything else, psychodynamic psychotherapists are listeners. We listen to our patients, and we listen in particular ways. We need to learn not only how to listen, but also how to think about and organize what we hear. We will discuss listening skills more extensively in Chapter 16. But one of the most important aspects of psychodynamic listening is the capacity to use what we hear in order to understand the ways that our patients experience themselves and their world. We call this **empathic listening**, and it is the subject of this chapter.

The ability to understand how another person experiences the world is a powerful ingredient in human emotional connection. Each of us has a unique view of reality, and we can know another's experience only approximately, by using our imagination and also drawing on our own experience. This ability is called **empathy**. How do we learn to listen empathically to our patients?

Learning to be an active listener

Asking questions

As empathic listeners, we have to listen *actively* to our patients in order to really try to get a sense of what they're experiencing. Two important principles to guide this type of listening are ''don't make assumptions about what the patient means'' and ''the devil is in the details.'' Understanding details and nuances can make a big difference. For example, let's say a patient says that she felt ''upset'' after an argument with her mother. We might know what *we* mean by the word upset, but what does *she* mean?

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The word ''upset'' can have many meanings, such as sad, hurt, frustrated, annoyed, or enraged. Questions such as:

You said that you were upset – can you describe what you mean by that?

or

When you got upset, can you tell me exactly what that felt like?

can help both you and the patient understand her experience more deeply and precisely.

Using reflecting statements

Reflecting statements allow for confirmation or revision of mutual understanding. An example might be:

Patient	*So for my birthday my mother got me a cookbook. But she knows that I hate cooking. I was so mad!*
Therapist	*It sounds like you felt that your mother didn't care about what you wanted.*
Patient	*Yes, that's what got me so angry.*

The therapist has heard something and has an idea that she understands her patient's way of viewing the situation, but she uses the reflecting statement to check to make sure that this is what the patient experienced. Reflecting statements often start with words like, ''It sounds like . . . ,'' ''So what I'm hearing is . . . ,'' ''It seems that what you're saying is . . . .'' Sometimes the patient makes a correction that helps our capacity to listen empathically:

Patient	*I was so happy that my sister said that she was coming home for Christmas.*
Therapist	*I guess you'll be glad to see her after all these months.*
Patient	*Maybe, but it really means that I won't have to be with my parents alone.*

Here the reflecting statement helps to clarify the patient's experience so that the therapist has a better idea of the way *the patient* is looking at the situation.

Looking into yourself in order to understand someone else

Aside from making sure that you're as clear as you can possibly be about what your patients are trying to communicate, another way to listen empathically is to use your own reactions to your patients to help understand their experience. You can do this in several different ways.

Putting yourself in your patient's shoes

As you listen to your patients, you may find yourself imagining being in the patient's place. Memories may come to you about similar experiences, situations, or feelings.

You may have the sense that you really ''get it,'' or can relate to what the patient is describing.

Example

Ms A is a 25-year-old student who is talking about her anger and resentment at the unreasonable demands one professor is making on her. Her therapist, Dr Z, is a third-year psychology graduate student. As he listens to Ms A, he finds himself remembering a recent experience he had with his thesis advisor whom he felt was being unreasonable and demanding. He realizes that Ms A's anger feels very familiar to him.

Recognizing the way in which your patient's experience resonates with one of your own can be very helpful. Remember, though, don't assume you know exactly what the patient means just because you're having this kind of empathic response – test it out with a reflecting statement to be sure.

Paying attention to our own feelings

Sometimes we may become aware of feelings in ourselves that relate to the patient's experience, even before the patient becomes aware of his/her own feelings. This is not uncommon in psychodynamic psychotherapy, since many of our patients have unconscious feelings that contribute to their difficulties. Here's an example:

Mr B, a 33-year-old man who is married and has two young children, tells his therapist that in the last week he and his family moved out of their ''starter home'' into a much larger house in a better neighborhood. Mr B gives many details about the move and talks rationally about how this is a sign of progress. While he talks, his therapist notices that she is having a distinctly sad feeling. When Mr B pauses, the therapist says, ''I know that you're excited about this move, but I wonder if you have any other feeling about it.'' Mr B looks around, and then says that although his wife was very keen to move, he actually loved their house and feels wistful about moving. He says that the move also puts more pressure on him financially, which is making him anxious.

Here, the therapist's attention to her own feelings helped her to listen empathically, even though the patient hadn't directly communicated his experience.

Challenges to empathic listening

When the therapist has strong feelings about what the patient is saying

There can be many challenges to maintaining empathy while listening. For example, if patients are talking about something that makes us uncomfortable, it may be more difficult to attend to their point of view. This could be something that fills us with disgust, fear, or sadness. Imagine how challenging it would be for a therapist who had experienced racial discrimination to listen to a patient discuss derogatory

feelings about a particular ethnic group. Or for a female therapist whose heart was just broken by a man she was dating to listen to a male patient talk about his wish to seduce as many women as possible. Since we ask our patients to talk about whatever is on their minds, some of what they tell us may be hard to listen to. If we notice that our capacity to listen empathically is particularly challenged with a given patient, supervision from a peer or mentor can be extremely helpful.

When the patient is describing something with which it is very difficult to empathize

Sometimes, the patient may describe something that you feel you can't empathize with because it's just too different from what you have ever experienced yourself. Your emotional reaction in that case may be one of feeling detached, anxious, bored, or critical. In this situation, being curious about your response can be very helpful. Ask yourself:

- How am I listening to this material?
- Am I listening from the patient's viewpoint?
- What is it that I'm hearing and reacting to – is it triggering something specific in me, or does it feel more like something this person is doing to elicit this response in me?
- What do I imagine others (colleagues, supervisors) in my position might feel in response to what this patient is describing at this moment?

Maybe this patient's experiences, conflicts, and defenses are fundamentally different than your own. Or it could be that what the patient is describing is inherently difficult to relate to, such as a psychotic experience or evidence of antisocial personality traits. Again, asking the patient for clarifying details and summarizing your understanding can help.

Example

Patient	*I was so mad at my boss when I left work I just had to blow off some steam. I walked home, even though it was late. I saw a stone lying on the sidewalk, so I picked it up and just hurled it at the nearest parked car. The window smashed. It felt good.*
Therapist	*It felt good in what way? Can you tell me more about what you were thinking and feeling?*
Patient	*It felt good just to do something really physical, to throw that rock. But as soon as the window smashed, I kind of snapped out of it. I didn't feel angry anymore, just scared and really sorry. I can't believe I broke that car window!*
Therapist	*So throwing the rock felt like a release of tension, but then you realized you'd done something destructive.*
Patient	*Yeah, I guess so.*

or:

Therapist	*It felt good in what way? Can you tell me more what you were thinking and feeling?*
Patient	*I just felt in control. The sound the glass made as it smashed was great. I wasn't at all sorry I did it. If I'd had another rock I would have thrown that too.*
Therapist	*So it felt good to you to do something destructive. You didn't feel any remorse for damaging someone's car.*
Patient	*No remorse. Their insurance will take care of it.*

In these cases, asking questions helped the therapist to understand this potentially hard-to-relate-to experience.

When the patient has strong feelings about the therapist

It can be particularly difficult to stay attuned to our patients' point of view when they are voicing strong feelings about us, such as desire or anger. When this happens, we may be tempted to try to defuse the affect by explaining or defending ourselves rather than staying with the patient's point of view.

Example

In a recent psychotherapy session, Mr C discussed his ambivalence about an elective medical procedure that he was scheduled to have the next day. In recent weeks, he had talked about feeling that the therapist was not truly supportive of his decision to have this procedure, despite the fact that she had spent many sessions trying to help him to make a decision about it. At the end of the session, as he left the office, he said sarcastically, ''You could wish me luck, you know!'' In the session after the procedure, he was furious at the therapist for not having wished him good luck, and told her that she was cold and unempathic.

In a situation like this, a therapist might think, ''He is really overreacting! How can he think I'm cold and unempathic when I spent the whole session seriously listening to him and discussing his feelings! Okay, so I could have said good luck, but just because I didn't doesn't mean I'm not supportive!'' The challenge here is to put aside one's own emotional response in order to stay with the patient's experience. As we will discuss at length later in this book, this does *not* mean that you should *forget* your response, since it is likely to help you to understand the patient and his characteristic ways of relating to other people. Continuing to understand your patient's experience requires you to register your feelings while staying attuned to his perspective. You might, for example, say to him, ''I can see that my not having said good luck to you made you feel that I didn't understand what you needed or wanted.'' Here's another example:

Ms D has a tendency to come 5–10 minutes late for her sessions. One day, she arrives 10 minutes late, and the therapist keeps her waiting for several minutes in the waiting room while he finishes a phone call. As she enters the office she seems annoyed. She starts to talk about feeling irritated at her mother and at her boss. When the therapist comments on her angry affect, she is silent. She

then says she is angry with him for keeping her waiting, and that she felt it wasn't fair for him to retaliate for her lateness by being late himself.

In this example, the patient also accuses the therapist of a lack of empathy, though initially she expresses this non-verbally and indirectly. The therapist may feel a pull to defend himself, thinking, ''This patient is almost always late, and she can't cut me a break for keeping her waiting a few minutes?'' Again, the challenge is to put oneself in the patient's shoes and to try to experience things from the patient's vantage point. One response might be:

I know that you often feel bad about being late and missing part of your session, so it must have been very frustrating to arrive and have me keep you waiting. Let's look more at how it felt to you that I was retaliating.

When the therapist identifies with another person in the patient's life

Another potential barrier to listening from within the patient's perspective happens when we find ourselves listening from the imagined perspective of another character in the patient's story. This is often a person with whom the patient has a relationship, such as a family member, friend, or colleague. Sometimes we also find ourselves listening from the perspective of an outside observer or narrator. You might ask, ''Well, isn't that what we're supposed to do as therapists – to look objectively at what the patient tells us in order to try to uncover hidden meanings, affects, and defenses?'' The answer is yes and no. Ultimately, we are trying to help our patients see what they themselves may not see, by maintaining curiosity not just about everything the patient says, but also about what they don't say. But it's usually most helpful and productive when we don't jump to our own conclusions too quickly. The first step is to try to see and feel things the way the patient does, and to communicate that understanding to the patient.

Example

Ms E is a woman in her thirties who came to therapy complaining of depression and difficulties in interpersonal relationships. She lives alone, has a few social acquaintances, but has no close friends. She has worked at a series of secretarial jobs while trying to launch a career as a singer; the jobs have all ended either when she is fired or when she quits. Ms E complains of feeling chronically lonely and poorly treated by others. She generally describes people as rude, selfish, insensitive, or cruel. She feels she has had terrible luck to repeatedly encounter such unpleasant people, and wonders why she is always the victim. The reason her musical career has never taken off, she feels, is because she doesn't have the ''connections'' needed to break into the music business, which she cites as another example of how unfair the world is. In an early session, Ms E describes an argument she had with a co-worker she had arranged to meet for brunch on a weekend:

''I had asked S if she wanted to get together on Sunday. She said she could meet for brunch at 11, but I told her I like to sleep in on weekends. She made some excuse about being busy all afternoon, some play she already had tickets for. She probably didn't want to get together with me, but she's too passive-aggressive to say so. So I thought I'd call her bluff, and told her, OK, let's go for brunch. I guess she felt she couldn't back out then, so she agreed. We were supposed to meet at noon at this place near the theater she was going to, which was really inconvenient for

me. I woke up late – probably my alarm didn't go off the way it was supposed to. And then the bus never came – even though I was waiting for it for over 30 minutes! I called her and told her I was running late. When I finally got to the restaurant at 12:30, she said, 'Sorry, I already ordered, I don't want to be late to meet my friends at the theater.' Can you believe that? I was so mad, I barely talked to her for the rest of the meal.''

Here's how two different therapists responded:

Therapist #1: Well, I hear that you're quite angry with S. But could it be that you're jumping to conclusions too quickly about her? Maybe she really did want to spend time with you, even though she already had made plans. And how did you feel about being so late? Wouldn't you have been angry if you had been the one waiting?

or:

Therapist #2: So it really felt to you that S wasn't being sincere in agreeing to spend time with you. And it also sounds like you felt you had gone out of your way to agree to meet her at a time and place that wasn't convenient for you. You were frustrated about missing your bus, and then angry to find that she had gone ahead and ordered her food without you.

Therapist #1 listened to Ms E's material from the point of view of S, or from that of an ''objective'' outside observer. The questions he asks are aimed at trying to get Ms E to step *outside* of her own experience, rather than to convey an understanding that is *inside* her own experience. On the contrary, therapist #2 describes what he believes to be Ms E's point of view, without critiquing it. Once the therapeutic alliance with Ms E is strong, she is well into her treatment, and has some capacity to see things from other peoples' perspectives, she may be able to hear a gentle confrontation about her behavior. However, the way Ms E describes the situation, we have good reason to doubt her *current* capacity for self-reflection, or for seeing the situation from S's perspective. Particularly if Ms E is in an early phase of treatment, she may hear therapist #1's comment as unhelpful at best, and as highly critical and unempathic at worst. By helping her to feel understood, therapist #2's intervention can strengthen the therapeutic alliance.

Oscillating between our perspective and the patient's perspective

Ultimately, as psychodynamic psychotherapists, we oscillate between viewing things from the patient's point of view and viewing things from our point of view. We may also spend time viewing things from someone else's point of view – such as a person with whom the patient has a relationship [24, 25]. All of these perspectives are important to our ability to help the patient. However, if we find ourselves spending too much time in one perspective or another, this could signal that we are having difficulty listening empathically. Here are some things you can ask yourself to help you to know when it's time to shift perspectives:

- Am I having a very strong feeling?
  This can mean that you are lodged too tightly in one perspective.

  Example

  When Ms F talked about her anger at her daughter, the therapist became enraged. This helped the therapist to realize that she was having an identification with Ms F's daughter (related to her own relationship with her mother) and that she needed to shift perspectives.

- Am I feeling disconnected from my patient?
  This is another good signal that empathic listening is faltering. Boredom, forgetting things that the patient says, and thinking about other things during the session are clues that this might be happening.

Learning to shift perspectives in order to listen empathically is a little bit like learning to shift focus between something that is close up and something that is far away. With practice, it will become automatic, allowing you always to stay close to your patient's experience.

Suggested activity

Give an example of ''active listening,'' either a clarifying question or a reflective statement, for each of the following. What is your own emotional response to each?

1. Mr A is an elderly widowed man who you are seeing for an initial outpatient evaluation. He says:

   Ever since my wife died last year, the meaning has gone out of life for me. Things won't ever be the same. I often wonder, what's the point?

2. Mr B is a 28-year-old man who first came to see you a month ago, complaining of anxiety and mild depression. He just revealed to you that he is using cocaine multiple times a week, and frequently calling in late or sick to work. In the initial consultation he had denied current drug or alcohol use. He says:

   I guess I should have told you about my using cocaine, but people tend to be so judgmental. My parents think someone's an alcoholic if they have a glass of wine with dinner. I can get it under control if I want to.

3. Ms C is a 40-year-old woman who has come for psychotherapy because of conflicts about returning to work after the birth of her second child. In an early session, she says:

   I feel so torn about this decision. I worked so hard my whole life to get where I am professionally. I never thought I'd want to give up my career, but I also can't stand the thought of being away from the kids so much. It seems so much easier for my husband, he doesn't struggle with this. What do you think I should do?

4. Ms D is a 35-year-old woman with a diagnosis of schizophrenia. She has come to the clinic for a routine medication management visit. She says:

   I stopped taking the pills. They told me to take them, but the other ones said no, don't take them. They're not the same color they used to be, and you can't eat things that are that color, they could be poison.

5. Mr E is a 50-year-old man who was recently diagnosed with coronary artery disease. He comes for a consultation complaining about anxiety and insomnia. He says:

   It's natural that I'm nervous, I guess. My dad dropped dead of a heart attack when he was 55, and now I've got the same disease. I just need to get used to this new low-fat diet they've put me on, and really start exercising. I figured I'd cover all my bases and come see someone about stress management, because stress probably isn't good for my heart.

Comment

1. Mr A is talking about profound feelings of loss and hopelessness. The therapist should respond empathically to these feelings and also inquire about suicidal thoughts. For example:

   Losing your wife has been devastating for you. It sounds like you feel pretty hopeless. Tell me more about what you meant by ''what's the point?'' Do you ever have thoughts about your own death, or about suicide?

2. Mr B appears to minimize his troubles with cocaine and also his withholding of important information from the therapist. Most therapists will have an emotional response to both of these issues. As an initial tactic, reflecting your understanding of Mr B's feelings in a non-judgmental way will probably be most productive (although, as discussed in Chapter 10, if the cocaine use continues the therapist may need to adopt a different stance later). For example:

   It sounds like you were worried that I would react critically if you told me about your cocaine use. How do you feel talking about it now?

3. Ms C is struggling with a difficult conflict, and is inviting the therapist to weigh in with his or her opinion. It's likely that the therapist will *have* an opinion and may feel tempted to answer Ms C's question. An empathic response would reflect the patient's conflicting feelings and her struggle to come to her own decision. For example:

   I can see that you feel very torn about what to do, that it would feel painful either way – to go back to work and miss your children or to stay at home and give up your career. I can't know what the right decision is for you, but I can help you sort through your feelings and choices.

4. Ms D speaks in a confusing way and, given her diagnosis, the therapist should be suspicious of psychosis or auditory hallucinations. The therapist's first job is to try to clarify what the patient is thinking and feeling. For example:

It sounds like you're feeling nervous or scared about your medicine and that's why you stopped it. Could you tell me more specifically who told you what about the pills?

5. Mr E is clearly anxious about his diagnosis and prognosis. He may be seeking reassurance from the therapist, both about his anxiety and about the fact that he came for therapy. Reflecting this back to him and supporting his decision to seek treatment can be reassuring. For example:

   I can see why getting this diagnosis would be very stressful for you, or for anyone in your situation. It's great that you're doing so much to help yourself cope with this, including coming to see me.

14 Looking for Meaning

Key concepts

Beginning to think psychodynamically means starting to think about the unconscious meaning of our patients' words and behaviors.

We can learn about potential meanings of our patients' words and behavior by thinking about:

- the inherent characteristics of what our patients do and say
- ways in which what they do and say are incongruous with the surface affect
- our reactions to what they do and say

Finding potential meanings in a patient's words or behavior does not require us to discuss them with the patient. We use our understanding of whether we think that this will help the patient to guide these choices.

> *Mr A, a 50-year-old man who is very depressed and has never seen a mental health professional, has his first visit with a therapist. During this visit, the therapist asks about Mr A's father and mother. With difficulty, Mr A tells the therapist the story of his father's alcoholism and abusive behavior. At the end of the session, they make an appointment for the next Monday. On the day of the next session, Mr A calls the therapist to tell him that he cannot come in because he is sick. They reschedule for Friday. Mr A arrives 20 minutes late to the rescheduled session, explaining that the train was late.*

Why did Mr A miss his second appointment? Why was Mr A late to the rescheduled session? We can never know and there is never any one reason that explains a given behavior. Perhaps Mr A was sick and the train was late. But perhaps Mr A was ambivalent about returning to the therapist after what sounded like an upsetting session. Could this ambivalence have manifested as missing and lateness? While we can never know, we believe *that all words and behaviors have multiple meanings, some of which are unconscious*. Thus, Mr A's lateness and absenteeism could be related to ambivalence. Maybe Mr A's ambivalence led him to stall at home just long enough that any difficulty with mass transit would lead to lateness – then both explanations would be correct.

Looking for meaning is essential for beginning to think like a psychodynamic psychotherapist

Our patients say and do all sorts of things that can have multiple meanings. Difficult thoughts and feelings that are unconscious are often expressed in actions. Aggressive

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and sexual wishes, which can be particularly difficult to acknowledge, are often revealed in behavior. Here are some examples:

- **Missing sessions and lateness**: Although there are always many reasons why patients miss sessions and are late, patients who do so regularly might be communicating something, such as anxiety about the sessions, ambivalence about the therapy, or the wish to sabotage the treatment.
- **Leaving personal items in the office**: Anyone can forget things, but if a patient leaves something in your office it could mean something else, such as the wish to be remembered or the wish to give you a gift.
- **Eating or drinking in the session**: Patients who routinely eat or drink in the session could be unconsciously communicating something, such as the wish to make the therapy social instead of serious, or the wish to be on more familiar terms with you.
- **Calling you by your first name**: If you address your patient as ''Mr'' or ''Ms'' and introduce yourself in the same way, it's noteworthy if your patient addresses you by your first name. This could, for example, be a manifestation of the patient's wish to deny your role as the therapist or to ''cut you down to size.''
- **Bringing you gifts**: In therapy, even a cup of coffee is a gift. Patients who bring you gifts could be trying to make sure that you won't be critical of them, or could feel that without the gifts you would lose interest.
- **Clothing choices**: As psychodynamic psychotherapists, we think about the meaning of the clothing choices that our patients make when they come to see us. A patient who wears provocative, revealing clothing could be unconsciously communicating his/her erotic feelings toward you; an ordinarily well-groomed person who comes looking disheveled could be telling you that he/she has a wish to be better cared for.

This is by no means an exhaustive list – any behavior can have unconscious meanings. Similarly, the possible meanings suggested above are just that – possibilities. A type of behavior – for example, lateness – does not always mean the same thing. On the contrary, the meanings of each behavior are unique to that patient.

Beginning to listen for meaning

How do we begin to think about unconscious meaning? Here are three important questions you can ask yourself to help you think about unconscious meanings:

- **What are the inherent characteristics of what the patient is saying or doing?** Is something that your patient says or does inherently aggressive? Entitled? Loving? Even if a behavior seems innocuous, is there something about it that could be construed another way? Let's say that your patient slams the door loudly behind him/her every time that he/she comes into the office. Slamming a door is an inherently aggressive act. Could there be some way in which aggression toward you is part of what he/she is trying to communicate? Looking at the behavior itself can sometimes give you some clues regarding its unconscious meaning.

- **How do we feel about the words or behavior?** It's also important to register how you feel about the behavior. When Ms A misses a session, you feel very little, but when Mr B misses a session you feel neglected. What might that tell you about the unconscious meaning behind Mr B's absenteeism? Your own feelings can often be the best clues to unconscious meaning.
- **Is what the patient is saying or doing incongruous?** If something that the patient says or does is incongruous with his/her conscious experience, you can surmise that it may have unconscious meaning. For example, if a patient says that he/she ''loves'' psychotherapy but he/she either misses a lot of sessions or doesn't pay on time, you can hypothesize that the lateness and non-payment is imbued with unconscious meaning.

Should we talk about unconscious meanings with our patients?

Just because we suspect that a given behavior might have an unconscious meaning does not necessarily require us to discuss this with the patient. We often wait until we have observed the behavior many times before we bring it to the patient's attention. With more fragile patients, our hunches about unconscious meaning may guide our supporting interventions, but we may rarely, if ever, overtly discuss them with the patient. Here are two contrasting examples:

Ms B, a 42-year-old married mother of three who is a third-grade teacher, has been in a twice per week psychodynamic psychotherapy with a female therapist for two years. In this treatment, Ms B's discussions about her relationship with the therapist have helped her to better understand her relationships with women in general. Initially, Ms B idealized the therapist and felt that she could never attain her level of success but as Ms B gained confidence she began to explore the possibility that she, too, could feel that good about herself. One day, Ms B came into her session and told the therapist that she was very sorry but that she had spilled coffee on the therapist's new waiting room rug. The therapist suspected that despite her idealization, Ms B might harbor envious, aggressive feelings toward the therapist and that this accidental spill might be related to them. She asked Ms B if she had any thoughts about having spilled the coffee. Ms B said that although she felt bad, she was secretly glad that the therapist now had a stain on her rug just like the stain on her own living room rug. As they continued to discuss this, Ms B was able to begin to explore her envious feelings toward the therapist and her feelings about spoiling the therapist's beautiful office.

Mr C is a 53-year-old physical therapist who has frequent difficulties with aggression that have gotten him into trouble with co-workers. He sought treatment for depression and has been in a once per week psychotherapy with a male therapist for six months. In therapy, he has been working productively on alternate ways of handling himself when he gets angry at work. He has made some comments about the therapist's office and ''all the money he must have,'' but has been unable to discuss this further when prompted by the therapist. One day, Mr B came into his session and told the therapist that he was very sorry that he had spilled coffee on the therapist's new waiting room rug. The therapist noted to himself that this behavior could have aggressive meaning relating to the patient's envy of the therapist but, thinking that the patient could not use this material productively at this time, chose to reassure the patient about the spill and to continue to ask him

about how things had gone at work that week. Two weeks later, the patient remarked on how ''cool'' the therapist had been about the spill and that was in such contrast to the angry outbursts his own father would have had about a similar episode.

In each vignette, the therapist noted the behavior and hypothesized about possible underlying meanings. However, in the first case the therapist felt that the patient could benefit from exploration of potential unconscious meanings, while in the second the therapist felt that this would not be productive. It is interesting to note, however, that the choice not to uncover underlying meanings does not preclude eventual exploration of unconscious material – in fact it often facilitates it down the road.

In the technique section of this manual, we will further discuss how to listen for these behaviors and meanings and then how to use them to either help your patients to make these unconscious meanings conscious or to help support weakened functioning.

Suggested activity

Think about possible unconscious meanings of Ms A's words and behaviors:

Ms A is a 50-year-old woman who presents for psychotherapy because she is having difficulty with her family. She explains that after her father's death three years ago on Thanksgiving, her mother has ''pulled away'' from her and seems to spend time only with her two sisters and their families. She is upset and hurt but denies feeling angry. She says that her husband is ''relieved'' because he ''never liked my family anyway.'' Her two children are now out of the house and she feels ''isolated.'' She called for an appointment a month ago and cancelled, then called again on November 15 but ''wasn't sure why.'' She arrives 15 minutes late, apologizes profusely but becomes withdrawn as the session nears an end. She makes another appointment that she cancels but reschedules. Before her next session, she calls and leaves a message in which she is in tears. At her next session, she says that she is fine and that the message was just a ''blip.'' She says that she's not sure that she needs therapy and makes a negative comment about having to wait in a waiting area with other patients.

Comment

It seems likely that Ms A's canceling and lateness have unconscious meanings. She may be ambivalent about beginning therapy or about talking about these painful family circumstances. She may be ashamed of her show of emotion on the telephone. She may be worried about becoming dependent on a therapist, since she feels that she cannot depend on her mother or her husband. She may also be revealing some ways in which she unconsciously pushes people away, despite her conscious feeling that other people (namely, her mother and her husband) are the ones rejecting her. Finally, calling again in November may indicate that she is having an anniversary reaction to her father's death without being aware of it, and that she has an unconscious wish for more support during this time.

15 Medication and Therapy

Key concepts

In our work as psychodynamic psychotherapists, we shift between different models of etiology and therapeutic action in assessing and treating our patients. One example of this is our need to think about whether medication or psychotherapy will best address a patient's problems and symptoms at any point in time.

The prescribing and taking of medication has psychological meaning for both patient and therapist.

When a patient in psychodynamic psychotherapy is also taking psychotropic medication, sometimes the therapist will be the prescriber and sometimes there will be a separate pharmacologist. Each of these situations has different clinical implications.

The patients who come to us for treatment generally will not arrive asking specifically for medication versus psychotherapy. They will come complaining of a problem (or set of problems), of symptoms, and of difficulties in their lives. They may already be taking medication for these problems or symptoms, or may have taken medication in the past. Some patients will have strong opinions about medication, while others may not have given it much thought.

As psychodynamic psychotherapists, our listening is empathic and non-judgmental and involves asking open-ended questions, looking for hidden meaning, and helping patients to feel safe. However, we have to simultaneously listen as mental health professionals, which involves listening for medical and psychiatric symptoms and syndromes, side effects, and therapeutic effects. We also have to be able to shift gears in order to be more active when needed, to take the lead, to ask specific questions, and to give recommendations or advice about medication [26].

Using psychodynamic and phenomenological models simultaneously

The DSM takes a descriptive or phenomenological approach to psychiatric disorders, without reference to etiology. As psychodynamic psychotherapists, we have to learn to use both psychodynamic and phenomenological models of etiology and treatment simultaneously. Here's an example of how a psychodynamic psychotherapist might do this:

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Ms A, a 65-year-old widow with a history of recurrent depression, is in weekly psychotherapy for long-standing difficulties with self-esteem, as well as conflicts about intimacy in a new romantic relationship. She has been on several different antidepressants in the past. Six weeks ago, she and her therapist decided to add a selective serotonin reuptake inhibitor (SSRI) antidepressant to the bupropion she was taking, as she had complained of feeling mildly depressed and persistently anxious for over a month. In the first session after a three-week interruption in therapy due to vacation (hers and the therapist's), she described feeling emotionally ''flat'' and lacking in energy and motivation. She remarked that it was the second anniversary of her husband's death two weeks ago, and that she spent much of her vacation with her children and grandchildren, as well as with her new partner. She said that she did not feel ''fully present'' for much of the vacation, and was less able to enjoy her time with her family. She had a bit more trouble sleeping than usual. However, she felt less anxious than before starting the SSRI.

As we think about Ms A's story, we can approach it from different perspectives:

- **Thinking psychodynamically,** the salient features are:
  - the anniversary of her husband's death
  - the time spent with her children, grandchildren, and her new partner, and
  - the recent interruption in the therapy.
- **Thinking phenomenologically,** we hear symptoms, including:
  - mild anhedonia or affective blunting
  - decreased energy and motivation, and
  - insomnia.

What is the etiology of these symptoms? Here are some possibilities:

- Did the anniversary of her husband's death reactivate feelings of grief? Is this grief now complicated by conflict over being with a new romantic partner? Could her symptoms be related to trying to integrate her new partner into her relationships with her children and grandchildren?
- Is this a recurrence of a major depression, despite the fact that she is taking antidepressant medication?
- Has the addition of a new medication caused new side effects, such as insomnia, affective blunting, and decreased energy?

Choosing an approach

While it's interesting to think about these possibilities, we have to be agnostic about the fact that we can't really *know* what is *causing* Ms A's problems at this time. The challenge for the clinician is to decide which approach, or combination of approaches, will best serve the patient *at any one time*.

Here are some questions to ask yourself when you are making this kind of decision:

- How do I view the clinical picture psychodynamically?
- How do I view the clinical picture phenomenologically?

- Is my current way of looking at the current clinical situation leading me to use therapeutic interventions that are effective?
- If my interventions are less than effective, is there another way of looking at the current picture that might lead to more effective interventions?
- Does the patient present a constellation of symptoms that may be effectively treated with medication?
- Can the patient's symptoms be more fully understood and more effectively treated using a psychodynamic model?
- Which therapeutic interventions (psychodynamic or pharmacological) have been effective in the past, and for which symptoms?
- Is there currently a shift in my thinking about which model – psychodynamic or phenomenological – should guide my therapeutic interventions right now?
- If there is a shift, could it be influenced by something happening in the relationship between the patient and me (such as an interruption in the treatment or change in the frame), or a strong feeling that the patient is having about me or that I am having about the patient?

Adapted from Cabaniss [27].

In the case of Ms A, the therapist might start with asking her some open-ended questions about the recent events, and about her feelings about the anniversary of her husband's death as well as about the break in the therapy. As the patient talks, the therapist will listen empathically, while staying alert to specifics such as symptoms, severity, and timing. The therapist may shift from the mode of empathic listening to one of more active questioning to get more information. Here are some questions that are designed to get the details:

> *You've been talking about feeling emotionally ''flat.'' When did you become aware of this feeling?*
>
> *How frequent are these feelings? Do you have them all the time?*
>
> *How troubling are they?*
>
> *Are these feelings that you've had in the past during a depression?*
>
> *Are you having any other symptoms?*

Becoming comfortable with uncertainty

In some clinical situations, a therapist may feel fairly confident about which model provides the best framework for assessing and treating a patient's problem. In others, the challenge is to become comfortable with uncertainty, and to be able to discuss this with the patient. For example, a therapist might say to Ms A:

> *It seems that you've been experiencing a number of symptoms of depression in the last few weeks. Some of these are similar to the symptoms you've had in the past when you've been depressed. You've had some psychological stresses recently that could be contributing to this – the*

anniversary of your husband's death, spending time together with your partner and your family, and not seeing me during this time. But another possibility is that the new medication is causing some side effects that mimic your depressive symptoms. Let's make a plan to see if we can sort this out and help you to feel better.

Even if you choose to work with one model at one point in the treatment, you should be able to shift flexibly to another model at another point.

The meanings of medication

The prescribing and taking of psychiatric medication has psychological meaning for both patient and therapist [28, 29]. Depending on their level of ego function and characteristic defenses, patients may react in various ways to their therapists' recommendation for medication. Following is a list of some common reactions:

- **''It's a biological problem:''** The recommendation for medication may mean to a patient that there is something ''biological'' at play. This can feel like a relief or a validation. Patients may interpret this to mean that the symptoms are not their ''fault'' but are a result of something beyond their control. Common ideas are that the problem is caused by a ''chemical imbalance'' or that ''it's not me, it's my brain'' that is causing the problem.
- **Medication can feel like a blow to the ego:** Some patients experience the recommendation for medication as a blow to their self-esteem. It may feel as if they are being told that there is something defective about them, and this can be a source of embarrassment or shame.
- **Medication as gift:** The therapist's recommendation of medication can be experienced as a gift or as a ''special'' form of being taken care of.
- **Medication as mind control:** The therapist's suggestion of medication can be experienced as intrusive or controlling, as if the therapist is, via medicine, invading or controlling the patient's mind and body.
- **''I guess I failed therapy:''** For a patient in psychotherapy, the recommendation for medication can be experienced as a ''giving up on'' the therapy, by therapist, patient, or both. It may seem like an acknowledgment that therapy doesn't work for this particular person, or that the therapist can't help him/her.

Similarly, for the therapist, the decision to discuss or recommend medication with the patient can have a variety of meanings. Here are some examples:

- **''I failed as a therapist:''** A decision to suggest medication may feel like a failure to the therapist, or that he/she wasn't able to ''cure'' the patient with therapy alone.
- **Medication as relief:** Alternately, the therapist may feel relieved, or powerful, to have the ability to offer the patient relief from symptoms or suffering.
- **Medication as enactment of feelings about the patient:** The decision to recommend medication may reflect a shift in how the therapist is feeling about the patient, the treatment, or his/her own abilities or skills.

- **Medication as gratification of needs:** The prescribing of medication may feel to therapists that they are ''gratifying'' their patients by giving them something special to help them feel better.
- **Medication as shift to a medical model:** Shifting gears from a psychodynamic to a phenomenological model with a patient may make the therapist feel ''more medical,'' and thus alter the relationship with the patient in subtle or not-so-subtle ways.

These lists are not exhaustive; the particular set of meanings about medication will be complex and unique to each therapist/patient pair. The goal is to be able to shift back and forth between medical ''fact-finding'' and advice-giving, and psychodynamic exploration of the patient's and therapist's thought and feelings. Consider this example:

Ms B is a 35-year-old woman who came for psychotherapy during her divorce from her first husband. She initially complained of significant anxiety symptoms and trouble sleeping, but declined the therapist's suggestion that she consider anxiolytic medication. Over the first month of therapy, the focus was on Ms B's history of difficulty with intimacy, and mistrust of situations in which she felt overly dependent on others. Yet, she seemed to struggle with severe anxiety, verging on panic, when she felt isolated and overwhelmed by demands, as she did now, managing the stress of a full-time job, parenting two young children, and going through a divorce. Her therapist had begun to point out the conflict Ms B felt about relying on others versus doing it ''all by herself'' and the anxiety she felt in either situation. Though Ms B reported feeling somewhat less anxious soon after beginning therapy, she continued to complain intermittently about symptoms. During one session, she described feeling exhausted, having been unable to sleep the night before because of worry:

Therapist *I'm sorry that you had such a rough night. We've been talking a lot about how hard it is for you to rely on others or ask for help. When I suggested that we consider medication, during the first consultation, you said that you didn't want to take anything. Let's reconsider that now, in the context of this struggle about feeling dependent. Can you tell me more what it would mean if you were to take medication for anxiety?*

Patient *I don't want to have to rely on a pill to feel better. I should be able to manage this on my own, or with your help. It's not like I have a mental illness where I would need to take something. It's understandable that I feel stressed, given what I'm going through.*

Therapist *So if you were to take medication, it might mean that you've failed in some important way, failed to take care of yourself, failed to handle the stress in your life. It also might mean that I've failed to help you in the way you'd like to be helped, through talk therapy. Or it might mean that there's something more seriously wrong with you, a mental illness.*

Patient *Yes, I guess that's how I feel. When you put it that way, it also seems kind of extreme, that I wouldn't consider something that would help me feel better in the short term. But isn't there a danger that I might get addicted to the medicine?*

Therapist *Well, ''addiction'' is a word that's used in a number of ways. You don't have a history of problems with substance abuse, and the medicine I have in mind is not likely to*

lead to you becoming physically dependent on it. But tell me what you mean by the word ''addicted.''

Patient *I guess I'm afraid that if I do feel better on the medicine, I'll never want to stop taking it. Or if I do stop it, what if I go right back to feeling miserable? I don't want to feel so reliant on something.*

Therapist *That sounds a lot like what you've said about relying on other people.*

In this example, the therapist's focus is on uncovering the meaning behind Ms B's attitude towards medication. However, she also answers Ms B's question about addiction directly and provides some information about the medicine, before returning to further exploration.

Combined versus split treatment

When a patient in psychodynamic psychotherapy is also on psychotropic medication, sometimes the therapist will be the prescriber (**combined treatment**) and sometimes there will be a separate psychopharmacologist (**split treatment**). A separate psychopharmacologist may be involved either:

- because the therapist is not a psychiatrist, or
- because the therapist has determined that it would be preferable for a separate pharmacologist to prescribe the medication. This may occur when a specialist is needed, or when the logistics of the medication management take up a significant proportion of time in the therapy.

Each configuration has its own set of clinical issues.

Combined treatment

The challenge of combined treatment is for the therapist/pharmacologist to balance discussion of both therapeutic modalities during sessions. Patient and therapist sometimes collude to avoid discussion of the medication as if it were a less important part of the treatment. On the contrary, much can be learned from the patient's reaction to the medication:

Example

Mr B is a 56-year-old man who presents after a divorce. He is being treated by Dr Y, a 40-year-old female therapist who is also a psychiatrist. At presentation Mr B had clear symptoms of major depression, and Dr Y prescribed an antidepressant. The symptoms cleared within six weeks, and Dr Y no longer asked about the medication. Within a few months, Mr B began to date, although he showed no interest in having a physical relationship. Dr Y asked Mr B about this, particularly as it might relate to anger at his ex-wife. When Mr B mentioned having gone to a urologist to investigate new-onset erectile dysfunction, Dr Y realized that she had neglected to ask follow-up questions about Mr B's sexual function as it related to potential side effects. She wondered whether she and the patient were avoiding discussing this because of a growing erotic transference.

Prescribing medication can also impact the way a therapist conducts sessions. For example, the therapist/pharmacologist may need to be more directive, give advice, or make recommendations. Here are some examples:

> *Although you feel that your depressed mood is understandable given the circumstances of your life right now, the symptoms you're experiencing have been going on for several weeks and are causing you quite a lot of distress. There's a good chance that medication could help you to feel better fairly quickly.*
>
> *Now that we've agreed that medication is likely to help, and you want to give it a try, let me explain the different medication options and the pros and cons of each.*
>
> *I've given you a lot of information just now. Do you have questions?*

Prescribing medication may also require the therapist to direct the patient's attention to specific details, such as symptoms, side effects, therapeutic effects, dosage adjustments, and prescription refills. Points at which this is particularly important include:

- when the topic of medication is first introduced
- when the first prescription is written
- the first session after the prescription has been written
- when a therapeutic benefit is first noted or reported, and
- whenever a dose is changed, prescription is refilled, or medication regimen is altered

The therapist may choose to start a session with questions about symptoms or medication, or may wait to see if the patient brings this up. Sometimes, as in the following example, the therapist/pharmacologist may relegate discussion of medication to the margins of the therapeutic encounter:

> *Therapist: Our time is up for today. By the way, do you need a refill of your antidepressant?*

This precludes ample discussion of any practical or psychodynamic issues related to the medication, and may signal to the patient that the therapist is not particularly interested in this. Instead, the therapist/pharmacologist should be constantly aware of the issue of medication and the way it could be impacting the treatment, even when it is not a focus of the session.

Split treatment

Split treatment has its own challenges. The patient is now talking about his/her symptoms to two people. This requires the therapist and psychopharmacologist to closely collaborate in order to share information. Sometimes, patients will only talk about certain issues with one or the other professional – close communication is required in order to maximize care in this situation. Again, there is always something to be learned from the way in which the patient reacts to this situation.

Example

Ms C is a 25-year-old woman who is in therapy with Dr X, a 35-year-old female psychologist. She also sees a 55-year-old male psychopharmacologist, who prescribes the medication. She begins to have symptoms of depression, which she only discusses with the psychopharmacologist. He calls Dr X and tells her about this. In their next session, Dr X mentions this to the patient. They ultimately learn that Ms C's competitive feelings led her to hide her perceived ''weakness'' from Dr X. Discussion of this opens a new avenue of exploration.

Whether or not you will be both therapist and psychopharmacologist, it is important for you to learn to use both phenomenologic/pharmacologic and psychodynamic models in order to provide optimal, individualized treatments of each of your patients.

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PART FOUR: Listen/Reflect/ Intervene

Introduction

Key concepts

The basic technique of psychodynamic psychotherapy can be divided into three steps:

- listening
- reflecting
- intervening

Although we don't usually think about it, talking to another person involves a three-step process. We listen to what the other person has to say, we process what we've heard, and we respond. Ideally, in a social relationship, people listen and respond to each other in a fairly balanced way. But the therapeutic relationship, unlike most social relationships, is lopsided. Consequently, the set-up in a psychodynamic psychotherapy is that the focus is exclusively on the problems brought by the patient. Although the patient listens to the therapist, what the therapist has to say is generally about the patient, rather than about him/herself. Thus, therapists must train themselves to listen and respond in a new way.

In this manual, we will teach you the basic techniques of psychodynamic psychotherapy using three basic steps:

- listening
- reflecting
- intervening

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Listening is the step in which we bring in data, reflecting is the step in which we process that data and decide when and how to intervene, and intervening is the step in which we verbally interact with the patient in order to uncover unconscious material or support weakened ego function. We will first review each of these steps, and we will then apply them to the major elements that we listen for in psychodynamic psychotherapy.

16 Learning to Listen

Key concepts

We listen differently depending on what we're listening to.

We can conceptualize three modes of listening:

1. ambient listening
2. filtered listening
3. focused listening

As psychodynamic psychotherapists, we learn to move fluidly among these modes of listening while we listen to patients.

There are particular types of things that we learn to listen for in psychodynamic psychotherapy.

Listening to a patient means listening to sounds *and* silences.

While we listen to words, we also listen for the tone, pitch, volume, and timbre of a person's voice and ways in which these change. These can help us to understand the patient's affect and unconscious material.

Listening is the first step of the three-step technique of psychodynamic psychotherapy

Although we have listened to things throughout our lives, as psychodynamic psychotherapists we listen to our patients in particular ways. First we will address *how* we listen, and then we'll think about *what* we specifically listen to and for.

How do we listen?

Listening is not a homogeneous activity. We listen differently depending on what we're listening to. Think about the ways you listen to these different things:

- the woods
- a symphony orchestra
- street noises
- people talking in a cafeteria

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- a poetry reading
- someone speaking in a foreign language
- your friend talking to you on the phone
- an instructional video on how to set up your computer

As an example, click on the ''listening exercise'' found at *www.wiley.com/go/cabaniss/psychotherapy*.

After you've listened to it once, listen to it again, listening only for the background noise. Sounds different, doesn't it?

Now listen again, listening only for the birdcalls. What happens to your listening this time? Do you find that you're ignoring many of the other sounds as you wait to hear the birds?

Types of listening

What you've been doing is listening in different ways. You need to listen in many ways when you listen to a patient in psychodynamic psychotherapy. Here is a way to conceptualize the modes of listening that you've been doing:

1. **Ambient listening** – Ambient listening is the kind of listening you do when you're not listening for anything in particular. It's allowing sound to wash over you – like listening to all of the sounds in a forest, to surf crashing on the beach, or to street noises. Imagine walking into a cocktail party – lots of people are talking but all you hear at first is the din. When you think about it, it's hard to listen without focusing on anything in particular. In fact, we have to train ourselves to listen in this way when we're listening to patients because we have to remain open to everything that the patient says. If we're too interested or focused on one thing or another, we can miss important things that the patient says or doesn't say. This is particularly hard to do as trainees, when we're trying so hard to learn about things like transference that trying *not* to listen for them is very difficult. Ambient listening is important at many different times in a session, but it is almost always crucial at the beginning, when you never know what the important themes of the session are going to be.
2. **Filtered listening** – Continuing with our party analogy, once you're in the party room you begin to filter out the background noise as you start to pick out particular voices. Maybe you hear someone you know, or maybe you hear part of a conversation that interests you. The same thing happens when we listen to patients. As the patient speaks, we begin to hear certain things that stand out from the background material, for example repeated themes or strong affects. Although our attention is not yet focused on any one particular thing, we begin to screen out some ambient material as we start to hone in on what seems most important.
3. **Focused listening** – Our listening is focused when we fix our attention on something in particular and screen out most of the background noise. At the cocktail party, you've heard a voice you know and you now turn your attention to that person to have a conversation. Although the room is still loud, you begin to listen

only to the person with whom you are talking. This is focused listening – listening to one thing in particular and blocking out most of the background noise. We use focused listening with patients when we pick up an important theme or affect and begin to concentrate on it to the exclusion of other material.

Although ambient listening is particularly important at the beginning of the session, it is essential to be able to move fluidly from one mode of listening to another throughout a psychotherapy session. Even when focusing on a prominent theme or affect, we have to enable ourselves to disengage from the focus to listen ambiently again. In visual terms, this task is akin to the movie director on her chair, moving in and out of the close up. This is an analogy that will take us through many aspects of the technique of psychodynamic psychotherapy, as we take in the big picture and then focus in and out on particulars.

What we listen for

Silence

When we think about listening, we generally think about listening for sounds. But if we're listening closely, we also listen for the lack of sounds – for *silence*. We listen for when sound stops and starts, for the rhythm of the stops and starts and for how this changes – on a moment to moment basis, on a session to session basis, and across the broad trajectory of a whole treatment. If you really listen to silence, you begin to realize that it sounds different at different times. Silence can sound peaceful, furtive, or tense – once you begin to listen to silence you can begin to hear the differences.

Beyond words

We listen for words, of course, but we also listen for the *pace*, *volume*, *pitch*, and *timbre* (particular color or sound quality) of the person's voice – and how these change. These aspects of the patient's communication can often tell us as much or more about the meaning of the patient's words as the words themselves can. They are often good clues to the patient's affect, defenses, and resistances – and missing them deprives us of valuable information about his/her conscious and unconscious thoughts and feelings. Non-verbal communications are important too, such as facial expressions, eye contact, or the way someone shifts in a chair.

Patterns

We determine which themes and affects are dominant by listening for **patterns and repetitive elements**. If we hear the same thing several times in a session, or in a series of sessions, we hypothesize that it's important. Similarly, we listen for **incongruities and slips** – words, sounds, and affects that jar our listening. Think about listening to a melody – we have certain expectations about what the

next note might be and if it's very different than we expected, our ears perk up because it sounds jarring. The same is true of incongruities and breaks in patterns. For example, a patient might talk about something that sounds like it was frightening and then say that it was fun, or a patient might be talking about one person and then it suddenly sounds like they're talking about another person. We want to be tuned in to these shifts and incongruities. Slips are formally called **parapraxes** – they occur when someone means to say one thing and instead says something else [1].

Example

Last night I was talking on the phone to my mother – oops! I mean my wife.

These can be good clues that something is going on in the unconscious, so they're important to listen for.

Negation and double negatives

Listening for the way that patients say ''no'' can be very informative. One patient might say, ''I don't think I'll go to the party,'' while another says, ''There's absolutely no way I would take myself to that party – forget it.'' The affective power behind the second comes through loud and clear. Similarly, listen for the elusive ''double negative'' – consider these statements:

I'm going to go to law school.

I'm not not going to go to law school.

They both say the same thing – but why does the second person use two negatives to indicate the affirmative? There could be meaning in the paradoxical use of the double negative.

Passive voice

People often use the passive voice when they are unconsciously distancing themselves from their own choices and actions. Listen to the difference between these two statements:

On Friday night, decisions were made about the way our relationship will move forward.

I broke up with Suzy on Friday night.

Believe it or not, these two sentences could be about the same event. Listening to a patient's use of the passive voice can help us to understand the patient's sense of personal agency.

Nodal points

We can think of the unconscious as being a giant nodal network with points that are connected. Some points have more connections than other points. Think of a road map of California. Visualize San Diego, Los Angeles, and San Francisco – these cities have their names written in large bold letters and have many roads emanating from them, indicating that they are connected to many other points by major arteries. On the contrary, small towns are written in small letters and might have a single, thready line through them, indicating the one county highway that connects them to the rest of the world. Another kind of map that shows this well is the airline map that indicates its hubs – think of the Delta Airlines map and the lines emanating from Atlanta, compared with the lines emanating from Fargo. When we listen, we listen to everything, but as we begin to filter and focus we are listening for unconscious hubs that we can call **nodal points** [2]. It makes sense to aim for these well-connected points, as they can lead us down new paths into uncharted unconscious territory. It is also likely that these points will be near the surface of consciousness, since we are hearing many references to them. The technique for listening to nodal points involves listening for the following:

- repeated words
- repeated symbols
- points of clarity

These often signal the presence of nodal points.

Important content to listen for

Here are some of the things that we particularly listen for in psychodynamic psychotherapy. These all will be discussed in depth in Part Five of this manual:

- affects
- free association/resistance
- transference
- defenses
- unconscious fantasies and conflicts
- dreams

We all listen in different ways

Some of us have been trained to be listeners in other parts of our lives, for example when learning music, languages, or birdcalls. Some people are very adept at picking

up accents, while others have perfect pitch; some are more aware of ambient noise, while others focus on specific sounds. Part of learning to listen to patients means learning to understand our listening styles. You can begin to think about how you listen and what you tend to listen for. This will help you to understand yourself as a listener of patients and to think about listening skills that you might need to hone.

Once we've listened carefully to our patients, we have to decide how to use what we've heard to best help the patient. This process is called **reflecting** and is the topic of the next chapter.

Suggested activity

Read the following monologue. What do you hear as you listen ambiently?

> *I was really excited to come today. I've been looking forward to starting therapy. It's been on my calendar – I even circled it. I know that sounds silly – like it was my birthday or something. And I read a book about starting therapy. I've never been in therapy before. What do I do? I wanted to know what to do – you see people in the movies talking about really important things – I guess I could talk about my mother but I feel like I have silly things to talk about – like being irritated at my wife a lot – I mean, I love her but she drives me crazy. But that's not a very big thing – people have really bad problems. Maybe my problems aren't important enough – I don't mean important, but severe – something like that. But they're upsetting me . . . how much time do we have today? Anyway – what was I saying? Speaking of my family – they always thought that therapy was a waste of time. I don't think so but I don't really know. I hope that it can help. Do you think it can?*

Now read the monologue again. What do you begin to focus on?

Comment

1. **Ambient listening** – The patient talks continuously without pausing. He seems generally anxious. There are lots of questions and there is a shift in topic near the end.
2. **Filtered/focused listening** – The patient oscillates between questions for the therapist and thoughts about his family. He seems to make a connection between his wife and his mother. He seems insecure and eager to be a good patient. He is worried that the therapist will find him silly and his problems insignificant. Some of his words are strikingly childlike – like ''silly'' which he repeats many times. The focus on his birthday also has a childlike ring to it. He sounds conflicted about many things, including his feelings about his wife, his family, and whether the treatment will help.

17 Learning to Reflect

Key concepts

Once we listen to the patient's sounds and silences, we process this data in order to understand its meanings. We call this multi-layered process ''reflecting.'' Reflecting helps us decide how to focus our listening and how and when to intervene.

Whether we are uncovering or supporting, we want to comment on material that is closest to the patient's conscious mind and that he/she will be able to listen to and use productively at that moment.

To understand what is closest to the patient's conscious mind, we use what we call the ''three choosing principles:''

1. surface to depth
2. follow the affect
3. attend to the countertransference

To understand the patient's current ability to listen to/use what we have to say, we use what we call the ''three readiness principles:''

1. assess the state of the therapeutic alliance
2. assess the phase of the treatment
3. assess the current ego function

We also cautiously use the following information to help us to know what is happening in the patient's mind and in the therapeutic relationship:

1. historical information that we know about the patient
2. our own clinical experience
3. our knowledge of theory and technique

Reflecting may be conscious when we are learning to conduct psychotherapy but rapidly becomes procedural.

Reflecting

When we listen to patients, data streams into our minds. The next step is to process this data in order to:

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- understand its meaning, and
- decide how and when to intervene

We can call this process ''reflecting.'' Reflecting is the second step in the three-step technique of psychodynamic psychotherapy.

Let's think about the word **reflect**. When used as a noun (reflection), it sounds passive (like a reflection in a mirror) but when used as a verb (reflect, reflecting) it's full of activity. It comes from the Latin *reflectere*, which is a compound of *re*, which means *back*, and *flectere*, which means *to bend*; so to reflect means to bend or to throw back, for example light, heat, or sound.

So data comes in and we do something active with it. What we do with it depends on what our therapeutic goals are. In psychodynamic psychotherapy, we're always trying to think about what's in the unconscious, so we always reflect on how what we hear can help us to understand what's beneath the surface. Then we can think about how we can use what we've heard to begin to either uncover the unconscious material or to support weakened function.

Now, let's go back to our therapeutic aims. Because our overarching psychodynamic principle is that there are unconscious elements that affect conscious thoughts, feelings, and behavior, our principle technical aim has to be getting to unconscious material. This can be affects, thoughts, defenses, fantasies, and representations of self and others – all of which are unconscious. The material we hear – words, silences, tone – is all we have to help guide us toward material that is below the surface. These are the clues that we have in lieu of an actual map. If we think of each time we listen, reflect, and intervene as a unit, then the goal of each unit can be thought of as moving us a little closer to the uncharted territory of the unconscious.

Exactly how the reflecting process occurs will be different for each person. It's impossible to make it into a linear, cookbook-style process. However, we can think about the data as coming in and being processed through an information matrix, or being sifted or sorted according to principles that help us to best use the data to achieve our therapeutic aims. In essence, while we're listening to *everything*, we're picking the material that is most likely to move us forward *at that point*. It's about how we make choices – how we focus our listening and ultimately our interventions on the most salient, meaningful, useful, and usable material. Our interventions will be linked to these elements. We base these choices on two basic sets of principles that we call the ''three choosing principles'' and the ''three readiness principles.''

The three choosing principles

The three choosing principles are:

1. surface to depth
2. follow the affect
3. attend to the countertransference

We use the three choosing principles to decide where to intervene and which material will be most productive to address.

Surface to depth

The unconscious is not homogeneous. Some thoughts and affects are more deeply buried than others [3]. The hypothesis is that the more anxiety-provoking the thought or affect, the more deeply buried it has to be in order to reduce the likelihood of it coming into awareness. You can think of the unconscious as a stratified paleontological site, with bones fossilized in different geologic layers. If you're interested in the bones at the bottom, you can't go in with a bulldozer to get them; rather, paleontologists painstakingly brush dust off fossils with toothbrushes, gradually revealing layer after layer. In this way, all the bones are uncovered with minimal damage. They will ultimately get to the bottom – but it will take time.

The same is true for the psychodynamic psychotherapist. If you comment about something that is deeply out of awareness, it is likely that the person will reject the comment, or worse, erect more defenses to keep it out of awareness. Sometimes, we understand something about someone's mind that is deeply buried. While this can be interesting and can help us with our case formulation, it may be very hard – or even counterproductive – to address this until it is closer to consciousness. This flies in the face of many stereotypes of psychotherapy in which the therapist listens, discovers something deeply buried from the patient's childhood, tells the patient, the patient says ''a-ha!'' and is cured. In reality, we want to find the thought or affect that is just below the surface – that one that only needs a gentle tap to shift into consciousness [4]. So when we're sifting through what the patient says, we want to get some ideas of how his/her thoughts and affects range from surface to depth. Reflecting is like riding up and down on a forklift, choosing at which depth to land.

Example

A 45-year-old unmarried woman has been in psychotherapy for six months. Generally shy and isolated, she has only recently been able to tell her female therapist that she values the therapy and that she feels close to her. When she arrives at her second session after her therapist has moved into a larger office, she carries a small bag. ''I brought you a house-warming gift,'' she says, lifting out a boutique box of Kleenex, ''I noticed that you didn't have any last time.''

Bringing the therapist tissues and noting that they were missing in the previous session could be a way of criticizing the therapist. Perhaps the therapist's move to the new, bigger office made the patient feel neglected, or made her feel that the therapist was thinking about other things. However, the tissues were presented as a gift by a woman who has only recently begun to express her positive feelings toward the therapist. Thus, the positive feelings are closer to the surface than the negative feelings. According to the principle of surface to depth, the therapist will do well to

focus on the positive feelings *now* while remembering the deeper negative feelings and listening for them in the future.

Follow the affect

Remember the game ''hot and cold'' that you played as a child? Someone hid something and another person looked for it while the rest of the group shouted ''hot!'' or ''cold!'' as clues for the seeker. In the game of psychodynamic psychotherapy, locating affect is the best way to tell if we're close to important unconscious material. If the patient's free associations range from topic to topic but only one is tinged with real affect, it's likely that this is closest to something important to the patient. In our process of reflecting, this is essential to recognize.

Example

A 21-year-old man comes to his first session and tells you that he has been thinking about coming to treatment for three months and can't believe that the day has finally arrived. He says that he was looking forward to it all weekend and thus was very upset that he was almost late because he couldn't find his wallet as he was leaving the house. He spent the weekend reading books about therapy so that he could make sure that he said the right kinds of things and focused on the most salient issues. Halfway through this monologue, he looks up and asks, ''Am I doing all right?''

This patient is anxious! Although he is also excited, he is nervous that he will not perform well as a patient, or that he will disappoint the therapist. As we reflect on what he's said, we would choose to comment on this anxiety since it's the affect that's closest to the surface.

Attend to the countertransference

The term ''**countertransference**'' refers to the feelings that we, as therapists, have about our patients (see Chapters 12 and 22). The material that we receive from the patient has to be filtered through our own reactions to the patient and to the material. Like following the patient's affect, attending to our countertransference is an invaluable tool for processing the material that we hear from the patient. If we have a particularly strong reaction to something that the patient says, we have to pay attention to it – although it could be something idiosyncratic related to our own internal experience, it could just as likely tell us something about the importance or affective valence of what the patient is saying.

Example

In one session, a patient who has been in psychodynamic psychotherapy for four years mentions wanting to terminate therapy. She reports a dream in which she was in a modernist train station leaving for a new city – while trying to get on the train, she stumbles and falls, but is able to get up and move forward on her own. As the patient tells this dream, the therapist realizes that she is feeling sad; upon processing this, she thinks that it might mean that the patient is in fact finally ready to terminate.

If you listen for what's on the surface, follow the affect, and attend to what you're feeling in the session, you're most likely to pick up the most important themes of the session.

The three readiness principles

Once we have a sense of what's on the surface and what the patient is most affectively connected to, we have to assess what the patient will be able to hear and work with. To do this we'll use what we call the ''three readiness principles'' which are:

1. assess the state of the therapeutic alliance
2. assess the phase of treatment
3. assess the state of the patient's ego function

Assess the state of the therapeutic alliance

As we discussed in Chapter 9, the therapeutic alliance is a measure of the level of trust that develops between patients and therapists. This builds as therapists demonstrate over time that they understand their patients, have their best interests at heart, and can help them. A therapist may be able to say something that is quite painful to the patient once the alliance is strong that the patient wouldn't have been able to tolerate at the beginning of the treatment. Time alone doesn't strengthen the alliance – it takes effort on the part of the therapist and trust on the part of the patient. A paranoid patient may never be able to have a strong alliance, while a patient who has a history of being able to trust people may be able to develop a strong alliance early on. The state of the alliance can wax and wane as well, depending on what's happening in the treatment:

Example

Ms A is in her second year of psychodynamic psychotherapy and has felt very helped by her therapist, Mr Z. At one point, Mr Z forgets to tell Ms A that he is going on vacation until the week before he is scheduled to leave. Ms A becomes convinced that this means that he does not care about her and for a few weeks she is unable to process comments that she was able to use readily just a few months before.

Assess the phase of the treatment

There are three basic phases of treatment: the induction phase (beginning), the mid-phase, and the termination phase. As the patient and therapist work together over time, certain types of comments become easier for the patient to use:

Example

During the early months of Ms B's treatment, she insisted on writing Dr Y a check the moment she got the bill. When Dr Y asked Ms B about this, she was annoyed and said that she didn't

see anything wrong with paying bills on time. During the mid-phase of the treatment, Dr Y commented on this again, and at this point, Ms Y was able to explore her fear of being in a position of ''owing'' anyone anything and to deepen her understanding of their relationship.

Assess the state of the patient's ego function

As we discussed in Chapter 4, it is important to be constantly aware of the patient's current level of ego function. Even if you assess this at the beginning of the treatment, it can change at any point, for example when the patient is under stress, medically ill, or regressed for some other reason. A patient who is generally able to use certain types of interventions during most of the treatment might be unable to use them during periods of compromised ego function:

Example

During their work together, Dr X frequently used humor to help Ms C notice when she was avoiding certain topics. For example, he would say things like, ''. . . see, there you go again!'' in a way that helped Ms C notice her avoidance in a non-threatening way. However, when Ms C's husband developed cancer, she snapped at Dr X when he used humor to point out the way in which she arranged to have business meetings during all of her husband's radiation treatments.

Using the readiness principles will help you to learn when your patients are ready to listen to and use things that you have to say to them.

The information matrix

Along with these principles, we filter the patient's data through an **information matrix** that we already have, composed of:

1. historical information about the patient
2. our own clinical experience
3. knowledge of theory and theory of technique

Historical information about the patient

This includes information about the patient's life prior to therapy as well as the therapist's experience with the patient. When we listen to our patients, we use information that we have about them to process what they're saying. For example, if a single, female patient says that she is interested in a married man, we process this differently if (i) we know that she has done this before, (ii) we know that she has never done this before, or (iii) we know that her parents were divorced because her father had an extramarital affair. Our knowledge of the way the patient responded in the past, either in or out of therapy, will affect the way we process what the patient tells us.

Our own clinical experience

Although the reactions of each patient are unique, as we begin to see patients we start to recognize patterns that can help us as we process information. For example, if we have had several patients who had idealized us early on and then suddenly fled treatment, we listen and process a patient's early idealizing comments with this in mind. Similarly, once we have conducted a few termination phases, we begin to anticipate certain reactions and will be more attuned to them when we process the material of a patient in this phase. Note that initially your clinical experience may lean on the clinical experience of your supervisors or knowledge that you've gleaned from books.

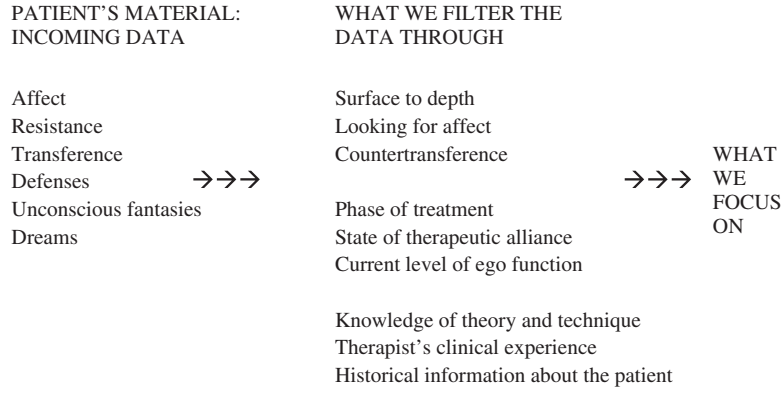
You can also judiciously use information from your own experience *outside* of the therapy room to help you to understand what the patient tells you. For example, if you had extensive experiences with teenagers as a camp counselor, this will inform the way you listen to your adolescent patients.

Knowledge of theory and theory of technique

It almost goes without saying that our knowledge of theory and theory of technique affects the way we process our patients' material. For example, if we notice that a patient tends to use defenses based on splitting when describing his office-mates, we will be especially attuned to splitting in the therapeutic relationship. Although this is inevitable, we also have to be wary of thinking about this excessively while with the patient, since it can hinder our capacity for ambient listening and fluid processing.

We use the data from our information matrix cautiously because our best clues are the immediate data – the patient's affect, our countertransference, patterns (nodal points), and breaks in patterns (slips, incongruities).

So, we can think of the reflecting process according to the following schematic:



Once we've reflected, we're ready to intervene, which is the topic of Chapter 18.

Suggested activity

For each of the following vignettes, list four things that you hear. Then order them from surface to depth.

1. Ms A is a 55-year-old woman who lives with her elderly mother. Here is some material from a session with her therapist:

> *My mother wandered off again yesterday. It took hours to find her – she left when I was sleeping. I was out in the neighborhood in my nightgown – me with my old flabby body. Poor thing. My sister was so angry with me for calling her – but I needed help. I don't get it – here I am – no life of my own – taking care of Mom 24/7 – and I call my sister for help and she's concerned that she won't get to her kids soccer game on time. It's funny, because she was the favorite when we were little. Mom hardly knows who I am now – but it's what I have to do. How could I not do it? I'm eating so much – I have to figure out a way to stop.*

Comment

Listen:	Empathy for her mother, who is getting more symptomatic Anger at her sister for not helping more with mother's care Anger at her mother for favoring her sister Resignation about her situation Contempt for the state of her body
Reflect: Surface	Anger at sister Empathy for mother Contempt for her body Resignation about her situation
Deep	Anger at mother

2. Ms B is a 39-year-old single lawyer:

> *I'm so worried about my friend Jane – she just had an abortion yesterday. She's miserable. I went over there, brought her soup. Her boyfriend just went to work – but I can be there for her. He's a jerk – men are like that. She's worried that she'll never have a baby. Do you think that that's true? Does having an abortion make it harder for you to have a baby? I was on the internet all night researching that – I didn't see anything like that. I hope that this doesn't make her depressed. When I had that abortion when I was 25, I didn't even think of that. I'm glad that I'm not fixated on babies – I would never have been able to make partner if I'd had a kid. Maybe I should stay at her house tonight, just to make sure that she's comfortable.*

Comment

Listen:	Concern for her friend Professional ambition Disappointment that she never had a child Wish for a child of her own
Reflect: Surface	Concern for her friend Professional ambition
Deep	Disappointment that she never had a child Wish for a child of her own

18 Learning to Intervene

Key concepts

An intervention is something that we say to a patient.

In psychodynamic psychotherapy, we use many different types of interventions.

We choose our interventions based on our main therapeutic goals for a specific patient at a specific moment in the therapy.

There are three types of interventions in psychodynamic psychotherapy:

- basic
- supporting
- uncovering

We use basic interventions in all psychodynamic psychotherapies in order to gather history, teach our patients to use the treatment, and convey understanding.

We use supporting interventions if our goal is to support the person's ego function.

We use uncovering interventions if our goal is to enhance the person's awareness of unconscious thoughts and feelings.

Both supporting and uncovering interventions are used in all psychodynamic psychotherapies.

Interventions can also include non-verbal communications, such as facial expressions and tone of voice.

After we intervene, we listen for what the patient says *next* in order to gauge the effect of our intervention. Lessening of anxiety or improvement in functioning indicate that a supporting intervention was successful. Further associations and deepening affect are indications that uncovering interventions were successful.

Introduction

Intervening is the third step in the three-step technique of psychodynamic psychotherapy. An intervention is simply something that we say to a patient. In psychodynamic psychotherapy, we have three types of interventions:

- basic
- supporting
- uncovering

Although some psychodynamic psychotherapies will have a preponderance of either supporting or uncovering interventions, *all* psychodynamic psychotherapies

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use all three types of interventions at some point in the treatment. In addition, no single technique is ever *exclusively* supporting or uncovering. What defines an intervention as supporting or uncovering is the therapist's *primary aim* in using that technique at any given moment in the treatment. You can determine your aim by asking yourself whether you are hoping to:

- directly improve functioning and change behavior (supporting aim), or
- enhance the person's understanding of unconscious processes (uncovering aim)

Interventions can be non-verbal

It's important to remember that we also communicate non-verbally with our patients. Smiling, making good eye contact, and speaking in a soothing tone of voice are all interventions. Our tone of voice can be encouraging or containing, and is a critical component of both supporting and uncovering interventions. Remember that this never involves physical contact – facial expressions and tone of voice will suffice.

Determining the success of our interventions

Once we make an intervention, the most important thing is to listen to what the patient says *next* [5]. New memories, further associations and deepening affect indicate that an uncovering intervention was successful, while decreased anxiety or a direct change in behavior signal the success of a supporting intervention. An increase in defensive behavior of any sort is usually an indication that our intervention was:

- too deep
- poorly timed
- incorrect or off the mark

That's good information, too – it helps us to recalibrate our reflection so that we can intervene more effectively the next time.

Section 1: Basic Interventions

Key concepts

Basic interventions can be used regardless of the aim.
They are used in all psychodynamic psychotherapies.
They include:

- directions and psychoeducation
- questions
- information
- empathic remarks
- calls for associations
- silence

Sometimes, trainees think that the only interventions we make in psychodynamic psychotherapy are interpretations. They think that asking questions or giving directions should not be a part of the technique, and they often apologize for interventions like this when reporting their work to their supervisors. Nothing could be farther from the truth. In psychodynamic psychotherapy, we make all sorts of interventions, and **basic interventions**, like questions and information, are essential to the process. They help us to take a history, learn details, teach our patients how to best use the treatment, and convey our understanding.

Basic interventions

Directions and psychoeducation

Trainees are usually intuitively aware that more impaired patients who have trouble organizing themselves need the therapist to provide structure, direction, and information. But psychoeducation is not only for low-functioning patients – helping our healthier patients learn how psychodynamic psychotherapy works is critically important at the outset and throughout a treatment. We ask them to say whatever comes to mind, encourage them and teach them to talk about dreams, and tell them that thoughts and feelings about the therapist are particularly important. For example, a patient who tells a dream early in treatment will often try to tell us what she thinks it means – we have to instruct her that a good way to use dreams in this type of treatment is simply to associate to the various elements. Patients frequently think that talking about banal thoughts is a waste of time – we have to tell them that we want to hear everything so that we can learn about how their minds work. Once we've said this a few times, we can then begin to think about their difficulties or reluctance to associate as resistance – but without instruction it's unfair!

Questions

Learning about how another person's mind works and how it came to be the way it is can be quite a project. Sometimes the person produces lots of information spontaneously, but sometimes there are things that we want to know that the patient doesn't freely offer. Every psychodynamic psychotherapy must begin with a careful evaluation and diagnosis, including personal, family, social, and sexual history. If these items are not volunteered, we have to ask for them. Conducting psychodynamic psychotherapy doesn't mean forgetting that we're well-trained mental health professionals. Asking questions is an essential part of technique throughout the treatment. If patients say something that we don't understand – like jargon from their field, a foreign expression, or a piece of their history that they think we know but we don't – we have to ask. It's not interrupting – patients are glad to know that we are interested and that we are invested in having the whole picture. Finally, it's important to remember that many secrets of the unconscious are hidden in *details*. When the patient says, ''I apologized to my mother but she was still angry,'' we have to ask, ''What did you say?'' If you find that you need to ask more questions with a particular patient, you may be learning about that person's defensive style, and this might ultimately be something to interpret.

Asking questions also demonstrates our interest. Following what the patient says and asking relevant questions is one of the best ways to communicate to the patient that we are paying attention and are interested in what they are telling us.

Closed-ended and open-ended questions

We ask two basic kinds of questions – **closed-ended questions** and **open-ended questions**. We ask closed-ended questions when we want a particular answer, such as an amount, time, or number. Closed-ended questions can often be answered with ''yes'' or ''no'' and can be helpful if we need to know whether or not something happened. Here are a few examples of closed-ended questions:

When did you first start feeling suicidal?

What did you hope that your mother would say to you at your graduation?

How many times did you pass the refrigerator before you started your binge?

In contrast, open-ended questions do not have specific answers. They invite patients to open up and deepen what they're saying. Open-ended questions often begin with ''how'' rather than ''why.'' For example, ''How does that make you feel?'' is a very different question from, ''Why did you feel that way?'' Asking ''why'' presumes that patients could tell you – and if they could tell you, they probably wouldn't need your help. When starting out as a psychodynamic psychotherapist, try asking ''what?'' or ''how?'' every time you think of asking ''why?'' We want to get our patients to *describe* rather than to *interpret*.

Learning to ask open-ended questions is a core skill for the psychodynamic psychotherapist. Many phrases are helpful to us in shaping open-ended questions, for example:

Can you tell me more about (how you felt, the dream, cutting yourself . . .)?

How did that make you feel?

What was your experience of (the dinner, this session, the consultation . . .)?

You can think of many more. Contrast these open- and closed-ended questions:

Closed-ended	*So the conversation with your boss made you really angry?*
Open-ended	*Can you tell me more about the experience of speaking with your boss?*
Closed-ended	*Why are you crying?*
Open-ended	*Can you tell me more about how you're feeling right now?*

Asking open-ended questions helps our patients to deepen their account of their feelings and inner lives.

Information

During the course of a treatment, we impart all sorts of information to patients. We tell them when we have times available, when we're going on vacation, and how much we charge. It is also sometimes appropriate to give other types of information to our patients, such as referrals for friends and relatives. If we think that patients are developing symptoms that require medication, we have to give them information about diagnosis, treatment options, consultations, dosages, and side effects. In addition, we always have to think about what it means to the patient to (i) ask for information from us and (ii) receive information from us. For example, a patient's frequent requests for referrals could be a wish to have one's whole family cared for by the therapist. Similarly, patients have many feelings when receiving information about medications from a therapist who is also the pharmacologist. This should not preclude us from giving information, but it should be in our minds as something that can help us to understand the patient's defensive style and that we might ultimately need to explore and address.

Empathic remarks

We use empathic remarks when we want the patient to know that we're listening or that we think that we understand how the patient feels. These can be very powerful interventions. For example, a woman who is overwhelmed by but ashamed of her hypochondriacal fears might feel very understood by the therapist who observes, ''It takes an enormous amount of energy to be so consumed by those thoughts every day;'' or the executive with fragile self-esteem, who has to pretend to be confident to his family and business associates, might feel very relieved if the therapist says simply, ''That must be very hard for you.'' Often, patients remember these comments years after we say them. When our primary goal is to uncover, we need to empathize

with our patients, but we also have to understand what our empathic remarks mean to our patients. For example, a man who seems to need an endless stream of empathic remarks may unconsciously want the therapist to be a warm and caring parent. We would also not be surprised to discover that he needs this level of empathic attunement from other people in his life and that this demand strains all of his relationships. Ultimately, we will want to interpret this to him so that he can understand this wish and the way that it impacts his life. When our primary goal is to support, it may be less important to have the patient become conscious of the effect of our empathic remarks. Remember that whether we are primarily uncovering or supporting, our patients are usually in a great deal of emotional pain and need to know that we are empathic. Trainees conducting psychodynamic psychotherapy sometimes feel inhibited about making ''too many'' empathic remarks, as if they're doing something ''wrong'' by intervening in this way.

Calls for associations

Calls for associations are the kinds of comments that frequently appear under therapy cartoons, such as the infamous, ''what comes to mind?'' One of the reasons that these kinds of comments are so frequently spoofed is that they really make people think – and that's often hard. These interventions are invaluable tools for the psychodynamic psychotherapist. While people tend to think of ''free association'' as a technique reserved for patients in more uncovering treatments, calls for association (''Any thoughts about that?'') are simply another way to encourage patients to elaborate on and be more aware of their inner experience. Calls for associations in more supporting treatments can have the goal of enhancing patients' self-awareness and helping them to understand how their minds work without necessarily exploring deeper unconscious material.

Silence

In psychodynamic psychotherapy, silence *is* an intervention. We make a conscious choice to be silent in a variety of situations. If patients can tolerate it, remaining silent helps them to continue associating on their own in order to move toward unconscious material. Silence can also help to slow a patient down, and can sometimes be soothing after a patient has talked about something very difficult. Silence is a very potent intervention that we have to carefully titrate according to the patient's comfort level.

Basic interventions

- Directions and psychoeducation
- Questions
- Information
- Empathic remarks
- Calls for associations
- Silence

Section 2: Supporting Interventions

Key concepts

Supporting interventions are designed to support deficient or weakened ego function. We support ego function in two basic ways:

- by *supplying* what patients cannot provide for themselves at that moment
- by *assisting* patients as they try to use their own, weakened ego functions

What is support?

Many people think of ''being supportive'' in psychotherapy as ''just being nice'' to the patient. It's certainly true that providing a supportive relationship is of central importance in all psychodynamic psychotherapies. Whatever the overarching goals of the treatment, we always offer patients implicit support in our *holding attitude* of acceptance, compassion, and respect, and in our commitment to working together with patients to understand their predicaments.

But how do we actually offer this support?

To answer that question, let's begin by thinking about the various meanings of the word **support**. The word comes from the Latin *supportare*, meaning *convey*, *carry*, or *bring up*. Now let's see how many additional meanings you can pick out in the following examples:

Flying buttresses *support* the walls at the Palace of Westminster.

His wife's love *supported* him throughout the long ordeal.

She was willing to accept any job to *support* her family.

Leading doctors *supported* his testimony.

Three hundred gathered at Seneca Falls in *support* of a woman's right to vote.

The star was *supported* by a talented newcomer.

Technical *support* enabled the hospital's computer system to remain in operation.

Buttressing, holding up, reinforcing, sustaining, supplying, providing for, endorsing, backing, assisting – these words represent the range of therapeutic effects we hope to achieve in using supporting techniques in psychodynamic psychotherapy. Patients need support when they either lack or are unable to mobilize adequate ego strength to function in the world. When this is true, rather than just commenting on their ego weakness, we either provide it for them or help them use their own weakened capacities. We offer support to people who – at least in the moment – are unable to provide it for themselves.

Consider these two examples:

Ms A	*I can't make a decision about which accountant to choose – I'm too stupid to know what to do.*
Therapist A	*You feel as if you can't choose an accountant because you are worn down from the divorce and you have grown to feel that only your husband could make decisions.*

The therapist's comment is an *uncovering intervention* (''You feel *as if* you are stupid because you are worn down by the divorce'') – it presumes that the patient *has* the capacity to make the decision and just *feels* as if she doesn't. The tactic is to make this assumption conscious so that she can explore it, understand it, and overcome her inhibition. Now consider the situation with Ms B:

Ms B	*I can't make a decision about which accountant to choose – I'm too stupid to know what to do.*
Therapist B	*But actually yesterday you made a terrific decision about your son's school so I know that you can do it. Let's think together about some of the pros and cons.*

This is a *supporting intervention* – or more accurately, a combination of several supporting interventions. Here, therapist B presumes that the patient does *not* have the ability in that moment to make the decision on her own and needs the therapist's help to supply or bolster the missing or weakened capacity (ego function). Let's look more closely at what the therapist said and the aim behind his interventions:

> *But actually yesterday you made a terrific decision about your son's school so I know you can do it. Let's think together about some of the pros and cons.*

In these two sentences, the therapist uses a combination of praise, encouragement, and problem-solving techniques to help the patient reach a decision. But what exactly is being supported? Hearing the patient's own harsh judgments about herself, the therapist praises (''you made a terrific decision'') and encourages her (''I know you can do it'') in order to buoy her *self-esteem*. He helps her to *test reality* by reminding her of her capacities. He supports her ailing *problem-solving (cognitive) abilities* (''let's think about the pros and cons'') and strengthens her ability to work in a *relationship* (''let's think together''). The therapist supports these functions to help the patient in the moment, but does it in a way that she might be able to use on her own in the future.

To summarize – we use supporting interventions to support deficient or weakened ego functions.

Supplying and assisting

We support ego function in two basic ways:

- by **supplying** what patients lack and are unable to provide for themselves
- by **assisting** patients as they try to use their own ego functions

A famous Chinese proverb provides an apt metaphor for these two ways of supporting:

> *Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime.*

When we *supply* support, we directly give patients something we think they cannot supply for themselves at that moment (the ''fish''). *Assisting* patients to use their own ego function is more of a ''teaching to fish'' approach. We assist when we think that, with some assistance, patients can mobilize their own ego resources. In psychodynamic therapy – as in parenting – we constantly balance our patients' need for support with their need for autonomy. We want to supply them with as much support as they need while looking for every opportunity to promote self-reliance.

Supplying interventions

Supplying interventions provide the most direct and immediate way to support deficient ego function. We use supplying interventions when we think the person is in most need of emergency ego repair. It's the tourniquet – if someone is bleeding, we don't say, ''Oh, look you're bleeding'' or even, ''Now, let's think about some ways to stop that blood'' – we just find whatever we can and we tie hard. Here are some of the major interventions we use to supply missing or grossly impaired ego function. Remember that many of these, such as encouraging and soothing, can also have non-verbal components, such as facial expressions and tone of voice. The supplying interventions are grouped in clusters according to similarity of aim, and each is followed by specific examples:

1. **Encouraging**: In order to have the energy and will to accomplish things, we have to have the feeling that there is a chance that we could succeed. The interventions in this group are designed to provide encouragement to people who can't muster this for themselves. They include:
   (a) **encouraging**

   > *Give it another try – things are usually easier the second time around.*
   >
   > *You've done it before. I'm confident you can do it again.*

   (b) **inspiring and motivating**

   > *When I was struggling with calculus as a pre-med, it really helped to get some tutoring.*
   >
   > *You really did well on that last report – I'm looking forward to seeing what you do with the next one.*

   (c) **offering optimism and hope**

   > *Your anxiety should lessen over the next few weeks as the medication takes effect.*
   >
   > *Your cancer is advanced, but some patients with your condition have had their lives prolonged by years with treatment.*

(d) **praising**

You made a good decision when you chose to call the emergency room.

You walked away from the fight, which was just the right thing to do.

It took real courage to admit you needed help.

(e) **reminding patients of their capacities**

Last time you felt like cutting yourself, you were able to hold off by writing in your journal and calling your friend. I think you can do it again.

You're feeling like you can't take care of your baby, but look at what a great job you've done with your two older children.

2. **Naming**: Being able to name things can help patients to understand their feelings and experiences. This can enhance self-awareness. It can also help them to manage strong affects and anxiety feelings (see Chapter 19). When people can't put things into words, we may have to do it for them. Here are some of the interventions that involve naming:

(a) **naming emotions**

You say you didn't really care about what he said, but you looked as if you wanted to cry just then. I imagine it felt humiliating.

(b) **putting experiences into words**

That sounds overwhelming – although you're not saying it directly, what you're telling me is that you had to take care of all those children by yourself.

3. **Redirecting**: Sometimes, the best thing we can do for ourselves is to turn away from a noxious idea or behavior. Often, however, people cannot do this for themselves. This can impair stimulus regulation and affect/anxiety tolerance. We have many interventions that can help to supply this function:

(a) **interpreting-up**: this type of intervention, which is sometimes called an ''**upwards**,'' ''**inexact**,'' or ''**partial**'' interpretation, supports weakened ego function by offering patients an alternate and generally more positive explanation for what they are feeling in order to lessen their anxiety and organize their experiences [6–9].

You're worried that you're not able to make a decision, but it sounds to me like you're carefully weighing your options.

(b) **redirecting**: The therapist consciously alters the direction of the conversation in order to help organize the patient or decrease his/her anxiety.

I can see that worrying that you're going to be in a car accident is upsetting you, but let's start by thinking about how things have been going in your relationship with your daughter in the last week.

(c) **supportively bypassing**: here the therapist registers what the patient says but does not address it directly because it might overwhelm or disorganize him/her.

Patient *I really think that this therapy is helping me and I also think that the dress you're wearing is beautiful.*

Therapist *I'm glad that you're feeling so good about the work that we're doing.*

4. **Reinforcing and discouraging**: Using these interventions, the therapist consciously and deliberately reinforces more adaptive behaviors and discourages others. These are key interventions for working with defenses in a supporting mode:

Your instinct about taking a friend with you when you visited you mother worked out well last time – you might think about doing it again.

It sounds like doing the hard sell during that job interview didn't work out so well – but you really had success the time you were prepared with lots of questions.

So when the guys on the loading dock make racial slurs, screaming back just seems to make things worse. You've done better when you've avoided that area of the plant whenever possible.

You've said you always feel calmer after yoga classes. Have you considered going more often?

5. **Soothing**: Many people have acute or chronic difficulty soothing themselves. This is related to problems with self-esteem regulation, affect/anxiety tolerance, stimulus regulation, impulse control, and capacity for play. Many soothing interventions, including reducing guilt and reassuring, can be very helpful with overly harsh super-ego function. Note that soothing can sometimes be accomplished with non-verbal interventions, like facial expressions or a calm tone of voice. There are also many verbal interventions that we can make that can supply this essential function:

(a) **soothing**

Why don't you relax for a minute before you go on – it sounds like you were very overwhelmed today.

Take your time – you're doing a really good job telling me what happened.

(b) **nurturing**

I know that Friday is the anniversary of your father's death . . . would you like to try to meet that day? I could see you in the afternoon, if that works for you.

(c) **reassuring**

I know you're frightened for your daughter, but from what the doctor said, actually it sounds like she's going to be fine.

You'll be all right.

(d) **reducing guilt**

You're taking responsibility for something you had no control over.

You did your best with your kids under difficult circumstances.

(e) **remaining calm**: sometimes the sheer act of not getting excited about something can be extremely therapeutic.

Patient *I just feel completely panicky – like when I leave here I don't know what I'll do.*

Therapist *I'm sure that we can figure this out together. Now let's think about your options.*

(f) **empathizing**

It sounds like that must have hurt you deeply.

Your experience of my canceling the session was that I was leaving you all alone.

(g) **demonstrating interest and understanding**

I'd like to hear more about what it felt like during your first year in this country.

I think I understand how desperate you felt when you lost your home.

(h) **explicitly joining**

Don't worry – we'll figure this out together.

You're not alone in this – we'll make sure that you get the best treatment.

6. **Protecting**: When our patients have impaired judgment and impulse control, they may put themselves or others in danger. When this happens, we may have to actively protect them. Here are some ways that we can do that:

(a) **protecting**

It would probably be a good idea to meet in a public place for the first date. You really don't know much about this man other than what is in his profile.

I hear it's really not safe to run alone in the park after dusk.

If you're not wearing a condom, you're taking your life in your hands.

(b) **setting limits**

Can we agree that if your weight falls below 75 pounds that will be the signal that you need to be hospitalized?

You can't come to sessions drunk.

7. **Advising**: Although we'd rather have our patients come up with their own ideas, sometimes they can't. This is often related to problems with judgment, cognitive function, and impulse control. When that happens, we supply this function by judiciously **advising**, **suggesting**, **guiding**, and **offering opinions**:

   Why don't you try writing down your questions before you see the doctor?

   Sometimes it helps to have a friend look over your profile to give you pointers about how to put your best foot forward.

   You might try acting differently than you feel for just a minute – you can learn to project self-confidence even when you're feeling very insecure.

   It's not always the best strategy to tell your wife all of your thoughts – sometimes editing might help you to not hurt her feelings.

8. **Structuring**: When our patients can't organize their lives and/or their thoughts, we can supply functions to help them with this:
   (a) **slowing down**

   I know that what your boss said made you want to quit your job immediately but let's take some time to think about how you're going to deal with this.

   (b) **structuring:** we can help people to structure their time in and out of sessions:

   People generally feel better about themselves if they get out of bed, shower, and get dressed every morning. We should also think about what else you might do during the day so you don't have so much unstructured time on your hands.

   You're changing the subject. Do you feel we've said as much as we need to say about your problems at work, or should we keep talking about that?

   (c) **organizing**: depending on the level of someone's ego function, this can be supplied or assisted (see below). When we supply, we can help people to organize many aspects of their lives:

   Because you're so upset, it's hard to know what to do first – but it sounds like after your father's funeral you're going to need to drive your mother home, make sure that your aunt has a place to stay, and arrange for a babysitter for the kids.

   (d) **breaking things into manageable parts:** people are often overwhelmed by tasks and projects because they don't know how to break them into manageable parts. Again, depending on the level of ego function, this can be supplied or assisted:

   Getting organized after you're discharged seems overwhelming to you, but there are really only three things that you're going to have to do today – fill your prescriptions, buy some food for the refrigerator, and do some laundry.

9. **Supplying perspective**: People can lose varying degrees of perspective on an acute or chronic basis. This can be related to reality testing and lack of self-awareness. When they are unable to regain perspective, we can supply it for them:
   (a) **correcting misperceptions**

   You feel that no one at the office likes you, but it's clear to me that Jane and Jill really went out of their way for you. I don't think that you have to feel no one is there for you.

   (b) **reframing**

   So another way to look at being single again is that you now have an opportunity to spend much more time with your children.

   (c) **universalizing**

   Most people feel a sense of loss when their last child goes to college.

   In this economy, lots of people are worried about their retirement funds.

   (d) **validating**

   Of course you're exhausted after moving your family cross-country!

   That kind of experience would be frightening for anyone.

   From everything you've told me, it does sound like your mother doesn't always have your best interests at heart.

10. **Providing practical support outside of the therapeutic relationship:** When our patients need even more support than we can provide, our job is to help them get the support they need in other ways. This can include hospitalizing a patient, suggesting a consultation, or offering to speak to their internist. These interventions can supply needed judgment, stimulus regulation, and impulse control:

    Right now, I think that the chaos in your household is making it even more difficult for you to recover from your depression. Plus, it's clearly so hard for you to stay away from marijuana when it's constantly available there. Coming into the hospital will give us a chance to address your symptoms, will give you a quiet place to recuperate, and will help you to think about new ways to cope with your anxiety.

Supporting interventions – supplying type

1. Encouraging cluster
   (a) encouraging
   (b) inspiring and motivating

(c) offering optimism and hope
(d) praising
(e) reminding patients of their capacities

2. Naming cluster
   (a) naming emotions
   (b) putting experiences into words
3. Redirecting cluster
   (a) interpreting up
   (b) redirecting
   (c) supportively bypassing
4. Reinforcing and discouraging
5. Soothing cluster
   (a) soothing
   (b) nurturing
   (c) reassuring
   (d) reducing guilt
   (e) remaining calm
   (f) emphathizing
   (g) demonstrating interest and understanding
   (h) explicitly joining
6. Protecting cluster
   (a) protecting
   (b) setting limits
7. Advising cluster
   (a) advising
   (b) suggesting
   (c) guiding
   (d) offering opinions
8. Structuring cluster
   (a) slowing down
   (b) structuring
   (c) organizing
   (d) breaking things down into manageable parts
9. Supplying perspective cluster
   (a) correcting misperceptions
   (b) reframing
   (c) universalizing
   (d) validating
10. Providing practical support outside of the therapeutic relationship

Assisting interventions

Assisting interventions help people to use their own weakened or faltering ego function. We can think of this as skill building for ego functions. We can break these interventions into groups depending on the way in which we're assisting:

1. **Modeling**: Modeling is an implicit way to show someone a new way to do something. We can consciously model behaviors and ways of thinking to our patients in the hope that they will copy, amend, and incorporate aspects of them.

   Example

   When Mr A said that he wanted to quit therapy, the therapist didn't get upset; rather, he asked Mr A to think about the pros and cons of leaving treatment. This modeled to Mr A a measured way of thinking about a decision.

2. **Instructing**: We can explicitly teach our patients things that they can do to help themselves, such as relaxation exercises, ways to organize themselves, and problem-solving techniques.

   Example

   Since you've been so anxious, I'm going to teach you some practical relaxation exercises. You can practice them at home and we'll go through them here, too. Ready? Close your eyes gently as I count down from five, and just focus on your breathing. Now try to imagine a soothing scene – you love the seashore, so it might be something like floating on a raft. Try to imagine yourself in the scene. Imagine what you smell, what you feel on your skin, what you see.

3. **Collaborating**: We always work alongside our patients, but when we collaborate we explicitly say to the patient that we are going to work jointly. Think about how people learn – actively doing something while working with a teacher is generally more effective than passively listening to a lecture. When we collaborate, we're essentially saying to patients, ''So, now you need to perform an ego function. Let's walk through it together. Then you'll have a model for how to do it yourself.'' This can be done in myriad ways – for example by simply talking, by making lists or charts together, or by assigning practice homework. We can collaborate with our patients to assist almost any ego function. If you put the word ''joint'' in front of something you want to assist the patient with, it becomes a collaborative intervention. The basic intervention sounds something like this:

   Let's work together to . . . (consider alternatives, problem solve, set goals etc.)

   Here are some important examples:

   (a) **Joint goal setting**

   ''Let's think about what you want to work on . . . ''

This intervention helps people to learn to set goals, focus, and organize their thinking. If patients are having trouble defining their own goals, try to make them partners in this process by asking questions like, ''What are we trying to accomplish here?'' Offering suggestions about possible specific and realistic objectives and getting feedback is also helpful.

Example

Patient	*Now that I'm feeling better, what do you think I should work on?*
Therapist	*That's a great question – maybe you can think about some of the things that you usually talk about here to help you answer that.*
Patient	*Well, I always talk about my anger – that would be good to fix.*
Therapist	*Yes, that does come up a lot – sounds like a good goal – although what do you think about saying that it would be good to learn new ways to deal with your anger, rather than saying that you need to ''fix'' it?*

(b) **Joint inquiry**

''Let's think about this together . . . ''

This intervention helps people to learn how to examine a problem. It involves learning to slow down enough to deliberate, and thinking about how to analyze something. It can facilitate ego functions such as judgment, self-awareness, and impulse control. It can also help to manage affect if the inquiry is about feelings.

Example

Patient	*Julie broke up with me last night – they all do. Why is that?*
Therapist	*That's an interesting question – let's think about it together. Can you think about things that make your last few relationships similar, and things that make them different? This might help us to begin to understand what's going on.*

(c) **Jointly exploring alternative ways of thinking or acting**

''Let's think about other ways to look at that/other things you could do . . . ''

We use this intervention when we think that the rigidity of our patients' thinking precludes their ability to think of alternatives. It can help with reality testing, judgment, cognition, relationships with others, and impulse control.

Example

I know that you feel that you have no alternative but to stay in this job that you hate, but let's think together about whether there might be other alternatives. What about that job you were offered last year in Washington DC?

(d) **Joint reality testing**

''Are there other ways to think about . . . ?''

As opposed to correcting misperceptions (which supplies a function), this engages the patient in thinking about whether there might be other ways to

perceive a given situation. This can be helpful when trying to assess whether someone is psychotic; it can also be helpful when trying to help someone to assess his/her capacities in a realistic way. You can think of this as a special category of **jointly exploring alternatives**, but it's so important that it deserves to be considered on its own.

Example

You've said that you think the boss is always talking about you – but can you think of other reasons that he might have been talking to your co-worker in his office today?

(e) **Jointly thinking through consequences**

''Let's think about what would happen if . . . ''

Patients often get in trouble because they can't see ahead to the consequences of their actions. If we see that this is a problem, we can work with them to develop this function. It often involves planning and predicting contingencies together. This can help to improve judgment, impulse control, and other cognitive functions.

Example

I know that your anger at your wife makes you want to leave immediately, but where would you go? Let's think through this together.

(f) **Joint problem solving**

''Let's try to figure this out together . . . ''

We do this so naturally that we may forget that some patients lack effective ways to solve problems. Collaborative problem solving involves weighing options and considering pros and cons together. This is very helpful for cognitive function, and can also help to improve relationships with others, judgment, stimulus regulation, and affect/anxiety tolerance.

Patient	*I'm so wound up about which internship I should take, I can't do any of my schoolwork. I just don't know how to decide.*
Therapist	*We can try to figure this out together . . . why don't you tell me about both of them and then we can think about the pros and cons of each.*

(g) **Jointly organizing/structuring**

''Let's think about how you can organize this . . . ''

Working together to help patients to organize their thinking or behavior can be extremely helpful to them. As above, we can either supply the organization, or we can assist patients to come up with their own plans:

I think that you're getting stuck on writing this paper because it seems like a big, amorphous roadblock. Why don't we work together to figure out a plan for how to begin? Why don't you start by thinking about what all of the components are, and then we can start to prioritize them together.

(h) **Jointly working on projects**

''Let's work on this together . . . ''

This includes working jointly on projects such as formulating schedules, organizing activities, or developing a budget. These projects can be worked on in sessions, or they can include work done at home that is brought in for review. This type of intervention presumes that the person has limited capacity to do projects like this without some assistance. Depending on the project, this can help with almost any ego function:

Sounds like you're having trouble putting together a budget. You need that in order to figure out how much you can spend per month on an apartment. Why don't you make a list of all of your monthly expenses and bring it to your next session? Then we can work together on putting together a budget for you.

Supporting interventions – assisting type

1. Modeling
2. Instructing
3. Collaborating
   (a) joint goal setting
   (b) joint inquiry
   (c) jointly exploring alternative ways of thinking
   (d) joint reality testing
   (e) jointly thinking through consequences
   (f) joint problem solving
   (g) jointly organizing/structuring
   (h) jointly working on projects

Supplying and assisting – a comparison

Supplying and assisting interventions target many of the same ego functions – the difference is the way in which the support is provided. For example, **correcting misperceptions** is a supplying intervention and **joint reality testing** is an assisting intervention – but they both address the person's faltering capacity to *test reality*. Here is an example of each to demonstrate the difference:

- **Correcting misperceptions**

Patient *I think that you put my session on Monday because that way you have to see me less – there are so many Monday holidays.*

Therapist *I can see that you're upset about that, but actually, if I remember correctly, you asked for Mondays because of your old work schedule. If your schedule has changed, we could try to find a time that leads to fewer missed sessions.*

- **Joint reality testing**

Patient *I think that you put my session on Monday because that way you have to see me less – there are so many Monday holidays.*

Therapist *I can see that you're upset about that, but are you sure that that's true? Do you think that there could be any other reason?*

It's also important to remember that many supplying interventions implicitly assist ego functions because helping one ego function supports others. For example, *encouraging* someone supplies self-esteem, and this could help someone to engage in a relationship, make a decision, or solve a problem.

Suggested activity

Consider the following exchange between a therapist and her patient and see if you can:

- list the different supporting interventions used by the therapist
- decide if the intervention is supplying or assisting
- determine what ego functions are being supported.

The patient is a 24-year-old college senior who presented several weeks earlier with ''out of the blue'' panic attacks. His parents divorced when he was three and he was raised by his mother until age 10 when she placed him in foster care because ''she couldn't take me anymore. I had temper tantrums. Plus, she needed to be able to go on the road for her singing career.'' He tells you he ''lucked out'' with his foster parents who are caring and, recognizing his intelligence, helped get him a college scholarship. The patient's major preoccupation is escalating tension in his relationship with his girlfriend of one year. This has been the latest and most long-lasting in a series of tumultuous relationships. The patient is currently sober, but when these relationships end disastrously – as they invariably do – he spirals into binge drinking and cocaine use. He had to drop out of college on two occasions to ''get myself straightened out.''

Patient *I can't decide what to get my girlfriend for our first anniversary. That's the paper anniversary, right? Aren't you supposed to get presents that match the anniversary?*

Therapist *I suppose that depends how important that sort of thing is to your girlfriend. Maybe it would help to focus on what she might like.*

Patient *That's the problem! She's so hard to please.*

Therapist *Have you asked her what she'd like?*

Patient *She gets upset if I don't automatically know what she wants, (sarcastically) like I should be able to read her mind by this point.*

Therapist	*(smiles) That sure would make things easier. (more seriously) I guess it's frustrating not knowing for sure what would please her, especially when it seems like it would be so easy for her just to tell you.*
Patient	*Exactly!*
Therapist	*What's the worst thing that could happen if she hates the gift?*
Patient	*Sometimes I feel like I have to do everything right, or she'll just exit stage right.*
Therapist	*Do you think that's really likely?*
Patient	*Well, no, not really. But she'll be, like, all sulky about it.*
Therapist	*That would be disappointing, but not the end of the world, I guess. If that happens, maybe you could offer to take her out shopping for something she might like better.*
Patient	*(skeptical) I don't know. I guess so.*
Therapist	*(silently noting that patient seems to feel he isn't getting what he needs from her, too). Why don't you tell me a little more about her and maybe we can come up with some ideas together.*

Comment

The patient starts with a seemingly innocuous request for **information** to help him with his decision about buying a gift, which the therapist provides. She then asks a series of **questions** in an effort to engage the patient in **joint problem solving**. The therapist notes (silently) that the patient seems to see himself as a well-meaning, caring boyfriend trying his best to please a difficult girlfriend who won't give him the answers he needs; she hears a similar pattern echoed in his childhood experience of abandonment by his mother, and wonders if the same sort of pattern may already be emerging in the therapy relationship. However, she decides to **supportively bypass** any mention of these relationship patterns, at least for the time being, because:

1. it is early in the treatment
2. the therapeutic alliance is still tenuous
3. the patient describes a history of important ego weaknesses, including tenuous impulse control, poor tolerance of anxiety, and stormy relationships.

By observing that the ''not knowing'' makes him ''nervous'', the therapist is **naming the emotion** and **validating his feelings** (without suggesting that his anger might be a way of fending off awareness of his anxiety about losing an important relationship). She **thinks through consequences** with him and the patient responds by letting down his guard and volunteering his deeper fears of abandonment. The therapist ends by making a concrete **suggestion** about alternative behavior that might minimize his own anxiety and uses the **collaborative intervention of working on a joint project**.

Section 3: Uncovering Interventions

Key concepts

Uncovering interventions translate material from the unconscious to the conscious mind. They include:

- confrontation
- clarification
- interpretation

Uncovering interventions

There are two definitions of the word *interpret*:

- to explain the meaning of; make understandable
- to translate

Both of these definitions are relevant to the way we use the word in psychodynamic psychotherapy. When we interpret, we explain the meaning of something that has been unconscious – to do this, we have to translate it from the language of the unconscious (**primary process**) to the language of consciousness (**secondary process**) (see Chapter 2). This is quite a task, and is best thought of as a process, rather than as a stand-alone intervention. Many of the basic interventions discussed in Section 1 of this chapter must occur before the formal process of interpretation begins. We need to give directions about free association, ask questions about behavior, and call for associations in order to get the information we need to begin to understand unconscious meanings. Once we think that we are dealing with something unconscious, we can begin the interpretive process, which is usually thought of as consisting of three steps:

- confrontation
- clarification
- interpretation [10]

Like the process of going from ambient listening → filtered listening → focused listening, the interpretative process is like the movie director going from the panoramic shot to the close up. Remember that we should only begin this process if we think that our tripartite measure of readiness (phase of treatment, state of the therapeutic alliance, and current level of ego function) indicates to us that the patient is ready/able to use the unconscious material we aim to uncover.

Confrontation

In everyday conversation, we generally use the word ''confrontation'' to describe a situation or an interaction that is somewhat aggressive or that involves some force. For example, someone might say, ''I confronted my daughter with her bad behavior and then grounded her.'' In psychodynamic psychotherapy, however, we use the word somewhat differently. Here, confrontation is the process by which we interest the patient in what's going on in his/her mind. When we think that we might be nearing something unconscious, our first step is confrontation. For example, if Mr A is talking about something and suddenly stops, we hypothesize that this might be the result of an unconscious thought or feeling. We don't know what it is, but we're interested and we want the patient to be interested, too. A confrontation in this situation might be:

I noticed that you just stopped talking.

We're observing a phenomenon and hoping that the patient will be curious about it, talk about it, and in this way help move us toward the unconscious thought or feeling that stopped the associations. The patient might then say, ''I feel blocked – like I have nothing to say.'' Now we have an idea that the patient stopped talking because his mind shut off at that moment. We can then begin to think about why that might have happened. If a patient makes a slip of the tongue, abruptly changes topics or obviously avoids talking about affect, we use confrontation to bring these phenomena to the patient's awareness. Although we are not using the word confrontation to mean ''calling someone'' on their behavior, we are pointing out something to patients that they might not have noticed.

Clarification

Clarification helps bring the unconscious into focus by linking similar phenomena. For example, if we notice that Mr A always seems to stop talking right after coming into his Monday session, we can comment on this – it's no longer just a confrontation of a single event. When we use a clarification, we're not just commenting on the feeling of being blocked (confrontation); instead we're linking times when the patient felt blocked and suggesting that the fact that this always happens on a Monday might have significance. A good clarification might be:

It seems like it is always hardest for you to talk on Monday mornings.

Interpretation

An interpretation is an intervention that explains a conscious feeling or behavior as being caused by something unconscious. Thus, it can always be reduced to what we'll call the ''because schematic:''

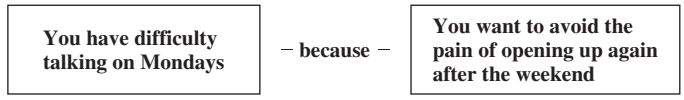
Staying with Mr A, let's say that in his Thursday session, the patient is talking about a dream, when he becomes tearful and says:

> *I can't believe that I have to wait until Monday to come back. That feels like forever. I'm so open now – opening up again feels so painful.*

Now we have some data upon which to base an interpretation of his blocking behavior. We hypothesize that his wish to avoid a painful feeling is what stops him from talking freely. The interpretation could sound something like:

> *Maybe that's why you find it so difficult to talk at the beginning of your Monday sessions – you're protecting yourself from the pain of opening up again.*

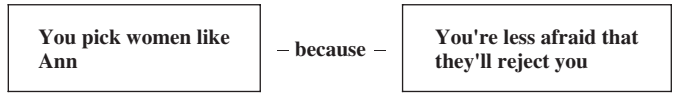
Here it is in the ''because schematic:''



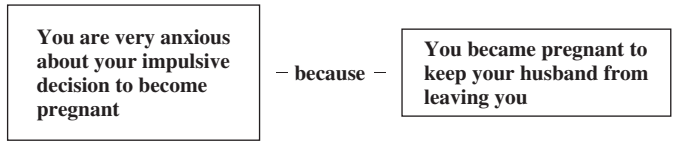
This is more than an observation – it's an attempt to explain the phenomenon by linking it to something unconscious.

Here are some interpretations so that you can hear what they sound like:

> *Perhaps you frequently pick women like Ann because you're less afraid that they will reject you.*



> *I wonder if your impulsive decision to become pregnant, which has left you feeling so anxious, was your attempt to keep your husband from leaving you.*



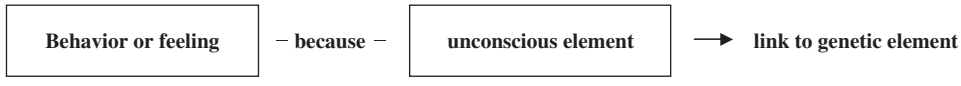
> *Maybe you're having trouble paying me on time because you feel that if I really cared about you I'd treat you for free.*

Note that all of these interpretations start with words like ''perhaps''. This is intentional: *interpretations are speculative by definition – they're hypotheses*. We invite the patient to speculate with us, rather than giving them the ''word from on high.'' We're

always interested in engaging the patient in being curious about his/her behavior, and the more our interventions convey this to our patients, the better.

Genetic interpretation

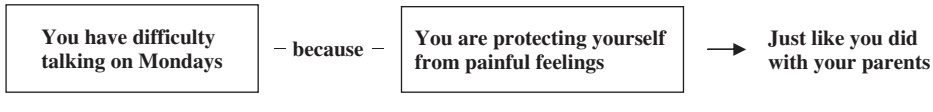
A genetic interpretation is one that not only explains unconscious material, but also links it to the person's early past [11]. The ''because schematic'' for a genetic interpretation looks like this:



For example, let's say that Mr A tells us that his parents were divorced and had joint custody, and that he split his weeks between his mother's and father's homes. Just when he felt comfortable, he had to go to the other place, where it took time for him to ''warm up.'' Given this, we could speculate that the defensive blocking is something that he has been doing since childhood and that it might even have had its origin in the separation from the parents. If the patient seems affectively connected to this historical material, we could venture a genetic interpretation that might sound like this:

> *I think that your difficulty talking on Mondays is a way of protecting yourself from painful feelings, just like it was when you had difficulty warming up when you got to one parent's house from the other's.*

Here's the schematic:



The genetic interpretation adds that last piece – the link to the patient's early history. Genetic interpretations should be used sparingly and carefully, and only when the patient's affect is clearly linked to the early material. Otherwise, genetic interpretations can take the patient away from the heat of the ''here and now'' situation in the treatment and can foster intellectualization.

Constructing a personal narrative

In the early days of psychodynamic psychotherapy, therapists talked about **reconstruction**, which meant literally trying to reconstruct what happened in the patient's early history [12]. This used to be a major therapeutic goal of psychoanalysis and psychodynamic psychotherapy. These days, however, most people think that this

can never be done – that even with photographs, videos, letters, and stories we can never really know what happened during the person's childhood. Now we generally think that the best that we can do is to try to construct a meaningful narrative of the past that helps patients to make sense of their thoughts and feelings about their early relationships and experiences [13]. We frequently intervene in a way to help facilitate the construction of this type of personal narrative, and this often involves the unearthing of unconscious material. For example, when Mr A talks about being shuttled from house to house each week, it might become clear to us not only how difficult this was for him but also that he blocked out his idea that the reason he had to keep shuttling was because his mother wanted more time to see new boyfriends. So we could say to him:

> *It sounds like you now have the idea that the reason that you had to suffer through being shuttled from house to house was because of your mother's wish to have more time to date.*

Here, we're not saying that we *know* that this was true, but rather that the patient is developing a new idea about his childhood and about why things happened the way they did. It involves material that was either not conscious or not consciously linked, but it does not involve current behavior. Helping patients construct personal narratives can be enormously helpful to them as they try to make sense of themselves, their lives, and the workings of their minds.

Now that we have reviewed the basic elements of the listen/reflect/intervene model, we can begin to apply it to the major kinds of data that we hear from our patients:

- affect
- resistance
- transference
- countertransference
- unconscious fantasy, conflict and defenses
- dreams
- working through (see Part Seven)
- termination (see Part Seven)

Uncovering Interventions

- Confrontation
- Clarification
- Interpretation
- Genetic interpretation
- Constructing a personal narrative

Suggested activity

How would you label the following interventions?

1. *Patient* *Whenever I come in here after I've just gone swimming, I feel really disoriented.*
   Therapist *You said the same thing last week.*

2. *Patient* *So I had a dream last night that I was in jail and didn't know why and there were two black horses in there with me. What do you think that means?*
   Therapist *Sometimes before we know what a dream means, we can look at different parts of it to see what comes to mind about them. For example, I wonder what comes to mind about black horses?*

3. *Patient* *This divorce is going on forever. When I started, I thought we'd be done in a year. I can't even think about what it's doing to the kids.*
   Therapist *It's taken a lot out of you this year.*

4. *Patient* *The office always smells bad after that patient leaves. I prefer Mondays, when he's not here in front of me. There's no smell then.*
   Therapist *Maybe you'd prefer to feel like I didn't have any other patients.*

5. *Patient* *I was fine when you were on vacation. No problems at all. In fact it was nice to not have to get up so early in the morning to come here. It's funny, though – I couldn't sleep in – I kept waking up at the same time as if I were coming to a session.*
   Therapist *Although it does sound like you were fine, maybe you had some feelings about not being here.*

6. *Patient* *This whole thing with my mother is looming in front of me like a black hole. I don't even know how to get started on it – I just feel like sleeping for a few days.*
   Therapist *Let's look at it together – why don't we start with the feelings that you had when she forgot your birthday?*

7. *Patient* *My son hates me. That's why he never calls. I think that he's been calling and hanging up a lot. My wife thinks that I'm crazy, but I'm sure that that's what's going on.*
   Therapist *Do you think that there's any other way to look at what's been happening?*

Comment

1. **Clarification**: this brings together two phenomena that are related.
2. **Psychoeducation and call for associations**: first the therapist instructs about exploration of a dream, then she directly asks for associations.
3. **Empathic remark**: the therapist is simply empathizing with the patient's difficulties.

4. **Interpretation**: this brings unconscious material to the surface. It could be re-written as, ''You are bothered by the smell on Monday because you would prefer to be able to feel that I don't have any other patients.''
5. **Confrontation**: the therapist is calling some potential ambivalence to the patient's attention.
6. **Collaborative intervention**: breaking things into parts, question – the therapist helps the patient to look at something that looks impenetrable by suggesting that they work together and then asking specific questions to get started.
7. **Joint reality testing**: the therapist explores the patient's ability to look at his conviction another way.

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PART FIVE: Conducting a Psychodynamic Psychotherapy: Technique

Introduction: General therapeutic strategies

Key concepts

As our patients talk in psychodynamic psychotherapy, we hear many things.

Listening for certain important elements helps us to understand our patients in order to:

- uncover unconscious material
- support weakened ego functions

These important elements include:

- affect
- resistance
- transference
- countertransference
- unconscious fantasy, conflict, defense
- dreams

All psychodynamic psychotherapies use both uncovering and supporting techniques. Regardless of the predominant mode, the therapist should be prepared to shift flexibly from one to the other depending on the need of patient.

All patients need some support in order to feel safe and understood in the therapy.

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Listening for important elements

In any given psychotherapy session, there are many themes that emerge. As we discussed in Chapter 16, we use ambient listening at the beginning of the session, allowing our attention to be drawn from topic to topic by the patient's flow of associations. However, as we begin to filter and focus, there are certain elements that we hone in on. These include patients' **affect**, ways in which they work against the treatment (**resistance**), their feelings about us (**transference**), as well as their **fantasies**, **conflicts**, and **dreams**. We also listen carefully to our own feelings about the patient (**countertransference**). These elements are particularly helpful in moving the patient toward unconscious material and in pointing us toward areas of ego weakness. Each chapter in this part of the book will discuss one of these essential elements. When you conduct a psychotherapy session, you should be able to name the dominant affect, resistance, transference, countertransference, unconscious fantasies, conflicts, and defenses in that session. The review activity at the end of this part will allow you to practice this.

Based on what you have learned in the initial evaluation about the patient's strengths, problems, and needs, you are also now able to make a decision about whether you think that the basic overarching approach that will best help your patient is:

- uncovering unconscious material, and/or
- providing support

Using a mix of techniques

This in turn defines the *predominant* set of techniques you will be using at the start of treatment – uncovering or supporting. The reality of everyday clinical practice, however, is that psychodynamic therapists typically use a blend of supporting and uncovering techniques matched to the particular needs and abilities of the patient in the moment. The particular ''mix'' varies from patient to patient, and sometimes from moment to moment with the same patient. Your choices about this are guided by your understanding of what aspects of the patient's emotional and mental functioning need ''support,'' and how able the patient is to tolerate learning about unconscious material. If you have chosen a predominantly uncovering approach, you can still use supporting interventions, and if you have chosen a predominantly supporting approach you can still make uncovering interventions.

All patients need some support

Remember, however, that *all* patients need some support. Healthier patients often need nothing more then the support present implicitly in all psychodynamic

psychotherapy – the feeling of being heard and understood in a non-judgmental atmosphere. Some patients may need more support at the beginning of treatment to help them feel safe in the therapeutic relationship. Still others may need more support later in the therapy when a crisis occurs. Finally, some patients may require consistent support throughout the treatment.

With this framework, let's move on to listen, reflect, and intervene with the major themes in a psychodynamic psychotherapy session.

19 Affect

Key concepts

Generally, the patient's primary affect leads us to the dominant theme of the session. This is called the principle of affective dominance.

Understanding the patient's dominant affect is the best way to choose where to focus and how to intervene.

Affects can be:

- conscious and unconscious
- conveyed through words and behaviors

Supporting techniques help patients to manage their feelings more adaptively.

Uncovering interventions help patients to become aware of unconscious affects and to use affects to understand other unconscious material.

Why is affect important in psychodynamic psychotherapy?

What are the things we remember most in life? The times we were sad, joyful, frightened; the moments that moved us and were full of feeling. Insight without affect is like a sunset without color. Affect is primary – it fluidly connects us to early, unconscious experiences in a way that mere thoughts cannot. As a psychodynamic psychotherapist, affect is your compass, your trailhead, your weathervane. If you stay close to the patient's affect, even when you're lost you'll have an idea of where to take your next step.

But affect can also cause tremendous difficulties for our patients. Many disorders we treat relate to problems with affect, such as anxiety, depression, mania, irritability, and panic. Identifying these affects and how our patients manage them is central to making a diagnosis, evaluating ego function, and selecting treatments. In psychodynamic psychotherapy, we focus on the patient's affect, not only to make a diagnosis or to describe the patient, but also to elucidate aspects of our patient's unconscious experience and to improve affect management.

Affects can be conscious or unconscious, verbal or nonverbal, expressed openly or defended against – as psychodynamic psychotherapists we have to learn to hear all of these and to use them in the following ways:

- **To understand what is most important to the patient at any given time:** During a psychodynamic psychotherapy session, the patient will talk about many things.

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The best way to determine which ones are most important to the patient is to listen for the elements that are most closely connected to affect. For example, let's say the patient spends 20 minutes talking in a near monotone about his work, but then becomes almost tearful during a momentary reference to the going away party for his research assistant. Follow the affect – it's a sure bet that there's something about this departure that's important to the patient.

- **To help patients to better understand their feelings:** In order to understand ourselves, we need to understand our affects. Patients can have different kinds of problems related to understanding their feelings, and we can help with all of them.
  - **Difficulty experiencing feelings** – Patients who are unaware of their feelings have problems in many aspects of their lives. Not knowing what we feel affects our ability to make choices, impedes our ability to connect to other people, and decreases our ability to enjoy life.
  - **Difficulty identifying feelings** – Some patients enter treatment unable to identify and express what they feel. It can be quite frightening to experience feelings without the ability to identify them. In addition, some emotions, such as anger, fear, envy, competition, and shame may be particularly difficult to identify and acknowledge. The capacity to label our affects gives us a sense of control and ultimately a way to reflect on what we feel, communicate with others, and understand our reactions.
  - **Difficulty linking feelings and experience** – For some, feelings may appear to come out of nowhere. As with learning to identify and label one's feelings, making links between affect and experience can also be a tremendous relief and can replace helplessness with a sense of control. Connecting feelings and their precipitants gives patients the capacity to communicate more clearly with others, get what they need from the world, and ultimately develop insight into how they make others feel.
- **To help patients manage affects:** Some patients are flooded or overwhelmed by their feelings. Almost all patients need some help with this, but for some patients this may be a focus of the treatment. As the therapist, your ability to tolerate the intensity of the patient's affect, to stay calm, and to help put feelings into words offers a healthy model for managing affects and can serve a powerful ''containing'' function [1–4]. Helping people to learn about the behaviors that they employ to manage or defend against affects can also be helpful with this problem.

Now let's move on to our techniques for working with affect.

Technique

Listening

If you think of yourself as a hiker looking for a path through the woods, affect signals the trailhead. If you start with the affect, you will generally proceed towards the dominant themes in the session. This is sometimes referred to as the **principle of affective dominance** [5–6]. Thus, as we begin to listen to the patient during a session,

our first order of business is to determine the dominant affect. This is not always so easy, since the dominant affect may be unconscious. So how do we do this? Here are some questions to ask yourself while you are listening to the patient that can serve as guidelines for identifying the dominant affect:

- **What is the patient feeling?** As you listen to the patient talk, ask yourself this question. Often, the patient is directly expressing emotions in connection to what they are talking about and the affect is obvious. For example, a 35-year-old single mother of two comes to her session crying because, once again, she has been thwarted in her effort to obtain a green card. *Her affect is obvious*. She is sad and frustrated, and she exhibits this using both words and behavior.
- **Is there an absence of feelings?** At other times, the patient is talking about something that seems significant, yet does *not express any emotion*. For example, if a patient shows no emotion while telling you that his girlfriend just broke up with him, you experience the absence of feelings. Generally, the absence of feelings may be a clue that a painful affect is being defended against. Depending on the patient and particular circumstances, you may choose to ask more about it or to respect the patient's defenses and **supportively bypass** the moment. Also, remember that the absence of feelings may be the symptom of a mood disorder, such as depression.
- **Do the affects match what the patient is describing?** Ask yourself whether the affect that the patient is expressing matches the content of what he/she is saying. As we discussed in Chapter 16, listening for *incongruities* is a critical part of listening to affect. For example,

  > *A 65-year-old retired barber chuckles as he tells you that he has just lost money in the stock market*.

  The patient's affect does not match the experience he's describing, suggesting that this is something to explore further.
- **Does the affect change during the course of a session, and if so, why?** Sometimes patients are hesitant and anxious at the start of a session and relax more as they start talking. At other times, patients seem to get annoyed by something you say, have a thought that changes how they feel, or close up as the time comes to an end. For example, a young patient begins to excitedly tell you about her relationship, and then becomes more subdued as she remembers that you are about to go on vacation. The patient's ability to express emotions has decreased because of her feelings about your being away.
- **Does the patient's behavior in the session indicate an affect?** If patients do not directly express their affect in words, they may be expressing their affect in their behavior. Behaviors can be subtle or obvious, for example sitting rigidly, fidgeting, talking softly, pounding the chair, giggling, or crying. Ask yourself whether the affect-laden behavior is consistent with the content. Thinking about how the patient looked in the waiting area and how they came into the room can also be very good clues to the patient's dominant affect. For example, a patient who is sitting with his head in his hands in the waiting area or who comes bounding into the office is clearly communicating his affective state.

- **Does the patient's behavior outside of therapy suggest an affect?** The patient's behavior outside of therapy may suggest an affect that is not directly verbalized. For example, a newly married 32-year-old female law student reports having a conversation with her mother about weekend plans and states that the conversation was ''no big deal'' but then went home and ate an entire box of Oreos. In this case, the patient's behavior outside of the office gives you a good clue to how she is feeling.
- **What is the quality of the affect? Is the patient's affect excessive or superficial?** Sometimes patients appear to express more emotion than we would expect in a given instance. How much crying is appropriate when one gets a bad grade on a paper? There are no right answers to these questions, but as you gain clinical experience you will feel more confident to wonder about an under- or over-reaction. An example of a superficial affect could be a 40-year-old male patient whose wife has just miscarried for the third time after their fourth trial of *in vitro* fertilization, who calmly states, ''I guess we have to go back to the drawing board.'' In this case you might wonder what he feels about having a baby and why he is so emotionless about these disappointments.
- **How does the patient manage his/her affect? Does the patient seem overwhelmed by what he/she is feeling?** Some patients do not have the ego strength and defensive structure to manage strong feelings and will become overcome by intense feeling states or engage in self-defeating behaviors as a way to soothe themselves, avoid, or manage their discomfort. Some people manage intense affects with shopping sprees, drinking excessively, sexual acting out, and even suicidal thoughts. Listen for these and other behaviors as clues that patients are not able to manage their affects.

Reflecting

Next, we turn to the choosing and readiness principles to consider how to intervene. Ask yourself whether the dominant affect is near the surface and check in with your countertransference. Think about the phase of treatment, the therapeutic alliance, and the patient's ego function. One guiding principle is that affect is almost always a good place to start. Empathizing with an expressed emotion or labeling an inchoate one is almost always a helpful, safe approach that offers relief, provides support, and points the way toward deeper material.

Which affect do I choose?

People are complex, and they do not express isolated emotions. How do we know which emotion to focus on? As we begin to reflect, we think about which affect or affects seem to be closest to the surface of the patient's mind. Which affect is mentioned most? Which affect explains the patient's behavior? The dominant affect may or may not be the affect that the patient says is most important. Our job is to discern whether it is conscious or not, using the questions and clues listed in the section on ''listening'' above.

Choosing the surface affect

Sometimes the best choice is the affect that feels most pressing to the patient. For example, a 30-year-old female patient is clearly anxious as she tells you that she and her husband are trying to become pregnant. She says that she knows that she has just ovulated but that it is too early to know if they conceived. Despite her anxiety, she says that if she just knew that she weren't pregnant, she'd at least be able to drink at the party she's going to that night. In this case, the surface affect is the patient's anxiety regarding her potential pregnancy. Her comment about drinking, however, suggests to you that other, deeper affects might be present – such as ambivalence about becoming a mother and giving up certain pleasures. Given the patient's anxiety, however, the better part of valor is to stay with the expressed affect and to empathize with the patient's anxiety, saying something like, ''That limbo state of not knowing is very difficult. Can you say more about that feeling?'' This tack is particularly helpful for new patients, patients who are overwhelmed by anxiety, or patients who have difficulty identifying their feelings on their own [5].

Choosing an unconscious affect or an affect which is being defended against

Sometimes, however, the better choice is the deeper, hidden feeling. With an established patient with whom you have a good alliance, focusing on feelings that are being defended against can be extremely helpful. Your countertransference is often your best guide to identifying hidden feelings. For example, let's say that a patient who has been in treatment with you for many years and with whom you have a good alliance seems cheerful as he tells you that he was just turned down for a job he really wanted. Having heard all of the details of the job pursuit and interview process, you realize that you were rooting for him and that you feel deflated as he tells you about the rejection. You reflect that you are experiencing the feeling that he is defending against, and you say:

> *I know how much you wanted this job yet you seem almost cheerful as you talk about this. Maybe it's too hard to think about being disappointed.*

This helps the patient to learn more about himself and to use his feelings to deal more effectively with this blow.

Intervening

Basic interventions

Psychoeducation, **direction**, **questions**, and **empathy** are essential for helping the patient to focus on affects. They are often steppingstones toward working interpretively or supportively in sessions. Let's return to the patient who ate the box of Oreos after discussing weekend plans with her mother. You might first intervene with some

psychoeducation and a **question** to let her know that one way to understand her binge is to think about what she might have been feeling right before the episode. One way to phrase this is:

> *For some people, binging is often a way of coping with uncomfortable feelings. What were you feeling right before you started eating the Oreos?*

or

> *What were you feeling after the conversation with your mother?*

If the patient states that she felt guilty because she had to tell her mother that she was going to her in-laws for Mother's Day, you could **empathize** by saying, ''That must have been difficult.'' Expressing your empathy communicates your interest and understanding to your patients and helps them to discuss difficult, shame-filled affects.

Supporting interventions

We select supportive interventions when our aim is to:

- lessen (or contain) intolerable affects that threaten the patient or the therapeutic relationship; and/or
- improve the patient's ability to manage and regulate affects

We all get overwhelmed by our emotions now and then. Basically healthy people are able to manage these feelings and to continue functioning productively, either by seeking appropriate help and comfort from others, or by finding other ways to soothe and calm themselves. However, some people are unable to manage intense affects on their own. Their emotions overwhelm them, impairing their everyday functioning and weakening their other ego functions. In addition, they often rely on self-destructive activities (such as drinking, using drugs, binging, cutting themselves, and engaging in unsafe sexual activity) to manage strong feelings. Impaired affect regulation can be acute or chronic. Its causes vary from psychiatric disorders (such as mood disorders, personality disorders, and substance abuse disorders) to a variety of stressful life situations (such as trauma and medical conditions). For example, a woman with fundamentally good affect regulation might develop dramatic post-partum mood swings from a combination of hormonal effects, sleep deprivation, and the demands of new parenthood.

When patients are overpowered by intense emotions, it is difficult, if not impossible, for them to try to explore what they are feeling [7, 8]. A capacity for regulating affect, containing anxiety, and self-soothing is a necessary foundation for self-observation and reflection. Until these capacities have been sufficiently developed, focusing on overwhelming affect is likely to escalate anxiety and further impair functioning [9].

In these situations, we use a variety of supporting interventions to *lessen and contain intolerable affects*, and to *improve the capacity to tolerate and manage affects*.

Lessening or containing affect

Infants are born unequipped to manage emotional distress on their own. They rely on the help of emotionally attuned, supportive caregivers to modulate their overwhelming affects. Caregivers do this by using both verbal and non-verbal responses to convey their empathic understanding and ability to tolerate and endure the baby's distress [1, 10]. Similarly, when our patients are very upset and unable to manage their own affects, we intervene in order to help them to lessen and contain their affects.

- **Lessening** affect involves using supplying interventions such as **naming emotions**, **nurturing**, **soothing**, **reassuring**, **empathizing**, or **validating** to reduce a patient's overpowering or intense feelings in a direct and immediate way.
- **Containing** affect refers to the ways in which therapists help their patients from being overwhelmed by their feelings [11]. Some of this is communicated non-verbally as a function of the **holding environment** (see Chapter 3) in which therapists tolerate and accept their patients' strong feelings. Containing affect is also accomplished using a variety of supplying interventions. These include **remaining calm** in the face of patients' intense feelings, **putting words** to their inchoate and threatening experiences, **demonstrating interest and understanding**, **interpreting up**, and **supportively bypassing** extreme feelings.

Here are examples of supporting interventions we might use to lessen or contain affect:

Patient	*When he left the house, my mind sort of went nuts. I went and got his best suits and cut them up with scissors (begins to sob uncontrollably). Am I going crazy?*
Therapist	*No, I don't think you're going crazy. What I'm hearing is that he really hurt you. I guess in the moment cutting up his suits was the only way you could think of to hurt him back – although it sounds like losing control like that frightened you.* (**reassurance**, **empathizing**, **reframing**, **naming emotions**)
Patient	*I'm shaking just thinking about it – I wanted to trash his TV, too, but at the last second, I couldn't do it.*
Therapist	*Given how upset you are, it's great that you're able to talk about it. Maybe you can take a little comfort in knowing you were able to exert some degree of self-control in the middle of feeling so angry. I'm thinking of that time last month when Rick really disappointed you and you felt like binging but you were able to rein it in and come talk about it here, which was great.* (**praise**, **soothing**, **reducing guilt**, **reinforcing, reminding patient of her capacities**)
Patient	*(Drying her eyes) A lot of good that did me today.*

Therapist *It's discouraging to see yourself doing the same old things. But you know Rome wasn't built in a day. It takes time to change some of the automatic ways we react to things. The next time you're feeling that way, maybe you could try . . .* (**validating, offering optimism and hope**)

Patient *. . . a good stiff drink? (smirks)*

Therapist *(smiles) I guess that works for some people, but for a lot of people, alcohol just takes the lid off and makes them more aggressive. But there's a good book on anger management I could recommend. They describe a lot of useful tips for controlling anger.* (**soothing, informing, suggesting**)

Patient *I feel better just talking about this – calmer. Maybe it gets a little easier each time.*

In this example, the therapist helps to calm the patient down by tolerating her strong affects, listening without judging, and lessening/containing affect using a variety of supplying interventions.

Improving the capacity to tolerate and manage affect

While it's sometimes necessary for us to lessen and contain our patients' affects, we also want to help them to develop the ability to manage strong affects on their own. Recall from Chapter 18 that *assisting* interventions are aimed at strengthening the patient's existing but faltering ego functions. Here, we're assisting weakened affect regulation with the ultimate goal of enabling patients to manage emotional distress independently.

Consider the following examples of supporting interventions we might use in *assisting* patients to tolerate and manage strong affects:

Patient *I couldn't sleep. My mind was going a million miles a minute. I felt desperate, like I just had to cut myself to calm myself down. It felt good when I saw the blood. I could finally relax.*

Therapist *I realize this behavior has been a way of coping for you . . . but my hope is that together we can figure out other less self-destructive ways for managing your feelings.* (**demonstrating interest and understanding, explicitly joining, joint goal setting**)

Patient *I try to do that – I can sort of see myself going down the wrong road – but then I'm cutting again.*

Therapist *That's great that you have some sense of that – and it's true that this can be hard to do on your own. Why don't we try to work on it together? Don't get too discouraged if you can't change the behavior right away. It's hard to break old habits but it can be done. Have you found anything that ever works to stop that cutting impulse?* (**praise, explicitly joining, encouraging, offering optimism, jointly exploring alternative ways of acting**)

Patient *A girl from group taught me how to do guided imagery – and I like that – I've done it in the past – sort of tried to drift off to some scene in my mind – but sometimes the impulse is too strong.*

Therapist *That's a great place to start, and we can practice that in our sessions.* (**praise, jointly working on a project**)

Supporting interventions can also facilitate uncovering work. For example, helping our patients to manage their feelings more adaptively often involves uncovering affective triggers:

> *You're usually inclined to drink when you're feeling angry or burdened and feel you deserve a reward.*

or

> *You tend to call old boyfriends when your partner is out of town and you're feeling abandoned and lonely.*

These can then become topics for the therapy.

Uncovering interventions

We use uncovering interventions when our aim is to:

- help patients to become aware of unconscious affects, and
- use affects to understand other unconscious material.

Confrontation

The first step in constructing an interpretive intervention is **confrontation**, which calls the patient's attention to their affect. We confront the dominant affect in order to:

- focus patients on their feelings, and
- stimulate patients to talk about their affects.

> **Example**
>
> *A 38-year-old recently married lawyer presents for psychotherapy because his wife says that he is emotionally distant. He has just told his parents that he cannot be home for Thanksgiving because he and his wife decided that they would spend the holiday with her family this year. He tells you that he told his parents of this decision by phone, which was difficult. After the phone call, he left work early, missing an important client meeting.*

When you listen, you are struck by the vagueness of the word ''difficult.'' In your reflection, you wonder if guilty feelings about his parents caused him to skip out on work. Since your aim is to learn more about what is happening in his mind, you decide to confront by calling the missing affect to your patient's attention. You say:

> *You said the call was difficult, but I am still not clear about what you felt. It must have been a strong feeling if it led you to skip out on work and miss an important meeting.*

The patient responds by telling you that he enjoys the rapport he has developed with his father-in-law, who is also a lawyer, and that he feels that this new relationship could help his career. He continues, stating that he feels guilty about having this ''new father'' because he always wished that his parents were more professional. Thus, your confrontation of the missing affect was successful because it uncovered his guilty feelings and helped him to articulate affect.

Clarification

Clarification highlights patterns by linking related examples. We use clarifications to work toward interpretations and to strengthen the case that something unconscious is operating. This technique will help us get into a deeper layer of the patient's experience, and open the possibility of making an interpretation. To continue with the example of the lawyer, let's imagine that he says that Thanksgiving with his in-laws was ''fine.'' You reflect that, once again, he has chosen a very nondescript word to describe an emotionally charged situation. At this point, you could offer a clarification saying:

> *You know, you used a word like ''fine'' when you said that the call to your parents was ''difficult.'' My sense is that you often use words like this when you're describing situations that are actually filled with a lot of emotion.*

This invites the patient to think about his use of these vague words and what it might mean about his avoidance of affect.

Interpretation

Once you think that you understand something about why the patient is avoiding strong feelings, you can venture an interpretation. Perhaps, in response to your clarification, the patient says:

> *Well, using these words is better than screaming all the time like my mother did. I just can't bear that.*

Your interpretation could then be:

> *So I guess that in order to differentiate yourself from your mother, you choose to almost dissociate yourself from your feelings by using these very vague words.*

The interpretive process has helped to uncover an unconscious motivation for the patient's emotional disconnectedness. As the therapy continues, this will repeat many times as he works through the way in which he uses his relationship to his emotions to differentiate himself from his family.

We're now ready to move on to transference, another important aspect of psychodynamic psychotherapy.

Suggested activity

Read the following clinical vignettes and then consider the study questions that follow.

1. The patient comes in and slumps into the chair. Her hair looks unkempt and she's not wearing any lipstick, which accentuates how tired and worn out she is. After a brief silence, she begins:

> *I just don't feel like talking about the same old things. It feels like we are not really getting anywhere. I feel stuck in my life. And, like I've lost hope for this therapy as a way to change things. I just feel bored at work, not really sure what my goals even are. Do I even care about making deals? I just feel like I'm not really sure I am qualified to do this job. I promised myself that I would sign up for one of those internet dating sites, but I haven't done that either and don't really want to. My friend has been doing that for six years and doesn't like any of the people she's met. I went on a bird-watching hike in the park, and the only other single person was a nerdy, geeky guy carrying a canvas bag with alternative energy buttons all over it. I'm so done with this. All of the good guys are married by now.*

- What affect is most on the surface? How did you decide?
- What might you say to this patient at the end of this passage?
- What interventions would be appropriate if it were a new patient and you weren't sure about her ego strength?
- What interventions would be appropriate if you had a strong alliance and this were a patient with high-level ego strength?

Comment

The surface affects are hopelessness and despair. This is clearly communicated by her thoughts and behavior. She also seems angry (expressed at the therapist indirectly and at herself in her frustration and self-punishing comments), but because she does not express this directly, we can hypothesize that it is a bit deeper. You might say, ''You sound hopeless,'' or ''So many things are frustrating you.'' In a supportive mode, you might stay with labeling the affects and/or suggesting ways she might help herself or reframe things. In an interpretive mode, you might focus on the anger, which is being defended against and likely to signal areas of unconscious conflict, including her relationship with you.

2. The patient comes in 15 minutes late, which is unusual for her, and is out of breath.

> *So sorry to be late! You would not believe what happened! It turns out that I have genital warts! It's probably from that football guy I ended up sleeping with during homecoming weekend. I am sure that this will be the end now. No one will ever want to be with me again. This happened to my roommate last year and she hasn't gone on a date since. What am I going to do – it is like having a Scarlet Letter!*

- What affect is most on the surface? How did you decide?
- What might you say to this patient at the end of this passage?

- What interventions would be appropriate if it were a new patient and you weren't sure about her ego strength?
- What interventions would be appropriate if you had a strong alliance and this were a patient with high-level ego strength?

Comment

The surface affect is panic. Other affects also present are shame and feeling sexually damaged. To intervene supportively you might say, ''You've just found out and are clearly alarmed, but let's take a moment to think about this. Have you spoken yet to your gynecologist to find out about treatment?'' To intervene interpretively after providing empathy about her panic and fear, you could say ''A Scarlet Letter . . . tell me more about that'' in order to deepen the exploration of her shame and feeling of being damaged.

20 Free Association and Resistance

Key concepts

Free association is the patient's attempt to say what comes into his/her mind without editing.

The flow of associations consists of thoughts, feelings, and memories that link together and lead us to material that was previously out of awareness.

Resistance is anything that opposes the work of the treatment and the flow of associations.

Resistance can also be thought of as defense in the context of the psychotherapy. It is an expectable part of treatment that helps us to:

- understand our patients' characteristic patterns of behavior
- hone in on unconscious material that is particularly difficult for our patients to access

Supporting techniques use our understanding of resistances to help patients make more adaptive choices.

Uncovering techniques aim to understand the unconscious meanings of resistance and to make patients aware of new unconscious material.

How do we get from the conscious to the unconscious mind? We have no map and we don't know where we are going. We are aided by one thing, however, and that is that our thoughts are linked in a non-random way. We call this **psychic determinism** [12]. We exploit the principle of psychic determinism all the time when we lose our train of thought and follow our associations to get back to what we were thinking. If each thought is connected in a meaningful way to the next, then it makes sense that if you keep following thoughts, you'll ultimately get to the unconscious. Thus, if we help patients to wander freely from thought to thought, we are likely to travel into unknown territory that is meaningfully connected to conscious experience. For example, let's say that a patient says that she feels sad but doesn't know why. She then just starts to talk freely in the session, saying:

> *I was feeling this way on the bus coming over. I was sitting next to the window. It's so gray today. I hate gray days like this. They remind me of rainy days at camp. They were so lonely.*

By freely associating, the patient has stumbled onto an early memory, and we can bet that something about that memory or the feeling invoked by the memory is related to the way she's feeling today.

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Free association

This kind of verbal wandering is what we call **free association**. Free association is the patient's effort to say whatever comes into his/her mind without editing [13, 14]. It's a very different way of communicating than most people use in social situations. For example, in a non-therapy setting you might choose not to tell your friend that you hate her dress, or you might hide the details of your wedding plans from a colleague who is in the middle of a divorce. We all edit all the time – consciously and unconsciously – in order to protect ourselves and the people with whom we are communicating. If you try to talk or think without editing, you'll find that it's nearly impossible. So when we ask our patients to free associate we are asking them to do something that's quite difficult. Nevertheless, we instruct them to do just that because it's the best way we have to move into the uncharted territory of the unconscious and to understand how their thoughts and feelings are linked.

Recall from Chapter 8 that helping the patient to learn to free associate (or speak freely) is important to do early in the treatment. Once the evaluation phase is complete and you and the patient have decided to begin psychodynamic psychotherapy, it is important to help the patient understand how he/she can best participate in the treatment. This involves explaining:

- the importance of free association
- how to try to speak as freely as possible

As a review, here are some examples of things that you might say in order to do this:

> *As we begin this treatment, try to say whatever comes to mind without editing. It's impossible to not edit at all, but if you notice that you are, see if you can let us know.*

or

> *Try to let yourself say whatever comes to mind, with particular attention to how you're feeling, any dreams you may have had or any thoughts that you have about the treatment.*

You can experiment with different versions of this until you find the one that feels right to you.

Do we always want patients to free associate?

Sometimes, clinicians worry that encouraging patients with weaker ego function to speak freely might overwhelm or frighten them, as if it is inviting them to take the ''lid off Pandora's box.'' The reality is that with the exception of some people with severe personality disturbances or psychosis, very few patients present in a state of such extreme vulnerability that an invitation to speak freely would result in rapid decompensation. In the unlikely event that the therapist's invitation to free associate

results in anxiety and disorganization, the therapist can step in with supporting interventions to reduce anxiety. Here's an example:

A patient with obsessive-compulsive disorder is talking about what he did over the weekend:

Patient *I had a good weekend with Jane. We saw a movie – oh, I can't believe that I just thought about the movie because it totally sent me into a tailspin. It was really violent and I kept having violent images all weekend. Now I'm afraid that that will start up again.*

Therapist *Well, let's get back to the rest of the weekend. Sounds like you had fun – what else did you do?*

Here the therapist **redirects** the patient away from his obsessive thoughts in order to contain affect and prevent him from feeling overwhelmed.

Breaks in free association offer clues to the presence of material that is difficult to bring into awareness

In addition to following the patient's free associations, observing how and when patients are *unable* to free associate is another important way to listen for unconscious material. Breaks in free association signal the presence of difficult material and the defenses that are keeping it out of awareness. For example, let's say a patient comes into session, greets you and while talking, notices that you are wearing the same shirt she just bought at the store. She then becomes quiet. This break in her verbal communication lets you know that something has made her uncomfortable. When you ask her about her thoughts in that moment, she says that telling you that she owned the same shirt that you are wearing felt too ''familiar.'' Her discomfort prevented her from associating freely – and we call this a **resistance**.

What is resistance?

Resistance is anything that the patient does that opposes the process of therapy [15, 16]. Early psychoanalysts likened free association to the flow of electrons in a circuit – thus, whatever the patient did to impede the ''electron flow'' was resistance. Anything can function as resistance – silence, hiding feelings, being too agreeable, missing sessions, not paying one's bills – anything. Resistances can be conscious or unconscious; they can be expressed verbally or in action. One way of thinking about resistance is that it is defense as it is manifested in the therapy. Here's an example:

Mr A has been in therapy for two years and has found it to be very helpful. He is always on time for his 2x/week sessions. Recently, Mr A has started to talk about his relationship with his wife in the context of her threats to separate from him. His therapist suggested that there might be some things that he was doing that were contributing to the problems in the marriage. In the next few weeks, Mr A was uncharacteristically late to many sessions. Together, he and his therapist came to understand that this lateness related to Mr A's wish to avoid dealing with this topic.

Mr A is defending against looking at his behavior. When it manifests as lateness to therapy, we call it resistance.

Why do we look for resistance?

One might think that because resistance is the patient's way of opposing the work of the therapy, it is a problem that we should eliminate. This is the way that the early analysts thought about resistance. However, the more we learn about resistance, the more we realize that understanding resistance is a very good way to understand our patients and to identify things that are particularly hard for them to think and talk about. For example, patients who don't pay their bills or who come late to sessions are showing us quite clearly that they are ambivalent about their treatment. Resistance is to the therapist what pain is to the doctor – it helps us to know ''where it hurts'' [17]. Given this, let's look again at the example of the patient who does not tell you she just purchased the shirt that you are wearing. Perhaps she is afraid of feeling closer to you by acknowledging she has the same shirt. Perhaps she worries that you would feel invaded by this comment about your clothing. Whatever her reason, her silence helps us see that this situation has made her uncomfortable. Her resistance thus points the way to unconscious feelings she has about you. Understanding these feelings will undoubtedly help you to understand her better.

Technique

Listening

Listen to the train of associations

In addition to affect, free association and resistance are central to what we listen for during a therapy session. Having explained to our patients the importance of saying whatever comes to mind, our job is to follow their thoughts on a journey to their unconscious. Some have described this listening stance as ''evenly hovering attention'' [18]. This type of listening is appropriate whether we are working in a primarily uncovering or a supporting mode.

Listen for breaks in the train of associations

Once you have explained the importance of associating freely, you can then view everything that impedes the process of free association as a potential resistance. Clues that breaks are occurring include silence, hesitation, rapid change of topic, and losing one's ''train of thought.'' Here's a common example:

> *After her Christmas vacation, Ms B talked about everyone she had seen in her family until she got to her sister – she then forgot what they had been talking about and changed the topic.*

The break in Ms B's free associations signals to us that feelings about her sister are especially difficult to bring into consciousness.

Listen for other examples of resistance

Resistance can appear in many forms, including skipping over thoughts, having a secret, coming late, forgetting to pay bills, or always starting the session with a dream. Some resistances occur in the form of actions either inside or outside the session. They function as resistances if they allow patients to express feelings rather than discussing them in sessions. **Acting out** refers to behaviors that occur outside of the sessions, such as looking up the therapist on the Internet or starting to date a psychologist at the beginning of the therapy. **Acting in** refers to behaviors that occur within the sessions, such as getting up and browsing through the therapist's books or falling asleep. Free association itself can be a resistance if the patient simply talks on and on without engaging with the therapist in a meaningful way. Transference, which we will discuss in the next chapter (Chapter 21), can function as a resistance if the patient speaks exclusively about the therapist without referring to problems that are occurring in his/her life. Good clues to the presence of resistance are boredom in the therapist and stasis in the treatment [19].

Reflecting

Once you have identified a resistance, the next step is to reflect on whether to call it to the patient's attention – and if so, how and when to do it. If we are primarily trying to uncover unconscious material, helping a patient to notice a resistance can be very fruitful; if we are primarily trying to support, we generally take note of the resistance without highlighting it to the patient. Since resistance is the patient's way of avoiding something painful, shame-inducing, or frightening, we have to use careful judgment to avoid seeming to attack or criticize the patient. Remember, when the patient is resisting they are just showing us ''where it hurts.''

Get to know the resistance, respect it, and live alongside it

Once you think a resistance is operating, your task is to *get to know it* [20]. Understanding a patient's characteristic way of resisting is a good way of getting to know the patient. In addition, you want to know a resistance pretty well before you begin discussing it with the patient. Your goal is not to eliminate the resistance – your goal is to use it as a way of understanding the patient. For example, if a patient is late to sessions, your goal is not to get the patient to come on time, but rather to understand *why* the patient comes late. In order to do this, you will want to wait until you have noticed it over a series of sessions and until the patient brings it up him/herself. In addition, you want to give yourself some time to monitor your countertransference. For example, when a patient is late, it's natural to get annoyed – but that's not usually the best time to comment on the lateness.

Think about why your patient resists

When you notice a resistance, it is helpful to think about why the patient is using it. This can help you to empathize with the patient and to decide if

and when to comment on the resistance. Some possible reasons patients resist include:

- **Fear:** Patients are afraid of change, feel threatened by the unknown, and are reluctant to let go of the adaptations they have made in life. The familiar is always a comfort and is generally developed for a good reason. It is hard to relinquish past adaptations even though they are no longer needed in the present. For example, let's say you have a patient whose mother was depressed and insecure about her parenting. In the therapy, you notice that your patient agrees with everything you say, always pays bills in advance, comes to sessions on time, and speaks only in glowing terms about the therapy. When you reflect, you wonder whether her perennially positive, cheery style is a resistance. You imagine that she might be afraid to express negative feelings for fear of angering others. Although this behavior, which may have been adaptive in her relationship with her mother, is no longer adaptive, it may nevertheless be difficult for her to relinquish.
- **Loss:** Resistance to change is also prompted by the wish to retain the gratifications that are afforded by habitual ways of thinking and behaving:

  > *Mr C, a 35-year-old businessman, pursues psychotherapy to understand why he consistently makes poor financial choices that threaten the stability of his family. In treatment, Mr C learns to identify his poor choices, but persists in making them time after time. You identify this as a resistance and then learn that the patient receives ''bail out'' checks from his wealthy parents every time he makes a financial mistake. You realize that he continues (unconsciously) to make bad choices because he is loath to give up the gratification that these checks provide. In order to mature, he would have to mourn the loss of this parental support.*

  Sometimes these losses are real and other times they are imagined, but in either case loss is involved.

  Sometimes a helpful therapy can precipitate real losses. For example, in an unhappy marriage, exploration of previously avoided feelings can sometimes lead to separation and divorce. In this case, resistance could be a way of avoiding this potential outcome.
- **Guilt:** Resistance can be a way of avoiding unconscious guilt. For example, patients who use their difficulties to magically atone for fantasized sins may unconsciously feel that they would have to grapple with their guilt if they were free of their symptoms. Here's an example:

  > *Mr D is a 40-year-old man who presents for therapy because he consistently sabotages himself at work. Taking a history, you learn that he has two disabled siblings who live at home and will never be independent. You wonder whether he unconsciously feels that he needs to prevent himself from succeeding so that he does not have to face his feelings of guilt for surpassing his siblings.*

  This patient may resist letting himself benefit from treatment because it would lead to guilt.

- **Shame:** In psychodynamic therapy, patients frequently feel humiliated and ashamed as they become aware of their unconscious fears and fantasies. Avoiding these feelings is another common source of resistance:

  Mr E is a 28-year-old man who came to treatment after having sexual problems with his fiancée. In the opening months of therapy he revealed having had homosexual fantasies since early adolescence that terrified him because he says that his family was homophobic. In the therapy, he resists full disclosure about his sexual fantasies because he fears the shame of discovering that he is gay.

- **Therapist error:** Resistances can also be a response to therapist error. If we misunderstand our patients, fail to empathize, or show a lack of interest, our patients may consciously or unconsciously resist our help. For example, if a patient is silent during a session to which you were late, you might consider that the reason for the resistance is your tardiness [22].

Reasons for resistance

- fear
- loss
- guilt
- shame
- therapist error

Adapted from Sandler *et al*. [21]

Consider whether the patient is ready to look at his/her resistance

Just because we identify a resistance doesn't mean that the patient can think about it in a way that will deepen the process. In order to make this decision, we consult the choosing and readiness principles. Ask yourself whether the resistance is near the surface, connected to the dominant affect, and related to your countertransference. Think about the phase of treatment, the therapeutic alliance and the patient's ego function. Many patients become curious about their own resistances and will let you know when they are ready. For example, they may say, ''I forgot your check again; guess I should think about what is going on.'' One good strategy is to make a trial interpretation in the form of a question to test the patient's readiness to address their resistance. Saying, ''I wonder if your lateness is related to how you feel about coming here today?'' or ''Your thoughts seem to wander over so many different topics today; I wonder if that reflects your feeling about our work together'' gives the patient a way out without having to be put on the defensive. Let's look at this example:

Ms F is a relatively new patient who came to treatment looking for help managing distress related to her job. As she talks about her problems at work, you become worried that she might be fired. She consistently arrives for her sessions 15 minutes late and says that this is because she is anxious about being seen leaving early.

Although you reflect that her lateness could be a resistance, the surface content, her affect, and your countertransference all steer you away from focusing on her lateness as a resistance at this time. On the other hand, if Ms F were an established patient with a strong alliance, a predilection for lateness in other parts of her life, and a solid record at work you might be more comfortable choosing to focus on the lateness as resistance.

Patients with chronically weakened ego function may rarely, if ever, be able to use confrontation of resistance productively. Here's an example:

> *Mr G is a 38-year-old man with a history of undiagnosed learning disabilities from childhood, who pursues therapy for chronic problems at work. He consistently comes 15 minutes late to sessions, and responds to any suggestions that this could be related to the treatment with demoralization and self-criticism.*

While the therapist may recognize the lateness as resistance, Mr G may not be able to use discussion of this in order to learn more about himself and his difficulties.

Intervening

Basic interventions

As in our work with affect, **psychoeducation**, **questions**, **direction**, and **empathy** can all set the stage for further work. Since your first goal is to get to know the resistance, questions designed to get details are key. Here are some examples:

Patient	*I had a fight with my wife last night. There's not much to say about it.*
Therapist	*Well, perhaps you could tell me more about the fight. How did it begin?*

Reminding the patient of the need to say whatever comes to mind without censoring can also be helpful. This can encourage the patient, particularly at the onset of the treatment. Direction in the form of mild prompts can also be helpful, such as asking the patient to comment on what they are thinking or feeling during periods of silence. Consider the following example:

> *Mr H is a 40-year-old executive who just lost his job and presents with anxious worry about employment, insomnia, and a general feeling of professional inadequacy. After completing the evaluation and setting the frame, Mr H has trouble getting started in sessions.*
>
Mr H	*I'm not sure where to start, Doc. I liked it when you were asking me questions.*
Therapist	*It's fine to just say what comes to mind about what is going on in your life, or about how you are feeling. Wherever you'd like to start is fine.*
Mr H	*I feel funny just talking about random things.*
Therapist	*It can sometimes be awkward at first for people, but you can just start wherever you like.*

In this case, the therapist empathizes with Mr H's experience of being a new patient and offers some **direction** to help him to more effectively begin the work.

Asking for associations to the resistance can also help to understand more about it. Here are a few possibilities:

Patient #1 *I'm sorry I forgot to pay you today.*

Therapist *Does anything come to mind about not paying me?*

Patient #2 *I know that I had a dream but I can't remember it. I'm having a hard time remembering any dreams.*

Therapist *What are your thoughts about that?*

These calls for associations are designed to help focus the patient on the resistance in order to begin the deepening process.

Supporting interventions

We choose supporting interventions when we elect to leave a resistance in place because, at least at the moment, dislodging it might undermine the patient's functioning. Supporting interventions can help the patient to:

- use more adaptive resistances, and
- lessen the ability of the resistance to derail therapeutic goals

For patients with weaker ego function, we still listen to the flow of associations; however, our immediate aim is generally not to bring unconscious material into awareness. Instead, the patient's free associations can help us to understand unconscious processes that can guide our decisions about what needs support [23].

Example

A 20-year-old female patient who was sexually assaulted as a young girl is now starting to date men. As she talks about dating in her sessions you notice that she changes the subject rather than admit to any sexual attraction. While you recognize this as a resistance, you also understand that it is remarkable that she is able to talk about this at all. Thus, you decide not to disrupt her new-found comfort by focusing her attention on the resistance. Rather, you decide to accept the resistance as an aspect of how she copes with the trauma while engaging in ongoing relationships with men.

Certain patients may use resistances such as acting out, missing sessions, not paying bills, or concealing aspects of their thoughts and behaviors to a degree that makes it hard to work with them. Some resistances may jeopardize the treatment or limit the potential for effectiveness. In this case, **directions** and **suggestions** may be helpful. For example, in response to a patient who missed a series of sessions, you might say:

I see that you are struggling with coming on time, but coming late gives us very little time to work. If you could come on time we'd really be able to do more.

Practical **suggestions** can also be helpful in this situation, such as:

> *I wonder if it makes more sense to take a taxi to session on the days when you leave work 15 minutes before we are scheduled to meet*.

Your aim in the moment is *not* necessarily to ''pave the way'' for future exploration of the resistances but simply to strengthen ego function by helping the person find less costly and less destructive ways of defending him/herself. However, it may well be that with certain patients these supporting comments could productively be followed by an interpretive intervention at another point in time or even later in the very same session.

Uncovering interventions

We select uncovering interventions when our aim is to understand the meaning of a resistance, elucidate unconscious elements at work, and ultimately lessen the effect of the resistance on blocking the forward motion of treatment.

Confrontation

As with affect, we start an interpretive exploration with a **confrontation**. In this case, confrontation is calling the patient's attention to the resistance. Your job is to make the patient as curious about the resistance as you are. For example, in response to the patient who comes into the room and does not talk, you might wait and then say, ''You are not saying much today.'' This is a simple confrontation – you are just calling the patient's attention to his silence and then waiting to see if he can talk more about it.

When resistance takes the form of shifting topics, confrontations can help to interest patients in potential connections between them. Consider this example of Mr I:

Mr I	*Jim and I had a great dinner out – we talked the whole time, including the cab ride home. We had a good time. When we got home, the dishes were still in the sink from lunch. We argued about who would take out the garbage and went to sleep without having sex. (pause) Anyway, that's what happened last night. Did I ever tell you that my mother used to punish me with long time-outs? Sometimes I'd even miss dinner*.
Therapist	*It's interesting – you were telling me about the argument and going to sleep without having sex and then thought back to the time-outs. Do you think that the two might be connected?*

In this example, your comment is a confrontation of the missing link in the patient's train of associations.

Clarification

Clarification helps bring the unconscious into focus by linking similar phenomena. One clarification technique is to bring together multiple examples. This is especially

helpful when you begin to see connections between seemingly unrelated forms of resistance. For example, if a patient:

- forgets about Tuesday's session saying that he ''lost track of time at work''
- forgets to bring his checkbook to pay last month's bill, and
- forgets the details of the dream he had last night you might say:

> *It seems that a lot of things aren't working as you planned. You missed the last session, forgot your checkbook, and can't remember your dream. I wonder if these things might be related.*

Linking these behaviors together encourages the patient to wonder if there might be an unconscious motivation underlying his/her behaviors. Remember that your tone should be curious, not punitive. Here's another example:

> *Mr J, a 50-year-old schoolteacher who sought therapy for ''general feelings of disappointment in life'' talks at length about being bored at work and about his concerns that ''today's kids'' are more interested in grades than learning. While the sessions seem helpful, you note that he never talks about his wife, and you begin to wonder whether talking about work might be a resistance against exploring more problematic areas. You confront the potential resistance, saying, ''While we are making progress in exploring your concerns about work, I am struck that we hardly ever talk about your wife.'' This comment surprises him, and he becomes curious about this unconscious omission. In a subsequent session, when Mr J is talking about his father, you realize that you know very little about his mother. This feels similar to his omissions about his wife, allowing you to make a* ***clarification*** *which links the two – ''Today, I notice that you're leaving out any mention of your mother, just like the other day when you left out any mention of your wife.''*

This is a clarification, linking similar resistances and supporting the idea that they might have a common unconscious source. Again, this is not said as a criticism – the resistance of neglecting a topic just pointed you in the right direction. One point never makes a line – when patients can link seemingly disparate resistances, the pursuit of unconscious motivations becomes more compelling.

Interpretation

When we think that we have found an unconscious motive for a resistance, we can make an **interpretation**. Let's think again about the patient who forgot the session, the payment, and the dream. Here's part of the session in which he forgot his dream:

Patient	*I know that I had a dream last night, but for the life of me I can't remember anything about it. It's so frustrating.*
Therapist	*Do you have any thoughts about forgetting it*? (**confrontation**)
Patient	*No – but it feels like it was important – like it would have shed light on how I'm feeling.*
Therapist	*It's interesting – you've forgotten a few things in the last few weeks – like your session on Tuesday and your checkbook last time. It also occurs to me that you haven't talked much about the fact that I'm going away for my summer vacation next*

week – it's kind of like you've ''forgotten'' to talk about that, too. I wonder if these things are all related in some way. (**clarification**)

Patient *Maybe – but it's fine that you're going away – you work hard and need a break. (pause) I just had this totally weird fantasy that you would send me a postcard. Not that I want you to, so I don't know why I thought that.*

Therapist *What comes to mind about the postcard?* (**call for associations**)

Patient *Well, when I went to summer camp, all the kids got postcards from their parents – even letters – like every week. But not me. I think that I got one postcard the whole time.*

Therapist *You thought that they had forgotten you.* (**empathic statement**)

Patient *I mean, I know that they didn't, but it felt that way. (He becomes tearful)*

Therapist *Perhaps some of your forgetting in the last few weeks is related to a worry that I'm going to forget you over my vacation, just like you felt your parents did.* (**interpretation, with genetic component**)

Patient *I mean I know you won't, but you'll be having fun with your family. You'll probably be glad to be finished for a few weeks with me and my problems.*

In this example, the resistances (forgetting a session, forgetting the checkbook, and forgetting the dream) avoided a strong affect (anxiety about the summer break), a painful memory (of not getting letters from his parents at camp), and a frightening fantasy (of being forgotten by the therapist). **Confronting** and **clarifying** the resistance allowed the patient to move into deeper territory to reveal the affects and fantasies that were affecting him. This is how the process of psychodynamic psychotherapy unfolds. In this example we also got a window into the patient's defensive style. The patient forgot the obligations he had made to the therapy process and the therapist, rather than leaving open the possibility of being forgotten.

Since resistance is protective, interpretation can feel threatening. Remembering this is the key to maintaining empathy during the interpretive process. Listen to these two examples in which the therapist interprets lateness as a resistance:

Therapist 1 – This is the third time this month that you've been late. It's clear that you're avoiding working more deeply in the therapy.

Therapist 2 – I've noticed that you've come late three times this month. We've just started to talk about your ambivalent feelings about your girlfriend, and I have a feeling that you might be coming late in order to avoid talking about it. What are your thoughts about that?

In the first interpretation, Therapist 1 sounds accusatory and punitive. The interpretation comes from ''on high'' – it sounds like the therapist is saying, ''here's the way it is.'' In the second interpretation, Therapist 2 empathizes with the difficulty that the patient is having talking about a difficult topic. The tone is collaborative and curious. Same resistance – different tone – and likely to get a different response.

Summary

In this chapter, we have explored the ways in which understanding resistance moves us towards understanding the patient's unconscious. It is an expected and welcome part of the process and one that helps us to learn about the patient's defensive style. In the next chapter we will introduce the concept of transference, which will help us in many of the same ways.

Suggested activity

Here are two vignettes that involve resistance – read them and consider the study questions.

1. Your patient is Ms A, a 34-year-old mother of twins who is currently taking care of them and volunteering in her community full time. She is very upset about her marriage because her husband never helps out around the home. She states he has a very traditional view that she should do all the daytime and child-related tasks since he is working and doesn't want to have to pitch in after work. You find Ms A to be highly competent, approaching childrearing as if it were an executive position, referencing child development experts, and reading prolifically. Similarly, she seems to have very high, exacting standards about taking care of her home. You have suggested a few ways that she might ask her husband to help on weekends but each time she responds by saying that he can't perform the task well enough for her to delegate it to him. You begin to feel that she is shooting down every one of your suggestions.

(a) Is there evidence of a resistance at work? List examples.
(b) How might you work in an uncovering, interpretive mode with Ms A? Suggest a possible confrontation, clarification, and interpretation of the resistance.

Comment

Ms A is exhibiting resistance by perennially rejecting your suggestions. She is avoiding making progress in the therapy by never trying anything new. A possible confrontation is, ''I wonder if you have noticed that you find a reason not to try everything I suggest.'' A clarification might be, ''It seems like your reaction to my suggestions is not unique, as you tend to be critical of the ways your husband does things as well.'' An interpretation could be, ''I wonder if you are avoiding asking your husband to help you because it might make you feel that you didn't have a real role in the family.''

2. To continue with the example of Ms A above: let's say that in an effort to point out her resistance you say, ''I am getting the feeling that you are not really interested in my suggestions.'' Before you even have a chance to add that she could be doing the same thing with her husband, she becomes enraged, stating, ''Have you ever had a child? Do you know what is involved here?'' Her defensiveness is quite strident and you feel very attacked, so you back away from the confrontation of her resistance.

(a) What does Ms A's response to your confrontation of the resistance suggest?
(b) What technique might you use going forward?

Comment

Ms A gets very defensive, suggesting that she is not ready to be curious about her behavior with the therapist or her husband. Going forward you might switch to a supporting approach designed to build her self-esteem. Over time, the increased self-esteem may lessen her defensiveness, improve her functioning in relationships, and make interpretive work more feasible.

21 Transference

Key concepts

Transference refers to the sum of the feelings that a patient has about the therapist.

Understanding the transference in psychodynamic psychotherapy helps us to understand how patients think about themselves and how they relate to other people.

In a supporting mode, we use the information that we get from the transference to understand the patient without bringing it to the patient's attention. We may also have to limit and contain the transference when we support.

In an uncovering mode, we interpret the transference in order to help patients to learn more about themselves and their relationships with others.

Patients can tell us over and over how they feel about their bosses, their partners, and their parents, but when they tell us how they feel about us we have a unique opportunity to see how they really relate to others. Patients will inevitably experience the same feelings about the therapist that they experience toward other people in their lives. We call these feelings the **transference**.

What is transference?

Transference is the sum of the feelings that a patient has about the therapist. Some of those feelings have to do with real characteristics of the therapist. Some of these feelings relate to feelings that the person had for people in his/her past that are now displaced onto the therapist. As we discussed in Chapter 1, thinking about all of those feelings is often a focus of psychodynamic psychotherapy.

Why do we care about transference?

In psychodynamic psychotherapy, transference feelings are a way to learn about the important relationships in a patient's life. If a patient reacts to us in a certain way, we can bet that they react that way to other people in their lives. Making these reactions conscious and linking them to their rightful source frees patients up to make choices about how they react to people in their daily life. In addition, once a transference reaction is observed, it serves as a gateway to exploring memories. Here's an example:

> *After a session in which Mr A began to talk about quitting his high-paying job to try his hand at writing fiction, he missed two sessions. When the therapist asked about this, Mr A said that*

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he assumed that the therapist would try to talk him out of this idea. As they discussed this, it became clear that Mr A made this assumption because his parents were very dismissive of artistic pursuits, and had convinced him to take a business job rather than trying to make a life as a writer.

Here, Mr A makes an assumption about the therapist that really belongs to his feelings about his parents. Helping Mr A to see that this assumption is displaced onto the therapist enabled Mr A to understand more about his expectations of people in his current life.

Is it reality or is it transference?

Frequently, therapists get sidetracked trying to decide whether a patient's reaction is ''realistic'' or ''transference.'' This is not an either/or question – our patients have feelings about us that are related both to our real characteristics and to the characteristics of other people in their lives. Here are two examples:

After Mr B's mother died, he felt very supported by his therapist, who called him on the phone and was attentive to his feelings of mourning.

Here, Mr B has warm feelings about things that his therapist actually did. He is responding to the therapist's real characteristics.

Ms C felt that her therapist's tradition of taking a two-week summer vacation indicated that she was inattentive to the needs of her patients.

Since a two-week vacation is not inappropriate for a therapist, Ms C's feeling that her therapist is inattentive is probably related to expectations established earlier in her life.

To work effectively with the transference, patients have to understand the ''as if'' quality of their feelings towards the therapist. That is, the patient experiences the therapist ''as if'' he/she were someone from their past. For example:

Ms D is a 22-year-old woman in psychotherapy who says that she is afraid to tell you shameful things because they could ''change her life forever.'' You inquire further and ask whether revealing secrets ever led to a bad outcome. She remembers that her mother once discovered her playing ''doctor'' with a young cousin. Her mother ''freaked out,'' took Ms D to the priest to confess and severed ties with the cousin's part of the family.

Your patient's fear that reporting a secret will be humiliating and have dire consequences probably relates to this early history. Thus, telling you a potentially shameful secret in therapy makes her experience you *as if* you were the mother of her early childhood.

Talking about the transference is important since ''you were there''

A patient's hostile reaction toward us is very different than one toward a bus driver or boyfriend because we are there and can corroborate the details of what

transpires. In general, it is helpful to explore the details of your patient's transference reactions, since you are a direct observer. Sorting out transference feelings within the real therapy relationship can be therapeutic in itself, since it offers the patient an opportunity to become comfortable talking about complex feelings while they are happening. It is important to be open and non-defensive about a patient's experience of you, your comments and your behavior. This interchange is one aspect of how we think therapy works.

Describing and understanding the transference

It is helpful to categorize transferences into broad subgroups so that we can better understand them, construct formulations about them, and discuss them in supervision and with colleagues. We will discuss three basic transference categories:

- transference related to affect
- transference related to a past relationship
- displaced transference

Transference related to affect

The most basic way we label transference feelings is by their associated affect. For example, sometimes our patients feel good about us and sometimes they don't. We call the good feelings the **positive transference** and the bad feelings the **negative transference**.

Positive transferences are those feelings that arise from loving, trusting, tender, passionate, and respectful attitudes toward the therapist and others. Some of these feelings, such as trust and respect, comprise the basic working alliance and thus are essential for the treatment and need not be interpreted. Sub-types of the positive transference include:

- **Idealization** of the therapist: involves perceiving the therapist as more intelligent, loving, and perfect than he or she really is.
- **Erotic transference:** refers to sexual or loving feelings that the patient develops towards the therapist. Falling in love with the therapist and wishing to be desired by the therapist are both examples of erotic transference.
- **Eroticized transference:** refers to specific kinds of sexual feelings toward the therapist that are aggressive as well as sexual. The eroticized transference often develops more rapidly than the more loving erotic transference. Trying to seduce the therapist to violate boundaries or recounting sexual fantasies in order to try to arouse the therapist are examples of the more aggressive, eroticized transference.

Note: *There is no need to interpret the positive transference* – the positive transference is the patient's good feelings about the therapist. These are the feelings of trust that support the therapeutic alliance and help the patient and therapist to work effectively together. Unless these feelings are getting in the way of the treatment – as they might

if they are over-idealized or eroticized – just leave them alone. They're the glue that holds the treatment together.

Negative transference includes feelings towards the therapist of anger, hatred, contempt, envy, and humiliation. It is almost always important to address the negative transference in some way, particularly if it is so negative that it threatens the treatment.

Transference related to a past relationship

Other transference feelings are reminiscent of relationships from early childhood. We can categorize transferences as **maternal**, **paternal**, or **sibling transferences** in order to cite the origins of the feelings [24]. Although today both mothers and fathers can be primary caregivers, we still speak of maternal transferences as being primarily related to the early, dyadic relationship. They often express longings for care, holding, and containing. On the contrary, paternal transferences often relate to fatherly roles, such as protection, and sibling transferences are often related to competition. The maternal and paternal transferences can stem from actual or fantasized childhood relationships. Here are two examples that demonstrate the difference:

> *Mr E was abandoned by his mother when he was five.*
>
> *Scenario 1 – In the therapy, he idealizes his female therapist and tells her that she is perfectly attuned to him.*

In this case, Mr E has a maternal transference related to the relationship with his mother that he wanted to have.

> *Scenario 2 – In the therapy, he always presumes that the therapist will leave him. This fear is particularly pronounced around vacations.*

In this case, Mr E has a maternal transference that is related to the actual relationship that he had with his mother.

We can also think of these transferences as originating from different phases of development, such as the **pre-Oedipal** and **Oedipal** phases [25]. Thus, you might hear of a pre-oedipal maternal transference, which refers to the early mothering figure that was needed for basic caretaking, need-fulfilling, and confidence-building roles. Alternately, you might hear of an Oedipal maternal or paternal transference that refers to the parents at a later stage of childhood. In over-simplified terms, the Oedipal mother is typically experienced as sexually desirable by a heterosexual boy and as a feared competitor by a girl. Conversely, the Oedipal father is experienced as sexually desirable by a heterosexual girl and as a feared competitor by a boy. (Note: the homosexual child generally desires the same sex parent and competes with the opposite sex parent.) These are some of the developmental labels you may hear referred to when psychodynamic therapists describe the transference. They describe unconscious fantasy constellations that will be discussed further in the upcoming chapter on unconscious fantasy and conflict (Chapter 23).

Displaced transference

When transference feelings are too immediate or intense to become conscious, the patient may experience them as if they were related to someone else. This is called a **displaced transference**, for example:

> *Mr F spends half of his session ranting about a contractor who has delayed beginning renovations on his house. The intensity of his affect makes you wonder whether his reaction might be related to your recent delay in letting him know whether you could reschedule one of his sessions.*

Here's an example that brings together all three transference categories:

> *Ms G is a 34-year-old female patient who is not married, has a busy career, and has trouble sustaining long-term friendships. In therapy sessions, she often comes from work dressed in designer business attire with a real flare for fashion. She has been talking about how other women dress at work and often makes derogatory comments about their outfits. She comments that they always wear flat shoes, don't reapply lipstick after lunch, and wear out-of-date styles. You begin to feel self-conscious about your clothes and wonder what she thinks of your outfit. You then realize that she is talking about feelings about you in the displacement and wonder if she is having a transference reaction.*

You might call this transference:

- displaced
- negative
- maternal
- Oedipal

since it is derogatory, competitive, and about others.

Transference and resistance

As we mentioned in the chapter on resistance, re-experiencing the past in the present relationship with the therapist is, among other things, a resistance to remembering the original feelings. In addition, many patients resist acknowledging transference feelings. Alternatively, patients sometimes resist accepting that they are having transference feelings and prefer to see their feelings only as ''real.'' We call this **resistance to the awareness of the transference** [26]. It sometimes sounds like this:

Patient	*I never get any help from my boss. You know, you expect certain things from the people who are supposed to help you in life, and you never get them.*
Therapist	*I wonder if you could be talking about me, too.*
Patient	*Oh no – I'm just talking about my boss. This doesn't have to do with you.*

Transferences are also layered, with one feeling helping to block awareness of another. For example, loving feelings toward the therapist can sometimes block awareness of more negative, competitive feelings, and vice versa.

Technique

Listening

Listening for transference, as with affect and resistance, generally involves consciously looking for it.

Listen for ''off the cuff'' remarks

Transference is often embedded in seemingly innocuous comments such as, ''Your office is really nice and warm,'' or ''I'll bet your feet hurt at the end of the day wearing shoes that high.'' In regular conversation they're throwaway lines – in therapy they're clues to the transference. You should register these remarks and remember them for future reference.

Tune into the beginning and end of the session

You can often find transference clues outside of the formal structure of the session, for example as the patient enters the room or leaves the session. Comments like, ''I always get going just as we near the end'' or ''It's so hard to get to your office in the rain'' may signal the presence of transference. As with affect and resistance, these clues are often in the form of behaviors rather than spoken language, such as coming late to the first session of the week, scanning the materials on your desk, or starting on a new topic as you are both standing up to end the session.

Listen for comments about other people – the displaced transference

Another common way we hear transference is as stories about friends, significant others, or co-workers. If these stories are filled with affect or if they remind us of something that is happening in the therapy, we should think about whether they represent displaced transference. In this case, it is helpful to listen for clues that the feelings may also relate to you and to the therapy relationship, for example:

> *A few months into treatment, Mr H, a graduate student, begins to discuss a teaching assistant who was unfamiliar with two of Derrida's main essays. Mr H is quite upset about whether he can work with this teaching assistant given her ''scholarly deficits.'' While listening, you are reminded of your own anxiety about never having read any Derrida and of having wondered if you should read some in order to better understand this patient.*

Here, the patient's fears about whether you can help him are displaced onto his feelings about the teaching assistant. While these fears may well relate to real issues

with the teaching assistant, they may also be a displaced transference, and exploring them can help to elucidate his feelings about you and his expectations of others in general.

Listen to your patient's general patterns of relating to others

Listening carefully to the details of your patient's relationships with other people can help you to anticipate transference feelings that might arise. For example, if your patient describes a history of being very sensitive to rejection or of having trouble expressing anger, this will likely arise with you as well. If your patient often has short relationships that end precipitously after a disappointment, be alert to the possibility that this may unfold in the transference. Listen for these broad outlines as potential scripts that could be repeated in the relationship with you, while you file them away for future reference.

Listen to your countertransference

Although we will discuss countertransference more thoroughly in Chapter 22, it's important to note that one of the best ways to understand your patient's feelings about *you* is to be aware of your feelings about *them*, for example:

> *Although Mr I was very quiet during his last few sessions, his therapist felt a sense of loss.*

Attending to his own feelings helped the therapist to become aware of transference feelings that the patient was protecting himself against. This can be one of the best ways to become aware of displaced or resisted transference feelings.

Reflecting

Once you have noticed a theme, a set of behaviors, or a series of comments that signal a transference feeling, the next step is to consider whether to focus the patient's attention on it at this time. Remember the ''three choosing principles'' and the ''three readiness principles'' and consider the following:

Is the patient ready and willing to work with transference?

Some patients are very engaged in describing events and relationships occurring in their lives outside of therapy and experience the relationship with you as less important. It is helpful to make trial inquiries about the transference and to monitor the patient's willingness to work in the transference throughout the treatment. Some patients are not able or ready, in which case you don't want to badger them or sound like the caricature of a psychoanalyst from a *New Yorker* cartoon. Sometimes a transference inquiry will fall on deaf ears or patients will respond concretely, both of which suggest that the patient is not ready to work in this mode. Sometimes people

say ''I don't understand – I thought I wasn't supposed to have thoughts about you since you won't tell me anything.'' This comment invites **psychoeducation**, which we discuss below. Remember to be on the look-out for the *non-verbal* signals that your inquiry has in some way upset or offended your patient, for example if she falls silent, purses her lips, shifts uneasily, crosses her arms, looks embarrassed, is anxious, or avoids looking at you.

Is the transference on the surface and the most affect-laden material in the session?

While transference is always operating, that does not mean that it is the most prominent or important topic to focus the patient's attention on in a session. For example, if a patient tells you that her son just had a serious bicycle accident and then asks you if you have children, you would focus initially on the son rather than on her transference curiosity about your life. It might be possible to explore her transference feelings later in the session, but it would be unfeeling not to inquire about her son at the outset. You could say, ''Maybe we can come back to that in a minute, but . . . '' or ''We can certainly talk about that if you like, but . . . I'm so sorry to hear about your son! How is he now?''

Sometimes the most important themes to explore occur out of the office. A frequent misconception about psychodynamic psychotherapy is that the transference should always be given priority. For example:

> *Ms J is a 50-year-old woman who experiences her therapist, Dr Z, as a warm, benevolent caretaker. One day she comes in crying after an airport customs official suspected her of trying to conceal items she purchased abroad. Through her tears she says that she is relieved to see you and then goes on to tell you about the humiliation she experienced at the airport.*

If you follow the affect, you would explore Ms J's experience with the airport official before asking her more about her relief at seeing you.

Should I interpret the transference now or let it evolve further?

It is important to understand transference feelings as fully as possible before making interpretive comments. Just as we discussed in the resistance segment, you want to *live alongside the transference* for a while to get to know it better.

Should I stay in the displacement or direct attention to the transference?

If the patient is talking about transference feelings in the displacement, it often makes sense to explore them in the displacement before confronting the transference. This allows you to learn more about the feelings while the patient is talking about them in a more comfortable sphere. Remember that good work can be done by discussing the displaced transference – it's not just treading water. Wait until the transference is very close to the surface before bringing it to the patient's attention.

Can the patient talk about the ''as if'' quality of the transference?

In making transference interpretations it is important to note whether the patient can work with the ''as if'' aspect of transference. Working this way requires the patient to (i) be able to experience feelings toward you and (ii) be able to step back and reflect on them. Some patients do not have the capacity to work with the transference in this way and will take it literally. They might only be able to experience the transference as real. In response to this kind of reaction, you can try psychoeducation (see section on ''Intervening'' below) or wait to interpret.

Is the transference too intense?

There are some patients who form rapid, intense transference reactions early on in treatment. This can also happen later in psychodynamic therapy. A ''transference storm'' – essentially, too much transference – can get in the way of treatment and may threaten the therapeutic alliance. Some patients have problems managing their transference feelings and will view the therapist as the embodiment of hostile or abusive people from their past. This can erupt in treatment as an intense paranoid, hostile, or devaluing transference. It is important to identify when patients are not able to manage their transference affects and to evaluate whether:

- they have lost reality testing
- they have lost awareness of the ''as if'' quality of transference
- they have acted out self-destructively based on these affects, and
- the treatment is directly threatened

This will guide your choice of intervention.

Intervening

Basic interventions

Most patients have to be taught about the transference and how to identify it. Some also have to be convinced that talking about the transference is a worthwhile endeavor, as it is often difficult to do and can bring up unsettling feelings. The process of helping a patient to talk comfortably about the transference is an important way to intervene in psychodynamic psychotherapy. Note that it can take a while and may not happen with all patients. Here are some useful interventions:

- **Psychoeducation** is a crucial first step in the process. It is helpful to tell people at the beginning of a psychodynamic therapy that:

  > *In this type of psychotherapy, we can learn a lot about you and your relationships with other people by discussing your thoughts and feelings about me.*

This statement can be included when you instruct the patient to say whatever comes to mind, as we discussed in the chapter on free association (Chapter 20). **Empathizing** with the awkwardness of the task and **explaining** how it can be helpful are key. It is important to realize that even if you explain this at the beginning of the treatment, you may have to repeat it as these feelings arise in the treatment. (Note: after a few repetitions, you can begin to interpret the patient's discomfort in discussing the transference as a resistance.) It is also helpful to **encourage** patients by telling them that it is useful to discuss their feelings about the therapist.

- **Questions:** In order to understand transference feelings, you have to learn about them. Asking questions such as, ''What was your experience of talking about that yesterday?'' or ''What were your feelings about my canceling that session?'' will help to give you valuable information about the transference.

Supporting interventions

We use supporting interventions to help a patient with weakened ego function feel less overwhelmed by their perceptions and feelings about the therapist, and to improve and preserve the therapeutic alliance.

Learning from the transference without focusing on it

Understanding the transference is always useful for the therapist – however, it may sometimes overwhelm a patient with weakened ego function. With these patients we want to listen for the transference, reflect on it, and learn from it; however, we do not necessarily want to uncover it. Although some reports indicate that patients with weakened ego function can be helped with vigorous interpretation of the transference, the general rule of thumb has historically been to try to work in a climate of a moderately positive transference and not to focus on transference – especially early in treatment [27–30]. Here's a good example:

> *Mr K sometimes missed the first session after the therapist's vacation. Although Mr K was never able to discuss this, whenever it happened the therapist knew that Mr K had had feelings about the separation.*

Talking to patients directly about their behavior in the treatment

With some patients, talking to them about the way they act in the treatment can help them to improve their relationships with others. Here are a few examples:

> *I noticed that you tend to come to sessions about 5–10 minutes late – do you do that at work, too? It might be one of the things that makes your boss upset with you.*
>
> *When you get angry with me, you don't tend to address it until a few weeks later. Talking about it up front sometimes helps to keep things from escalating. Maybe that would help you with your wife as well.*

Here, the therapist is commenting on the transference with the intention of supporting weakened ego function, rather than of exploring transference fantasies.

Repairing, reducing, and containing the transference

It's all well and good to say ''don't focus on the transference'' when you're using a supporting mode, but the reality is that people with weakened ego function are often the most vulnerable to becoming overwhelmed by intensely experienced transferences. Sometimes these feelings can disrupt the treatment from the outset, leaving you no choice but to address the therapeutic relationship directly. Some patients have trouble understanding the ''as if'' nature of the therapeutic relationship – if you ask, ''Do you notice that you're criticizing me for the same things you hate in your mother?'' the response is apt to be, ''Just my luck to get a therapist like my mother!'' With these more vulnerable patients, *reducing* negative transference and *repairing* ruptures in the therapeutic relationship are vital to preserving the treatment and may be the major ongoing priority related to the transference [31–35].

There is a specific set of supporting techniques for resolving the patient's intense or hostile transferences to you *without* necessarily helping him/her understand that these are reactions based on feelings toward important people from earlier years:

- **Naming affects:** putting feelings into words and accurately registering what a patient is feeling can help to manage the transference. It can sound like this:

  Maybe you were upset when I didn't return your call . . .

  It sounds like you feel you're not important to me.

  I guess it seems like I don't care.

- **Validating their experience:** If the patient has a feeling about you that's accurate, validating his/her experience can contain difficult feelings. Apologizing for lateness is an example of this:

Patient	*I'm really upset that you started 10 minutes late today.*
Therapist	*That makes sense – you expected to start at a certain time and that didn't happen. I'm sorry about that.*

  Often, validating the person's feelings, expressing your dismay, and leaving it at that is enough to right the ship, but if not, you can try to explain their feelings – openly and non-defensively in terms of things that are actually happening between the two of you that could account for what the patient is feeling:

  For reasons relating to the patient's safety, a therapist has had to stay in touch with the spouse of a suicidal patient. When the patient accuses the therapist of ''spying'' on her, the therapist might say, ''You're right – I have been in touch with your husband and I can see that that's made you feel like you're not in control of your own therapy. But to me, the most important thing is your safety, so I need to be in touch with him temporarily so that we can keep you as safe as possible. Let's continue to talk about your feelings about this.''

- **Interpreting up:** this can help to diffuse strong transference feelings by relating them to things that are occurring in a patient's current life and relationships outside the treatment:

> *It must have been especially upsetting not to be able to reach me during this time when your wife is away and your parents are not being very supportive.*

- **Gently correcting misperceptions and jointly reality testing:** If the alliance can withstand it, you also can try to gently correct misperceptions and reality-test the person's distortions about you, while expressing your regret about being misunderstood or having unintentionally wounded the patient:

Patient	*I hate it when you're patronizing!*
Therapist	*What did I say that sounded patronizing?*
Patient	*I don't know. It was more your tone.*
Therapist	*I'm very sorry that what I said made you feel insulted . . . that certainly wasn't my intention.*

If all else fails, stay calm under fire and try not to become angry. Showing the patient that you can tolerate their strong feelings without judging them, becoming upset, or causing a rupture in the treatment is one of the most critical features of the ''holding function'' of psychotherapy. Such ''holding'' convinces them that, like the mother of a toddler in a tantrum, you will continue to support them even if they are having strong negative feelings [36]. As their therapist, you may be the first person in their life to offer them this kind of security.

Uncovering interventions

We select uncovering interventions when we want to explore the transference in order to uncover unconscious thoughts and feelings.

Confrontation

The first step in interpretation is **confrontation**. We confront when we want to call the patient's attention to the transference. Here are some confrontations of the transference:

> *You got very quiet after the last comment I made. Did you have some feelings about it?*
>
> *Sounds like you're angry about my vacation. Can you say more about that?*

Here's an example in which a confrontation of the transference is used:

> *Mr L is a 26-year-old philosophy graduate student who frequently disparages people who don't understand his area of interest. You wonder if he is talking about you, but you initially explore*

this in the displacement. During the first session back after your weeklong spring vacation, you see him glance at a brochure sitting on your desk from the Walt Disney cruise you just took. While he doesn't refer to it directly, he begins to talk condescendingly about the fraternity his younger brother is in at college and the crude ''road trip'' he went on to Florida. You think that his feelings about you are near the surface but, because he is not mentioning them directly, you decide to confront the transference, saying, ''You are thinking about how people spend their vacations, but you haven't mentioned thoughts about my vacation.'' He then says that he saw the brochure and was embarrassed that you took such a ''plebeian'' vacation.

The confrontation enables the patient to deepen his discussion of the transference.

Clarification

If you notice that the patient has similar reactions to you in two or more different situations, you can clarify the transference. **Clarifications** of the transference often sound like this:

You're very quiet today – and it's the last day before my vacation. This happened the last time I went away, too.

Every time you talk about your wife you're sure that I'll be judgmental.

Although for a while you thought that I understood what you were feeling, for the last few weeks you haven't had that feeling at all.

Clarifications help people to have conviction about their transference feelings because they see that they have occurred in several different situations.

Interpretation

There are two basic types of **transference interpretations**. In one, the therapist interprets the patient's behavior as the result of the unconscious transference feelings:

I think that you've been late for the last two sessions because you're worried that I'm angry with you.

In the other type of transference interpretation, the therapist interprets the transference as being the result of a distortion related to a past relationship:

I think that you're worried that I might be angry with you because your mother was always upset when you made decisions on your own.

Both types of interpretations help patients to understand themselves and their relationships to others. Here's an example of interpretive work related to the transference:

Ms M is a 34-year-old female school nutritionist who has been in therapy for two years. She is heterosexual but not married. She has a good alliance with Dr Z, her female therapist, whom she

tends to idealize. She has many friends for whom she does too much, generally prioritizing the needs of others. This has been a major focus of the therapeutic work, and Ms M is beginning to assert her own needs. As a child, her father wasn't around and she had a younger brother with cerebral palsy who took up much of her mother's time. Although it seems to the therapist that the mother neglected Ms M, Ms M has generally pitied her mother and tried to do everything in her power to make her life easier. In the week prior to the following session, the therapist told Ms M that she was going to have to miss one of their twice-weekly sessions the next week. This is the session prior to the session that would be missed.

Patient	*So, the weekend – I had invited my co-worker Yvette and her new husband over for lunch, but they couldn't come at the last minute. I had all this food – but was alone as usual.*
Therapist	*That sounds very disappointing.* (**empathic remark**)
Patient	*Well, I had a lot to do – and it allowed me to catch up on work. She always cancels, so I should know better than to invite them without other people.*
Therapist	*It sounds like it's a little hard to feel upset about it.* (**confrontation**)
Patient	*Upset? It's just lunch – it's not like it was my wedding or something.*
Therapist	*Maybe weddings are on your mind – like Yvette's wedding.* (**confrontation**)
Patient	*(one tear runs down her face) Yvette was the last one – we were together in ''singlehood'' – now she has someone and better things to do. But what good does it do me to cry about it? It's not going to make her more likely to show up at lunch. Maybe that lunch wasn't very important to her, but it was the center of my weekend. And she canceled at the last minute, like she didn't even care.*
Therapist	*You're talking about your friend today, but I canceled at the last minute too. Maybe you're focusing on her because it's hard to get upset with me.* (**interpretation**)
Patient	*You have a life – you have things to do. I'm not the center of your life.*
Therapist	*Maybe you wish you were.* (**interpretation**)
Patient	*(crying) – I wish that I were the center of someone's life. Yvette has Rodney, you have your family – my mother was always taking care of my brother. I don't think that I'll ever be someone's number one priority.*

In this session, the therapist stays in the displacement for a while, since the patient is expressing affect and the patient is moving into new emotional territory. **Confrontations** help to decrease the patient's resistance to admitting how upset she is. Once it becomes clear that the feelings about Yvette are nearly identical to those that she has about the therapist, Dr Z connects the displaced feelings and the transference. Ultimately, the patient links her friend, her therapist, and her mother – none of whom, she feels, puts her needs first. Recognizing these feelings is her first step towards understanding how she defensively subjugates her own needs in order to stave off disappointment and anger.

Now that we've explored the transference, it's on to the feelings of the therapist – the countertransference.

Suggested activity

Here are two vignettes that involve the transference. Read them and consider the study questions.

1. It is the third visit with a new patient, a 25-year-old single musician who had abruptly ended his prior treatment when his therapist told him that she could not have sessions with him at the local coffee shop. He tells you that he could not work with the prior therapist because she was very rigid and recounts how she would not have coffee with him, often ended the sessions even if he was in the middle of an important topic, and seemed not to be interested in dreams. He states that he hopes that you can be more helpful and flexible.

(a) Is the patient exhibiting a transference to you?
(b) What type of transference did he have to the prior therapist?
(c) What interventions might you make now?
(d) What interventions might you make at a later point in the treatment?

Comment

The patient is hopeful that you will be a ''good mother'' and is exhibiting a positive maternal transference at the moment. He had a negative maternal transference to his prior therapist at the point that he ended the treatment. In listening, you wonder if he is using splitting to see you as potentially all good and the old therapist as all bad. Since this is a new patient, you might register the transference but make sure that he understands the frame of the treatment. This could involve both **demonstrating understanding** and **psychoeducation**:

> *It sounds like you have mixed feelings about your former therapist that are important to talk about – but it's also important to know that most therapists wouldn't have coffee with their patients because the treatment only happens during sessions in the office. I'm glad you brought that up because it's important to be clear about that at the beginning of the therapy.*

If this came up later in the therapy, for example at a moment when he felt that you were frustrating him, you could **interpret** the displacement, saying:

> *I think it's easier to evoke your memories of your frustrations with your former therapist than it is to talk about your current frustrations with me.*

2. You are treating a 32-year-old woman who sought your help just over a year ago, complaining of longstanding unhappiness in her marriage, frequent fighting with her husband and feeling trapped by the relationship. She fears that she may have married the wrong man, but is terrified that if she ends the marriage she will never have children. She has been seeing you twice weekly and is feeling very engaged by the therapy. A year into the therapy she gets an ideal job offer; however, she will have to move one of her sessions and you cannot accommodate her scheduling needs. She is very upset and feels that you are making her choose between the perfect job opportunity and therapy. She feels trapped by the relationship with you, and fears that you could possibly stand in her way

of taking this job. She states, ''If it weren't for you, I would be happily moving ahead in my career. Now I have to either compromise my therapy or not take the perfect job.''

(a) Is the patient exhibiting a transference to you?
(b) What type of transference is this?
(c) What interventions might you make if she has weakened ego function?
(d) What interventions might you make if she is able to do uncovering work?

Comment

The patient sees you as standing in the way of her progress. This could be a competitive Oedipal-level maternal transference; that is, she could be experiencing you as if you were a mother who holds her daughter back to prevent her from winning the affection of her father. It could also be a negative maternal pre-oedipal transference related to an envious mother. A supporting intervention might be to **correct misperceptions** by pointing out that you are trying to accommodate her. You could then discuss the idea that she tends to feel trapped when arrangements don't go her way, just like in her relationship. An **interpretive** intervention might include a **confrontation** about her affective experience of feeling trapped, such as:

> *What comes to mind about feeling trapped?*

You could follow up with a **clarification** about the similarity between her feelings about her husband and you:

> *It's interesting that you're feeling trapped by both me and by your husband – do you have thoughts about that?*

An **interpretation** could ultimately point out that she feels trapped because she both needs you and is experiencing you as if you were standing in the way of her progress:

> *You're upset with me because you feel conflicted – on the one hand you feel you need me, but on the other hand you feel that I'm keeping you from moving forward.*

Having uncovered this conflict, you might be able to learn more about her feelings about this, and/or about how it related to her early relationships.

22 Countertransference

Key concepts

Countertransference is the sum of the therapist's feelings toward the patient. It includes both conscious and unconscious feelings.

Countertransference is ubiquitous. Far from being something to avoid, it informs our work with patients in many ways.

Understanding countertransference is important because:

- being aware of our feelings toward patients makes it less likely that we will act on them
- feelings that we have about our patients can help us to make assessments, formulate treatment recommendations, and conduct the treatment
- countertransference can help us to learn about the important relationships in our patients' lives
- countertransference feelings can help us to learn about ourselves and our reactions to patients

Countertransference informs our understanding of the patient and our interventions, but is generally not shared directly with patients.

When two people sit in a room and talk to each other week after week, they *both* have feelings about *each other*. In the same way that patients have feelings about their therapists, which we call the transference, therapists have feelings about their patients, which we call the ***counter*transference**. Although early analysts thought that therapists were supposed to be free of feelings about their patients, we now know that our countertransference feelings can help us to conduct psychodynamic psychotherapy in many ways [37].

What is countertransference?

As we began to discuss in Chapter 12, countertransference is the sum of the feelings that a therapist has about his or her patients. It includes both conscious and unconscious feelings.

There are two kinds of countertransference feelings – some are about the patient and some are about us. Sometimes, our feelings about our patients are engendered in

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us by a specific trait or behavior that originates in the patient. Here are two examples of countertransference feelings that are about the patient:

> *After Ms A forgot to pay her bill for three months in a row, her therapist felt very angry with her. He did not, however, feel angry with his other patients.*
>
> *Mr B's risky sexual practices made his therapist quite anxious. The therapist realized that Mr B was projecting his anxiety on to her in order to remain in denial about the amount of danger he was placing himself in.*

It is important to see that these therapists were not generally angry or anxious, but rather that these feelings originated in the patients. Other countertransference feelings, however, originate within the therapist. They arise when something about a patient reminds the therapist of something in his or her own life, such as a symptom, a traumatic situation, or a relationship. Here are some examples of this type of countertransference:

> *When Mr C described his father's death, the therapist, whose own father had just died, felt that he might begin to cry in the session.*
>
> *Dr Z always feels protective of young patients who have very stern mothers. This is related to her own early experiences with a very harsh mother.*

In these cases, the strong feeling is due to something in the therapist's life or inner emotional experience. One good way to tell the difference is to ask yourself whether you only have the reaction to *this* patient – which would indicate that your feeling originated within the patient – or whether you have the reaction to *many* patients – which would indicate that it originated within you.

Why do we care about countertransference?

Understanding our countertransference is important for many reasons:

- **Acknowledging and understanding our feelings about patients decreases the chances that we will act on them:** It is inevitable that in the course of working with patients we will have a range of feelings towards them, including anger, irritation, affection, and boredom. The more aware we are of these feelings and of the potential reasons for them, the less likely we are to unconsciously act on them. Consider these two situations:

  > *Therapist 1 fights against acknowledging his boredom with his patient and begins to consistently fall asleep in sessions.*
  >
  > *Therapist 2 acknowledges his boredom with his patient. He discusses this with a supervisor and realizes that it is related to a resistance that the patient is manifesting in the treatment that is preventing him from engaging with the therapist. The therapist becomes more attentive in the sessions as he reflects on the patient's conflict.*

These examples illustrate the way that acknowledging countertransference decreases the likelihood that we will act on these feelings and increases our ability to use them to understand the patient and to conduct the therapy.

- **Countertransference feelings can help us to diagnose, assess, and treat our patients:** Having very strong positive or negative feelings about patients can help us to recognize the predominance of splitting-based defenses. Understanding our feelings about patients during sessions can help us to recognize many aspects of our patients' functioning, including defenses and their ways of relating to other people. We will discuss this further below.
- **Countertransference feelings can help to guide our interventions in a moment-to-moment way by helping us to recognize what is important in the session:** As we discussed in our chapter on reflecting, understanding our countertransference can be one of the best ways to understand when and how to intervene. We will discuss this further below.
- **Countertransference can help us to learn more about ourselves as we work with different patients:** Do you always become hopeless when a patient reveals that they have an eating disorder? Do you tend to feel depressed when you talk to patients who have substance abuse problems? Do you dread seeing patients who are taking medications? Acknowledging your reactions to your patients will help you to understand yourself as a therapist and, sometimes, to make career decisions that will enable you to do the work you most enjoy.

Is it bad to have countertransference?

As we've mentioned, countertransference used to be thought of as something that interfered with treatment and needed to be eliminated. We no longer believe that this is true, and we now accept that countertransference is a useful element in our work with patients. Countertransference is only harmful to a treatment when it is unacknowledged by the therapist or when it is acted upon in ways that violate the frame of therapy. This topic is covered in the chapter on setting the frame (Chapter 8).

Types of countertransference

In the course of a treatment, it is common to empathize or identify with the patient. This is called a **concordant countertransference**. Here's an example:

> *Ms E is a 32-year-old woman with an eight-month-old baby. Since having the baby, she has missed many sessions. When she does come, she is often late, arriving breathless and describing how much difficulty she has timing her nursing schedule in such a way that she has enough time to get to your office. You feel that it really is too difficult for her to manage both being in therapy and being a new mother and you therefore tolerate her lateness and missed sessions without asking her if there is something else she is feeling about you that might contribute to her lateness. You realize that this is not your usual approach to patients when they are late and miss a lot of sessions and thus you ultimately realize that you are having a* ***concordant countertransference*** *reaction.*

At other times your identification might be with the people with whom your patient has (or has had) relationships. This is called a **complementary countertransference**.

> *With Ms E, you might become frustrated and angry that she is not making therapy a priority. You might become aware that your anger at her is stronger than what you usually feel towards patients who are acting out by missing sessions. As you think about this more, you recall that she told you that her mother was very exacting, with no room for error, even when the patient was sick or had a crisis. You realize that you are feeling the way the patient's mother did when the patient was a child – thus you are having a* ***complementary countertransference*** *in which you are identifying with the patient's mother.*

Both concordant and complementary countertransferences can help us to learn about our patients and their relationships with other people [38].

Technique

Listening

How do you know if you're having countertransference? Here are some thoughts about how to figure this out:

- **Think about how you feel toward the patient:** For the beginning therapist, it often takes time to learn how to identify your feelings towards the patient. To start, develop the habit of asking yourself, ''How do I feel about this patient?'' You can do this after the session or later in the day. Ask yourself this question in a general way as well as in reaction to particular moments during the sessions. Often these thoughts will randomly enter your awareness and, when they do, you should pay attention to them and begin to identify them more precisely.

  It is helpful to talk to someone about your patient as a way of understanding your countertransference. Many psychodynamic psychotherapists will discuss a case with a colleague, omitting any potentially identifying data. This can occur as a consultation, in an ongoing supervisory relationship, or informally.
- **Think about your behavior in relation to the patient:** In addition to exploring your feelings toward the patient, you can also think about your behavior regarding the patient before, during, and in between sessions. Whenever you find yourself preoccupied about patients outside the session, behaving differently because of your relationship with the patient, or acting atypically in session, you should think through potential reasons for these behaviors. Some examples include:
  - dressing in a particular way when you see the patient
  - deviating from your usual therapy technique (such as talking less or more)
  - dreaming about your patient
  - having a strong feeling (such as anxiety) in anticipation of seeing a patient
  - changing aspects of the frame with a patient, such as forgetting to tell a patient about a vacation or not charging for a missed session

Another common example of countertransference is anxiety that the patient will leave treatment. Sometimes these feelings impede the therapist from pointing out that patients are angry with them in the transference, or from following through on a cancellation policy. This limits the patient's opportunity to explore the negative transference, which is a potentially productive area of your work together. Therapists are especially vulnerable to this anxiety if they actually depend on the patient for course credit or to fill their practice hours

- **Listen for similarities between the way you feel toward patients and what they describe happening in their other relationships:** Sometimes you may notice yourself identifying with a set of feelings that the patient is describing either in him/herself or in another relationship:

  Example

  A patient describes feeling that her mother never worried about her. While she is talking, you realize that you have never worried about her either, even though you have often worried about other patients.

  If you allow yourself to notice this sudden countertransference reaction, it will undoubtedly help you to understand the patient. For example, perhaps the patient has induced this guilty reaction in you because he/she thinks that this is the only way that you will take care of him/her.

Reflecting

Once you have identified a feeling or behavior as a countertransference reaction, the next step is to reflect on the nature of your feelings in order to understand if and how they can be used to deepen the treatment. Here are some questions that you can ask yourself in this process:

- Is my countertransference informing me about an *affect* that the patient feels? You might have a feeling that:
  - the patient consciously feels (concordant)
  - the patient is repressing (concordant)
  - someone in the patient's life might feel toward the patient (complementary).
- Is my countertransference related to a *resistance* that I had not been aware of until now? For example, the patient may be talking away, but your boredom or distractedness in a session could reveal to you that the patient is avoiding something.
- Is my countertransference related to *my own history or emotional experience*? If so, is it still relevant to one of the above aspects of the therapy, or is it unrelated to the therapy?

Countertransference helps us to decide when and how to intervene – ''Attend to the countertransference'' (Chapter 17) is one of the choosing principles because understanding

our feelings about patients is one of the best tools we have to help us decide when and how to intervene. Particularly when a resistance is operative, we may know what the patient is feeling well before they do. Our anxiety level can signal our patients' underlying unconscious affect, or the tenuousness of the therapeutic alliance. For example:

> *Ms F is a new patient who seems motivated for treatment and who starts off talking about a variety of topics. She arrives 15 minutes late for her first two sessions. The therapist, Ms Y, thinks that this is probably a resistance related to her ambivalence about treatment. When Ms Y thinks about saying this to the patient, she becomes anxious and realizes that she fears that it will make Ms F very angry. The therapist decides to wait to confront the resistance.*

Here the therapist's countertransference picked up on the patient's anxiety before it was consciously communicated to her. This helped the therapist decide what was on the surface, as well as how and when to intervene.

Intervening

Do you ever tell the patient about your countertransference?

Generally, we do not directly share our countertransference with the patient. Instead, we use it to develop ideas about what is most affectively rich and ready for interpretation. Our private feelings of anger, irritation, and affection are best left for our own reflection and discussions with supervisors. We do, however, sometimes tell patients how we feel. Here are some of those circumstances:

- **In response to a socially appropriate cue**: When important things happen to our patients, such as a death in the family, a child's graduation, or the arrival of new baby, we respond. It's fine to say ''I'm so sorry'' or ''Congratulations'' – in fact, if we don't, our patients might find it odd. This type of response is often critical for the ongoing therapeutic alliance. In a supporting mode, the intervention might stop there; when uncovering, we will ultimately want to understand the patient's feelings about the intervention.
- **When we have a strong opinion**: ''I'm worried about your depression and think that you should have a consultation for medication,'' or ''I'm concerned about your safety – I'd like to call your husband to make sure that he can stay with you'' both convey feelings that you have about the patient. These disclosures are essential to providing optimal treatment.
- **To help elucidate a repressed affect**: When used judiciously, disclosure of the therapist's affect can help the patient to connect to repressed feeling. For example, the therapist who tells her patient, ''It's interesting – your bar exam is coming up in two weeks and I seem more anxious about it than you do – what do you make of that?'' is helping the patient to understand that she has feelings that she is unconsciously communicating to the therapist.

Asking patients to imagine your feelings

Patients can often learn about how their behavior affects other people by trying to imagine how they affect us [39, 40]. For example, with a patient who skips sessions and is late but never calls, we might encourage the patient to imagine their emotional effects on us by asking something like, ''What do you imagine I felt when you did not come to session or call me?''

Validating the patient's experience of the countertransference

Sometimes a patient will intuit what we feel toward them. They might say, ''I know you are angry with me, don't deny it.'' In an uncovering mode, we try to validate in a general way, while continuing the uncovering process – so you might say, ''Let's imagine that you're right – do you have any thoughts about that?'' while in a supporting mode you might try to use that information to teach the person about their effect on others by saying, ''It sounds like you understand that you have been trying to get me to feel angry at you. I wonder if that happens with other people?''

Countertransference can inform our choice of supporting or uncovering approaches

''Attending to the countertransference'' (Chapter 17) not only helps us to know when and how to intervene, it also helps us to choose whether a basic, supporting, or uncovering intervention will be most effective at any given moment. For example:

> *Mr G is a 32-year-old chef whose sensitivity to perceived slights has resulted in his abruptly leaving jobs. On occasion, Mr G has called his therapist to reschedule when he was running late. Early in the treatment, the therapist generally changed his time if her schedule permitted it because she worried that if she didn't accommodate him he might leave treatment. In the course of therapy, Mr G has developed a strong alliance and has been able to understand his vulnerability and its origins. Later in the therapy, Mr G's requests for scheduling changes make the therapist feel irritated at his sense of entitlement. The therapist notes to herself that as the patient has improved, her countertransference has shifted. She uses her new-found understanding of the shift in her countertransference to begin to confront the patient's behavior, saying, ''I have often been able to make these scheduling shifts in the past, but I wonder what it would feel like if I couldn't accommodate you and you had to pay for the cancellation.''*

Thus, the countertransference informed her initial choice of a supportive approach to his requests and the shift in the countertransference signaled that he might be able to tolerate a more uncovering type of intervention.

Summary

Now that we have reviewed the fundamental elements of psychodynamic therapy – affect, free association, resistance, transference, and countertransference – we are

ready to combine these elements in understanding how to approach unconscious conflict and fantasy.

Suggested activity

Consider these vignettes and questions.

1. A patient is talking about her reaction to the September 11 attack on the World Trade Center and tells her therapist that she had been at home that morning, getting ready for work, and happened to listen to the radio and hear about the events. She quickly thought about whether she knew anyone in or near the towers and couldn't think of any one at risk. She talked about having felt sadness and loss for all those directly affected by the event. As she is talking the therapist realizes that she has been feeling guilty that her dog is home alone and is unable to go out for a walk until she gets home.

(a) What is the countertransference?
(b) Is it concordant or complementary?
(c) How might the therapist intervene?

Comment

In the countertransference, the therapist associated to her dog, who was also alone in an apartment, and she experienced his helpless dependence on her. Her countertransference could inform her that there was a connection between the patient's affect and the dog's imagined experience. Thus, her associations reflected a countertransference attunement to her patient's unexplored affect. This is a concordant countertransference. It could help her to realize that the patient felt lost and alone herself. If the therapist is working in a predominantly supporting mode, she could help the patient to **name her emotions** by saying something like:

I wonder if you felt helpless in the face of this crisis?

If the therapist is working in a more uncovering mode, she might choose to begin by **confronting** the resistance to the affect:

You remember thinking about the feelings of others, but not about your own feelings.

2. A 66-year-old retired widower is having difficulty with the transition to this stage of life. He has sought psychotherapy for help with insomnia, feelings of worthlessness and passive suicidal thoughts. After a few weeks of psychotherapy, his depression lifts but he is still struggling with how to spend his time. The therapist notices that he is bored and sleepy during the sessions.

(a) What is the countertransference?
(b) What questions might the therapist ask himself to better understand the countertransference?
(c) How might the therapist use what he learns from his countertransference to help the patient?
(d) What could the therapist say if the patient suddenly comments, ''Hey Doc, I feel like I am boring you?''

Comment

Boredom and fatigue are the countertransference reactions. The therapist might ask himself why he is having this reaction to the patient. He could consider whether his boredom is: (i) a concordant identification with the patient's boredom in retirement, (ii) a complementary identification with an important person from the patient's early life, (iii) a projective identification in which the patient has unconsciously projected his boredom and emptiness into the therapist, (iv) a sign that he is uncomfortable with something the patient is experiencing, or (v) a sign that he is having difficulty empathizing with the patient. Depending on his answer to these questions, he uses this understanding to guide his interventions. If the patient asked the therapist about his boredom, the therapist could **confront** this by saying, ''Tell me more about your feeling that you are boring me,'' or ''I wonder if your thought that I am bored is telling us something about what you are feeling.''

23 Unconscious Conflict and Defense

Key concepts

An unconscious fantasy is a wish or fear that pervades a person's unconscious, driving behavior, and shaping characteristic defenses.

Clusters of linked unconscious fantasies are called complexes.

Unconscious conflict happens when opposing unconscious fantasies collide.

Unconscious conflict produces anxiety, which triggers the ego to mount defenses to decrease the anxiety.

Primary gain is the decrease in anxiety that happens when a defense successfully diminishes unconscious conflict.

Secondary gain is the advantage that the defense or symptom gives the person in their life.

Listening for anxiety, other affects, parapraxes (slips), incongruities, and nodal points is the best way to detect the presence of unconscious conflict.

In a supporting mode, we try to identify and reinforce healthy defenses and to help patients adopt new, more adaptive ways of dealing with anxiety.

In an uncovering mode, we help patients to become conscious of their conflicts and the defenses they are using in order to enable them to make more adaptive defensive choices.

Imagine that you're the fire warden for a vast, northern forest. Your job is to search for fires in thousands of acres of silent trees. You have a watchtower and a helicopter. Where do you start? How do you know where the trouble is? You look and smell for smoke. You look for ash. You watch the behavior of the birds and other animals. Why? Because you know that where there's smoke there's fire. It's your only clue.

The same is true for the psychodynamic psychotherapist who is looking for unconscious conflict. The mind is vast and the conflict is hidden (unconscious). There's no map. Where to look? Well, where there's smoke, there's fire. Here the smoke is **anxiety**. When you rub two sticks together you get heat (friction); when you rub two opposing unconscious fantasies together you get anxiety. You can think of anxiety as the intra-psychic equivalent of the heat of friction. Of course, some people are hard-wired for more anxiety than others and not all anxiety is caused by intra-psychic conflict, but it's a good bet that some kind of intra-psychic conflict is behind a lot of the anxiety that you will come across.

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What is intra-psychic conflict?

Intra-psychic conflict is what happens when two opposing unconscious fantasies collide [41]. An unconscious fantasy is an unconscious wish or fear that exists in a person's mind. Some people think that fantasies are always things we want – we can help our patients to learn that fantasies can be things that we want or things that we fear. One way to think about unconscious fantasies is that they are the sentences or stories that populate our unconscious minds. ''Father'' is just a word – in itself it is not an unconscious fantasy. ''I want my father to love me'' is an unconscious fantasy if it is out of awareness. Here are some other common examples of unconscious fantasies, although there are as many unconscious fantasies as there are minds:

I want to be taken care of.

I don't want to be abandoned.

I love to be adored.

I want to be powerful.

I don't feel whole without another person.

I fear having to be in control.

Being taken care of makes me feel loved.

Having to take care of myself makes me feel alone.

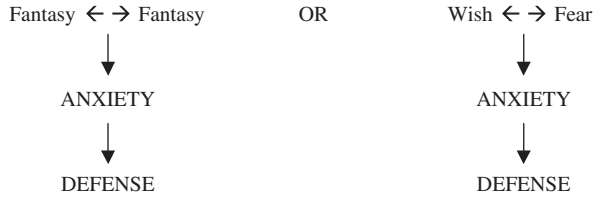
Complexes

Clusters of related unconscious fantasies are called **complexes**. One of the most famous complexes is the so-called Oedipus complex [42]. It's nothing more than a cluster of related unconscious fantasies. For the heterosexual little girl, it goes something like this:

I love my father and want him all for myself. My mother has my father. I wish that I could get rid of my mother so that I could have my father. But if I try to attack my mother she'll counter-attack and I could be in danger. Plus, I also love and need my mother (opposite for the heterosexual boy; same-sex longings for homosexual children).

Freud thought that all people have Oedipus complexes. These unconscious conflicts do seem potent for most people. There are some unconscious fantasies that seem to be quite common. But all people also have unconscious fantasies and complexes that are unique. By the time most people are adults, their fantasies and complexes are fairly fixed – they might develop new ones and drop old ones but there are core unconscious complexes that remain relatively stable for people over time. We know this intuitively; when we say that one person is driven by abandonment issues while another is consumed with power we're talking about stable, core fantasies. *Understanding these fantasies is central for our understanding of how a person operates in terms of defenses, relationships with others, and self-perceptions.*

One thing about fantasies – they collide and then there's trouble.



For example, one person might have the following two fantasies; ''I feel loved when I'm taken care of,'' and ''I feel like a strong man when I don't need anyone.'' These are two powerful fantasies that are about as far apart as they can get – 180°, if you will. People are not one-dimensional – they want lots of things that are not necessarily compatible. This person wants to feel both strong and loved and his fantasies about these wishes are seemingly completely incompatible. If both fantasies are dormant or if they aren't active at the same time, things might be okay for a while. But problems arise if they are both active at the same time. For example, let's say that these two fantasies belong to Mr A:

> *Mr A is a 28-year-old gay man whose father left the family when he was a young boy. While on vacation he meets B, a 32-year-old gay man with whom he falls in love and has a relationship. His lover is caring and solicitous and Mr A feels wonderful and loved. Unconscious fantasy #1 (''I feel loved when I'm taken care of'') is in full force. However, Mr A and his boyfriend live in different cities and after the vacation they return home. Despite frequent e-mails and calls, Mr A feels that B is less attentive than he is and begins to get angry when B goes a day without making contact. He feels anxious and begins to sleep poorly. He becomes irritable with B when he does call, becomes aloof, decides that he's too busy to have a relationship, and ultimately breaks up with B. Now back at work, he is glad that he doesn't have to take time to be involved in a relationship.*

What happened? In the face of growing dependence on B, unconscious fantasy #2 (''I feel like a strong man when I don't need anyone'') kicked into gear, making Mr A feel weak in the face of needing B's attention and care. Since this was not in Mr A's awareness, the conflict was *unconscious* and the result was *anxiety*.

Notice that something else happened after the anxiety – Mr A became aloof and decided that he was too busy for a relationship. This means that Mr A mounted a **defense** or a set of defenses (some combination of **reaction formation** and **rationalization**). When anxiety is generated by unconscious conflict, the ego is activated to mount defenses. As with unconscious fantasies, the defenses that the ego mounts become characteristic. In other words, people tend to use the same set of defenses repeatedly over time. In the case of Mr A, when the care that made him feel loved seemed threatened (even if he was just *feeling* that it was threatened) his feelings of dependency made him feel weak and anxiety was generated. Not everyone would have a conflict about this – perhaps Mr A's early abandonment makes him particularly vulnerable to feeling weak when he notices that he needs care. The conflict leads to anxiety, and the anxiety triggers defenses.

The particular defenses that Mr A uses give him both primary and secondary gains [43]. **Primary gain** is the decrease in anxiety that happens when a defense successfully diminishes unconscious conflict. The primary gain is that he no longer

has as much anxiety because he is **repressing** (making unconscious) his feelings of dependency in order to regain his feeling of strength. Thus, the conflict is sapped of strength and not as much anxiety is generated. **Secondary gain** is the advantage that the defense or symptom gives the person in his/her life – in this case, the secondary gain is that Mr A feels that he can work more efficiently because he is relationship-free. Note that the unconscious fantasies continue to exist in Mr A, but in the absence of the relationship they are not activated and the conflict is dormant.

So – unconscious fantasies collide, cause unconscious conflict, generate anxiety, and cause the ego to mount defenses. The defenses decrease anxiety *but at a price*. Mr A has difficulty with relationships unless he is 100% assured of the care of his lover – which is a hefty price if you're interested in being with real people. We can help them to ''pay a smaller price'' in one of two ways. For people with good ego function, who are self-reflective and psychologically minded, bringing their unconscious fantasies, conflicts, and defenses to light can help them to develop more flexible defensive operations, improved relationships with others, and better self-esteem management. For people who have weakened ego function and are less psychologically minded, we can use our understanding of their unconscious thought processes to identify and strengthen healthy defenses and to suggest new, more adaptive ways of dealing with their anxiety. In psychodynamic psychotherapy, we work backwards from anxiety to defense and ultimately to unconscious conflict and fantasies in order to help people recognize what is causing them anxiety, problems, and symptoms.

Technique

Listening

There are a lot of things to listen for here: unconscious fantasy, unconscious conflict, and defenses.

Listening for unconscious fantasy

Just like listening for the dominant affect, the dominant transference, and the dominant countertransference, we listen for the dominant unconscious fantasy in a session. We do this by listening to the stories that patients tell us about their fears, wishes, and relationships with others, and we start to notice stories that sound similar. When we listen for affect, we think, ''What does this patient feel right now?'' When we listen for unconscious fantasy, we think, ''What does this patient want or fear right now?'' To hear what's unconscious, listen for *hidden stories* – that is, the stories behind the stories. It's like an optical illusion – when you look at it one way you see one picture but when you focus on it in a different way you see another, hidden scene. Our patients tell lots of stories, but the stories that are unconscious fantasies are short and child-like. For patients who have weaker ego function, these stories are often on the surface, but for patients who have stronger ego function

these stories are more hidden. These higher functioning patients are embarrassed and ashamed by their child-like wants and fears but the fantasies are there. When you hear something that sounds child-like from an adult, you are likely hearing an unconscious fantasy.

Example

A 28-year-old woman tells her therapist:

I don't know why I feel so angry with my father for getting remarried so quickly after Mom died. He's a great guy and he deserves all the happiness he can get after taking care of Mom for so long. And Marsha's pretty nice. But I hoped that they'd plan the wedding for after the baby was born – I don't know why that makes such a difference to me, but it does. It's ridiculous – it's not like they're going to help me take care of it or anything.

Here, the conscious story is that a 28-year-old woman wants her father to be happy and is confused by her anger at him. But the hidden story is that she wants to be her father's first (or only) priority. The patient has repressed this story (put it out of awareness – made it unconscious) because it's a child-like wish about which she is ashamed. Why should a grown-up woman who is having her own baby want her father all to herself? Why should she want her Dad to take care of her instead of taking care of himself? Why indeed – because we all have wishes that persist from childhood. If those wishes were not well gratified when we were young, they may be more persistent and less **resolved**. A wish that was perfectly appropriate in childhood but causes shame when it persists into adulthood is said to be **unresolved**, and can wreak havoc on the adult's efforts to navigate the world of grown-up relationships. Psychodynamic psychotherapy is designed to help with that.

Listening for unconscious conflict

Like the warden looking for fires, we're listening to conscious material for evidence of defenses and the unconscious conflicts that underlie them. This mostly involves listening for anxiety, new affects, and incongruities – hints that there's conflict beneath the surface.

- **Listen for anxiety**: Remember that when we listen for anxiety we listen for:
  - overt statements about anxiety
  - anxious behavior in the room – such as fidgeting, irritability, looking at the clock or watch
  - anxious behavior outside of therapy – such as eating difficulties, sleeping problems, irritability with others, procrastination, difficulty concentrating, increased impulsivity, difficulty with judgment
  - anxiety dreams
- **Listen for affects**: Any change in affect can be a clue that there is anxiety. Irritability, depressed mood, or even a precipitously elevated mood can indicate the presence of anxiety and conflict.

- **Listen for incongruities**: It makes sense that conflicts produce incongruities. Two things are active that oppose each other – this will produce all sorts of mismatches. Examples include affects that are not matched with experiences (such as crying at one's birthday party), affects that are not matched with thoughts (such as feeling depressed when thinking about a loved one), and thoughts that are not matched with each other (such as being sure that inviting both sets of in-laws to Thanksgiving is a good idea even though you know they always end up fighting).
- **Listen for parapraxes**: Parapraxes (slips of the tongue) occur when repressed thoughts or feelings inadvertently ''pop out'' in speech (see Chapter 16). They are often an excellent clue to the presence of unconscious conflict. Example: A man who is having trouble with his boss says:

  Yesterday, when I was on the phone with my father – I mean, my boss.

  This parapraxis suggests that something about the difficulty with the boss has to do with unconscious fantasies and conflicts involving the man's father.
- **Listen for dreams**: Anxiety dreams often signal the presence of anxiety and unconscious conflict. Interpretation of these dreams can help us to understand dominant fantasies and their attendant conflicts.

Listening for defenses

Since resistance is defense in the treatment, the presence of resistance means that we're listening to a defense. Blocking, silence, lateness – all of these are good clues. During the induction phase it may be hard to know which thoughts and behaviors are defensive, but as we get to know patients we become familiar with their characteristic defenses. For example, if a patient is irritable before you go on vacation for the first time in the treatment, you might not know what you're listening to, but when this happens each time you begin to tune in to the defensive nature of the irritability.

Reflecting

Once we've tuned into the patient's unconscious frequency, we can then begin to identify the dominant unconscious fantasies, the components of the unconscious conflict, and the dominant defenses. We do this by thinking about what we're hearing most frequently and what is most connected to the dominant affect. We should be able to put the dominant unconscious fantasies into one or two sentences. We have to think about which type of fantasy is most prominent, for example it could be a wish, a fear, or a way of thinking about oneself. We begin to deconstruct the unconscious conflicts as we identify the opposing fantasies. And finally we identify the prominent defenses.

A man who has recently immigrated to this country presents with difficulty sleeping and vague stomach complaints. He tells you the following:

All I want is for my children to do well. That's it. That's why I came here. My daughter is very smart – I hope that she'll get into a wonderful college. That's why I'm driving a cab – you know, I'm trained as an engineer in my country, but it's fine. I'd rather be here, doing this than be back in my country being an engineer. I don't care about my own career. But if I'm sick, I won't be able to work at all and then the whole move will be for nothing.

The surface story is about a man who has sacrificed his own career for the good of his children. However, the repetitive nature of his insistence that he doesn't care suggests the presence of unconscious conflict. His fantasies, conflicts, and defenses might sound something like this:

- **Unconscious fantasies**: I want to be successful. I want to be recognized and admired for my intelligence.
- **Unconscious conflict**: I want these things for myself, but I can't have *both* what I want for myself *and* what I want for my children.
- **Defenses**: Reaction formation, somatization.

Now, what to do with all of this? Often, we hear lots of unconscious material but it is very far away – deep beneath the surface. Remember the choosing and readiness principles from Chapter 17. It's important to remember that *just because we hear unconscious material doesn't mean we can use it*. We can remember it and we can wait for it to become closer to the surface, but if it's deep our interventions won't touch it. Worse still, they could increase resistance, causing the unconscious material to be even less accessible to consciousness. As before, *we let the dominant affect guide us towards the surface*. We want to pick the unconscious element that is just below the surface – the one that we can gently nudge into consciousness. Here's an example that illustrates this layering of unconscious material:

> *A 38-year-old woman whose father had many affairs presents because she wants to have a baby and has become panicked about her fertility. When you ask her about whether this is something that she has been worried about for a while, she realizes that her fear escalated after her friend was found to be in premature menopause. She sobs in your office, saying that she is afraid to go to the doctor to get checked out because she is sure that she will have the same problem since she has always had irregular periods. She acknowledges that she is frequently phobic about going to the doctor. When you ask about her relationships, she says that she is very much in love with her boyfriend, a wealthy 50-year-old man who is married and whose wife lives in another state. She says that it is practically a done deal that he will leave his wife. She becomes irritable when you ask about her previous relationships but nevertheless tells you that her last boyfriend was married as well.*

Reflection – There are many unconscious fantasies, unconscious conflicts, and defenses operating here.

- On the *surface*, she has a symptom, which is her fear of going to the doctor. This comes with attendant anxiety, which is the dominant affect. An early intervention – a question – brings an unconscious connection (her friend's premature menopause) into awareness. This is a clue that this is close to the surface and ready to be dealt with.
- On a *deeper* level, her fear of not being able to have a baby could be related to denial about the likelihood that her 50-year-old married boyfriend would leave his wife to start a family with her. You might wonder whether the panic about the friend's infertility is in fact a defense against her fear that her boyfriend won't leave his wife. The unconscious conflict could be her wish for her boyfriend to choose her versus her anger at him for not leaving soon enough for her to conceive a child before she is too old. This might be producing anxiety and her defense could be

shifting the anxiety by identifying with her friend. If the problem is that she's infertile, then not having a baby would be her fault (her body's fault) rather than her boyfriend's fault. This defense allows her to keep her rage at her boyfriend out of awareness. This formulation might be true, but the patient's defensiveness makes it clear that it is not on the surface.

- At the *deepest* level, conflicts about her philandering father and her defenses against awareness of them might be resulting in her choosing boyfriends who are just like him – you might think of this immediately, but it is too deep to address now.

In this way, we reflect on the unconscious elements that we hear in order to choose the ones that are closest to the surface. As before, we can cautiously use our past experiences, our theories, and our understanding of the therapeutic alliance and the patient's phase of treatment to guide us. For example, once there is a high degree of trust between patient and therapist, the therapist needn't be put off by a bit of defensiveness on the part of the patient, and can go a bit deeper than the patient's comfort level might have allowed at first.

Intervening

Basic interventions

As we've said, defenses are in place for a reason – they protect against frightening or shame-filled feelings that are often very deep. This means that we have to be very respectful as we begin intervening. Starting slowly is the name of the game, and basic interventions will help you with this. **Questions**, **calls for associations**, and **empathic remarks** will help you to get your patients talking about the details of their lives which contain the clues to their unconscious fantasies, conflicts, and defenses. Here are some examples:

Patient 1 *I don't know whether to take this new job or to stay where I am.*
Therapist *Can you tell me more about the new offer? What seems attractive about it?*

Patient 2 *I really like Clara but I can't seem to get myself to call her.*
Therapist *When did you last think about calling her?*
Patient 2 *Last night.*
Therapist *Can you go back to that moment in your mind? What were your thoughts?*

In both of these situations, the therapist hears something that sounds like it might be connected to an unconscious fantasy or conflict. The first interventions should be open-ended questions, designed to get the patient to say more.

Supporting techniques

We choose supporting techniques when we want to strengthen adaptive defenses and suggest alternatives to maladaptive defenses. When we suspect that ego function is chronically or temporarily compromised, we generally do not encourage

exploration of unconscious fantasy or conflict since this is likely to increase anxiety and disorganize the patient.

All defenses serve to protect people from uncomfortable affects and associated conflicts but they differ in the degree to which they ignore the realities of the outside world, squelch feelings, or disrupt relationships [44]. Defenses are most adaptive when they allow some expression and gratification of wishes and needs while taking into account the realistic constraints of the environment and minimizing any negative social consequences. Consider the following example:

> *Mr C yearns to be loved and cared for but fears that people will ignore him. There are a range of defenses he might use to protect himself from the uncomfortable feelings of hurt, anger, and unworthiness associated with this conflict.*

- He could **devalue** others (''Who needs them? I can take care of myself!'') – but then other people would see him as having a ''chip on his shoulder'' and steer clear of him.
- He could bury the anger along with the yearnings for love (**isolation of affect**) but then his wishes to be cared for would remain ungratified.
- He could redirect the hurt at a smaller annoyance, for example by upbraiding the telephone operator who can't find a number he needs (**displacement**).
- He could channel his anger into football, becoming the star quarterback on his football team and the focus of adulation from his peers (**sublimation**) even if he still can't seem to get the girl.
- He could decide to go to medical school and dedicate himself to caring for others (**altruism**) which both allows him to enjoy the experience – if only vicariously – and boosts his self-esteem.

Each of these solutions has a different ''adaptive'' value. In working supportively with this man, you would *listen* for the clues about the unconscious fantasies and conflicts at work, *reflect* on the defenses he uses to manage uncomfortable affects, and *intervene* if necessary to help him find more adaptive ways of defending himself.

Intervening supportively with defenses is a three-part process

1. **Identify the defense:** Direct the patient's attention, gently and tactfully, to the problematic behavior that needs to be addressed.
2. **Identify the ''cost:''** Demonstrate the negative consequences for the patient in the behavior.
3. **Identify alternatives:** Encourage healthier, less ''costly'' behaviors.

Depending on the patient's needs in the moment, we can use either supplying and/or assisting interventions for each of the three steps outlined above. To illustrate this, consider Mr C, the man who yearns to be cared for but fears that others will ignore him:

> *Mr C often feels slighted, hurt, and angered by perceived interpersonal disappointments but has trouble acknowledging or tolerating these emotions, much less the yearning that lies beneath them.*

*He defends against his anger by **projecting** it and, as a result, often feels unfairly attacked by other people, including you. His peevish, blaming behavior irritates co-workers and actually provokes them into mocking him, which makes him feel even more ostracized and bitter. Here is a segment taken from a session early in therapy*:

Mr C — *I went into the employee lounge this morning to get a cup of coffee, and Jim and Karen were there talking. They gave me this look that really pissed me off. I mean, they didn't say it but it was obvious they wanted me to get lost. Everyone knows they have a thing for each other.*

Therapist — *I suppose it's true that two people who are dating like to be alone but I find it's hard to know for sure what someone else is thinking, especially if they haven't said anything directly. Can you think of other reasons why they might have looked up at that moment?* (**validation, psychoeducation, reality testing**)

Mr C — *(shrugs) I don't know.*

Therapist — *Maybe they just wanted to see who came in. Does that seem plausible to you?*(**reality testing**)

Mr C — *Yeah, I guess it's possible.*

Therapist — *So then what happened?* (**question**)

Mr C — *I figured they wanted me to leave, so I said kind of loudly, ''Am I interrupting anything?'' Except I said it sort of sarcastically, and told them, ''The lounge is for everyone, you know.'' I wasn't going to be pushed around. So Jim said, ''Lighten up, will you? We're just having a cup of coffee.'' And Karen sort of shook her head and snickered at me, like I was crazy.*

Therapist — *It seems like your first instinct was a good one – to ask if you were interrupting – but things might have gone more smoothly if you had left out the sarcasm. These are problems we could work on together so you won't feel so hurt and angry. Maybe you don't have to suffer so much.* (**praising, advising, explicitly joining, empathizing**).

Mr C — *OK – I'm not 100% sure you're right, but it's sure worth a try.*

In this example, behind Mr C's actual words, the therapist hears the disavowed yearning to be acknowledged and cared for. She also hears the unconscious conviction that others will ignore him or, worse still, that he is not worthy of their affection. These unconscious wishes and fears generate feelings of anger, envy, unworthiness, and despair that Mr C finds intolerable. The therapist infers this from the defenses – principally maladaptive projection – that Mr C has marshaled against these affects. Using these defenses, Mr C protects himself against rejection and betrayal by other people – but at the great cost of ending up alone and shunned. Note that the therapist is careful *not* to confront Mr C with these feelings, fantasies, and conflicts that are out of his awareness. The treatment is young, the therapeutic alliance is tenuous, and Mr C has not yet developed a capacity for observing himself or tolerating the powerful feelings that might emerge if his defenses were interpreted. The therapist wisely selects the most ''maladaptive'' of Mr C's defenses to address first – his tendency to project anger – as this seems most disruptive of his relationships. Then, using a mix of supplying and assisting interventions, the therapist gently focuses Mr C's attention on the behavior, **reality-tests** his misperceptions, and

suggests more adaptive alternatives, all the while offering direct support in the form of **empathy** and **praise**. The therapist later learns that Mr C has taken up jogging alone during his lunch breaks (**sublimation**) and has devoted himself to reading everything ever written by Gandhi (**reaction formation**, **intellectualization**). The therapist decides that these defenses are adaptive enough in that they are not causing either the patient or those around him great suffering and might be left alone – even though Mr C's wishes for a loving and affirming relationship remain unrealized for the time being.

Uncovering techniques

We choose uncovering techniques when we want to make someone aware of their unconscious fantasies, conflicts, and defenses in order to free them up to make more adaptive choices.

We have several goals when we intervene to uncover this material:

- Unconscious fantasies affect behavior but do so out of the person's awareness – bringing them to light in a safe environment can help the patient to have less shame about them, to understand them, and to be able to make choices without being enslaved to them.
- Unconscious conflicts paralyze people. If unresolved, they lead to tremendous morbidity caused by anxiety and stasis. They activate more ''costly'' defense mechanisms that decrease anxiety at the heavy price of problematic behavior patterns and unsatisfactory relationships. Interpreting unconscious conflicts (making people aware of them) can help to resolve them, allowing people to use more flexible, adaptive defense mechanisms and/or have less need for defensive operations.
- Unconscious defenses tend to be inflexible and problematic. When these are brought to the surface, people can then use secondary process thinking to alter their characteristic defense patterns, leading to healthier functioning and to mutually satisfying interpersonal relationships.

Uncovering unconscious fantasy and defenses in order to promote more adaptive defensive functioning is an essential part of psychodynamic psychotherapy, but it's important to remember that we have to do it very slowly and carefully. There's a reason that these conflicts and fantasies are unconscious – they cause anxiety and uncomfortable affects. Defenses are not bad; in fact, they're necessary. They help to modulate anxiety and protect the self in myriad ways. We interpret not to eliminate defenses, but rather because we think that patients could protect themselves in ways that would exact a lesser price.

Knowing that we have to have respect for defenses and for the shamefulness of unconscious fantasy, we forge ahead. Once we choose material that is close enough to the surface (choosing principles) and we think that the patient is able to handle the inevitable anxiety of learning about unconscious material (readiness principles), we

begin the interpretive process (**confrontation**, **clarification**, **interpretation**). Early in treatment, much of what we do is to ask questions, confront and clarify until we really have something to translate into consciousness. Don't worry about not interpreting quickly – it probably means that you're being careful, respectful, and really trying to learn about your patient's unique unconscious material. Plus, each interpretative sequence is not an end in itself – it will have to be repeated and repeated in the **working through** in order for real change to occur (see Chapter 29).

Here are some examples. Note that for the sake of illustration, these examples are compact – in the real world, the interpretative process could extend over many sessions as the unconscious material comes more clearly into focus.

Interpretation of unconscious fantasy

The patient is a 32-year-old woman who has been living with her 33-year-old boyfriend for three years.

Patient *Marcus took me out to a wonderful restaurant last night for my birthday. I've been wanting to go there for months. It's great – very romantic. I looked good – wore that new dress that I just bought – it was all perfect – but that night in bed I just started to cry. I felt so stupid – the whole evening was lovely, and he was so nice and I know that he loves me.*

Therapist *Can you tell me more about the dinner or what happened after dinner?* (**question**)

Patient *(exasperated) Nothing happened! That's what was so weird. We walked home – stopped and had a coffee at that nice café that opened on our block. When we got home there was a wrapped package on the coffee table – I don't even know how he got it there – it was a cashmere sweater – and that was so thoughtful of him – he's not a shopper and I know that he hates going into all of those cutesy shops that I love – but he did it and it was really thoughtful. He's such a great guy – I'm really lucky – so why am I so upset?*

Therapist *You said that the gift was thoughtful – but you didn't say that you liked it.* (**confrontation**)

Patient *How could I not like it? He got it for me and I know that he took time to pick it out and everything – it's selfish for me to think about whether I liked it or not (tearful) But you know, two weeks ago, we were at the mall and we went by this store and I saw this other sweater that I loved – it was too expensive to just go in and buy for no reason and I sort of oohed and aahed over it – and, I don't know, I was just hoping that he'd get me that one – and he didn't. The one he bought is fine but the color is sort of off for me. He kind of doesn't get it when it comes to shopping, style – he tries so hard, but it's not his thing. Cliff (her old boyfriend) had such a flare – he always guessed exactly what I wanted – it was like magic – it would just appear. I never had any anxiety before birthdays – he just knew what to get. But he was a jerk in so many other ways.*

Therapist *If you really wanted the other sweater, you could have asked for it.* (**confrontation**)

Patient *But it's no good that way. That's not a present. It's like when I had to nag him to read my manuscript – he did it and was helpful, but he should just want to do it.*

Therapist *So in both cases – with the sweater and with the manuscript you get upset when he doesn't figure it out himself*. (**clarification**)

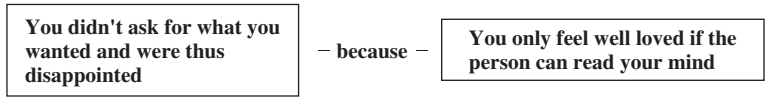
Patient *Yes – that's it – but that's so unfair – he did read the manuscript and he gave me this lovely birthday and he's so great – but it makes me uneasy – like does he really get me like Cliff did? (more tearful)*

Therapist *Having him be able to read your mind makes you feel loved – if you have to ask, you don't feel well loved*. (**interpretation**)

Patient *It's true but it sounds so silly. No one can read minds. My mother never could – she always got us what she wanted for herself*.

In this example, the patient has an unconscious fantasy that goes something like this, ''If someone loves you, they know what you want and give it to you without your having to ask for it.'' She is a grown woman and knows that people can't read minds, and that someone can love you without being able to read your mind, but this is a **core fantasy**. Despite her seemingly good relationship with Marcus, this fantasy kicks in and ruins what would have been a perfectly lovely evening. His ''mistake'' with the gift makes her feel ''misread'' and the unconscious fantasy leads her to feel less well loved. In terms of the therapist's technique, the first clues that an unconscious fantasy is at play are the patient's *anxiety* and *incongruous affect* (upset about a lovely birthday). The therapist wants to know more and asks a **question** – this also helps to indicate what's closest to the surface – getting details is key. The therapist **confronts** the incongruities twice – then when the patient remembers another similar instance, the therapist brings things into focus with a **clarification**.

Once the patient's affect indicates that the unconscious fantasy is close to the surface, the therapist tries to interpret it. We know that this is an interpretation because we can write it as a ''because schematic:''



The patient has more affect, and adds a deep, genetic association indicating that the interpretation was well timed and aimed at the right level. The hope is that revealing this fantasy in the safety of the therapeutic relationship will help the patient to feel less shame about it, to own it, to understand it, to have more control over it in the future, and to potentially even resolve it.

Interpretation of unconscious conflict

The patient is a 35-year-old man in treatment for two years with a 50-year-old male therapist. The patient has just been offered a large promotion:

Patient *So I'll be a vice president before the age of 40. Ha! My father was never a vice president – he wanted the corner office so badly he could taste it. He was so bitter about that. I don't know how the other guys will take it – they don't seem to like me*

much. So much of my doing well at work has to do with my work with you here. It means much more money as well. I always feel weird telling you about money – I don't know how much you make and if you make more than I do or less.

Therapist *What are you thoughts about that?* (**question, call for associations**)

Patient *Oh I don't know – I think that people in my field make more than people in your field – you're a professional, you know that, so what's the big deal.*

Therapist *But it sounds like you had a bit of anxiety telling me that you were going to make more money.* (**confrontation**)

Patient *Well sure – people don't talk about this in ordinary conversation. I know, I know, this isn't ordinary conversation – but still, we're two guys, and you're older – you might feel bad or something.*

Therapist *Can you say more about what you think my feelings might be?* (**question**)

Patient *(frustrated) – What am I supposed to say? Yeah, okay, I'm always a little worried that when I tell you that I'm making more money that you'll raise my fee. I feel bad saying that because you've been very helpful to me but I've got lots of things besides therapy that I want to spend this extra money on.*

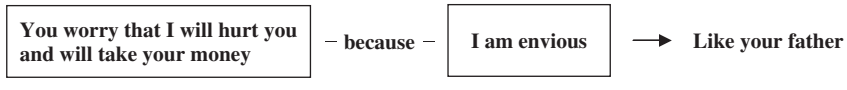
Therapist *Part of you wants to tell me about your good fortune but part of you wants to hide it from me.* (**confrontation of unconscious conflict**)

Patient *I guess so – I can't tell my Dad about the money either – not the amount. He'd totally flip out – and they're having financial problems now – I worry that I'll have to support them and then all that work – down the drain.*

Therapist *So although you hope that I'll be happy for you, you also fear that I'll hurt you by taking your money, just like you fear that your father will – perhaps because you think I'm envious of your success.* (**interpretation**)

Patient *I know you won't – you've always been very fair with me – but the fear is there. It makes me guarded with you and a little afraid.*

In this example, the patient has an unconscious conflict that is making it difficult for him to work well with and trust other men, including the therapist. He has one fantasy that the therapist will be happy for him and another opposing fantasy that the therapist's envy will cause the therapist to attack and injure him (take his money). The patient worries about the therapist's reaction, then takes it back – this incongruity signals the **conflict** that the therapist **confronts**. The confrontation allows the therapist to focus in on the conflict. Finally, the therapist **interprets the unconscious conflict**. Note that the therapist adds the genetic link that is present in the associations. Again, note that this interpretation can be written in the ''because schematic:''



This interpretation is both a transference interpretation and a genetic interpretation since it includes a hypothesis about how an early relationship plays an etiological part in the conflict.

Interpretation of defense (defense analysis)

The patient is a 68-year-old man who has been in therapy for three years with a 39-year-old woman. This is the first session back after a four-week summer break:

Patient	*Once again I was fine during August. It was nice to have a break from therapy and my accountant approves of the break from the expense. I don't know why I always think that it will be hard. I kept taking the medication and wasn't as anxious as I thought I'd be.*
Therapist	*Of course you were fine – we talked about that before I left – the days of crisis are over.* (**validation, confrontation**)
Patient	*So why do I keep coming here twice a week? I was thinking during the break that maybe I should just come once a week. You've been very helpful to me. I know that there are plenty of things that we could talk about – there were no blow-ups this summer, but it's not like Janet (his wife) and I were perfect – still no sex since her operation – is this forever? But what's the use of talking about my feelings about it.*
Therapist	*Can you say more about what's happening with your wife?* (**question**)
Patient	*Don't try to change the subject – I'm talking about therapy and my appointments. I remember feeling the same way last year – sort of tired – am I going to start again? We're old – Janet and I – what's the use?*
Therapist	*It's true that you felt this way last year after the break as well – do you have any other feelings about that*? (**clarification**)
Patient	*It's hard to be away and then to have to slog through all of those weeks with you – get to trust you all over again – sometimes I feel like I'm too old for this, give it a rest – it's too difficult.*
Therapist	*Because it feels painful to get back into the relationship with me after the break, your inclination is to pull away, put distance between us so that the breaks are less painful.* (**interpretation**)
Patient	*If you were just, say, writing the prescriptions, yeah, it would be easier. It's hard for me when you go. You should have a vacation, but I've really come to rely on this room . . .*
Therapist	*And on me.* (**interpretation**)
Patient	*That's harder to say.*

In this example, the patient has an unconscious conflict. He relies on the therapist and has strong feelings about her but feels that the dependency may be too painful to tolerate. This causes anxiety and a defense is mobilized. The defense is some combination of denial of affect, rationalization, and acting out: ''I don't need her, that would be less expensive, and I should pull away from her by decreasing to once a week.'' The defense first rears its head when the patient says that he doesn't actually need the therapist in order to not fall apart – the therapist **confronts** this incongruity

by reminding the patient that she had previously agreed with this. When the patient remembers that he felt the same way last year, the therapist is able to **clarify** the defense. Once the patient's affect comes to the fore, she feels that he can hear the **interpretation of the defense**. The patient acknowledges the defense, but still uses it when he distances from the therapist by saying ''this room'' rather than ''you.'' Note that her next intervention, ''And on me'' is short but is nonetheless a **defense interpretation** – it's a short cut between people who know each other well. See if you can put these interpretations in the ''because schematic.''

Comparing supporting and uncovering work with defenses

To summarize the *key differences* between supporting and uncovering goals in addressing defenses:

- In *supporting* work, we are more selective about which defenses we choose to address. We want to identify and encourage those defenses that lead to adaptive functioning while suggesting alternatives to problematic defenses. We may also choose to respect – or ''supportively bypass'' without comment – the ''healthy enough'' defenses that are doing no great harm, even if not ideally adaptive in the moment.
- In *uncovering* work, we help patients to gradually make defenses conscious in order to uncover the underlying fantasies and conflicts and to subsequently make more adaptive choices.

Another way to pursue unconscious fantasies and conflicts is through the exploration of dreams, which is the topic of our next chapter.

Suggested activity

Read this opening monologue of a session and write three unconscious fantasies that could be operative for this 32-year-old man:

> *I have an image of my wife sleeping – when I left this morning she was sleeping with a smile on her face. I felt like we were nesting – like she's taken care of – safe – bundled up in the bed with the dog at her feet. I had to leave early to get here – I took my bike – I practically took the whole bike apart this weekend, but I fixed it – I had a great sense of accomplishment – now I know that I can fix it myself. I was thinking about our last session – what you said about my mother – that I was dealing with her differently. I realized that I didn't feel defensive about your saying that. I thought, ''That's cool,'' like, ''Oh, you're pointing something out that's helpful.'' But then I thought, ''Maybe that's your technique'' – to tell me that I'm making progress so that I know that you're helping me.*

Comment

A few possible unconscious fantasies include:

I feel good when I'm taking care of my family.

I feel good when I feel masculine.

People don't usually say nice things unless they have an ulterior motive.

Maybe you only care about me because you're my therapist.

24 Dreams

Key concepts

Clinical experience indicates that dreams can offer us a window into the unconscious.

The manifest dream is the story of the dream: the latent dream is the unconscious material behind the dream.

Everything that a person says just before and after telling a dream can be thought of as associations to the dream.

Dreams can be thought of as being composed of the day residue from the dreamer's recent past (one to two days) that becomes linked to related memories and unconscious fantasies.

When working in a predominantly supporting mode, we do not generally encourage our patients to report dreams. If they bring them up spontaneously, we can use the manifest dream to help them to learn about issues and concerns on the surface of their mental life.

When working in a predominantly uncovering mode, we use material in the dream to help patients to learn more about their unconscious minds, including affects, transferences, fantasies, expectations of relationships, and self-perceptions.

There is nothing in the technique of psychodynamic psychotherapy that sounds more daunting or romantic than ''dream interpretation.'' But using dreams in psychodynamic psychotherapy is nothing to be afraid of. Dreams and their related associations are productions of the patient like any other. They are interesting and fun and can be very technically productive since they are often closer to unconscious material than other things that patients say. Trainees often feel that they have to ''know'' what dreams mean in order to talk to patients about them. We rarely ''know'' what a dream means by the time we start to discuss it. In fact, it's a distortion to think that we ever ''know'' what a dream means; all we know is that dreams emerge from the unconscious mind and can thus help us learn about thoughts and feelings that are out of awareness.

Dreams occupy a special place in the history of psychodynamic theory. *The Interpretation of Dreams* (1900), considered by many to be Freud's *magnum opus*, was his attempt to explain the workings of the mind via an exploration of dreams [45]. When Freud called dreams ''the royal road to the unconscious,'' he meant that listening to dreams offered a direct route to unconscious material. Freud believed that all dreams – even anxiety dreams – are dreamt in order to fulfill unconscious wishes. In Freud's model, the unconscious wish ''hitches a ride'' into consciousness using something that is related to it from the dreamer's current life. This current event, which could be a perception, an impression, a wish, or a thought, is called the **day residue** [46]. The day residue, which is usually from the last 24–48 hours,

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acts like a magnet, pulling the unconscious wish into the dream. Because the unconscious material (the **latent dream**) has been inadmissible to consciousness, it is transformed in the dream via the properties of the unconscious (primary process – see Chapter 2) – condensation, displacement, and symbolization. These produce a story that is admissible to the dream, and we call this story the **manifest dream**. Freud called the process of transforming the latent dream into the manifest dream the **dream work**, so interpreting the dream involves understanding the dream work in order to work back to the unconscious material [47].

Example

A 36-year-old man, who is still financially dependent on his parents, cannot allow himself to consciously acknowledge angry feelings towards his father. He sees a movie in which a young lawyer has a screaming match with one of the firm's elders. That night, he dreams that he is having a fight with the actor who played the older man. In therapy, he is able to link the dream to feelings about his father that were previously inadmissible to consciousness.

In this example, the movie, which is the day residue, presents a situation that is similar to the patient's wish to express his anger at his father. This finds its way into the dream via displacement. In therapy, he recognizes the displacement and works backwards to link the feelings to his father.

Today, most psychodynamic psychotherapists do not believe that all dreams are wish fulfillments, nor do they believe that dreams are caused by wishes in the unconscious. Some neurobiologists believe that dreams are used in the service of consolidating memories – but the truth is that the etiology of dreams remains opaque [48]. Nevertheless, dreams seem to be composed of elements from a deeper, unconscious part of our minds and our clinical experience has shown us that we can learn about the unconscious by understanding the symbolic elements represented in dreams. Since we know that we are trying to get to unconscious material, we still believe that dreams offer us a unique window into the unconscious and thus the interpretation of dreams remains a cornerstone of the technique of psychodynamic psychotherapy.

Technique

Listening

As with anything else that a patient tells us, we listen to a dream in order to understand how it can help us to learn about the patient's unconscious mind. First, we let it wash over us without focusing using **ambient listening** – then as we begin to reflect, we **filter** and then **focus** our listening. When listening to a dream, ambient listening is aided by the fact that the dream is discrete – however, from the moment the patient says, ''Oh – I just remembered that I had a dream last night . . .'' we have to think of everything that the patient says as being related to the dream. We also have to backtrack to the moment before the dream report, since it prompted the memory of the dream and is thus related to it. Similarly, everything that comes after

the dream must be considered **associations to the dream** – even if what the patient says next seems unrelated. Consider this dream and associations:

> *I'm sorry that I forgot to bring your check today – I'll bring it next week. Oh, I forgot, I had a dream last night. It was completely random – I have no idea what it means. I was in a car, I think in the back seat and the doors were all closed – someone came into the front seat and started the car but I had no idea where we were going. Whatever that was about. Anyway, I don't want to talk about that – I need to talk to you about work. My boss is giving me such a pain in the neck . . . my old boss gave me a long leash and now I feel like I have no independence . . .*

Despite the patient's protestations, the material that comes directly after the dream is about being controlled, and the dream is about not being in control – so the dominant theme of the dream and the immediate associations are linked. Similarly, the transference material that precedes the dream might be related to this theme as well – could the forgetting of the check relate to a feeling of being controlled by the therapist? We learn the most about a dream when we listen to all of the material around it as if it were linked to the dream in some way.

Listen for mood and affect

We always want to listen for the **mood** or **affect** in the dream because this will give us the best information about which part of the dream is closest to the surface. This will guide our choices about how and when to intervene.

> **Example**
>
> *A young woman dreamed that she was in a forest pursued by wild animals. The therapist thought that this was likely to be a frightening dream but, rather than assuming this, asked about the patient's feeling in the dream. Contrary to the therapist's expectation, the patient said that it seemed exciting and freeing. The therapist thus asked more about this feeling, while thinking that the fear might be less accessible to awareness.*

Listen for connections and nodal points

We are also aided by listening for connections to other material such as:

- what came before the report of the dream
- what came after the report of the dream
- at what point in the session the dream was reported
- words in the dream that seem related to material surrounding the dream
- themes in the dream that seem related to surrounding material
- concepts in the dream that seemed related to the surrounding material

As before, the technique for listening to nodal points involves listening for words and symbols that get repeated, as well as for points of clarity.

Reflecting

Once we let the dream wash over us, we already start to filter it through our reflecting matrix. As always, we're trying to figure out what's closest to the surface and where the nodal points are. Our best guides for this are affect and repetitive, clear elements. Dreams are formed according to the principles of primary process (condensation, displacement, and symbolization). Here's a review of these as they relate to dreams:

- **Condensation** – two related elements in the unconscious combine to form a single dream element.

  Example

  ''I had a dream about a woman. She looked like my ex-girlfriend, but she also sort of looked like this picture of my mother in college''.

  The ''mother/ex-girlfriend'' combination is a condensation that suggests that these two people are linked in the dreamer's mind.

- **Displacement** – one element in the manifest dream stands for something else in the latent dream.

  Example

  A 50-year-old man on the eve of a biopsy reports the following dream:

  ''I had a dream last night about being late for my bar exam.''

  Here, the anxiety about a ''test'' in his future is displaced by the story of a ''test'' in his past.

- **Symbolization** – an element in the manifest dream symbolizes something in the latent dream, such as a person, wish, thought, or idea.

  Example

  A woman who was two months away from terminating psychotherapy reported this dream:

  ''I dreamt that I was in an airport alone waiting for a plane . . . I felt frightened about the trip.''

  In this dream, the symbol of ''taking a trip alone'' may symbolize her feelings about her future without her therapist.

When dreams were thought to be divinely produced and predictive of future events, dream books that gave one-to-one explanations of dream elements were common. Think of Joseph's famous interpretation of Pharaoh's prophetic dream of Egypt's seven years of famine. Using the ancient method of ''decoding,'' associations were not necessary – the symbols gave the meaning. In *The Interpretation of Dreams*, Freud refuted this idea, suggesting instead that the meaning of the dream was to be found in the associations. Paying close attention to the associations still remains good technical advice when reflecting on dreams. The same element can mean vastly different things in the dreams of two people – only the associations can give us the meanings.

Example

A 23-year-old young woman in psychotherapy with a 35-year-old female therapist reports the following dream:

''We were here in your office but it wasn't your office – it was more like a living room and we were having coffee. It was a nice feeling, like we were chatting, more than like we were having a session.''

Associations – the patient notes that she felt good that the therapist offered her a few moments to compose herself after a very emotional session the day before. This prolonged the session by a few minutes and the patient felt that this indicated that the therapist cared about her.

A 19-year-old man who is in psychotherapy with a 35-year-old female therapist had the following dream:

''I came to your office but it was different – I think that it was your house. You said, We don't have to talk about the session, and you started to talk about a movie you had just seen. I also think that there was someone else there, but I'm not sure.''

Associations – The patient had recently noticed that the therapist was pregnant, and worried that her concern about the baby would detract from their therapy.

The manifest dream in these examples is similar – in each, the patient is in a more casual setting with the therapist. However, in the first, the symbolic change represents an increased feeling of closeness, while in the second it represents a feeling of distance or indifference. Listening for the associations before beginning to think about the symbolic meaning is thus an essential part of reflecting on a dream.

Although each dream is unique, there are common elements to think about in terms of the types of unconscious themes that are transformed into manifest dream elements. These include:

- **Transference themes:** Thoughts and feelings about the therapist are frequently represented in the dreams of patients in psychodynamic psychotherapy. It is often hard for the beginner to imagine that he or she could be ''important enough'' to show up in the patient's dreams – but many of the patient's dreams will be about the therapist. Again, as we reflect, we often discover references to the transference. We then use the choosing and readiness principles to decide whether these references are close enough to the surface to pursue with uncovering interventions.
- **Unconscious fantasies:** All dreams aren't produced by unconscious wishes, but unconscious fantasies abound in dreams. Think of the person who denies aggressive feelings towards a loved one but dreams of that person's death – while this might reflect a fear, it might also reflect unconscious aggressive fantasies.
- **Representations of relationships:** Dreams often include other people and contain important clues about the patient's relationships with significant others – or at least the patient's *perceptions* about those relationships. When thinking about the way relationships are represented in a dream, pay attention to the potential for displacement – a dream about ''my boss'' is usually not just about the boss but may be about some earlier relationship and the feeling it engenders in the patient.

- **Self-perceptions:** Dreams are frequently about how the patient thinks about him or herself. Remember that the dreamer can be anywhere in the dream – don't be fooled if the patient doesn't appear as him/herself in the manifest dream. When the dreamer appears in the dream, it's a good bet that this does in fact represent him/herself. Here's an interesting example of a self-perception dream in which the dreamer is represented in a displaced way:

  A 35-year-old man who had a difficult relationship with his father is in psychodynamic psychotherapy with a 50-year-old male therapist to whom he reports the following dream: ''I dreamt that you and I were painting a house together. You also had a young assistant – a boy – it seemed perfectly natural that he was there with us, too.'' Although the patient's first associations are to whether the therapist has children, he then talks about the way in which the therapist has helped him to feel good about himself as a man in a way that father never did. In reflecting on this association, the therapist wonders whether the young assistant is a displacement for the patient himself and thus symbolizes the patient's wish to have the therapist as a father.

Just because we think that the dream work has transformed unconscious elements of the dream into a more admissible manifest dream does not mean that we can't also use the story of the manifest dream itself. Often, the elements of the manifest dream are closest to the surface and thus most ripe for intervention. If patients talk fruitfully about the story of the manifest dream, explore it with them – anything that deepens their understanding of themselves is worthwhile for the treatment.

Reflecting on the dream also involves passing the material of the dream and the associations through the matrix of things that we already know about the patient and his/her history. We can also *cautiously* use our own experience of the dreams of others in order to guide hypotheses about the meaning of the dream:

Example

A 38-year-old single woman who steadfastly maintains that she is not interested in having children begins to have dreams in which she is growing unexpectedly fat or in which she has something wrong with her internal organs.

It is not a leap to imagine that this woman is having unconscious thoughts about having children despite her protestations to the opposite. Caution is the name of the game here – while we can use our past experience with others to help guide our hypotheses, *this can not substitute for listening to the unique associations of each patient*.

Intervening

Basic interventions

Psychoeducation/teaching about the interpretation of dreams

Generally, the first intervention we make about dreams is to teach our patients how to work with them. Many people think that the manifest dream is the whole dream, and many patients who have not had previous experience with therapy will find their dreams confusing and random. Patients frequently tell us that they have ''no

idea'' what their dreams mean and will often precede the reporting of a dream by saying that they think that the dream is ''not relevant.'' Early in therapy, we let our patients know the following:

- Dreams can help elucidate what is going on out of awareness, so trying to remember and talk about dreams in therapy can be very productive.
- You don't need to know what the dream means in order to work with it, so it's good to talk about any dream the patient has.
- When trying to understand a dream, the dream story itself is often less important than associating to the various elements of the dream.

For example, consider the following excerpt from the therapy of a 32-year-old woman who has been in treatment for one month:

Patient *I had a dream last night but I don't know what it means. I think that I was on a boat or something – yeah, a boat – on a lake – and there was some sort of natural disaster happening on the shore – I could see it but I wasn't in it. Maybe it was a tidal wave or an earthquake. Then I was in the restroom and was locked in and was trying to figure out if I could climb over the top. That's just weird. Why would I dream about the restroom of a boat?*

Therapist *Well, often the ''story'' that you remember when you wake up in the morning seems strange and disjointed, and it's hard to know what the dream ''means.'' When we work with dreams in psychotherapy the best way to proceed is to just think about different images or pieces of the dream and to say whatever comes to mind about them. For example, in this dream, I wonder what comes to mind about being on a boat on a lake or being trapped in a bathroom?*

Patient *The only boat I remember was my uncle's boat on the bay – I used to like to go on that boat with my cousins – they were very nice, my aunt and uncle – much more relaxed than my parents – and they didn't fight like my parents did. I used to lie in bed at night and wish that they would adopt me.*

In this example, the fantastic story of the manifest dream disorients the patient; however, once the therapist points her in the direction of associating to elements in the dream, the patient is able to deepen the material. Perhaps she symbolically depicted her parents' marriage as the disaster on the shore. After a while, the patient will begin to engage in associations to the dream elements without being prompted.

Questions and calls for associations

Once the patient is talking about the dream, even an experienced patient will sometimes miss an element that you think might fruitfully yield associations. In this case – ask! The patient who does not talk about a central element in the dream will likely be doing this because of a resistance – so it is as important to think about the resistance as it is to think about the associations themselves. Choosing whether to comment on the resistance or the content once again involves the choosing principles. For example, let's say that a patient tells a dream about being abandoned in a desert holding only a guitar and then only talks about the guitar. It could be that the associations to the guitar are close to the surface affect, or it could be that the patient

is talking about the guitar in order to avoid talking about the feelings of abandonment or desolation. We use the choosing principles to reflect on this and to choose our point of intervention.

Supporting interventions

We choose supporting interventions in our work with dreams when we think that using dream elements to uncover unconscious material could increase anxiety and be potentially disorganizing.

In general, we don't encourage patients with weakened ego function to report dreams because we think that uncovering unconscious material may heighten their anxiety rather than helping them understand themselves better [49, 50]. When these patients report dreams spontaneously, we have to make a judgment in the moment about whether the person with his/her particular array of ego strengths and weaknesses is likely to tolerate the feelings that might emerge in exploring the dream. For example, a patient with impaired reality testing, who is already struggling to separate reality from delusions, might find it terrifying to delve into the unconscious fears and fantasies suggested by a dream. Similarly, a person straining to control angry impulses might not be helped by associating to a dream about being at his father's funeral. When such a patient tells a dream but then seems disinclined to talk about it, we often choose *not* to confront the resistance, but rather to respect the patient's avoidance of a topic that might be overwhelming by **supportively bypassing** the dream. We can also listen to the dream and reflect on possible connections to the patient's unconscious, but then use the elements of the manifest dream to address conscious concerns.

Example

A young man with schizophrenia, committed involuntarily to the hospital the previous night for an acute psychotic break, is meeting his therapist for the first time:

Therapist	*I hope you had a reasonably comfortable night. Sometimes it's not easy sleeping in the hospital the first night*. (**nurturing, soothing**)
Patient	*Are you kidding? How can anyone sleep when they play those movies in your head all night?*
Therapist	*That would be very upsetting – and scary. Any chance that it might have been a dream?* (**empathizing, naming emotions, jointly reality testing**)
Patient	*They're messing with me*.
Therapist	*Try telling me about it. Talking about things in the light of day usually makes them less frightening*. (**encouraging, reassuring**)
Patient	*I was locked in a dungeon, no food or water. Guards came to torture me. But I found a gun. I thought I was going to be okay. But when I pulled the trigger, it just clicked, and nothing happened (shudders).*
Therapist	*That sounds awful – You know, for a lot of people, being hospitalized can feel like being put in jail – understandably. There are locks on the door, your stuff is taken away . . .* (**empathizing, validation, interpreting up**)
Patient	*That's how I feel – I can't wait to get out of here. At least you understand*.

Since the patient is still ruminating about a dream that has frightened him and has become part of his persecutory delusion, the therapist decides to work with it in the interest of establishing an alliance and helping with reality testing. By reflecting on the general affects and themes suggested in the dream, the therapist is able to use his understanding of the dream to offer an alternative explanation that links the manifest dream content to the patient's fears and concerns about being forcibly hospitalized. Without exploring the dream any further, the therapist is able to engage the patient, lessen his anxiety, and organize his experience.

Uncovering interventions

We choose uncovering interventions when we think that the patient can use the dream to learn more about his/her unconscious mind.

Confrontations of resistance

Not talking about a reported dream is a common resistance. When the patient tells a dream and does not return to it, you can easily confront the resistance simply by saying, ''I notice that you haven't returned to talking about the dream that you told me.'' This may prompt the patient to talk about the dream, but don't forget the resistance – there was undoubtedly a reason for it.

Confrontation/clarification/interpretation

Like all interpretations, dream interpretation is a process – one that needs good ''set up'' to be admissible to consciousness and to help the patient to deepen understanding and affect. This process changes with the phases of treatment. As we develop the therapeutic alliance with patients and accumulate many shared experiences with them, short cuts become possible, for example we may be able to jump directly to an interpretation without having to pave the way with as much confrontation and clarification. However, the development of good technique involves practice with confrontation and clarification. In addition, we need confrontation and clarification to know enough to interpret – we generally do not understand enough about the dream to venture an interpretation until the confrontations and clarifications elucidate the unconscious associations to the dream.

As always, **confrontations** are intended to interest the patient in his/her own mental phenomena. Confrontations in dream interpretation often sound like this:

> *What do you make of the fact that there is a monarch butterfly in the dream?*

We do not know why it's there, either – we're just trying to interest the patient in the fact that he/she dreamt about a particular element.

Clarifications point out that an element of the dream has occurred before and suggest a possible relationship to other unconscious material. Here's an example:

> *You often dream about your grandfather when you're about to go on a trip.*

Finally, **interpretations** offer explanations of the unconscious underpinnings of dreams.

Here is an example of a reported dream, followed by confrontation, clarification, and interpretation:

Patient *All I wanted to do was to get engaged to Fred but since he's given me the ring I feel all out of sorts. I don't really know why – I love him and I'm not interested in anyone else but I just feel blah – am I having second thoughts? My mother called about starting to make arrangements about the wedding and I just wanted to sleep. She's being very nice about it – it's like she's more interested in the wedding than I am. Oh – I had a weird dream last night – it seems irrelevant – I got a kitten for my birthday and was petting it and suddenly it was huge – like ferocious – but also like a house cat too – it was very weird. I think that there were other parts but I can't remember them. I wonder if I need to go on medication again – am I getting depressed? My friend needed medication before her wedding – even on the day of the ceremony.*

Therapist *You've veered away from talking about the dream – does anything else come to mind about it?* (**confrontation of resistance**)

Patient *Not really – it just seemed like a weird dream. I don't even have a cat. I did, though, I loved my cat – I had it when I was very small. It was my cat – it was a very sweet cat – it slept on my bed – but it scratched the living room furniture and we had to get rid of it.*

Therapist *Who made that decision?* (**question**)

Patient *My mother. I cried and cried. I must have been about seven years old. We never got another pet. I wonder if Fred would be into getting a cat.*

Therapist *What was your mood in the dream*? (**question**)

Patient *Hmmm – I think that I was confused – I couldn't tell. I thought that it was a sweet cat and then it was scary. Like it turned on me. Anyway, I've got to get going on the wedding stuff. My mother is on my case – calling all the time. She's right – I've got to do it – she's got all these ideas about places that her friends had their weddings – I mean their kids' weddings – but I think that I want to do it in the city.*

Therapist *You've mentioned your mother a few times in the discussion of this dream – do you have any thoughts about that?* (**clarification**)

Patient *I know that she means well and she's paying for it after all – but she's sort of driving me crazy. I mean it's my wedding, right? But I feel bad saying that – they had no money when they got married and she had nothing – and they've been fighting recently . . .*

Therapist *Perhaps the cat in the dream is sort of like your mother – sweet, but you're afraid that it will turn on you. Maybe your blah feeling after getting engaged has to do with your fear that starting to plan the wedding will bring out something scary in your mother that feels dangerous.* (**interpretation**)

Patient *It's just that she always wants whatever I have – I know that she didn't have all the advantages that I have – but she copies my clothing and my jewelry and I guess I'm afraid that she's going to try to co-opt this wedding. Maybe we should just elope.*

In this sequence, the patient sets up the dream, tells it, and then drifts away because of the difficult content. The therapist doesn't know what this is yet and is just listening. The resistance is the first clue about this difficulty as the therapist begins to reflect. The therapist's **call for associations** produces an early memory that involves conflicted feelings and is linked to the mother. The therapist reflects on this and begins to hear a nodal point – mother. The therapist then makes a **clarification** about the nodal point and the patient deepens the material and affect to the point where the therapist can **interpret** the dream. The therapist hypothesizes that the cat in the dream symbolizes the patient's mother – seemingly sweet but able to turn into a something ferocious and scary. The ferocious and scary part represents the mother's envy which the patient senses but hasn't fully allowed into consciousness. Defending against her feelings about her mother's envy has resulted in a symptom – the ''blah'' feeling and lack of interest in the wedding. The symbol ''worked'' because it was very linked to the mother – a ''house'' pet, like the mother in the house, and linked to the mother since she gave it away. The interpretation was successful because it produced a deepened understanding of the unconscious and further affect. The dream has moved the process along. We can speculate that the ''blah'' feeling and apathy about the wedding may be mitigated after this interpretive work, although it may have to be repeated in the **working through** before the understanding is consolidated.

Now that we have discussed supporting and uncovering techniques related to affect, resistance, transference, countertransference, unconscious fantasy and conflict, and dreams, let's look at a whole session and consider the way one therapist listens, reflects, and intervenes.

Suggested activity

Read the following dream and consider the study questions:

> *I had a dream last night. It was about a car – I think that I was in it – and we conked out on the side of a small highway. It was dark. After a while a car drove over and gave us a jump-start and the headlights went on.*

What if this were the dream of a 40-year-old woman who was recovering from depression and feeling that psychotherapy wasn't helping her much? What might you think of as she told you the dream? What might you say? How might this dream be related to the transference?

Comment

If this were the dream of a 40-year-old woman recovering from depression, perhaps the car might symbolize her – conked out but jump started by treatment. You might say:

> *I wonder if you feel like the car – when you were depressed you thought you'd never run again, but you feel jump-started by therapy.* (**interpretation**)

The therapist might be the car who gave her the jump-start – interventions to explore this idea include:

> *There's another car in the dream – any thoughts about who might have been driving it?* (**call for associations**)

If the patient couldn't use uncovering interventions, you might use the symbolism in the dream to help the patient to understand that she was feeling better:

> *Sounds like a pretty positive dream – makes sense, since you're starting to feel better – like you're getting a new start, too.* (**offering optimism, naming emotions**)

Review activity for Part Five – understanding a moment in therapy

By this point you've learned a tremendous amount – how to assess a patient; how to listen, reflect, and intervene; and how to work with different threads that emerge in the therapy. Along the way, you've done some exercises to help you to practice the new skills taught in this book. In many ways, they all come together in the ability to analyze all of the moment-to-moment interactions you have with your patients. Being conscious of everything that is going on is crucial for being able to successfully conduct psychodynamic psychotherapy. For any given moment that you have with your patient(s), you should be able to describe:

- what you heard
- how you reflected on what you heard
- how and why you decided to intervene as you did

You should then be able to identify:

1. the dominant affect
2. the dominant resistance
3. the dominant transference
4. the dominant countertransference
5. the dominant unconscious fantasy
6. your dominant technical mode

If you can do this, you're well on your way to becoming a psychodynamic psychotherapist. See if you can identify the above elements (#1–6) in the following excerpt from a psychotherapy:

> *Mr B is a 35-year-old married, African-American lawyer who has been in 2×/week psychotherapy with a white, female therapist for three years. Last Wednesday he came to his 5:45 pm session saying that he hadn't really wanted to come but didn't know why. He said that he usually looked forward to coming to sessions, but today had almost called to cancel. He then shifted and began to describe his latest case in great detail.*
>
> *As he talked, the therapist realized that she was becoming very bored with the details of the case and that her mind was beginning to wander. Since this patient was usually quite engaging, she wondered why that was and thought that he might be resisting talking more about his feelings about the treatment. She decided to confront this resistance, saying, ''You mentioned not wanting to come to the session, then shifted to talking about the case.'' ''The case is on my mind,'' he replied, ''The partner I'm working for is driving me really hard. I'm there on nights and weekends. I even have to go back after the session tonight.'' The therapist immediately felt bad, as if she should have been able to offer him a later session, although he had her last session. Why was she feeling so bad, she wondered? She thought that the wish to not come to the session and the partner had something*

to do with each other – perhaps a displaced transference – but she did not know what it was. She decided to just wait to see what the patient said next.

After a pause, the patient said, ''The thing that's driving me crazy about this case is that there are two of us – two associates – working on it. I'm working my tail off on the research, but I think that the other guy is going to get the #2 chair at the trial. It's not fair. I think that it might be because he's white.'' As soon as he said this, the therapist felt bad again – was it because she was white, she wondered? She considered whether what he was saying was true, and she had the impulse to directly empathize with him. She recognized that she didn't know enough and that the impulse was the result of a countertransference that she didn't fully understand. She thought about her whiteness again and thought again that his anger at the partners might have to do with her, although she didn't know how.

She decided to go back to the beginning of the session and again confront a potential resistance by saying, ''You mentioned needing to go back to work after the session, but I wonder if anything else comes to mind about not wanting to come to the session.'' ''No, I don't think so,'' he said, ''But you probably don't like working this late either. You work long hours – on Monday I come here early in the morning – and you see patients back-to-back without a break. You probably want to go home by this time of night.'' This was an interesting turn, she thought – why was he suddenly concerned about her? And what did it have to do with her guilt?

Since the patient was starting to get more specific about things that were going on in the therapy, the therapist opted to call for more associations. ''What about my seeing patients back-to-back?'' she asked. ''Well,'' he said, ''When I was seeing my therapist in college, he had two doors – one that you came in through, and one that you went out through. That way I never knew who was ahead of me or behind me. I liked that better. Here, I can always see who's coming out of the office before I go in. If you didn't have your patients so close together, I'd never know.'' Then the therapist realized that in the last two weeks, a new patient had started in the session before Mr B – a tall, blonde white man around his age. There was the link to the #2 man at the law firm and to her guilty countertransference feeling. He was angry that the therapist was making him see that she was treating a handsome white man.

But was this anger near the surface? He was moderately able to acknowledge his anger at the partner for preferring the white man, but he needed to mitigate his anger at her with concern that she worked too hard. She decided that the anger at her was still too deep to address. But she also knew that she should address something about the transference, since it had almost resulted in the patient's skipping the session. Was she ready for an interpretation? There were only 15 more minutes in the session – and he seemed to be willing to talk about this – so she decided to give it a try. Should she go for the whole interpretation – that he didn't want to come to the session because he didn't want to see the new patient? She decided to start more slowly, confronting his resistance to talking about the new patient. ''Perhaps you have some thoughts about someone you've seen leave the office,'' she ventured. He paused, and then said, ''I rarely look up in the waiting room. I keep my head in the magazine. But last time I was here, this guy almost trips over me to go to the restroom before he leaves. I had to look up. Brooks Brothers from head to toe. I know that type – those frat guys from college who used to wait for us after games. And in your office – in this chair!'' He was very close, she thought, so she decided to make the interpretation. ''Maybe you didn't want to come today because you didn't want to see that patient.'' Looking at the ceiling, he said, ''I liked that chubby girl who used to come before me. That was fine. But this guy. And now I'm probably going to have to see him every week.'' The therapist knew then that he was jealous and thought that she preferred the white frat guy to him, just as the partner preferred the other associate. She also realized that her guilty feelings had to do with the idea that she had been insensitive to put these patients back-to-back, and that if she understood this she might learn more

about the patient's relationship to his race, to women, to white men, and to her. But time was up – it would have to wait until next week.

Comment

- Dominant affect – anger
- Dominant resistance – missing sessions
- Dominant transferences – jealousy, maternal, erotic
- Dominant countertransference – guilt
- Dominant unconscious fantasy – ''As a black man, I will always be passed over for white men''
- Dominant technical mode – uncovering

See if you can do this with a moment from a therapy that you are conducting. The more you allow yourself to understand your own feelings, the better you'll be at this. If you need help, discuss it with a peer, a supervisor, or even a therapist of your own. If you can understand one moment, you can string them together to understand the whole treatment. Once you become good at this, it will happen almost automatically as you and your patient learn about his/her unconscious thoughts and feelings.

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PART SIX: Meeting Therapeutic Goals

Introduction

Key concepts

The major goals of psychodynamic psychotherapy are:

- improving self-perceptions and self-esteem regulation
- improving relationships with others
- improving ways of adapting to external and internal stimulation
- improving other ego functions

Both supporting and uncovering strategies are used in meeting these goals.

In the previous sections of this manual you have learned how to:

- evaluate patients for psychodynamic psychotherapy
- establish the treatment
- listen to patients, reflect on what you're heard, and intervene to both support and uncover
- use listening, reflecting, and intervening to respond to affect, resistance, transference, countertransference, conflict, fantasy, and dreams

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You are now ready to use these techniques to help patients to meet their therapeutic goals. This is the main work of the **midphase** of the therapy. In the next four chapters we will apply the techniques that we have outlined to four major goals of our work with patients:

- improving self-perceptions and self-esteem regulation
- improving relationships with others
- improving characteristic ways of adapting to internal and external stimuli
- improving other ego functions.

25 Improving Self-Perceptions and the Ability to Regulate Self-Esteem

Key concepts

Self-perception plays a major role in determining how people function in the world.

Improving self-perceptions and the ability to regulate self-esteem is a major goal of psychodynamic psychotherapy.

Self-perceptions may be unconscious.

Developing more realistic self-perceptions can help people to:

- improve self-esteem regulation
- have a better understanding of their capabilities and limitations

Supporting techniques can help patients with weaker ego function strengthen their sense of self and improve self-esteem regulation.

Uncovering techniques can help patients with stronger ego function by making unconscious self-perceptions conscious.

Problems with super-ego functioning can distort self-perception and can be re-worked in psychodynamic psychotherapy.

For our self-esteem, life is a battleground. We are pelted daily with blows – small and large – to our sense of self. Store clerks who ignore us, bosses who critique us, and mirrors that show us aging faces and bulging midriffs, all pummel our ability to feel good about ourselves. The ability to buoy our self-esteem – to right ourselves amidst the blows that buffet our egos every day as we journey through life – is central to being able to function. It's one of our primary ego functions. If we feel bad about ourselves, we don't function well, either on a chronic or acute basis. Our other ego functions weaken, and we become less able to tolerate affects and anxiety, to make realistic appraisals of our capabilities and weaknesses, to make judgments, to control our impulses, to relax – the list goes on. For some people, this happens on a short-term basis, but for others this is a chronic problem. Consider the following examples:

> *Mr A, a successful 30-year-old architect who is well-liked and generally has a good feeling about himself, was in a meeting in which he was told that his plans were inadequate and had to be redone. He began to have an upset stomach and excused himself to go to the restroom. While there, he looked in the mirror and thought that he looked old. That night, he went on a date and had a good*

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time but worried that the woman wouldn't be interested in him. By the next day he felt back to himself, re-drafted the plans, and had a good weekend on a bicycle trip with friends.

Ms B, a 50-year-old writer who has published three well-regarded books, had a manuscript rejected by her editor. She refused to return phone calls and began to drink heavily in her house. She decided that she would never write again and plunged into a depression for six months for which she did not seek psychiatric help.

Both Mr A and Ms B derive self-esteem from their careers and received blows to their sense of self. These blows upset their ability to self regulate – both had altered perceptions of themselves, disruption of their ability to regulate anxiety and affect, and disordered behavior. However, Mr A righted himself quickly – he continued to work and socialize and was back to himself by the next day. In contrast, Ms B was derailed for months with a debilitating depression. A person's reaction to a blow to their self-esteem depends on two major factors:

- the force of the blow
- the person's underlying capacity to regulate self-esteem

For example, a person with a healthy sense of self could suffer tremendous loss of function if the blow is catastrophic, as in major physical illness, betrayal in a love relationship, unemployment, or emigration. On the other hand, a person with a fragile sense of self could fall apart in response to a minor blow, such as an insult or an easily repaired physical problem.

A solid sense of self is characterized not only by the ability to feel good about oneself but also by the ability to realistically assess one's capabilities and limitations and to right oneself after a blow to the ego [1]. Although we don't know exactly how people develop their perceptions of themselves and their capacity for self-esteem management, it makes sense that it results from a combination of inborn traits and interaction with important early caregivers – nature and nurture [2]. We can't change temperament, but we can offer people the opportunity to reassess their sense of self in the context of a new relationship – that is, with the therapist.

Super-ego function and self-perception

Problems with **super-ego function** can also contribute to distortions in self-perception and difficulty with self-esteem management [3]. As we discussed in Chapters 2 and 4, the super-ego is a cluster of functions that generally maps to the person's conscience and to his/her ideals for him/herself. Super-ego functioning is problematic when it is either too *harsh* or too *lax*. Here are two examples:

Ms C felt guilty if she didn't volunteer for every fundraiser organized by the Parent Teacher Association despite the fact that she didn't have time for these activities. She was consequently exhausted and resentful.

Ms C has an overly harsh super-ego. This leads to a distorted self-perception that she is lazy if she doesn't overdo things.

Mr D used his business account to pay for vacations for his family, saying that the Internal Revenue Service is too busy catching ''real criminals'' to bother investigating his finances.

Mr D's super-ego function is too lax – he is only interested in doing the ''right thing'' if he thinks that there's a chance that he'll get caught. Psychodynamic psychotherapy can be very effective in helping people with harsh super-egos to be less ''hard on themselves'' and to thus have a more realistic self-perception. The techniques of psychodynamic psychotherapy are generally less effective in bolstering weak super-ego function.

The goal

As we discussed in Chapter 2, helping people to develop new ways of thinking about themselves and of regulating their self-esteem is a primary goal of psychodynamic psychotherapy. Depending on the person's level of ego function, we do this with primarily supporting or uncovering techniques. Our hope is that this will enable our patients to regulate their self-esteem in a more adaptive way, and will improve their functioning in many aspects of their lives, including their work life, their social life, and their emotional life. In the sections that follow, we will outline:

- how to recognize problems relating to self-perception and self esteem regulation
- therapeutic strategies for improving these problems

Recognizing the problem

By definition, people with difficulties in self-perception and self-esteem regulation have fragile egos. However, some people with this problem scaffold their poor self-image with overblown, grandiose, unrealistic perceptions of themselves, while others have more manifestly poor self-esteem. Consider these examples:

Ms E considered herself the best salesperson in the store – better, even, than the owners. When she got a lukewarm year-end review, she didn't appear at work for two weeks, wrote enraged e-mails to her colleagues, and was intermittently suicidal.

Mr F rarely spoke up at meetings because he considered his opinion to be less valuable than those of others. When he got a lukewarm year-end review he was depressed and socially withdrawn for weeks but thought that it was evidence of what he already knew about his performance.

Both of these individuals have maladaptive ways of modulating their self-esteem in response to a blow. However, one does it using grandiosity, while the other sinks into depression. Thus, when we are listening for evidence of distorted self-perceptions, we have to be attuned both for grandiosity and for overtly low self-esteem. Anger, depression, social withdrawal, emotional self-flagellation, and impulsive behaviors are common but maladaptive ways that people try to buoy their sense of self. ''Lording it over'' someone else – including the therapist – may transiently make a

person feel a little better about themselves in the face of a self-esteem blow, as in this example from a patient in psychodynamic psychotherapy:

> *My boss is such a jerk. He promoted almost everyone in the department except for me. He couldn't see talent if it hit him between the eyes. By the way, you're out of tissues again. That's really unprofessional – you should really make an effort to keep up your office better than you do.*

This patient temporarily increases his sense of self by criticizing his therapist. At the opposite extreme, over-idealization of the therapist and others can also signal problems with self-esteem regulation.

We also want to understand whether our patients do or do not have a realistic sense of their capabilities and limitations. Having a distorted sense of self can lead to major ego weakness and may require the person to sustain an emotionally costly ''false front'' in order to maintain positive self-regard. Here are a few examples of what this can sound like:

> *Mr G worked as a high-level executive at his family's business despite the fact that he had not graduated from college and had limited skills as a manager. When his father died, he mismanaged the company and then blamed his staff for the ensuing financial debacle. Although most of his workers became disgruntled and left, Mr G remained unable to admit any responsibility for the company's problems. He was increasingly bitter, angry, and socially isolated.*
>
> *Ms H is a 60-year-old single woman who presented for depressed mood in the context of ''not getting any good singing gigs.'' She explained that she has been a gospel singer for 40 years and that she once ''cut a record'' in her 20's. Since then she has been pursuing a recording contract. ''Many were interested,'' she says bitterly, ''but now they aren't looking for talent – they're looking for sex appeal.'' She has been offered work as a singing coach for an after-school program, but has refused this saying, ''That's for has-beens.'' She has not sung in public for years and is on the brink of financial ruin but refuses to apply for bankruptcy.*
>
> *Mr I feels demoralized at his job in advertising. He has many creative ideas but is too afraid to share them so has been relegated to a supportive, peripheral role.*

For these patients, the inability to realistically assess their capabilities and limitations has adversely affected every aspect of their lives – their work life, their social life, and their emotional life. Listening for this helps us to notice distortions in self-perception and difficulty managing self-esteem. Here are some questions you can ask to help screen for these problems:

> *How would you describe yourself?*
>
> *How do you think that other people would describe you?*
>
> *Do you think that other people would describe you as confident? Underconfident?*
>
> *How would you describe your strengths and weaknesses to someone else?*
>
> *When was the last time that something happened to you that really shook your self-esteem? How did you handle it?*
>
> *Do you think that your parents are (were) supportive of you? How did they show it?[4]*

Distorted self-perceptions can often involve distorted assessment of body image, intelligence, likability, or work performance. A story about any one of these areas can be mined for information about the way a person views him/herself.

Therapeutic strategies

How can we help people to make their perceptions of themselves more realistic? Our hypotheses are that:

- Unconscious self-perceptions prevent people from using objective data to think realistically about their capabilities and limitations.

  Example

  Ms J, a brilliant student, idealizes her father despite the fact that he always told her that she had the ''most inferior intellect'' of all the siblings. She accepts that this is true and consequently believes that she will never be truly successful in academics. When she receives an award for best thesis in the university, she cannot use this to help her reappraise her perception of her capabilities.

- Unrealistic self-perceptions lead people to have difficulty righting themselves when faced with a blow to their self-esteem.

  Example

  Mr K had always been told that he was an outstanding athlete. He did very well on the high school football team despite being somewhat short. When he didn't make the college team, he was unable to accept that this was because other students were more qualified. Instead, he became enraged at the coach and sure that he had been unfairly persecuted for racial reasons.

Making people aware of their distorted self-perceptions can help them to assess themselves more accurately and to regulate their self-esteem more easily. Since we generally think that our sense of self develops early in life, re-working our self-perceptions can be considered a way of **reactivating development**. We can address this with both supporting and uncovering strategies.

Supporting strategies

Self-esteem management is an ego function that often requires support. We choose to support self-esteem directly when we feel that patients either cannot do this on their own or can't tolerate efforts to explore their distorted perceptions. Both supplying and assisting interventions are helpful. For example, patients with very low self-esteem may regularly need encouraging-type interventions, such as **praise** and **encouragement**. Patients with overly harsh super-egos may be helped by comments designed to **reduce guilt** and that **correct misperceptions**. If patients can do some of this work on their own, **collaborative interventions** that allow therapist and patient to reconsider thought patterns, such as **reality testing**, promote development

of new self-perceptions. Here's an example that uses both supplying and assisting interventions:

> *Mr L is a 28-year-old writer who sought psychotherapy saying that he was dissatisfied with his career. Mr L calls his job as a staff writer for a magazine the ''dream job I had always hoped for,'' but he is plagued by the ''terrible'' feeling that he is a ''fraud.'' ''Basically, my father got me the job,'' he explains, '' If he hadn't made that call, there's no way they would have even looked at my resume.'' His boss has been ''nagging'' him to finish assignments on time; Mr L says, ''He's really getting on my case.'' Mr L alternates between agonizing self-doubt and bitter resentment that his boss doesn't take the time to give him more supervision – ''It's like he wants me to fail.'' He feels paralyzed at his computer, and at night smokes pot ''just to calm down and sleep.'' Lately, he has started going out to bars because, ''I can't stand staying home and staring at a blank screen – it might as well be a neon sign blinking 'Loser'.''*

Here's some process from an early evaluation session:

Mr L	*I'm such a screw up – I just can't write. I keep staring at the screen and nothing comes out. I'll never be a good writer.*
Therapist	*Are you saying you've* never *written anything you felt good about?* (**confrontation**)
Mr L	*No – I've written some good things – but this guy is really after me.*
Therapist	*Do you think that there's another way to think about your editor's behavior?* (**joint reality testing**)
Mr L	*I said no – I can't write and he's going to fire me.*
Therapist	*I wonder if it would help if we thought about some of the things that could be contributing to your difficulty writing.* (**joint inquiry**)
Mr L	*The sleep problem is huge. I'm exhausted.*
Therapist	*I'll bet – I'm actually wondering if you might be depressed – depression can make it difficult to sleep, to work, and to concentrate. Treating the depression might help you a lot. There's also the issue of your pot smoking – that can also knock out your ability to concentrate.* (**empathizing, validating, psychoeducation**)
Mr L	*I never put those together. What do you suggest?*
Therapist	*I think that treating your depression and cutting out the pot smoking will make a big difference with your ability to write. Many writers also work with a partner, or use a writers' group to help with deadlines. If we can get you writing again, I have a feeling that you'll be able to feel better about your work and about yourself.* (**offering optimism, psychoeducation, suggesting**)
Mr L	*That sounds good – it's definitely worth a try.*

The therapist hears the self-esteem problem – the patient presents himself as a ''screw up'' who will never amount to anything. However, the therapist suspects there may be more to the story – it seems implausible that Mr L got his current job at a prestigious magazine solely on the strength of his father's connections. He decides to **confront** this distortion and to **reality test** the patient's contention that his boss is

out to get him. However, the patient is unable to use either of these interventions to begin to think about possible unconscious material. The therapist then shifts tack and uses **empathy** and **psychoeducation** to address some of the difficulties that could be affecting the patient's ability to write at this point. This engages the patient and helps him to think about ways to improve his current self-esteem problem.

Uncovering strategies

We can use all of our uncovering techniques to help our patients become more aware of their distorted self-perceptions. This can help them to develop a more realistic sense of self. Here are some examples:

Interpreting defenses

Mr M is a 28-year-old writer who sought psychotherapy saying that he was dissatisfied with his career. Mr M, who works as a staff writer for a magazine, has co-authored several successful articles with his editor. His co-workers are aware that Mr M wrote these articles almost entirely by himself, and are encouraging him to write an article on his own. When he tries to do this, he is plagued by self-doubt and writer's block. Of note, Mr M's father is a formerly successful actor who told endless stories of his early triumphs but had little time to read his son's stories.

Mr M *I'm such a screw up – I just can't write. I keep staring at the screen and nothing comes out. I'll never be a good writer.*

Therapist *It's interesting because when you wrote the article with your editor this wasn't a problem at all.* (**confrontation**)

Mr M *You're right – that felt so different. Everybody loved that article – though I'm not sure that it was really as good as they thought it was. My editor liked it – but he wasn't effusive. He's won a Pulitzer, you know. He was a major journalist about 20 years ago. And even though everyone else has been encouraging me – he hasn't. I thought – well, maybe he's just measured in his response – but a good mentor would do that, right?*

Therapist *You know, I wonder if you might be having difficulty writing this new piece on your own because you're worried that it might upset your editor.* (**interpretation**)

Mr M *It's almost funny to think that he'd be upset by that – but I have thought that it's almost painful to watch him in his office – he looks unhappy. I can picture him as a young writer. Now everyone on staff is young – we hang out – he's just doling out assignments and talking about his Pulitzers.*

Therapist *Sounds a little bit like your Dad.* (**genetic component of the interpretation**)

Mr M *Yeah, I guess it does. Talking about the old days. But I'd love him to want me to do well, too . . .*

As with Mr L, the therapist hears the self-esteem problem – the patient perceives himself as a ''screw up'' who will never amount to anything. However, the therapist knows that the patient is capable of writing and decides to **confront** the incongruity

between the patient's perception of his capabilities and the objective evidence. This leads to a break in the resistance – the patient says that he's thought about an alternative way of looking at the situation. He also mentions the editor. The therapist wonders if the patient's problem is related to the editor, and ventures an **interpretation**. Although the patient has difficulty thinking about this alternative way of looking at the situation, his affect and use of humor suggest that this is just beneath the surface. The genetic link is now accessible, and the therapist decides to make a **genetic interpretation**, which further deepens the patient's understanding of the situation.

In this case, we suspect that Mr M's distorted self-image may be *defensive*. Worried that his own successes would threaten his father, Mr M may have unconsciously hidden his talents and begun to think of himself as less capable than he actually is. Uncovering this defense could enable Mr M to understand why he does this, and to subsequently feel less afraid of demonstrating his talents. The therapist knows that this uncovering process will continue in future sessions. His hope is that the patient's increased ability to understand his **unconscious fantasy** that the editor/father will only mentor/love him if he denigrates his own abilities will help him to gain a more realistic view of his own capabilities and will help him to have less distortion in his self-perception.

Interpretation of the transference

Distorted self-perceptions inevitably come up in the transference, and thus interpretation of the transference is often a very good strategy for re-working ways that patients think about themselves. As an example, let's consider Ms N:

Ms N consulted the therapist because she had difficulty asserting herself. During her therapy, she has generally been very self-reflective and is able to discuss her relationship with the therapist. Recently, she cancelled a session because of a business meeting and did not ask to reschedule. Here is part of a session from several weeks later:

Ms N — *Oh – I remember that I had a dream last night – I can't remember all of it – I was in a session – it wasn't here – it was your office, but there was a whole group of people here – you knew them. I couldn't tell if we were all patients of yours – but then I thought that maybe it wasn't my session – maybe it was more like a party. That's all I can remember.*

Therapist — *Does anything else come to mind about the dream?* (**call for associations**)

Ms N — *It was weird that there were so many people there. I rarely see anyone here – maybe just the person before me or the person after me. You work incredibly hard – you don't even have a break between patients. I don't know how you do it. You're a very busy person. I'm lucky to be able to schedule two sessions a week with you. I did notice that the patient who comes after me on Mondays is new – at least she hasn't come at that time before. I wonder how many new patients you see each week. I figured that that's why you wouldn't be able to reschedule my session.*

Therapist — *It's interesting – at the time you didn't ask about rescheduling. In fact, I can't remember your ever asking to reschedule. Do you have more thoughts about that?* (**confrontation/clarification**)

Ms N *No, I never do. I mean, it's my fault that I'm not coming – I'd feel guilty asking you to change your schedule for me.*

Therapist *But your dream and your thoughts about the dream suggest that you have other feelings about this. Maybe the reason that you never ask to reschedule is that you worry that you're not as important to me as other people are.* (**interpretation**)

Ms N *It seems so unfair – you give me so much – my problems aren't so terrible – maybe that new patient has something really wrong with her. And I've never been in a situation where someone else would go out of their way for me . . . but I guess you're saying that maybe you would.*

The therapist hears the dream and the clear transference references. He notes the breaks in pattern, ''It was your office – it wasn't your office – it was my session – it wasn't my session,'' which hint at conflicting unconscious thoughts and feelings about the therapist. The therapist wonders if the meaning of the resistance (not discussing the missed session) could have something to do with feelings about the therapist. He thinks that uncovering work could begin and starts with a **call for associations** related to the dream. The patient then brings up the missed session and her fantasy that the therapist would be too busy with other patients to offer time to reschedule. The therapist decides that this is close enough to the surface and full of affect, so he chooses to **confront** the fact that the patient had not brought up the wish to reschedule. In addition, he recalls that this has happened before, so he makes a **clarification** that ties these together. The patient resists the confrontation, and the therapist thinks that this might be a manifestation of her feeling that she is not worthy of asking the therapist to change her schedule, as well as overly harsh super-ego function. However, the dream and the associations to the dream suggest that the patient has feelings about this, and that she might feel that the therapist favors others over her. The therapist decides that this is close enough to the surface to try an **interpretation**. This enables the patient to uncover new ideas about the therapeutic relationship.

In this vignette, Ms N's self-esteem problems lead to an assumption that others won't go out of their way for her. This prevented her from asking the therapist if she could change the session time and is likely linked to her difficulty asserting herself. This is something that happened in *real time* between the therapist and the patient. The patient made an assumption – as she must with most people in her life – that the therapist would not go out of her way for her. But when the therapist points out that this is not necessarily an appropriate assumption, the patient is exposed to an alternative way of viewing herself. If our strategy is primarily uncovering, we call this to the patient's attention; if we are using primarily supporting techniques we might just allow it to happen.

These examples illustrate how we use supporting and uncovering techniques to help improve self-esteem management and self-perceptions. Now let's go on to think about how we use these techniques to improve relationships with other people.

26 Improving Relationships with Others

Key concepts

For most people, the ability to have meaningful relationships with others is critical to the way they function in the world.

There are many reasons why people have difficulty with relationships – these include:

- unconscious fantasies about/expectations of others that impair their ability to engage in relationships;
- impairment of ego functions, such as the capacity for empathy and the ability to read social cues

A major goal of psychodynamic psychotherapy is helping people to develop mutually satisfying relationships with other people.

Supporting interventions can help patients with weaker ego function increase their capacity for empathy and their ability to interact meaningfully with others.

Uncovering techniques can help patients with stronger ego function improve their relationships by becoming more aware of their fantasies about/expectations of others.

Although some people truly prefer to be alone, most people feel that their lives are richer if they spend them interacting with others. There are all sorts of relationships – romantic, collegial, familial – and though they are all different, they are all important. People generally want to be attached to other people and to have people in their lives they care about and who care about them. However, there are many reasons why people are unable to have the mutually satisfying relationships they long for.

The goal

Having difficulty with relationships is one of the major reasons that people seek psychotherapy – and psychodynamic psychotherapy is a good treatment for this. Helping people with problems that cause them to have difficulties with relationships is a major goal of psychodynamic psychotherapy.

Psychodynamic Psychotherapy: A Clinical Manual Deborah L. Cabaniss, Sabrina Cherry, Carolyn J. Douglas and Anna Schwartz
 ISBN: 978-0-470-68471-9

Recognizing the problem

Problems with relationships come in all shapes and sizes. Here are some chief complaints that signal the presence of problems with relationships:

> *I just can't seem to get along with people at work.*
>
> *There are no good men out there.*
>
> *I've been dating her for two years but I'm not sure that I want to get married.*
>
> *My mother is driving me crazy.*
>
> *I don't have any close friends.*
>
> *My daughter won't talk to me any more.*

Loneliness, problems with commitment, complaints about loved ones, frequent arguments, and disappointment in others all point to the presence of interpersonal difficulties. Anybody can have difficulty with one person or another, but if a person has consistent difficulties in their relationships we should be alert to the possibility that these problems are due to an ongoing problem with their emotional functioning.

Generally, it is not hard to recognize that a person has interpersonal difficulties. The challenge is to define the kind of problem. Some people are able to have relationships but have difficulty with some of them because of unconscious fantasies and expectations. On the other hand, some people lack the skills required to have any successful relationships. Let's take a look at these two types of problems:

Unconscious expectations of and fantasies about others

As people grow up, their early interactions with important people in their environment make an indelible mark on the way they interact with others throughout their lives. People who are loved and well cared for learn to expect that from others, while people who are abused or neglected learn to expect mistreatment [5]. Even if the person is not conscious of these *expectations*, they affect every interaction they have. Consider these examples:

> *Mr A was raised in foster homes – as soon as he became used to one family he was moved. As an adult, he has a pattern of leaving his girlfriends before they break up with him. He presents feeling dissatisfied with his romantic relationships.*
>
> *Ms B's mother stayed at home and attended to her every need. As a newlywed, Ms B is enraged that her husband wants to occasionally go out alone with his friends. She presents with disillusionment about her young marriage.*

The adult relationships of both Mr A and Ms B are affected by their early relationships, albeit in different ways. Mr A expects to be left so has learned to leave first to avoid the pain of separation. Ms B expects that her husband will attend to her in the same

way her mother did and is disappointed when he doesn't. Although we may see this clearly, their chief complaints suggest that they are completely unaware of the way their current problems are influenced by their past relationships. Bringing these expectations into awareness can help both of them to better understand the problems they are having in the present.

We are affected by what *did* happen to us with people in our past, but we are also affected by what we *hoped* would happen. **Fantasies** about people in our early life can persist in our unconscious and affect the choices we make in our adult relationships. Here are a few examples:

> *Dr C's father was highly critical and rarely praised him. As a young pediatrician, Dr C works 100 hours a week and never asks for help. He presents because his domestic partner is ready to move out because Dr C is never home and is constantly preoccupied with work.*
>
> *Ms D's father was a flamboyant sportsman who intermittently took Ms D with him on exciting ski and hiking trips. Generally, though, Ms D was left with her shy mother, who was disabled by rheumatoid arthritis. Ms D presents with confusion about her engagement – although she loves her fiancé she worries that he's not ''manly'' enough.*

Both Dr C and Ms D have fantasies about people in their early lives. Dr C has a fantasy about a father/authority figure who will finally praise him. Ms D has a fantasy about a man who possesses the idealized aspects of her otherwise disappointing father. Whether or not they are aware of them, these fantasies affect their choices, their affect, and their behavior with the people in their adult lives.

As with all unconscious fantasies, these remain out of awareness because they cause shame, anxiety, or other strong uncomfortable feelings. If they are unaware of their unconscious needs, people cannot choose others with whom they will have mutually satisfying relationships. For example, a person might consciously wish to be independent and autonomous but unconsciously wish to be taken care of. Or someone might consciously wish to be nurtured but unconsciously feel undeserving and expect rejection from others. In either case, this person might consistently choose non-nurturing partners who rapidly disappoint them. We can become aware that unconscious expectations and fantasies about others are active when interpersonal expectations seem out of sync with objective data. Two examples are a man who is always afraid that his girlfriend will leave him despite the fact that she keeps hinting about getting married, and a woman who is repeatedly promoted at work but is sure that her boss wants to fire her.

Problems with social functioning

While some people know how to interact with others but are impeded in their ability to do so by unconscious expectations and fantasies, others are unable to have relationships because of gaps in their functioning [6]. We consider the ability to have relationships with others an ego function, but there are important sub-functions that are essential for healthy relationships. Here are a few examples:

Capacity for empathy

As we discussed in Chapter 13, empathy can be defined as the ability to see life through someone else's eyes. We have to be able to do this in order to have healthy, mutually satisfying relationships with other people. Without this, we cannot understand how other people see the world. Empathy helps us to know how to care for our loved ones, how to soothe our friends when they are in distress, and how to solve interpersonal disputes. People who lack empathy are generally self-absorbed, entitled, and emotionally distant. All of these traits impair the ability to engage in relationships with others.

Example

Mr E comes home from work everyday and talks endlessly about the politics in his office without asking his wife about her day. He cannot understand why she calls him ''insensitive,'' saying simply that his work is ''more stressful than just taking care of the kids all day.''

Mr E's lack of empathy renders him unable to understand his wife's experiences, and could jeopardize their relationship.

Ability to read social cues

When people interact, they give each other verbal and non-verbal cues that reflect their level of interest, their preferred physical and emotional distance, and when and how they want to end the interaction. If someone has difficulty reading these cues, they will inevitably have difficulty negotiating relationships with others.

Ms F cannot understand why she does not have more friends at the office. She explains that she is a fabulous friend – as soon as she meets someone she likes, she is ''always available,'' calling them frequently and wanting to get together as much as possible. She says that the people around her seemed ''shallow'' and that after a few weeks, they seemed to ''disappear.''

Ms F's inability to understand that she is crowding her new friends makes her unable to sustain meaningful relationships with them.

Temperamental shyness

Although we don't always understand the reasons, some people are more outgoing than others. We may wonder if a person's shyness is the result of inhibitions or an anxiety disorder (like social anxiety disorder), but if the history indicates that shyness has persisted from childhood, it may be the result of temperamental shyness [7].

After transferring schools in the ninth grade, Ms G ate lunch alone for five months before she worked up the nerve to sit with other students. Now, in her 20's, Ms G has the same problem in her corporate cafeteria.

Shyness can greatly hinder a person's ability to engage in relationships with others and can lead to tremendous loneliness.

Therapeutic strategies

Here are some examples of both supporting and uncovering strategies for helping to improve relationships with others.

Supporting strategies

If we think that a person's relationship problems stem from gaps in social functioning, then our interventions have to be aimed at supplying missing functions or assisting weakened functions.

Supplying interventions for improving relationships may include praising, empathizing, nurturing, soothing, validating, and offering hope, but often focus on:

- **Advising:** We can advise patients about the basic guidelines for interacting with others and understanding social cues.

  If she hasn't returned your call after the third try, chances are she's not interested.

  You're putting a lot of pressure on yourself and on her. You might do better if you give yourself time to get to know each other before you make big decisions about the relationship.

- **Correcting misperceptions:** This can help patients to re-think the ways that they interpret the behaviors and intentions of others.

  I don't understand why you think you're going to be fired – didn't your boss just give you a raise?

  I think you might be reading too much into what she said.

  There are other explanations for what's going on that make more sense to me – for example, is it possible he wasn't angry at you but was just in a bad mood for some other reason?

- **Reinforcing** adaptive defenses and behaviors: If some adaptive behaviors are present, highlighting them can be very helpful.

  Leaving the room when you started to feel steamed was definitely the right way to go.

  That was a great idea to exercise during your lunch hour – I think that it's helping you to feel less frustrated with your husband when you get home after work.

- **Suggesting** alternatives to maladaptive defenses and behaviors: This is helpful when adaptive behaviors are present, or if the patient needs more options.

  I suppose that a drink after work helps some people unwind, but for you it just seems to take the lid off, and you end up fighting with your wife and kids . . . maybe it would help more if you sat quietly and read the paper when you get home.

  When you have that impulse to yell at your son, I think that you need to reach out to someone – that would be a good time to call a friend.

Assisting weakened functions related to relationships

- **Modeling** social skills in the actual interaction with the patient, for example:
  - listening empathetically and demonstrating understanding – this is a crucial form of modeling the give-and-take of healthy relationships
  - helping the patient to imagine what the therapist (or others) might be feeling or thinking. Questions like the following can foster this and help with the development of empathy:

    How do you think I/they felt when you did that?

    I'm aware of feeling cautious in what I say to you, as if I could easily say or do the wrong thing.

    It feels to me like you're withdrawing right now.

- **Modeling** willingness to accept responsibility for your behavior and to apologize:

  I'm sorry if that hurt your feelings.

  I didn't realize that the fact that you called me indicated that you wanted another session – I missed that.

- **Collaborating:** We can collaborate with patients to think through ways that they can improve their relationships with others. Here are some examples:
  - **Jointly exploring alternative ways of thinking about and perceiving interactions**

    Are you sure he meant to insult you? Is that the only explanation for what's happening?

    You say that Patty and Susan have been giving you the cold shoulder at drop-off, but didn't they ask you to bring your daughter for a play-date twice last week? What does that suggest to you?

  - **Jointly thinking through consequences of an intended behavior**

    If you tell off the boss, how is he likely to respond? Are you prepared to deal with the fall-out? Is there any other less risky way to approach him about your grievances?

Uncovering strategies

We can uncover unconscious expectations of/fantasies about others either by talking to patients about their relationships with people in their lives or by talking to them about their relationships with us.

Interpreting aspects of our patients' relationships with others

Patients spend a lot of time discussing their relationships with others. When we think that we hear evidence that an unconscious expectation or fantasy is affecting

a patient's interpersonal functioning, we can try to uncover that material in order to help the person's relationships:

Ms H is a 35-year-old woman who perceived that her father, a famous academic, lost interest in her after she was diagnosed with dyslexia. Over the years, she has often worried that friends and boyfriends will reject her for various ''deficiencies.'' In her 20's, she had one ovary removed because of a large cyst. She has had difficulties maintaining romantic relationships, but is now in a deepening relationship that she hopes will lead to marriage. Ms H describes her boyfriend, Calvin, as attentive and loving, but is ''terrified'' of telling him that she has only one ovary. Here is a moment in a session when this comes up:

Ms H	*We had brunch with some of my friends today – they all have kids. Calvin loves kids and is great with them. After, he was particularly loving, and started to talk about baby names he likes. I can't believe that I'm actually going to have to tell him that I only have one ovary – he'll probably break up with me when he finds out.*
Therapist	*What makes you think that?* (**confrontation**)
Ms H	*I'm defective (she begins to cry) – why should he have a defective wife when he could have a normally fertile wife?*
Therapist	*But everything you've said about your relationship indicates that he loves you very much – so I wonder if your fear that he'd break up with you might be related to the kinds of worries you've had with other people.* (**reassuring, clarification**)
Ms H	*I know what you're saying and I get that – and who knows if it will even affect my fertility – but I'm hysterical about this and it feels like it will be the deciding blow to our relationship.*
Therapist	*I think that you're worried because you have the expectation that he'll reject you because you're ''defective'' just like your father rejected you because you had a learning disability. But there doesn't seem to be any evidence of that with Calvin.* (**genetic interpretation, reassuring**)
Ms H	*It's hard for me to think any other way – but the fact is, he's nothing like my father. I'm just so terrified of losing him.*

The therapist hears the pattern break – it sounds like Ms H thinks that the relationship is going well and then she suddenly says that she thinks it will end. The therapist hears enough affect that he decides to **confront** the incongruity. This produces more feeling in the patient (evidenced by the word ''defective''). The therapist suspects that the feeling of being defective is deeply held and would be hard to confront. The therapist also knows that the patient has worried about being rejected by others. He begins with some **reassurance** that also serves to **test reality**, and then makes a **clarification** that ties Ms H's worries about her boyfriend to past fears. The patient is able to consider this clarification and to question her views – despite the continued presence of high affect. Ultimately, the **genetic interpretation** allows Ms H to consider the idea that her fears of losing her boyfriend are related to an unconscious expectation of relationships based on her childhood relationship with her father – rather than on the realities of the current situation.

Interpreting aspects of our patients' relationships with us (transference)

Interpreting the transference can be one of the most powerful ways to help people rework their unconscious expectations of others. Patients can tell you as much as they can about their difficulties with other people, but when it happens with you in the therapy you can see it right in front of your eyes. There's much less possibility of misperceiving the situation. Think of the difference between these two situations:

> *Ms I constantly complains that her boyfriend doesn't pay any attention to her. She describes him as self-absorbed and dismissive.*
>
> *In session, Ms I tells you that the fact that you glanced at the clock once during her session indicates that you are not paying attention to her and that you are thinking about other things in your life.*

In the first situation, you have no idea what to make of Ms I's complaint. Not knowing her boyfriend, he could in fact be dismissive and self-absorbed. However, when she complains about you in the context of the therapy, you know what the situation is. You can see that her perception of you is out of proportion to what actually happened. Perhaps Ms I has a very low threshold for feeling that someone is ignoring her, and perhaps this is based on expectations set in her past relationships. Having such a low threshold undoubtedly affects her current relationships. Helping her to see the distortion in her expectations of others in order to improve her current relationships is the goal of our work in this area.

Here's an example of how we do this:

> *Mr J is a 44-year-old man who presented because he was having difficulties with colleagues at work. A somewhat bitter person, Mr J felt that his co-workers ''dumped'' on him and he came to expect that they would be unsupportive. In the following session, the therapist uncharacteristically began the session 5 minutes late. This is a sequence from the last 15 minutes of a 45-minute session*:
>
Mr J	*I think that that's all I have to say – I feel like I just ran out of gas.*
Therapist	*That's quite unusual for you – I wonder what just happened?* (**confrontation**)
Mr J	*I don't know – I just became aware that the session is almost over and our session is going to be cut short today.*
Therapist	*So you expect that you'll lose time in your session today because I started 5 minutes late.* (**interpretation**)
Mr J	*Yeah, I guess I do – even though you don't usually do things that way. I think that I was getting mad, sitting here thinking about it. That's what happens at work, too.*

The therapist registers the resistance of Mr J's having nothing to say. As this is unusual for this patient, the therapist decides to **confront**. The therapist hears the patient's expectation that the session will be shorter because of the late start and

interprets that this is the product of an unconscious expectation of others. This deepens the patient's understanding of his unconscious fantasy.

In this example, uncovering the patient's unconscious expectation that people will exploit him is facilitated by the fact that this happens with the therapist. Five minutes may not be much, but it looms large in this patient's mind as a symbol that even the therapist will rip him off. Seeing this within their therapeutic relationship helps:

- the therapist to understand the patient's unconscious expectation, and
- the patient to recognize this pattern and to begin to imagine that he could realistically have different expectations of people in his environment.

The hope is that the patient can gradually re-work his unconscious expectations of others as he sees that the therapist does not conform to what he generally anticipates from people in his environment. As with changing self-perceptions, this can be conceptualized as **reactivating development**.

Now that we've explored the way we can use our techniques to improve self-esteem regulation and relationships with others, let's move on to the way we use them to shift characteristic coping mechanisms.

27 Improving Characteristic Ways of Adapting

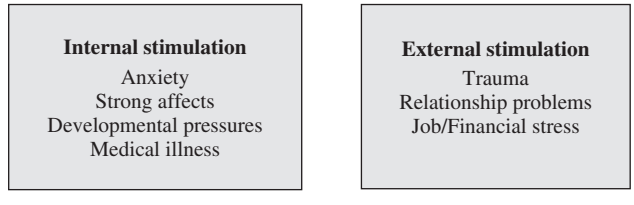
Key concepts

We all have characteristic ways of coping with internal and external stimulation, some of which are more adaptive than others.

When these coping mechanisms operate unconsciously, we often call them defenses.

Improving the ways that we characteristically adapt to stimuli is a major goal of psychodynamic psychotherapy.

Every system has its characteristic ways of dealing with stress. Electrical systems are programmed to shut down when things get too hot, animals play dead, and hungry infants cry. The same is true of our minds. Just like any system, our internal mental system has characteristic ways of dealing with threats to its homeostasis. Stress can be anything – we can think of it as something that overwhelms the system's usual way of operating. As we discussed in Chapter 4 on assessment of ego function, stress to the system can be in the form of excess internal or external stimulation. *Internal stimulation* can be anxiety, strong affects, developmental pressures (such as adolescence), or medical illness. *External stimulation* includes trauma, problems with relationships, vocational difficulties, and financial stress.



Helping people to adapt to stress in a way that is most adaptive is a major therapeutic goal of psychodynamic psychotherapy [8–10].

Conscious and unconscious coping mechanisms

Our adaptations to stress can be conscious or unconscious. Sometimes, we consciously say to ourselves, ''That's too much for me – I can't think about that right now.'' But more often, these adaptations are unconscious, kicking into action without our

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awareness. Unconscious adaptations are often called **defense mechanisms** (see Chapters 4 and 23). Defense mechanisms operate out of awareness to help protect us from internal anxieties and feelings that threaten to overwhelm us, as well as from external stressors that threaten to overload our capacity to deal with them.

In what ways can defenses be maladaptive?

Often, our characteristic ways of adapting to stress cause morbidity in their own right. For example, a person who is anxious in public may characteristically avoid people, leading to chronic loneliness. Or a person who has endured severe trauma may frequently dissociate, disrupting his/her ability to think, feel, and interact with others in a meaningful, ongoing way. To review, there are several ways in which defenses can be maladaptive:

- **Defenses that use up too much ego function**: Sometimes, the maneuvers that we use to prevent ourselves from being overwhelmed by internal or external stimulation require so much mental energy that we are left with very little ability to use other vital functions. Examples are **dissociation** and **projection**.
- **Defenses that impede our ability to have mutually satisfying relationships with others**: If the only way we can stave off being overwhelmed by internal and external stimuli is to **split** – that is, to see some people as all good and others as all bad – we may decrease our internal stress load at the expense of having full relationships with others. Examples of this kind of defense are **splitting**, **idealization**, **devaluation**, and **projective identification**.
- **Defenses that impede our ability to experience feelings**: Some defenses cut us off from our feelings (like **isolation of affect** and **intellectualization**) while others exaggerate certain feelings to avoid dealing with others (**excessive emotionality**). Knowing what we are feeling is central to our ability to know ourselves and to have relationships with others – thus, these maneuvers can be quite maladaptive.
- **Defenses that are too rigid**: All systems need to have the ability to shift adaptations on a moment-to-moment basis in response to changes in the environment. The same is true for defenses. Using the same defenses regardless of the situation can be very maladaptive.
- **Defenses that are self-destructive**: This may sound like an oxymoron, but many defenses are self-destructive. **Acting out behaviors**, like binging and purging, self-mutilation, and unsafe sex are examples of this. They may temporarily decrease anxiety or overwhelming affects but they do it in a way that has the potential to be dangerous or harmful to the person.
- **Defenses that lead to physical distress**: **Somatization** and **conversion** deal with emotional stress by converting it to physical distress, often leading to tremendous morbidity.

The goal

A primary goal of psychodynamic psychotherapy is helping people to cope more adaptively with internal and external stressors. There are different ways to conceptualize this goal. If defenses are categorized according to their degree of maturity, then trying to use the most mature defenses would be the goal [11–13]. Others prioritize the degree of flexibility in the system [14]. Basically, if we think about each individual patient, we want to decrease suffering and maximize functioning in ways that are important to that person. For example, one person might prioritize relationships with others and another person might not – thus, optimal functioning would look different for each of them. In this chapter we will discuss recognition of maladaptive coping mechanisms and therapeutic strategies for improving functioning. Again, we use the terms **adaptations** and **coping mechanisms** to refer to maneuvers that are both conscious and unconscious, while we reserve the term **defenses** for mechanisms that operate out of awareness.

Recognizing the problem

How do we recognize that maladaptive coping mechanisms are at play? Here are some clues to help you with this:

- **Symptoms**: The presence of symptoms is a sure sign that the person is using maladaptive coping mechanisms. Eating symptoms, anxiety and mood symptoms, somatic symptoms, and phobic symptoms are all included. Sometimes these symptoms meet criteria for other treatments, such as medications.

  Example

  Mr A complained of not being able to have a relationship but spent all of his time going from doctor to doctor in search of relief from fatigue that after years of tests seemed to have no somatic basis.

- **Distress**: Subjective feelings of unhappiness and distress often mean that the person is not dealing with stress in a way that is adaptive.

  Example

  Ms B binged every time her boyfriend failed to call her at night and then cried herself to sleep.

- **Problems in relationships with others**: Maladaptive defenses often impair the person's ability to have successful relationships – thus, problems with relationships can be a good clue that characteristic modes of dealing with stress are maladaptive. This can manifest in personal relationships as well as work-related difficulties (such as repeated loss of jobs).

Example

Mr C was distraught that he couldn't hold a job that would support his family. He had been fired three times for ''insubordination'' but couldn't figure out what had happened.

- **Countertransference**: Significant early feelings toward a patient (positive or negative) often indicate that maladaptive defenses are prominent. This can be a very good way to pick up prominent splitting-based defenses during an assessment.

Example

In their first session, Ms D told Mr Z that he was the smartest therapist she'd ever consulted. The therapist felt good for a few minutes, but then wondered whether Ms D was idealizing him.

Therapeutic strategies

Both uncovering and supporting strategies can help to improve our patients' adaptation to internal and external stimulation. For both, a first step is to help patients to recognize that their way of adapting is a problem. Many people are not aware that their coping mechanisms are maladaptive. Here's an example:

Ms E presents saying that she has problems with her children. She says that they are ''brats'' who ''don't behave'' and who are causing her to ''get an ulcer.'' It becomes immediately clear to you that she resorts to yelling and screaming at the slightest sign of disobedience, causing the children to escalate their misbehavior. When you ask Ms E about this, she becomes irate, telling you not to blame their naughtiness on her – she's just reacting.

The best strategy for helping patients like Ms E to become aware of the way in which their coping mechanisms are problematic is a combination of **confrontation** and **collaborative interventions**. Telling patients that they have problems is of limited utility; helping them to come to that conclusion with you is much more effective. First, look for an opportunity to **confront** a discrepancy or incongruity that might interest the patient in another way of looking at a situation or problem. This kind of confrontation can sound like this:

I know that you said that you haven't had any problems at work, but you also said that you've been fired three times this year. Do you think that something could be tripping you up that's been hard for you to notice?

Here the therapist juxtaposes ''no problems at work'' with ''three firings in a year'' to try to interest the patient in the possibility that he might have a work-related problem. Here's another example:

You said that the new job was easy to handle but you also said that you've gained 40 pounds since beginning it – do you have any thoughts about that?

Once you interest the patient in a discrepancy, you can use **collaborative interventions** such as **joint inquiry**, **jointly exploring alternative ways of thinking and acting**, and **reality testing** to look more closely at the situation:

> *So it does seem like something you're doing might be contributing to your difficulty in keeping a relationship going. Let's look at this together – we can start with your last relationship. Can you think of anything that you might have done that could have had a hand in some of your arguments?*

This type of joint inquiry fosters the therapeutic alliance, which is crucial at all times but especially when you're encouraging the patient to become vulnerable enough to admit to a maladaptive defense. *Remember that defenses are our protection* – they may be maladaptive, but we need them. We don't want to leave our patients without any protective coping strategies, and we want to do this work very gently, so as to cause as little pain as possible in the process.

Once the patient understands that there is a problem, we can move ahead to improve their characteristic mechanisms for dealing with stress. Our aim is to diminish dependence on less adaptive coping mechanisms and to increase the use of more adaptive coping mechanisms. Sometimes this involves discussion of defenses that the patient is already using, and sometimes it involves helping the patient to come up with and try completely new ways of dealing with overwhelming stimuli. Depending on the person's ego function, we can use supporting or uncovering strategies to help our patients to cope with stress in more adaptive ways.

Supporting strategies

Both supplying and assisting interventions are helpful here. When we supply, we presume that the patient can not come up with new ways of adapting on their own – either on a chronic basis or at the moment. **Discouraging** maladaptive patterns and **reinforcing** adaptive patterns can sound like this:

> *Wow – what a difference it made when you were able to contain your negative comments at the dinner table last night. It sounds like everyone had a better time – including you.*

This also **praises** the patient – although even more overt praise may be necessary for some patients:

> *You've come such a long way – you've been talking to your son for the better part of this year. That's a real change.*

If the patient can't come up with a new solution that's more adaptive, **suggesting** or **advising** can help:

> *Why don't you try this – the next time your daughter-in-law starts criticizing your housekeeping, just walk out of the room.*

Psychoeducation is often helpful as well:

> *For a lot of people, it's really hard to stop overeating after a stressful day. Many people find it helpful to come up with some other type of activity, like reading or taking a relaxing bath.*

For people who have some capacity to think about how to cope with stress more adaptively, assistance may be all that's needed. **Collaborative interventions**, like **joint inquiry** and **thinking through consequences** can be very effective with these patients:

Therapist	*So now we know that it drives you crazy when your co-worker starts talking about personal things while you're trying to get things done and we know that yelling at him just makes you unpopular in your department. Let's think together about some other things you could do when he starts that up again.* **(joint inquiry)**
Patient	*What about giving him the cold shoulder?*
Therapist	*That would definitely be less volatile – but how do you think that would work in the long run?* **(thinking through consequences)**

In general, assisting interventions ''stick to the ribs'' better because the patient had a hand in them – so you might start there and then supply if needed.

Uncovering strategies

The aim of uncovering strategies is to make maladaptive defenses conscious so that patients can:

- know what they're doing, and
- begin to deal with overwhelming affect and anxiety in more adaptive ways

Example

Ms F presented to therapy complaining of difficulty with relationships. She was self-reflective and able to work in an uncovering mode. In describing her relationships, it became clear to her therapist that she was unconsciously withdrawing from her partners when they became too intimate with her. Here's an exchange from a session:

Ms F	*So I've been dating Sara for several weeks and I really like her but something has changed – I don't know what it is. She just wants to come over every night – constantly cook dinner together – and I just feel like I don't know – I don't want to – even though I really like her. Maybe she's just too much . . .*
Therapist	*Too much?* (**confrontation**)
Ms F	*Too much – well, like my mother is too much. If I give her an inch, she takes a mile. I invite her for dinner, suddenly it's ''let's spend the afternoon together too,'' and ''can I go shopping with you?'' and then I just can't get rid of her – even though I love her.*

Therapist	*You're worried that if you give Sara an inch, she'll take a mile, too. Maybe that's why you're pulling away a little.* (**interpretation**)
Ms F	*Pulling away – I guess I am – I hadn't thought about it like that – but I need to breathe. But I also like having her around.*
Therapist	*So may be she's not as much like your mother as you fear.* (**interpretation**)
Ms F	*(laughs) Right – not at all – and a much better cook . . .*

In this example, Ms F became anxious when Sara got too close; this was related to an unconscious fantasy that Sara, like her mother, would rob her of her independence. Ms F did not necessarily experience this anxiety, and if she did, she did not experience it as being related to the unconscious fantasy. Rather, she was distressed about her difficulty with relationships but did not know how she was contributing to the problem. Uncovering Ms F's anxiety and tendency to withdraw helps her to see the way that her mechanism for coping with anxiety has been getting in the way of deepening her relationships. It links the anxiety to an unconscious fantasy. Once the link is made conscious, Ms F has an affect (marked by laughter) and can decide to make another type of choice.

Defenses are only one ego function that we aim to improve with psychodynamic psychotherapy. Let's go on to consider several others in the next chapter.

28 Improving Other Ego Functions

Key concepts

Improving ego functions is a major goal of psychodynamic psychotherapy.

Both uncovering and supporting strategies can help patients to strengthen ego functions such as reality testing, judgment, stimulus regulation, self-awareness, and cognitive functions.

Determining whether a person ''can'' or ''cannot'' perform ego functions is essential to choosing whether to uncover or support.

In the last three chapters, we've discussed improving three important ego functions – self-esteem regulation and self-perceptions, relationships with others, and characteristic adaptations (including defenses). In this chapter, we will discuss strategies for improving several other ego functions, using both uncovering and supporting strategies.

Can they or can't they?

In order to help someone with a problem related to ego function, we have to make some judgment as to whether the patient *has the ability to perform the ego function but is ''blocked''* in his/her ability to use it by something in the unconscious or whether the patient *lacks the capacity to perform the ego function*. Traditionally, this has been thought of as a question of **conflict vs. deficit** – if the person has the capacity to perform the ego function but is blocked, this was thought of as a problem that is caused by a *conflict*, whereas if the person lacks the capacity to perform the ego function, this was thought of as a problem caused by a *deficit* [15]. However, we know that unconscious issues other than conflicts, such as affects, fantasies, and defenses, can cause impairment in function, and we know that people who have the capacity to perform ego functions can sometimes temporarily lose their ability to use them due to stress, medical illness, psychiatric syndromes, and other circumstances that overwhelm their capacity to function in the short-term. Thus, evaluating a person's ego capacities in terms of ''can they?'' or ''can't they?'' may be a better way to think about these problems.

Examples

Mr A, a 45-year-old successful businessman, presents for therapy shortly after his father's death. He has been appointed executor for the estate but finds himself unable to organize his father's

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financial affairs. Before his father died, Mr A had been angry with him for ''running his finances into the ground'' and putting the burden on his children to organize things. He now worries that he is getting attention deficit disorder and wonders if he needs a stimulant. When you take the history, you find that he is able organize financial matters at his job without difficulty and only encounters problems in relation to arranging his father's estate. You hypothesize that he possesses the capacity to be organized about finances, but that unconscious feelings about his father and his father's death are blocking him from being able to perform to the best of his ability in this particular situation.

In this example, we know that Mr A *can* organize his finances because:

- this has never been an area of weakness for him in the past
- he is currently using organizational skills without apparent difficulty in other aspects of his life

His unconscious feelings about his father prevent him from being able to use his generally intact ability to organize finances in a circumscribed area of his life. Given this, an uncovering strategy is indicated. Now think about the contrasting example of Mr B:

Mr B, a 45-year-old writer, presents for therapy because he is terrified of losing his home. He has taken out a second mortgage and is unable to make the monthly payments. When you ask him about his budget, it becomes clear that he has never had a budget and that he has no sense of how much income he needs per month to cover his expenses. The history reveals that he has experienced trouble planning ahead in many other ways, including a lifelong inability to plan vacations or to manage his time on weekends. He thinks that he was diagnosed with a learning disability as a child but is unsure what kind.

Mr B *cannot* organize his finances. His history indicates that he has never been able to do this in any aspect of his life, suggesting that this is an area of chronic ego weakness. Supporting strategies are indicated. Finally, consider the situation of Mr C:

Mr C is a 45-year-old high school principal who presents with symptoms of major depression during a divorce. After a 20-year marriage, his wife has just left him for his best friend. He is devastated and has symptoms of insomnia, anhedonia, and a 15 pound weight loss. Although he is afraid that he will lose his children, he has not organized himself to get a lawyer and pay the required retaining fee. In fact, although he has always been the family money manager, he has not paid any of his bills in three months and recently had his lights turned off for lack of payment.

This is a much more ambiguous situation. Clearly, Mr C has had the capacity to organize his finances in the past – so what's happening now? Are unconscious thoughts and feelings causing Mr C to be unable to use his fundamentally good capacity for financial organization? Is depression, anxiety, or acute grief impeding his organizational skills? All we know at the moment is that, for now, Mr C is unable to use this essential ego function – and he is in a compromised situation because of this. We have to presume that, *for the time being*, Mr C's ego function requires support and that he *cannot* perform certain essential functions.

The goal

A primary goal of psychodynamic psychotherapy is helping people to improve their ego function. When people have absent or faltering ego functions, we can help them to develop new capacities or to strengthen weakened ones; when people are unable to use ego functions because of unconscious issues, we can help them to ''unblock'' the capacities that they have.

Recognizing the problem

How can we tell if a person can or cannot perform an ego function? Here are some strategies for parsing this out.

Is the problem global or selective?

This is probably your best guide for determining whether the person can or cannot use an ego function. Can a patient call everyone back except his mother? Is he able to use good judgment in all situations except when purchasing expensive shoes? Is he able to tolerate loud noises except when his 18-year-old son is playing the drums in the basement? These situations suggest that the capacity to use these ego functions is present, but that unconscious factors are blocking the ability to use them.

Asking the following questions can help you to make this determination:

> *Are there any situations in which this is not a problem for you?*
>
> *Do you find that you just can't do this when you're anxious/tired/depressed/with people you don't know?*
>
> *Do you have any strategies that allow you to do this even though it's difficult?*

Is the problem longstanding or recent?

If an ego function problem began in childhood or adolescence, it is more likely that the person lacks that capacity than that he/she has been chronically blocked by unconscious feelings, fantasies, or conflicts. This is true of many problems in the cognitive realm, but may also be true of ego functions like impulse control and judgment. Here are two contrasting examples:

> *Mr D is at risk of losing his job because he cannot manage his time properly. Formerly a high-level consultant, he previously was able to manage large, multi-center projects. After Mr D lost his job in a massive layoff sweep, he reluctantly took his current job, which is at a much lower level. He is contemptuous of his boss and feels listless during work hours.*

Mr D has recently been managing his time poorly but in the past performed well in this area. There is ample evidence that unconscious feelings are impeding his previously intact time management skills.

Mr E is at risk of losing his job because he cannot manage his time properly. He has had difficulty with this since childhood – he had tutors throughout high school and college who helped him to break down long-term projects into manageable tasks. He briefly took stimulants but felt that he had ''outgrown'' the need for them and wanted to ''do it on his own.'' Now in his first job, he cannot manage this for himself and hides from his boss because he knows that he is behind on many projects.

There is strong evidence that Mr E has had this difficulty with time management since childhood. His anxiety about not being able to perform certain tasks is well founded since he has never been able to perform them without assistance. Unfortunately, rather than acknowledging his realistic limitations, using coping skills that served him well in the past, and asking for help, he is using *maladaptive* ways of coping, including denying his need for help and avoiding his boss.

Is the problem in ego function associated with other kinds of psychiatric symptoms?

No one knows exactly how ego functions develop, but it seems clear that problems like mood and anxiety disorders, substance abuse, and other psychiatric syndromes can play a role in (i) how ego functions develop and (ii) how well they work over time [16]. For example, if a young man develops bipolar disorder in early adolescence – a critical stage during which most teenagers are developing and practicing the capacity to regulate affect and control impulses – he may experience ongoing difficulties in these areas of ego function in adulthood, even during periods when his mood disorder is quiescent. Determining whether a patient's apparent difficulties in ego function are exacerbated by or developed in the setting of other psychiatric problems can help you decide if the person basically ''can'' or ''cannot'' perform a given ego function. Here are a few examples:

Ordinarily very decisive, Mr F becomes unable to make choices when he is depressed. This has become a marker that he and his therapist use to pick up early signs of relapse.

Although she is generally a very responsible mother, when Ms G is anxious her judgment about her children is impaired – she forgets to pick them up from school and allows them to stay out later than they should.

Fearing another panic attack, Mr H was unable to stay in an important business meeting and ran out of the room. When he is gripped with fear, his impulse control is impaired.

In these examples, understanding the constellation of symptoms involved is essential to assessing whether the person ''can'' or ''cannot'' perform a given ego function.

Therapeutic strategies

Your therapeutic strategy will differ depending on whether you decide that a person can or cannot perform a given ego function. In general, uncovering strategies will

help to ''unblock'' ego function when unconscious issues are getting in the way, while supporting strategies will help to assist faltering ego function or to supply absent ego functions.

We will describe these differing approaches in relation to a number of ego functions:

- reality testing/sense of reality
- judgment/impulse control
- stimulus regulation
- self-awareness
- cognition

As we explore each of these areas, you can think about the questions outlined above to begin to hone your decision-making about therapeutic strategies:

- Is the problem in ego function global or selective?
- Is the problem longstanding or recent?
- Is the problem associated with other kinds of psychiatric symptoms?
- Can the patient exercise the ego function with minimal help from the therapist or does he/she require the therapist to ''supply'' or ''assist'' in exercising the missing capacity?

Reality testing/Sense of reality

You don't have to be psychotic to have impaired reality testing. Patients with personality disorders who are not frankly psychotic may have misperceptions or distortions related to their use of reality-blurring defenses like **denial** or **projection** (see Chapter 4). Such defenses are commonly seen in patients with borderline personality disorder but may also be used by patients who generally use higher-level defenses. Here are two examples of patients with disturbances in reality testing. As you read each example, remember to ask yourself the questions outlined above.

Case 1

Mr I is a 37-year-old single, unemployed man with a history of schizophrenia. He is the eldest of four sons, three of whom are physicians. Shortly after learning that his youngest brother has just been awarded a prestigious research fellowship, Mr I abruptly stops his antipsychotic medication and is admitted to the hospital in a floridly delusional state. Here's a sequence from his inpatient intake:

Therapist	*Can you tell me something about why you came to the hospital?* (**question**)
Mr I	*(glances around nervously, then mutters under his breath) The Tuskegee experiment.*
Therapist	*I don't know you well enough yet to understand what you mean, but I gathered from the doctors in emergency room that you're afraid something like the Tuskegee experiment might be happening to you.* (**demonstrating interest and understanding, joint inquiry**)

Mr I *I can't talk about it. The government would kill me.*

Therapist *Well, I can reassure you about one thing – this is not a research hospital, we do not perform experiments here, and there are laws to protect people against the sort of thing you're worried about.* (**reassuring, correcting misperceptions**)

Mr I *They want my brain. I have a very rare disorder. This was my brother's idea. He told the doctors that I wasn't making sense.*

Therapist *I guess your brother was concerned that your thinking may have become confused again, after you stopped the medication for your illness. Do you think that might be possible?* (**correcting misperceptions, jointly exploring alternate ways of thinking**)

Mr I *What? Ohh . . . the Seroquel, you mean? . . . I don't need it anymore . . . Do I?*

In this situation, the disturbance in reality testing is most likely caused by an acute exacerbation of a longstanding psychotic illness, triggered by the patient's discontinuation of his medication. The therapist *notes to himself* that Mr I's non-compliance with medication may have been motivated by an unconscious reaction to his brother's most recent achievement and hypothesizes that Mr I's paranoid and grandiose delusions about being a ''rare'' and special research patient may compensate for painful feelings of failure and envy. However, although these reflections will *inform* his choice of intervention, the therapist also decides that, at least at this moment, Mr I *cannot* discriminate reality from delusion and that he thus needs to ''supply'' the missing ego function in addition to restarting the patient's medication.

Case 2

Ms J is an 18-year-old high school senior who is just two weeks shy of graduation. She has been in psychotherapy for three years for symptoms of anxiety and depression, intermittent suicidal ideation, and binge eating, all of which typically worsen at the beginning of each new school year. She has a solid alliance with her therapist and, with the help of the treatment, she has been functioning very well. During this past (senior) year of high school, she had no problems with the transition back to school and she sailed through the college application process without apparent difficulty. As recently as a week earlier, she had seemed content and stable, so it was with some surprise and a little anxiety that the therapist received an ''emergency'' message from her parents, saying that Ms J was ''paranoid.'' After assuring himself that the patient is neither medically ill nor using substances, the therapist has the following exchange with the patient in the next session:

Ms J *(sobbing) I hate you! I know I made you angry and you've been waiting for your chance to get rid of me!*

Therapist *You're obviously really upset with me. Let's slow down for a minute and try to understand what's going on between us. When did you start to have these thoughts about me?* (**naming emotions, slowing down, explicitly joining, jointly reality-testing**)

Ms J *(irritably) I don't know. A couple of days ago. After the prom.*

Therapist *The prom – how was the prom?* (**question**)

Ms J *Awful – a complete sham – my date dumped me. On my way home alone, I just got a weird feeling – like I was out of my body – like everyone hated me, particularly you – and that you've just been waiting for all this to happen to me. (crying) I feel like I'm going crazy.*

Therapist *You and I know that when you're under a lot of stress, you can become pretty spaced out, right? Do you remember something like this happening a few years ago, when you were about to go abroad for the summer? You may have forgotten – you talked yourself through it and it didn't last long. Any ideas about what might be stressing you out now?* (**clarification, reminding patient of capacities, offering optimism, question**)

Ms J *Everything seems so pointless. The prom was horrible. I was really looking forward to it, but then when I got there, it all seemed so false. Why have a big party, and pretend you're all happy, when everybody is leaving in two weeks?*

Therapist *I wonder if things feel unreal to you because something sort of unreal is about to happen to you – you're about to leave home in two months. That means leaving your friends, your family – and me. I think that may be upsetting you more than you're aware of*. (**interpretation**)

Ms J *I can't believe that I have to leave here – you – you're what's held me together this year. How am I going to do it without you?*

In this example, Ms J does not have a psychotic illness but she is experiencing difficulty with reality testing in the setting of a number of significant milestones – graduating from high school, moving away from home, ending treatment with her therapist, and starting college. She has had difficulty with such transitions and separations in the past. Her therapist quickly determines that there has been no recent drug use, medical problem, or other psychiatric problems that might account for her sudden disorganized and paranoid thinking. He feels reasonably certain that her trouble with reality testing is related to unconscious anxiety about separating from her parents and therapist, along with conflicting feelings of humiliation and anger about still needing and depending on them. However, the therapist knows that in order for Ms J to be able to explore these difficult feelings, he will first need to help her feel safe, calm her overwhelming affects, and reduce her paranoid perceptions about him.

Bear in mind that there are degrees to which people can test reality. Mr I cannot test reality at all and needs the therapist to *supply* that capacity; Ms J became paranoid under stress and needs the therapist to *assist* her in exercising her capacity to test reality before she and the therapist can *uncover* the unconscious factors that led to her loss of equilibrium. Note that in both examples, the therapist attempts – gently and tactfully – to help the patients:

- recognize they are misperceiving things
- consider alternative perspectives in a more flexible way

Judgment and impulse control

People with good judgment have the capacity to anticipate the consequences of their actions, predict how other people are apt to react and, if necessary, hold themselves in check, shift set, and rethink plans. Thus, sound judgment requires good impulse control, and improving judgment often goes hand-in-hand with decreasing

impulsivity. When impaired judgment and impulse control might lead to a life-threatening situation, we may need to directly intervene (for example, by hospitalizing the patient or directing them to use safe-sex precautions – see Chapter 10) However, when impaired judgment and impulse control are not directly endangering the patient, another person, or the treatment, our goals are to help improve these functions using either supporting or uncovering techniques. Here are two examples of patients with impaired judgment and impulse control problems. In the first example, the therapist uses mostly supporting interventions (supplying and assisting) to strengthen the faltering ego capacities, while in the second case, the therapist supports and uncovers to help the patient.

Case 1

Mr K is a 28-year-old radio ad salesman who sought consultation at his father's insistence and who says, ''I'm fed up with my job, and my Dad's fed up with paying my rent. I don't know why he cares – he never takes any interest if I'm doing well.'' Mr K describes a pattern of starting new jobs with great enthusiasm then becoming quickly bored and quitting or getting himself fired. This is his third job in as many years, and after only a few months he is already ''sick of talking to whiney clients on the phone all day.'' He tells the therapist that he nearly quit earlier in the week after his boss pointed out he was well short of his three-month sales goal and had already been late six times that month.

Mr K	*I really wanted to tell my boss to take the job and shove it. He's full of criticism but doesn't give me any help.*
Therapist	*Wow – sounds rough. What's the job market like these days?* (**empathzing, question, jointly thinking through consequences**)
Mr K	*Terrible. It took me three months and five interviews to get this job.*
Therapist	*So quitting would put you right back out there.* (**continuing to think through consequences**)
Mr K	*I never think of that in the moment. It goes out of my mind when I get so frustrated.*
Therapist	*I get that – let's work together to think of some strategies that you can use during those moments.* (**joint problem solving**)

The therapist wonders whether the patient might be playing out something with his boss that belongs to his relationship with his father, and thus that unconscious factors might be leading to his poor judgment. However, taking into account the three readiness principles (see Chapter 17) – state of the alliance (so far non-existent), the patient's ego function (weakened), and the phase of the treatment (first meeting) – as well as the fact that the patient's job may be in jeopardy, the therapist elects to **supportively bypass** these unconscious conflicts and to focus on building an alliance and buttressing Mr K's faltering judgment, impulse control, and maladaptive coping through supportive means.

The therapist both uses supplying and assisting interventions, like **empathizing**, **thinking through consequences**, and **joint problem solving** to try to bolster Mr K's weakened judgment and impulse control.

Case 2

Ms L is a 42-year-old married business executive whose husband recently announced that he was having an affair and wanted a divorce. Ms L is still in shock and feels too humiliated to tell her friends and family – especially her mother who never liked her husband and said, ''He's a user – just like your father.'' On her way to the airport for an overseas trip, Ms L shares a cab with the company chief executive and begins flirting with him. Although Ms L says that friends regard her as a cautious person with a tendency to ''over-think'' decisions, she invites her colleague back to her hotel room for a drink and ends up spending the night with him. After the trip, Ms L calls her former therapist. The following is from their first appointment:

Ms L	*This is getting totally out of control! I know I should end it. He's married! But every time I hear his voice, I just can't help myself. Why am I doing this?*
Therapist	*Do you have any ideas about that?* (**confrontation**)
Ms L	*He's smart. He's handsome. He makes me feel sexy and desirable.*
Therapist	*Ah . . . but my guess is that you have more complicated feelings about it.* (**question, confrontation**)
Ms L	*Yes – it's crazy!! Sleeping with the boss? I must be out of my mind – I keep saying to myself, ''don't call him'' and then before I know it I'm calling him again.*
Therapist	*This has been a really hard time for you. I know that you're focusing on this relationship, but I haven't seen you since your husband left.* (**empathizing, confrontation**)
Ms L	*(bursts into tears) I feel totally humiliated! Again!*
Therapist	*Again? – sounds like this situation is related to feelings you're still having about your husband.* (**clarification**)
Ms L	*I don't know – You must be thinking, ''I can't believe she did it again!''*
Therapist	*Your husband's betrayal was devastating. Perhaps seducing your boss was a way to feel that **you** were in control – not victimized, like your mother.* (**interpretation, with genetic component**)
Ms L	*I guess you're saying I can take control of the situation if I want to. It's not just his call.*

In the setting of a recent, humiliating blow to her self-esteem, this ordinarily self-controlled woman with impeccable judgment suddenly begins behaving in erratic and risky ways. Her therapist uses a mix of supporting and uncovering interventions to help her to begin to understand the way in which her behaviors are linked to unconscious thoughts and feelings that she has been hiding from herself and others.

Cognition

Some patients have lifelong difficulties with basic cognitive functions such as attention, memory, and linear thinking. Other patients have intact basic cognitive functions but have difficulty coordinating them. These patients often experience trouble prioritizing, starting and finishing work on time, keeping track of tasks, completing long-term projects, or planning for the future. These coordinating activities are sometimes called ''executive'' cognitive functions [17]. Still other people have problems in the realm of what is called ''synthetic'' or abstract thinking – their weaknesses can

include making connections between different thoughts, feelings, and experiences, seeing patterns, making sense of inconsistencies, and connecting experiences with their subsequent reactions [18]. Patients with these kinds of difficulties in cognition generally benefit – at least initially – from a more supporting approach aimed at strengthening these areas of relative weakness. If, however, there is compelling evidence that unconscious feelings are impeding generally intact cognitive skills, a more uncovering approach may be helpful. Here are two examples of patients with different problems with cognitive function – the first more global and longstanding, the second more selective and apparently related to unconscious conflict stimulated by recent life stressors.

Case 1

Mr M is an 18-year-old college student who has just been asked to consider taking a leave of absence from his freshman year because of failing grades. His parents brought him in for a consultation hoping to help him ''get back on the horse'' and finish out the semester. They report that Mr M is chronically restless and fidgety, talks excessively, and needed the help of tutors in 11th and 12th grade to finish papers and complete college applications on time. Mr M was very optimistic about his ability to function on his own as he started the school year; however, he is now significantly behind in all of his courses. In the therapist's office, Mr M is panic-stricken, saying he is too overwhelmed to finish out the semester but can't imagine going home ''with my tail between my legs.'' After the therapist takes a full history and assesses all of Mr M's symptoms, he and the patient have this exchange:

Mr M	*(jiggling his legs nervously and running his hands through his hair) I don't know what to do. I'm stuck.*
Therapist	*You're stuck?* (**confrontation**)
Mr M	*I don't think I can make it through the semester. But if I drop out, what am I going to tell my friends from high school when they come home for winter break? That I'm an epic failure?*
Therapist	*You can look at it that way, or you can say that you've been trying to tell the people around you that you need more help than you've been getting. Perhaps we can think about some of the things that are tripping you up with your schoolwork so that we come up with the best plan to help you.* (**interpreting up, explicitly joining, joint inquiry**)
Mr M	*(brightening) I guess you're right – what do you suggest?*
Therapist	*First of all – there's no shame in continuing to need tutors or help with organizing. You'd be surprised how many people need that kind of assistance – and not only students. Sounds like you should also have a consultation to see if you might have attention deficit disorder – you have many of the symptoms and medication might really help. Then, we can work on honing in on some of the difficulties you're having. Maybe you can start us off . . . what's the last assignment you had difficulty with?* (**reassuring, validating, universalizing, jointly working on a project**)
Mr M	*That history research project really nailed me – that's exactly the kind of thing that makes me crazy – I don't know where to start so I bury it under a pile.*
Therapist	*Perfect – that's a great place to start. So let's talk about what you do when you first get the assignment . . .* (**praise, joint inquiry**)

The history obtained from the parents is consistent with the therapist's initial impression of a longstanding undiagnosed attention deficit disorder. The therapist speculates that when faced with the challenges of college level work – and without his parents' support and guidance – Mr M was unable to organize a study schedule or manage his time effectively. Instead of marshaling appropriate resources and asking for help, Mr M avoided his schoolwork. The therapist uses both supplying and assisting techniques to approach the delicate task of addressing Mr M's problems in organization and time management while simultaneously buttressing his self-esteem.

Case 2

Ms N is a 59-year-old recently widowed mother of three grown children who says that she is at risk of losing her job because, ''I can't seem to manage my time properly.'' Ms N explains that she was formerly a highly sought-after organizational psychology consultant and that she was able to manage complex multi-faceted responsibilities. However, after losing her job in a massive layoff sweep, she was obliged to accept her current position at a much lower level – and with a considerable pay cut. Ms N feels listless and distracted during work hours, often finds her mind wandering, and is experiencing more difficulty getting reports to her boss on time.

Mr N	*A year ago, I could have done this sort of work blindfolded, with one arm tied behind my back. Sometimes I think I'm developing Alzheimer's.*
Therapist	*I haven't noticed any problems with your memory, but are you having trouble managing your time and staying organized in other areas of your life – keeping up with bills, organizing doctors' appointments, planning vacations, that sort of thing?* (**reassuring, question**)
Ms N	*Not really. That's what's so weird. I'm okay in my outside life, but when I come into the office it's like a black veil descends.*
Therapist	*Black veil?* (**confrontation**)
Ms N	*A black veil . . . like I'm going to my own funeral! (laughs).*
Therapist	*Well, you've had a lot of losses recently.* (**empathizing, clarification**)
Ms N	*It's been exactly one year since Jerry died. (she becomes tearful) If he were still alive, I wouldn't have to be at this crummy job.*
Therapist	*You clearly miss him so much. But I think that you might also be angry that you have to take care of yourself now. I have a feeling that this might be linked to some of the difficulty that you're having at work.* (**empathizing, naming the emotion, interpretation**)
Ms N	*I hate to feel angry with him because I miss him so much, but I wish that I had options now, and I just don't.*

Ms N's ''black veil'' metaphor suggests to the therapist that unconscious feelings about her husband's death are related to her current difficulties. After a **confrontation**, the therapist is able to **interpret** the way in which Ms N's unconscious anger is impeding her ability to function well at work.

A few things make the case of Ms N different from the case of Mr M. Ms N used to be able to perform these functions easily. There are clear, unconscious elements that could be contributing to her impaired performance. Finally, the therapist's attempts to engage Ms N in a discussion of these unconscious elements immediately deepen her associations.

Self-awareness/Psychological mindedness

In all psychodynamic psychotherapies – even predominantly supporting treatments – we are always interested in enhancing the patient's self-understanding. However, as we discussed in Chapter 3, some people readily conceptualize their minds as having unconscious elements while others do not. Assessing the way in which patients think about their mental functioning is essential for deciding which type of technique is most appropriate. Uncovering techniques require the patient to have at least some basic ability to reflect on their inner mental life, while supporting interventions can help develop or strengthen this capacity. Here are two examples that relate to the capacity for self-reflection:

Case 1

Ms O is a 36-year-old married woman with three children under the age of 10 who has been referred by her internist to be evaluated for possible underlying depression. Ms O launches immediately into a litany of physical complaints, including headaches, back and neck discomfort, and ''terrible'' premenstrual syndrome, for which she has consulted many specialists. These symptoms began after the birth of her baby a year ago, and now severely limit her ability to take care of her children. This exchange is from the intake:

Ms O	*My doctor thinks I need an antidepressant.*
Therapist	*What do you think?* (**question**)
Ms O	*I think I'm in pain.*
Therapist	*Do you think that there's anything that is causing you to have pain now?* (**question**)
Ms O	*How should I know? I'm not a doctor. They can't figure out what it is but it's something. It's not in my head.*
Therapist	*Sounds like it's been really difficult. Do you notice that there are any situations or times of day when the pain is better or worse?* (**empathizing, question**)
Ms O	*Mornings are the worst – getting breakfast together, sending the kids off to school, all the while holding the baby . . .*
Therapist	*That must send your stress level through the roof . . . As your internist may have already told you, stress can really exacerbate pain by increasing muscle tension and stimulating activity in the sympathetic nervous system.* (**empathizing, validating, informing**)
Ms O	*I didn't realize that. All I feel is pain, but you're right that the stress probably makes it worse.*

In the course of the evaluation, the therapist satisfies himself that although Ms O seems tense and unhappy, she does not have major depressive disorder. However, Ms O clearly has trouble thinking about the way in which her problems might be related to her thoughts and feelings. While this ego weakness is likely longstanding, it does not appear to have caused significant problems in her relationships and general functioning until the past year. The therapist speculates that her somatic preoccupation may be a defense against unacceptable feelings of resentment generated by the birth of her youngest child. However, the therapist recognizes that, for the

time being, Ms O needs help simply labeling her feelings and registering emotional reactions to events in her life. He decides to begin by ''going with'' her defense by talking about her difficulties in terms of her physical problems, while trying to help her to look at things in a new way. The therapeutic strategy is to gradually help Ms O consider that her pain might be related to stress and emotions. This can be a first step in increasing her self-awareness.

Case 2

Ms P is a 32-year-old woman who presents saying that she ''can't decide'' which graduate school to attend. She has gotten two very good offers and is in a ''panic'' because she says that she has to make a decision in two days. She says that she is usually very good at making decisions but this one is ''driving (her) crazy.'' In your first session she produces reams of papers with ''pros and cons'' lists written on them. She also tells you that her boyfriend of two years lives in the city that houses one of the programs but she insists, ''That isn't an issue.'' Here's part of a session:

Ms P	*So the dorms are better in School A, but the stipend is better at School B. Ah! I just keep going around in circles.*
Therapist	*Circles?* (**confrontation**)
Ms P	*Yes – as soon as I feel like I'm going to make a decision, something else comes up and then I'm back to the drawing board. I'm driving my boyfriend crazy with this too – we've spent hours on the phone talking about it.*
Therapist	*Does he have an opinion?* (**question**)
Ms P	*No – he's completely measured – which is good – he's completely committed to making this all about me and what I want. That's the best – I wouldn't want him to weigh in – absolutely not.*
Therapist	*That was a lot of ''no's'' – is there any possibility that you might want him to have an opinion?* (**confrontation**)
Ms P	*I said no because I mean no – I'm an educated, independent woman and my career comes first. Right?*
Therapist	*That's up to you, of course, but I wonder if you might have several different feelings about it. Part of you might want to be completely independent, but part of you might want to feel like he really wants to be with you.* (**confrontation**)
Ms P	*(tearful) – Well, I'm 32 years old! I'm not getting younger! It will be at least six years before I get my PhD – then I'll be 38. Maybe he doesn't care about that.*
Therapist	*You mean about having a family?* (**confrontation**)
Ms P	*I hate that it matters to me, but I guess that it does.*
Therapist	*Maybe it's been easier to think of this in terms of the ''pros and cons'' of the programs than to think about how hurt you feel that he's not being more proactive about trying to be together.* (**interpretation**)
Ms P	*(sitting back into her chair) That's hard to swallow, but it makes sense. What do I care about what the dorms are like?*

In this situation, the patient can generally make decisions, so the therapist hypothesizes that something that's out of awareness might be making Ms P think about this situation too concretely. Together, they discover that Ms P's ability to be self-aware

was blocked by unconscious thoughts and feelings. Helping her to see this brings back her ability to be more reflective about her situation.

Stimulus regulation

Oversensitivity to sensory stimuli can be chronic or acute, severe, or mild. It has been associated with a wide variety of medical and psychiatric conditions that range from garden-variety anxiety to acute stress reactions. It can also be an isolated problem in otherwise healthy children and adults [19]. Supportive interventions are aimed at teaching various strategies for managing and avoiding sensory overload, while uncovering approaches can be helpful in addressing sources of emotional distress that may temporarily compromise a patient's otherwise intact ability to regulate sensory stimuli.

Case 1

Ms Q is a 53-year-old woman with mild autism who has worked for many years as a mail carrier with consistently excellent performance reviews. Temporarily sidelined after slipping on the ice, Ms Q is asked to switch to a window service job that entails dealing directly with customers. Ms Q says she has been feeling more anxious and overwhelmed since assuming the new position. The overhead lights seem harsh and glaring – ''they hurt my eyes.'' She also finds it hard to screen out background noises in the post office, and listening to customers or even talking on the telephone have become nearly impossible for her.

Ms Q *I feel bombarded with noises that blast through my brain. It makes me feel paralyzed. Some sounds have always bothered me – like static on a radio – so I stay away from them. But I can't stay away from my job. It makes me want to scream. It's never been this bad.*

Therapist *You're very brave to stick it out. What sorts of things have helped you in the past?* (**praise, question**)

Ms Q *Sometimes I just wear earplugs – like if I have to ride the subway. But at the post office I need to be able to hear the customers and answer the phone.*

Therapist *So we'll have to get creative and think of some other ways to make the environment more bearable for you. What about finding a dark and quiet room to lie down for a while? Or maybe taking extra time in the bathroom just to get away from the lights and noise for a few minutes?* (**explicitly joining, suggestion**)

Ms Q *Like taking a time out . . . I like that idea.*

Here the therapist actively works with the patient to think of ways to reduce sensory input and tolerate stimulus overload.

Case 2

Ms R is a 54-year-old woman who says that she needs sleep medication because her husband's snoring is ''more than I can take.'' She frequently leaves the bedroom at night in a huff, dragging the communal quilt into the living room, where she sleeps fitfully for a few hours. The therapist learns that she has been married for 30 years and that her husband has always snored. However, it is only in the last two months that it has started to bother her. When the therapist asks what

happened two months ago, she says, ''Oh, nothing. It just started to bother me when we got back from dropping off our youngest son for his freshman year of college.'' Here is an exchange from the intake:

Ms R	*Even at dinner I'm tense. I'm thinking – oh no, it's almost bedtime. That sawing sound! Just thinking about it makes me tighten up.*
Therapist	*So it started in September – is that right?* (**question**)
Ms R	*Yes – right we when got home from taking James to college.*
Therapist	*Wow – three boys in school – the house must seem different!* (**call for associations**)
Ms R	*You're right – it is. No more dirty socks on the floor – I can use the TV whenever I want – no more loud music coming from their rooms.*
Therapist	*It must be very quiet.* (**call for association**)
Ms R	*I guess it is. It's just us.*
Therapist	*So all you can hear is yourselves.* (**putting experience into words**)
Ms R	*Huh – that's true – not only is my husband all I can hear, but he's the only person I talk to most days. It's sort of lonely.*
Therapist	*Sounds like you miss the kids.* (**confrontation**)
Ms R	*I didn't think I would miss them this much – when the other two went, I missed them, but James is my baby – he's a great kid – we'd often stay up late, watching movies. My husband doesn't really like books and movies – he works and likes bowling with the guys and football – James was really my buddy. I do miss him a lot.*
Therapist	*I know that you're really annoyed by the snoring – but it seems like it might be symbolic – you're kind of upset that you're left alone with just your husband.* (**interpretation**)
Ms R	*I guess I am – I'd rather that he'd have gone to college and left James home. When I say it out loud, though, that sounds terrible . . .*

This new onset of sensitivity to noise suggests the contribution of out-of-awareness thoughts and feelings. Once the therapist satisfied herself that this new problem is not the result of a mood, anxiety, or substance abuse problem, she begins to listen for unconscious meanings. In this case, Ms R's sensitivity to her husband's snoring covers a wish that she feels is unacceptable – to replace him with her son. Helping her to understand this meaning is likely to help her to understand her new-onset symptoms.

Although the vignettes that we've presented in these chapters on therapeutic goals are fairly short, it often takes many iterations to lead to lasting change. We call this process ''working through'' and it's the topic of our next chapter.

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PART SEVEN: Working Through and Ending

Introduction

Key concepts

The later phases of a psychodynamic psychotherapy are the mid-phase and the termination phase.

During the mid-phase, patient and therapist work together to gradually effect lasting change by addressing core problems as they emerge repeatedly in the treatment. This is called working through.

Termination, the final phase of psychodynamic psychotherapy, marks the end of the treatment and requires the therapist to use particular techniques suited for this phase.

Just as the beginning of the treatment calls for specific techniques, so too do the mid-phase and termination phase. Mid-phase is usually the longest phase, and the time in which patient and therapist have a strong alliance and are working well together. This is the time to address all of the therapeutic goals we discussed in Part Six. Termination is a time of strong feelings, regression, mourning, and consolidation. In the following chapters we will review these phases, with special attention to how and when to modify your technique.

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29 Working Through

Key concepts

Working through can be thought of as a three-phase process in which a person gradually changes some aspect of his/her mental functioning. These phases progress from:

- Phase 1: lack of awareness of a problem or the cause of a problem, to
- Phase 2: increased awareness of a problem and/or practicing new ways of functioning, to
- Phase 3: lasting change in thought patterns or behavior

These changes can occur in many aspects of a person's mental functioning, including ego function, sense of self, expectations of relationships with others, and super-ego functioning.

In psychodynamic psychotherapy, we expect that these changes happen slowly over time through a gradual process of working and reworking of the same issues until lasting change occurs.

What is working through?

Have you ever tried to change even one aspect of your behavior? Think about all those New Year's resolutions you've made over the years – to eat only healthy foods and to exercise regularly – most are out the window by the time you go to brunch on January 1st. Imagine, then, someone who is trying to change her habitual ways of thinking about herself, relating to others, and reacting to stress – it's very hard. As adults, we've been perfecting our characteristic patterns of thought and behavior over a lifetime, so trying to change them is daunting at best. Although we still don't know exactly how psychotherapy changes our neural circuitry, it clearly must, and those changes take time [1]. This gradual process is called **working through** and it's a central feature of psychodynamic psychotherapy [2, 3].

Whether we're working in a predominantly uncovering or supporting mode, we can think of working through as the way change occurs in psychodynamic psychotherapy. The miraculous psychotherapeutic epiphanies dramatized in movies like *Spellbound*, in which someone realizes why they behave the way they do in one fantastic moment and are changed forever, are just the stuff of movies. Although people do have flashes of insight, these rarely produce lasting change in thought patterns, ways of relating to self and others, or habitual patterns of reacting to stress.

As with resistance, the fact that this is a gradual process is not to be thought of as a hindrance; rather, understanding and accepting its slow pace is essential and

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fundamental to its success. Consider the following exchange between a therapist and her supervisor:

Therapist *I can't believe that Mr A is sabotaging himself at work again! We've discussed this so many times in his treatment. And the frustrating thing is that he sees what he's doing now but he still provokes his boss when he gets anxious. Is this ever going to work?*

Supervisor *Absolutely. This is the way things move and change in psychodynamic psychotherapy. A few months ago, Mr A wouldn't even have been able to see what he was doing – as this pattern continues to repeat itself, you'll be able to continue to work on it and gradually he'll start to change his behavior as well.*

Rather than signifying failure, this is the way in which the process works. Realizing this is fundamental to learning how to conduct psychodynamic psychotherapy. In addition, it helps us with the feelings of countertransference frustration that are inevitable in the face of this kind of slow change. A good way to think of it is as *practicing* – no one learns to walk, read, or play a sport well immediately – it takes constant repetitions to get it right. The same is true for psychodynamic psychotherapy. Working on the same issues time and time again helps the patient to practice new ways of thinking and behaving which over time become automatic.

Working through can be thought of as having three phases:

- **Phase 1** – *limited awareness* of the problem or the cause of the problem.
- **Phase 2** – *increased awareness* of the problem or the cause of the problem and/or *practicing* new ways of functioning.
- **Phase 3** – *change* in thought pattern or behavior.

Increase in awareness is sometimes called **insight** and psychodynamic psychotherapy is sometimes called **insight-oriented psychotherapy** [4]. However, looking at working through in this way helps us to realize that while insight is helpful, it is really only a way station to lasting change. In addition, some change happens without frank insight. In a more contemporary way of looking at psychodynamic psychotherapy, insight is one thing that can promote change, but so can *experiencing* other aspects of the treatment, such as the relationship with the therapist and the holding function of therapy [5]. As with anything else that we want to become an automatic part of how we think and behave, we need more than insight to make that happen.

We can think of working through as a learning process that occurs continuously throughout a psychodynamic psychotherapy – from the first encounter to beyond termination. Working through of different issues occurs at different paces; for example, a person might experience lasting and profound change in the way they view themselves, yet lag behind in changing their expectations of how others will behave in relationships. Our awareness of the phases of the working through process will help us to be attuned to our patients as they work to change patterns of thought and behavior that, until this point, have been fundamental to who they are.

Technique

Listening

What do we hear in the different phases of working through? What are we listening for?

Phase 1 – limited awareness

In this initial phase, the person is either unaware that a problem exists or has very limited awareness of its internal causes. This is how these two situations can sound:

Limited awareness of the problem

Mr B	*Is it okay if I wait until next month to pay you? I'd really appreciate that because I want to buy a new car this month and I'm going to need all my spare cash for the down payment.*
Therapist	*That request is interesting for two reasons: (i) it's not the agreement we made when we started this treatment and (ii) your difficulty with paying bills late is what led to the end of your last therapy.*
Mr B	*That's just because my old therapist wasn't flexible – and I guess you're not either.*

Here, the patient is threatening the frame of the treatment in a way that clearly recapitulates a problem that he has in other aspects of his life. The therapist **confronts** this behavior but the patient is completely unaware that it is problematic.

Limited awareness of the cause of the problem

Ms C	*Why can't I have a relationship? All my friends are getting married and I can't even get a third date. And I thought that the second date went really well. I'm so frustrated!*
Therapist	*Could you have misperceived how well things were going on that last date?*
Ms C	*Maybe – but I really can't think of why I would do that. Something is clearly wrong but I haven't the vaguest idea of what it is.*

Unlike Mr B, Ms C knows that she has a problem – in this case with relationships – but she doesn't know why. Again, the therapist **confronts** the problem, but Ms C has little ability to deepen her awareness of the cause.

What do we listen for to know that we are in this phase? As illustrated in the above examples:

- **Affect:** Affects like frustration, anger, hopelessness, and incredulousness are typical of this phase. Patients may also sound stubborn or willful as they seemingly refuse to acknowledge awareness of their difficulties.

- **Limited capacity to associate:** During this phase, our invitations to patients to deepen their associations are often met by shallow responses, such as ''What do you mean 'can I say more about that?' What's there to say? My boyfriend is just a jerk.''
- **Resistance:** Prominent resistance is the rule during this phase. Since resistance is the mind's way of keeping things out of awareness during therapy, we can think of it as the person's way of staying in Phase 1. Listen for all kinds of resistance – from silence to lateness.
- **Externalization:** A good indication of lack of awareness is the patient's insistence that problems are arising from external sources. ''I'm always late because the mass transit system in this country is a mess,'' ''Women are fickle – that's why all of my relationships have failed,'' and ''The problems in my marriage all boil down to my mother-in-law'' are examples of this.
- **Countertransference:** Our own frustration, irritation, and hopelessness about our ability to help the patient are also potential indications of this phase.
- **Patterns:** Listening for patterns is crucial for this phase of the working through process.

Example

Ms D complained to her therapist that her thesis advisor was unfairly treating her. The therapist recalled that the week before she had complained about the fact that her landlord preferentially fixed leaks in her neighbor's apartment.

Listening in this way helps us to understand that something is going on that the patient is unaware of.

Phase 2 – increasing awareness and practicing

In this phase, we can listen for clues that patients are gaining increased awareness of their problems and that they are starting to practice new ways of functioning:

- **Insight:** Insight is indicated by increased self-awareness of problems and/or causes. Phrases that start with ''I realized that . . . '', ''I'm starting to figure out . . . '', and ''It's starting to make sense to me that . . . '' are all good indications that insight is developing.
- **Continued frustration:** Despite burgeoning insight, this phase is often characterized by a continuation of ''old'' habitual thought or behavior patterns. In fact, it is the *discrepancy between increased insight and continuation of old behaviors* that is the *sine qua non* of this phase. Here are some examples:

Last night when I was talking to my mother I knew that she was just pushing my buttons but I still couldn't help myself from getting annoyed with her.

When I was flirting with that girl at the bar last night it felt different – this time I knew that she was the wrong kind of person to get involved with but I just kept it up.

When I woke up half an hour late for the session, I knew that it was because I was upset about what we talked about yesterday.

These patients have *insight* into their behavior but still haven't *changed* their behaviors.

- **Shame and depression:** Increased insight can often provoke shame as patients come face to face with problematic thoughts and behaviors. Far from being signs of regression, these painful affects generally signal that patients are moving forward and allowing themselves to be more aware of unconscious, maladaptive patterns. For example:

  Mr E became depressed as he realized that his estranged relationship with his brother was the result of his own provocative behavior.

- **Anxiety and fear:** Beginning to try something new always comes with ambivalence – and anxiety is part of that.
- **Excitement:** Increased insight can also produce feelings of excitement and mastery, as patients begin to glimpse the light at the end of the tunnel. For example:

  Ms F looked pleased and proud as she reported to her therapist that their work on goal setting made her realize how much this could help her in other aspects of her life.

- **New behaviors and thought patterns:** This phase is characterized by a mosaic of old and new patterns. Remember that development is not linear – after patients try out new ways of thinking and behaving they often revert to their tried and true patterns. No need to think of these as a regression – this forward and backward motion is part and parcel of this phase.

Phase 3 – lasting change in thought and behavior patterns

What can we listen for to know when things have changed?

- **No fanfare:** When change happens, it usually happens quietly. As opposed to the high affect/anxiety states associated with maladaptive patterns of thought and behavior, patients often notice change in hindsight. They are often surprised to realize that they have behaved in a new way, so we have to listen very carefully for it. For example:

  Ms G, who had been obsessively worried about leaving her son with a babysitter for much of the treatment, reported on a wonderful weekend away with her husband. When her therapist asked about whether she had been worried about leaving her son, she realized that, although she had carefully arranged the childcare, she hadn't worried about it at all.

- **Decreased anxiety and affect about previously charged topics:** As above, it's often the *lack* of affect about things that were previously highly charged that we have to listen for.

- **Countertransference:** Noticing that our patients have changed often makes us feel proud. Change that might lead to termination may also induce feelings of loss as we anticipate the impending separation from someone we have worked with for a long time.

Reflecting

When we reflect on working through, we try to think about what phase of the process we're in. Is the anxiety we're hearing indicative of a lack of insight, or the fear that accompanies trying something new? Is the patient tolerating the process of change, or do we need to support ego function? Would sharing observations about the patient's progress help or hinder the process? As always, the choosing principles can help guide your decision making – staying close to affect, surface material, and your counter-transference will help you to understand how the patient is feeling. But here the readiness principles and your history with the patient will be your best guide. Where are you in the treatment? Is this something that you've been working on for a while? Does the patient's way of talking about it sound new? Does it sound like the level of insight has increased? As always, use your moment-to-moment understanding of the patient's ego function to help you decide whether to support or to uncover. Here are two contrasting examples:

> *Ms H comes to her third psychotherapy session in a state of high anxiety. ''Based on what we talked about last week, I realized that my parents really screwed me up and I decided to confront them. They screamed at me and hung up and now I'm a mess.''*

In this example, the patient and therapist have very little history with this – or any other – topic. The insight seems premature, as does the action, and it has produced intolerable anxiety for the patient. As the therapist reflects on what he has heard, he decides that the patient is still likely to be in the phase of limited awareness.

> *Mr I, who has been in psychotherapy for three years, comes to his therapy session and says, ''I'm feeling anxious today because I realize that I was angry with you after the last session. I figured it out once I got home and worried about it, but I thought that after all this time I really should discuss it with you despite the fact that that makes me nervous.''*

Here, the therapeutic alliance seems strong, and the history is extensive. The therapist sees that something new has happened – the patient, who was generally loath to discuss his negative feelings about the therapist, tries to do this despite his attendant anxiety. The therapist decides that the patient is in the phase of increased awareness.

Intervening

Although we will outline specific interventions designed to facilitate working through, one of the most important things that the therapist can do to promote this process is to have *patience*. Repeating the interventions described in this

book, whether supporting or uncovering, over and over in a way that respects the tremendous difficulties that human beings have in altering habitual modes of thought and behavior is what will ultimately help patients to achieve lasting change in their mental functioning. Like a patient parent or coach, the therapist should presume from the outset that these repetitions are part of the process. Thus, they are an expected aspect of the therapy, rather than the result of the stubbornness of the patient or the incompetence of the therapist. This stance not only indicates an understanding of the mechanism of action of psychodynamic psychotherapy, it also helps to reduce countertransference frustration and transference shame. As you read the following examples, think about the different ways in which the therapists convey this need for repetition to their patients:

Mr J *So there I was again, screwing up a job interview. I knew what was happening, but the guy was such a jerk I couldn't help myself.*

Therapist *That's the third time that's happened since you started therapy – if you keep that up you'll never get a job. We'd better work on that.*

This therapist understands the pattern, but her intervention is borne of frustration. The therapist sounds exasperated and blames the patient for something that may well be out of his control. Here is another possible intervention:

Therapist *That sounds like it was really frustrating. But it wasn't the same as before because this time you knew what was happening. Why don't you tell me more about the interview so that we can learn what happened to help you next time.*

This intervention incorporates basic, supporting and uncovering interventions in a non-judgmental way in order to promote working through. It validates the patient's affective experience, confronts the fact that the patient has done something new, calls for more associations, and invites a collaborative process.

The aim of our interventions in the working through process can either be to support ego function with the goal of having the patient internalize the support over time, or to make unconscious processes increasingly conscious so that new adaptations can become habitual. Here are some specific interventions that we use to facilitate the working through process:

Supporting interventions

Encouraging and **praising** the patient's attempts to think and behave in new ways is extremely helpful in this process. These interventions can be quite varied. Consider the following:

It's terrific that you were able to stop yourself from binging after your exam this time.

The way you're talking about your mother today is quite new and represents a real shift in your thinking.

Marking ways in which mental functioning is changing is useful whether the dominant therapeutic mode is supporting or uncovering. Any supplying intervention

that promotes this aim can be used. Assisting interventions can also help the process:

> *I see a real change in the way you went about working on that project. Let's go through how you did it in order to help you understand how new your approach really was.*

This is a **collaborative intervention** that aims to help the patient to understand his own progress and to break it into component parts.

Uncovering interventions

Confronting and **clarifying** new ways of thinking and behaving help to interest the patient in the changes that are going on in his/her mind. For example:

Patient	*I wanted to call and call him until he answered but I didn't.*
Therapist	*You waited – that's new for you.*
Patient	*You're right – I didn't realize that – I just did it. Last year I couldn't have tolerated waiting.*

The therapist's **confrontation** of the new behavior invites associations and promotes uncovering of something new – the realization of change.

Interpretations of many sorts can also aid this process. Interpretation of resistance to change is often important here, as is interpretation of resistance to recognizing change. Here are two examples; the first highlights the resistance to change:

> *It's hard for you to think of yourself as dealing with your boss in a new way because you can't imagine behaving in a way that's different from the way you acted with your mother.*

The next interpretation highlights the resistance to the recognition of change:

> *It's hard for you to see the new ways you're behaving with your boss because you worry that it's a betrayal of your mother to behave in a way that's different from hers.*

All patients need to know that they're progressing. Whether you're uncovering or supporting, it's important to let your patients know that they're making changes and that you recognize it. How do you know when enough change has occurred and you're ready for termination? That's the subject of the next chapter.

30 Termination

Key concepts

Termination is the final phase of psychodynamic psychotherapy.
The major work of termination includes:

- ending the treatment
- consolidating goals
- reviewing the treatment
- realistic appraisal of change and possibility for future change
- planning for future treatment if necessary
- leave taking

The termination phase is usually proportional to the length of the treatment.
Technique alters during the termination phase, reflecting the wish to ''close up'' and finish the work.
Termination can be a time of intense transference and countertransference.

Ending any very intense experience is difficult. Think of graduation from college. After four years of hard work, students and faculty come together in a ritual that involves celebration and sadness, looking forward and looking backward, progression and regression. This tradition is an essential part of the process itself, and it is designed to mark an important moment of passage. The same is true of termination of psychodynamic psychotherapy. After two people – the patient and the therapist – have worked together, week after week for months and even years, it's time to end. As we will see, this period shares many features of a graduation, and it's just as important to mark.

We will talk about several aspects of termination, including:

- How do we decide when or if to terminate a psychodynamic psychotherapy?
- What happens during the termination phase?
- How does our technique alter during the termination phase?
- What are some typical transference and countertransference reactions?

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How do we decide when to terminate a psychodynamic psychotherapy?

Thinking about the goals of psychodynamic psychotherapy is the best way to decide when to terminate the treatment [6, 7]. Although the goals will be different for each patient, we generally think about some common aims:

- **Development of a stronger and more realistic sense of self and others:** This is very often a goal, particularly in patients with significant problems trusting and establishing healthy and mature relationships with others. With such patients, establishing a stable therapeutic alliance despite the inevitable disappointments, empathic failures, separations, and ruptures along the way can often be the central achievement of a psychodynamic psychotherapy. Increased confidence and sense of self is key, as is a consistently realistic appraisal of one's talents and limitations.
- **Improved relationships with others:** This can be evidenced in healthier relationships – inside and outside of the treatment – as well as by shifts in the patient's unconscious expectations of relationships.
- **Shift to healthier, more adaptive defenses:** This is often a main goal of psychodynamic psychotherapy. For example, a patient may come into treatment tending to use very costly defenses and alter this in the course of treatment.
- **Improved function:** Most importantly, we want the patient to have an improved quality of life. This includes symptom alleviation as well as better functioning at work and at play. This may include aspects of life such as improved sexual function, enhanced creativity, and an increased ability to relax.
- **Capacity for self-analysis and self-reflection:** This used to be the *sine qua non* of readiness for termination – that is, that patients are ready to leave when they are able to interpret themselves. Despite the fact that we now think about change in psychodynamic psychotherapy as being about more than interpretation and insight, the capacity for self-observation can still be a clue that termination is near.
- **Independent functioning:** Many patients, especially more fragile and dependent patients, commonly have the fantasy that any gains they have made in the therapy will disappear without the continued presence of the therapist. Patients may be nearing termination when they accept their gains as their own rather than as being contingent with continued therapy.

Either the therapist or the patient can introduce the subject of termination. When the patient brings this up, it is important to understand the motivation for this wish. Early in the treatment, this can be a resistance – the desire to leave before there is too much dependency, for example, or the wish to leave to avoid uncovering of painful affects. Knowing whether the request for termination is a resistance or whether it is a reasonable time for the patient to finish takes time and experience; however, a few rules of thumb are helpful here:

- **How far into the treatment are you?** If this is a few weeks or months into a psychodynamic psychotherapy, consider the possibility that this may represent

resistance. Since this treatment often takes some time, if you've just gotten started and the patient is talking about termination, it's worth trying to understand the context in which this is coming up. Patients will sometimes have what is called a ''**flight into health**'' after beginning treatment that makes them feel as if they have solved all of their problems. When this happens, we can acknowledge the good feelings while also suggesting that this might just be the beginning of more exploration and change. The prospect of a ''long-term treatment'' may be exciting at the beginning, but soon the ''long'' takes over and can feel oppressive to the patient. Think of your excitement at the beginning of a long hike versus the fatigue at hour 6 or 7 – you can empathize with this frustration and remind the patient that lasting change often takes time. Since our goal is generally to change lifelong patterns of behavior, one useful comment can be, ''You know, it took you 34 years to develop these patterns – we'd be surprised if you could change them so fast!'' At the same time, don't forget the occasional patient can get the help he/she came for in just a few sessions.

- **What is the context of the discussion of termination?** If patients begin to talk about termination right after beginning to explore something painful, or if they start new relationships in the context of the treatment and then want to terminate – think about resistance.
- **How does the patient talk about the wish to end therapy?** Asking patients their ideas about termination or why they want to terminate is central to your technique in this situation. Time and money concerns are often at least partially real, but can also hide other fears and anxieties.
- **What is the patient's affect?** Is the patient angry with you? Is he/she dismissive? Patients who have worked well with you in a psychodynamic psychotherapy are usually quite ambivalent about termination – they are generally grateful, eager to ''try it on their own'' but also pretty sure that they will miss you. If you don't pick up this kind of three-dimensionality, think about how this might not be the time to end.
- **What is your countertransference?** Are *you* angry with the patient? Are you relieved that he/she doesn't want to continue? Do you feel hurt, or sense that things are being disrupted midstream? If so, there is likely to be more here than just a wish to terminate. Often, the therapist who has worked well with a patient has complementary feelings to those of the patient – there is pride that things have gone well and that the patient has improved, accompanied by the anticipation of loss. Think of the parent who is proud of a child who is moving ahead but will miss the fun of that phase, or who is vacationing with a child who will go off to college in September. If these are not the kinds of feelings you're having, you might consider the idea that something else is going on that has to do with whether the patient is really ready to terminate.

The technique for discerning these distinctions relates to the technique that you have been using throughout the treatment:

- **Listening:** Listen for affect and ask questions to get more information about thoughts, feelings, and fantasies related to the idea of terminating. Often the

patient will have dreams relating to termination that can be helpful. For example, a dream of escaping from something versus a dream of taking a tearful leave of beloved relatives can mean different things about readiness to terminate.

- **Reflecting:** Process what you've heard to determine what's closest to the surface and where the dominant affect is. Think about whether what you're hearing is defensive and thus related to a resistance against deepening the work.
- **Intervening:** Tread lightly here – we always want to take the patient's wish to terminate seriously, and not just ''interpret it.'' If the patient is ultimately going to agree that it is not time to terminate, you want to give him/her a face-saving way to change his/her mind. If you think that the wish to terminate is resistance, then you will ultimately interpret this.

Sometimes, the patient will want to terminate before you think he/she is ready. Perhaps you think that there is an active resistance or that the patient has more work to do. You will do best to explore the wish to terminate, and then to gently confront and interpret the resistance. For example:

Patient	*How long will I have to keep coming here twice a week? I feel much better and it's so hard to get here in the morning.*
Therapist	*Things have changed for you, that's clear – but I have a feeling that you've been talking more about the wish to stop therapy ever since you started dating Maya.* (**empathic remark, confrontation**)
Patient	*Maybe – I think that I'd rather that she didn't know that I was seeing you.*

Here, the therapist acknowledges the good feelings but connects the patient's wish to terminate with the potential shame of telling his new girlfriend that he's in therapy.

In some cases, the wish to stop treatment is actually an expression of entrenched expectations about people and relationships. For example, a patient who tends to feel that others will trap him or not allow him to do what he wants will often begin to itch to leave as the transference deepens. This can be the crux of the treatment for a patient like this and is thus very important to understand and potentially interpret. Consider the following example:

Patient	*I feel like I'm stuck here – like even if I want to leave you won't let me.*
Therapist	*Let you?* (**confrontation**)
Patient	*Yeah – like I have no control in this situation.*
Therapist	*Of course you know that you can stop therapy anytime you like – but I'm struck by the fact that you're having that same feeling about your girlfriend.* (**empathic remark and clarification**)
Patient	*It's all on her terms – ever since we got serious, she makes plans for us all weekend – what if one night I just want to go out with the boys?*
Therapist	*Maybe you're feeling the same way with me too.* (**transference interpretation**)

In this situation, it is clear that the wish to terminate is analogous to the characteristic expectation that getting close to someone will mean loss of autonomy.

Giving the patient some encouragement to stay is not against the rules. If you really think that the patient is about to leave and you think that it's not a good idea, you can tell him/her that you think he/she should stay. The idea is not to rigidly avoid saying things like this, but rather to remain consciously aware of the ways in which they could be manifestations of the transference, the countertransference, or both. For example, therapists might try to convince patients not to terminate because they have affectionate feelings for them, or because they feel guilty that they haven't done a good enough job in the therapy. Real-life factors, such as potential loss of income or academic credit could also fuel the therapist's countertransference in this situation. Staying alert to the possibility that countertransference feelings are informing your ideas about a termination is key to handling the situation in the best way possible. Having extremely strong feelings about this or getting into a power struggle with the patient should signal the need for discussion of the case with a supervisor or peer.

It's also important to remember that patients are likely to react strongly – both positively and negatively – when their therapists suggest that they should stay in treatment rather than terminate. Exploring these feelings can deepen their understanding of the transference.

Example

Mr A is a 42-year-old man who never felt that his parents cared whether he finished things or not. During sessions in the second year of therapy, he pushes to terminate. Here is a segment from that point in the treatment:

Mr A	*This is done – I've changed enough and I have so much do to in the rest of my life.*
Therapist	*I'm surprised that this is coming up now, because it seems to me that you're just starting to get to some of the issues that brought you here to begin with. I think that this is an important time for you in therapy and that it would be helpful for you to continue. Do you have any thoughts about that?*
Mr A	*What do you care? You can just fill the slot with someone else – they might even pay more than I do.*
Therapist	*I think that you're feeling that I, like your parents, don't care whether you continue or not.*
Mr A	*You're right – they never did. I quit all sorts of things and they didn't care as long as it didn't upset their tee-times.*

Mr A decided to stay in treatment. Here's a segment from a session six months later:

Mr A	*I had a dream last night that we were finishing the session and you asked me to stay for another 5 minutes.*
Therapist	*What are your thoughts about that?*
Mr A	*I thought about it this morning and remembered that session when you said that you thought it was important for me to stay in therapy. I almost quit – just at the wrong time. I was surprised that you said that.*
Therapist	*It felt new to you – you always felt that your parents were indifferent to whether you quit things or not.*
Mr A	*Yeah – it made me almost unable to understand that it mattered to you.*

In this case, the way in which Mr A and his therapist ultimately explored and understood his reaction to the suggestion that he stay in treatment led to an important shift in the transference and in his expectations of others.

If these techniques do not work and patients want to leave treatment, then let them – provided you think that this is a safe choice. There are two types of terminations:

- **Bilateral terminations:** Clinician and patient agree that goals have been attained and the treatment is ready to end. In time-limited treatments, this is set at the onset of the treatment; in open-ended treatments this is decided during the course of the treatment.
- **Unilateral terminations:** Clinician or patient terminates the treatment for some reason. This could be because a trainee is finished with his/her program, or because the patient is moving away [8].

Life and therapy are long – sometimes patients have to leave in order to figure out that they want to come back. If you are respectful of their wishes while demonstrating care and interest, they are more likely to return. Always let them know that your door is open – even if the termination is unilateral.

How long should the termination phase be?

The length of the termination phase should generally be proportional to the length of the treatment. Thus, a seven-year treatment might have a termination phase of a year, while a one-year treatment might have a two-month termination phase. Planning the termination phase gives the patient adequate time for reviewing, mourning, and leave taking [8]. Working together to choose an actual termination date makes the end a clear reality and facilitates this phase.

Technique

Listening during the termination phase

The termination phase begins when you and your patient decide that it is a good time to end the treatment. In the case of unilateral terminations, this happens when an imposed deadline (like the end of an academic year for residents or the patient's graduation from school) necessitates the end of the treatment. Although these are very different situations, enough aspects are similar that we will consider them together. Regardless of what instigates it, the termination phase is a time for closure. This is very different from the rest of treatment, when our whole technical approach is designed to be open-ended. While we still want to be somewhat open-ended, there are things that come up in the termination phase that you will not have adequate time to deal with and will thus handle in a different way. Despite the fact that the termination phase is a time for closure, important work can happen during this time.

There are some typical things that happen during termination – knowing about them will help your listening during this affect-filled phase:

- **Regression:** Without fail, patients in the termination phase regress to symptoms and transference manifestations that neither patient nor therapist has seen for months or even years. This can derail the inexperienced therapist, who may worry that this means that the patient is not ready for termination. On the contrary – it is absolutely characteristic of this phase. Patients who were late during the induction phase will suddenly start to come late again; patients who hadn't questioned your billing or cancellation policies in years will resume arguing about them. Anticipating regression and the way in which it covers other feelings can help you to ''hear it'' during the termination phase.

  Example

  Ms B, who had been very skeptical of her therapist's interest in her during the first year of treatment, had come to trust him and had spent a great deal of time during the termination phase talking about the way in which he was one of the first people who really cared about her. Three months prior to Ms B's termination, the therapist uncharacteristically picked up a phone call during one of Ms B's sessions. The therapist was surprised when Ms B became enraged about this, saying that the therapist's caring was ''all a charade'' and that perhaps she should just end now. Exploration of this revealed Ms B's fantasy that the therapist was now more interested in other patients, and her jealousy that someone else would have ''her time.''

- **Mourning:** Patients often become very sad during termination. Therapists will do well to remember how important they are to their patients – this is often most apparent during the termination. Tearfulness and feelings of loss are the norm. Occasionally, a patient will become depressed during this phase – always be on the lookout for the need for medication, though these feelings may also subside on their own. When you think about it, termination is a very strange thing to do – two people develop a very intense, meaningful relationship – and then they don't see each other again. Previously, a patient's wish to see his/her therapist after termination was thought to indicate that the treatment was unfinished; now, however, it is very common for patients to return for ''check-ups'' during stressful or exciting times in their lives. If the patient is on medication and the therapist is also the prescriber, monthly medication checks may continue even after the formal period of therapy concludes. However, even with the possibility of occasional visits in the future, the end of the therapy proper is a loss for the patient. It may be that no one has ever listened to the patient as intensely as the therapist has, or that no one has ever been as regularly interested in his/her life. Even if new relationships have been found thanks to the treatment, the therapist needs to remember that the loss of the therapist is a *real* loss and thus that mourning is natural and expected. In fact, if the patient does not talk about feelings of loss and mourning, the therapist should suspect resistance to these feelings.

  Another thing that is mourned during the termination phase is the fact that while some things have changed, others have not [8]. The loss of the fantasy of endless possibilities is often very difficult. The end of therapy is generally a

time when people come to terms with their capabilities *and* their limitations. The fact that they still have difficult parents, or that the person that they married during therapy is not as empathic as they would have imagined, can bring on feelings of resignation. This is true of unconscious fantasies as well – there may be disappointment that the therapy did not completely cure the person's shyness or that a symptom still emerges in times of stress. This can be also very difficult for therapists, particularly if they have their own fantasies about how they wanted to optimally help the patient. Exploring these fantasies in our patients and in ourselves is the best technique at this point – along with acknowledging the affect and attendant disappointment. Remember that therapy, like mothering, need only be ''good enough'' – so disappointments are inevitable. Just as the child's disappointments with the good-enough mother help him to develop, so too do the patient's disappointments with the therapist and therapy help him/her see the therapist more realistically and to separate during the termination phase.

- **Finding a replacement relationship:** It makes sense that a person anticipating a loss might want to find a replacement – and the therapist is wise to listen for this. As in the beginning of treatment, it is common for patients to find new friends and lovers during the termination phase. Listening and anticipating this can help the therapist to point out the connection between the new relationships and the loss of the therapist. This does not necessarily negate the worth of the new relationships, although knowing the connection can help patients to look more objectively at these relationships to evaluate their depth.

Reflecting during the termination phase

As with listening, reflecting during the termination phase is aided by knowing that this phase has distinct characteristics. We still use the choosing principles and the readiness principles to think about where to focus, but during this time we pay special attention to the *phase of treatment*. Just as we filter most things that we hear at the beginning of treatment through the lens of beginning, we now filter what we hear through the lens of ending and we think about everything we hear as if it might relate to the termination. How might this affect be related to ending the treatment? How might this dream relate to feelings about termination? How might this new relationship be compensating for loss of the therapist? How might this symptom be a recapitulation of an old symptom in the context of regression during the termination phase? Although we might not comment on this every time that it occurs, we give priority to termination-related themes during this time. This is because they are likely to be dominant and because this will help the patient to make sense of many of the feelings and fantasies that are related to ending the therapy.

Example

During termination, Mr C has a dream that he is an astronaut who is about to go on the first manned mission to Mars. His associations are to excitement about the trip, but as he is strapped in to the rocket, he realizes with a start that he is alone. The therapist's reflection about this dream is that this relates to the ambivalence of termination – the excitement of new possibilities, alongside the anxiety of ''going it alone.''

Intervening during the termination phase

As with the other phases of therapy, we use basic, supporting, and uncovering interventions during the termination phase. Since a goal of the termination is to close the treatment, we can think of ourselves as somewhat limiting our interpretive comments to themes related to termination. When the patient opens up new areas during this time, we may limit exploration, trying always to relate them to themes that have been worked on and to the work of termination.

Example

A patient in the midphase of treatment says, ''I have a funny feeling – as if I'm falling off a cliff.'' The therapist reflects that this is a new theme and says, ''Can you tell me more about that?''

A patient who is terminating in two weeks says, ''I have a funny feeling – as if I'm falling off a cliff.'' The therapist reflects that this is likely to be related to ending the therapy and says, ''I wonder if this has to do with the fact that we won't be meeting after next week.''

The therapist will still do well to call for associations in order to make sure that the affect or fantasy is related to termination, but once this seems certain, it makes sense at this point in the treatment to relate it to the termination rather than just opening it up for further associations.

In psychodynamic psychotherapy we often adopt a neutral stance and steer clear of praise or judgments to facilitate the patient's ability to fantasize and associate freely. However, since this is somewhat less essential during this phase, termination is a time when the neutral stance can be somewhat relaxed. Remember that the neutral stance has a purpose and when that purpose is less essential the therapist can be somewhat freed up to be a little less neutral. For example, we generally do not want to guide the patient's free associations *because* we want the patient to go wherever their associations take them. This is essential to the technique of uncovering psychodynamic psychotherapy in that it helps us to move into the unconscious. However, a goal of the termination phase is consolidation of gains, and thus guiding the patient toward review of the treatment and gains becomes an important technical tool. Thus, the therapist during this phase will help the patient to understand him/herself, the treatment, and his/her gains by directing the patient to review the treatment.

Example

Patient	*It was so funny at the bar last night – I could see from 10 yards away that guy just wanted a one-night stand. So I just looked away and kept talking to my girlfriend.*
Therapist	*That's very different than the way you looked at things a year ago.*
Patient	*You're right – I didn't think of it that way – I guess that there has been a change.*
Therapist	*It's a big change – it's hard to see when you're in it, but we might take some time during these weeks to think about the ways in which you're seeing things differently.*

This technical maneuver is distinctly different from the technique during the midphase of the treatment and can be very helpful and consolidating for the terminating patient.

The relaxation of some aspects of neutrality also means that the technique of the termination phase can be filled with a bit more humor and mutuality. By this stage of the treatment, you and your patient have been working together for a long time – there is a lot of trust and the therapeutic alliance is strong. Therapist and patient often have ''short cuts'' at this point – ways of talking about things that they've gone over many times. A comment like, ''there's that fear of commitment again'' might be premature during the early phase of treatment, but once you've commented on it a few hundred times, you and your patient know exactly what you're talking about. Similarly, you may be able to interpret dreams and fantasies more quickly without as many associations when you and your patient both recognize certain patterns. At the very end of the treatment, patients often ask therapists personal questions that the therapist may be a bit more likely to answer than early in the treatment. Again, our decision during most of the treatment *not* to answer personal questions is not arbitrary – it has a rationale that is based in our theory of technique. Early in treatment, the goal is to allow the patient to fantasize as broadly as possible about the therapist in order to foster the development of the transference. However, as therapy comes to a close, there is no reason not to answer the patient who asks, ''So where are you going after your training?'' While this is a bit of a tightrope walk, you should think about why you're saying what you're saying. No need to be a ''blank slate'' at this point – but you also want to protect your boundaries. This is good for the patient, who doesn't need to be burdened by knowing too much about you, and it's good for you, since you deserve to have your own private life. So when the patient asks what you're doing next, you might say, ''I'm going to be working on an inpatient unit'' or ''I'm going to work as a therapist in a community clinic.'' This amount of information tells them that you are a person whose life is continuing and that you value the relationship enough to share this piece of information with them. Remember, however, that patients who terminate may return for treatment months or even years later. Continuing to generally maintain anonymity helps to keep the door open for future work with you [9].

Ending and supporting

It is important to recognize that for various reasons some patients cannot – and should not – be pressed to talk about their feelings of loss around ending the treatment. For patients who have trouble forming attachments, any admission that the therapist has become important to them may be intolerable; other patients need to think they improved by themselves. With patients who continue to struggle with managing painful affects, the therapist might choose to **supportively bypass** the patient's difficult feelings about ending, instead emphasizing the gains made and the therapist's ongoing concern and availability. It may be useful in certain situations to taper visits gradually and plan to continue meeting with the patient at least intermittently until the patient indicates that he is ready to stop. As with people with

chronic medical illnesses, termination may not be recommended for those patients who require ongoing support from the therapist to maintain stability [10].

Choreographing the last sessions

It is often useful to ask the patient if they have any thoughts or fantasies about the last sessions. Some patients hope that you will hug them, while others fear that you will try to. Here, as before, good boundaries are key – the therapist should not initiate any physical contact beyond a handshake at the door. Don't underestimate how meaningful that handshake can be to a patient. Allowing the patient to talk about the wish for a hug will usually allow the two of you to talk about it and what it means rather than actually having to engage in it. Patients may also give you a gift. If they give it to you at the beginning of the last session, open it with them and have them tell you about it. No interpretations now – ''thank you'' will do. Again – the time for uncovering has come to a close. The gratitude may be tinged with a still not completely explored fantasy or expectation – but it is also real and should thus be acknowledged.

Communicating your thoughts about the treatment

Many therapists use the last session or the last few sessions to tell the patient something about their impressions of the treatment. This often includes thoughts about changes that have occurred in the patient's emotional life and functioning in the world. It can also include ideas about what things might prove challenging to the patient in the future, as well as some thoughts about the therapist's experience of the therapy. Here is an example:

> *In the last few weeks, you've been talking so much about what has changed over the course of this therapy and what it's meant to you. But before we stop, I wanted to say something about that, too. When you first came, you were on the verge of losing your job and your relationship – and you've learned so much about why that was happening. It's been remarkable and rewarding to see the way in which learning more about yourself has helped you to improve your relationships and so many other aspects of your life. As we've discussed, things may come up in the future that may put stress on you and make some of those ''old ways'' come back – but I have confidence that our work together will help you to recognize when that's happening. Those might be times that you want to drop in here for a few sessions to get back on track – that will always be fine. I also want you to know that it has been a pleasure to know you and to be your therapist, and that I've learned a great deal from our work together.*

Of course, never say something you don't believe, but try to emphasize the positive in what you are able to say. All through the therapy, you presumably have been trying to help the patient to see that his or her relationship with you is real – now is the time to put your money where your mouth is. Real people in real relationships take leave of *each other* – so it's natural for the therapist to comment on the leave-taking

as well. Again, though – say just enough to convey this within the context of good boundaries

In sum, the termination phase is marked by:

- listening for new things – like regression and mourning
- reflecting on how the patient's words can be linked to the work of termination
- intervening in ways that facilitate consolidation of gains, closure, and leave-taking
- strong transference and countertransference, so supervision can be very helpful during this time to help you to metabolize your feelings and to take leave of your patient in a meaningful way that also maintains boundaries.

Suggested activity

Read the following and think about how you would respond if the patient were:

- in the midphase of the therapy
- in the termination phase of the therapy.

Patient 1

Last night I was on the train going home from work and I had this memory of the last night of camp. You know, the bonfire – you look forward to that bonfire all summer – plan songs, and so on. But it's also sad – you won't see all of these close friends for another year. I haven't thought about that in a long time.

Patient 2

You are really annoying me today. You're totally off base. You haven't annoyed me like this since we started the treatment. Sometimes I wonder if you ever understood me at all.

Comment

Patient 1 is having a memory about the ambivalence of leave taking. In the middle of the therapy, you might ask for more associations in order to understand why this is coming up at this time, or you might confront the temporal relationship between this memory and something that is happening in the patient's life and/or the therapy. In the termination phase, you might first consider whether this memory is coming up in relationship to the termination. You might say:

This camp memory is about the ambivalence of leave taking – it's exciting but also involves leaving people you care about. I wonder if that reflects something about the way you feel about leaving me?

Patient 2 is feeling angry about what she perceives as your inability to understand her. In the middle of the therapy, you might validate her feelings and ask her to tell you more about them. You might also think about why these feelings are coming up at this time. In the termination phase, this is likely to be related to ending the treatment. It could relate to

disappointment about things that were not fully worked through, or the patient's anger could be defensively covering feelings of mourning and loss. How you respond would depend, of course, on the therapeutic alliance that you had with the patient throughout the treatment. Presuming that the patient generally had felt that you did understand her, you might consider this to be a regression, particularly since the patient references her feelings about you from the earliest phase. You might say:

> *You're certainly very frustrated with me today, and it could be that I've been off base. But you're right – you haven't been this frustrated with me for a very long time. I wonder if it could be related to feelings you're having about the fact that we're only going to be meeting for a few more weeks?*

31 Continuing to Learn

By this point, you've learned a tremendous amount about psychodynamic psychotherapy. You've learned to evaluate patients and to begin the treatment; to listen to what patients say, reflect on what you've heard, and intervene in order to uncover unconscious meanings or to support weakened ego function; and to use these tools to achieve important therapeutic goals such as improving self esteem, relationships with others, and characteristic ways of adapting. Now you can take these skills into your clinics, offices, inpatient units, or wherever you work to continue the process of becoming a psychodynamic psychotherapist. Doing this work means learning something new every day. Each patient presents new challenges; each treatment teaches us new things. Ultimately we learn from our supervisors, our patients, and ourselves.

Learning from our supervisors

The best way to complement what you've learned by reading this manual is to conduct psychodynamic psychotherapies with patients of your own. In doing this, you will be greatly helped by supervision. There are many types of supervisors. Trainees generally have one or more assigned supervisors. Some of these supervisors may be experienced psychotherapists, although they may or may not have expertise in psychodynamic psychotherapy. Graduates sometimes seek out private supervision or they may present cases to peers. There are several ways in which supervision will enhance your learning in psychodynamic psychotherapy. First, experience helps. Until you accumulate experience of your own, you can lean on your supervisor's expertise. Second, discussing the case with another person will foster reflection about the case. This can be done with a more experienced person or with one or more peers. When you're very close to a case, you can't always accurately assess your countertransference, and thus talking to trusted teachers or colleagues can be invaluable. Even after your training is completed, seeking out supervision for help with particularly challenging cases should be something that you always feel comfortable doing.

There are many ways to share your work with your supervisors. General discussion of the case is helpful; however you should also examine some verbatim session material together. This will allow you to analyze what you heard, how you reflected, and what interventions you chose. You can use notes (written either when you're with the patient or immediately after), video, or audiotape. You and your supervisor can discuss what will work best in your particular situation.

However you share your work, being a proactive learner will help you to get the most out of the supervisory experience. Too often, learners think that their supervisors

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are there to ''tell them what to do.'' Analogous to our ''supplying and assisting'' model of supporting interventions, sometimes a supervisor will make suggestions, but a collaborative model is generally most helpful. If you are a supervisor, you can foster collaboration by having clear goals for the learning experience. Here, the various models presented in this manual can be helpful to you:

- **For evaluation**: the Problem → Person → Goals → Resources model
- **For technique**: the listen/reflect/intervene model, the choosing and readiness principles, and the concept of uncovering and supporting interventions.

If you are a supervisee, try sharing some of what you've learned in this manual with your supervisors by asking them questions like:

- What did you hear when the patient said that?
- How would you process that?
- How would you choose what to say?
- What did you think about what I said?
- I was confused about what to say there – can we hone in on that moment?
- What kind of intervention would you call that?

Here is a segment from a session between a therapist and her supervisor:

The therapist is a 40-year-old woman who has been treating a 28-year-old man in twice a week psychodynamic psychotherapy for two years. In the last few weeks, she has not been looking forward to this patient's sessions.

Therapist *It's interesting – I usually really enjoy working with this patient, but for the last few weeks I haven't been feeling that way. Once last week, I even thought, ''Oh no, it's Monday – Mr. A is coming today.'' But I'm not sure what's going on.*

Supervisor *This is a great thing to talk about. Do you have any sense of something that's happening in his life or in the treatment?*

Therapist *No – that's the funny thing – he's actually working more deeply in the treatment and feeling more connected. That's just what we've been working towards.*

Supervisor *Let's hear some process to see if we can see what's happening. Can you read some material from one of the sessions in which you felt that way?*

Therapist *Sure – here's a segment from yesterday's session*:

Patient *I'm really getting into this now – I look forward to every session – I almost wish that I could come every day. I had a dream that I was sleeping in your waiting area – like there was a little bed in that alcove out there.*

Therapist *Can you say more about the dream?*

Patient *It was really cozy – like you were going to tuck me in.*

Supervisor *Let's stop there for a moment – what do you hear in this material and how did you reflect on it?*

Therapist *Well, there's the dream – being ''tucked in'' sounds like it's from childhood so it probably has to do with an unconscious fantasy of having me take care of him the way his mother did. But we know that his mother was quite neglectful. In the session, his surface affect was excitement – like he's excited to become so close to me.*

Supervisor *I hear that too – your patient is almost breathlessly telling you that he wants a tremendous amount from you – he's ready to figuratively ''move in'' – and you might be pulling back from that.*

Therapist *Well, as you know, I have two children of my own – I don't need another one! I mean, I know that he wouldn't really be another child, but maybe I feel that way.*

Supervisor *Exactly – I think that we're getting to some of your recent difficulties with him and learning a great deal about the patient as well.*

Here the supervisor was able to help the therapist to learn more about her countertransference. The therapist's ability to discuss her feelings openly was key to the process. Notice that the listen/reflect/intervene method can work in supervision as well.

Communicating what you're learning in your classes or from this manual with your supervisor will help you to both be on the ''same page'' and will enhance the supervisory experience.

Learning from your patients

There's an old adage that ''your patients are your best supervisors.'' In many ways, this is true. Each patient will teach you new things about people, their adaptations, their strengths, and their weaknesses. Each therapeutic relationship will teach you about how to interact with patients in order to help them most. If you focus on something too deep, your patients will react by defending themselves in some way – if you attend to this, you can easily right yourself on a moment-to-moment basis. Here's an example:

Patient *I was upset at the end of the last session because you started late and then you didn't give me extra time.*

Therapist *I reminded you of the way your mother focused more on your brother and left you feeling cheated.*

Patient *Whatever – I'm talking about you – my mother wasn't here last time – you were.*

Therapist *You're right – and I'm glad that you were able to bring this up. Can you tell me more about the feeling you had?*

This patient is an excellent supervisor; the affect was in the transference and the therapist focused on a genetic interpretation. Not the time to get defensive – if you listen to the patient you can refocus on what feels most important to him or her.

Learning from yourself

Ultimately, understanding yourself will be your best tool in your work as a psychodynamic psychotherapist. The degree to which you allow yourself to be aware

of your feelings during sessions and your reactions to your patients will be directly correlated with your ability to help your patients. No need to think that you have to complete some process of self-awareness before you begin treating patients in psychodynamic psychotherapy – just as you will keep learning from your patients, you will continue to learn from and about yourself throughout your career as a therapist. That said, it may be helpful, either at the beginning of your training or at any point along the way, to engage in your own personal psychotherapy in order to facilitate your ability to learn from yourself. Some therapists undertake this as a matter of course, while others seek out their own therapy in response to particular challenges they face as they mature as therapists. Some training programs, such as many programs that train psychoanalysts, require personal therapy or personal psychoanalysis as part of the educational experience. Clues that a personal therapy might be helpful include strong negative or positive feelings to most or all of your patients, undue anxiety or depression related to your work, or the tendency to cross boundaries. Just as you will do for your patients, therapists will offer *you* confidential treatment that is likely to enhance your work and your life.

With or without personal therapy, ongoing self-reflection is key. We are all busy, but taking the time to reflect on our work is well worth it. This is as true in the middle of a session as it is in between sessions – we are often so eager to ''say something'' that we don't always take the time when we are with patients to think about what's happening in the moment. These moments of reflection are time well spent and will turn you from a proficient to an outstanding psychodynamic psychotherapist.

Ending

People have searched for meaning since the beginning of time. Psychodynamic psychotherapy helps people to find meaning within themselves – meaning that is present but out of awareness. This quest will always be relevant to people and to how they make sense of their lives. Learn from others, learn from your patients, and learn from yourself as you continue your journey as a psychodynamic psychotherapist.

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