Long-Term Psychodynamic Psychotherapy

A Basic Text

corecompetencies
in psychotherapy

Glen O. Gabbard, M.D., Series Editor

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Contents

Introduction to the Core Competencies in Psychotherapy Series

With the extraordinary progress in the neurosciences and psychopharmacology in recent years, some psychiatric training programs have deemphasized psychotherapy education. Many residents and educators have decried the loss of the "mind" in the increasing emphasis on the biological basis of mental illness and the shift toward somatic treatments as the central therapeutic strategy in psychiatry. This shift in emphasis has been compounded by the common practice in our managed care era of "split treatment," meaning that psychiatrists are often relegated to seeing the patient for a brief medication management session, while the psychotherapy is conducted by a mental health professional from another discipline. This shift in emphasis has created considerable concern among both psychiatric educators and the consumers of psychiatric education—the residents themselves.

The importance of psychotherapy in the training of psychiatrists has recently been reaffirmed, however, as a result of the widespread movement toward the establishment of core competencies throughout all medical specialties. In 1999 both the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) recognized that a set of organizing principles was necessary to measure competence in medical education. These six principles—patient

care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice—are now collectively referred to as the *core competencies* in medical education.

This movement within medical education was a direct consequence of a broader movement launched by the U.S. Department of Education approximately 20 years ago. All educational projects, including those involving accreditation, had to develop outcome measures. Those entrusted with the training of physicians were no exception.

Like all medical specialties, psychiatry has risen to the occasion by making attempts to translate the notion of core competencies into meaningful psychiatric terms. The inherent ambiguity of a term like "competence" has sparked much discussion among psychiatric educators. Does the term mean that practitioners are sufficiently skilled that one would refer a family member to them for treatment without hesitation? Or does the term imply rudimentary knowledge and practice that would ensure a reasonable degree of safety? These questions are not yet fully resolved. The basic understanding of what is meant by core competencies will be evolving over the next few years as various groups within medicine and psychiatry strive to articulate reasonable standards for educators.

As of July 2002, the Psychiatry Residency Review Committee (RRC) mandated that all psychiatric residency training programs must begin implementing the six core competencies in clinical and didactic curricula. Those programs that fail to do so may receive citations when they undergo accreditation surveys. This mandate also requires training directors to develop more sophisticated means of evaluating the progress and learning of residents in their programs.

As part of the process of adapting the core competencies to psychiatry, the Psychiatry RRC felt that reasonable competence in five different forms of psychotherapy—long-term psychodynamic psychotherapy, supportive psychotherapy, cognitive behavioral psychotherapy, brief psychotherapy, and psychotherapy combined with psychopharmacology—should be an outcome of a good psychiatric education for all psychiatric residents.

Many training programs have had to scramble to find faculty who are well trained in these modalities and teaching materials to facilitate the learning process. American Psychiatric Publishing, Inc., felt that the publication of basic texts in each of the five mandated areas would be of great value to training programs. So in 2002 Dr. Robert Hales, editor-in-chief at American Psychiatric Publishing, appointed me to be the series editor of a new line of five books. This series is titled Core Competencies in Psychotherapy and features five brief texts by leading experts in each of the psychotherapies. Each volume covers the key principles of practice in the

treatment and also suggests ways to evaluate whether residents have been trained to a level of competence in each of the therapies. (For more information about the books in this series and their availability, please visit www.appi.org.)

True expertise in psychotherapy requires many years of experience with skilled supervision and consultation. However, the basic tools can be learned during residency training so that freshly minted psychiatrists are prepared to deliver necessary treatments to the broad range of patients they encounter.

These books will be valuable adjuncts to the traditional methods of psychotherapy education: supervision, classroom teaching, and clinical experience with a variety of patients. We feel confident that mastery of the material in these five volumes will constitute a major step in the acquisition of competency in psychotherapy and, ultimately, the compassionate care of patients who come to us for help.

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Introduction

This basic primer in long-term psychodynamic psychotherapy was prompted by the Psychiatry Residency Review Committee mandate that all psychiatric residents must be trained to competency in five different psychotherapies. However, I have written it with a broader audience in mind. Many other mental health professionals—future psychologists, social workers, licensed counselors, nurses, and others—are also in training programs that teach this modality, and they may find this a useful beginning text as well. Indeed, much of the material in this volume has grown out of my weekly experiences with trainees in all the major mental health professions in the Baylor Psychiatry Clinic Case Conference. Each Wednesday morning, a trainee in psychiatry, psychology, or social work presents a clinical problem encountered in psychotherapy that serves as a nidus for teaching the principles of good therapeutic technique. Rather than stipulate what topics will be covered, I have geared the Case Conference to the difficulties that the trainees are struggling with. This approach has taught me a good deal about the common dilemmas experienced by beginning therapists and their needs as students. I have tried to write this textbook with those struggles in mind so that beginners will feel that the case examples and the principles illustrated by those examples will be directly applicable to their learning experience. I have also written this volume with training directors in mind, and I hope that they will find my ideas about evaluating competency useful in their own educational programs.

No brief text can cover a complex treatment comprehensively. Hence I have given a brief overview of theoretical principles in Chapter 1 ("Key

Concepts"), with the advice to readers to consult my companion text, *Psychodynamic Psychiatry in Clinical Practice*, 3rd Edition (Gabbard 2000), for more detailed discussions of the major theoretical models in psychodynamic psychiatry and the approaches to specific disorders. Similarly, the text is meant to be accompanied by didactic instruction and weekly supervision. Long-term psychodynamic psychotherapy is an art that requires intensive teaching and experience, and only with these additional methods of training can one hope to become competent in the practice of this treatment.

Space considerations precluded a discussion of mental health financing or the problems inherent in practicing long-term psychodynamic psychotherapy in an era of third-party intrusions on the privacy of the psychotherapeutic relationship. Despite the fact that resources are shrinking for psychiatric treatments in general, a substantial number of patients continue to seek a long-term therapeutic relationship in which they can feel understood in the privacy of a confidential professional relationship. Moreover, the principles learned in the practice of long-term dynamic therapy—empathy, the therapeutic alliance, unconscious meanings, transference, resistance, and the influence of the clinician's countertransference—are more generally applicable to all treatments in psychiatry.

Although dynamic therapy can also be delivered in group settings, in family or conjoint therapies, and with children and adolescents, I have limited the focus of this text to long-term dynamic work with adults in individual therapy. To venture into the other areas would exceed the space limitations within which I was required to operate. I have also chosen to omit discussions of combining medication with psychotherapy, because another volume in this series addresses that topic comprehensively.

Even with adults in individual long-term dynamic therapy, however, the treatment itself is highly diverse. The theoretical orientation in which one is trained may dictate the way a therapist conceptualizes the patient's difficulties and implements therapeutic interventions. In addition, the therapist's personality places a personal stamp on the therapy conducted. Therefore it is impossible to cover all approaches to long-term psychodynamic psychotherapy in one text. The approach described in this volume draws on several theoretical models, reflecting the pluralism in the field today and my own synthesis of those diverse conceptual frameworks. The therapy taught in this book also reflects my personal style, which has evolved over a quarter century of practice in which I have learned a great deal from trial and error. Some readers will have valid disagreements with how I do things, and I fully accept those legitimate differences in perspective.

I owe a special debt of gratitude to my colleagues and students in the Baylor Psychiatry Clinic, who sustain my enthusiasm for teaching and treating patients on a daily basis. I am fortunate to work in a setting where mutual support, good humor, and dedication to patient care are the order of the day. Some of my colleagues were kind enough to read early drafts and make valuable suggestions about the text. These include Drs. Linda Andrews, Kristin Kassaw, Kim-Lan Czelusta, and Jason Garvin. I am grateful to them for pointing out omissions and blind spots. I also want to thank some of my outstanding students for providing some of the clinical vignettes in the book. Among these contributors are Drs. Ali Ashgar-Ali, Faye Brown, Kim-Lan Czelusta, Estelle Cline, Theresa Lau, Rebecca Maxwell, and Daniel Rogers. I also owe a special thanks to Bob Hales, editor-in-chief of American Psychiatric Publishing, and John McDuffie, editorial director, for their steadfast support and wise counsel during the development of this book. Like most writing projects, this one has been a team effort. Diane Trees Clay, my dependable and always optimistic assistant, typed many drafts of this book and was a continual source of comfort at times of discouragement.

Lastly, I want to express my appreciation to my patients, who have taught me more than any of my professors or colleagues over the years. I thank them for tolerating my mistakes of tact, judgment, timing, and interpretation and for their patience while I learned the art of long-term psychodynamic psychotherapy.

Reference

Gabbard GO: Psychodynamic Psychiatry in Clinical Practice, 3rd Edition. Washington, DC, American Psychiatric Press, 2000

1

Key Concepts

> During the last session of a 3-year dynamic psychotherapy process, the patient, a 31-year-old professional man, was silent for a few minutes. Then he looked up at his therapist and started to speak: "It's difficult to say what's on my mind today. I owe you such a debt of gratitude for all you've done. I didn't have a clue about what was going on inside me when I first came to see you. All I knew was that I was a mess. Now, for the first time in my life, I actually have a sense of who I am and what it is I'm seeking from others. I wasn't an easy patient. I hid out from you for a long time. I played games with you to avoid looking at myself. But you found me…eventually. You were incredibly patient and persistent. I can't thank you enough for that. I'll tell you something—even though you haven't said a lot about yourself, I feel like I know you intimately, and I'll never forget you."

In this poignant communication to his therapist, a grateful patient offers a glimpse into the reasons for the continued popularity of long-term psychodynamic psychotherapy. The thirst to understand, to "know thyself," persists despite managed care, the quick-fix mentality of our society, and the remarkable progress in psychopharmacology. The much-publicized *Consumer Reports* survey of patients ("Mental Health" 1995) showed that patient satisfaction increased with increasing duration of therapy. Patients seeking in-depth knowledge about themselves may pay for therapy out of their own discretionary funds even though the treatment often takes years. Yet despite the continued popularity of long-term dynamic therapy, it is widely misunderstood. Common misconceptions include the following:

1. The psychodynamic therapist is largely silent.
2. Breakthroughs occur in dramatic emotional catharses when a repressed memory is suddenly uncovered.
3. The main focus of such therapy is the patient's sexuality.
4. All reactions to the therapist are distortions of the current situation based on past relationships.
5. The therapy is both interminable and ineffectual (much like the treatment of the protagonists in Woody Allen's films).
6. The psychodynamic therapist is a stone-faced blank screen who does not disclose any of his or her own personal reactions to the patient.
7. The psychodynamic therapist never expresses an opinion that communicates a judgment about what the patient says.

Although long-term psychodynamic therapy is derived from psychoanalysis, even Freud practiced in a way that differed dramatically from these various misconceptions about psychodynamic therapy. Psychodynamic therapists today are more likely to be actively engaged with the patient, to resonate emotionally with the patient's affect states, to be far from passive or stone-faced, to be talkative when it is useful, and to be mindful of how they themselves contribute to the patient's perception of them. They are also rarely privy to dramatic revelations from the deeply buried past.

If we were to attempt to characterize contemporary long-term psychodynamic psychotherapy, we might use the following definition: "A therapy that involves careful attention to the therapist-patient interaction, with thoughtfully timed interpretation of transference and resistance embedded in a sophisticated appreciation of the therapist's contribution to the two-person field" (Gunderson and Gabbard 1999, p. 685). The conceptual models for this therapy include unconscious conflict derived from ego psychology, object relations theory, self psychology, and attachment theory.

Although long-term psychodynamic therapy once meant an exclusively open-ended process that did not have a defined end point, today there are therapies of 40 or 52 sessions that have targeted end points from the beginning but still use many of the same principles inherent in long-term psychodynamic therapy (Barber et al. 1997; Svartberg et al., in press; Winston et al. 1994). In an era of managed care, where 8–12 sessions may be the maximum number allowed, time-limited therapies of 40–52 sessions should definitely be included within the overarching rubric of long-term treatment. We thus have two categories: 1) time-limited, in which the number of sessions is predetermined, and 2) open-ended, in which the therapy is designed to end naturalistically. For purposes of definition, one must make an arbitrary boundary. With full awareness of the arbi-

trariness inherent in this cutoff point, in this book we define *long term* as therapies with duration longer than 24 sessions or 6 months.

A set of fundamental theories and principles constitute the foundation of psychodynamic therapy, and these are reviewed extensively in my companion text, *Psychodynamic Psychiatry in Clinical Practice*, 3rd Edition (Gabbard 2000). A brief overview is provided here to lay out the essential concepts and their theoretical implications (Table 1–1).

Key Concepts of Psychodynamic Psychotherapy

Unconscious Mental Functioning

Although Freud did not discover the unconscious mind, he elaborated a theory and technique that gave it central importance. This emphasis on unconscious mental life remains at the heart of psychoanalytic or psychodynamic psychotherapy. However, the way we think about unconscious mental functioning has evolved considerably since the days of Freud's early writings. Freud originally focused on the *topographic model* of the mind, which involved a stratified hierarchy of conscious, preconscious, and unconscious domains. Although material in the unconscious could not be brought into awareness easily, preconscious contents could be retrieved by simply shifting one's attention. Much of Freud's writings focused on "the unconscious," a reservoir that contained dynamically repressed contents that were kept out of awareness because they created conflict. Freud's initial approach to psychoanalysis was to try to bring those unconscious contents to the surface beyond the repression barrier so they could be examined and understood. Freud soon learned, though, that the derepression of memories through cathartic abreactions did not result in durable changes.

Table 1–1. Basic principles of psychodynamic psychotherapy

Much of mental life is unconscious.
Childhood experiences in concert with genetic factors shape the adult.
The patient's transference to the therapist is a primary source of understanding.
The therapist's countertransference provides valuable understanding about what the patient induces in others.
The patient's resistance to the therapy process is a major focus of the therapy.
Symptoms and behaviors serve multiple functions and are determined by complex and often unconscious forces.
A psychodynamic therapist assists the patient in achieving a sense of authenticity and uniqueness.

Freud's model gradually became more complicated, culminating, in 1923, in the introduction of the tripartite structural theory comprising ego, id, and superego (Freud 1923/1961). In the structural model, the ego is viewed as distinct from the aggressive and sexual drives. The conscious aspects of the ego include the executive functions of the mind, such as decision making, integration of perceptual data, and mental calculations. The unconscious aspects of the ego principally involve defense mechanisms designed to counteract the powerful instinctual drives harbored in the id. Sexuality and aggression are regarded as the basic drives, and they require massive defensive efforts from the ego to prevent them from becoming disruptive to the person's functioning.

As shown in Figure 1–1, the id is entirely unconscious and is controlled both by the unconscious aspects of the ego and by a third agency called the superego. The superego is predominantly unconscious and represents the internalization of moral values from parents and others in the individual's environment. Sometimes the superego is subdivided into an ego ideal and a moral conscience. Whereas the ego ideal proscribes (i.e., dictates what one should *not* do based on one's value system), the moral conscience or superego proper prescribes (i.e., dictates what one *should* do).

This structural model lends itself to a theory of unconscious conflict. The three intrapsychic agencies of id, ego, and superego are in constant conflict, revolving around the expression and discharge of sexuality and aggression. Signal anxiety is produced by conflict between these agencies (Freud 1926/1959). This type of anxiety alerts the ego that a defense mechanism is required to curb expressions of aggression or sexuality that seem forbidden. The formation of symptoms related to neurotic conflict evolves in this manner. In other words, conflict produces signal anxiety, which then results in a defense, which then leads to a compromise between the id and the ego or the id and the superego. A symptom, then, can be understood as a compromise formation that defends against a wish while also gratifying the wish in disguised form.

Although unconscious conflict continues to be a pervasive phenomenon addressed in psychodynamic therapy, our understanding of unconscious mental activity has undergone a transformation over the intervening century since Freud formulated his theories. His basic premise, that much of mental life is unconscious, has been extensively validated by research in the field of experimental psychology (Westen 1999). However, the view of "the unconscious" as a spatial metaphor where contents reside is much less prevalent in modern discourse. Today a neuroscience-informed psychodynamic therapist would be more likely to refer to unconscious mental functioning or unconscious representations rather than "the unconscious." Memories are stored differently depending on the type of knowledge involved.

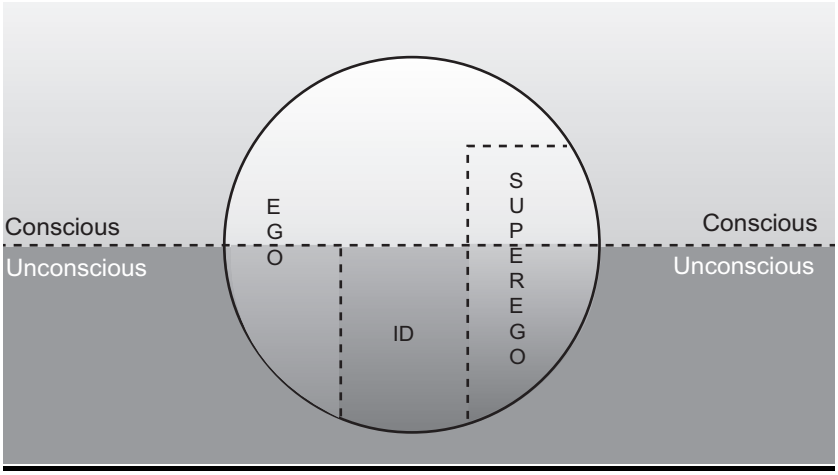

Figure 1–1. The structural model.

Note. The preconscious has been deleted for the sake of simplicity.

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Declarative memory involves facts or generic knowledge, whereas procedural memory involves skills (Figure 1–2) (Squire 1987; Westen and Gabbard 2002a, 2002b). Memories of either type can be either *explicit* or *implicit*, which refers to the mode of expression of retrieval—that is, whether or not there is conscious awareness (Westen and Gabbard 2002a). Remembering the name of one's fifth-grade teacher is an example of explicit declarative memory, because the fact is readily retrievable by simply shifting one's attention. On the other hand, if hearing a certain song on the radio evokes tears and the listener has no idea why, this may well be an example of implicit declarative memory. In other words, an event related to the song—perhaps the breakup of a relationship—is forever connected to the song, but the exact connection between the event and the song does not readily come to mind. Therapeutic exploration, however, might retrieve that connection.

Procedural memory involves knowledge of "how," whereas declarative memory involves knowledge "of" (Gabbard 2000). The "how-to" of relatedness is internalized early in life, and there are automatic ways that each person relates to others, based on early experience. Procedural memory is generally implicit when it involves the natural way that the patient relates to the therapist when walking through the door and greeting the therapist each day. Implicit procedural memory is also responsible for many defense mechanisms, which automatically deal with unpleasant feelings by driving them out of one's awareness. However, procedural memory can also be explicit if

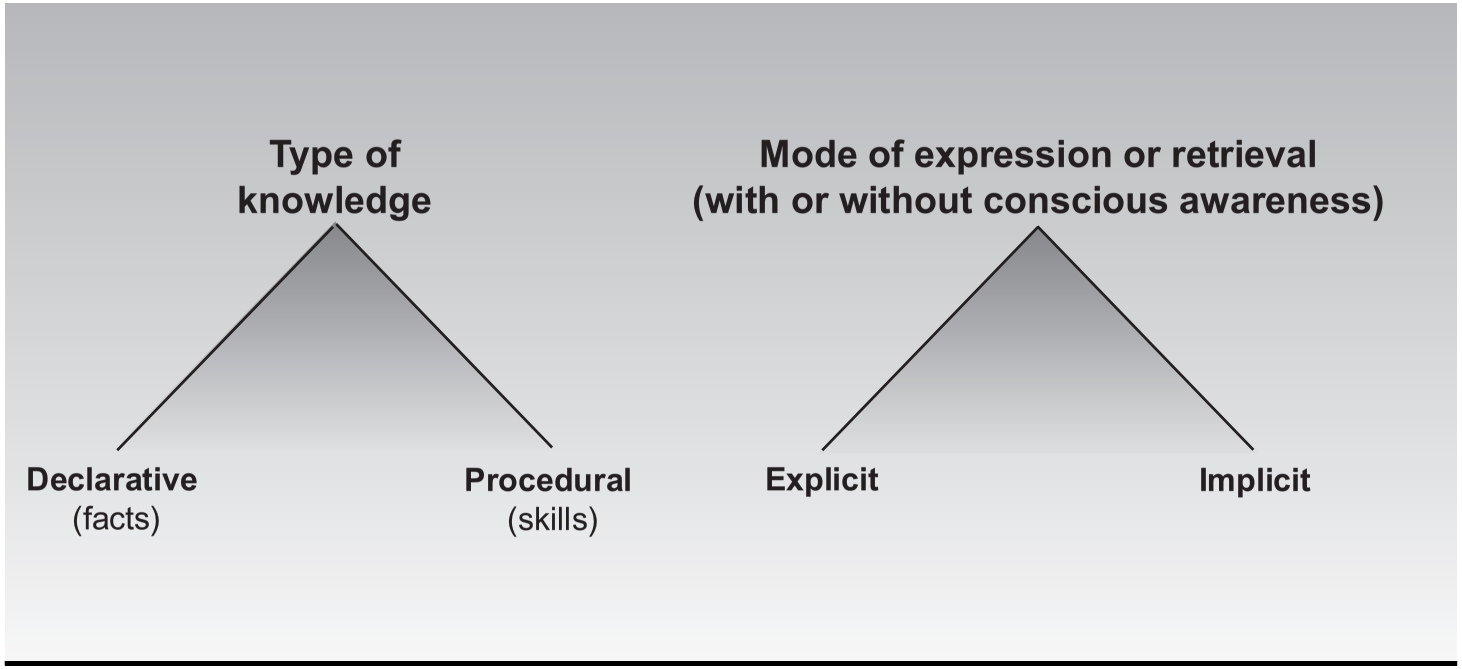

Figure 1–2. Type of knowledge versus mode of expression.

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the mode of expression is with conscious awareness. Suppression is such a defense mechanism. If a male patient finds himself angry at his therapist but is afraid the relationship will be damaged by an expression of anger, he may consciously suppress the anger and push it out of his conscious awareness. Procedural and declarative memory work in an integrated fashion, and in practice it is difficult at times to separate the two types of memory.

A Developmental Perspective

The need for a developmental point of view is a core assumption of psychodynamic thinking. Childhood experiences, in concert with the genetic characteristics of an individual, shape the adult person. Our knowledge of genetics and cognitive neuroscience suggests that the genetically based temperament of the child shapes much of the interaction with the parents. Characteristics that are inherited evoke specific parental responses (Reiss et al. 1995). The behavior of the parents, in turn, shapes the child's personality. In this regard, it is an oversimplification to blame parents for their children's problems. A complex interaction between the child's inherent traits, the parents' psychological characteristics, and the "fit" between parent and child is crucial to the developmental perspective (Gabbard 2000).

Early psychoanalytic theory involved an understanding of development that was based on libidinal zones. The child's libido or sex drive was linked to oral, anal, and phallic regions of the body. The child then entered an oedipal phase in which he or she wished to be the exclusive love object of the opposite-sex parent. This phase involved an acute awareness of a complicated triangle involving mother, father, and child. The *negative* oedipal constellation describes the child's longing for the same-sex parent, wherein the opposite-sex parent is seen as a rival. Both positive and negative oedipal themes are typically observable in development.

In the male child, the development of the superego was regarded as the outcome of the oedipal phase of development. The child resigns himself to the fact that he cannot possess his mother because of the aggression toward his father that is inherent in such wishes, and the child reluctantly resigns himself to the fact that it is better to identify with his father than to risk the father's retaliation. Castration anxiety was viewed as a fundamental concern of the male oedipal-phase child, who fears that his father might retaliate by attacking the child's genitals. To avoid this dire possibility, the boy identifies with his father and looks for a woman like his own mother so that he can avoid directly competing with his father.

The oedipal constellation for the female child was not nearly as coherent in Freud's classical conceptualization. Feminist theories of development have superseded the classical view of the girl child as an inferior

male who suffered from penis envy. More contemporary views of female psychological development regard the development of female identity as involving complex contributions from genes, culture, identifications with parents, and internal object relations rather than simple assumptions about anatomical differences (Benjamin 1990; Chodorow 1996).

Another key feature in developmental theory is the notion that early experiences of the self with others, along with their associated affect states, are internalized to produce representations of those interpersonal interactions (Fonagy and Target 2003). These internal object relationships are repeated again and again throughout life, and the problematic interactions of a patient described in psychotherapy generally derive from early relationship difficulties encountered as a child. The internal representation of a parent may not be exactly the same thing as the external figure on whom the representation is based. The child's fantasies about the parents may exaggerate tendencies that are inherent in the parental interactions, so that the self and object representations that become etched in specific neural networks may, to varying degrees, depart from the actual characteristics of the external figure.

Object relations theory as we know it today largely developed in the United Kingdom, where Melanie Klein tried to integrate drive theory with internal object relations. Subsequent thinkers, such as W.R.D. Fairbairn and D.W. Winnicott, developed what is known as the *British independent* perspective, which argued that the primary motivation of the child is object seeking rather than drive gratification (the classical Freudian view) (Gabbard 2000).

Whereas ego psychology emphasizes intrapsychic conflict, Heinz Kohut (1971, 1977, 1984) developed self psychology based on a deficit model of development. Kohut suggested that many individuals lack developmentally appropriate empathy from their mothers, and this leaves them with a deficit within them. This sense of something missing leads them to seek out responses from others to make up for the functions they lack within themselves. Kohut called these *selfobject functions*. Development, in his view, depends on a process whereby the self is gradually made more cohesive through selfobject responses from caregivers.

The self psychological perspective is consistent with some of the infant observation work of Daniel Stern (1985, 1989). He noted that validating and affirming responses from one's mother or caregiver are crucial for the developing infant's sense of self. Kohut stressed that without these responses, the self is prone to fragmentation, creating a clinical picture of extreme narcissistic vulnerability.

Although attachment theory is somewhat related to object relations theory, it developed separately. Bowlby (1988) repeatedly emphasized the

importance of the child's *real* experience rather than fantasy, in sharp contrast to Kleinian thinking. Bowlby believed there was an entire system of behavior on the part of the child that was designed to maintain proximity to the mother or caregiver (Fonagy 2001). In attachment theory the motivation of the child is not simply to seek out an object but rather to achieve a soothing psychophysiological state that derives from physical closeness to the mother or caregiver. Different classifications of attachment have been developed from studying the infant's response to what is known as the *strange situation* (Ainsworth et al. 1978). When exposed to brief separations from the mother, a child may react in one of four general categories that allow for attachment classification: 1) securely attached, 2) anxious-avoidantly attached, 3) anxious-ambivalent or resistant, and 4) disorganized/disoriented. These attachment categories have some degree of correlation with analogous categories of adult attachment: 1) secure/autonomous; 2) insecure/dismissing adults who idealize, denigrate, deny, and devalue both past and current attachments; 3) preoccupied adults, who are confused or overwhelmed by close relationships; and 4) unresolved or disorganized individuals, who often have been victims of trauma or neglect. Insecure attachment accompanied by trauma or neglect may hamper the development of the capacity to *mentalize*, that is, conceive of another person's mind or one's own as a source of motivation.

This cursory survey of some of the leading developmental theories does not do justice to the controversy and complexity about development that characterize contemporary psychoanalytic views. (For more detailed discussions, see Gabbard 2000 and Fonagy and Target 2003.) Each of the models may be of value in specific clinical situations, and the psychodynamic therapist adapts the theoretical model to the patient (Table 1–2).

Regardless of the theoretical model of development, the psychodynamic view is consistent in approaching the adult patient as a product of important early experiences that continue to be repeated in the present with others, including the therapist.

Transference

When childhood patterns of relatedness are repeated in the present with the therapist, one can observe the core psychodynamic concept of transference. Qualities of a figure from the past are attributed to the doctor, and feelings associated with that figure are experienced in the same way with the doctor. Freud's original idea was that transference was a "stereotype plate" (Freud 1912/1958). Freud assumed that libidinal or sexual desires from childhood were transferred directly onto the person of the analyst. The Kleinian and object relations theorists expanded the notion of

Table 1–2. Developmental models

Theoretical model	Motivation	Basic units of development	Psychopathology
Ego psychology	Drive gratification	Ego Id Superego	Conflict/compromise formation
Object relations theory	Object seeking	Representation of self and other linked by an affect	Recurrent maladaptive relationship patterns based on externalization of internal object relationships
Self psychology	Self-cohesion/self-esteem	Self-selfobject	Fragmentation of self/narcissistic vulnerability
Attachment theory	Physical sense of safety	Internal working models	Insecure attachment/failure of mentalization

transference through the concept of *projective identification* (Feldman 1997; Gabbard 1995; Joseph 1989; Ogden 1979; Spillius 1992). In projective identification, the patient unconsciously projects a self or object representation into the therapist and then, by exerting interpersonal pressure, "nudges" the therapist into taking on characteristics similar to the representation that has been projected. Thus the patient may behave in an irritating way until the therapist becomes irritated and unconsciously conforms to an angry object from the patient's past.

Self psychology has expanded the understanding of transference by emphasizing that selfobject transferences involve the therapist as a completion of the patient's self. Because the self is seen as being in a deficit state, the transference object must fulfill functions that are not within the patient as a result of inadequate parental empathy. Thus the patient may seek to complete the self by viewing the therapist as admiring or validating. Stolorow (1995) extended the self psychological understanding by emphasizing that transference is fundamentally bidimensional. There is a repetitive aspect, as Freud described, but there is also a reparative aspect in which the patient seeks a new object experience that will be healing.

More recently, postmodern perspectives in contemporary psychoanalysis—such as relational, constructivist, and interpersonal theories—have influenced the way that transference is viewed. The constructivist model of transference (Hoffman 1998) emphasizes that the therapist's actual behavior is always influencing the patient's experience of the therapist. From this perspective, there are always real aspects of the interaction that are based on the therapist's actual characteristics that interact with the recreation of an old object relationship from the past. Virtually all contemporary views of transference would agree that the patient's perception of the therapist is always a mixture of real characteristics of the therapist and aspects of figures from the past—in effect, a combination of old and new relationships.

Countertransference

A hallmark of psychodynamic thinking is that the patient and therapist have two separate subjectivities that interact in a meaningful way during the course of the therapy. The psychodynamic therapist is not a scientist looking through a microscope at a specimen. Rather, she is a fellow human being with conflicts and emotional struggles of her own. She unconsciously experiences the patient as someone from her past at the same time that the patient experiences her as someone from his past. Thus the therapist's *countertransference* is similar to the patient's transference. Over time, however, this narrow or Freudian view of countertransference has been expanded to a broad view that regards countertransference as the

therapist's total emotional reaction to the patient. This expanded definition has also normalized the concept so that countertransference is viewed not just as an obstacle to helping the patient but also as a source of important information about the patient. Countertransference is now considered a major therapeutic and diagnostic tool that tells the therapist a great deal about the patient's internal world.

Most theoretical perspectives today view countertransference as entailing a jointly created reaction in the clinician. In other words, part of the therapist's reaction to the patient is based on the therapist's past relationships brought into the present, as in transference. In addition, however, other aspects of the therapist's feelings are *induced* by the patient's behavior. Through projective identification, the patient recreates an old object relationship in which the therapist plays a principal character from the patient's past (Gabbard 1995). For example, if the patient makes the therapist angry, the therapist's anger may stem from past relationships in the therapist's internal world while also deriving from the patient's actual behavior that evokes a reaction in the therapist similar to objects from the *patient's* past.

Resistance

An anchoring principle in psychodynamic psychotherapy is that the patient is ambivalent about change. The patient's intrapsychic equilibrium has been reached after years of using specific defense mechanisms to keep painful affects at bay. Entering therapy threatens that equilibrium, so the patient may unconsciously oppose the treater's efforts to produce insight and change. The patient's characteristic defense mechanisms, designed to deal with unpleasant emotions, are activated by the therapy in the form of resistance (Greenson 1967). The difference between resistances and defense mechanisms is simply that the former can be observed by the therapist, whereas the latter must be inferred (Thomä and Kächele 1987).

The resistance can take many forms, including silence, having nothing to say, forgetting to pay the therapy bill, talking about superficial matters that seem irrelevant to therapy, refusing to develop goals to work on in therapy, coming late to appointments, forgetting to take medication, forgetting what the therapist said, or making fun of the therapist's interventions.

Many resistances are *transference resistances.* Patients may oppose a therapy because of specific fantasies about how the therapist is viewing them. Patients may not tell their therapist their most shameful secrets because of a conviction that the therapist will humiliate them and criticize them for revealing these secrets. The manner in which a patient resists is likely to be a recreation of a past relationship that continues to influence vari-

ous present-day relationships. Hence resistance is not simply an obstacle to be removed from the therapy. It is a revelation of a highly significant internal object relationship from the patient's past transported into the present moment with the treater (Friedman 1991). The therapist tries to help the patient understand what is being recreated and how it influences the patient's capacity to work on problems in the therapy.

Psychic Determinism

The fundamental psychoanalytic concept of psychic determinism refers to the notion that what we do with our lives is shaped by unconscious forces in dynamic relationship with one another. Similarly, symptoms or behaviors generally serve several functions and solve many problems, even though the unconscious causation is beyond our grasp. Sherwood (1969) pointed out that "Freud clearly held that the causes of behavior were *both* complex (overdetermined) and multiple (in the sense of there being alternate sets of sufficient condition)" (p. 181). In other words, behaviors or symptoms are at times caused by a specific intrapsychic constellation of factors that work together to produce the end result, whereas at other times they are produced by different etiological factors. Unconscious fantasies associated with pleasurable wishes or safety are often motivators that determine the way we deal with others, the way we control painful feelings, and the way we lead our lives (Fonagy and Target 2003).

Psychiatrists understand that genetic, biological, traumatic, and social factors also shape behavior. A patient with a brain injury may forget because of damage to brain areas rather than for dynamically significant reasons. Nonetheless, a psychodynamic psychotherapist believes that meanings are attached to the consequences of genetically or socially produced symptoms and behaviors. These meanings relate to long-standing unconscious beliefs, thoughts, and feelings that can be usefully explored with the patient.

The Patient's Unique Subjectivity

A final principle of psychodynamic thinking is that we don't really know ourselves. Because of a variety of conflicts, prohibitions, anxieties, and defenses, we tend to hide from ourselves, and the task of the psychodynamic therapist is to pursue the patient's true self.

Winnicott (1960) noted that infants whose initiatives are consistently thwarted by parents who cannot receive or validate them will find an alternative pathway to connect with their parents. This strategy usually involves the development of a *false self* whom the parents recognize and appreciate. The true self may become shrouded in shame, however, and some degree

of authenticity is lost. In psychodynamic therapy, the therapist pursues a uniquely subjective truth for each patient. The therapist seeks to recognize and validate the true self of the patient. This true self is rarely a monolithic entity, however, and most patients have a multifaceted self structure that varies with their relational setting. This search for the hidden aspect of the patient may involve unmasking a number of self-deceptions and unflinchingly exploring the patient's most shameful fantasies, fears, and wishes. The need to be known, validated, and recognized may be as fundamental as the wish to understand in the course of dynamic therapy.

What Does Research Tell Us?

Psychoanalysts and psychodynamic therapists were complacent for years. Patients lined up at their doors, so research was seen as peripheral to the practice of the therapy. As a result, vigorous research on the outcomes of psychoanalytic and psychodynamic treatments is relatively scarce compared with the extensive research in cognitive-behavioral therapy, for example. To be sure, there are formidable obstacles to conducting research on extended psychodynamic treatments (Gabbard et al. 2002). The cost of a project that would measure outcomes from treatments that last 1–5 years would be extraordinary compared with the costs of 16-week trials of brief therapies. Finding a suitably matched control group would also be problematic. A basic principle of psychoanalytic and psychodynamic therapies is that the treatment must be self-selected because of the motivation necessary to engage in sometimes-painful exploration. Therefore randomized assignment of patients to one modality versus another presents major obstacles to researchers. Similarly, in a multiyear treatment, the number of dropouts from either the treatment group or the control group might severely hamper meaningful statistical analyses (Gunderson and Gabbard 1999).

A substantial body of research on brief psychodynamic therapy has provided some credibility that the principles of the treatment are sound. Anderson and Lambert (1995) conducted a meta-analysis of 26 studies and determined that short-term dynamic therapy was equally effective as other therapies at follow-up. Three separate studies have demonstrated that accurate interpretation of core conflicts predicts better treatment outcomes within sessions and across sessions (Crits-Christoph et al. 1988; Joyce and Piper 1993; Silberschatz et al. 1986).

When we turn to extended psychodynamic therapy, only a handful of studies have utilized a randomized, controlled design, the gold standard of scientific rigor. Winston et al. (1994) conducted a controlled trial of 25 patients with Cluster C personality disorders who were treated in

dynamic therapy with a mean length of 40.3 sessions. The sample improved significantly on all measures compared with control patients on a wait list. At follow-up 1.5 years later, the patients demonstrated continued benefit.

Svartberg et al. (in press) randomly assigned 50 patients who met criteria for Cluster C personality disorders to 40 sessions of either dynamic psychotherapy or cognitive therapy. The therapists were all experienced in manual-guided supervision. The outcomes were assessed in terms of symptom distress, interpersonal problems, and core personality pathology. The full sample of patients showed statistically significant improvements on all measures during treatment and during the 2-year follow-up period. Patients who received cognitive therapy did not report significant change in symptom distress *after* treatment, whereas patients who underwent dynamic therapy treatment did. Two years after the treatment, 54% of the dynamic therapy patients and 42% of the cognitive therapy patients had recovered symptomatically. The investigators concluded that there is reason to think that improvement persists after treatment with dynamic psychotherapy.

In the Boston Psychotherapy Study (Stanton et al. 1984), patients with schizophrenia who received supportive therapy were compared with those who were provided with psychoanalytic therapy at a frequency of two or more times a week by experienced psychoanalytically oriented therapists. Although certain outcome measures seemed to improve differentially in each group, overall no significant advantage was conferred on patients who were treated with psychoanalytic therapy (Gunderson et al. 1984). Heinicke and Ramsey-Klee (1986) compared intensive (four times a week) psychodynamic therapy to once-a-week sessions for children with learning difficulties. This randomized, controlled trial involved treatments lasting more than a year. The children who were seen once a week showed a faster rate of improvement than those receiving four weekly sessions. At the time of follow-up, however, the children who had four sessions per week showed much greater improvement.

Bateman and Fonagy (1999) randomly assigned 38 patients with borderline personality disorder to a psychoanalytically oriented partial hospital treatment or to standard psychiatric care as a control group. The primary treatments in the partial hospital group consisted of once-weekly individual psychoanalytic psychotherapy and three-times-weekly group psychoanalytic psychotherapy. The control subjects received no psychotherapy. At the end of treatment at 18 months, the patients who received the psychoanalytically oriented treatment showed significantly more improvements in depressive symptoms, social and interpersonal functioning, need for hospitalization, and suicidal and self-mutilating behavior.

These differences were maintained during an 18-month posttreatment follow-up with assessments every 6 months (Bateman and Fonagy 2001). Moreover, the treatment group continued to improve during the 18-month follow-up period.

Other studies that did not involve randomized, controlled design also suggest positive effects of psychoanalysis and psychoanalytic psychotherapy (Monsen et al. 1995a, 1995b; Sandell et al. 2000; Stevenson and Meares 1992; Target and Fonagy 1994a, 1994b). An encouraging finding that is recurrent in psychodynamic research is that follow-up measures indicate continued improvement, suggesting that patients have learned a particular way of thinking about their experience that they can apply on their own following termination.

Summary

Long-term psychodynamic psychotherapy can be defined as a treatment that focuses on thoughtfully timed interpretation of transference and resistance and a sensitive appreciation of how the therapist contributes to the interaction with the patient. For purposes of this text, the definition of *long term* is a duration greater than 24 sessions or 6 months. A set of basic theoretical models are also fundamental to dynamic therapy. These include ego psychology, object-relations theory, self psychology, and attachment theory. In addition to these theoretical models, a psychodynamic therapist is guided by a set of key concepts: 1) much of mental life is unconscious; 2) childhood experiences in concert with genetic factors shape the adult; 3) the patient's transference to the therapist is a primary source of understanding; 4) the therapist's countertransference provides valuable understanding about what the patient induces in others; 5) the patient's resistance to the therapy process is a major focus of the therapy; 6) symptoms and behaviors serve multiple functions and are determined by complex and often unconscious forces; and 7) a psychodynamic therapist assists the patient in achieving a sense of authenticity and uniqueness. A research base in long-term psychodynamic psychotherapy has been slow to develop, but the findings of existing studies are encouraging.

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Assessment, Indications, and Formulation

The success of psychodynamic psychotherapy depends on selecting patients who are truly suited for it. Treatment must always be tailored to the patient, not the other way around. Assessing the suitability begins with an intake or consultation meeting in which patients are allowed to tell their own story in their own way. Two principal assessments are made: 1) Are the patient's clinical symptoms likely to respond to long-term psychodynamic psychotherapy? and 2) Does the patient have the psychological characteristics that are suited to a psychodynamic approach? These determinations may be complicated, though, and the suitability of some patients may be hard to assess until they have had a good trial of therapy. In the clinician's mind, the intake process is designed to establish an accurate psychodynamic diagnosis rather than provide treatment. From the patients' perspective, however, it may be highly therapeutic to have someone listen to their story and accept them as they are. Therefore the nonjudgmental listening that is inherent in good psychodynamic interviewing may pave the way for a psychotherapeutic relationship to follow.

In the first meeting, the clinician may wish to orient the patient to the purpose of an evaluation. It may be helpful to explain that before prescribing any kind of treatment, a good diagnostic understanding needs to be established. The patient should be told that more than one meeting may be necessary to accomplish that goal.

Assessment

Psychodynamic Interviewing

Psychiatric residents learning psychodynamic interviewing must, to some extent, unlearn the medical interviewing techniques that have been ingrained in them through years of education. Because of their anxieties about the interview situation, patients may steer clear of a linear course that goes from symptoms to diagnosis. Patients need to tell their story in their own way, and a wise interviewer will let a patient ramble for a while as a way of getting to know who the patient is and what is important to him. The diagnostician must elicit information that allows for the development of a descriptive diagnosis based on symptoms and history, but the route to that end point may be highly variable. The way the patient *resists* may provide clues to the major conflicts that haunt him.

Patient and Therapist as Collaborators

In any case, the psychodynamic interviewer wishes to go beyond a descriptive diagnosis and get to know the patient as a human being. The patient must be a *collaborator* in a psychodynamic interview (Gabbard 2000; Peebles-Kleiger 2002; Shevrin and Shectman 1973). To prepare the patient for psychodynamic therapy and to assess the patient's suitability, dynamic interviewers need to know if their patients can help them figure out how the patients' troubles grow out of a matrix of experience from the past and from present circumstances. The interviewer might ask, for example, "You said that your anxieties about death began last January. Do you have any idea about what was going on then that might have triggered these concerns?" A male patient who has recurring problems related to the women he chooses to date may see himself as a victim of mistreatment by women or as an active contributor to the problem. The interviewer wants to know which it is, and might ask the patient, "Can you see any role that you are playing in the recurrent pattern of difficulties you have in all female relationships? Do you find that you select a particular type of woman?"

Dynamic psychotherapy does not fit well with a surgical model. The patient is not the passive recipient of an active intervention from a doctor. Rather, the patient and the therapist are partners in an exploratory journey. The interviewer wants to make this clear from early in the assessment process to set the tone for what will follow. The increasingly sophisticated application of neuroscience ideas to psychodynamic thinking has resulted in a greater appreciation for nonverbal communications during

the course of an evaluation. Psychodynamic interviewers must carefully observe *how* the patient relates to the interviewer, knowing that the "how to" of relatedness is laid down in procedural memory from the earliest attachment relationships occurring in the patient's childhood. One patient may avoid eye contact, bow his head, and speak in a soft voice with a deferential manner. A second patient may stare at the interviewer without blinking and clearly bask in the interviewer's gaze as though it were a spotlight. A third patient may break eye contact every time he mentions his sexuality, suggesting shame at the very mention of the topic.

As long ago as 1914, Freud noted that what the patient does not remember and verbalize will be repeated in action in the consulting room (Freud 1914/1958). The manifestations of the unconscious, in terms of implicit procedural memory, are on full display throughout the interview in the patient's body movements, tone of voice, breathing, and manner of speaking.

Transference and countertransference begin to take shape even before the interview, and they become more and more evident as the actual interview progresses. Each party has expectations of the other based on comments from the referral source, phone conversations, or information from a receptionist taking information in the clinic where the patient is seen. Assessment of personality is always an essential feature of a psychodynamic assessment of the suitability for psychotherapy. Information on transference and countertransference that emerges in an interview tells one a great deal about the personality makeup of the patient.

A contemporary view of personality includes four basic components (Gabbard 2001): 1) a biologically based temperament, 2) a constellation of internal representations of self and other that are linked to affect states and are externalized in interpersonal relationships, 3) a characteristic set of defense mechanisms, and 4) a related cognitive style. Psychodynamic interviewers will find it to be of great value to think about the personality of the patient in the following way: This patient unconsciously attempts to actualize certain patterns of relatedness that reflect wishes that are barely conscious or completely outside of conscious awareness. Each patient subtly tries to impose a certain way of responding and experiencing on the interviewer. In this way, character traits play a role in actualizing an internal object relationship in the transference-countertransference dimensions of the interaction with the interviewer (Gabbard 2001; Sandler 1981). Psychodynamic clinicians must immerse themselves in the here-and-now experience of a clinical interaction as a way of getting a privileged glimpse of the patient's internal world and the typical patterns of relatedness in other relationships. Consider the following example of a male patient and female psychiatrist:

Patient: I am 33 years old, I'm single, and I have never yet met a woman who treats me well. My first girlfriend cheated on me and dumped me. My ex-wife used my credit cards until they were maxed out, and then filed for divorce. Every woman I meet seems to want to use me in some way. None of them care about me as a human being.

Psychiatrist: You must be losing your faith that any woman can be counted on.

Patient: I think you're on to something there. I am beginning to think I might be better off leading a solitary existence. However, I heard you were the best psychiatrist around, so I was hoping that I could count on you to be different from other women who have let me down.

Psychiatrist: My only interest here is in helping you understand yourself. You can count on me to be trustworthy and reliable. I promise to earn your trust.

The way the patient presents himself to his female psychiatrist is a clear example of actualizing an internal object relationship in the here and now of the clinical interaction. He makes it clear that he has been treated terribly by women in his life, and he evokes a specific response in his evaluator—she is determined to be different from all the unreliable women in this patient's life. He flatters and idealizes the interviewer, and she readily takes on the role of the idealized rescuer to his role as the much-maligned victim. The patient's way of relating evokes a countertransference response that represents a powerful internal figure in the patient's world.

In this case, the interviewer accepted the role being thrust on her by the patient. Another therapist might have defended against the role by assuming an opposite stance. For example, a different female therapist might have been nudged into a questioning attitude and challenged the patient's victim status in such a way that the patient felt further victimized. Yet another therapist might have unconsciously begun identifying with the abandoning female role and defensively become overly empathic and kind as a reaction against the pressure to get rid of the patient. Clinicians will respond differently based on their own set of internal object relationships and based on whether or not the patient reminds them of someone from their own past. Any of these responses may lead to useful exploration. The evaluator needs to be open to all responses and avoid striving for the "correct" way to react to the patient.

Defense Mechanisms

The psychodynamic clinician is also interested in assessing the particular constellation of defense mechanisms that characterizes each patient.

Within the structural model, defense mechanisms are viewed as preventing awareness of unconscious sexual or aggressive wishes, but in contemporary psychodynamic thinking, they are less likely to be construed as only defending against drive pressures. Today, the psychodynamic evaluator would view defenses as preserving a sense of self-esteem in the face of shame and narcissistic vulnerability, ensuring a sense of safety when one feels dangerously threatened by abandonment or other perils, and insulating oneself from external dangers (through denial, for example, or minimization).

Defense mechanisms do not simply defend against an affect or an unacceptable idea; they also change the relationship between self and object (Vaillant and Vaillant 1998). They may enable a patient to manage unresolved conflicts that exist either with internal objects from the past or current significant others in external reality. Defenses are almost always embedded in relatedness when one evaluates the personality of a patient. Specific defenses are linked with specific personality types or, in some cases, personality disorders. Patients with paranoid personalities, for example, use projection as a primary defense because it allows them to disavow unpleasant feelings and attribute them to others. Hence they may assign their own self-criticism to the clinician who is interviewing them and choose to withhold information rather than subject themselves to critical attacks.

Schizoid individuals, on the other hand, often use a retreat into fantasy as a major defense against the anxieties inherent in interpersonal relationships. Psychodynamic evaluators may find that a schizoid patient is so remote as to be inaccessible, and in their countertransference responses to such patients, therapists may feel increasingly distanced to the point that no emotional contact seems possible. Defenses then work in concert with the patient's internal object relations to evoke a specific set of transference and countertransference developments during a psychodynamic interview.

Defense mechanisms can be viewed as hierarchical, from the most primitive to the most mature (Table 2–1).

The primitive defenses, such as splitting and projective identification, are commonly connected with primitively organized personalities, such as borderline personality disorder. In splitting, contradictory aspects of self and other are compartmentalized in such a way that they remain unintegrated and do not create conflict. Thus, someone who uses splitting can engage in diametrically opposed behaviors without being conflicted about them. For example, a 29-year-old female patient with borderline personality disorder repeatedly complained that men would stare at her body as though she were nothing but "a piece of meat" or "a sex object." She then sent a photograph of herself in a bikini to *Playboy* magazine and

Table 2–1. A hierarchy of defense mechanisms

Defense mechanism	Description
Primitive defenses	
Splitting	Compartmentalizing experiences of self and other such that integration is not possible. When the individual is confronted with the contradictions in behavior, thought, or affect, he/she regards the differences with bland denial or indifference. This defense prevents conflict stemming from the incompatibility of the two polarized aspects of self or other.
Projective identification	Both an intrapsychic defense mechanism and an interpersonal communication, this phenomenon involves behaving in such a way that subtle interpersonal pressure is placed on another person to take on characteristics of an aspect of the self or an internal object that is projected into that person. The person who is the target of the projection then begins to behave, think, and feel in keeping with what has been projected.
Projection	Perceiving and reacting to unacceptable inner impulses and their derivatives as though they were outside the self. Differs from projective identification in that the target of the projection is not changed.
Denial	Avoiding awareness of aspects of external reality that are difficult to face by disregarding sensory data.
Dissociation	Disrupting one's sense of continuity in the areas of identity, memory, consciousness, or perception as a way of retaining an illusion of psychological control in the face of helplessness and loss of control. Although similar to splitting, dissociation may in extreme cases involve alteration of memory of events because of the disconnection of the self from the event.
Idealization	Attributing perfect or near-perfect qualities to others as a way of avoiding anxiety or negative feelings, such as contempt, envy, or anger.
Acting out	Enacting an unconscious wish or fantasy impulsively as a way of avoiding painful affect.
Somatization	Converting emotional pain or other affect states into physical symptoms and focusing one's attention on somatic (rather than intrapsychic) concerns.
Regression	Returning to an earlier phase of development or functioning to avoid the conflicts and tensions associated with one's present level of development.
Schizoid fantasy	Retreating into one's private internal world to avoid anxiety about interpersonal situations.

Table 2–1. A hierarchy of defense mechanisms *(continued)*

Defense mechanism	Description
Higher-level (neurotic) defenses	
Introjection	Internalizing aspects of a significant person as a way of dealing with the loss of that person. One may also introject a hostile or bad object as a way of giving one an illusion of control over the object. Introjection occurs in nondefensive forms as a normal part of development.
Identification	Internalizing the qualities of another person by becoming like the person. Whereas introjection leads to an internalized representation experienced as an "other," identification is experienced as part of the self. This, too, can serve nondefensive functions in normal development.
Displacement	Shifting feelings associated with one idea or object to another that resembles the original in some way.
Intellectualization	Using excessive and abstract ideation to avoid difficult feelings.
Isolation of affect	Separating an idea from its associated affect state to avoid emotional turmoil.
Rationalization	Justification of unacceptable attitudes, beliefs, or behaviors to make them tolerable to oneself.
Sexualization	Endowing an object or behavior with sexual significance to turn a negative experience into an exciting and stimulating one, or to ward off anxieties associated with the object.
Reaction formation	Transforming an unacceptable wish or impulse into its opposite.
Repression	Expelling unacceptable ideas or impulses or blocking them from entering consciousness. This defense differs from denial in that the latter is associated with external sensory data, whereas repression is associated with inner states.
Undoing	Attempting to negate sexual, aggressive, or shameful implications from a previous comment or behavior by elaborating, clarifying, or doing the opposite.

Table 2–1. A hierarchy of defense mechanisms *(continued)*

Defense mechanism	Description
Mature defenses	
Humor	Finding comic and/or ironic elements in difficult situations to reduce unpleasant affect and personal discomfort. This mechanism also allows some distance and objectivity from events so that an individual can reflect on what is happening.
Suppression	Consciously deciding not to attend to a particular feeling, state, or impulse. This defense differs from repression and denial in that it is conscious rather than unconscious.
Asceticism	Attempting to eliminate pleasurable aspects of experience because of internal conflicts produced by that pleasure. This mechanism can be in the service of transcendent or spiritual goals, as in celibacy.
Altruism	Committing oneself to the needs of others over and above one's own needs. Altruistic behavior can be used in the service of narcissistic problems but can also be the source of great achievements and constructive contributions to society.
Anticipation	Delaying of immediate gratification by planning and thinking about future achievements and accomplishments.
Sublimation	Transforming socially objectionable or internally unacceptable aims into socially acceptable ones.

asked if they would be interested in hiring her to pose for their magazine. Her therapist pointed out that wishing to pose for *Playboy* seemed to be in direct contradiction to her concern that men would view her as a sex object. With bland indifference to the contradiction, she replied, "Oh, no. *Playboy* does very tasteful photographs."

Splitting is less common in neurotically organized patients, because they are usually experiencing intrapsychic conflicts between opposing wishes, self representations, and object representations. A person with obsessive-compulsive personality characteristics, for example, would be more likely to use defenses such as isolation of affect, reaction formation, and intellectualization (Gabbard 2000). These defenses are specifically designed to tone down intense feelings and emphasize cognition instead. When a man with an obsessive-compulsive personality disorder is confronted with anger, he is likely to focus on facts and data to avoid intense

feelings (intellectualization) and be overly kind and considerate to avoid expressing his hostility (reaction formation). These defenses would then work in concert with a set of internal object relationships to actualize a specific wished-for interaction during the evaluation process. The patient may wish to appear as a dutiful and responsible child who is gaining the approval of a parental figure (i.e., the clinician conducting the interview). In this way, the wished-for interaction itself can be regarded as a defense against a feared interaction in which the therapist becomes an embodiment of the patient's harsh and critical superego (Gabbard 2001).

Reflective Function and Mentalization

The concepts of reflective function and mentalization, which stem from attachment theory, provide yet another dimension of a psychodynamic assessment that helps identify the level of organization of the patient's character or personality. There is a strong connection between primitive personality organization and insecure attachment (Alexander et al. 1998; Patrick et al. 1994; Stalker and Davies 1995). Patients with primitive personality disorders, such as borderline personality disorder, are frequently unable to resolve early trauma they have experienced, and therefore they cannot come up with a coherent mental framework that helps them work through the trauma.

Fonagy et al. (1996) studied these difficulties with the processing of early neglect and trauma, and they developed the concept of *reflective function*, which was defined as "the developmental acquisition that permits the child to respond not only to other people's behavior, but to the *conception* of their beliefs, feelings, hopes, plans, and so on" (Fonagy and Target 1997, p. 679). Reflective function is dependent on the capacity to *mentalize* (although the terms are often used interchangeably). When attachment is secure, mentalization takes place automatically and nonconsciously in the same way that playing the piano or riding a bicycle is encoded in procedural memory. When children are securely attached, they develop the ability to understand people in terms of their feelings, desires, beliefs, and expectations. Thus, mentalization is a capacity that allows the child to perceive an internal world that motivates oneself and others to behave in certain ways. It also allows the child to recognize the difference between a *perception* of others associated with a *representation* of those figures and the way the persons actually are.

If we view mentalization from a developmental perspective, a child who is younger than age 3 tends to function in a psychic equivalence mode, in which no distinction is made between how things actually are and how they are perceived. But between ages 3 and 6, a child gradually in-

tegrates a pretend mode with the psychic equivalence mode, provided that there is a secure attachment to a parent or caregiver. Then the distinction between representation and reality begins to solidify. If a 4-year-old boy, for example, asks his 8-year-old sister to play "baby and mommy" with him, he will know that the sister is not really his mother and that he is not really a baby. He recognizes that he and his sister are simply playing because they have the capacity to mentalize. In dynamic psychotherapy, this capacity to "play" is crucial because it allows a patient to recognize the difference between a transference perception of the therapist and the way the therapist really is. Even in a diagnostic evaluation, one might explore the patient's capacity to differentiate perception or belief from fact. One might ask, for example, "Do you think your boss *really* hates you? Or do you think you might just be perceiving him that way?"

Level of Personality Organization

The psychodynamic clinician uses a combination of defense mechanisms, internal object relations, ego strengths or weaknesses, and an assessment of reflective function to determine the patient's level of personality organization (Table 2–2). This assessment differs from one based on DSM-IV-TR categories (American Psychiatric Association 2000). It involves diagnostic *understanding* of the person, rather than a diagnostic label. Its value is primarily in the way it informs the psychotherapy.

Patients who are neurotically organized see themselves and others as people with both good and bad qualities and do not have to compartmentalize people into "all good" and "all bad." They also have a fairly stable identity over time, as opposed to people who are organized at a borderline level who have identity diffusion and look quite different from day to day to others (Kernberg 1976). Neurotic individuals also have a superego that functions fairly smoothly but is also harsh and critical, so the person might be rather self-denigrating and guilty much of the time. They may also worry a great deal about seemingly trivial matters. The superego does not function so smoothly with persons organized at a borderline level. They may be capable of doing harm to others without guilt at one moment, and at another moment feel extraordinarily guilty and suicidal over what they have done. Whereas borderline organization is associated with primitive defenses (such as splitting, projective identification, idealization, and devaluation), neurotically organized people are much more likely to have the neurotic range of defenses (such as reaction formation, intellectualization, displacement, and repression).

People who are neurotically organized experience a great deal of intrapsychic conflict, and they have intact reflective function so they can rec-

Table 2–2. Level of organization

Neurotic level	Borderline level
Superego well integrated but punitive	Superego integration minimal; capacity for concern and guilt fluctuating considerably
High-level defenses, including repression, reaction formation, intellectualization, doing and undoing, and displacement	Primitive defenses, including splitting, projective identification, idealization, and devaluation
Identity reasonably stable, and internal object relations characterized by ambivalently regarded whole objects and triangular conflict	Identity diffusion and object relations of a "partial" rather than "whole" nature—split into "all good" and "all bad" aspects
Notable ego strengths, including good impulse control, intact judgment, consistent reality testing, and capacity for sustained work	Nonspecific ego weaknesses, including impulsivity, impaired judgment, brief compromises in reality testing, and difficulty sustaining work
Conflict-based pathology	Significant deficits existing alongside conflicts
Intact reflective function	Impaired reflective function

ognize that their representation of a person or event is not necessarily the same as the actual reality of the person or event. They also can understand that their behaviors are motivated by internal beliefs or feeling states. By contrast, people with a borderline level of organization often have substantial deficits in the self-structure alongside their conflicts and have poorly developed reflective function. They often experience things as just happening to them, rather than being motivated by internal states. Finally, ego strengths—including impulse control, judgment, capacity for sustained work, and reality testing—are typical of people who are neurotically organized. Borderline organization is associated with various ego weaknesses, such as impulsivity, impaired judgment, difficulty persevering in sustained work, and occasional lapses in reality testing. These lapses generally involve transient paranoid thinking under stress or a mild loosening of associations in unstructured situations.

The assessment of the patient's level of organization is extremely useful in determining suitability for psychodynamic psychotherapy. Dynamic therapists tailor their approach to the patient on a continuum from being highly exploratory or expressive to being supportive or suppressive. A neurotic level of organization augurs well for a highly exploratory approach

to dynamic therapy, whereas a borderline organization generally requires that the therapist also offer support and psychoeducational interventions to improve reflective function, support deficient areas in the patient's ego, and help the patient integrate disparate views of the self and others. In determining a patient's suitability for highly exploratory or expressive psychotherapy, several additional characteristics are predictive of a good capacity to use exploratory therapy: 1) strong motivation to understand oneself, 2) significant suffering, 3) good frustration tolerance, 4) psychological mindedness (making insight possible), and 5) capacity to think in terms of analogy and metaphor.

When one is evaluating a patient, it is also useful to offer some insight as a trial interpretation to see if the patient is psychologically minded enough to use that approach. For example, a 41-year-old male patient complained to the psychiatrist evaluating him that he felt he did not measure up to other men his age in the work setting. He was stuck in middle management, while others were progressing to becoming CEOs or executive vice presidents. He seemed to have difficulty expressing himself, and at one point he said to the evaluating psychiatrist: "It's kind of humiliating to talk about this stuff with you." The psychiatrist responded, "Maybe you're also comparing yourself to me in this situation and feeling that you don't measure up in my eyes, either." The patient reflected for a moment, and responded as follows: "Well, you seem to be a successful academic psychiatrist, and I've done nothing in comparison to you. I'm a nobody." With this trial interpretation, the psychiatrist tried to bring to the patient's awareness the possibility that his experience of comparing himself with other men in the workplace was also taking place in the doctor-patient relationship during the evaluation. The patient used the insight well to further understand what was happening in the evaluation. This response suggested good suitability for exploratory psychotherapy.

By contrast, a number of features in addition to the borderline level of personality organization suggest that some supportive work will be necessary in the dynamic psychotherapy (Gabbard 2000). These factors include 1) the patient being in the midst of a severe life crisis; 2) poor frustration or anxiety tolerance; 3) excessive concreteness, leading to a lack of psychological mindedness; 4) low intelligence; 5) little capacity for self-observation; and 6) difficulty in forming a trusting relationship with the evaluator.

Other Aspects of the Evaluation

Although the emphasis in this chapter is on assessment for long-term dynamic therapy, a good evaluation does much more than that. A clinician evaluating a patient for psychotherapy must also attend to an accurate

descriptive diagnosis. After the patient is allowed to tell his or her story, the interviewer must focus the patient on symptoms, course, family history, and medication response to gain a full clinical picture. In a true biopsychosocial model of diagnosis and treatment, a descriptive diagnosis and somatic treatments tailored to the diagnosis (where indicated) must be part of the overall treatment plan.

A thorough physical examination conducted by a primary care practitioner should be scheduled to rule out the presence of physical illness. Laboratory and imaging studies may be necessary in some cases. Also, psychological testing is extremely useful in challenging diagnostic cases. Although some patients insist on complete privacy, others have no objection if the evaluator supplements the historical information by interviewing family members or significant others. These collateral sources of data may be extremely valuable because loved ones may bring in information based on first-hand observations that the patient has left out. An interview with a family member or partner may also provide an opportunity to provide education about psychotherapy and to clarify that it will be confidential. Finally, meetings with the family will often shed light on cultural and social factors relevant to the patient's clinical picture.

Indications

As noted in the preceding section, a psychodynamic assessment involves evaluating the personality structure of the patient to determine whether psychodynamic therapy would be suitable as well as determining whether the patient's disorder or clinical symptoms are likely to respond to dynamic therapy. Indications for extended psychodynamic therapy are not rigorously developed because of the lack of systematic controlled data on what conditions respond to this particular modality. If a brief course of psychotherapy or a particular medication will successfully treat the patient's problem, *and* if the patient is not interested in in-depth understanding, extended dynamic therapy may not be appropriate. However, when brief therapeutic approaches and pharmacotherapy both fail to address the patient's suffering, an extended dynamic therapeutic approach may be indicated. Patients with personality disorders—such as obsessive-compulsive, avoidant, dependent, self-defeating, and hysterical (higher-level histrionic) personality disorders—who have neurotic character organization may benefit from extended psychodynamic psychotherapy or psychoanalysis (Gunderson and Gabbard 1999). Certain patients with generalized anxiety disorder may also use extended psychodynamic psychotherapy to gain a greater grasp of the reasons for their anxiety and to tolerate it so that it doesn't interfere with their lives. Other anxiety disorders—such as

panic disorder, social phobia, and posttraumatic stress disorder—may not respond to brief treatments. In these cases, long-term dynamic therapy may be needed to explore the patient's resistances to change and to understand the dynamic origins of the symptoms. Patients with certain eating disorders, including those with anorexia nervosa, may also need extended psychodynamic psychotherapy (Dare 2001).

Three of the Cluster B personality disorders—narcissistic, borderline, and histrionic—are also indications for the use of extended psychodynamic psychotherapy because they rarely respond to brief therapy (Gunderson and Gabbard 1999). However, some supportive interventions usually need to be added to deal with deficits of the self-structure and impaired reflective function. Depending on the patient, ego weaknesses may also be present that require a supportive approach in conjunction with insight to be most effective. Certain patients with major depressive disorder, dysthymic disorder, or depressive personality characteristics may require long-term dynamic therapy, often in conjunction with antidepressant medication, to reach maximum benefit (Blatt 2004; Gabbard 2000).

Contraindications for extended psychodynamic therapy include direct treatment of symptoms of obsessive-compulsive disorder. No matter how fascinating the meaning of obsessive-compulsive symptoms may be in patients with obsessive-compulsive disorder, there are no reported cases in which the symptoms of obsessive-compulsive disorder disappear with psychodynamic psychotherapy alone. The combination of behavior therapy and a selective serotonin reuptake inhibitor is generally the treatment of choice. Nevertheless, dynamic therapy may be useful as an adjunctive treatment to address relationship problems or problems of compliance with medication regimens. A patient who is actively abusing alcohol or drugs is also not likely to benefit from extended psychodynamic psychotherapy until the substance abuse is under control. Persons with antisocial personality disorder are generally unresponsive to any form of therapy unless they have an Axis I diagnosis of major depressive disorder or have some capacity for remorse or guilt (Woody et al. 1985).

We have not yet discussed patients who are organized at a psychotic level. Generally, patients with schizophrenia will require a good deal of pharmacotherapy, hospital treatment, cognitive-behavioral techniques, and supportive therapy as part of an overall treatment plan. They may also require cognitive remediation and vocational assistance. Nevertheless, principles of psychodynamic psychotherapy may frequently be of great assistance in the overall treatment plan (Lucas 2003). Even when other treatments are primary, psychodynamic understanding of the psychotic patient can be helpful in evaluating the patient's resistances to getting better or the treater's countertransference difficulties. Some bipolar patients

may also be treatable with psychodynamic therapy when they are euthymic, but always in conjunction with medication (Gabbard 2000).

Psychodynamic Formulation

After the patient has been thoroughly evaluated and the level of object relations, ego strengths and weaknesses, self-cohesion, reflective functioning, and deficits versus conflicts have all been assessed, a psychodynamic formulation is helpful in planning the treatment. Psychiatric residents and other trainees often have a great deal of difficulty with the formulation because they try to do too much. A good psychodynamic formulation is biopsychosocial in nature, and it consists of a succinct statement of understanding the patient that explains the clinical picture and informs the treatment.

Three components of a psychodynamic formulation are essential (Sperry et al. 1992). First, in a sentence or two, there should be a brief description of the nature of the clinical picture and the associated stressor or stressors. Second, and perhaps most difficult for beginners, is a set of explanatory hypotheses. How do biological, intrapsychic, and sociocultural factors contribute to the clinical picture? Also, how do these three sets of factors interact with one another? The third component of the psychodynamic formulation is a succinct statement about how the first two components will inform the treatment and the prognosis.

Identifying and articulating these three components can seem formidable to trainees learning psychotherapy. However, the task can become less daunting if several key principles are kept in mind (Kassaw and Gabbard 2002):

1. Do not try to be all-inclusive. It is impossible for anyone to explain all of the patient's difficulties. Focus on one or two crucial themes that appear to be at the core of the patient's problems.
2. Keep in mind that the patient's historical narrative is a construction that conveys a good deal about the patient's theory of pathogenesis. The way patients conceptualize their life histories and problems will tell you a great deal about who they are.
3. Always look for stressors that may trigger symptoms or unpleasant emotional states that have led the patient to seek help.
4. Pay attention to nonverbal information and *how* the patient talks to you—not just what the patient says.
5. Draw on the here-and-now transference and countertransference data derived from your interaction with the patient to understand the patient's characteristic difficulties in both past and present relationships.

6. The best way to observe the patient's defense mechanisms is by noting how they serve as resistances in the assessment interviews.
7. Predict how the patient's relationship patterns may emerge in the psychotherapy and influence its course.
8. Always keep in mind that a psychodynamic formulation is *only* a hypothesis or a set of hypotheses. The formulation must be revised continually as new data appear and the therapist gains greater understanding of the patient.

A clinical example will illustrate these principles:

> Ms. A, a 38-year-old divorced woman, came to a trainee clinic because she was beginning a new relationship with someone who was "trouble," and because she was experiencing depressive symptoms. She said that she had never been able to overcome her depressive thoughts and feelings since she was a late teenager. She described feeling "down," having no interest in anything, lacking motivation, experiencing hypersomnolence, and having reduced concentration. She also described feeling hopeless and worthless.
>
> Her parents divorced when she was 12, but she said she could see it coming from the time she was 8 years old. She married at age 19 and had a child 5 years later. The demands of a child were overwhelming for her, and she was quite depressed for the first 7 years of her son's life. She said she did not have a good role model at home, so being a mother was extraordinarily challenging for her. Her husband wanted her to work, and she could not meet his expectations either.
>
> She had divorced 4 years before coming to the clinic and was currently living on her own. She spends most of her free time with her son, who lives with her ex-husband. She dates two recent boyfriends and works as a clerk in a store. She also tries to go to college on the side to get a bachelor's degree.
>
> She told Dr. B, the male resident evaluating her, that she was addicted to alcohol and sex. She said she had been drinking since age 13, when older men in her apartment complex would buy alcohol for her. Even as a young teenager, she was sexually attracted to these older men and would flirt with them. One of them who bought her alcohol was particularly appealing to her, and she had intercourse with him when she was only 13. Eventually she began to use cocaine, amphetamines, and other illegal drugs, and she described herself as highly "promiscuous" with many sexual partners. She said that her mother had never really been able to take care of her because her mother was emotionally unstable and upset all the time. She remembers her mother shouting at her father frequently, and she often thought that her mother might be psychotic.
>
> The patient expressed significant contempt toward her alcoholic father, who was an open "womanizer" throughout the marriage. He paid very little attention to Ms. A, and his only positive comments and interactions revolved around her physical appearance. She said that her father and most of her family would usually treat her like a doll, and her main

means of getting attention was to "look cute." She recalled an instance in college when her father visited her and told her that she was dressed in a manner that was too slovenly.

Ms. A attends Alcoholics Anonymous (AA) meetings, and her sponsor instructed her to seek female-only groups, because she felt that a part of her desire to attend AA meetings was to meet men. She expressed great frustration about being at a gay male group where she felt "invisible," as she was unable to attract the men in the group. The patient denied having any close female friends and had difficulty recalling any significant female relationships before age 12.

Dr. B found himself with unusually positive feelings toward Ms. A. He was more than eager to shift his schedule to accommodate appointment times with her. He also noted that he found himself trying to please her, at times avoiding topics that might be upsetting for her. He noted that he was inordinately empathic. For example, he worked diligently to reduce her sense of responsibility about choosing men whom she felt were not good for her. He assured her that the men were just as responsible as she was. Dr. B noted that he was careful to dress well on the days he saw Ms. A and that he always noticed her clothing. He felt that she called attention to her body in a way that managed to make him feel embarrassed about noticing her physical characteristics. He had trouble ending the hours with her, and even offered her extra sessions if she needed them. In addition to the sexual attraction he felt, Dr. B also sensed himself wanting to be paternal toward her.

The first component of the formulation is a simple statement of the clinical picture and the nature of the stressor. Ms. A is a 38-year-old, divorced white female who presents with a history of depression and substance abuse in the context of lifelong relationship problems with both men and women. The most recent stressor was starting a new relationship with a man she regarded as "trouble."

The second component involves a biopsychosocial effort to explain the patient's clinical picture. A psychodynamic formulation must be embedded in an understanding of the patient's genetic and biological diatheses and the patient's sociocultural milieu. Biological factors contributing to the picture include a family history of possible psychosis and a genetic predisposition to alcohol abuse based on her father's alcoholism. A psychological hypothesis might be stated as follows: Ms. A grew up in a tumultuous childhood situation where she felt neglected by her mother, so she attempted to get love and admiration from her father by attending to her appearance and sexualizing their relationship. This past pattern of relatedness is carried into the present with men she meets in AA and with Dr. B. Through projective identification, she transforms Dr. B into a rescuing paternal figure who is sexually attracted to her and wants to accommodate her in any way he can. She dresses in a way that appeals to him and relates to him in such a way that the interpersonal pressure creates an

identification in Dr. B with the projected object representation, that is, an all-good father who wishes to rescue her and save her from "bad men." Splitting may also be manifested by viewing other men and her mother as "all bad."

Two relevant sociocultural factors are her severe financial constraints, which have led her to need support from men all her life, and her reaction to a society that overvalues youth and beauty as she approaches middle age.

The final component is a prediction about the course of the therapy based on the other two components of the formulation: Ms. A will need to continue her 12-step program, because her psychotherapy would be compromised by ongoing substance abuse. We can anticipate that she will approach the psychotherapy by trying to charm Dr. B into a paternal but sexualized role. When Dr. B attempts to help her reflect more on herself and work on exploring her inner world, she may feel rebuffed and make him into a "bad object." She may then become enraged at Dr. B and seek another man to meet her needs elsewhere.

This formulation takes into account biopsychosocial aspects of the clinical picture and, in a modest way, tries to hypothesize the major themes that will affect the psychotherapy. Antidepressants will also be part of the treatment plan, along with the 12-step program, because the patient appears to have dysthymia in addition to the substance abuse on Axis I. On Axis II, Ms. A appears to have histrionic and borderline features that will require further clarification as the therapy progresses. Her primitive defenses and split object relations suggest a borderline level of organization. Her reflective function is limited at this point, and the psychotherapy will need to attempt to enhance her capacity to look within.

Summary

Assessment of patients for psychodynamic psychotherapy should include an evaluation of the patient's psychological characteristics in terms of the patient's capacity to use a psychodynamic approach. In addition, the clinical symptomatology must be assessed in terms of whether or not it is likely to respond to long-term dynamic therapy. Hence, psychodynamic interviewing must be geared to the patient's personality as well as to that patient's capacity to collaborate in a search for understanding. In reaching a conclusion about the suitability of the patient for dynamic psychotherapy, it is essential to evaluate several key characteristics: 1) the nature of superego functioning, 2) the level of defense mechanisms typically used by the patient, 3) the characteristic pattern of object relationships reflecting the patient's internal world, 4) ego strengths and ego weaknesses, 5) the

presence of conflict-based pathology versus significant deficits, and 6) the patient's capacity for reflective function. These characteristics will help the evaluator determine whether the patient has a neurotic or a borderline level of character organization. Neurotically organized patients are ideally suited for long-term psychodynamic therapy, whereas those organized at a borderline level usually require some supportive strategies to make dynamic therapy possible.

After a careful assessment of the patient, an initial psychodynamic formulation can be developed to guide the therapy. The key components are a brief description of the nature of the clinical picture and the stressors that may have brought the patient to treatment; a set of explanatory hypotheses that touch on biological, psychological, and sociocultural factors; and a prediction about how the treatment and the prognosis will be informed by the factors that contribute to the patient's clinical picture. Psychodynamic formulations should always be biopsychosocial and should be considered to be a set of hypotheses that require constant revision as more information is learned about the patient in the course of the psychotherapy.

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3

The Nuts and Bolts of Psychotherapy

Getting Started

Some patients start psychotherapy with the same clinician who conducts their initial intake evaluation or consultation. Others are referred by the consultant to someone else for psychotherapy. If the patient is referred by a colleague, the manner in which the referral is made reveals important information about the patient. One can discern a good deal of useful data about potential transference-countertransference dynamics from what the referring clinician says.

One patient was referred with the following note: "This patient doesn't have any particular psychiatric diagnosis or even emotional difficulties but would like to explore himself a bit in a psychotherapy process." The psychotherapist's private response was "Oh, really? What is the patient doing in therapy then? Does this reflect a collusion between the patient and the evaluating clinician to deny and disavow psychological conflict or emotional suffering? Is the patient too ashamed to admit problems?" The therapist took this up with the patient in the first session. She asked the patient how he viewed his goals for the therapy. He responded that he wanted to become "even more perfect." It soon became apparent that the patient had a narcissistic personality disorder and wanted confirmation of his exceptional mental health rather than an understanding of his need to present himself as having transcended emotional problems.

In another case, the referring doctor told a psychiatric resident who was going to be the therapist of a patient he had evaluated, "This patient is probably the best candidate for psychotherapy and the most motivated patient I have ever seen. The only reason I'm not taking her into treatment myself is that she can't afford my fee. It's very important that you handle her with great care. Don't try to confront her or say anything that would be viewed as hurtful because she has had a terribly difficult life." Anytime a referral source says that the patient is the "most" or the "best" of anything, the therapist must be wary. This packaging of the patient as "special" often reflects a countertransference idealization of the patient that suggests an identification with an all-loving or all-protective parent that the patient has projected into the therapist. Part of this transference-countertransference constellation is the unconscious agreement to keep all aggressive and negative feelings out of the dyad. This arrangement is also a setup for splitting between the referring doctor and the new therapist, who is unlikely to live up to the expectations of the referring clinician and is likely to "fail" the patient because of it.

One agenda for the initial meetings with the new therapist should be to explore any feelings the patient has about the evaluation and the referral process. Did the patient feel "dumped"? Was there any curiosity about why the intake doctor did not agree to treat the patient? How does the patient feel about the new therapist? One may also inquire about whether the patient withheld specific problems or historical data from the evaluating clinician because the material was so shameful that it could only be shared with the treating therapist.

In any case, whether the patient is referred by another clinician or is evaluated by the psychotherapist, the patient and the therapist undergo a process of getting acquainted with one another that determines whether or not they will ultimately work together. If the therapy "takes," it is often because of a certain chemistry between the two parties, that elusive construct known as therapist-patient match.

More than good fortune is at work, though, when the therapist and patient decide to embark on the therapeutic journey together. Establishing rapport with a patient is an art that can be learned. A therapist who is truly present with the patient and who listens in an accepting way to the patient's story validates that the patient's life has meaning and value. The patient may feel heard and understood for the first time. One of the reasons that people continue to seek out long-term dynamic psychotherapy and psychoanalysis is that they are haunted by the prospect of an unobserved life. They long for a *witness* who can recognize what they've been through and who will listen to their story. Poland (2000) describes the role of witness as "one who recognizes and grasps the emotional impact of the

patient's self-exploration in the immediacy of the moment, yet who stays in attendance without intruding supposed wisdom" (p. 18). Among the rarely discussed functions of the psychotherapist are to observe the patient's life and to appreciate its specific meanings to the patient.

Empathic and concerned listening also promotes a therapeutic alliance between patient and therapist. The therapeutic alliance is a fundamental concept that is applicable to all forms of psychotherapy, even to pharmacotherapy. Although it is variously defined, research consistently shows that the alliance is a critical ingredient in the outcome of psychotherapy (Horvath and Symonds 1991; Martin et al. 2000). In an analysis of the role played by the therapeutic alliance in the National Institute of Mental Health Treatment of Depression Collaborative Research Program, Krupnick et al. (1996) examined outcomes of the four different arms of the study: brief interpersonal therapy, brief cognitive-behavioral therapy, medication plus clinical management, and placebo plus clinical management. They found that the therapeutic alliance was the most crucial factor in determining outcome. In fact, it accounted for more variance in treatment outcome (21%) than any of the treatment interventions themselves!

A positive therapeutic alliance is an important mediator of symptom change and a necessary condition for effective interpretation of unconscious conflict (Luborsky 1984). Good interpersonal relations and positive pretreatment expectations tend to predict a good therapeutic alliance (Gibbons et al. 2003).

How the patient reacts to the therapist is a good indication of whether a therapeutic alliance has been established. The alliance is present when the patient feels helped by the therapist, and specifically when the patient feels that the therapist is collaborating in pursuit of common therapeutic goals (Frieswyck et al. 1986; Horwitz et al. 1996). To foster an alliance, the therapist enlists the patient's help in figuring things out from early in the first consultation.

Throughout the process of therapy, the patient is asked to identify with the therapist's interest in understanding and reflection. Therapists must seek to inculcate a sense of curiosity in the patient. A major part of the first session or two is a collaborative effort to identify reasonable goals for the treatment that both patient and therapist can endorse. The systematic discussion of these goals often solidifies a beginning therapeutic alliance.

Some patients are reluctant to enter therapy. They may be chagrined to learn that there is no magic pill that can cure what ails them. They may lack basic trust in the therapist's intentions. They may have read in *Time* magazine that Freud is dead (he is ritually killed off by the media every couple of years, only to be resurrected). They may have heard that the

benefits of psychodynamic therapy are "unproven." They may have read sensational accounts in the newspapers about therapists who sleep with their patients or otherwise exploit them. Converting an intake evaluation or a consultation into a psychotherapeutic process is thus a major challenge in many instances.

Psychotherapists should be prepared to discuss with their patients what psychotherapy is and what it is not. They may need to explain that much of mental life is unconscious and that problematic patterns in the patient's life are likely caused by factors that are not completely within the conscious awareness of the patient. A psychotherapist has knowledge of how the mind works that may help the patient understand these unseen factors. Moreover, a basic axiom of human nature is that others can see things about you that you cannot see yourself. One role that a therapist plays is making observations about the patient that others probably won't bring up. The patient should be told that the therapist's primary task is to help the patient gain understanding. Some patients may benefit from explanations about how the therapist's role differs from that of a parent, friend, or lover. Other patients will ask why it takes so long. Human beings are complex. The process takes time because the defenses of a lifetime don't easily lend themselves to dismantling and exploration. The patient will resist the process and will tenaciously hold on to the familiar ways of doing things for quite some time before change seems possible.

For some patients who are skeptical, it may be useful to offer a trial of treatment for 3 months or so to see if the process is worthwhile. A reassessment can be made at the end of that time. During this trial phase, the patient may note that the familiar patterns of conflict creating distress are also present in the relationship with the therapist, and that the therapeutic relationship itself may be the subject of scrutiny as things progress.

Myths may need to be dispelled as well. The therapist is not totally silent. The therapist cannot read minds. The therapy does not last forever. The therapist is not interested in changing your sexual orientation. The patient does not have to lie on a couch and free associate. The process is not an archaeological dig for buried remnants of the past that must be recovered through hypnosis in a dramatic emotional catharsis or abreaction.

In the course of this discussion, the collaborative nature of psychotherapy should be clearly spelled out. The patient will need to set goals, bring relevant material to work toward those goals, and assist the therapist in figuring out how current patterns of behavior fit with the patient's past. The therapist can meet the patient halfway, but not much further. When confronted with a question from a passive patient—such as "You're the expert. Aren't you supposed to tell me what causes this?"—the beginning therapist must be nondefensive and open. A possible response might be

the following: "I can't figure out everything by myself. You and I have to seek the causes together. I can't do it on my own."

For a patient who is highly ambivalent about starting psychotherapy, it is rarely useful to take a "hard sell" approach in which one tries to persuade the patient that therapy is a necessity. This zeal is likely to make a skeptical patient even more hesitant because the therapist seems too invested in "arm-twisting." In many cases when the therapist is a trainee, the patient may start to feel like the investment in the therapy is more related to the trainee's need for a case rather than the patient's need for treatment.

For such patients, the "Tiffany's approach" may be more productive. For years the famed jewelry store in New York (now found all over the country) had the reputation of being reluctant to sell jewelry. If a customer asked about a particular necklace, for example, the salesperson might look reluctant and ask, "What do you have to wear with it?" The surprised customer would then be in a position of trying to convince the salesperson that she should sell the necklace to her.

The analogy to "selling" someone on psychotherapy should be clear. The patient may actually respond better when a therapist is not too eager to start the process in light of the patient's ambivalence. It may be much more helpful to say, "I can tell you have real reservations about starting therapy at this point. The success of therapy depends on the patient's motivation. So I'm not sure this is the best time to start. You may want to think about it awhile. It's a long and at times difficult process, and you shouldn't rush into it unless you're ready." This approach is authentic because it recognizes how the patient actually feels, and some patients will appreciate the therapist's sensitivity to their deep reservations.

If the patient then insists on starting, as is often the case, the therapist should still be cautious and spend a good deal of time with the patient discussing realistic goals for the therapy. As noted above, it may also be helpful to agree on a trial of treatment with an agreement to reassess how things are going in 6–8 weeks.

Practical Considerations

Many beginning therapists have practical questions that don't often appear in textbooks. For example, what do you say to the patient in the waiting room? Many patients are terribly ashamed about the need to see a psychotherapist and may not wish to have their name spoken aloud when the therapist comes up to them in the waiting room to make introductions. Instead of saying "Are you Mr. Wilson?," therapists may dis-

creetly ask the receptionist in the waiting area to point out the new arrival. Then they can simply greet the patient by saying, "Hello, I'm Dr. Smith." This approach leaves patients free to determine whether they wish to speak their name aloud in a semipublic waiting area.

Most dynamic therapists allow their patients to begin the session with whatever is on their mind. But what if the patient actually "begins" the session before it starts? As patient and therapist walk together to the office, some patients may prefer to be silent, which the therapist can certainly respect. Others may engage in chit-chat about the weather, current events, or other matters. Some curious patients may even ask the therapist personal questions or make observations about the therapist: "How long have you been working here?" "Are you in training here?" "Your accent sounds like you might be from Europe. Which country?" "You look awfully young to be a psychiatrist." "You look more like a model than a therapist." These questions are a bit disarming for a new therapist, and there is no "cookbook" approach to managing them.

"When in doubt, be human" is a useful rule of thumb. A beginning therapist can very easily err on the side of being nonresponsive and seemingly inhuman if one is completely silent in response to the patient's comments or questions. Some degree of chit-chat on the way to the office may make patients more comfortable so they feel they can open up to the therapist when the session begins. If patients start the session by bringing up their personal problems in the hallway, one may wish to say, "Let's talk about that when we get into the office," as a way of signaling that things aren't confidential in the corridor.

Regarding personal questions, different therapists have different attitudes about self-revelation. Some who are more private by nature may prefer to say next to nothing about themselves. Others may share certain aspects of their lives in a way that does not burden the patient. Another consideration to keep in mind is that there are some questions a patient has the right to know when starting a new therapy process. Among the items in that category would be whether or not the therapist is in training or under supervision, what the fee will be, if the therapist is planning to leave in the next few months as a product of change in clinical assignment or graduation from a training program, how long the sessions are, and how missed sessions are managed.

There are a number of other questions that fall into a gray area where no simple rule is possible. These include the therapist's marital status, religion, age, and sexual orientation. With gay patients, some therapists might choose to reveal that they are gay if they think it would facilitate the process by helping a particular patient overcome a sense of shame or embarrassment. Other therapists might prefer to keep their private lives

out of the therapy process. If there is doubt about the value of answering the question, the therapist can certainly explore why the information is important to the patient. Revealing one's religion is rarely productive in psychotherapy. If patient and therapist have different religions, some patients may feel that the therapist will never understand them. If the religion is the same, numerous assumptions may be made by the patient about the therapist's beliefs, some of which are likely to be erroneous. These assumptions may not come up in the therapy if patients feel certain that they know what the therapist believes.

Age and marital status are loaded issues in therapy, and the therapist would do well to explore the reasons for the questions. Ultimately, the therapist has a right to privacy. It is completely acceptable to tell a curious patient, "I don't mean to be impolite, but I prefer to keep my private life out of the therapy. This process is for you, and the focus must be on how I can help you."

Many questions come up in the course of therapy that are not particularly personal. Patients may ask their therapists if they have seen a particular film or television program. They may bring up a prominent person and ask if the therapist knows whom they are talking about. Most therapists freely answer such questions as a way of facilitating a spontaneous, free-flowing exchange. Some questions are too personal to answer, of course, but therapists should be wary of too much formality or rigidity in their approach to the patient's questions. The stereotype of turning all questions back to the patient—"What do *you* think about that?"—may inhibit the patient's capacity to open up in psychotherapy.

What about the seating arrangement in the therapist's office? While it is customary in training clinics to have small offices with two chairs facing each other, this arrangement may not be optimal for either patient or therapist. Sitting across from one another may carry with it a sense of obligatory eye contact that is distressing to both parties. If one looks away, it may make one feel self-conscious, or at the very least, socially awkward. By contrast, if the two chairs are arranged at a 45-degree angle to the wall (see Figure 3–1), the patient may choose to look at the therapist or look away if that feels more comfortable. The natural line of vision in this arrangement makes eye contact less obligatory. Some issues are so embarrassing that patients may find it much easier to talk about them if they are not under the therapist's visual scrutiny.

This arrangement also facilitates the monitoring of the time during the session. Most therapists feel self-conscious looking at the clock and may attempt to sneak furtive glances at their watch or an office clock when the patient looks away for a minute or sneezes. This "monitoring by stealth" is less than optimal and can upset the patient, who sooner or later be-

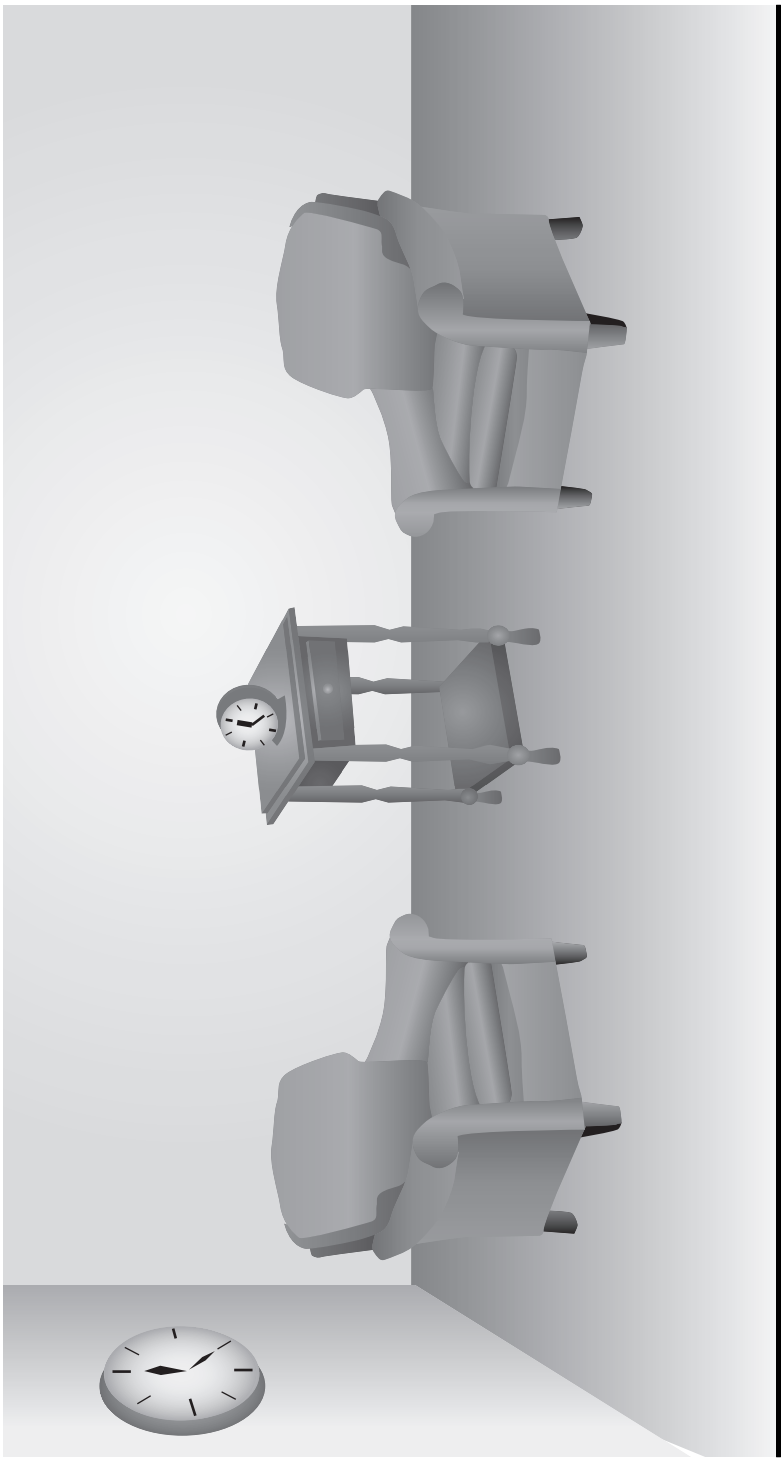

Figure 3–1. Recommended seating arrangement (with therapist's chair on the right).

comes aware of the therapist's tactic. Even if the therapist is quite open about checking the time, some patients will feel slighted or hurt. They may feel that the therapist is ignoring them or is bored with their material. These reactions can, of course, be fruitfully explored with the patient and may lead to productive work on similar situations where the patient feels slighted. By having a clock on the wall across from the therapist's chair, however, the time can be monitored from one's peripheral vision. Some therapists prefer to have a desk clock on the table between the chairs (along with some tissues) so that both parties can easily see the time during the therapy.

Boundaries and Frame Issues

Long-term psychodynamic psychotherapy operates within a frame that is composed of a set of professional boundaries, such as the location of the session; the duration of the session; the fact that the therapist is paid to deliver a service; the absence of physical contact (except for a handshake in some cases); limited self-disclosure on the part of the therapist; confidentiality; and the absence of dual relationships outside the therapy, such as financial or business relationships, social get-togethers, or romantic involvement. The entire setup is designed to be asymmetrical so that the therapist's unequivocal purpose is to help the patient with the problems that led to therapy.

Beginning therapists often misconstrue boundaries to imply rigidity. The notion of a "frame" is perhaps problematic because it often conjures up a visual image of an inflexible picture frame. The flexible ropes of a boxing ring might make a better image (although an analogy with boxing is problematic in other ways!), whereby the frame can be extended or reshaped for various reasons. Boundaries are designed to create an envelope within which the therapist can be empathic, warm, and responsive and to establish a holding environment where the patient feels understood and validated. If a vacationing family visits the Grand Canyon, they will find a guardrail that prevents them from falling into the abyss. Children (and adults) can thus play and enjoy themselves without fearing disaster.

Similarly, the boundaries in therapy create a safe and secure context within which therapist and patient can enter a "play space" where feelings, perceptions, thoughts, and memories can be played with and explored. The physical aspects of the frame allow the boundaries to be crossed psychologically through empathy, projective identification, and introjection (Gabbard and Lester 2003).

Moreover, boundaries are frequently stretched or even crossed to accommodate a patient in some way or because the therapist enacts a coun-

tertransference response to the patient. An example of accommodating a patient may occur when an elderly patient enters the office, trips on a rug, and falls to the floor. The therapist jumps to her feet and helps the patient up, asking if the patient is hurt. Ordinarily, the therapist refrains from touching the patient, but in this case the therapist would be making a serious error by sitting motionless and being unresponsive. The patient might well choose not to come back.

An example of the occurrence of a countertransference response is when a beginning therapist allowed a patient to stay in the office 15 minutes past the end of the hour because she felt sorry for the patient and didn't want to "throw her out." The therapist explored this incident under supervision and then brought it into the next session with the patient to discuss how the exception had affected the patient. The patient reported that the therapist had made her feel "special," leading to an exploration of how her mother had never made any exceptions for her. No harm resulted from the extension of the hour, and the therapeutic discussion was productive.

The two examples above represent boundary *crossings* as opposed to boundary *violations* (Gabbard 2000; Gutheil and Gabbard 1993, 1998) (see Table 3–1). They are breaks in the frame that are benign and even helpful. They are attenuated (in the sense of being minor), usually occur in isolation, and are discussable in the therapy. By contrast, boundary violations, such as sexual involvement, are exploitative, tend to be repetitive, and usually are not discussable. In other words, when patients try to bring up their concerns about the therapist's kisses or hugs, the therapist dismisses the concerns by saying they are part of the "real relationship" and don't require discussion (Gabbard and Lester 2003).

Table 3–1. Boundary crossings versus boundary violations

Boundary crossings	Boundary violations
Are benign and even helpful breaks in the frame	Are exploitive breaks in the frame
Usually occur in isolation	Are usually repetitive
Are minor and attenuated in most cases	Are egregious and often extreme (e.g., sexual misconduct)
Are discussable in therapy	Therapist generally discourages discussion in therapy
Ultimately do not cause harm to patient	Typically cause harm to the patient and/or the therapy

In the spirit of keeping boundaries flexible, therapists must recognize that each therapist-patient dyad gradually constructs a frame that is unique to the two of them. This interactive matrix (Greenberg 1995) involves some compromise between the patient's needs and the therapist's personal characteristics. Some patients may require a little more emotional expressiveness, more verbal activity from the therapist, and even more use of humor. Some patients may be lost if the therapist cannot make minor accommodations to make the patient feel comfortable enough to participate in therapy. Others may wish to have a therapist who is willing to chat briefly about superficial news items or popular films. Some therapists may be reasonably comfortable doing so, whereas others may be private persons who prefer to keep their opinions to themselves. The therapist-patient dyad works out some compromise or balance between the two subjectivities present in the consulting room.

There are times when a therapist's personal preferences may be challenged. A middle-aged patient came into a therapist's office sobbing and told him that she had just heard about the death of her son overseas. She extended her arms to him to embrace the therapist, and he made a split-second decision that, under the circumstances, it would be disastrous to reject the embrace. So he gently returned her overture for a hug and held her for a moment as she sobbed. He then sat her down in a chair to hear more about what she was feeling. He did not feel comfortable hugging the patient but felt that under the circumstances it was the lesser of two evils. A hug occurred only once in the entire course of therapy and was later discussable as the patient came out of her grief.

Many patients ask for hugs. Some even expect to be hugged because hugging has been part of a previous therapy or a 12-step group they attend. They may see a therapist as being cold and heartless for *not* hugging. The problem for the therapist, however, is that one never knows in advance what the impact of a hug will be. Even when therapists have the best intentions in embracing the patient, the impact on the patient may be substantially different from the intent (Gutheil and Gabbard 1998). A therapist may feel his hug is nonsexual, but the patient may have a history of childhood sexual abuse and be extraordinarily sensitive to any invasion of her physical boundaries. She may feel sexually assaulted by a hug, despite the therapist's intent. Moreover, therapists can never be sure of their own intentions. We are unconsciously enacting various needs of our own when we relate to patients, and we can be masters of self-deception. We may think we are hugging a patient because he or she was deprived in childhood and therefore needs love in the present to make up for what was missed in the past. However, we may be unconsciously acting on our own sexual wishes or needs.

Several rules of thumb are useful in deciding about any physical contact beyond a handshake. It is rarely advisable for the therapist to initiate a hug. If the patient initiates a hug and the therapist returns it, it should be an extraordinary event under extraordinary circumstances in the therapy. It should also be discussable—both with the patient and with one's supervisor. Regular embraces are likely to reflect the beginning of a descent down the slippery slope of ever-increasing boundary violations (Gutheil and Gabbard 1993).

Most egregious boundary violations, such as sexual relations with patients, begin with subtle countertransference enactments that may seem benign initially. But they often snowball as therapists convince themselves that what they are doing is simply accommodating to the patient's needs and furthering the process of the therapy. Often the first step down this slippery slope is the self-disclosure by the therapist of personal problems, leading to a role reversal. The patient becomes a sympathetic listener as the therapist describes his or her own difficulties with a divorce, a sick child, or a personal illness. The patient's initial response to the disclosure may be so positive that the therapist assumes it actually helps the patient to be more open. Soon the patient may be comforting the therapist and providing a brief embrace at the end of the session as a way of bolstering the therapist in a time of need. Hugs may progress to kisses, kisses may progress to caresses, and soon the therapist and patient are meeting outside the office for a rendezvous. Hence the frame must be monitored in terms of the deviations that are occurring. Therapists should talk about these deviations in supervision, and they should note why deviations are being made so that the reasons are clear and are justified by the overall treatment plan.

Countertransference is ubiquitous in psychotherapy. In fact, because countertransference is primarily unconscious, we generally know about it through actions that surprise us. These can be explored with a supervisor or consultant on the one hand and with the patient, in terms of their meaning, on the other.

A fundamental component of psychotherapy that may actually transcend considerations of boundaries and frame is that the therapist is there *for* the patient. Therapists don't take phone calls or respond to pages during sessions because their time belongs to the patient during the 45 or 50 minutes of the session. Emergencies occasionally arise, however, and there are exceptions to this usual policy. However, these exceptions should be rare and should be actively discussed with the patient. Additional time may be offered at the end of the session to make up for the time during which the phone call took place. If the emergency completely disrupts the session, the therapist can offer to reschedule and not charge for the interrupted session.

Note taking is often helpful during an evaluation to be sure that the historical facts are noted correctly and to retain essential information for developing a treatment plan. However, note taking during a psychotherapy session may interfere with the development of rapport and empathy. It may also disrupt the therapist's immersion in the countertransference produced by the patient so that important information for the therapy becomes obscured. Therapists may want to jot down a few notes for supervision about key interventions they made or themes that the patient brought up. These notes, however, are best done after the session before the next patient arrives or later in the day.

The notes describing the session are called *psychotherapy process notes* and should be kept separate from the patient's primary chart or medical record. When a patient requests a medical record or a legal action results in subpoena of a record, the psychotherapist's process notes are not discoverable if they have been kept in a separate file. They are regarded as the therapist's property, and therefore trainee therapists can feel free to write down notes about their own countertransference or their impressions of the patient, some of which they may prefer not to have the patient read. By contrast, the official progress notes in the chart may be read by the patient or by anyone involved in a litigation process and thus should be brief and respectful of the patient's confidentiality. Such notes might touch on broad themes in the therapy, such as "The patient discussed his complicated relationships with women today, and we explored how that related to transference issues." Important material that has potential legal consequences may also be included in these notes, such as medication reactions and changes, suicidal thoughts, or major decisions about the treatment.

Fees

Fees are among the most difficult problems for beginning therapists. Most beginners feel that they don't really deserve a fee, because they are inexperienced and just learning the craft. However, therapy is hard work, and practitioners deserve to be paid for it. Bills might be allowed to accumulate because a trainee therapist is reluctant to broach the issue. Among the fears that the therapist might have are that the patient will quit therapy or that it may seem insensitive to discuss the patient's failure to pay.

Feelings of anger and aggression often lurk behind the issue of the fee. Beginning therapists must remember that the fee is an ever-present reminder that the therapeutic relationship is not a friendship, is not a family relationship, and is not a romantic relationship. Winnicott (1954) pointed

out that both love and hate are inherent in the therapeutic relationship. The provision of empathic understanding in a holding environment is experienced as loving and caring by the patient. However, the patient may construe the fee and the time constraints as reflecting hate and aggression. Many patients harbor a wish for the therapist to be the perfect parent they missed having in childhood. If the therapist does not charge, the patient might begin to think that this idealized fantasy figure has finally been found. When patients are confronted about the bill, they may indeed become angry, but the exploration of their expectations regarding payment may be extraordinarily productive for the therapy. They may reveal barely conscious fantasies of being taken care of without having to be responsible to pay the bill.

Beginning therapists must remember the old saying, "You get what you pay for." A therapy that is being provided in essence for free, since the bill is not being collected, may convey a message to the patient that what is being provided is not worth much. Also, if the therapist is reluctant to bring up the bill for countertransference reasons, what does the patient make of this reticence? Is the therapist so self-denigrating that payment seems inappropriate? Psychotherapy should involve some degree of sacrifice by the patient. If no sacrifice is necessary, patients might wish that the process will go on forever and might not feel mobilized to work toward the completion of goals. Many training clinics have sliding scales, and when the therapist departs from those scales, the reason should be clear and should be thoroughly discussed with a supervisor.

When trainees graduate from their training program and enter practice, they rapidly realize that charging too low a fee can lead to resentment on the therapist's part. The patient is unlikely to receive optimal treatment if the therapist is resentful about the financial arrangements. This resentment may well be present in training settings too:

> A third-year resident was seeing a patient in a public hospital outpatient clinic, where the patient paid nothing. However, the therapist had to use a parking garage that cost her $5.00 each time she went to the therapy appointment. She gradually noted that the therapy was actually costing *her* instead of the patient. She often felt that *she* was the one making sacrifices instead of the patient. To her credit, she recognized this specific countertransference response and discussed it with her supervisor.

Patients may well sense the beginning therapist's reluctance to set a reasonable fee and to insist on payment. They may take advantage of this vulnerability in the therapist by insisting on a low fee even though they are spending money on a variety of items that may seem frivolous by comparison to therapy. One beginning therapist had asked for a special

exception to the training clinic's policy of a sliding fee scale. His patient was paying only $20 per session for the therapy, and he told his therapist that even that amount was a hardship in light of his limited budget. The therapist was chagrined to learn later that his patient took a trip to Hawaii when he had a week off from work. The patient even told the therapist how wonderfully relaxing the trip had been!

Gifts

Patients often feel like bringing their therapist a gift. Although gifts were once thought to be completely off limits in psychodynamic psychotherapy and psychoanalysis, the thinking on this matter has changed over time. Inexpensive gifts or items the patient has made may be accepted with gratitude from some patients at some points in therapy. At times, it may be devastating to the therapeutic alliance and to the patient's self-esteem if such gifts are declined. Some patients need to feel they can give something back to the therapist, and the refusal of gifts can be a shaming experience that some patients may have difficulty getting over.

On the other hand, gifts can also be used as unconscious bribes to curry favor with the therapist or to manipulate the therapist into a collusion with the patient about the avoidance of certain difficult issues in the therapy or as a way of fending off any aggression or anger in the therapist. Therefore, even if gifts are accepted, the meaning of the gift should generally be explored with the patient to evaluate the possibility of hidden meanings attached to the gift.

The therapist is occasionally in a position where the appropriate course of action is ambiguous. Therapists may be uncertain about the cost of a gift, or they may worry that the patient's feelings will be hurt if they decline the gift. Another situation that may be ambiguous is the cultural meaning of gifts. For example, when a trainee therapist turned down a gift of cash from a Middle Eastern patient, the patient informed him that in his country they had a saying, "He who rejects my gift is my enemy." In situations of ambiguity, the therapist may wish to defer a decision on the gift. The patient can be told that the therapist needs to discuss the gift with a supervisor or to check on clinic policy before making a decision. In these situations, the therapist may keep the gift in the office or have the patient keep it and bring it back at the next meeting.

Confidentiality Concerns

A sense of privacy is an essential part of the frame of psychotherapy. Patients will not disclose their darkest secrets and most shameful fantasies

unless they feel that their confidences will be kept. Beginning therapists understand this principle, but they also present psychotherapy process material to supervisors and hear presentations in clinical case conferences where confidential patient communications are openly discussed. This atmosphere may lead to a looseness about confidentiality that can be highly problematic.

Trainee psychotherapists should be reminded that confidentiality is not to be treated lightly in any circumstance. Therapists should not be speaking about their patients to their spouses or family members. If they see a patient in a restaurant or at a public event, they should not acknowledge the patient openly unless the patient speaks first, nods, or waves. Some patients will prefer to keep the fact that they see a therapist completely private and will not even acknowledge their therapist when they are with family members. Even the fact that one is seeing a patient is confidential. Hence, if someone asks a therapist, "Do you see Jane Smith?" the best answer is something like, "I can't reveal whom I see or don't see in therapy because of confidentiality concerns." Even the material that one hears in psychotherapy should remain confidential. For example, if one hears titillating gossip about a mutual acquaintance or friend through a patient, that material should not be repeated to anyone. When one must use case material for a presentation in a teaching conference, the identifying features of the patient should be carefully disguised so the identity is not clear to the listeners. If a trainee in a case presentation starts to feel that he or she might know who the patient is, the trainee should discreetly leave the conference.

Beginning therapists may be caught in a difficult dilemma if a family member of a patient calls them. Some family members may wish to be given a progress report on the patient. Others may want to inform the therapist about patient behavior that they believe the patient is not reporting to the therapist. In such circumstances, the therapist may patiently listen to what the family member has to say, but then the therapist is obligated to explain to the family member that what goes on in psychotherapy is confidential and thus nothing can be revealed to the family member. Because of the potential for damage to the alliance if the patient finds out the therapist has been talking to a family member, the therapist must also inform the caller that the patient will need to be told about the call at the next psychotherapy session.

Summary

The first order of business in beginning a psychotherapy process is to establish a therapeutic alliance by listening empathically to the patient's

concerns. Certain questions that patients ask us at the beginning of therapy may need to be answered directly, whereas others fall into a gray area where clinical judgment must be used to determine the appropriate response. Long-term psychodynamic psychotherapy must occur within a frame that is composed of a set of professional boundaries. These boundaries—including the fee, the office setting, the absence of physical contact, the absence of dual relationships with the patient, the duration of the session, and limited self-disclosure by the therapist—are designed to create a safe and secure context where the patient can feel free to say or feel anything without concern about adverse consequences to the relationship. Benign breaks in the frame, referred to as *boundary crossings*, should be differentiated from *boundary violations*. The former are helpful transgressions of the frame that usually occur in isolation, are minor in nature, and are ultimately discussable with the patient. Boundary violations, on the other hand, are frequently repetitive, are not discussable, and are harmful to the patient.

Note taking during sessions should be avoided so that rapport with the patient and an immersion in the patient's experience are possible. Beginning therapists often have a difficult time charging and collecting fees, and this difficulty should be addressed in supervision rather than avoided. Confidentiality is sacrosanct, and therapists should always be mindful of situations where confidential information may leak out unintentionally.

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4

Therapeutic Interventions

What Does the Therapist Say and Do?

If they have innate talent, most beginning psychotherapists can establish rapport and listen empathically to the patient's story. Then they begin to ask themselves two basic questions: what do I say, and what do I do? Images of the blank-screen, silent therapist usually haunt them. Most beginners are inclined to think they are reacting too spontaneously, saying too much, and being too active in their engagement with the patient. All these things are possible, of course, but a more likely scenario is that the young therapist—fearing spontaneity, human engagement, and a naturalness of response—is overly rigid and formal.

Neutrality, Anonymity, and Abstinence

Three principles of technique that are often attributed to Freud—neutrality, anonymity, and abstinence—have created misunderstandings in new therapists for decades. Freud himself did not actually subscribe to these principles in his own clinical work (Lohser and Newton 1996), and he probably admonished his disciples for fear that they would engage in wild analysis and damage the reputation of his young science. In the last couple of decades, psychoanalysis and psychodynamic therapy have undergone a sea change in how the therapist's participation is defined. Few would regard as desirable the outmoded image of the therapist as a stone-

faced cipher. All three of these terms are useful to some degree, but only in a *relative* sense. None of them should lead a beginning therapist to be cold, aloof, or remote from the patient.

Neutrality was never intended to imply coldness or remoteness. The most widely accepted view of the term has been to retain equidistance from the id, ego, superego, and external reality. Those metapsychological constructs are often difficult for a therapist to locate, however, and putting the definition into action may be a formidable challenge. The underlying principle, which is still valid to some degree, is that a psychodynamic therapist tries to remain nonjudgmental about the patient's wishes, longings, and even behaviors to some degree, in the service of understanding them. Patients are much more likely to open up to a therapist if they feel understood rather than judged.

One of the major difficulties in implementing a nonjudgmental atmosphere in psychotherapy is that therapists are privately passing judgments on the patient all the time. How can any one of us consistently keep our feelings, reactions, and opinions from showing? We are making a host of judgments in every session with the patient. We have opinions about how patients dress, what they say, whom they choose for a romantic partner, what they do in bed, how they spend their money, and how they choose to spend their time in psychotherapy. At the same time, however, a psychodynamic psychotherapist endorses the principle that patients should have autonomy to make their own decisions in their lives. Above all, the therapy should not be coercive.

Fortunately, on many matters of importance to the patient, the therapist may be able to maintain a reasonably nonjudgmental attitude. A patient who has complicated marital problems, for example, may obsess about the pros and cons of getting a divorce. A therapist may be able to see both sides of the patient's dilemma and maintain a position of reasonable neutrality as the patient ultimately makes the decision. On other matters, such as the abuse of a child, the committing of a crime, or the refusal to pay the therapy bill, the therapist may have unequivocal reactions that are clear to the patient. At times it is even useful to acknowledge those feelings to the patient. Therapists who don't react to reports of egregious crimes or instances of cruelty, for example, may be seen as tacitly endorsing the patient's behavior and colluding with the patient's rationalization that it is somehow acceptable.

This discussion of neutrality leads directly into the concept of *anonymity*. It is now widely accepted that therapists are self-disclosing in a variety of ways all the time. The choice of art and photographs in the therapist's office, the way the therapist changes facial expressions in response to various comments by the patient, and even the therapist's choice of when to

comment within a session all say a great deal about the therapist. Therapists do not talk about their private lives, their families, or their personal problems, however, because the inherent asymmetry of the relationship makes it imperative that the major focus be on the patient's issues. Sharing personal problems with patients can burden them so that they feel responsible to take care of the therapist.

The original view of anonymity was that it was necessary to conceal the "real characteristics" of the therapist from the patient to avoid "contaminating" the patient's transference to the therapist. This view is no longer endorsed by most dynamic therapists because it is now widely understood that whatever the therapist does has a continuing impact on the patient's perception of the therapist, so it is virtually impossible to avoid influencing the patient's transference. For example, if therapists choose to assume a silent, remote, stone-faced posture, the patient will view the therapist as aloof, silent, and difficult to engage emotionally. The transference will, in part, be a realistic perception of the way the therapist is behaving rather than a reflection of the patient's past relationships.

Abstinence as a principle is an admonition to avoid excessive gratification of the patient's transference wishes. A total absence of gratification, however, would result in losing the patient. Unless the patient gets something from the therapist, the therapy is unlikely to continue. Even worse, the patient may masochistically submit to a cold therapist, thinking there will ultimately be some reward for submission. Therapists provide a good deal of gratification in simply listening in a humane and warm way to the patient's concerns. They may laugh in response to a joke. They may tear up on hearing a sad story. They may obviously enjoy seeing the patient at the beginning of each session as manifested in their facial expression. They certainly *do* maintain abstinence regarding the gratification of sexual wishes and any other form of potential exploitation of the patient for their own personal needs.

An attitude of *restraint* is probably the current-day derivative of this psychoanalytic tradition based on anonymity, neutrality, and abstinence. Therapists generally want the patient to be in a position of deciding what's best for them, regardless of the therapist's attitudes. At the same time, some degree of spontaneity is also desirable. Therapists must allow themselves to be engaged by the patient's "dance" and allow a certain degree of countertransference to run its course to get to know the patient's internal world. If a therapist is completely unwilling to follow the patient's lead on the therapeutic dance floor, the music may stop. As Gabbard and Wilkinson (1994) noted, "The optimal state of mind for therapists is when they can allow themselves to be 'sucked in' to the patient's world while retaining the ability to observe it happening in front of their eyes. In such

a state, therapists are truly thinking their own thoughts, even though they are under the patient's influence to some extent" (p. 82).

The Therapist's Interventions

The therapist's comments to the patient are often grouped into time-honored categories of psychotherapeutic interventions. Some comments do not fit any of these categories, however, and concern about using the proper intervention should not interfere with spontaneous conversation as it unfolds in the therapeutic dialogue. Interventions can be conceptualized on an expressive-supportive continuum, as shown in Figure 4–1.

On the left side of Figure 4–1, the most expressive intervention is interpretation. This intervention is often regarded as the primary tool of the psychodynamic psychotherapist in providing insight and understanding to the patient. The intent is to make patients aware of things that are currently outside their awareness. While this sometimes means that one is making conscious something that was previously unconscious, at other times it involves pointing out connections between phenomena when the patient does not see the linkage. There is also an explanatory aspect to an interpretation. Therapists try to help their patients gain insight by explaining motives and meanings. The following vignette gives an example of interpretive work.

> A 22-year-old young man who is having difficulty establishing himself in the world tells his female therapist that his mother is upset with him because he is still living at home and can't find any productive work that he enjoys. He complains to his therapist.
>
> *Patient:* My mother is always nagging me. I hate living under her thumb. I wish she would just leave me alone.
> *Therapist:* Yet you don't apply for jobs so that you could establish yourself independently.
> *Patient:* That's because I can't find anything interesting in the classified ads.
> *Therapist:* Sometimes you may have to work at a job that you don't really like just so you can be on your own and not be pressured by your parents.
> *Patient:* Believe me, I've looked through the classifieds and there's nothing available in the current situation of high unemployment. We're in an economic crisis.
> *Therapist:* You know, I have the impression that you actually create a nagging situation with both your mom and me by taking an oppositional stance regarding trying a new job. I wonder if being nagged makes you feel like someone cares about you.

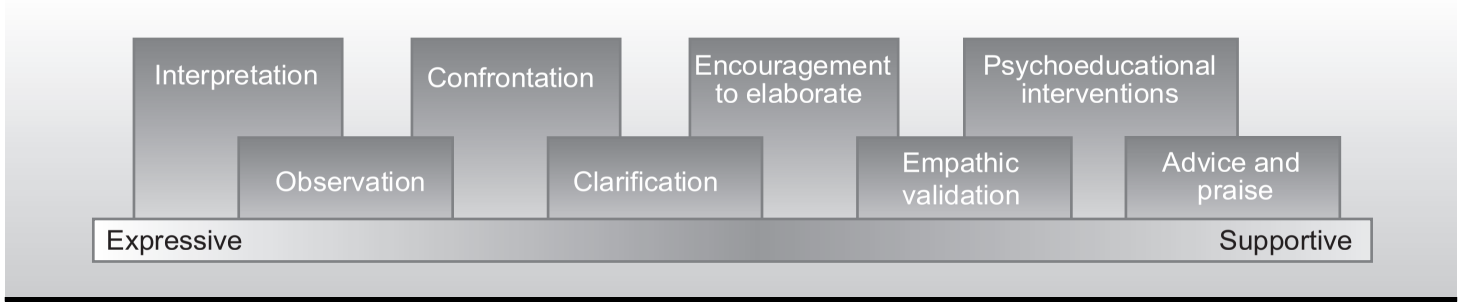

Figure 4–1. An expressive-supportive continuum of interventions.

In this interpretation, the therapist draws a link between what is happening with the patient's mother and what is happening in the transference with her. In both situations the patient persists in a pattern of opposing the other person's urging to apply for a job. On the basis of the therapist's perspective that the patient is clearly ambivalent about changing the situation, she deduces that he may be invested in maintaining the status quo for reasons that are beyond his conscious awareness. She points out that he feels cared for and watched over and that he doesn't want to lose that protection. She delivers the interpretation as a possibility—"I wonder…"—to avoid an authoritarian stance and to allow for the possibility that the patient has a different view. Unconscious wishes, fantasies, and beliefs may often be the focus of interpretive work, because they appear in childhood relationships, in current relationships outside the therapy, and in the transference.

Beginning therapists often make the mistake of equating transference with what patients say they feel toward the therapist. Transference may certainly include those verbal expressions of feelings, but it may be more apparent in the way a patient talks or relates to the therapist. Feelings that develop in the transference may be unconscious at first. In most cases one infers the wishes, fears, and feelings of transference before they are actually in the patient's conscious awareness and are verbalized. As a general principle, one has to postpone the interpretation of transference until it is close to the patient's awareness. If it is prematurely interpreted, the patient may be totally unable to relate to what the therapist is saying and might feel misunderstood. One useful adage suggests that one should formulate the interpretation and think about it four times before verbalizing it. Sometimes postponing the interpretation of transference provides time for patients themselves to recognize their transference feelings.

> Mr. C, an attorney in his mid-30s, was in psychotherapy with Dr. D, a female psychiatrist of approximately the same age. He had had a good deal of difficulty in finding satisfying intimacy with a romantic partner in his life, and after the therapy was well established he began dating a single female minister at his church. He didn't seem to recognize that this might be a problem for the minister in that he was placing her in a dual role with one of her parishioners. In a broad sense, it was a boundary problem for her. He soon broke up with the minister and began dating a physician. He expressed frustration to his therapist because when he went to the woman's home, he sat on the couch, but she chose to sit in a chair across from him. One time when he tried to kiss her, she turned her cheek before their lips met.
>
> On hearing this, Dr. D silently noted that he had dated two female professionals, one of whom was in the same occupation as herself. She also recognized that the seating arrangement he described in the woman's home was almost exactly the same as the seating arrangement in the ther-

apist's office, where she sat in a chair and he sat across from her on a couch. However, she knew that the patient could not yet make this connection, so she simply made a silent interpretation to herself that he was probably acting out transference wishes in other relationships.

As Mr. C left the office, he asked Dr. D if she would like a ticket to a forthcoming concert, since he worked for an organization that had easy access to the tickets. Dr. D declined his offer, explaining that accepting gifts from him might affect the therapeutic relationship in unforeseen ways.

After breaking up with the physician, the patient rapidly developed a romantic relationship with another physician, and the therapist was growing increasingly convinced that the pattern reflected a displacement of erotic transference feelings onto other women professionals. As yet, the patient was unable to verbalize this dimension of his romantic involvements.

A week later, the Mr. C arrived at a session with great concern that his flight was going to be canceled because of weather. He asked the therapist if he could borrow her phone to call the airline. She quickly said yes, and the patient called, finding out that the flight was indeed scheduled to depart. When he returned to his seat, he noted, "It was sweet of you to allow me to use your phone." He then said that he had two things he wanted to mention to her before the session was over. He brought up the first issue, which didn't seem that pressing. The therapist's mind wandered as she wondered why she had allowed him to use the phone, since he probably had a cell phone and since there was a pay phone right outside the building. Suddenly her attention returned and she heard him say the following words: "I mean, here is this beautiful, caring woman that God puts in my life. I know I can't really have her—it's not right to date your therapist, but I just wish so much…"

Suddenly Dr. D turned red and thought to herself, "My God. He's talking about me!" She gathered herself and made the following comment to the patient: "I'm glad you're able to feel secure enough in here to bring feelings like this into the process. It's very common to develop a variety of feelings toward your therapist, including loving ones." She was nodding reassuringly but could feel that her face was a bright crimson. This exchange occurred at the end of the session, and the patient quickly stressed that he needed to get to the airport. Both of them raced to the door, almost tripping over one another.

When Mr. C came to the next session, he began by saying, "I hope it was OK that I brought up those feelings for you last time." He didn't seem to have noticed her blushing, but he *did* seem concerned that maybe he shouldn't have brought up the subject.

Dr. D responded, "Of course it was. Therapy is a place where you can say anything without having to censor your thoughts. Besides, by exploring feelings that you have for me, we may understand more about your relationships in general."

This time the patient blushed: "It seems like a pattern, doesn't it?"

The therapist said, "Well, you've been dating physicians, women with the same occupation I have, and finding them insufficiently responsive to you. Maybe what's happening here is analogous to the pattern outside of

here. You fall for professional women who really can't respond to you in the way you'd like them to."

In this vignette, the therapist postponed interpretation of the erotic transference until it was so close to awareness that she didn't need to deliver the interpretation; the patient acknowledged it himself. When the patient did verbalize his feelings, Dr. D was discombobulated by them and was obviously embarrassed in such a way that the patient probably noted her blushing—unconsciously if not consciously. Many therapists become flustered when a patient says, "I love you," or "I'm attracted to you." Dr. D recovered nicely from her embarrassment and was able to make productive use of the erotic transference in the following session. She didn't need to interpret it, since it was already conscious, but she *did* interpret the link between his dating unavailable professional women outside the therapy and his longing for the therapist.

Interpretation may also address the architecture of resistance. Therapists may make their patients aware of how they use defenses and what they are defending against. In other words, they may point out specific fears and fantasies that suffuse the process and that often apply to the developing transference.

The extent to which a psychodynamic therapy process is more expressive or exploratory rather than supportive is based not only on the number of interpretive interventions but also on the degree to which the focus is on transference issues.

The degree of expressive versus supportive emphasis in the therapy is related to the frequency of sessions as well. In general, a therapy that is designed to be more expressive places greater emphasis on the transference and will occur 2–3 times weekly, whereas supportive therapy can be once weekly or less. By increasing the frequency of sessions, the transference intensifies, so it can be a central target of interventions by the therapist. Long-term psychodynamic psychotherapy is extremely difficult to do at frequencies less than once a week, because the continuity from session to session becomes disrupted and because it is difficult to focus on transference issues at lesser frequencies.

At times it is advisable to avoid interpreting the transference. If the patient's transference is predominantly positive and facilitates the work, some therapists will choose not to interpret it or explore it because of the basic principle of "if it's not broken, don't fix it." A useful guideline is that *the transference needs to be interpreted when it becomes a resistance to the process.* Negative transference may be one of the most obvious examples. If a patient is showing up late for the sessions, refusing to reflect on the therapist's observations, and generally not making progress, the therapist may choose

to provide insight about what is happening with an interpretation such as the following: "I've been wondering if your tendency to come late here and not reflect on the observations I make could be related to experiencing me as though I'm your father. You've told me so often that you couldn't listen to anything he had to say." If this intervention is accurate, the patient may begin to consider how his experience of the therapist is so much like that of his father that he feels he cannot allow the therapy to help him.

Some therapists will focus primarily on extratransference situations because the patient finds it extremely uncomfortable to talk about feelings for the therapist. Many of the same conflicts that appear in the relationship with the therapist also appear in outside relationships. Psychoanalysts and psychoanalytic therapists often tend to glamorize transference work, as though exploration of relationships outside the transference won't be as productive. This bias may lead therapists to force the patient to look at transference issues when they're not ready to do so. Some patients find it too shameful and embarrassing to talk about "here-and-now" feelings directly in front of the therapist. Moreover, therapists should always keep in mind that transference is not an end in itself but is rather a means to an end. We use the transference to help the patient understand significant relationships *outside* the therapy.

Extratransference interpretations may be extremely useful for providing insight into relationships with romantic partners, children, parents, and other significant individuals. A young man who was chronically smoldering with resentment about the way his boss treated him described the relationship with uncanny similarity to his description of his relationship with his father. However, he had not made the link between the two, so the therapist pointed this out to him: "Each time you talk about how much you resent your boss's control over you, you remind me so much of how you talk about your relationship with your dad."

Transferences vary in the course of the psychotherapy. Whereas in classical psychoanalytic thinking, great emphasis was placed on *the* transference neurosis, this conceptual model has changed considerably. The transference neurosis was a construct that assumed that all the patient's conflicts, defenses, and relationship patterns from childhood would come into focus with the figure of the analyst in one predominant transference paradigm. In fact, most patients manifest a number of transferences in the course of psychotherapy. In an extended process, patients may experience the therapist as a father, a mother, a sibling, or—with an older patient—even a child. Moreover, with each of these transferences, the affective quality may vary from time to time. Feelings of love may alternate with feelings of hate, envy, indifference, or anger. Patients may also go through a variety of different types of positive and negative transferences.

Noninterpretive Interventions

Much of what a therapist does in dynamic psychotherapy is noninterpretive. Looking at the continuum depicted in Figure 4–1, the next most expressive intervention after interpretation is observation.

Observation stops short of interpretation in that it doesn't include attempts to explain or link. The therapist merely notes a behavior, the sequence of a comment, a flash of affect, or a pattern within the therapy. The motive or explanation is left untouched, with the hope that the patient will reflect on the meaning of the therapist's observation. A therapist might, for example, note, "You teared up when I asked about your sister," or "I notice that you always avoid eye contact with me when you leave," or "I don't know if you're aware of it, but you always change the subject when I make connections to your father's abandonment of you."

Confrontation generally involves an attempt to draw a patient's attention to something that is being avoided. Unlike observation, which usually targets something outside the patient's conscious awareness, confrontation usually points out the avoidance of *conscious* material. Because confrontation may be aggressive, some beginning therapists are reluctant to use such interventions, thinking that it might result in the patient quitting therapy. A good example of a confrontation is bringing up the bill: "I noticed that you haven't paid your bill for 3 months. What are your plans for doing something about that?" However, confrontations can also involve turning the patient's attention to an avoided subject with empathy and gentleness. A patient who had recently lost her mother came to therapy on the day after Mother's Day and seemed particularly down. The therapist made the gentle observation: "I noticed you haven't told me how you felt on your first Mother's Day since your mother passed away." The patient then broke down in tears and talked at length about what an awful experience it had been. Confrontation may also involve setting limits, especially with patients who are organized at a borderline level. For example, a therapist might say, "If you want to continue this session with me, you'll need to lower your voice, because I can't think when you scream."

Clarification is the next intervention on the continuum. This intervention is a way of bringing clarity to issues that are vague, diffuse, or disconnected. It can be a way of helping the patient recognize a pattern or of checking the correctness of a therapist's understanding with a patient. A therapist might say, "If I understand you correctly, every time you are involved with a man, you start to have the feeling of being used and want to break off the relationship before it gets any worse. Is that right?" Clarification can also be a way of summarizing key points of information that the patient is making by repackaging what the patient has said (Gabbard

2000). For example, the therapist might clarify a narrative account a patient has given: "So what I hear you saying is that when you went to the party, each time you tried to strike up a conversation with a woman, you felt that you were seen as undesirable and the women were more interested in other men." Still another form of clarification is simply checking on details of history or the recounting of a recent event: "Excuse me for interrupting, but I need to clarify something: Did your mother and father always drink that much at dinner, or was that an unusual situation?"

Toward the supportive end of the continuum, one finds interventions like *encouragement to elaborate* and *empathic validation*. Both may be used extensively as a way of gathering information and promoting a solid therapeutic alliance. Encouragement to elaborate can involve simple comments like, "Can you tell me more about that?" It can also occur when a patient falls silent: "I noticed you stopped in the middle of your sentence. I'm curious about what made you stop. Can you elaborate?" Empathic validation comes from a perspective in which the therapist tries to immerse herself in the patient's internal state. An effort is made to see the patient's internal world from the patient's perspective. This allows for the patient to feel understood and validated with comments such as, "I can appreciate why you would feel so horrible when your mother refused to comment on such an outstanding report card." Empathic validation may be particularly important early in the therapy because it helps the patient feel understood and paves the way for a strong therapeutic alliance.

Another form of empathic validation is to tell the patient, "You have every right to feel hurt when someone treats you that way." These affirmative interventions are especially useful with patients who have experienced childhood trauma but had their feelings about that trauma invalidated. Killingmo (1995) defines an affirmative intervention as "a communication which removes doubt about the experience of reality and thereby re-establishes a feeling of identity" (p. 503).

> A 29-year-old female patient, who had been an incest victim of her stepfather, had repeatedly told her mother what was going on, and her mother insisted that she was lying. Hence, when she had feelings of despair about the incestuous situation, she felt she could not go to her mother because her feelings would be invalidated. It was of great value in the psychotherapy for the therapist to repeatedly state that the patient's feelings made sense and were completely understandable in light of what she'd been through.

Although empathic validation is frequently associated with self psychology, since Kohut (1971) emphasized empathy as the cornerstone of technique, all theoretical models in dynamic psychotherapy require some degree of empathic validation to make the patient feel understood and helped.

Therapists learn the hard way that one cannot rush in too quickly with interpretations and confrontations of transference material. Many patients require preparation for transference work with other interventions. Especially with patients who have borderline personality disorder or who are otherwise struggling with various types of ego weakness, transference interpretation is a high-risk, high-gain intervention (Gabbard et al. 1994). If the timing is correct, patients can use transference interpretation to understand how the pattern occurring in the therapy is similar to patterns in other relationships. However, transference interpretation can be viewed as an attack if the proper holding environment hasn't been created first with a series of empathically validating comments that make the patient feel understood. When it comes from out of the blue and the patient does not feel prepared for it, he or she may feel criticized and persecuted by the therapist. Monitoring how the therapeutic alliance fluctuates in response to transference work can be an effective way of monitoring the usefulness of transference interpretation (Horwitz et al. 1996). Patients who bring in new material or who collaboratively work with the therapist on the insight are responding with an improved therapeutic alliance. Those who shut down or get furious may be responding with a deterioration of the therapeutic alliance.

At the supportive end of the continuum, one finds *psychoeducational interventions* and the giving of *praise* and *advice*. These interventions are much more common in supportive psychotherapy, but some patients require these interventions from time to time in expressive forms of psychotherapy. A psychoeducational intervention involves teaching the patient about the information the therapist possesses by dint of professional training. A clinician might, for example, explain to a patient that depression tends to be a disorder characterized by recurring episodes. Praise is designed to reinforce constructive and positive behaviors or attitudes. Advice involves the offering of the therapist's opinion about a matter of concern to the patient or therapist.

One way of predicting transference developments is to listen carefully to the patient's experience of previous treaters. Even perceptions of authority figures who are not therapists may give the therapist strong clues about what is to come. Patients who talk about how much pain they had at the dentist's office and how unfeeling the dentist was may eventually come to view the therapist similarly. However, transferences also vary according to the real characteristics of the professional, and it would be premature and clumsy to jump in immediately with a comment like, "I wonder if you also feel that I am inducing pain here and am equally unresponsive." Therapists should give the transference time to build, fleshing out evidence for it by listening to accounts of other relationships and observing direct data in the therapeutic relationship, before drawing those connections. Beginning therapists are often overzealous in their wish to jump onto the transference with both feet.

Gender Constellation and Transference

Four gender constellations are possible in dynamic psychotherapy: male therapist–female patient, female therapist–male patient, male therapist–male patient, and female therapist–female patient. Although it was once believed that the sex of the therapist made little difference—since all relationship paradigms would emerge over time no matter what the gender constellation—a more recent consensus is that gender can make considerable difference in the unfolding of the therapy. Transference is based on internal object relationships that were laid down in neural networks early in life (Westen and Gabbard 2002). These involve a self, an object, and an affect connecting the two. Real characteristics of the therapist will trigger one neural network of representations rather than another. Features of the analyst—such as gender, age, appearance, manner, way of speaking, clothing, and hair color—will trigger conscious and unconscious associations in the patient's neural networks. Whether the patient is female or male will make a great deal of difference regarding the development of transferences, because gender is likely to be one of the major triggers that activates a particular neural network constituting an object representation (Westen and Gabbard 2002).

A female therapist might trigger an immediate negative transference if a patient has had a particularly conflictual relationship with her mother during childhood. In such cases, the patient may be better off with a male therapist because a male therapist's characteristics may be less likely to activate the emotional turmoil associated with the neural network of representations regarding the mother. Many patients explicitly ask for a man or a woman because they intuitively know they will get along a lot better with that particular gender. Some transferences eventually emerge regardless of the gender constellation, but not all of the object relationships etched in neural networks will necessarily be triggered by every therapist. These considerations must be taken into account when assigning a therapist.

Therapists should also keep in mind that as dynamic psychotherapy deepens, gender and even sexual orientation become quite fluid in the therapeutic relationship. A female patient may experience her female therapist as her father at times and might react as though the therapist *is* the father. A straight male patient may have sexual feelings for a male therapist. The counterpart of this gender fluidity is in the countertransference. Female therapists who consider themselves heterosexual may find themselves attracted to a woman patient, for example.

Gender stereotypes also get activated in the therapy because they exist in the culture at large. A male patient may feel in a "one down" position with a female therapist and may be deeply distressed by this power differ-

ential. He may become seductive and regard his therapist as a sexual object as a way of reversing the power imbalance and restoring the cultural stereotype of the man as the dominant member of a male-female dyad. Erotic transferences can be much more difficult for female therapists with male patients because of their greater sense of vulnerability in the face of male aggression. A female therapist can feel quite unsafe in a room with an unstable male patient who is sexually aroused by her. The following example illustrates the potential for problems in this gender constellation:

> Mr. E, a 28-year-old man, was referred to Dr. F, a 29-year-old female psychiatric resident. Mr. E was seen in weekly psychotherapy for problems involving mood lability, angry outbursts, and a possible sleep problem. About 4 months into the therapy, Mr. E asked if he could tape sessions with a hand-held recorder. Although Dr. F felt somewhat uncomfortable, she allowed him to go ahead with the taping. He became increasingly suspicious as time went on, and he told Dr. F that his boss and coworkers were talking about him behind his back. He got quite angry at his boss, who was a married woman to whom he felt a great deal of attraction. He eventually made a pass at his boss, who refused his overture and told him that they were "just good friends."
>
> About the same time that Mr. E approached his boss, he told Dr. F that he had strong feelings for her that distracted him from the therapy. Although Dr. F was flustered by his profession of attraction, she managed to convey her appreciation for his honesty and said they should continue discussing it. Between this session and the next, she realized that he often made comments about her hair or clothing and made inquiries into what she would be doing over the weekend.
>
> At the next session, Mr. E said to Dr. F after fumbling for words for a few minutes, "If I reveal my feelings, you should reciprocate. I need to know if I have to kill these feelings." Dr. F responded, "The frustration must be very great right now." Several moments of silence passed, then Mr. E recounted a history of attraction to inaccessible women, including a college professor on whom he still had a crush. Dr. F felt some degree of threat from his insistence that the feelings should be reciprocated, and she asked him if he had noticed her engagement ring. She realized in retrospect that it was an error, but she felt cornered by his insistence.
>
> Mr. E became angry and accused Dr. F of allowing his feelings to develop when she was already with someone else. He looked menacing and said, "Aren't you supposed to pick up on these things?" She blurted out that she had not encountered this circumstance before. Realizing her error, she expressed confidence that the two of them could process even the most uncomfortable issues together. She told him that a declaration of his feelings was evidence of progress. He continued therapy with her and continued to talk about the attraction in therapy. Dr. F pointed out how his attraction to her had kept him from disclosing certain information in the service of trying to appear more appealing to her.
>
> Mr. E began making numerous phone calls to Dr. F's voice mail. He reported an emergency on one of these voice mail messages, in which he

asked Dr. F to call back. On returning his call, she discovered that he had severed ties with his family earlier in the day. She empathized with how much he was suffering, but she said this was not an emergency that warranted contact between sessions. Mr. E complained at the next session that he felt abandoned and wanted more time with her. She declined to extend the hour but said they could devote their next session to his concerns. He then left another voice mail message conveying rage and demanding that she apologize for not doing her job. He also accused her of breaking confidentiality and talking to his parents about him. Dr. F felt increasingly threatened and spoke with her supervisor. She even canceled the next session because she was afraid to see him alone, and she had the director of the training clinic call him on the phone with her so she could feel safer about the ongoing contacts with him. The clinic director emphasized that Mr. E was behaving in a way that was threatening to Dr. F and encouraged her to bring that up in the next appointment.

Before the next appointment, Dr. F experienced a harrowing dream in which she was pursued around her home by a dark figure who ultimately overtook her. The next morning before leaving for to work, she put a can of pepper spray into her handbag because of her sense of being threatened. Realizing how intense her fear had become, she once again called Mr. E and arranged for a phone visit in place of the clinic appointment since she was feeling frightened.

After the intervention involving the clinic director and after Dr. F made it clear to Mr. E that she felt threatened and frightened by him, he calmed down a bit and agreed to take medication for his paranoid thinking and impaired reality testing. However, Dr. F began scheduling his appointments in midafternoon instead of late afternoon so she would feel more secure and comfortable with him during the sessions.

This clinical illustration reflects how certain forms of transference are not easily amenable to interpretive work. Dr. F needed to set clear limits and even bring in her clinic director as a way of confronting what was going on. These noninterpretive interventions, especially limit-setting confrontation, brought the transference under control so the patient could talk in therapy without presenting a threat to the therapist. She also used some limited self-disclosure in letting the patient know that she was frightened by him. Self-disclosure, while not usually considered a formal intervention in dynamic therapy, can be valuable in such cases. This case also illustrates how transferences are multilayered. When we talk about a transference as being positive, that is rarely the whole picture. One regularly finds a good deal of anger or aggression underneath the surface of an erotic transference, particularly when the erotic overtures appear to be thwarted. A basic premise of psychodynamic therapy is that the therapist must remain somewhat skeptical about the face value of feelings, transferences, and perceptions. One always looks beneath the surface for complexity and ambivalence.

Summary

Neutrality, anonymity, and abstinence are now considered principles of questionable value, and most contemporary dynamic therapists exercise restraint while also recognizing that it is impossible to keep one's own subjectivity entirely out of the therapeutic process. Although it is important to create a feeling of a spontaneous dialogue between therapist and patient, beginning therapists may also find it useful to have a conceptual model of interventions that serves as a useful guideline on what to say and when to say it.

The most expressive interventions in the expressive-supportive continuum are interpretation, observation, and confrontation. Empathic validation and encouragement to elaborate are at a midpoint in the continuum and are useful in promoting the therapeutic alliance. The most supportive interventions involve advice and praise; these comments are sometimes necessary to facilitate expressive work. The degree of expressiveness of a therapy may also be defined by the extent to which transference is a focus of the therapist's interventions. However, extratransference interpretations can be an extremely useful part of expressive therapy, since some patients find it difficult to work within the transference.

The gender constellation of therapist and patient may be an important factor in determining the suitability of a male versus a female therapist. Moreover, erotic or erotized transferences may pose greater problems if the patient is male and the therapist is female, because of the female therapist's greater sense of vulnerability to male aggression.

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5

Goals and Therapeutic Action

One cannot formulate interventions and track the patient's progress without a sense of how psychodynamic therapy works. Determining the mechanisms of therapeutic action, however, is a formidable challenge. Where do we start? We can use outcome data to demonstrate that patients improve in a broad range of symptomatic domains and in their overall functioning, but how do we know how such changes are brought about?

The idea of asking the therapist these questions is fraught with problems. We therapists tend to overvalue our theories and see our therapeutic results in terms of our favorite theoretical perspective. We like to think that our exquisitely formulated interpretations lead the patient to profound insights. However, one finding of follow-up research is that patients typically don't place much weight on interpretive interventions or even remember individual interpretations (Mitchell 1997). These findings are a bit humbling to therapists. When they see former patients in consultation, they often find that the patient's fondest memories of the treatment may be random events, such as a time when the therapist told a joke.

Seeking answers to the questions of therapeutic action from patients, however, may be equally problematic. Patients are probably no more able to provide reliable assessments of what helped than are therapists. Much of the change that occurs probably takes place unconsciously, so the conscious memory of important moments may be the tip of the iceberg.

A researcher would have an even more daunting task to try to isolate which specific interventions or emotional interactions in 50–100 sessions were critical in the process of change. The researcher also has the disadvantage of observing *from outside* the intersubjective matrix of the therapy dyad. Moments of meaningful connection and poignant emotional resonances may not appear in an audiotape transcript.

Despite the inherent complexities in figuring out how dynamic therapy works, we are gaining increasing knowledge about these mechanisms through empirical research in both psychotherapy and neuroscience and by careful study of psychotherapy process. For many years, the delivery of insight through interpretation was viewed as the primary arrow in the therapist's quiver. Now most clinicians and researchers feel that insight through interpretation has historically been idealized and that change also occurs through the experience of a new kind of relationship in psychotherapy.

This either/or polarization of insight versus relationship has given way in recent years to the recognition that these two mechanisms of change operate synergistically in most cases (Cooper 1989; Gabbard 2000b; Jacobs 1990; Pine 1998; Pulver 1992). The field no longer dwells on a sharp demarcation between relational and interpretive aspects of therapeutic action. Insight into aspects of the relationship itself that are corrective may foster further change, and the content of interpretive comments may at times be less important than their relational meanings transmitted in the course of the interpretation (Pulver 1992; Stern et al. 1998). There is now a general acknowledgement in the field that the search for a single mode of therapeutic action in dynamic therapy is no longer useful, since the mechanisms of change will always be individualized according to characteristics of both the patient and the therapist (Pine 1998).

Goals

Attempting to determine the specific mechanisms of action takes us into murkier waters, because defining therapeutic action requires some uniformity in conceptualizing the aims or goals of psychodynamic therapy. Goals are to therapeutic action as the destination of a journey is to the vehicle designed to take us there. For some destinations an automobile will suffice, whereas for others a plane or a boat may be necessary. And here we immediately encounter a problem: the psychotherapeutic journey has a multiplicity of destinations, depending on the patient and on the theoretical perspective of the therapist (Gabbard 2001).

Goals are shaped by the psychotherapist's theory of how therapy works. Some theories are more in the domain of the medical model of symptom removal, while others have to do with assignment of meanings and enhanced experience of the self. Although an attempt to catalog all the diverse goals within the field of psychoanalytic therapy would require an entire volume, it might be useful to provide a sampling of this diversity to illustrate how the goals of treatment are commonly construed.

Some Goals of Psychodynamic Psychotherapy

- **Resolution of conflict.** Ego psychologists understand conflicts and symptoms as growing out of compromise formations. The aim of dynamic therapy would be to explore the nature of the unconscious conflicts and to resolve the symptoms they produce. Thus, a young man may have writer's block because he fears that his success will put him into dangerous competition with his father. When this conflict has been explored and understood, the young man may be able to write, because his anxiety has been diminished by his understanding of its origin. Conflicts are not regarded as being completely eliminated in this formulation, but more effective and adaptive compromise formations are instituted (Brenner 1976).
- **A search for truth.** Some dynamic therapists see the goal of the therapeutic process as self-knowledge. Guided by the age-old exhortation to "know thyself," therapists of this persuasion guide their patients to take an unflinching look at themselves and to recognize who they are as opposed to who they want to be. This may take the form of identifying the distinction that Winnicott (1962/1976) made between the *true self* and the *false self*. The outcome of therapy should result in feelings of "living in one's own skin" and of being authentic (Gabbard 1996).
- **An improved capacity to seek out appropriate selfobjects.** Writing from a self psychological perspective, Kohut (1984) argued that we never outgrow the need for others to perform certain functions for us, including mirroring, affirmation, validation, and idealization. As noted in Chapter 1 ("Key Concepts"), Kohut called these *selfobject functions*, and he maintained that they are as necessary to survival as oxygen in the atmosphere. The goal of psychoanalytic therapy would be to help patients move from a position of using selfobjects in an immature or maladaptive way to one of using them in a more mature and appropriate way.

- **Improved relationships as a result of a gain in understanding about one's internal object relationships.** Therapists of an object relations or relational orientation will see the primary goal of therapy as being the acquisition of an understanding of how one's internal self and other representations shape interactions with people in the external world. One part of this goal would be to help patients reintegrate aspects of themselves that they repeatedly project into others. For example, a woman patient who reacts to her female therapist as though the therapist would be envious of any type of success may learn that these fantasies stem from an internal representation of her mother, who seemed lacking in enthusiasm whenever the patient succeeded in academic endeavors. Gradually the patient recognizes that her view of her therapist as envious is a projection of a maternal representation within herself. A process of reintegration or "re-owning" takes place so that the patient recognizes what belongs to her and what belongs to others (Steiner 1989). The result is improved relationships. One way to view this transformation would be that the patient is more capable of living in the world instead of in fantasy.
- **The generation of meaning within the therapeutic dialogue.** New meanings emerge as a result of psychotherapeutic exploration. Dynamic therapists today are less likely to search for *the* meaning, in the sense of the one correct interpretation of events or experiences. Instead, the two participants in the psychotherapy work to construct meanings together in the course of the process (Mitchell 1997). There is a dialectical tension between *discovering* unconscious meanings that have been there a long time and *creating* meanings through the therapeutic dialogue where both therapist and patient contribute. This goal is a variation on making the unconscious conscious in the sense that the result is a person who has a greater grasp of meanings that were formerly elusive and outside of awareness.
- **Improved reflective functioning.** With patients who have had their capacity to mentalize impaired through early traumatic or neglectful experiences, improving reflective functioning may be a major goal. At the end of the therapy, the patient would be expected to have the capacity to differentiate between an internal representation of someone and the way the person is in external reality. Moreover, the patient should be able to have a sense of another person's internal world and recognize that it is different from one's own. This awareness of two separate minds interacting with one another is also referred to as the achievement of intersubjectivity (Benjamin 1990). An improved capacity to mentalize allows patients to recognize how their behaviors are generated through internal feelings, beliefs, conflicts, and motivations, rather than occurring randomly.

This brief survey of various goals of psychoanalytic therapy reflects conscious theoretical conceptualizations of what happens in treatment. We must also take into account that therapists are never free from their own unconscious agendas. We go into the field partly because of conscious and altruistic wishes to help people. However, like our patients, factors beyond our awareness shape our decisions. We may be unconsciously attempting to repair our own internal objects or our parents; we may be seeking an exclusive special relationship with a patient that provides something for us that we missed in childhood; we may be attempting to make the patient love us or idealize us to make up for perceived failures in our parents; or we may try to bring the patient under our omnipotent control for purposes that are not necessarily in the patient's best interest (Gabbard 1995). Those who choose to spend a good deal of their professional careers conducting dynamic therapy may wish to seek their own personal treatment to elucidate some of these motives that are unclear and to gain a greater grasp of what roles they are casting on their patients. We can never be entirely sure what we are up to in any psychotherapy process, and there is no substitute for ongoing self-scrutiny and self-analysis. Dynamic therapists may have an unconscious fantasy of establishing a particular kind of dyad that will make the therapist feel good at the end of the workday. For example, some therapists may have a specific form of object relationship in mind involving a selfless, devoted helper and an appreciative patient who acknowledges having been helped (Gabbard 2000a).

Patient's Goals Versus Therapist's Goals

Patients come to therapy with their own theories of etiology and pathogenesis. They may have specific goals in mind that are entirely unrealistic from the therapist's standpoint. A gay male patient came to therapy complaining that he had had a series of painful romantic relationships with partners who had betrayed him and mistreated him. When his therapist asked him about his goals for therapy, he said that he was tired of being mistreated. The therapist responded that the two of them would be unable to influence how his partners treated him for the most part, but a reasonable goal was to explore why he got involved with certain types of partners who ended up breaking his heart.

The goals of the patient might conflict with those of the therapist, because the two individuals conceptualize the process differently. Many patients approach psychotherapy with the expectation that they will be "fixed" by active interventions from the therapist. The therapist must disabuse them of that notion and help them see that their goals have to be jointly defined and collaboratively pursued. Moreover, whereas therapists

may be more inclined to think of intrapsychic goals, such as "strengthening the ego" and "superego modification," patients are more likely to think of goals in terms of life changes. Compromises have to be reached in the formulation of the goals. A patient who says her goal is a satisfying romantic relationship leading to marriage has every right to seek that in life. However, the therapist can't realistically promise that she will find a suitable partner and end up happily married following therapy. The therapist *can*, however, offer the possibility of exploring the patient's conflicts about intimacy, her inhibitions about giving herself fully to another person, and any problematic relational styles that might interfere with her romantic pursuit.

As the therapy proceeds, therapist and patient must reevaluate goals from time to time. Patients may begin with one set of concerns and expectations only to find that these are gradually modified with the greater understanding brought to bear from the psychotherapist. A young man who presents with problems finding a fulfilling job might identify his goal as being able to work in a gratifying occupation. As he gets increasing insight from the psychotherapy process, he may recognize that he is highly conflicted about leaving home and growing up, leading to a redefinition of his goal as one of psychological separation from his family of origin. Some conflicts might be entirely unconscious and therefore are not available for the initial discussion on the setting of goals.

One cautionary note that needs to be stressed about goals in psychotherapy is that too much emphasis on the pursuit of goals can lead patients to rebel against what they see as the therapist's agenda for them. Even worse, a therapist who insists on the attainment of specific goals may foster a "false self" compliance in which the patient professes to have changed in order to please the therapist. Paradoxically, the therapist who is too concerned about the achievement of goals may promote a transference-countertransference impasse in which the patient defeats the therapist's efforts, thereby winning by losing (Gabbard 2000a).

Hence there may be value in allowing for substantial periods of time when patients are allowed to be somewhat aimless or goalless during the therapy (Holmes 1998; Mitchell 1997). Certain patients who are riddled with envy and are incapable of acknowledging help from the therapist may need to demonstrate their freedom from the therapist's expectations by being without goals and simply engaging in self-exploration for some time. Other patients allow themselves to change only *after* termination of the therapy as a way of depriving the therapist of the gratification of seeing them change (Gabbard 2000a). Thus, for many patients some balance between a pursuit of goals and goallessness may be necessary for an optimal therapeutic climate.

Multiple Modes of Therapeutic Action

In an era in which it is widely acknowledged that there are multiple modes of therapeutic action, we should probably speak in terms of "therapeutic actions" instead of "therapeutic action" (Gabbard and Westen 2003). We now know that different patients use different aspects of the treatment to facilitate change. A skilled therapist is sufficiently flexible to be able to shift approaches based on the needs of the particular patient in a given psychotherapy process. Wallerstein (1986) studied the 42 patients in the Menninger Psychotherapy Research Project for a span of 30 years. He found that in a number of cases with good outcomes, the therapists had modified their approach from a highly expressive mode to a more supportive strategy. He noted that insight is often idealized but that supportive treatment appeared to produce as much structural change with as much durability as did highly expressive or exploratory therapies.

In a reexamination of the same patient group, Blatt (1992) found that the psychotherapeutic approach to these patients had to be varied, based on the nature of the patient's psychopathology (Table 5–1). He divided the patients into two groups: 1) patients with *introjective* pathology, who were more ideational, were primarily concerned with the development and maintenance of the self concept, and who viewed intimate relationships as secondary or peripheral; and 2) those with *anaclitic* psychopathology, who were much more concerned about relationship issues than about the development of the self. This latter group used avoidant defenses—such as denial, disavowal, displacement, and repression—whereas the introjective group tended to use defenses like intellectualization, reaction formation, and rationalization. In examining the treatments of the two groups, Blatt noted that the anaclitic group appeared to be less responsive to insight through interpretation but that they gained considerable benefit from the therapeutic relationship itself. The introjective patients, on the other hand, seemed to respond with much greater improvement to insight and interpretation.

Blatt's distinction is useful, but therapists should keep in mind that many patients will have mixtures of these features and will benefit from both the relationship and insight. In many cases, patients will value an increased sense of mastery and agency as well as an increased capacity for intimate relationships with others. Jones (1997, 2000) developed an integrated model of therapeutic action that takes into account both interpretation and interaction occurring in the relationship, which he termed *repetitive interaction structure*. In this model, therapeutic action occurs in the recognition, understanding, and experience by both members of the treatment dyad of a repetitive pattern of interactions.

Table 5–1. Features of introjective versus anaclitic psychopathology

Characteristic	Introjective patients	Anaclitic patients
Motivation	Primarily concerned with self-development; intimate relationships viewed as secondary	Primarily concerned with the development and maintenance of relationships; self-development viewed as secondary
Primary defense mechanisms	Intellectualization, reaction formation, rationalization	Denial, disavowal, displacement, repression
Mode of therapeutic action	Insight through interpretation	The therapeutic relationship itself

Source. Based on Blatt 1992.

Contributions From Neuroscience

Recent developments in cognitive neuroscience help us articulate how change occurs and what the therapist must do to facilitate change. Although the goals of different therapists with different theoretical orientations may be quite different, almost all of them can be partially understood in terms of altering unconscious associational networks (Gabbard and Westen 2003). Among these unconscious associational networks are those that trigger problematic defensive strategies, those that trigger problematic interpersonal patterns, and those that underlie problematic emotional reactions. One obvious target of associative change would be the unconscious connection between a feeling state and an object representation. For example, someone may fear that authority figures will always be angry and retaliatory. A second type of associative network involves unconscious wishes that others will behave in a certain way. A third type is unconscious pathogenic beliefs that control what the patient does. A patient might, for example, believe that if she allows herself to express anger, there will be no one left to love her. Yet another target of associative change involves the style of defenses one uses to regulate emotional states.

Whether the goal is to alter unconscious fantasies, defenses, pathogenic beliefs, or problematic links between feelings and object representations, the change in functioning of associational networks generally involves specific processes (Gabbard and Westen 2003). The first is a weakening of links between nodes of a network that have been activated together for years or decades and a general lowering of their level of chronic activation. Representations are not "things" stored in memory but are connections among mental units (ideas, memories, sensations, and affects) that "fire together." Representations can be viewed as *potentials for reactivation*—that is, patterns of neural firing that occur under certain conditions based on their prior levels of activation. A representation of self or an object plays a powerful and recurrent role in a patient's inner life. It is a potential that has been activated many times before and exists in a heightened state of potential. Thus, associative change means weakening links between mental processes that have become associatively linked. The second process involves structural changes in associative networks that create *new* associative linkages, or the strengthening of links that were previously weak. Hence, a treatment that results in structural change does not obliterate or completely replace old networks. Rather, lasting change requires a *relative* deactivation of problematic links in activated networks and increased activation of new, more adaptive connections so the patient will find new, more adaptive solutions.

A patient may begin therapy with a conviction that the therapist, a much older man, is bored and uninterested in what the patient has to say. In time the patient might recognize that he is assuming that his therapist has these qualities because his father—the template for all authority figures—always acted bored and disinterested when he tried to engage him in conversation. This is an associational network that is powerfully active in the patient's everyday life. Over time the therapist's steadfast interest, concern, and persistence in wanting to help the patient lead to a relative deactivation of the old network while strengthening the new network in which older male authority figures are regarded as interested in the patient.

For many years, psychoanalysts and psychoanalytic therapists assumed that the most significant interventions were those that target the "deepest" processes, meaning the most deeply unconscious (Wachtel 1997). To some degree this line of reasoning makes sense, because clinical experience often suggests that focusing only on conscious thoughts or feelings produces rather short-lived changes. Implicit processes are psychologically and neurologically distinct from explicit ones, and targeting only conscious processes is likely to leave many significant associational networks untouched.

Nevertheless, conscious thought processes may be a source of considerable torment. One patient, for example, was consumed with thoughts about a man she hoped would propose to her and who instead spurned her. She spent most of her waking (conscious) moments for the following year ruminating about what she might have said, what he meant when he said particular things, and so forth. Over time the patient came to understand her tendency to ruminate as a defensive strategy that had once allowed her to cope with the uncertainty of having an intermittently abusive parent. This insight-oriented work was aimed at examining the unconscious function of rumination for her, which was tied to its etiology. At the same time, however, the therapist helped her to distinguish modes of conscious self-reflection: *introspection*, which is aimed at examining experiences in the past or present with an attitude of curiosity and self-exploration and with the possibility for change in the future, and *rumination*, which draws on the past with an attitude of regret. The former is ultimately likely to lead to a sense of freedom from prior emotional constraints, whereas the latter is likely to further ensnare the patient in these constraints and perpetuate her anxiety and depression. In fact, with the patient mentioned above, this distinction proved very helpful in regulating spirals of negative affect. When she began to catch herself ruminating, she would shift gears by asking herself questions about the functions rumination was serving at those very moments. For example, she would say to herself, "What am I getting out

of this right now?" or "What would I be feeling if I *weren't* ruminating?" Indeed, exploration of this conscious dynamic led to a better understanding of why she was initially using the treatment process in the service of rumination (and self-flagellation) rather than change.

Conscious thoughts can amplify feelings, which can in turn lead people either to undertake or to avoid actions that profoundly affect their lives, particularly in self-defeating patients whose conscious attitudes toward themselves, like their unconscious attitudes, contribute to their failure to attain or maintain jobs, relationships, and other gratifications. Most dynamic therapists routinely call depressed patients' attention to the way they consciously berate themselves, expect the worst, and discount their own abilities. Although doing so is unlikely by itself to change unconscious networks, it may well help stop self-defeating spirals and allow patients to make better life decisions, which in turn can affect their future happiness.

Another target of therapeutic action involves conscious affect states. Focusing on conscious feelings may involve efforts to alter the frequency or intensity of particular emotional states, helping the patient recognize and tolerate contradictory feelings (e.g., love and hate toward the same person). The therapist may also help a patient tolerate feelings that are uncomfortable instead of taking self-destructive actions to deal with them. Patients often come in with the explicit goal of reducing adverse emotional states like anxiety and depression. At other times, however, the therapist may seek to help a patient increase awareness of particular emotions. One finding of the Menninger Psychotherapy Research Project was that patients who had good outcomes often reported an increase in anxiety. They had learned to tolerate anxiety enough so that it could be used as a signal of something being amiss intrapsychically (Siegel and Rosen 1962).

Still a third conscious strategy may be to examine the patient's coping styles. Patients may be helped to use humor to cope with unpleasant realities and self-criticism. Patients with severe personality disorders who lack basic affect regulation skills may be taught conscious coping strategies as a way of containing the affect.

The major point here for any area of therapeutic action is that both conscious and unconscious associational networks need to be altered as part of the therapeutic process (see Table 5–2 for a summary of the targets of therapeutic action).

Now we will turn to look at some of the specific therapeutic techniques that foster therapeutic change.

Table 5–2. Targets of therapeutic action

Unconscious	Conscious
Altering associational networks that trigger problematic defensive strategies	Distinguishing between modes of conscious self-reflection
Altering associational networks that trigger problematic interpersonal patterns	Addressing conscious attitudes toward oneself
Altering associational networks that underlie problematic emotional reactions	Altering the frequency or intensity of conscious emotional states
	Helping the patient tolerate feelings or become more aware of them
	Examining the patient's conscious coping style

Technical Strategies for Fostering Therapeutic Change

The methods of fostering change are many and varied, but most fall into three classes of intervention: those aimed at fostering insight, those that derive from aspects of the therapeutic relationship, and "secondary strategies" such as self-disclosure, exposure, and affirmation.

Fostering Insight

In traditional psychoanalytic practice, two major techniques are advocated: free association and interpretation. Both of these have some application to psychodynamic therapy. Free association provides a way of seeing defenses in action and occasionally gaining a glimpse behind the defenses. Because defenses emerge as resistances in the psychotherapeutic setting, the therapist gains a good deal of information about what particular topics lead to a shutting down of the process or a changing of the subject. For example, a patient may be talking freely about his work situation until he mentions his female boss. He then abruptly changes the subject to what he did the previous evening. The therapist sees the defensive flight away from an important figure in his life, leading to an inference that the female boss creates anxiety in the patient. Free association also allows the patient and therapist to map the patient's implicit networks of associations, much as cartographers of the mind would create a model of the networks that lead the patient to think, feel, and act in specific ways. A woman patient was speaking about a date she had with her new boyfriend, in which she became quite humiliated. In the middle of a description of the event, she said an image of her father suddenly flashed into her mind. The therapist recognized that something about the humiliating

experience with the boyfriend was associationally connected to experiences with her father and pointed that out.

Interpretation, as described in Chapter 4 ("Therapeutic Interventions"), may be directed at a wide array of mental events that are interconnected: fears, fantasies, wishes, expectations, defenses, conflicts, transferences, and relational patterns that are observed from the patient's narrative descriptions of outside events. One may also interpret the patient's avoidance of certain thoughts and feelings, as well as linkages between thoughts and feelings or between elements of associational networks that the patient has not recognized. Transference interpretations classically connect the relationship to the therapist with past relationships and extratransference relationships. Although transference interpretation is a central feature of psychoanalysis, it varies considerably in psychodynamic therapy, depending on the patient's capacity to work in the transference and the degree of supportiveness needed to make the therapy viable.

In addition to free association and interpretation, observation from an outside perspective also fosters insight. As described in Chapter 4 ("Therapeutic Interventions"), observation stops short of explaining but may nevertheless lead to understanding. One of the main reasons that dynamic psychotherapy is helpful is that the therapist has an *outside perspective* on the patient. In brief, patients cannot know how they come across to others because they are *inside* themselves. Therapists have the perspective of an *object* and therefore can comment on the patient from an *external* frame of reference. A good analogy here is the common experience of seeing oneself on videotape. Typically, one's reaction is, "Do I really look like that? Do I really sound like that?" We don't have a good idea of how we come across to others, and the therapist can make helpful observations based on the fact that the therapist's perspective is different from the patient's (Gabbard 1997).

As noted in Chapter 1 ("Key Concepts"), the "how-to" of relatedness is embedded in implicit procedural memory. Therapists have the opportunity to observe these automatic and unconscious patterns in action. A therapist might say, "You looked so sad when you spoke of your ex-husband," or "I notice that you disagree with almost everything I say about your mother, and you often wince while I'm talking about her." In this way, the therapist makes unconscious automatic defensive reactions and internal object relations more available to the patient's conscious awareness. These interventions do not explain the meaning of the observations, only the fact of their existence. Fonagy (1999) emphasized that a crucial avenue for therapeutic change may lie in the patient's increasing capacity to "find himself" in the therapist's mind (p. 51). By commenting on feelings and nonverbal communications that are seen only by the therapist, the patient

may begin to assemble a portrait of himself or herself based on the therapist's observations. Implicit patterns thus become more available for conscious reflection.

Aspects of Therapeutic Action Deriving From the Therapist-Patient Relationship

The therapeutic relationship serves as a vehicle for change in a variety of ways. First, central to contemporary relational views is the notion that experiencing a different kind of relationship can be an important source of therapeutic action. Adding a neuroscience perspective, we might say that the experience of a new relationship alters networks of association, including the fears, wishes, motives, and defensive strategies that are associatively linked to representations of objects or affect states.

Therapeutic change does not occur by merely playing a role. If a therapist simply behaves differently from objects in the patient's internal world, durable change is unlikely. What appears to be crucial is that the therapist not only is different from an object in the patient's past but in some respects is *similar* to it. Features of the therapist or the therapeutic situation must bear enough resemblance to prototypes from the past to activate the core networks that require reworking. At times the patient's activated networks will, in turn, pull the therapist into patterns of behaving that resemble objects from the patient's past. It may be crucial for the patient and therapist to understand and transform these patterns. In writing about psychoanalysis, Greenberg (1986) astutely observed, "If the analyst cannot be experienced as a new object, analysis never gets underway; if he cannot be experienced as an old one, it never ends" (p. 98). Hence the therapist must hover in an intermediate zone between being an old object and being a new object to interrupt the patient's complex "script" and reflect on what is transpiring.

A second way the relationship contributes to change is through internalization of the therapist's functions. For example, a soothing experience of the therapist's care and concern may contribute to a patient's learning to self-soothe (Adler and Buie 1979). At times this may begin through forming a representation of the therapist that the patient uses consciously when upset. Over time the representation may be activated automatically and unconsciously. In this context it is important to emphasize that internalizing this function does not require the use of a conscious declarative representation. The therapeutic relationship itself is accompanied by unconscious affective connections that have been referred to by Lyons-Ruth and her colleagues (1998) as "implicit relational knowing." This phenomenon refers to moments of meeting between therapist and patient

that are not symbolically represented or dynamically unconscious in the ordinary sense. This notion is based on the mutual regulatory moves in the infant-caregiver relationship as described by Tronick (1989). In other words, some change that occurs in dynamic therapy is in the realm of procedural knowledge involving how to act, feel, and think in a particular relational context (Stern et al. 1998). Implied in this conceptualization is the important point that many changes that occur are *outside* planned technical strategies. A teary eye, a shared laugh, or a meaningful glance at the end of a session may promote change, even though the exchange is entirely spontaneous and is not within the therapist's conceptualization of "technique." Through interactions with the therapist, prototypes of object relationships stored in implicit procedural memory can be modified by new experiences. Psychotherapy can thus be viewed as a new attachment relationship that has the potential to restructure attachment-related implicit procedural memory (Amini et al. 1996).

A third way the relationship can be therapeutic is through internalization of emotional attitudes of the therapist. For some patients, this involves a tempering of a hypercritical superego. The patient begins to internalize the therapist's nonjudgmental, curious, exploratory stance toward material that the patient has regarded as shameful or as "bad." This internalization process may occur through explicit comments by the therapist, but gestures, intonation, and other forms of nonverbal communication may also be registered implicitly or explicitly.

Patients may also internalize conscious strategies for self-reflection. In this manner, patients become their own therapists who can think about their internal experience in the way the therapist does. One frequently observes this strategy during a vacation, when the patient begins to imagine a dialogue with the therapist while the therapist is out of town and identifies with the analyzing function of the therapist. Another variation on this theme referred to earlier (see "Fostering Insight") is the patient's capacity to find himself or herself in the therapist's mind (Fonagy 1999).

A final mode of therapeutic action related to the relationship is the simple identification of recurrent transference-countertransference themes. Repetitive interactions eventually become obvious to the patient, even without the therapist's interpretation. The therapist may simply call attention to them or observe them without understanding or explicating their underlying motivation.

Secondary Strategies

In the category of secondary strategies are included a number of interventions that are classically regarded as not truly psychoanalytic. All psycho-

analytic therapists, however, use a variety of interventions to bring about change every time they see a patient (see Table 5–3). Helping the patient change is far more important than being true to a theory.

The first class of secondary strategies is the implicit or explicit use of suggestion, often in a variation on confrontation. Freud wanted to distinguish interpretation from suggestion as a way of distancing himself from hypnosis. Yet most current thinkers view suggestion as an integral part of the therapist's authority that one should not disavow (Levy and Inderbitzin 1997). For example, even interpretations may call the patient's attention to behavior patterns with an implicit or explicit suggestion that the patterns are problematic and may require change (Raphling 1995). Directing the patient's attention to one set of associations or linkages may, by implication, suggest to the patient that certain aspects of mental life or behavior are worth more attention than others.

Another secondary strategy that may lead to change is the *confrontation of dysfunctional beliefs*. Cognitive therapists regularly use this type of intervention, but most dynamic therapists also use it, either implicitly or explicitly. The examination and confrontation of irrational or dysfunctional beliefs is an inevitable component of any good psychotherapy for depression or anxiety. Regardless of the theoretical underpinnings of the treatment, therapists must help patients see that anxious and depressed mood states recruit ways of thinking that perpetuate dysphoria and therefore need to be directly addressed.

A third class of secondary strategies involves efforts to address the patient's *conscious decision-making* or *problem-solving methods*. Although psychodynamic therapy is often referred to as "nondirective," this adjective is a generalization that has many, many exceptions. Dynamic therapists frequently direct the patient's attention to problematic ways of thinking or behaving. Even patients who are high functioning and suited for exploratory therapy can benefit from an explicit focus on problem solving. Such approaches may help a person make more adaptive life choices, which in turn influence her subsequent decisions. For example, one patient who worked in an academic setting was enraged at her department chair, for reasons that involved both real perceptions and transference distortions (Gabbard and Westen 2003). She was planning to go to his office shortly after a psychotherapy session to confront him in ways that would have been disastrous for her career. The therapist interrupted her plan with two approaches: by confronting the self-destructive way she was planning to deal with her anger and by exploring other ways that she could address her concerns with her department chair that would accomplish her conscious goals without undermining herself. The patient then went on to interact with her chair in a way that addressed her needs while also avoiding shooting herself in the foot.

Table 5–3. Modes of therapeutic action in long-term dynamic psychotherapy

Techniques aimed at fostering insight	Aspects of therapeutic action derived from the therapeutic relationship	Secondary strategies
Free association	Experiencing a different kind of relationship	Implicit or explicit use of suggestion
Interpretation	Internalization of the therapist's function	Confrontation of dysfunctional beliefs
Observation from an outside perspective	Internalization of therapist's emotional attitudes	Addressing the patient's conscious problem-solving methods
	Internalization of conscious strategies for self-reflection	Exposure
	Identification of recurrent transference-countertransference themes	Forms of self-disclosure
		Affirmation
		Facilitative techniques

As this example suggests, helping patients solve problems may be particularly useful in the presence of strong affects, since their reasoning can be compromised under such circumstances.

Exposure is a primary mode of therapeutic action in behavioral treatments, particularly for anxiety states. However, variations on exposure occur even in dynamic therapy. Fundamentally, exposure refers to presenting the patient with a stimulus or situation that provokes anxiety while forcing the patient to confront the situation until the anxiety dissipates. This approach alters associative links. In the treatment of panic disorder, cognitive-behavioral researchers have had considerable success in addressing the *fear of fear* that panic patients develop. The hypervigilance of such patients amplifies the anxiety and may lead to further panic attacks (Barlow 2002). Experimental evidence suggests that the association between internal states (such as shortness of breath) and anxiety about potential panic can over time become wired at subcortical levels involving the thalamus and amygdala. These associative links may not be easily amenable to verbal or cerebral treatments such as psychodynamic therapy, except to the extent that the patient's insights into the problems force confrontation of the feared situations. Analysts from Freud on have noted that for phobic patients little progress will be made unless the patient faces the feared situation (Gabbard and Bartlett 1998).

Patients undergoing psychodynamic treatments manifest avoidance in many areas of their lives, and this avoidance is self-reinforcing. It keeps anxiety at bay, which in turn reinforces avoidance of memories, thoughts, or situations associated with anxiety or other negative affect states. An exposure model can be useful for thinking in object relations terms about affects associated with warded-off representations, such as when a depressed patient actively wards off positive self-representations. Many patients with depressive dynamics fear feelings of pride in accomplishment and actively ward off both the recognition of others and self-recognition. To what degree this is best addressed by exploring the meaning of the defense; by inducing the patient to examine and "sit with" positive, self-warded-off self representations; or by some combination of the two approaches is an open question. For some patients, it may be that no amount of analysis of defense will overcome the natural tendency to avoid what is threatening. Without active confrontation of the feared situation, no progress may be made.

Many interventions in psychoanalytic therapy actually rely heavily on exposure (Wachtel 1997). The diminution of transference anxieties over time is in part related to exposure as the patient recognizes that her fears of being criticized or humiliated by the therapist are unrealistic. The patient habituates to the anxiety with repeated visits to the therapist, who does

not react in the way that the patient anticipates. As Fonagy and Target (2000) pointed out, helping patients differentiate belief from fact, and fact from fantasy, is a part of exposure in which the therapist acknowledges the patient's psychic reality of fear while simultaneously providing an alternative perspective that suggests safety.

A fifth class of secondary strategies involves forms of *self-disclosure.* Judicious and limited self-disclosure may be useful in helping patients learn to understand the internal world of others. (Judicious self-disclosure is discussed at greater length in Chapter 8, "Identifying and Working With Countertransference.") In this regard, it may promote mentalization (Gabbard and Westen 2003), leading to enhanced reflective function in the patient. For example, by sharing a feeling with the patient, the analyst might help the patient to see that his perception of how the analyst feels is only a *representation*—one that can be played with and understood.

A sixth mode of secondary intervention is *affirmation*, as described in Chapter 4 ("Therapeutic Interventions"). Patients who have experienced severe childhood trauma may construe interpretation as invalidating the patient's subjective experience in the same way that parents disbelieve the child's reports of trauma. Notions of validation and acceptance have long been central to theories of therapeutic action outside psychoanalysis (Rogers 1959), and they began to gain acceptance in the psychoanalytic literature with their introduction by Kohut (1971).

A final class of secondary strategies involves what might be called *facilitative* techniques. These are interventions that help the patient become more comfortable collaborating with the therapist to understand the workings of the mind. They can range from the use of humor or educational comments to various forms of reassurance or soothing that can be helpful in encouraging a patient to confront difficult or shame-inducing material.

Summary

The goals in psychodynamic therapy vary according to the therapist's favorite theory, the therapist's own unconscious motivations, and the patient's problems and interests. Goals may shape the preferred mode of therapeutic action. The patient's individual characteristics also influence the therapeutic strategies, and no single path of therapeutic change applies to all. Some principles of change and techniques for eliciting change are likely to be useful for most patients, while others are likely to be useful only for some. Dynamic therapists should always attempt to tailor the therapeutic strategy to the individual patient. Moreover, nothing guaran-

tees that the various goals of treatment and techniques useful for facilitating change outlined here will be free of elements that are conflicting or at cross purposes, any more than we would expect people's motives to be free from conflict. Less active, exploratory techniques may at times inhibit alterations in associative networks that could come about if the patient were encouraged to confront a feared situation more directly. On the other hand, more active techniques that foster changes in associative networks may at times interfere with exploration, impeding the patient's sense of autonomy and possibly activating oppositional dynamics.

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6

Working With Resistance

Resistance is the daily bread and butter work of the dynamic therapist. In 1912 Freud wrote, "The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving toward recovery and the opposing ones" (Freud 1912/1958, p. 103). As noted in Chapter 1 ("Key Concepts"), the patient's characteristic defenses emerge as resistances in the interpersonal setting of therapy. Hence the way the patient opposes a therapist provides valuable information about the patient's intrapsychic life.

Even though patients may be thoroughly miserable, they become attached to their ways of coping with the world. They have reached an internal equilibrium that is threatened by the beginning of psychotherapy. Change can be the most frightening prospect of all to people who are entrenched in specific patterns of behavior, thought, feeling, and relatedness. Circling the wagons against the potential intrusion of the therapist may seem like the safest course of action. Patients may resist the therapy in myriad ways: They may come late, keep secrets, forget to pay, forget the session, fall silent, restrict their comments to television shows they have seen in the past week, or focus on news headlines for 30 minutes of a 50-minute session. One of the most common forms of resistance is avoiding any continuity in subject matter from one session to the next, as though each hour of therapy is a new beginning.

The concept of resistance connotes an obstacle that must be removed and thus may evoke military metaphors. The therapist may feel that a

frontal assault on the resistance is necessary to get on with the therapy, but directly attacking resistance frequently serves to strengthen it. Dynamic therapists should regard the resistance as an informative and illuminating revelation about who the patient is.

When Freud began psychoanalytic work, he asked his patients to say whatever came to mind. Frequently, his patients would shut down and be unable to free associate. He gradually discovered that what shut them down often had to do with feelings about the analyst. Thus transference served as a resistance that stopped the analysis. At the same time, transference was enormously revealing about the patient's internal object relations and how the past repeated itself in the present. Friedman (1991) characterized transference as "the perfect resistance insofar as it brings reporting to a halt, but it is also the necessary (and troublesome) vehicle conveying unconscious material into the field of analytic operation" (p. 576).

These discoveries were made early in Freud's career when he saw analysis as primarily a process of retrieving memories that would explain the patient's neurosis. As he shifted from the memory-retrieval model, he recognized that resistance should not be regarded as stoppage. He was much more impressed with the positive desire inherent in resistance (Friedman 1991). The patient's longings for the analyst superseded the wish for understanding. Freud gradually came to see that the clinical task was not to clear away resistance so that memories could surface. Rather, the task was to help patients develop a divided consciousness so that they could observe and reflect on their active aspirations toward the analyst. Hence the opposition or resistance was redefined as a *preference for nonreflective action rather than this desired state of divided consciousness* (Friedman 1991). As Friedman put it, "The patient must feel both 'I want…' and 'it is a (troubling) feature of my mind and my life that I (conflictedly) want…'" (p. 590).

Psychodynamic therapists often do what is counterintuitive in the consulting room. Dealing with resistance is no exception. They must enter more deeply into the resistance rather than clearing it away. The therapist invites the patient to be curious about the resistance because a detailed exploration of what impedes the therapy illuminates wishes, fantasies, conflicts, and desires.

To illustrate this approach, let us consider a patient who is verbalizing freely in the session and suddenly falls silent. Because dynamic therapy is fundamentally noncoercive, it is not useful to insist that the patient verbalize what is being withheld. Most therapists would sit quietly for a bit to see if the patient wishes to talk again. But when the silence continues, the therapist has many options. One is to say, "I noticed that you stopped

talking right after you mentioned the dinner you had last night with your mother. Any thoughts about that?"

In making this comment, the therapist invites the patient to be curious about the occurrence of the silence/resistance right after a specific event that is being recounted to the therapist. Another therapist might be less inclined to make such a linkage and simply inquire, "Any thoughts about what made you stop talking?" Transference and resistance are inevitably linked in the clinical process, but dynamic therapists would probably postpone introducing a transference interpretation in this case because it would be premature to assume that the silence was related to fantasies about the therapist. One would want to accumulate data over time suggesting that a particular transference paradigm was related to the patient falling silent. Does the patient think the therapist is critical? shaming? envious? contemptuous? angry? These questions will ultimately be answered, but not until a clear pattern of falling silent at certain times in the session emerges.

One must grow comfortable with resistance. It is expected and is understood empathically rather than removed by fiat. Silence has multiple meanings, and only with time do those meanings start to become clear. With some patients, silence may be necessary for periods of time, and the therapist can convey an acceptance of that silence. If gentle inquiries about the origins of the silence fail to re-engage the patient, a therapist might wish to say, "Maybe you'd prefer to sit in silence together for a while." The therapist conveys not only acceptance of the silence but also a message that the patient is not alone during the silence.

Acting Out/Acting In

The original meaning of *acting out* can be found in Freud's classic 1914 work, "Remembering, Repeating, and Working Through," in which he made the following observation: "We may say that the patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it without, of course, knowing that he is repeating it" (Freud 1914/1958, p. 150). The original meaning, then, was of unconscious repetitions in the consulting room that served as substitutes for remembering and verbalizing.

In contemporary psychodynamic parlance, these phenomena would be referred to as *acting in*, since they occur within the treatment setting. The term *acting out* is now used to describe events that occur outside the therapeutic setting. For example, as described in a case example in Chapter 4 ("Therapeutic Interventions"), Mr. C started dating a female doctor he

met at a social occasion as a way of acting out his transference feelings toward his therapist. The acting out serves a resistance function because the patient is taking something into action rather than verbalizing it and understanding it with his therapist. The term *acting out* is also used to describe a general defensive style found in individuals with Cluster B personality disorders. These patients channel feelings into actions that may be destructive to self or others instead of reflecting on the feelings and processing them with the therapist.

As in the example of the male patient who starts dating a female doctor, acting out in therapy is often related to transference issues. In other words, it is viewed as a displacement of transference feelings onto another figure in the patient's life. Nevertheless, beginning therapists often make an erroneous or poorly supported assumption that behaviors occurring outside the clinical setting always reflect acting out of transference issues. In fact, the behavior may or may not be linked to transference, and the therapist may be better served by exploring it openly with the patient rather than jumping to the immediate conclusion that the two things are related. Often such acting-out behavior has a long history that predates the patient's entry into therapy.

Acting in is best defined by three features (Paniagua 1998): 1) it is a nonverbal form of action involving somatic musculature; 2) there is conscious or unconscious intentionality and meaning that are potentially conducive to the exploration of dynamics; and 3) the action or its consequences occur during the treatment session and are directly observable by the therapist.

Common examples of acting in include partially undressing in the middle of a session, leaving the session early, falling asleep, secretly taperecording a session, writing out a check to pay the fee but failing to sign it, and refusing to look at the therapist. One patient brought a CD player to the session and asked her therapist if he would like to dance with her. The therapist responded calmly that he did not dance with patients, but he would like to discuss with the patient her fantasy about dancing with her therapist.

Another patient leaped from her chair during the session, turned around 360 degrees, and said to the therapist, "You haven't commented on my new skirt. Do you like it?" The therapist responded by asking if the patient had been hurt by his nonresponse.

These examples should make it clear that acting-in or acting-out behaviors should be understood empathically rather than regarded pejoratively and critically by the therapist. They are valuable conveyors of meaning, as are all resistances, and the therapist should attempt to take an accepting and reflective attitude toward them.

Kohut (1984) viewed resistances in an entirely different way than ego psychologists. He believed that a therapist may be misguided by regarding resistance as derivatives of the sexual and aggressive drives and the defenses against them. Instead of interpreting or confronting defenses, self psychologists influenced by Kohut understand such resistances in terms of activities undertaken "in the service of psychological survival, that is, as the patient's attempt to save at least that sector of his nuclear self" (p. 115). These psychologists argue that we should empathize and respect the patient's need for defenses and not attempt to challenge the patient with his or her defensiveness.

Because of the highly variable nature of acting-in and acting-out behavior, one cannot generalize about the optimal strategy for dealing with such resistances. Some acting out, such as engaging in unprotected sex or drinking while driving, must be vigorously confronted because the patient's life may be threatened by the behaviors. Patients who repeatedly miss sessions may need to be told that therapy is impossible if they absent themselves. Patients who cut themselves or take drugs during a session may also need to be confronted and have limits set on the behaviors.

On the other hand, many forms of acting in need to be tolerated, explored, and observed for some time before their meaning is complete. Much of the resistance accompanying acting-in phenomena involves transference resistance. In other words, the patient creates and lives out a particular fantasy with the therapist without observing and reflecting on the meaning of this behavior. A clinical illustration will provide a useful example of this phenomenon:

> Ms. G, a 36-year-old woman, came to psychotherapy with Dr. H, a female psychiatric resident, because of "problems with [her] temper." She described significant difficulties in multiple areas of her life. She had been in multiple abusive relationships with men and had gone through two divorces. She was afraid of being alone, and on several occasions she had made decisions to live with men after knowing them for only 2 or 3 weeks. Ms. G had a very strained and difficult relationship with her mother, feeling that she had never received any approval from her mother. Her repeated experience was that her mother withdrew her affection if Ms. G did anything of which the mother disapproved.
>
> Ms. G had a childhood history of being sexually fondled by a stepfather at a young age. She told her mother about the fondling, and the mother confronted the stepfather, who promised not to do it again. The abuse continued in the same fashion, however, for the next 3–4 years. He threatened Ms. G by saying that he would start abusing her sister if she told anyone. After her mother and stepfather divorced when she was 13, Ms. G told her mother about the continued abuse. Her mother expressed outrage at the time. However, when they later became financially desperate, her mother decided to move back in with the stepfather.

Ms. G left home at age 15 and eventually went to college, where she engaged in excessive drinking and sexual relationships with multiple partners. She told her therapist that she had a Rolodex with the names of all the men she had slept with.

She dropped out of college and moved out of state with a man she had only recently met. She worked as a topless dancer and became involved with a man who was physically and sexually abusive and who at times threatened to kill her. She escaped this man by marrying another man she had met only 8 weeks before. During this marriage, she had a brief affair with a man she met on the Internet who was 10 years younger than herself. When her husband found out, he could not forgive her and divorced her.

In the psychotherapy, her history unfolded in layers. Often she would get defensive if Dr. H attempted to pin her down on exact details of what had happened when. A pattern emerged in the therapy each week in which Ms. G would describe an extraordinary event about which the therapist knew nothing. One day, for example, she came into her session and said in a cheerful voice, "I went to a PEP meeting this week." Dr. H asked what PEP stood for. Ms. G replied, "It's a local group called People Exploring People."

Dr. H indicated that she was not aware of this organization. Ms. G explained that it was an organization for people interested in bondage, domination, and sadomasochism (SM). She explained that she and her current boyfriend also practice SM: he ties her up, blindfolds her, and chokes her. She said that she did not feel endangered by this behavior, because she felt sure that she was in control of how much choking her boyfriend did. She said matter-of-factly to her therapist that she was really only fully sexually satisfied when some form of SM was enacted, always with her in the submissive role. Her therapist was surprised, if not shocked, to hear about these activities, as there had been no previous mention of them.

In her next session Ms. G revealed that several years previously she had been addicted to crack cocaine and had prostituted herself to get sufficient funds to buy the cocaine. She boasted that on one occasion she performed oral sex on five men standing in a row for $500, and on another occasion had sex with 17 men in one night. She proudly stated to her therapist, "That was my record."

Each time Ms. G revealed another story, Dr. H found herself feeling more emotionally disconnected and incredulous. She started to feel that she could no longer relate to Ms. G in any meaningful way. In fact, the therapist noted that she was objectifying Ms. G and feeling more and more like she was watching a "freak show." Reflecting on her countertransference, she recognized that she was beginning to objectify Ms. G in the way that Ms. G had been objectified sexually by others throughout her life. When telling Dr. H about one of the PEP meetings, Ms. G explained that some members of the organization perform public sex acts. Ms. G herself described how she was tied up publicly at one of the meetings while another woman used a vibrator on her. Dr. H began probing for details about exactly what happened, trying to get a picture of the scene in her head. Because of Ms. G's vagueness, the therapist spent at least 10

minutes trying to elicit the details. At one point, Ms. G observed, "Those acts are mostly for the exhibitionistic types."

When the session was over, Dr. H had the uneasy feeling that something had gone awry. Reflecting on it with her supervisor, she remembered that Ms. G was smiling the entire time, seeming to enjoy the process with her therapist. As Dr. H considered what had happened, she realized that it wasn't absolutely essential for her to obtain all the details of the scene at the PEP meeting. Her supervisor pointed out that she had become a voyeur to Ms. G's exhibitionist.

Ms. G was creating in the transference to her therapist something that commonly occurred in her life outside the treatment. She was engaging in a sexualized exhibitionism that shocked and fascinated Dr. H, so that she assured herself of having the therapist's attention. However, it served a resistance function as well, because it was not accompanied by any reflective observation about its meaning, its origins, or how it might represent psychological or emotional conflict for the patient. She expressed no interest in changing the behavior, and Dr. H even wondered why she was bringing it up in therapy.

This example also illustrates how acting-in behavior frequently elicits a desired response in the therapist. Dr. H noted how the "dance" created by the acting in of Ms. G evoked an exhibitionist-voyeur scenario similar to what happened in the PEP meetings. However, this insight came after some time of observing the acting in and allowing herself to be "sucked in" by what was happening. In this regard, this form of resistance was extremely useful in that it was a *revelation* of a powerful internal object-relations scenario that was present in the patient's outside life and that led to a good deal of difficulty in relationships, not to mention dangerous romantic situations with partners. The therapist pointed out the pattern to Ms. G and suggested that they might usefully explore what was going on between them and why this repeated pattern of relatedness had so much attraction to her. However, Dr. H also recognized that to some extent the resistance had been a two-person phenomenon, since she had participated through her own *counter-resistance*. These transference-countertransference recreations are inevitable, are useful to the process, and are ultimately discussable with the patient.

Resistance to the Awareness of Transference

Some patients offer a form of resistance in which the significance of the therapist is repeatedly denied (Gill 1982). Before taking a 3-week vacation, a therapist said to his patient, "I wonder if you're having any feelings about my 3-week absence." The patient responded that she hadn't given

it a thought. She told the therapist that she viewed him just like an accountant, a dentist, or any other professional and had no particular feelings of attachment toward him. For narcissistically organized patients, the apparent absence of the transference *is* the transference. These patients may have chronic difficulties in forming meaningful connections to others, and this serious problem in object relationships manifests itself similarly in the therapy process. From the perspective of attachment theory, these patients have a dismissive style of attachment. Dependency may be terrifying to such patients, and the therapist may decide that only extratransference work will be possible, recognizing that the insistence that the therapist is not important represents an important safeguarding of the self that prevents narcissistic wounding in the patient. In other cases, the therapist may interpret the patient's resistance to the awareness of transference and can help the patient overcome anxieties about dependency. One must be judicious, however, in confronting the patient's reluctance to acknowledge attachment to the therapist. Therapists who are too eager to point out transference implications of the patient's comments may appear excessively self-preoccupied to the patient. Paradoxically, such a therapist may heighten the defensiveness of the patient, who will insist even more vehemently that he or she has no feelings of any kind for the therapist.

With patients of this nature, therapists are well advised to bide their time and look for the emergence of unmistakable transference feelings, either in dreams or in offhand comments at the beginning or the end of the session. There is often a particularly heightened transference associated with an "exit line" after the patient has gotten up from the chair and moved to the door (Gabbard 1982). Occasionally the exit line may be the most important communication of an hour, conveying a message that the patient feels cannot be said while sitting in the chair during the formal part of the session. The patient may have in mind a partition between what is said in the chair versus what is said on the way out the door. These comments deserve careful attention because the patient is not likely to bring them up in the next hour. The exit line is stated while leaving because the patient wants to keep it *out* of the session. More precisely, the patient is *ambivalent* about communicating this material in this session. Hurling it as a parting shot is a compromise between saying it and not saying it. A communication may be so emotionally charged that it can be conveyed only as a session ends, when the therapist will not have an opportunity to respond.

Mr. I was a 28-year-old man who was seeing a female therapist in twice-weekly dynamic psychotherapy. He frequently talked about a previous

therapist, whom he referred to by first name, and with whom he had a close and affectionate relationship. His therapist would periodically suggest to him that he might be telling her about the kind of relationship he wanted with her. Mr. I denied that he had any concerns about his new therapist and was quite satisfied with the way things were. He also denied any curiosity about her private life. However, at the first session following the therapist's 2-week vacation, he strode to the door at the end of the session and asked, "Looks like you got a tan on your vacation. Did you go skiing with your boyfriend?" Mr. I's therapist was caught off guard by the question but had the presence of mind to say, "Let's discuss it next time." As might be expected, Mr. I did not bring up the comment when he showed up for his next session. After about 15 or 20 minutes of the session, the therapist pointed out that although they had agreed to discuss his exit line at this session, he had so far made no reference to it. He quickly said that he had forgotten it and that it was really an inconsequential comment anyway. However, the therapist persisted to explore its meaning, and eventually Mr. I acknowledged that he was curious about the therapist's personal life and hoped to gain a special relationship like the one that he had with his previous therapist by obtaining some inside information about her.

Final comments in many contexts have privileged positions (Gabbard 1982). When time is running out, a sense of "now or never" comes into play, and the patient may finally say something that has been withheld for a long time. Final words of the therapy session are heavily invested because they bear the feelings derived from earlier separations. In psychotherapy, time is our master. At the end of each hour, the patient is reminded of the limits of the relationship. Exit lines can be poignant efforts to prolong the time with the therapist or to redefine the relationship as a personal one rather than a professional one.

One way of understanding why these words are saved for the end is that the therapist then has no time to reject the patient. There is a feeling of safety in bringing up the comment at the end of the hour. This explanation also helps us understand why patients do not want to return to the theme of the exit line at the next session. Therapists must be prepared to bring up the issue if the patient "forgets."

Aggression or anger may also be expressed in an exit line, even though there is no hint of negative transference during the hour itself.

A 31-year-old man who had been intermittently suicidal was speaking with his therapist during the last session before the therapist's 1-week absence. Although the patient expressed no concern about the absence during the session, things changed at the end. As he reached for the doorknob, he turned to the therapist and said, "Well, I'll see you in 2 weeks if I don't commit suicide."

This exit line was intended to leave the therapist with anxiety and guilt about being gone for a week and abandoning the patient. Another way to understand how the patient was handling his anger is that he attempts to spoil the therapist's vacation by planting the idea of suicide as a possibility during the absence. He ensures that he will be on the mind of the therapist during the 1-week absence. In fact, the therapist, who could not think quickly enough to come up with a response, simply watched his patient leave and then worried about the patient during his entire vacation. In this way, there is both an expression of hostility and a defense against being separated from the therapist for a week. The patient imagines that a representation of him will torment the therapist during the entire time they are apart.

Characterological Resistances

To a large extent, therapists get to know their patients by the way patients resist the therapy process. As noted in Chapter 2 ("Assessment, Indications, and Formulation"), the patient's characteristic defenses become resistances when the patient enters therapy. Defenses and resistances are embedded in relatedness, and anxieties produced by the presence of the therapist become apparent as the patient enters into the process. The specific characterological defenses and internal object relations that have been etched in the patient's neural networks over a lifetime will come to the fore in each case, so the patient's fundamental personality is presented in bold relief when the threat of being known by someone (i.e., a therapist) is confronted.

The dynamic therapist may find it useful to track the emotional state of the patient. The way that the patient handles disturbing affects will say a great deal about the characterological defenses of that patient. Feelings of shame and humiliation may prevent the patient from assimilating observations made by the therapist. A specific intrapsychic conflict may be heralded by the emergence of a certain feeling state. When a flash of anger, sadness, or anxiety appears in the session, what does the patient do with it? Abrupt shifts from one topic to another may represent a defensive flight from a subject that evoked anger, for example. The therapist may wish to call attention to a patient's conflict about the anger and the defensive strategy used to deal with it (Gray 1990). A clinical example will illustrate the emergence of characterological resistances and how they may be addressed in dynamic therapy.

> Mr. J was a 38-year-old man who came to treatment with concerns about relationships and work. He sat on the edge of his chair and spoke at con-

siderable length about his issues. He informed Dr. K that he had been able to identify eight contributing problems. He brought written notes with him and went through the notes systematically. Problem 1 was an ambiguous conflicted relationship with a female colleague. Under the heading of her name, Mr. J had generated a list of 12 different thoughts and descriptions of their previous interactions. One of these items, titled "Info on her," had its own list of 12 facts that he felt were relevant to understanding their relationship. Despite the clear importance of this relationship, Mr. J talked about these matters in a way in which no affect was really expressed whatsoever.

Dr. K noted the obsessive-compulsive characterological style of the patient early in the process. The patient used a host of defenses associated with that personality disorder, including doing and undoing, isolation of affect, reaction formation, and intellectualization. Mr. J clearly controlled his feelings by compiling facts and "data." His problem list and the lists within the list were a way of gaining an illusion of control over difficult feelings. In this way he could avoid "losing control," a situation he feared almost more than anything else. It was also clear that he attempted to control the therapeutic situation in the same way that he tried to control the relationship with his female colleague. He would use the time in the therapy sessions to describe in great detail the facts associated with his experience of feeling weak and overwhelmed. He would identify all of the aspects of the conflicted relationship with the woman and review every detail of that situation, both in and outside the session.

Mr. J arrived at one session, for example, by stating, "I just don't know what to do. All I've been doing is thinking about this girl." He reported that she had called a few nights earlier at 4:30 in the morning asking him to wake up because she had something important to talk about. Mr. J said, "I laughed at her and told her she should be getting sleep. I think she thought I was being rude because she hung up." After describing this interaction, Mr. J reported that he had been thinking about why she called and now knows what she wanted to talk about. He made reference to a time she had led him to believe that they would be having dinner together at her apartment. When he arrived, he found that three other male guests were already present. Mr. J stated, "I think she's finally feeling guilty about that night. She knows she hurt me, and now she wants to see what I'll say." He went on to describe in detail how, despite her guilt, she still could not control herself from bringing up the situation out of a desire to be punitive and mean. Dr. K noted that most of the information and facts Mr. J claimed to know were largely extrapolations from a rather vague 30-second phone call. He also noted that in Mr. J's rambling, detailed account, there was an obsessional overinclusiveness that hid the forest by attention to the trees. This cognitive style and defensive way of approaching affectively charged material, typical of many obsessive-compulsive personality disorders, controlled the entire session so that Mr. J's therapist found it very difficult to get a word in edgewise. When the therapist would try to talk, Mr. J would often respond by saying, "Let me just finish the account first." Often the entire 50 minutes would be filled up with the various extrapolations that Mr. J had developed from brief encounters with the woman

and left almost no time for any input from the therapist. In this way, Mr. J controlled Dr. K, controlled his own anxiety, and deprived himself of getting help.

Another difficult issue that arose in the therapy was Mr. J's strong need to derive the perfect solution before taking the action. This perfectionism manifested itself in sessions when Mr. J became paralyzed with indecisiveness after outlining the pros and cons of two competing plans of actions. He would then undertake an extensive examination of the pros and cons and conclude that one particular plan of action was better than the others. Just when he appeared to have decided on the best plan, he would revert back to an alternative position, thinking that what he had chosen might, in the long run, be the wrong decision.

Like many people with obsessive-compulsive character structure, Mr. J was plagued with doubt about any decision that was made for fear that the outcome would be less than perfect. Hence the pattern of doing (decision making) and undoing (revoking the decision) was a recurrent pattern within the psychotherapy. The doing and undoing also applied to his conflicts about his expressions of anger or aggression. In one instance, he did not say "hello" to the receptionist at the entrance to the office building where he saw Dr. K, and he became terribly concerned that he might have hurt the receptionist in some way. Therefore he left the waiting room to go back down the elevator and tell the receptionist "Good morning" before his session began.

At times, the paralyzing indecisiveness led Mr. J to beg Dr. K to provide the perfect solution to his dilemma so that his choice would be the "correct" one. For example, at one session he said to his therapist, "My mother wants to come to our next session and meet with us. I think it's a good idea so she can tell you what she observes about me. What do you think?" The therapist asked Mr. J about why he felt this was useful and also noted the urgency with which he approached the issue. Mr. J said he had been thinking about the usefulness of such a meeting for some time and was feeling pressure from his family to make arrangements. He outlined potential pros and cons, eventually settling on the idea that it might be best to postpone a meeting with his mother until there was a clearer sense of what the specific goals were for the meeting. Having reached the conclusion that it would be a good idea to postpone the meeting, Mr. J and Dr. K ended the session, and the patient walked to the door. Mr. J's exit line reversed the decision, "So I think I'll see if my mother can come next time. I think that will be the best."

After Mr. J left, Dr. K felt that all the tiring work they had done during the past hour had disappeared. It was as though a drawn-out contract negotiation had fallen apart at the last moment. Dr. K was left fuming about what had happened, and he felt he needed to address this with the patient next time. At the beginning of the next session, Dr. K made the following observation, "I know you want my opinion on what to do here, but I often feel I know too little about your experience to make such suggestions. Last time we worked together to make a decision that I strongly endorse, only to have you change your mind as you left the office. I think one of the ways that you create conflict in your relationships is engaging people

to help you, only to dismiss their help when you ultimately decide what to do. This is one way that your aggression seeps out of you even though you try to control it as much as you can."

In this clinical vignette, Dr. K used a here-and-now process to help explicate how Mr. J tried to defend against his anger and aggression unsuccessfully. His tendency to control the sessions by being overinclusive, his insistence on getting the therapist's opinion only to undo it, and his paralyzing indecisiveness all led others to feel exasperated with him, including his therapist. Over time the therapist was able to help the patient track his own concerns about anger and aggression and the defensive style by which he resisted the therapist's help.

Dr. K also worked to help Mr. J recognize that he operated with the assumption that there was one correct choice for every decision. This belief led to the idea that he had to identify the "right answer" before acting. Dr. K ultimately helped him to understand that when faced with a choice, either decision could ultimately work out, depending on how he dealt with the choice after committing himself to it.

Because the patient's characterological resistance took the form of rigidity and isolation of affect, Mr. J seldom expressed humor. The therapist also tried to inject humor into the decision-making process whenever it seemed appropriate. Mr. J eventually could laugh and recognize the inherent absurdity of his perfectionistic goal.

Flight Into Health

Another common mode of resistance is demonstrated when patients assert that they have been "cured" early in the therapy before things have been thoroughly explored. These flights into health are defensive ways of avoiding discussions of painful conflicts or affect states. The therapist may wish to help the patient determine how many of the goals established at the beginning of the therapy have actually been attained. It may also be useful for the therapist to empathize with the patient's underlying anxiety about reflecting on what is happening inside.

Flights into health at times lead to early or premature termination of therapy. A general rule of thumb is that the first time a patient brings up termination, the decision is probably serving a resistance function. Although this rule of thumb is not absolute, it is certainly worth considering when the patient is wishing to terminate therapy before a number of issues have been examined. However, there will be times when the patient is insistent on termination, even though the therapist thinks it may be ill-advised. In such cases, the therapist is probably wise to accept the deci-

sion and pave the way for the patient's return. The timing of termination of therapy is discussed further in Chapter 9 ("Working Through and Termination").

Lateness and Missed Sessions

Two of the most common forms of resistance are lateness and missed sessions. Some patients are characterologically late and are virtually never on time, while others are late only when something about the therapy is troubling them. Some patients are extraordinarily concerned about punctuality and feel it is irresponsible when they come a few minutes late. Others feel no concern whatsoever about keeping people waiting for them and rarely mention their lateness.

Therapists have to carefully assess the particular meanings of lateness for each patient and the patient's reaction to the lateness. The way the therapist intervenes depends on the characteristics of the individual patient and the specific situation. For example, in someone who shows no anxiety whatsoever about arriving late and keeping the therapist waiting, the therapist may wish to promote mentalization. At a well-timed moment, the therapist might ask, "Do you have any thoughts about what I might have been feeling while waiting for you today?" The patient may not have considered the therapist's internal state and not contemplated the impact the lateness has on the therapist. To help the patient begin to mentalize about the therapist's internal reactions may require a number of such interventions until the patient becomes more curious about the therapist's internal world. The therapist can then generalize from the transference situation into outside relationships where the patient keeps people waiting. Is there a sense of entitlement that others should adjust their schedules to his? Does the patient express anger toward others by keeping them waiting? Was the patient made to wait as a child in situations with his parents or siblings, for which he is now seeking revenge by making others wait for him?

In any case, the therapist is well advised to maintain the time frame as originally established. If the session is to begin at 2:00 and end at 2:45, the session should end at 2:45, even if the patient does not appear until 2:20. If the therapist extends the session, the patient receives the unconscious message that it is alright to expect others adjust to his schedule. If the patient gets angry because the therapist maintains the time frame, this anger may lead to useful exploration about the patient's pattern of lateness.

When patients who are ordinarily punctual come late to therapy sessions, therapists might be inclined to address the lateness immediately, but

this often promotes defensiveness. A better strategy is to see how the patient explains her lateness and whether she sees it as having any meaning for the therapy or as being simply the result of traffic problems or other external matters. Although reality factors do conspire to make people late for appointments at times, therapists should always keep in mind that resistance finds the best hiding place. Even if traffic is particularly slow, the circumstance of being delayed in traffic can provide a convenient hiding place for anxieties that the patient has about bringing up difficult issues with the therapist. At the same time, the therapist does not want to push the agenda of resistance when the patient is simply not open to exploring it. The underlying concerns of the patient will undoubtedly return in future sessions and can be examined at that point. Another factor worth exploring is whether the patient is coming late as a way of avoiding a return to an issue or discussion that occurred in the previous session that she found troubling.

Missed sessions are another common form of resistance, and one of the reasons many therapists charge for missed sessions in psychotherapy is that this practice often results in much better attendance. Patients who are not charged when they miss therapy may have a host of rationalizations for absences. When they are expected to pay whether or not they show up, absences mysteriously evaporate along with the excuses for them. For this reason Freud (1913/1958) advocated "leasing" an hour to the patient:

> Under a less stringent regime the "occasional" non-attendances increase so greatly that the doctor finds his material existence threatened; whereas when the arrangement is adhered to, it turns out that accidental hindrances do not occur at all and intercurrent illnesses only very seldom.... Nothing brings home to one so strongly the significance of the psychogenic factor in the daily life of men, the frequency of malingering and the non-existence of chance, as a few years' practice of psycho-analysis on the strict principle of leasing by the hour. (p. 127)

In today's climate of clinical practice, implementing Freud's recommendations may be difficult. Some insurance companies and governmental third parties will not pay for missed appointments. If the patient is paying out of pocket, however, many therapists still contract with the patient to pay for missed sessions before starting the treatment (unless, of course, they are able to fill the opening with another patient). Others use variations of this policy that allows for some flexibility. For example, some therapists may charge *unless* the patient gives them 24 hours' notice of the absence. Others allow a limited number of sessions per year to be missed without billing for them. Bona fide emergencies or serious illnesses are also treated as exceptions by many therapists.

Beginning therapists often wonder if it is advisable to call patients who do not show up for their psychotherapy sessions. If suicidality is a concern, therapists probably should call the patient to check on the patient's safety. On the other hand, some chronically suicidal patients with borderline personality disorder may take advantage of the therapist's anxiety about a potential for suicide and begin to expect a call from the therapist as a regular response to not appearing for a session. If this pattern develops, the therapist certainly needs to take it up with the patient and examine the patient's motives.

With patients who are not suicidal or self-destructive, most therapists would not call after one missed session. However, if two consecutive sessions are missed, it is probably a good idea to telephone the patient and see if he or she is interested in continuing therapy or if some external circumstance has occurred that has kept him or her from attending. Patients who say they have decided to quit therapy should be invited to come for one more session and explore the pros and cons of that decision, while making it clear that ultimately therapy is a voluntary endeavor and that it is entirely up to the patient whether or not to continue.

Summary

Resistance is an everyday aspect of the dynamic psychotherapist's work. Whereas the term was originally applied to patients in analysis who stopped free associating, it has now taken on a much broader meaning of almost anything that opposes the work of the psychotherapy. In particular, it manifests itself as nonreflective action rather than a stated divided consciousness whereby the patient is participating in the work of therapy while simultaneously engaging in self-observation. *Acting in* refers to nonverbal behavior observable by the therapist that has significant meanings requiring explanation. *Acting out*, on the other hand, generally refers to behavior outside the session that has some meaning in terms of transference issues.

Many forms of resistance involve transference, and often the patient's fantasy about what the therapist is thinking or who the therapist is interferes with the patient's capacity to do productive work in therapy. On the other hand, patients may also resist awareness of the transference and proceed with the therapy as though the therapist is not a significant figure to them. Sometimes only at the end of the hour, when the patient goes to the door and hurls a parting shot, known as an exit line, will the transference to the therapist emerge. Hence exit lines should be carefully noted. Many patients have characterological resistances that are embedded in long-

standing defenses and internal object relations that serve to resist the therapist's efforts. Other common forms of resistance involve flights into health, lateness, and missed sessions.

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7

Use of Dreams and Fantasies in Dynamic Psychotherapy

The study of dreams has always been a valued part of psychoanalysis and psychodynamic therapy. Freud (1900/1953) viewed the interpretation of dreams as the "royal road" to the unconscious. Core conflicts may be so troubling to a patient that they are banished from the patient's waking thoughts. However, when the defensive vigilance dissipates with the onset of sleep, the conflicts may emerge in dream material. Some would question whether dreams are still *the* royal road because we now view transference, resistance, and nonverbal behavior as other avenues to unconscious issues, but the understanding of dreams continues to be a major tool of the dynamic therapist.

Neuroscience research on dreaming and rapid eye movement (REM) sleep has proliferated in the past 30 years. Although some investigators (Hobson 1988) have tried to minimize the psychodynamic importance of dreams by emphasizing neurophysiological findings, Reiser (2001) emphasized that the neurophysiological domain and the psychodynamic domain are not interchangeable. Neuroscience findings cannot disprove the psychodynamic value of dreams. Mind and brain use different languages and techniques, and the dreamer's mind appropriates the dreaming brain's physiological state to depict meaningful psychological issues. Hence many of the time-honored principles of psychoanalytic dream interpretation continue to apply in the work of the contemporary dynamic therapist.

Dreams

Understanding Dreams

One of the core psychoanalytic tenets is that a dream is a disguised version of a wish. Freud insisted that unconscious childhood wishes were transformed into disguised symbols through a censor that made sure the dreamer's sleep would not be disturbed. Freud distinguished between two layers of dream content. The *manifest* content is the dream's surface as perceived by the dreamer. The *latent* content refers to unconscious wishes and thoughts that threaten to awaken the dreamer and therefore must be disguised. A set of defense mechanisms that operate within the dreamer's ego serve to disguise the latent content and transform it into manifest content.

Today we would recognize that dreams may depict other internal processes besides unconscious childhood wishes. They also represent fears, conflicts, and (in the case of traumatized patients) recurrent efforts to master and metabolize traumatic experiences. Nevertheless, the defense mechanisms used by the dreamer's ego continue to be useful in trying to decipher the meaning of the dream.

- **Condensation.** This mechanism combines more than one wish, feeling, or impulse in one manifest dream image. One figure in a dream, for example, may have the bald head of one person, the beard of another person, and the clothing of a third person. The feelings associated with these three different individuals may thus be disguised and become apparent only through psychotherapeutic work on the dream.
- **Displacement.** In this mechanism, the intensity that is associated with one person may be diverted to a separate person to become more acceptable to the dreamer's ego. For example, the dreamer may feel that it is forbidden to have sexual feelings for one's therapist, so the feelings are displaced onto another person in the patient's life.
- **Symbolic representation.** This method of disguise involves the use of a simple concrete sensory image to represent a complex set of feelings that may be highly charged. Freud (1900/1953) suggested that a flower, for example, is a common representation of female genitalia. The inside of a house may depict the inside of one's mind. However, Freud also stressed that most dream symbols are used idiosyncratically by each dreamer, and the unconscious meaning can be discerned only through hearing the patient's associations to the material. The arbitrary assignment of meanings to dream symbols, such as can be found in publications sold in supermarket checkout lines, has little value. A special instance of symbolic representation is called *synecdoche*, when

a part stands for a whole. For example, in referring to sailboats, one might say, "I saw at least 15 sails on the sea today," indicating 15 sailboats. This figure of speech is regularly incorporated in dreams that represent a whole by depicting a part.

- **Secondary revision.** Mechanisms of displacement, condensation, and symbolic representation are characteristic of a primitive mode of cognitive activity that Freud referred to as *primary process*. More advanced and reasonable aspects of the ego serve to organize these primitive elements into a more coherent framework. This process, known as *secondary revision*, involves an effort by the dreamer to take the irrational and bizarre components of a dream and edit them into a more rational story. Even after the dreamer has awakened and begins to remember or write down the dream to tell it in therapy, further changes may occur as the dreamer attempts to make the dream content more coherent. Therefore the dream that is told in psychotherapy may be significantly different from the one that was dreamt.

Another important concept originated by Freud is the *day residue*. An event that occurred during the day may appear in disguised form in a dream. In Dorothy's dream in *The Wizard of Oz*, the three farmhands she encounters before the tornado appear in disguised form in her dream as the Scarecrow, the Tin Man, and the Cowardly Lion. Miss Gulch becomes the Wicked Witch of the West. A dynamic therapist often looks for elements of the day residue in collaboration with the patient as the dream is understood and interpreted.

Technique of Dream Interpretation

One central concept in psychodynamic therapy and psychoanalysis is that the understanding of a dream requires the associations of the patient to that dream. Therapists should avoid taking an omniscient stance of telling the patient what a dream means without first listening to the patient's thoughts about the dream. Thus a useful way to approach the process of dream interpretation is to say to the patient after he or she has finished telling the dream, "What comes to mind as you think about the dream?" Sometimes the manifest content so obviously depicts a major issue in the dreamer's life that associations may seem unnecessary. Nevertheless, a therapist is still wise to postpone interpreting the dream until the patient has associated about the dream content. Often the dreamer's associations take the dream in an unexpected direction. Specifically, one always hopes that associations will illuminate how the dreamer has transformed the latent content into the manifest content.

In psychotherapeutic work with dreams, numerous resistances may emerge. Patients may view the therapist as a soothsayer who can discern the true meaning of the dream without the patient's help. Some patients may say they have no associations and look to the therapist to explain the dream in the manner of a television psychic. In such cases, the therapist may need to remind the patient that psychotherapy is a collaborative endeavor and that the therapist is unable to interpret the dream without the patient's help. Highly competitive patients may try to beat the therapist to the punch by interpreting the meaning of the dream instead of freely associating to it. They may tell the therapist what they think each symbol means in a controlling and highly intellectualized fashion to avoid dropping their defenses and letting their mind wander in the manner of free association. A third common form of resistance in work with dreams is that certain highly charged dream images are avoided in the patient's associations. This avoidance frequently occurs around depictions of the therapist in a dream, and the therapist may need to ask the patient specifically what comes to mind about the avoided dream image. Indeed, a common technical strategy is to ask the patient directly about certain dream images that seem to be of relevance from the therapist's point of view.

Dreams themselves may be used as a powerful resistance to psychotherapy. One occasionally sees a patient who will flood the entire session with dream material, leaving no time to work with the therapist on any of the dreams. Such a patient may jump from one dream to another without pausing to associate to the dream material, so the therapist is overwhelmed with the task of trying to keep track of the different dreams and what they depict. A dream might also be brought up at the end of the hour in "exit line" fashion so that there is no time to analyze the dream. One's dreams can serve as a royal *detour* away from the unconscious as well as a royal road to it.

Some clinical examples of dream work in psychotherapy illustrate some of the foregoing concepts.

> Ms. L was a 27-year-old woman who was undergoing dynamic psychotherapy twice weekly with Dr. M. She had an older sister (age 32) whom she always felt had been the apple of her father's eye and with whom she was extremely competitive. Her sister was a physician like her father, but Ms. L was in a totally unrelated field. She longed for her father's attention, but she always felt she could not compete with her sister. After a Thanksgiving weekend at the family home, she returned to therapy on Monday morning and reported a dream that had occurred on Sunday night. The patient was in a house, and she heard noises in another room. She walked into the other room and found her older sister in bed with her father. She woke up at that point.

The therapist asked what came to mind about the dream. Ms. L responded with silence and then said, "Nothing." Dr. M empathized with the patient's embarrassment and said, "It is very disturbing to imagine an incestuous relationship between your father and your sister, even in a dream." This empathic comment helped the patient to feel understood, and then she began to associate, "Yes, it *is* embarrassing to talk about this with you. It doesn't surprise me, though, in a way." Dr. M asked, "Why not?" Ms. L explained: "Well, last night my father took my sister and me to the airport so we could catch our flights home. He hugged me and kissed me on the cheek, and then he went to hug and kiss her, and she kissed him squarely on the lips. I couldn't believe it. They seemed like two lovers." Here Ms. L associates to the day residue that undoubtedly triggered the dream. Dr. M said, "It must have seemed almost like they were in bed together." Ms. L replied, "But in the dream they were *not* having sex in the bed." Here the defensive forces of the waking ego come to the rescue to make sure that something unacceptable depicted in the dream was not as bad as it may have appeared. Dr. M took the material a bit further by saying, "Yes, I understand that, but at times you have felt very excluded by their relationship, as though they were in the parental bedroom together and you were on the outside looking in." Ms. L continued her associations: "The whole Thanksgiving weekend they talked about medicine nonstop. I felt that I was not part of their relationship, and I think my mother felt the same way. It was almost as though those two were a married couple, and the rest of us were excluded. I hate to say this, but I am still so jealous of her." Dr. M responded, "There's probably a part of you that would like to be in the parental bedroom with your dad in your sister's place." Ms. L nodded, reluctantly admitting that she had always wanted to be her father's favorite.

In this bit of dream work, the dreamer disguises her wish to have her father to herself and to triumph over her sister by the use of displacement. It is her *sister,* not she, who is actually in bed with the father. The day residue served as a useful vehicle to disguise this wish. Because Dr. M and Ms. L had a strong therapeutic alliance that had developed over many months of therapy, he was able to help her see the displacement based on having worked through the same theme over and over again in the therapy. The sister may have also served as a displacement from Ms. L's *mother* in the dream, the patient's original rival for her father's attention. However, this reference was too far from Ms. L's conscious awareness to bring it up, so Dr. M chose to keep it to himself.

Another case illustrates the mechanism of symbolic representation, and particularly synecdoche.

Ms. N was a 42-year-old woman who came to psychotherapy after the death of her son from muscular dystrophy. She was a stoic woman who had defended against her grief by becoming active in the local muscular dystrophy organization and by insisting that helping others kept her from

feeling sad about her son. Nevertheless, she would occasionally tear up as she talked about him, only to flee from her feelings when they became uncomfortable.

One day Ms. N came to therapy and said, "I had a dream last night. I don't know what to make of it. It was a very short dream. I looked at my fingernails, and they were all broken." The therapist asked her what came into her mind as she thought about that image of broken fingernails. She hesitated a moment and then said that when she was changing her son's bed sheets, which was a frequent necessity during his last days alive, she would often break her fingernails. She reflected on how completely ridiculous it was to worry about such minor trivia as a broken fingernail when her son was dying. Her therapist tuned into the meaning of the dream and said, "In some ways it would be nice to have broken fingernails again, because it would mean your son is still alive." The patient cried quietly.

Ms. N was someone who wished to avoid uncontrolled sobbing and overwhelming grief after the death of her son. The dream depicts a disguised wish. The depiction of broken fingernails is a symbolic representation. Using synecdoche, the image substitutes a part for the whole. Broken fingernails have a specific meaning to Ms. N—her son is alive, she is changing the sheets on his bed, and she is fulfilling the wish to have him in her life once again so she can devote herself to him and escape her grief. The dream also expresses a wish to redo the last few weeks of her son's life in a different way—that is, she would not concern herself with trivial worries about such things as broken nails and would devote herself to her son in a more emotionally complete way.

In these examples, the therapist has interpreted the manifest content as representing a disguised version of the latent content. This work is only the tip of the iceberg, however, because we rarely can plumb the depths of a dream and look at the myriad determinants that have led to the creation of the dream imagery. In Shakespeare's *A Midsummer Night's Dream*, after Bottom wakes up from his extraordinary dream, he says, "It shall be called 'Bottom's Dream,' because it hath no bottom" (Wright 1948, p. 56). Dreams are bottomless, and we cannot expect to discern all of the multiple layers of meaning in any one dream. We generally have to content ourselves with the most significant content for the patient at the time the dream is dreamt.

Fantasy

The American writer Ursula K. Le Guin once made the following observation: "We like to think we live in daylight, but half the world is always dark; and fantasy, like poetry, speaks the language of the night" (Le Guin 1979). The language of the night—dreams—is indeed closely linked to

the language of daytime fantasy. Both transport us from reality into wish-fulfilling nether regions of the psyche where life is the way we'd like it to be. However, daydreams may be more embarrassing and more shameful than night dreams. Many patients would much rather share a dream from the previous night than a daydream they had only minutes before the session began. Patients seem to feel more responsibility for daydreams and therefore feel that their secret fears, wishes, deficiencies, and conflicts are transparent when they share daydreams with their therapists.

Fantasy is one of our primary ways of adapting ourselves to the disappointments of reality (Person 1995). Fantasies often provide substitute gratifications for wishes in our lives that are painfully unfulfilled. They serve as consolations for what we do not have, and they also may heal wounds from our past.

> A 16-year-old boy went through his adolescence narcissistically wounded. In physical education class, he was always the last person chosen for teams when competitive sports were played. He also felt uncoordinated and weak in comparison to the other boys in his class. He feared that girls would not be interested in him because of his poor athletic prowess. To compensate for this painful and humiliating reality, he elaborated extensive fantasies from reading Superman comic books. He imagined that he would have all of Superman's powers bestowed on him through magical contact with some type of supernatural figure, such as a genie or fairy. In his fantasy, he would appear at the Olympic trials and would set astounding world records in multiple events, leading to his appearing on the cover of *Time* magazine. He imagined the other boys in his physical education class watching television in stunned silence as he received one gold medal after another in Olympic competition.

Daydreams and reveries are often used synonymously with fantasy, but they probably represent a subset of fantasy. Reveries and daydreams are conscious. They often involve storylines and serve powerful psychological functions. As in the case of the teenage boy who lacked athletic skills, his daydream helped him master the trauma of being the last one chosen in every sports activity and extracted revenge as he contemplated with glee how his peer group would react to seeing him in the Olympics on television. Fantasies also supply a sense of fulfillment and gratification in parts of our lives where we feel deprived of such pleasures. Even though daydreams and reveries are private, they are often powerful forces that influence our lives in ways that may be beyond our comprehension. They can be part of a shared cultural fantasy or can be extremely idiosyncratic and private (Person 1995).

Other fantasies, however, are unconscious and may emerge only through psychotherapeutic work. At times these unconscious fantasies become

apparent in the transference relationship with the therapist, while at other times they begin to emerge as patient and therapist piece together the current themes in the patient's life outside therapy.

> Mr. O was a 52-year-old man whose wife had divorced him approximately 18 months before he came to therapy. He told his therapist that he remained mired in grief. He was anxious, depressed, and virtually immobilized. After he had talked about the grief in therapy for some time, his therapist became aware that he was more or less "stuck" and was unable to move beyond the feeling of having been abandoned and wronged by his ex-wife. He could not let go of any of the physical evidence of his marriage around his home. Whereas she moved into an apartment, he stayed in the house they had shared. He slept in the same bed, even though one of the two nightstands was gone. He kept pictures and memorabilia of her everywhere. One day his therapist suggested that perhaps he was harboring a fantasy that she would actually return and live with him again. Mr. O responded that he had had no contact with his ex-wife and she had made no efforts to reconcile, but he still wondered if it might be possible. With his therapist's help, an unconscious fantasy started to surface about a possible reconciliation. Part of the fantasy involved her taking pity on him when she saw how much he was suffering and how immobilized he was. If she felt sufficiently sorry for him, maybe she would return to take care of him. He also imagined that the main reason she left him was his lack of "earning power." He began to think that if he could find a way to win the state lottery, he might woo her back with a large check in hand. Hence, beneath the paralysis was a powerful fantasy that was fueling his need to stay immobilized. If she could just see how much he suffered, perhaps she would return. Meanwhile, maybe he could win the lottery and woo her back with promises of wealth.

Mr. O had a fantasy that largely involved someone outside the therapy. Some unconscious fantasies emerge only through careful understanding of transference wishes that are not apparent at first. Some fantasies about the therapist may be hidden for long periods of time for fear that if they are discovered they will never be fulfilled. Sidney Smith (1977) described the *golden fantasy*, a common if not universal fantasy that emerges in many cases of psychoanalysis and long-term dynamic psychotherapy. In brief, it is a "wish to have all of one's needs met in a relationship hallowed by perfection" (p. 311). This particular fantasy may appear as a powerful resistance to psychotherapeutic work. Certain patients may relate to their therapists as though the therapist can solve all their problems by loving them and taking care of them. They may listen to insight with interest, but they rarely internalize the insight and reflect on it in a way that translates into changes in their everyday lives. Alternatively, they may have no interest in insight whatsoever and simply do whatever they can to ensure that the therapist loves them.

When this fantasy is uncovered and examined in the light of day, a major feature of the fantasy is that somewhere in the world there is one special person who is capable of fulfilling all the patient's needs. The patient assumes a position of passivity while being cared for in such a complete way that no effort whatsoever is needed by the patient. Often patients tenaciously hang onto this fantasy, feeling that to lose it would be to give up their sense of meaning and to launch themselves into a horrible state of existential despair. As the fantasy is explored, one often finds that the patient believes that it represents a paradise lost from childhood. It is as though perfect caretaking actually existed at one time (although it is highly unlikely that it ever did), and if the patient simply behaves properly, the paradise will be restored. When the fantasy is identified and elaborated, it often leads to a useful mourning process that is a regular accompaniment of long-term dynamic psychotherapy. Many dreams, fantasies, and wishes are reluctantly moderated in the course of treatment as patients learn to live in reality more than in fantasy. Nevertheless, psychotherapy also teaches patients the value of fantasy and its adaptive and useful aspects throughout the life cycle.

The Role of Erotic Fantasy

Many patients assume, when they are asked about fantasies, that the therapist is referring to *sexual* fantasies. In popular usage, the term *fantasy* often has that connotation, and patients may feel particularly embarrassed about any fantasies connected with the therapist. Sometimes an educational intervention is needed to clarify what is meant by fantasy when it is used in psychotherapy.

Erotic fantasy plays a central role in the life of the human psyche. Stoller (1979) emphasized that sexual fantasy is something we explore in psychotherapy because the themes in erotic fantasy transcend issues of sexuality. Erotic fantasy is often a window into the internal object relations, unconscious conflicts, narcissistic wounds, and traumas of a person's past. As Stoller (1979) put it, "The function of daydreams is to state a problem that has been disguised and then to solve it, the problem and solution being the poles between which excitement flows" (p. xi).

Like many other daydreams, erotic fantasies, especially those that accompany masturbation or sexual relations with others, are often shameful and embarrassing. While erotic fantasies vary widely, each adult has a specific erotic pattern that Person (1980) refers to as the *sex print*.

Sex prints may fit the person's personality style or may be surprisingly at odds with the person's usual behavior and interpersonal style. Fantasies may be heterosexual, bisexual, or homosexual and may involve particular

places or multiple partners. Some of the excitement in sexual fantasies may be shameful to the person, and often what he or she is imagining during sex with a beloved partner is a source of deep shame because it is so different from what is actually occurring in the bed. The sex print that each adult harbors generally has its origin in themes of power and pleasure that relate to early life experiences and conflicts involving gender and pleasure (Person 1995). The fantasy might be necessary for the person to reach orgasm, or it might be at least ancillary to other sexual activities.

Erotic fantasies may be viewed as unacceptable or "politically incorrect." Therefore patients may hope to conceal them throughout the psychotherapy so they will be spared the humiliation of exposing their secret wishes. For example, in a study of 193 university students, 30% of women and 31% of men acknowledged that they had sexual fantasies of "being tied up or bound during sex activities" (Person et al. 1989). Patients are often highly unforgiving about such fantasies, and therapists must handle their fears with considerable tact. Some patients may go through an entire psychotherapy process without ever discussing their sexual lives or fantasies because of the shame. Therapists can work with their anxieties about revealing such matters, but some patients may be quite reluctant and might never discuss their sex lives with the therapist for fear that they will be humiliated for sharing their most private and shameful fantasies.

Many other patients readily speak about their erotic fantasy lives and hope to learn something more about themselves from exploring these fantasies. Frequently the erotic fantasy life provides hope and compensation for the despair existing in the person's actual intimate relationship. Sexualization may transform feelings of destructiveness, neediness, and dysphoria into excitement and euphoria (Coen 1992; Gabbard 1996).

> Ms. P was a 42-year-old woman who came from an extremely religious family of origin and had always been perfectly behaved throughout her childhood, adolescence, and young adulthood. However, she came to therapy explaining that her husband had had no interest in her sexually for 10 years, and she had reached a point of despair. She had had breast augmentation surgery and had gotten a personal trainer to tone up her body. All of this was to no avail, as her husband continued to pay little attention to her. In the course of the work with the personal trainer, however, she began to become infatuated with him and had extensive sexual fantasies about him. She particularly loved the idea that he was a "bad boy type." She imagined that she could be "dirty" with him and do things that her husband would never do. She bought a black "Hummer" and gradually developed a new identity associated with the car and with her fantasy love life involving the personal trainer. She explained to the therapist that

she bought the Hummer because it was "cocky and bad-ass." She also said that when she drove around town in it she had an illusion of power and invulnerability. She mentioned in passing that Hummers had become popular in the early 1990s after the Gulf War. When she drove around her hometown in her Hummer, she had explicit sexual fantasies about running into her trainer and having a sexual liaison in the back seat of the vehicle.

The fantasy life of Ms. P served multiple functions. It clearly compensated her for her experience at home of not being desired. It also provided hope that she would somehow find a man who would find her exciting. By choosing a "bad boy" and a Hummer to drive, she also undid the rigid constrictions of her extremely religious family life and fulfilled her dream to be wild and adventurous, unrestrained by family obligations or religious beliefs.

Therapeutic Approaches to Fantasy

Because fantasy is ubiquitous, the therapist will be immersed in the patient's conscious and unconscious fantasies throughout the therapy. Narratives about the past will help the therapist learn what the patient is trying to overcome with current fantasies about others. Expectations of romantic partners, colleagues, children, and bosses provide a rich source of the patient's crucial fantasies as they operate in the present day. Similarly, when therapists discuss expectations of therapy with the patient, a variety of transference fantasies emerge about what therapists can or should do.

Fantasies are closely linked to what Luborsky (1984) referred to as the *core conflictual relationship theme.* The theme usually involves some type of need or wish that is in conflict with a control function of the ego or superego. For example, the patient may wish to succeed in a job situation but might worry that ambitious strivings will be punished. To resolve the conflict, the patient decides not to even try to succeed at work. Thus, one way to discern fantasy is to identify a wish, a fantasized response from another person to that wish, and a subsequent response from the self (Book 1998).

Exploring expectations and disappointments in others generally provides a direct path to discovering details of a patient's fantasy life. Some patients may balk at the term *fantasy* because of their association of the term with sex or because of the shameful nature of their daydreams. Therapists must use tact in exploring private fantasies. If the patient is reluctant to talk about secret fantasies, the therapist may choose simply to accept that decision and wait for a subsequent time when the alliance is stronger.

Another option is to approach the reluctance to talk about fantasies like any other resistance, such as silence or avoidance. A dynamic therapist does not go directly after the underlying content or the "secret." Dynamic therapists assume that resistance is there for good reason, so they explore the patient's anxieties about revealing something to the therapist rather than verbally twisting the patient's arm to reveal the secret. Often when therapists explain to the patient in these circumstances that therapy is not coercive and the patient has every right to conceal material from the therapist, such statements have a paradoxical effect. Some patients will feel more comfortable in sharing because they sense that the therapist is not unduly voyeuristic or nosy about the patient's secrets. Moreover, when therapists explore the patient's anxieties about revealing shameful material, they often come across transference fantasies about the therapist's probable reaction that are extremely useful in understanding the patient's fears and wishes.

Some patients are reluctant to express sexual fantasies because they are convinced that the therapist will disapprove of them or think them perverse. Hence when patients are discussing erotic or otherwise shameful fantasies, therapists who maintain a matter-of-fact attitude may help patients overcome the certainty that the therapist is thinking humiliating thoughts about them. It is frequently helpful to point out to patients that they themselves are the ones who find the fantasies disgusting and that they assume (through projection) that others share their views.

At times certain fantasies take on life-or-death importance and need to be pursued more aggressively. Patients who are determined to commit suicide, for example, may harbor powerful fantasies about the impact their suicide will have on others. Parents of small children may assume their children will be better off if they commit suicide, and exploration of that fantasy with such patients may help them increase their mentalizing capacities and recognize that the children will not feel exactly the way the patient imagines they will. Some patients feel that if they cannot measure up to their excessively perfectionist self-expectations, suicide is the only viable option (Smith and Eyman 1988). Examining these unrealistic fantasies of what is possible in their own lives may help them reach a more moderated view of what to expect from themselves. Revenge fantasies are often present in persons who are planning suicide, and there may be an intensely hateful wish to destroy the lives of others through the act of suicide. Finally, reunion fantasies may be present in the motivation for suicide, and patients who look forward to a joyous reunion with a loved one may find suicide highly enticing (Gabbard 2000).

Too often discussions of suicide are fraught with anxiety, especially by beginning therapists. A frank discussion with the patient about what will

happen after suicide may lead to critically important dynamic themes that can be discussed and understood. The more these fantasies are laid bare, the more viable alternatives may be seen to be realistic, and the patient may learn that there is a way to continue living with pain instead of ending it all with suicide.

Summary

Dreams reveal unconscious struggles that the patient may have difficulty verbalizing during waking life. The latent content of a dream may be disguised using condensation, displacement, symbolic representation, and secondary revision. In working with dreams, the therapist must elicit the patient's associations to the dream and recognize that dreams may also serve resistance functions.

Fantasy is ubiquitous. Some fantasies help us survive disappointments and traumas. Reveries and daydreams are conscious, but other fantasies are largely unconscious and require therapeutic work to bring them to the surface. Erotic fantasies may be windows into conflicts, defenses, and internal object relations. Powerful fantasies may also be the source of suicidal wishes.

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8

Identifying and Working With Countertransference

Dr. Q, a 29-year-old female psychiatric resident, brought her new patient, Mrs. R, into her office for their first session. Mrs. R was an attractive 54-year-old woman who appeared younger than her age and spoke in a fairly dramatic style. Her speech was rapid, and her thought processes tended to be somewhat circumstantial, so she rambled in a discursive way as she told Dr. Q about her history. She had multiple complaints about both her feelings and her situation. She said her husband did not work enough, her two grown daughters were ungrateful, and she had chronic financial problems. She said she had attended an anger management clinic, where she had pounded on a chair while expressing her anger toward her mother. She asked Dr. Q if there was anything she could do to "get to the bottom of my anger," and before Dr. Q could answer she said, "I doubt if you can help—even God doesn't love me."

Dr. Q's initial reaction to Mrs. R was to feel smothered and overwhelmed. She found it difficult to keep up with Mrs. R and to follow her train of thought. Dr. Q also found that it was extremely difficult to interrupt her or to get a word in edgewise. Near the end of the first interview, Dr. Q found herself wondering where to begin. She frankly doubted that she would be able to help Mrs. R.

As the weekly sessions continued, Mrs. R complained extensively about her husband. She said that he had had a recent angioplasty, but it was "no big deal," and she said that he only had himself to blame, since he never exercised and had terrible eating habits. She would talk a lot about how unresponsive her mother was to her, and she noted that her two daughters also seemed uninterested in her or her suffering. Mrs. R tended to speak as though Dr. Q already knew the details of her life. She fre-

quently mentioned names without giving any explanation whatsoever. Dr. Q began to feel as though she was only a sounding board to Mrs. R. She found it difficult to interrupt so she could ask for clarifications about the names that Mrs. R mentioned. These efforts to get further information were rarely successful, because Mrs. R rambled on as if she didn't really care whether or not Dr. Q knew who she was talking about. Dr. Q began to feel used. She felt that Mrs. R did not truly want psychotherapy but simply wanted someone to accept her point of view uncritically and provide sympathy for all of the mistreatment she experienced at the hands of her family members and others. Dr. Q began to dread each session with Mrs. R and found that her mind frequently wandered onto what she would fix for dinner that evening, a problem with her babysitter, and a research project she was developing. When her mind wandered back to Mrs. R, Dr. Q had a fleeting thought that the way Mrs. R was talking reminded her of how her mother had talked to her on the telephone the previous evening. Dr. Q found that thought highly disconcerting and quickly shifted her attention back to the content of Mrs. R's narrative.

Dr. Q's struggles with her emotional reactions to her patient are familiar to all of us. As noted in Chapter 1 ("Key Concepts"), one of the central notions of psychodynamic therapy is that there are two subjectivities—some would say "two patients"—in the consulting room. The two complex human beings who are interacting in the course of psychotherapy are mutually influencing one another all the time and are evoking a variety of feelings toward one another.

Countertransference is thus ubiquitous. In the same way that Kohut's self psychology universalized narcissism, the theoretical shift within psychoanalysis from a one-person to a two-person psychology has legitimized countertransference as a useful part of the therapist's daily work. The original Freudian version of countertransference, the so-called *narrow* view, has a slightly pejorative connotation—that is, the therapist has countertransference because of unresolved personal conflicts. This pejorative tone is now considered a relic of the past. As noted in Chapter 1, the narrow Freudian view is only part of the picture. The prevailing view that crosses most theoretical schools is that countertransference feelings involve a joint creation with contributions from both patient and therapist (Gabbard 1995). In other words, the therapist brings her own past into the dyad, but the patient also *induces* feelings in the therapist.

If we apply these conceptual ideas to the case of Dr. Q and Mrs. R, we can see that Mrs. R relates to Dr. Q in a particular way. She controls the session by not allowing Dr. Q to speak, rambles discursively about how others have failed her, and places pressure on Dr. Q to accept her point of view uncritically. Dr. Q begins to feel overwhelmed, useless, and frustrated because she finds herself virtually unable to make a useful comment that might allow her to be a participant in a two-way conversation.

Like many patients who are narcissistically organized, Mrs. R has a sender but no receiver (Gabbard 2000). This treatment of another person as a sounding board induces what Kernberg (1970) referred to as a "satellite existence." Dr. Q's response of losing interest and dreading the sessions is completely understandable. Moreover, Dr. Q's countertransference suggests that the internal world of Mrs. R has been recreated in the interpersonal field between Mrs. R and Dr. Q. Mrs. R describes having a mother who is uninterested in her and two daughters who seem to lack interest in her. These internal objects are represented within her and, through projective identification, are externalized in the process of the psychotherapy. Dr. Q identifies with that projected uninterested object and begins to feel and behave like the representation in Mrs. R's mind. However, Dr. Q also brings her own past to the table, manifested by a fleeting thought regarding the similarity between the telephone conversation with her mother and the situation in therapy. Dr. Q recognizes that Mrs. R is about the age of her mother and that the two have certain characteristics in common. Dr. Q may feel like tuning out Mrs. R in the same way she feels like tuning out her mother at times. This fleeting thought of Dr. Q's suggests that there are self and object representations within her that serve as convenient "hooks" for what is projected by Mrs. R. Through careful processing of what she is feeling, Dr. Q can start to appreciate that she is experiencing what others, such as Mrs. R's daughters, experience when they are talking with Mrs. R.

Projective Identification and Countertransference Enactment

Two terms, *projective identification* and *countertransference enactment*, have worked their way into everyday discourse among psychoanalysts and psychodynamic therapists. Both involve similar processes in the therapeutic dyad, but the former is derived from Kleinian and object relations thinking, while the latter developed out of the work of American ego psychologists.

The concept of projective identification has evolved over time through the contributions of many British and American contributors (Bion 1962a, 1962b; Gabbard 1995; Klein 1946/1975; Ogden 1979, 1982, 1992; Rosenfeld 1952; Scharff 1992). The definition that has become most popular, although by no means universal, is one that involves two steps: 1) a self or object representation (often accompanied by an affect state) is projectively disavowed by unconsciously placing it into someone else, and 2) the projector exerts interpersonal pressure that nudges the other person to experience or unconsciously identify with that which has been projected

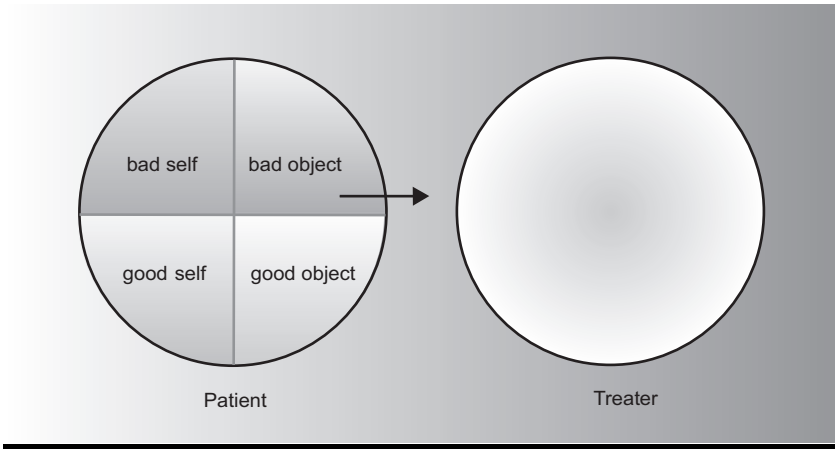

Figure 8–1. Projective identification—step 1.

The patient disavows and projects a bad internal object onto the treater.

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(Figures 8–1 and 8–2). The first step is a type of transference, whereas the second step can be regarded as countertransference.

If the situation is in a psychotherapeutic context, then a third step occurs. The recipient of the projection, the therapist, contains and tolerates the problematic self or object representation along with its affect and processes the projected contents, allowing them to be taken back (in a somewhat altered form) or reintrojected by the patient who projected them (see Figure 8–3). In this manner the construct of projective identification can be viewed as both an intrapsychic defense and an interpersonal communication. It can even be regarded as having therapeutic implications, in that the patient sees the therapist can tolerate difficult internal states that seemed unbearable to the patient. When the patient takes back the projected contents, the self or object representation, along with the affect accompanying it, is modified to some extent so that over time there is an alteration in the patient's internal object relationships.

In light of the broad consensus that projective identification relies on interpersonal pressure or "nudging," rather than a mystical or supernatural exchange of psychic content, the countertransference response arising in the therapist must be viewed as having been a latent structure that was somehow triggered by the patient's nudging. The preexisting nature of the therapist's conflicts and defenses and internal object relations will determine whether or not a projection and its recipient are a good fit. Even when countertransference is experienced by therapists as an alien force sweeping over them, what is actually happening is that an affect-laden re-

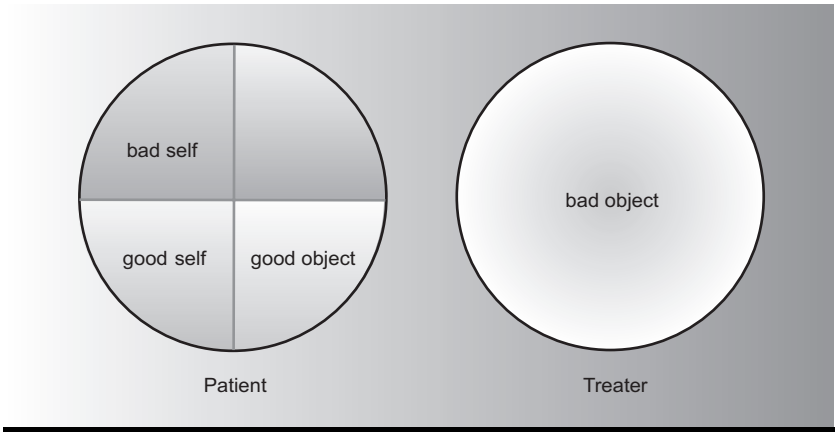

Figure 8–2. Projective identification—step 2.
The treater unconsciously begins to feel and/or behave like the projected bad object in response to interpersonal pressure exerted by the patient (projective counteridentification).
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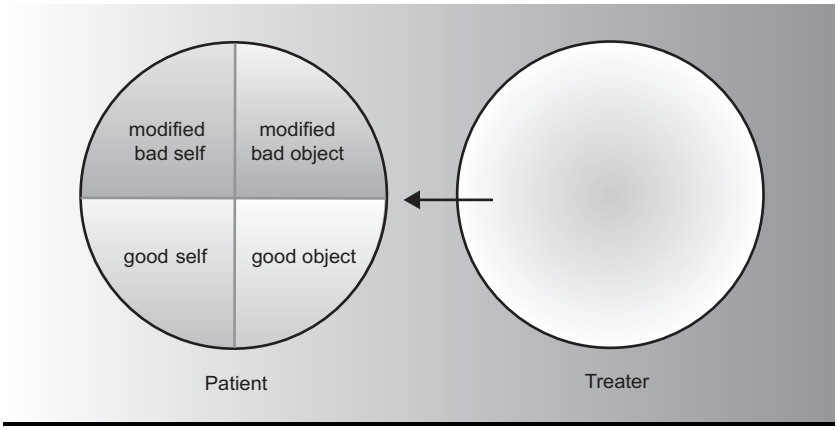

Figure 8–3. Projective identification—step 3.
The treater contains and modifies the projected bad object, which is then reintrojected by the patient and assimilated (introjective identification).
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pressed self or object representation has been activated by the interpersonal pressure of the patient. Hence a therapist's usual sense of a familiar, continuous self has been disrupted by the emergence of these repressed aspects of the self. Symington (1990) described this process as being one in which the patient "bullies" the therapist into thinking the patient's thoughts rather than the therapist's own thoughts.

Therapists may begin to appreciate that the projective identification is occurring when they begin to experience that they are not acting like themselves. They become abnormally angry, unusually forgiving, atypically bored, or excessively voyeuristic. When the feeling that "I'm not myself" appears, therapists should carefully consider what might be transpiring between them and their patients.

At times the manifestations of countertransference are much more subtle. Like transference, countertransference is unconscious, at least initially. Hence therapists may know about their countertransference only through various kinds of actions. They may forget a session; return a phone call or do paperwork before taking a patient five minutes late; find themselves clenching a fist while the patient talks; or find themselves dressing in a special way on the day they see the patient. All of these behaviors might be the first sign of feelings that are still unconscious.

Projective identification can involve the projection of either a self or an object representation. When the therapist identifies with an aspect of the self that is projected, this process, often referred to as *concordant countertransference* (Racker 1968), is closely related to empathy. If the therapist identifies with an object representation that has been projected, this phenomenon is known as *complementary countertransference* (Racker 1968). Take, for example, an adult patient who has been a victim of severe childhood abuse. Within this patient is an object representation of an abuser and a self representation of a victim. In the course of the therapy, the therapist may feel like the object at times and become angry or verbally abusive with the patient. At other times, the patient may be angry and demanding, and the therapist may feel like a victim, identifying with the patient's self representation, while the patient is identified with her own internal object representation of an abuser.

The challenge for the therapist is to identify the particular mix of contributions from the patient and from the therapist that constitute a particular countertransference. Projective identification can be so intense that the therapist may feel colonized by the patient's projections and unable to think clearly (Schafer 1997). Therefore it may take a good deal of time to process what is happening. Many times the powerful feelings engendered by the therapy can be understood only *between* sessions.

We often think about containment as the process by which projective identifications are metabolized; that is, one goes from thinking the patient's thoughts to thinking one's own thoughts (Gabbard and Wilkinson 1994). During the process of containment, therapists engage in several different activities. They don't simply endure the patient's unconscious attack on their thinking. They carefully sort out their own contributions versus the patient's and contemplate how they are recreating the patient's

internal object relations. They also try to work their way back to the desired state of dual consciousness in which they are enacting something with the patient while also observing themselves as it happens. They may also engage in self-analysis, wherein they reflect on how their own conflicts are being reactivated by this particular patient. They may formulate silent interpretations to explain what is happening before speaking. Finally, they may simply ask for clarification from the patient to help the patient elaborate on his or her own experience of the transference-countertransference developments.

Not all therapists will have the same countertransference responses to a patient. The notion of a hook in the therapist and a good fit between patient and therapist implies that the therapist's internal world will determine to some extent the nature of the response to the patient's transference. Ogden (1983) made the following observation: "Projective identification is a universal feature of the externalization of an internal object relationship, i.e., of transference. What is variable is the degree to which the external object is enlisted as a participant in the externalization of the internal object relationship" (p. 236). Hence some therapists may not have their "buttons pushed" by a particular patient as much as another therapist might. Sometimes the transfer from one therapist to another improves the therapeutic situation because the new therapist has an entirely different subjectivity from the old one and is not as easily provoked.

In the 1990s, a number of American ego psychologists began contributing papers on the topic of countertransference enactment (Chused 1991; Jacobs 1993a, 1993b; McLaughlin 1991; Renik 1993; Roughton 1993). The term gradually took on a meaning quite similar to projective identification. The fundamental idea was that "enactments occur when an attempt to actualize the transference fantasy elicits a countertransference reaction" (Chused 1991, p. 629). These enactments often were regarded as involving both the narrow form of countertransference and something induced by the patient. Roughton (1993) described this as actualization: subtle forms of manipulation on the part of the patient that induce the therapist to act or to communicate in a slightly special way or to assume a particular role with the patient that silently gratifies the transference wish or, conversely, defends against such a wish.

Enactments can be a kind of acting in by the patient, but American ego psychologists have also emphasized that there can be a corresponding acting in by the therapist. The idea of countertransference as a joint creation is supported by the constructs of both projective identification and countertransference enactment. The therapist's actual behavior influences the patient's transference, while the patient's actual behavior influences the therapist's countertransference.

Management of Countertransference

Countertransference must be identified as such before one can speak of managing it. As noted in the discussion under "Projective Identification and Countertransference Enactment" above, enactments may be the first sign of feelings that are still unconscious. A dream about a patient might be among the first signs of countertransference. One might dream of being angry with a patient or of being in bed with a patient while not having any conscious anger or erotic feelings for the patient. In any case, when the countertransference enters into the therapist's conscious awareness, then the process of containment—in which one considers the relative contributions of therapist and patient—begins.

The therapist then has a number of options about how to manage specific countertransference feelings, all of which may be therapeutic in some situations.

Tolerating the Countertransference

Winnicott (1971) once noted that the patient must destroy the therapist, and the therapist must survive the patient's attacks, before the patient can truly make use of the therapist. Inherent in this formulation of what happens between therapist and patient is the notion that the therapist's durability may be a significant factor in producing therapeutic change.

Thus at times the therapist need not do anything but simply sit with the feelings, contain them, and finally understand them to have a powerful impact on the patient. When patients observe their therapist tolerating feelings formerly regarded as intolerable, a mutative process may occur (Carpy 1989). When they then reintroject the feelings and representations, they can "re-own" them without feeling quite so overwhelmed.

Using the Countertransference to Inform Interpretive Understanding

Another way of managing countertransference is to use it in the service of formulating an interpretation about the patient's internal world. If something is being externalized and recreated with the therapist, it reflects a self-other constellation within the patient's inner world. Returning to the case of Mrs. R and Dr. Q, the patient was providing a good deal of information about her external relationships by enacting her usual style of relating in the therapy sessions. Dr. Q recognized that she felt entirely peripheral and useless to Mrs. R, and she felt that it became hard

to stay present in the session and to listen to Mrs. R's story. Knowing that Mrs. R described her mother and her two daughters as inattentive, Dr. Q might have formulated an interpretation based on her countertransference experience that went something like this: "I've noticed that often you don't quite make room for me to engage with you by sharing my observations in the sessions here. Is it possible that your daughters and your mother appear not to be listening to you because you don't make an effort to listen to them?"

In this interpretation, the starting point is the therapist's countertransference experience of being shut out and being unable to speak. Since her experience seems as if it parallels those of Mrs. R's daughters and mother, she offers a tentative formulation that what is going on in the therapy session parallels what happens with Mrs. R's family members.

This strategy is one that may backfire as well, and the therapist needs to give careful thought to the timing. As noted in Chapter 4 ("Therapeutic Interventions"), transference interpretation can be a high-risk, high-gain proposition, especially with more disturbed patients (Gabbard et al. 1994). Some patients will not be ready to hear an interpretation if they see it as a way the therapist is trying to unload her own feelings onto the patient. For example, one therapist who became increasingly exasperated with his patient who had borderline personality disorder finally said to her: "I think you are taking all of your anger and projecting it into me." The patient paused for a moment and said, "Can you think of anything better to do with it?" She was basically making it clear to him that she needed him to take on the role of the "bad object" as a way of getting the feelings of hatred and contempt out of herself and into someone else. In essence, her comment was a way of supervising him to let him know that he was prematurely unloading his difficult countertransference feelings.

Transference and countertransference can be viewed as opposite sides of the same coin. Often the therapist may feel like getting rid of difficult feelings by interpreting them as residing in the patient. However, in situations of intense negative transference—such as anger, hatred, envy, or contempt—interpretation may be viewed as a confirmation that the therapist is an attacker or persecutor trying to victimize the patient by cramming feelings down the patient's throat. Carpy (1989) emphasized that one needs to postpone interpretation originating in countertransference feelings until patients are capable of using the interpretation, which often means when they can recognize aspects of themselves in the therapist. The therapist, too, must be in a frame of mind that is optimal for using interpretation. When the therapist feels colonized by projective identification, the capacity to think, reflect, and formulate an interpretation may be severely compromised.

The timing for interpretation depends a great deal on the setting and the therapeutic moment. If both therapist and patient are in an *analytic space*, meanings can be played with, understood, and considered (Ogden 1986). The notion of analytic space derives from Winnicott's (1971) concept of potential space, where patients experience the transference as both real and not real, while the therapist can experience countertransference as both real and not real. There is an "as if" quality to each party's experience. A patient may feel that the therapist is unfair and unjust, but the patient recognizes that it is "as if" the therapist is her mother rather than insisting that the therapist is exactly like her mother. In an analytic or potential space, a patient is capable of thinking, "I have all the intensity of feelings I had for my mother when we would get into fights, but I know that you are actually not the same person as my mother and that I am imposing some of these feelings on you unfairly." When strong feelings are present in either patient or therapist, that sense of the "as if" can collapse, which can cause the meaning of the perception of either party to be less amenable to exploration.

Often when interpretive work is postponed until the subsequent session, a "cooling off" has ensued whereby the capacity to enter into an analytic space is restored. Both therapist and patient have processed their strong feelings toward one another, and the atmosphere is more conducive to the patient's seeing that something has been projected into the therapist that might not fit. Pine (1986) elucidated this useful principle of postponement of interpretation by saying, "Strike while the iron is cold" (p. 528).

Employing Judicious Use of Self-Disclosure

As noted in Chapter 5 ("Goals and Therapeutic Action"), thoughtful disclosure of the therapist's feelings to the patient can be therapeutic even though self-disclosure is not ordinarily regarded as a dynamic psychotherapy intervention. Most therapists eschew disclosures about their private lives or about personal problems. However, a specific type of disclosure involving feelings generated in the here and now of the therapeutic situation may be highly effective in helping the patient see the impact that she or he has on others.

In the example that opened this chapter, another strategy that Dr. Q could have considered is to make a direct statement about her experience. She might have said to Mrs. R, "I sometimes feel like I am just a sounding board for you, and that you really don't want to hear what I have to say." This type of self-disclosure is closely linked to confrontation, in that it draws the patient's awareness to the way she is treating the therapist.

Self-disclosure must be used with caution, though, because therapists can easily deceive themselves into thinking that what they are saying is therapeutic, when they are simply retaliating against the patient or trying to make the patient feel guilty. We must always be suspicious about our motives when we decide to disclose something about our feelings to the patient. Many corrupting agendas can lie behind a sincere wish to help a patient. Greenberg (1995) expressed some concerns about deliberate self-disclosure when he noted, "There are always multiple perspectives on the participation of each party. This means that whatever is revealed is simply one person's understanding at a given moment—never…the last word on the subject.…I am not necessarily in a privileged position to know, much less to reveal, everything that I think or feel" (p. 197).

Because we cannot be sure what we are up to when we are disclosing our own feelings to the patient, self-disclosure should be thought about carefully before using it. Talking with a supervisor to discuss potential unforeseen consequences is generally a wise course of action. Frequently, however, one does not have the opportunity to talk with a supervisor, especially when the self-disclosure is urged by a patient with a direct question. For example, a patient may see nonverbal manifestations of anger on the therapist's face and ask, "Are you angry with me?"

In such situations, the therapist is caught on the horns of a dilemma. If the therapist's face is red, his jaw clenched, and his neck veins bulging, his anger may be unmistakable, and the patient is making an accurate observation. If the therapist chooses to say, "No, I'm not angry," the patient then has two problems: an angry therapist and a dishonest therapist. If the therapist is "clearly caught" in his anger, he may be much better off acknowledging that the patient's perception is accurate and trying to work with it therapeutically. For example, the therapist might say, "I think you are picking up on something going on in me. I think what you're doing is irritating me to some degree, and I'd like to explore that with you since I'd rather help you than get irritated with you. Have you had this experience with others?"

In this intervention, the therapist acknowledges the anger while also maintaining his professional role, which is geared toward helping the patient understand himself.

Some feelings, however, should probably *not* be disclosed for fear of burdening the patient unnecessarily or collapsing the analytic space in which the perception of the therapist is in the "as if" realm. For example, disclosing sexual feelings to the patient will rarely be useful. If the therapist admits having sexual feelings for the patient, he or she may feel that it is difficult to continue talking about sexual feelings in a symbolic realm. As Modell (1991) has noted, "Gratification at any one level of reality leads to

paradoxical frustration at another" (p. 26). What should have remained symbolic becomes concrete when one acknowledges sexual feelings for the patient. A father would not tell his daughter that he had sexual feelings for her, even though the daughter might sense such feelings through interactions with her father. The fact that a father does not disclose such feelings toward his daughter allows her to engage in an important developmental task involving a complex fantasy about him as a love object, knowing there is an aura of safety to do so, created by the boundaries the father establishes (Gabbard 1996).

By analogy, a male therapist who expresses sexual feelings toward a female patient is likely to make her feel that the therapeutic setting is not as safe as she had previously thought. If he is directly asked by his patient if he has sexual feelings for her, he might choose a modified version of self-disclosure by disclosing his dilemma about answering the question. For example, he might say to her, "Your question places me in a real dilemma. If I say 'No, I don't find you sexually attractive,' you may feel devastated. If I say that I do, you may feel that this therapy is not as safe a place as you had thought it was. So I think it's best not to answer that question."

As a general principle, one can fall back on sharing the dilemma rather than disclosing direct feelings in many situations where self-disclosure has been considered. For example, Dr. Q could also have said to Mrs. R, "I'm in a dilemma here because I feel like I have to barge in and interrupt you to make an observation. On the other hand, if I say nothing, I feel like I'm not being of any help to you. Any thoughts about how we can manage this dilemma?"

Varieties of Countertransference

Rescue Fantasies

The wish to rescue the patient is pervasive among people who choose to be psychotherapists. We all wish to make a difference in our patients' lives, and particular patients tug at our heartstrings in a special way that makes us want to become actively involved in the rescue, even though it may take us outside of a purely psychotherapeutic role. Certain types of rescue wishes may go completely unnoticed as a category of countertransference because they are so consonant with therapists' views of themselves as healers. The therapist's heroic efforts to save a patient from suicide, for example, may seem ethical, caring, and entirely appropriate. If a therapist in this situation begins to take calls at all hours of the night, extends sessions by 20 or 30 minutes, and professes undying love for the patient,

then one might wonder if the rescue effort has gotten out of control as a result of serious countertransference difficulties.

Many countertransference fantasies are inextricably linked to specific transference fantasies. For example, patients who harbor the golden fantasy (described in Chapter 7: "Use of Dreams and Fantasies in Dynamic Psychotherapy") may seek treatment with the hope that their fantasy of finding a perfect rescuer will be fulfilled by the psychotherapist (Smith 1977). When these patients discover that all of their fantasies will not come to fruition because of the professional boundaries inherent in the psychotherapy relationship, they may become desperate and convey to the therapist that only a cold and callous ogre would deny the gratification of their transference wish. This wish to be rescued may be a "good fit" with the therapist's preexisting rescue fantasies, and the therapist may feel compelled to step outside the professional role and become a literal rescuer for fear that the patient will be devastated if professional boundaries are maintained. Some therapists may hug the patient. Others may give the patient money to buy food. Still others may take the patient on social outings to try to convey that the therapist is caring and is not simply doing a job.

The optimal management of these rescue fantasies is to recognize them in their earliest form, before they actually become boundary transgressions. For example, if a female therapist is feeling like mothering her female patient by holding her and putting her head on her breast, she should recognize that she is at risk for enacting such a fantasy. She may then assist the patient in the necessary mourning process entailed in not having all of one's fantasies gratified in the therapeutic relationship. She might say to the patient, "I know how difficult it is for you that I can't be a literal mother who will hold you and love you, but we can understand how this longing affects your life and particularly how it influences other relationships. I can still be of help to you in providing that understanding, even if I can't directly gratify that wish." Often the avoidance of setting limits is fueled by another countertransference fantasy that the therapist is being sadistic if the patient's longings are not gratified. In the long run, however, indulging the fantasies may lead to false hope that is ultimately even more cruel to the patient. The mourning process must not be bypassed. Sooner or later, the patient has to mourn what she missed in childhood and what she cannot receive now from the therapist.

The Bored or Sleepy Therapist

Listening to patients all day can be exhausting to the therapist, but certain patients may promote a countertransference boredom or sleepiness

more than others. A beginning therapist's usual response to sleepiness or boredom is to feel guilty, as though it is emblematic of doing something wrong. Beginning therapists may chastise themselves and work harder to stay alert and listen carefully to the patient.

A central feature of psychodynamic therapy, though, is to explore one's own feelings in a nonjudgmental way to discern some as-yet unfathomed part of the therapeutic process that may illuminate hidden meanings. Why is this particular patient on this particular day boring? The therapist could be sleepy because she was up all night taking calls in the hospital. On the other hand, the last patient may not have induced this feeling in her in the way her current patient does. Why is there a difference, when the same amount of sleep deprivation is active in both processes?

Patients are boring for different reasons, and therapists experience them as boring for a multitude of reasons. Some patients are characterologically boring in all settings. A patient with obsessive-compulsive personality disorder, for example, may try to retain tight control over all spontaneous feelings by talking in a dry, affectless monotone and including a great many irrelevant details. The patient may also be attempting to "anesthetize" the therapist with this style of controlling the sessions so that the therapist is unable to make an unexpected intervention that might catch the patient by surprise.

A patient with narcissistic personality disorder, on the other hand, may bore the therapist because of the total self-absorption inherent in the patient's narrative. The therapist is not regarded as having a meaningful role in the patient's life, and the use of the therapist as a sounding board begins to dull the senses of the therapist, who feels there is no role for the therapist's interventions in the patient's monologue. A steady feeling of nonexistence may create feelings of drowsiness and intense boredom in any therapist who treats such a patient.

There are other patients who are lively and engaging most of the time, but on one particular day or around one particular topic they become excruciatingly boring and difficult to listen to. As with any other countertransference feeling, therapists may wish to begin by studying themselves to determine if they are having difficulty with the subject of the therapy. Does the boredom say more about the therapist than it does about the patient? Some therapists may feel anger at the patient and try to dull their anger by feeling sleepy and bored so as not to fully experience the intensity of the anger. Alternatively, certain patients may express their anger by trying to bore the therapist to death. (One should keep in mind that the phrase "to put to sleep" means "to kill" in veterinary usage.)

Whatever the cause of the boredom and sleepiness, beginning therapists must resist the urge to simply disparage themselves and tank up ahead of

time on more and more caffeine. The art of therapy includes making the boring patient a fascinating subject of study. What is the patient getting out of inducing this state in others? Actively exploring with the patient what is going on between the two parties may be a way of perking up the therapist while also interrupting a vicious cycle of sleep-inducing boredom.

Here are some examples of interventions that might be considered in such cases: "You know, I have the feeling that you are not terribly interested in what you are saying today. You seem to be kind of going through the motions." "When you talk today, I get the impression that you really don't expect me to be terribly interested in what you're saying." "What do you think is going on right now between the two of us in here?" Any of these interventions, or others like them, open up the interpersonal field of the therapy for exploration and emphasize that there are two people in the room, and each is affecting the other.

Erotic Countertransference

Sexual feelings for a patient can be quite discombobulating for a therapist. Beginning therapists may project their emerging sexual feelings into the patient and see the erotic feelings as emanating purely from the patient. This defensive maneuver is particularly common when a beginning male therapist is treating a female patient. As a way of managing the disturbing erotic feelings that emerge from the countertransference, the male therapist may refer to the female patient as "seductive" (Gabbard 2000). In this way, the problem lies in the patient, rather than in the therapist.

In other cases, the erotic countertransference remains unconscious, but the therapist begins to notice minor enactments suggestive of special interest in the patient. Some therapists might check the mirror before they see the patient. Others might pay special attention to what they wear on the day they see the patient. Some may find themselves unusually sympathetic to the patient. Certain negative issues may be avoided for fear of upsetting the patient. A case example illustrates some of these themes:

> Dr. S was a 32-year-old female psychiatric resident treating a 34-year-old male attorney. The attorney had recently been dumped by his girlfriend, and he spoke at great length in the sessions about his feelings of devastation. He recounted how she had such high demands that he was unable to meet her perfectionist expectations.
>
> Dr. S listened to her patient with considerable concern. She felt that the patient had probably been poorly treated by his ex-girlfriend, who had been entirely unreasonable in her demands on him. She also thought that he was a genuinely good-hearted person who had made a sincere ef-

fort to make the relationship work. After several weeks of therapy, she noted a striking departure from her usual therapeutic strategy. She had not asked the patient on a single occasion what *he* had contributed to the difficulties. She tended to see the ex-girlfriend as the villain of the piece, while the patient was predominantly regarded as a victim of ridiculous expectations. Dr. S also noted that almost all of her interventions were empathic in nature and that she withheld any confrontational comments for fear of hurting the patient's feelings.

She also began to think that her patient needed to find a more sympathetic woman. She became convinced that if he had had a better match, he would not be in the current situation at all. She found herself encouraging him to find women with more reasonable expectations who could be more sympathetic to him rather than demanding. In the course of the sessions, she had fleeting thoughts that maybe she would be a good match for him if they had not met under the conditions of the current professional relationship. She even found herself speculating on what he might provide to her that her own husband did not.

With the help of her supervisor, Dr. S gradually recognized that her countertransference enactment took the form of what she said, rather than what she did. Although her behavior was entirely professional, she allowed the patient to get off the hook in terms of his own responsibility. Almost all of her comments empathized with how awful he felt, rather than helping him take a clear-eyed look at how he might have undermined the relationship so that the same thing wouldn't happen with the next romantic partner. Her supervisor also helped her to see that she was harboring a fantasy similar to that of the patient—namely, that the problem was finding "Ms. Right" rather than looking within at patterns in him that might undermine relationships.

Erotic countertransference often manifests itself in rescue fantasies because they are relatively more acceptable to the therapist's conscious perception of his or her professional role than overt sexual feelings (Gabbard 1994). The feelings may arise in direct response to the patient's nudging. Dr. S was undoubtedly being influenced by the engaging presentation of the patient that painted him as a victim of the mistreatment of a harsh and unsympathetic woman. He managed to gain Dr. S's sympathy and was attempting to seduce her into taking his side (and doing a rather good job of it!). One therapeutic strategy that Dr. S might have considered is to interpret her patient's wish to get her completely on his side by the way he presented himself. In other words, she would have made a major point of how his style of telling his story was designed to enlist her as an ally or a "better woman" than his ex-girlfriend.

At times, erotic countertransference may seem unmanageable to the therapist. Certain patients are so attractive and appealing that therapists may find themselves incapable of thinking clearly and acting with the patient's best interests in mind. In such cases, supervision or consultation is

essential. If talking with a colleague is not helpful and the problem continues, referral to another therapist should be considered. Some therapists may wish to automatically set up a meeting with a consultant or a supervisor whenever they begin treatment with a new patient whom they find especially attractive.

Incapacitating Countertransference

There are times in the lives of most therapists when they feel as though they can no longer think like a therapist or function in a professional role because of their reaction to a patient. These incapacitating moments can occur under a variety of circumstances. In some cases, a therapist might feel physically threatened and make a comment such as "When you frighten me in this way, I can't think. We need to make this a safe environment for us to continue to work in therapy." Some patients may be so overtly seductive and frankly sexual in their overtures to the therapist that the therapist feels the frame of the therapy is being violated and he or she cannot function as a therapist. One male therapist, for example, was rendered silent when a female patient unbuttoned her blouse and showed her breasts to him. He felt it was impossible to do therapy, so he told her to button up her blouse and sit back down in her chair. Direct limit-setting was probably the best approach for the moment, while he bought himself some time to think.

At times, intense explosions of anger can make the therapist feel incapacitated.

> Ms. T was a patient with borderline personality disorder who had been seeing Dr. U for approximately 8 months in long-term dynamic psychotherapy. She repeatedly brought in reports of arguments over the phone with her mother. On this particular occasion, the patient began the session with Dr. U by describing a phone conversation on the previous night. She said that her mother had asked her how her job was going, and Ms. T became convinced that her mother was suspicious that she had quit the job and was checking up on her. Dr. U replied that he thought this might be the type of example they had discussed before, where she was construing her mother's interest and care in the most negative manner possible. Ms. T sulked and stared at the floor and said, "Yes…I am aware that I do that sometimes." Dr. U told her that he thought she looked hurt.
>
> Ms. T then became extremely upset. Her face was red to the point of looking like she would explode, and she screamed at the top of her lungs at him: "I don't know why you're saying this! I already know that I do that! I could have told you that before you even said anything! I know that I see things she says negatively. That's why I'm discussing it here! I'm trying to understand my behavior. I can't believe you would say anything so obvious and stupid!"

Dr. U was completely taken aback by the explosion of anger, which he had not anticipated in the least. He felt ashamed, abused, misunderstood, falsely accused, and enraged. He felt that her behavior was entirely inappropriate in response to what he had observed, and he felt that nothing he could say would be useful. So he simply remained silent. The patient could see how upset he was, and Ms. T simply stopped screaming and fumed silently as she stared at the floor. Finally she said to Dr. U, "Well, aren't you going to say anything?"

Dr. U decided to use some self-disclosure and said, "I'm so distressed by your shouting at me that I really don't think I can say anything very helpful at this point."

The two of them remained silent for awhile. Then Dr. U finally spoke: "What I was trying to do was to help put your reaction into a larger pattern so you could understand your assumptions about your mother, rather than just assume she was checking up on you. I had no idea that you would become so angry when I made that comment."

Ms. T looked sheepish: "Now I'm feeling guilty that I hurt you."

Dr. U responded, "I think what you're picking up on is my feeling that my attempt to help you is misunderstood by you. My predominant reaction is not so much that you hurt me but that you completely misunderstood what I was trying to get across. I had no idea that you would explode like that."

Ms. T responded, "Isn't it good to be angry?"

Dr. U inquired, "How so?"

Ms. T replied, "Well, the psychologist who did my testing said that for me, anger is gold."

Dr. U asked her if she thought the psychologist meant that exploding at people is gold.

Ms. T reflected for a moment and said, "Probably not. The patients in my group therapy say it frightens them and alienates them when I get angry there. They also told me they stop listening to what I say. But it feels good for me to do it. I wish you would like it when I get angry with you, because I think it's good for me."

Her therapist said, "If you try to reflect on this for a moment and imagine my experience of the explosion, what do you think I'd like about it?"

Ms. T responded rapidly to the question: "If someone screams at you, that means that you must mean something to them. Someone cares enough to scream at you and get upset with you. It gets their attention! I would feel connected. I would much rather have somebody scream at me than to act passive-aggressive. A lot of people try to act nice then they're really mad at you, and they don't let you know it."

Dr. U responded, "It sounds like you imagine that I feel the same way you do, instead of how I actually feel."

Ms. T then said, "Well, I'd like for you to, but I realize you probably feel different from some people. I just wish I could do things that feel good for me, and other people would appreciate them instead of getting alienated from me because of them."

Her therapist then asked if she was worried that she had alienated him.

> Ms. T responded, "No, I don't think so. I think it's good for me to get anger out instead of keeping it pent up inside. It's a destructive process to keep your anger inside of you all the time."
>
> Dr. U responded, "But isn't there a middle ground, a vast middle ground between exploding and keeping it all in? Maybe we've defined a good goal to work on here."

In this vignette, Dr. U has gone from being completely incapacitated in his ability to respond to making productive use of the moment. Initially, he could only sit silently because he was at a loss for words. Therapists should always feel free to delay responding until they are ready. Especially with borderline patients, therapists may frequently want to say that they need time to think about what has happened before giving a knee-jerk response. Dr. U used this to his advantage because he could then discuss what happened in a way that promoted mentalization in Ms. T. He continually pointed out that she imagined that he felt the way that she felt. He tried to get her to see that there were other possibilities. He also had her reconsider the all-or-nothing thinking that one either keeps anger inside or explodes. This helped her to moderate between extremes so she could reconsider the best way to manage anger.

Summary

Countertransference is a ubiquitous phenomenon that should not be regarded pejoratively. The prevailing view is that countertransference feelings involve a joint creation with contributions from both patient and therapist. *Projective identification* and *countertransference enactment* are two terms from different theoretical traditions that describe how the patient uses subtle interpersonal pressure to transform the therapist into an approximation of the patient's internal representation. There are a number of different techniques the therapist may use to manage countertransference. These include tolerating the countertransference, using it to inform interpretive understanding, and employing judicious self-disclosure. Common varieties of countertransference include rescue fantasies, boredom or sleepiness, erotic feelings, and feelings of helplessness or incapacitation.

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9

Working Through and Termination

Trainees who learn long-term psychodynamic psychotherapy are often perplexed by the task of determining when enough is enough. External factors, like changing a clinical rotation, may be the determinant of when work with a patient stops, often leading to the patient being transferred to another trainee. Much of the work of psychotherapy seems repetitive, and the end point may seem arbitrary.

When Freud developed psychoanalysis, he felt that *working through* was the process that ultimately created changes that would lead to a natural termination of the process. However, the definition of the term remained somewhat vague throughout his writings. He appeared to have in mind a process through which characteristic patterns of defenses and internal object relationships emerge again and again in different contexts and are repetitively interpreted, observed, confronted, and clarified until the patient relinquishes the resistances to accepting the analyst's interpretive understanding. Much of the work with resistances discussed in Chapter 6 ("Working With Resistance") could be viewed as the heart of the working-through process. Shafer (1983) defined working through as analyzing resistances "again and again, patiently, through a seemingly endless series of repetitions, permutations, combinations, and variations" (p. 76). He also felt that part of the working through of these resistances involves a recognition that the resistances or defenses are the patient's own creation and responsibility. Hence a key factor in working through and in readiness for termination would be the

patient's sense of being an agent or author of his or her own life.

As psychoanalytic theory has moved from a drive-defense emphasis to a greater reliance on object relations and attachment theories, working through has begun to take on new meanings. The working through of the relationship with the therapist as a new object that will serve to alter old object relations patterns moves to center stage. In addition, working through also involves a recognition of how the relationship with the therapist reflects relationships from childhood and current extratransference relationships (see Figure 9–1).

This triangle of insight involving relationship patterns is crucial to the systematic working-through process of repetitive problematic relationships (Menninger 1958). The therapist identifies the recurrent relationship patterns in every aspect of the patient's experience. Luborsky's (1984) concept of the core conflictual relationship theme (noted in Chapter 7: "Use of Dreams and Fantasies in Dynamic Psychotherapy") is another way of approaching this repetitive process. The patient's expectation about how others will react and a defensive response to that expectation will come up again and again, both in the relationship with the therapist and with people outside of therapy. The therapist points out these patterns and relates them to the patient's early experience.

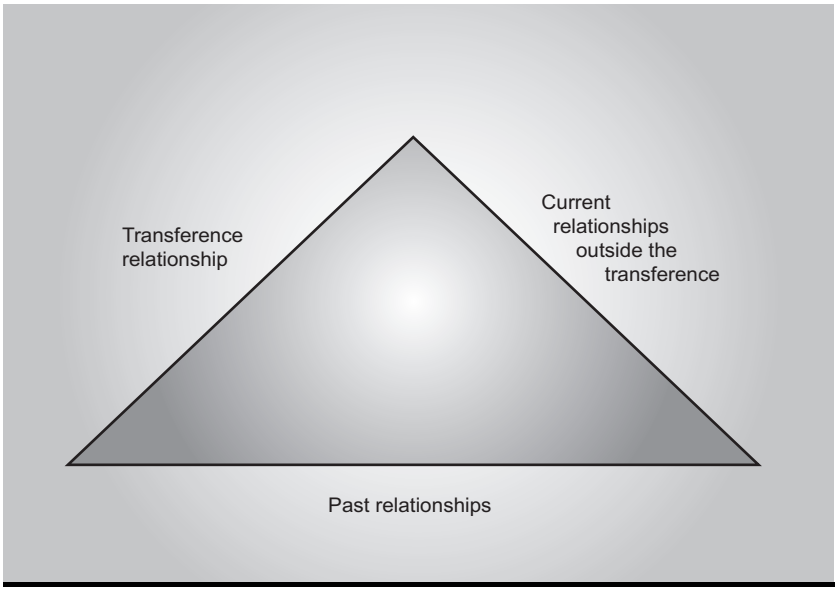

Figure 9–1. Triangle of insight (modeled after Menninger 1958).

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In the course of the confronting and clarifying of the patient's unique mode of object relatedness, the therapist explores with the patient the tenacious attachment to adverse experiences and "bad objects" from the past. Why, for example, does a woman patient repeatedly choose male romantic partners who are dishonest and unreliable, leading to heartbreak? A variety of explanations may emerge as the therapy continues. Attachment to bad objects may be predictable and familiar, and the devil one knows may be better than the devil one does not know. A bad object may also be better than no object at all. A woman's repeated involvement with men who are unreliable and dishonest may also preserve a fundamental attachment to her mother, who made it clear that men were not to be trusted and that when push came to shove, one could rely only on one's mother to be a loyal confidante. The woman may also harbor a fantasy of transforming "bad" men into "good" men.

At the same time that the patient is engaging in self-defeating relationships outside the therapy, she may also be entrenched in a pattern of relatedness with the therapist that is less than optimal. She may persist in seeing the relationship pattern she encounters as a problem of not finding the right man, and therefore she expects the therapist to rescue her from a string of bad experiences by being the idealized and perfect man in her life. This variation of the golden fantasy may need to be confronted and interpreted repeatedly until the patient finally recognizes that she will have to find a way to rescue *herself* from her life rather than to expect a knight in shining armor to emerge.

Fantasies die hard. Much of the difficult working-through process involves helping the patient to mourn the loss of unrealistic dreams and fantasies that get in the way of a natural developmental pathway toward maturity. Giving up these fantasies may be intensely resisted, and the patient may fight the therapist to preserve her vision of how things should be.

As the process of working through unfolds, the patient is also internalizing a certain way of viewing herself and her internal world that the therapist has modeled for her. Thus accepting the therapist's way of thinking is part of working through. The therapist has also resisted being transformed into something other than a therapist (Aron 1991). In contemporary parlance, part of what is worked through is the actual relationship between therapist and patient so that the patient openly accepts who the therapist is and the limits of the relationship. As noted in Chapter 5 ("Goals and Therapeutic Action"), patients don't get better simply because the therapist acts like a "good" object. What is critical is that patients repeat with their therapist certain patterns of complicated relatedness that have haunted them throughout their lives. In the process, the old neural networks involving maladaptive self and object representa-

tions are gradually weakened, while the new neural networks involving a different kind of relatedness are strengthened. Just as a patient's defenses are developed over a lifetime, so are the neural networks representing object relationships, and only time is likely to make durable changes in these structures.

To summarize what is being said, therapists do indeed function as new objects that are internalized by the patient. However, they are also drawn into playing problematic figures from the patient's past, and one of the therapist's tasks is to help patients see how they themselves recreate conflictual patterns of object relationships in the here-and-now laboratory of the transference-countertransference interactions. So the insight involved with showing patients how they are agents in repetitively recreating problematic connections with others works hand-in-hand with the internalization of the therapist as a different object and the therapist's way of thinking and observing interactions.

A critically important aspect of the working-through process involves the therapist's shift from a first-person perspective to a third-person perspective (Goldberg 1999). In other words, therapists must empathically validate the patient's "I" experience, the first-person perspective, while also bringing to bear their own outside experience, the third-person perspective. By empathetically immersing oneself in the patient's perspective, an experience of being understood becomes part of the atmosphere of therapy. Within that context, patients can begin to hear something about themselves that at first seems alien because it is observed from outside the patient. As Goldberg (1999) emphasizes, "The unconscious is experienced not as a first-person phenomenon but as something alien and apart" (p. 357). Therefore part of the working-through process is that therapists gradually provide interpretation, observation, and confrontation from an outside or third-person perspective as a way of familiarizing patients with their own unconscious life. Only gradually, through the repetition of this point of view, will patients be able to own what is unconscious and what comes from a third-person perspective as part of their own first-person perspective.

Promoting Mentalization

In more disturbed patients, particularly those whose personality is organized at a borderline level, the shift from an exclusively first-person perspective to a third-person point of view is accompanied by an increased capacity for mentalization. Over time a patient recognizes that the therapist is representing her in his own mind. As the therapist constructs and reconstructs an image of the patient and the patient's internal experi-

ence, the patient herself will gradually start to view herself differently and to recognize that her perception of the therapist and others is only a representation, not an accurate replica of a pure form of external reality (Fonagy 2001).

If the therapeutic alliance is strong, the therapist can more fully elaborate how his or her perspective differs from the patient's, so the two can openly discuss differences between the first-person and third-person perspectives. Part of the balance that is achieved is a sense of safety in a new attachment relationship accompanied by a willingness to take risks and to see things in new ways. Another dialectical tension created in long-term dynamic therapy is acceptance versus expectation of change. Good therapists convey to their patients that they are valued and accepted as they are. At the same time, therapists acknowledge their patients' suffering and offer the potential to relieve that suffering by collaborating with them in the discovery of new ways of relating to others.

In a working-through process that has the aim of promoting mentalization, a number of techniques are useful. The therapist may ask the patient to elaborate his fantasies about what is happening in the therapist's mind. When the patient draws a blank, the therapist may encourage the patient to think more about the therapist's internal world, with an emphasis on how the therapist represents a different subjectivity, or a different "first person" entity, that may have some things in common with the patient's internal world but that also has many things that are different.

Another useful technique is to identify and focus on the patient's mental states. The therapist may observe that the patient appears angry, for example, as a way of helping the patient discover herself in the therapist's eye. If the patient can own some of this anger, she may then see how a feeling state may color her perception of others. A therapist might say, for example, "I can see that when you're feeling angry toward me, it's hard to imagine that I'm actually here to try to help you." This type of comment promotes mentalization in that patients must recognize that their own emotional states create, in part, how they perceive others.

Ultimately, patients begin to see that the way they perceive reality involves an internal representation that can be played with and understood as having particular meanings. As they begin to recognize themselves, they also recognize the therapist's separate subjectivity and respect the fact that the therapist's internal world is different from their own.

When a patient acts impulsively on feelings, the therapist promotes mentalization by helping the patient see that an affective state precipitated the impulsive action; it did not simply come out of the blue. Following an impulsive incident, a therapist might say, "What do you remember was going on at the time the impulsive behavior started? What were you feel-

ing at the time? "The patient might initially respond "I don't know" or "I don't remember." The therapist must not accept these answers as the end point but should continue gently pushing the patient to think back on what internal experience was present at the time.

Impasse

In the course of working through, many times therapists will feel that they are at an impasse with a patient. Interpretations have been offered, resistances have been confronted, and the patient's first-person feelings have been empathically validated. Observations from the therapist's perspective have been systematically offered. Although the working-through process has begun, the entire psychotherapy appears to be stuck. The patient does not appear to use the insights productively or to make changes in behavior. The therapist may start to feel discouraged and may even think that it might be time to give up.

A dynamic therapist is wise to remember that impasses or stalemates may often simply reveal the heart of the transference-countertransference work that needs to be examined (Gabbard 2000). One should not anticipate that psychotherapy will go smoothly. Marcus Aurelius once commented that the art of living is more like wrestling than dancing. The same could be said for psychotherapy.

What might be most helpful at times when the therapy seems to be stuck is to investigate the possibility that the patient's transference and the therapist's countertransference have recreated the most powerful and tenaciously defended internal object relationship of the patient. If that can be openly discussed with the patient, progress may be possible.

> Mr. V had been seeing Dr. W for about 9 months of therapy. He had come with a lot of concerns about restoring himself to productive work and satisfying relationships. After working successfully for a number of years, he had been laid off, and he had been unable to find another job for a period of 2 years. His wife had left him, and he found it hard to get mobilized again. He was taking an antidepressant that had helped him with vegetative symptoms of depression, but he continued to find it difficult to change his life in any productive way. He would repeatedly say to his therapist, "Just tell me what to do to get better." The therapist repeatedly pointed out that the two of them would have to collaborate together to figure out what would be most helpful.
>
> Mr. V came to the sessions but always minimized any improvement that might have taken place. He had made feeble efforts to find a job, but repeatedly said that nothing was out there of interest to him. Dr. W would try to get Mr. V to discuss some of the issues that made him feel discouraged about his situation, but Mr. V would avoid talking about these is-

sues and would go off on tangents about external events that seemed to have very little relevance to the therapy. What was going on in the therapy was parallel to the patient's external life to a large extent. At one point, Mr. V's grown children arranged a birthday party for him. His sister and her husband joined them at the party. Dr. W asked if it was a good party. He replied, "It was nothing much." He then went on to say how his sister and her husband, as well as the two grown children, didn't really go to that much effort to help him.

He would frequently come to the sessions and say that nothing was changing. When Dr. W would ask him how his job applications were going, he would reply, "I just haven't gotten around to doing anything. I've been quite discouraged about any prospect of productive work." On one particular occasion, Mr. V came to the session and began by saying, "I can't see where I'm doing well at all." The therapist tried to offer some encouragement by saying, "You're now answering your phone when people call, you cry much less, you're starting an exercise program, you're seeing family members, and you're sleeping a lot less during the day." Mr. V replied, "I'm really not exercising all that much, and I would say my mood is still the same. I hate to tell you that, but it's true."

Dr. W recognized that she was unable to get past the impasse by emphasizing the positive observations she was making about Mr. V. At the next session he began by saying, "I'm still depressed." The therapist responded by saying, "Do you really think any of this treatment is doing you any good?" He replied, "Very little." Then Dr. W tried to put the stalemate in perspective by offering an interpretation: "I'm starting to wonder, Mr. V, if there is some kind of need deep within you to remain unsuccessful and to thwart others who try to help you." Mr. V was a bit startled by the interpretation, but then surprisingly said, "I heard Dr. Phil on television say something like that. I think there's something to it." Dr. W continued: "What are you afraid will happen if you do allow yourself to get better or be successful?" Mr. V thought for a moment and said, "I think I'm afraid of being rejected if I try." His therapist asked, "Has anyone rejected you lately?" Then Mr. V began to cry and said that his brother had been very upset with him, to the point where he told him, "I'm fed up with you and can't tolerate you anymore." Dr. W then pointed out, "I think your tendency to stay exactly as you are and thwart others' efforts to help you results in your getting rejecting responses from others anyway."

In this case, Mr. V's "stuckness" involved anxieties about change. What he started to see, with the help of his therapist, is that the impasse was related to aggression toward those who tried to help him. By digging in his heels and resisting any type of change whatsoever, Mr. V was beginning to make both his family members and this therapist feel fed up with him. By pointing out his investment in remaining unsuccessful, Dr. W opened up the problematic relational pattern to be examined by the two of them.

As the work continued with Mr. V, the therapist began to recognize powerful motivations to stay the same. Being helped by others made Mr. V

feel small and inadequate. If Dr. W was able to help him, Mr. V felt envious that the therapist had insights that he didn't have. He felt he should have thought of any interpretive understanding himself. To deal with his envy, he had to spoil the help offered by his therapist and devalue that help by saying he still did not feel any better.

This tendency to get worse with accurate and helpful interpretations has been referred to as the *negative therapeutic reaction*. Freud first identified this effect when he found that some patients responded to accurate insight by an exacerbation of their symptoms. A more contemporary definition of the negative therapeutic reaction is that it applies to situations where patients tend to get worse in the face of being helped by the therapist. The reasons for negative therapeutic reactions are varied, and each case must be carefully evaluated for the underlying motives.

In many cases, however, what is going on in the transference-countertransference dimensions of the treatment will reflect residuals from longstanding patterns that started in childhood. Revenge fantasies are often at the core of negative therapeutic reactions (Gabbard 2000). The therapist has become a parent in the transference, and the patient derives tremendous satisfaction from defeating the therapist's efforts. In many cases, one hears that the patient's parents were terribly invested in the child's success and needed a child to succeed for the parents' own narcissistic gratification. Whether or not this depiction is completely accurate, the patient believes it vehemently and is determined to fail as a way of thwarting the parents' expectations. From this perspective, failure may be equivalent to success. Just as the patient wishes to deprive the parents of pleasure by failing, he may also wish to deprive the therapist of taking pleasure in a successful treatment. Often such a patient is terribly concerned that the therapist will take credit for the patient's success in the same way that the patient's parents took credit when the child succeeded in school or in extracurricular activities.

Patients who are entrenched in these dynamics may even postpone substantial improvements until after therapy is terminated. They do not want the therapist to become excited about any improvements made during the therapy, so they postpone making real changes in their lives until the therapist is no longer around. In that way, these patients imagine a secret triumph in which only *they* derive gratification from the changes, and the therapist does not. When such patients are encountered years after termination, they often surprise the therapist with how well they are doing.

In this era of a two-person psychology, we would be naïve to assume that these impasses involving revenge fantasies are completely one-sided. Therapists often play a role in such negative therapeutic reactions. Our con-

scious or unconscious wish to succeed with the patient and to receive the patient's gratitude for our help may work synergistically with the patient's wish to defeat us (Gabbard 2000). Many therapists are drawn to the field by a long-standing desire to establish a specific type of internal object relationship in which they are in the role of a selfless, devoted helper and the patient is expected to conform to a specific expectation—namely, to make progress in the way the therapist expects and to express gratitude for that progress (Feiner 1979; Gabbard 2000; Gorkin 1985). This much-desired mode of relatedness may be unconsciously designed to repair old relationships from the past in which one was not properly appreciated or validated.

The problem with the therapist's needs coming to the fore in this way is that the patient may sense that in one way or another he is being used for the therapist's own purposes. The desire for the patient to give us satisfaction in our work, however, is not simply a highly pathological goal of a few therapists. These kinds of wishes to help are inevitable and are present in virtually everyone in the psychotherapeutic field. Patients may sense our need to receive gratitude for the help we offer and to have patients get better to maintain our sense of professional self-esteem. Armed with this knowledge, a patient might take great pleasure in tormenting the therapist by refusing to get better and maintaining a posture of total ingratitude. In this way, failing in the treatment is a triumph over the therapist.

While none of us can be totally detached from the wish to help the patient, one of the obvious lessons to be learned from such impasses with patients is that we must constantly monitor any kind of *furor therapeuticus* (Gabbard 2000). We must recognize that ultimately the patient has the right to resist change and even defeat the therapy if success is too threatening. Rather than becoming like a cheerleader, who encourages the patient to change against all of the her wishes to do so, therapists are well advised to systematically analyze what the patient gets out of staying ill or dysfunctional and what pleasure may be derived from defeating the therapist. When this fantasy is explored in depth, patients generally must confront the notion that they are "cutting off their nose to spite their face." In other words, they have to come to grips with the idea that they are really only defeating themselves when they try to thwart the therapist's efforts.

Therapists who can closely monitor their countertransference wish to cure in these situations will also find that their disengagement from extraordinary investment in changing the patient alters the playing field from the patient's perspective. When such patients see that their therapists aren't going to be devastated by their refusal to get better, they may no longer get a "kick" out of defeating the therapist's efforts. They must

then turn inward and look at what they are doing to themselves.

Some patients continue to deteriorate in their functioning or grow more suicidal despite the therapist's careful examination of countertransference issues and the self-defeating dynamics of the patient. A beginning therapist may become desperate at such times and might be tempted to depart from a professional role and engage the patient at a personal level outside professional boundaries (Gabbard 2003). This choice can be disastrous for both patient and therapist. A better alternative is a systematic evaluation of the dynamics of the impasse, a reconsideration of the role of medication (or electroconvulsive therapy), and a consultation with a senior colleague.

A subgroup of patients who are ensconced in a negative therapeutic reaction may be treatment failures. When the underlying dynamics of the patient's resistance to change are elucidated and still nothing shifts in the process, therapists may have to consider ending the treatment or referring the patient to someone else. These issues are fraught with countertransference pitfalls, and the decision to stop the treatment is generally best made by consulting with one's supervisor or another colleague about the details of the impasse and by exploring all possible alternatives before reaching a decision.

Termination

Termination of long-term dynamic psychotherapy is rarely as orderly and systematic as many trainees are led to believe by the teaching of their professors and the sections in textbooks devoted to the subject. One might even say that something of a mythology has developed around the notion of termination that often makes beginning therapists feel they are falling far short of the ideal. In this mythological version, therapists and patients come to the conclusion that the goals established at the outset have been accomplished, transference feelings toward the therapist have been resolved, the intrapsychic changes have been translated into life changes, and a specific number of weeks or months are mutually agreed on as the "termination phase" of the process.

Such mutually satisfying terminations may occasionally occur in cases of long-term dynamic therapy when fortune shines down on both parties and a productive process has unfolded. However, often factors such as time, money, relocation of either party, or disagreement about the achievement of goals interfere with a mutually endorsed termination. In the real world of clinical practice, there is considerable variation in termination (see Table 9–1).

Table 9–1. Varieties of termination

Mutual agreement of therapist and patient based on achievement of goals
Preplanned termination based on number of sessions
Forced termination because therapist graduates or changes clinical assignment
Forced termination because patient relocates
Forced termination because patient's third-party payer discontinues reimbursement
Unilateral termination in which patient feels there is no value in continuing
Unilateral termination in which therapist feels there is no value in continuing (and refers patient elsewhere)
Failed attempt at termination leading to "therapeutic lifer" status
End setting as a therapeutic strategy

If the therapy is one that is time-limited to 40 or 52 sessions by design, the therapist and patient are working toward the end point with full knowledge from the beginning. By contrast, in open-ended long-term dynamic therapy, the decision to terminate will emerge only after one or both parties begin to feel it is time, and the length of the therapy is unknown at the outset. Some psychotherapies have forced terminations because the trainee leaves the clinic where she has been assigned or because the patient or therapist moves to another city. Finally, there are unilateral terminations, in which one party feels that it is time to stop, and the other does not.

In considering the variations on termination, one begins to recognize that the process is much messier than many textbooks or papers suggest. Moreover, termination may not even be termination, since a large number of patients end up returning for more treatment. Sometimes the term *interruption* may be more precise than termination. One study (Beck et al. 1987) suggested that fewer than 20% of patients in community mental health centers actually have a mutually negotiated termination process. We must also accept the fact that there is a small subgroup of patients who really find it nearly impossible to terminate therapy. In his study of patients in the Menninger Psychotherapy Research Project, Wallerstein (1986) identified this subgroup as "therapeutic lifers." He noted that these patients may do well as long as they are never expected to terminate. Some of them may be able to reduce the number of sessions to one every 3–6 months, but as long as they know they are going to continue to see their therapist, they appear to function well. When the therapist threatens termination, however, they often fall apart.

Assessing Readiness for Termination

In long-term dynamic psychotherapy that is open-ended by design, patients are usually allowed to initiate termination when the time seems right to them. The request for termination should be thoroughly explored with the patient, particularly in terms of whether the goals set at the beginning of the treatment have been accomplished. This discussion will provide glimpses of the patient's underlying motives for wishing to terminate. Therapists need to ask themselves a series of questions: Is the patient running from something? discouraged with psychotherapy? wanting to quit because of anger at the therapist? enacting a flight into health? As noted in Chapter 6 ("Working With Resistance"), the first time termination is brought up by the patient, it often serves a major resistance function.

In assessing a patient's readiness for termination, a key variable for the therapist to evaluate is whether the patient has sufficiently internalized the psychotherapeutic process so that the therapist's way of thinking and processing feelings can be carried out independently. For example, a patient told his therapist that he was able to imagine talking to her while she was on vacation when he got into a conflict with his mother. He thought to himself, "What would my therapist tell me at this point about how I am annoying my mother and making the conflict worse?" He then interrupted his usual escalating cycle with his mother because of an internal dialogue with a representation of his therapist. Patients who are unable to use what they have learned in therapy in the absence of the therapist may need further treatment before termination is reasonable.

A number of countertransference issues on the therapist's part may interfere with a careful assessment of the patient's readiness to stop therapy. Beginning therapists may idealize psychotherapy and have highly perfectionist expectations of what treatment can do. They may have aspirations for a type of structural change or transference resolution that is not entirely realistic. The external functioning of patients in their life setting should be an index of the success of therapy, regardless of how much internal change has taken place. Trainees may make a countertransference error by failing to endorse a termination process because their ambitions for their patients are greater than those of the patients themselves. Therapists may hold onto patients for their own needs as well. Rescue fantasies may be at work. Certain patients may enhance the therapist's self-esteem in ways that make it difficult to let the patient go.

Negative countertransference feelings may also enter into a decision to terminate. Certain patients may arouse contempt, boredom, hatred, and anger in therapists. There may be a thoroughgoing sense of relief when the patient speaks of terminating, and some therapists may avoid explor-

ing the patient's wish to stop as a way of getting rid of the patient.

In the case of dynamic therapies that are time-limited by design, countertransference may also enter into a decision about whether the patient needs more therapy. If, for example, a therapy is designed to be 40 weeks in length, beginning therapists may feel that they have failed if the patient wants more therapy after the 40 sessions because of ongoing issues that need to be discussed. Therapists must remind themselves that patients have their own rates of change, of overcoming resistances, and of coming to terms with long-standing conflicts and anxieties. The patient's internal timetable may be quite different from the timetable of therapy as established according to external policies.

Regardless of whether therapy is time-limited or open-ended, the issue of whether one has failed is a common countertransference concern among beginning therapists. Both patient and therapist generally begin therapy with expectations that may be unrealistic. Patients harboring one variation or another of the golden fantasy may hope that they have finally found the perfect parent or parental substitute who will love them unconditionally, take care of them, and establish a perfect state of bliss. *To some degree, then, therapists must ultimately fail their patients.* In other words, patients must come to terms with the limitations of what another human being can do to gratify the longings that have been built up over a lifetime. Similarly, therapists who are beginning their practices need to mourn the loss of their cherished fantasies of healing others and shielding them from anxieties, stresses, periods of dysphoria, and fundamental existential dilemmas. Therapists also need to mourn the limits of their profession while the patient mourns long-held fantasies.

The Work of Termination

If the patient is in a training clinic, the work of termination often begins with the initial contract to work together. If the therapy is viewed as a long-term dynamic process, the patient needs to be aware of the therapist's tenure in the clinic. When therapists know they will be transferring to a new assignment or graduating in June, the patient should be clear on this arrangement as soon as the therapy has begun. Many trainees wish to conceal the fact of their transience for fear that the patient will then ask for someone else who is more permanent. Similarly, as June approaches, many beginning therapists wish to avoid the subject of termination altogether and may not remind the patient of the imminent ending of the process. Patients may also forget the knowledge they learned at the beginning, and it is helpful for the therapist to revisit the issue of the ending of therapy periodically when it seems appropriate.

Some patients do better with the annual hand-off to another trainee if they are asked to collaborate in the process of transfer. During the last month of the termination process, the new therapist can join the current therapist and the patient for a session so that introductions can be made. In the same meeting, the patient's goals can be discussed, and the patient can have an opportunity to ask the new therapist any questions that may have arisen. Patients can also be asked if they have any preferences regarding the gender of the new therapist, the timing of the transition, and how the transition should be conducted. This collaboration helps patients get some sense of empowerment at a time when they may feel that they are passively experiencing an abandonment.

Even if the therapy has reached a natural end and there is a mutually agreed-on termination, some of the same themes appear as in forced terminations. The fantasy of the ever-available therapist has to be mourned. The reality that our relationships are ultimately transient must also be faced. Memories of other abandonments or breakups may surface, and the patient may have an opportunity to examine those in more detail.

A great many patients who are troubled about the termination have difficulty verbalizing their feelings to the therapist. Often the concerns emerge in various types of symptomatic behaviors. These must be contextualized as part of the reaction to termination and should not simply be "managed."

> Ms. X, a 24-year-old woman with borderline personality disorder and bulimia, had been seeing Dr. Y in weekly individual therapy for 11 months. She had completely stopped self-mutilation several months before the initiation of termination. She had also improved greatly in her capacity to mentalize and to think before acting impulsively. With 4 months to go before her graduation from her residency, Dr. Y decided to bring up termination with Ms. X about 10 minutes into a session. Ms. X began crying quietly and continued off and on throughout the rest of the 40 minutes. She said that she felt sad and couldn't face starting with a new therapist. She also expressed anger at Dr. Y because she felt as though her therapist was leaving just as she was "beginning to open up." Dr. Y felt guilty about leaving her patient, but she was glad she had brought it up early enough to have time to discuss it with her. She even thought about the possibility of continuing Ms. X's treatment in her private practice, but her supervisor cautioned her that at such a low fee, she might end up resenting having made the decision at a time when she was tormented by guilt.
>
> Ms. X came to the next session and began with an announcement to Dr. Y: "I cut myself last night." Dr. Y silently agonized over this development, as she had thought the self-mutilation was in the past. Again, she began to feel guilty about what the termination was doing to her patient. Ms. X went on to say that the cutting was prompted by visiting an old boyfriend who was in jail. After the visit, she had called the young man

on the phone and had broken up with him. She cut herself in an effort to ease the emotional pain connected with the breakup. However, she admitted to Dr. Y that the cutting did not actually help her. She made no link to the previous session, when she learned that she would have to terminate with Dr. Y. Therefore, Dr. Y brought up the fact that the cutting had disappeared and had reemerged only after the announcement of the termination of the therapy. Ms. X thought for a moment and then replied that she had had a fantasy before cutting herself that self-injury might result in her requiring hospitalization. (Ms. X had never had a psychiatric hospitalization in the entire course of her difficulties.) When Dr. Y inquired what made her have such a fantasy, Ms. X responded that if she were in the hospital, other people, such as her mother and her boyfriend, might care more and feel responsible for her. Dr. Y noted silently that Ms. X did not include her therapist in the group of people who might care for her more. Ms. X did ask, however, if one of the male therapists in the clinic whom she had seen in passing might be her new therapist.

The patient began the next session by saying she was feeling "lost." Dr. Y wondered with her if the feeling might relate to the upcoming termination. This time, Ms. X could acknowledge the link and became tearful. She rapidly changed the subject, however, and asked Dr. Y her opinion about various job options. Dr. Y pointed out how she was avoiding the topic of termination, and Ms. X became tearful again. Quietly she offered the following comments, "You know, they say all good things come to an end." After a moment of silence, she then recalled how her father had left her mother when she was 7 years old. She then associated to her grandmother's death when Ms. X was 14. Finally, she brought up an emotionally painful breakup with her first boyfriend in high school. She noted that these losses were somewhat similar to the loss of her therapist, but she rapidly denied being angry, saying that she recognized that it was not Dr. Y's choice to leave her. By the end of the session she said that she felt surprisingly better after talking directly about it and crying a bit.

In this vignette, the patient expresses feelings about the loss of her therapist through action. Often there is return of symptoms at the time of termination, just as Ms. X began cutting herself again after many months of good impulse control. In some ways, the return of symptoms can be seen as a protest against the imposed loss of the therapist. Dr. Y did an effective job of helping the patient see how the acting-out behavior was related to unbearable feelings about losing a therapist. By helping Ms. X to articulate those feelings, Dr. Y was also making the point to Ms. X that the feelings could be borne even though the emotional pain did not immediately go away.

Some patients don't respond to the therapist's interpretation of the meaning of the behavior, however, and the therapist may need to back off for a while. Therapists who persist in interpreting the patient's comments and behavior as being linked to termination may actually make matters

worse, because the patient will become insistent that there is nothing to explore. If the topic is brought up repeatedly, the patient may start to feel that the therapist is pursuing his or her own agenda rather than the patient's.

Termination is a time when boundaries may become a little more permeable. Patients may feel they have the right to ask the therapist personal questions. Therapists who feel guilty may feel the need to take a more personal approach and reveal more about themselves. Both patients and therapists have difficulty with losing a significant relationship, and there is an ever-present risk of colluding with a denial of the loss. This collusion may take the form of planning posttermination meetings or imagining a social relationship together. Therapists should be particularly alert to a compromise of professional boundaries during the termination phase. Some patients may wish to offer the therapist a small gift on the last session, and often the therapist is well advised to graciously accept the gift, since there would be no time to process its meaning. However, if the gift is expensive or if its personal nature raises concerns in the therapist, he or she may well wish to decline the gift and discuss the patient's reaction to their decision not to accept it. Some patients may give a spontaneous hug to the therapist at the last session, and again the therapist has to face the fact that if the hug is rejected, there will be no time to process it in the future. Most therapists will simply accept the hug and wish the patient well. With patients who have a particularly erotic or erotized transference, the therapist may wish to head off such an incident by talking about it well in advance and discussing the potential meaning of a hug in the last session.

Some patients will ask if they can contact the therapist if they have problems in the future. When there has been a mutual termination with no subsequent therapist taking over the treatment, the potential for further treatment should certainly be left open. The patient can be told that "the door is always open." However, if the patient is being transferred to another therapist in a clinic setting, there is considerable potential for splitting if the patient continues to contact the old therapist while seeing the new therapist in person. Posttermination contact should be discouraged in such situations.

End Setting as a Therapeutic Strategy

At times a therapist will feel forced into arbitrarily setting an end point for the therapy because the patient is clearly not using the therapy in a way that is productive. Some patients may lack any motivation to work toward goals and simply wish to use the therapist as a sounding board. A friend can be a sounding board, and if the patient is not interested in ex-

ploring unconscious motives and making changes in maladaptive patterns, therapy is probably not worth the time or money. Other patients may refuse to discuss or even think about termination despite substantial improvement. These patients may also require the setting of an arbitrary termination date as a way of "lighting a fire" under them. Sometimes the certainty of the termination will focus the patient's thinking around what needs to be accomplished before the ending and on what the obstacles are to working collaboratively toward termination. As noted above under "Termination," some patients find that they are unable to terminate therapy. These "therapeutic lifers" are often not identifiable until after many years of treatment when termination is attempted. They may begin to have severe symptoms when termination is planned, and some even require hospitalization. Therapists must be open to the "lifer" strategy with a small subgroup of patients who may need to have regular contacts at regular intervals of 3, 6, or even 12 months to head off decompensation. Before this decision is made, however, therapists are advised to discuss this strategy with a consultant or a supervisor to be sure that it is not growing out of countertransference guilt.

Unilateral Termination

At times, therapists are forced to terminate a patient unilaterally. A patient may refuse to comply with the conditions of treatment. Limits may have been set, such as abstinence from illegal drugs or the cessation of phone calls in the middle of the night, and yet the patient continues to engage in behaviors that compromise the treatment. Another reason to unilaterally terminate treatment is the patient's refusal to pay the bill. Sometimes the therapist's countertransference is so intense that it interferes with the therapist's capacity to think. In such cases there may be no other option than to transfer the patient to someone else. If the therapy reaches a crisis of this nature, the therapist is wise to seek a consultation with a senior colleague to discuss the pros and cons of ending the treatment.

Patients may also be terminated unilaterally if they refuse to come to sessions. If the patient misses one session without calling, most therapists would wait and see what happens at the next appointment before taking action. If a patient who is known to be suicidal misses a scheduled session without calling, most therapists would probably call the patient to see if the patient was thinking of suicide or planning some kind of self-harm. However, even nonsuicidal patients who miss two consecutive sessions should probably be called to see if they wish to continue. If the patient has a good explanation for missing the sessions and wishes to continue, the therapist may make allowances. If the patient does not return the calls or continues to

miss sessions, most therapists would send a letter indicating that the therapy is being discontinued. In most states, it is perfectly legal to discontinue treatment with a patient provided that suicidality or danger to others has been carefully assessed. One provides notice of termination in writing, and a list of other potential treaters or clinics is provided in case the patient tries to seek treatment in the future.

Summary

Working through is the systematic interpretation, observation, confrontation, and clarification of repetitive patterns in the patient's life, both inside and outside the therapeutic relationship. In seriously disturbed patients this process may include repeated efforts to promote mentalization by specific techniques designed to help patients see that their perceptions of others are based on their own emotional states and internal representations.

Despite diligent efforts at working through, some therapeutic dyads will become stuck at an impasse. These stalemates may yield to a careful examination of the transference and countertransference aspects of being "stuck." A subgroup of impasses may reflect a phenomenon known as negative therapeutic reaction, whereby the therapist's attempts to help are met with deterioration in the patient's condition.

Termination must be collaboratively assessed according to whether or not the patient's goals for therapy have been achieved. Symptoms may return at the time of termination and may be the patient's way of expressing feelings about the ending. Some patients may dig in their heels in the face of termination, and a variety of strategies can be considered.

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10

Use of Supervision

Long-term psychodynamic psychotherapy occurs in a dyad but is learned in a triad of patient-therapist-supervisor. The patient unloads painful feelings and shameful memories onto the therapist and expects the therapist to contain them. The trainee therapist, in turn, unloads the same material on the supervisor, with the same expectation that the supervisor can handle what is difficult for the therapist to manage. For beginning trainees, supervisors are role models with whom the trainee identifies. During the course of supervision, trainees are likely to internalize the supervisor to the extent that they sometimes feel like they are "playing" supervisor when they are doing therapy with their patients. Indeed, trainees eventually bring the supervisor into their offices with them as an internal representation that guides them through difficult moments in therapy.

Individual supervision usually occurs in a once-weekly format in which the supervisee explains what is happening in therapy to the supervisor. Good supervisors eschew an authoritarian stance of telling the supervisee exactly what to do (except in cases of egregious errors). Rather, they raise questions about potential consequences of whatever intervention is contemplated. They teach their supervisees a way of thinking about the psychotherapy process that will maximize its effectiveness. In this regard, the supervisor is more democratic than autocratic in how information is conveyed to the supervisee (Greben and Ruskin 1994).

The Data of Supervision

The data of supervision vary from one training center to another. Some encourage the use of videotapes. Others prefer audiotapes. Still others use detailed process notes. Each of these approaches has various advantages and disadvantages.

Videotaping of sessions has the advantage of capturing both what was actually said in the session and the nonverbal communications of both parties, suggesting what went unsaid. Supervisors gain a good sense of how their supervisees actually conduct themselves with the patient and how well they can think on their feet. The disadvantages, however, must be carefully weighed. Ethologists know that it is difficult to examine an animal in its natural habitat, since the presence of the observer alters the natural habitat. Similarly, the presence of the video camera alters the fundamental frame of psychotherapy. What is meant to be a confidential communication behind closed doors in the privacy of an office is opened up to an unseen observer. Patients may consciously or unconsciously be influenced by the presence of the video camera in such a way that they present a filtered version of their problems to the therapist. Shameful secrets may be concealed, and the knowledge that someone is observing the process may lead them to avoid painful emotional states that might embarrass them. Beginning therapists may be similarly inhibited by the use of videotape. This inhibition may take the form of a greater formality or a feeling that they must avoid spontaneity in the service of making the "correct" interventions—those designed to win the supervisor's approval. Hence the videotaping of the session may have the feeling of a performance to both parties.

Videotaping also presents other challenges. Patients may give informed consent at the beginning of the therapy to be videotaped, but they may secretly feel that they have little choice and that they are being coerced into a situation where they feel their privacy is violated. If they harbor this feeling of being exploited, they may find this experience of being used very difficult to talk about, so that it ends up as a concealed backdrop that affects the entire therapy. Trainees who choose to videotape should explore the options fully with the patient and make it clear to the patient that the taping is optional. Another drawback to videotaping is that it may occupy so much time in the supervision that the supervisor's emphasis is on the details of the interaction rather than the overarching themes in the therapy.

Audiotaping as an alternative may initially seem less intrusive, but the same problems inherent in videotaping are present when one turns on a tape recorder. The ethical questions are also similar. Moreover, inhibition

in both patient and therapist may be the same. The advantage of having visual, nonverbal data is lost with audiotape.

Presenting process notes of sessions is probably the preferred modality of supervision for individual long-term dynamic psychotherapy in most training centers. The reason for this preference has a lot to do with how "data" are defined in psychodynamic work. Psychodynamic therapists are interested in more than the dialogue between the two parties. On the basis of the conceptual model that psychotherapy is essentially a two-person enterprise, supervisors in dynamic therapy want to know what is happening inside the therapist. When process notes are presented in supervision, supervisors want to know how the therapist felt about the patient, how the therapist thought about various interventions presented to the patient, and how the therapist experienced the patient's response to the interventions. Data, in this regard, are construed as involving the therapist's subjectivity and countertransference in all their various manifestations. Did the therapist delay the beginning of the session? Did the therapist feel bored and restless during the session? Did the therapist have difficulty ending the session on time? If so, why?

One major obstacle to reporting this kind of material to one's supervisor is the supervisee's insistence on writing down everything that was said in the session. Some trainee therapists are so concerned that they will leave out important data that they feel compelled to write down as close to a verbatim transcript as they can. Excessive concern about getting the patient's every word on paper interferes with empathic immersion in the patient's experience as well as observation of the subtle transference and countertransference enactments that arise in the course of a session. Note taking during sessions is discouraged (see Chapter 3: "The Nuts and Bolts of Psychotherapy") because of this concern. Above all, therapists must be *present* with their patients and be open to experiencing the affective states that arise in the context of the therapeutic relationship.

More useful information will be presented to the supervisor if trainee therapists make notes after the session. These notes should convey the primary themes that were discussed during the hour as well as some sample interventions that the therapist made. The supervisory time will generally be more productive if supervisees can begin by talking about the general themes in the treatment and their particular struggles. For example, a supervisee might come to the supervisor with the following report:

> I find myself at a loss as to what I should be doing with this patient. He occupies the entire time with accounts of external events without describing much of his inner world or what is bothering him. He generally doesn't allow space for me to comment on anything, and when I do, he

> dismisses it. I find myself dreading the sessions each week, and I sometimes start them late because I really don't want to go through another tedious hour with him. When I sit there, my mind often wanders, and I'd really like your help in trying to figure out how to break this cycle where I feel so deskilled.

After an introduction that sets the tone of the problems in the therapy, the supervisee can recount the details of one particular session to illustrate the overarching themes. By presenting the material in this way, the supervisee also identifies a learning problem so that the supervisor can focus the supervision on helping the trainee with that particular problem.

The Supervisory Alliance

The supervisee's vulnerability in the supervisory relationship is in many ways similar to the patient's vulnerability in the therapeutic relationship. Therefore we can speak of a *supervisory alliance* that has much in common with the therapeutic alliance (Lomax et al., in press). Supervisors have multiple responsibilities that may inhibit the supervisee. They must ensure that the patient receives competent treatment. They are also responsible for teaching the supervisee the basic skills of psychotherapy. In addition, in most training centers, they are responsible for evaluating the trainee's strengths and weaknesses and making a report to a training director. Supervisors have the task of creating a safe environment so that the supervisee can be completely open in reporting the sessions. Creating this sense of safety requires exquisite sensitivity to the trainee's vulnerability.

Lomax et al. (in press) offer several suggestions for establishing and maintaining a supervisory alliance that is safe enough for the therapist to reveal in a candid way what is transpiring in the therapy. Supervisors may wish to begin a supervisory process by finding out what the supervisee knows about psychotherapy and the nature of his or her previous training. Supervisors may also want to know about areas of difficulty the supervisee has encountered in previous psychotherapy experiences. In training experiences where the supervisee has selected the supervisor, it may be worth exploring the supervisee's expectations and the reasons for choosing the particular supervisor. Both supervisor and supervisee should be quite candid about how they conceptualize supervision and how it can be most effectively used. Supervisors should convey to the trainee therapist what kind of information would facilitate the learning process in an optimal way. The expectations of rescheduling supervision appointments or handling cancellations should be discussed openly. Supervisory appoint-

ments should have sufficient flexibility that topics unrelated to the patient can be brought in periodically. However, supervisors must also maintain a clear vision of what the meetings are for and must be sure that the supervisory time is not eroded in such a way that the supervisee is deprived of a good learning experience.

Perhaps the most challenging aspect of supervision is facilitating an environment in which the trainee feels as though anything that happens in the therapy can be disclosed to the supervisor. Beginning psychotherapists typically feel an acute sense of narcissistic vulnerability as they present their tentative efforts to behave like a psychotherapist when they're really not sure what they're doing. Some may deal with this vulnerability by focusing almost entirely on the comments and behavior of the patient, while leaving their own contributions out of the picture (Issacharoff 1984). Supervisees who are psychiatric residents may feel more comfortable with this medical model of reporting data that treats the patient as a specimen rather than as part of a two-person process. Trainees who are learning psychotherapy face a conflict between presenting what makes them look good so they will receive a positive evaluation versus sharing their struggles and difficulties, which may maximize the learning process but could result in a less glowing evaluation (Greenberg 1980; Wallace and Alonzo 1994).

Unfortunately, it is well known that supervision often involves falsification of material, filtering or censoring of embarrassing moments, and deliberate distortion of process notes to curry favor with the supervisor and avoid criticism (Betcher and Zinberg 1988; Chrzanowski 1984; Hantoot 2000). Some selection of the data in the direction of making a favorable impression is probably unavoidable in a situation where one is being evaluated. However, attention to a solid supervisory alliance at the beginning of the supervision can create an environment where the trainee's concerns about being shamed are minimized. Supervisors may, for example, emphasize to the supervisee that they want to hear about the supervisee's mistakes and uncertainties because only by showing those elements of the process can maximal learning take place. Supervisors may enhance this possibility by emphasizing that they do not expect the trainee to be a competent psychotherapist at this stage of training. Moreover, if they underscore that the evaluation is based to a large extent on the student's capacity to openly share struggles and process them with the supervisor rather than giving a perfect performance, the supervisor's values will be made more apparent and will put the supervisee's mind at rest about any excessive expectations.

Supervisees will go through their professional lives seeking out consultations from colleagues long after they are out of training. Open sharing

about struggles they experience with their patients maximizes the learning process. It also goes a long way toward preventing serious boundary violations when they are tempted to deviate from the usual practices of psychotherapists. In this regard, two basic axioms should always be remembered by beginning therapists (Gabbard 1996):

1. If there is anything that you are doing with a patient that cannot be shared with a supervisor or consultant, you may be starting a dangerous descent down the slippery slope of boundary violations.
2. The thing you most wish to avoid sharing in supervision is probably the most important issue to discuss with your supervisor.

When supervisor and supervisee are negotiating the parameters of supervision, the supervisor may wish to have the supervisee describe the frame of treatment. That way, the supervisor knows what sort of deviations are occurring from the usual professional boundaries and the therapist's rationale for those deviations (Gabbard 2000; Waldinger 1994). Supervisees who are extending sessions to 60 or 65 minutes instead of 45 or 50 can explain why they feel compelled to draw out the end of the session. Those who are not charging a fee or are not insisting on collecting the payment from the patient also can explain what they are doing. This approach allows them to get help with any countertransference concerns that may prevent them from setting appropriate boundaries with patients.

Boundary Issues in Supervision

The discussion of what the supervisee discloses in supervision touches on the broader issue of the boundaries inherent in the supervisor-supervisee relationship. The obvious boundaries are those associated with a fiduciary relationship. Most mental health professional organizations, for example, specifically prohibit sexual relationships between a supervisor and a supervisee. Supervisees are expecting a specific service from their supervisors that should not be contaminated by personal agendas of the supervisor. The more complicated boundary, however, is one involving the interface of treating and teaching (Gabbard and Lester 2003). In an era in which the emphasis on a two-person psychology makes it imperative for supervisees to share a good deal about themselves, supervisors must be vigilant about not crossing the line from being a teacher or supervisor to being a therapist to the supervisee. When a supervisee discloses an error, such as prematurely interpreting transference before it has become close

enough to the patient's conscious awareness to be meaningful, the supervisor can point out the mistake, considering it as simply a matter of teaching about psychotherapy. However, when a problem in technique clearly grows out of countertransference issues, the supervisor may struggle over whether or not to point out the therapist's personal involvement with the patient, knowing that there is no contract for therapy inherent in supervision.

A general understanding can be negotiated between supervisor and supervisee about the usefulness of including countertransference within the purview of supervision. Nevertheless, the exact boundaries of countertransference are hard to delineate in an abstract sense. When supervisees are struggling with the heat of transference-countertransference enactments, the boundaries between supervision and therapy may become blurred.

Supervisees may help maintain a reasonable boundary between education and therapy by sharing their here-and-now responses to the patient without going into great detail about their personal problems and their childhood origins. Supervisors can facilitate an intact boundary by focusing on countertransference in the broad sense of what the patient is *inducing* in the therapist rather than focusing on how the therapist's past is being recreated in the present with the patient. In other words, supervisors do not make interpretations of the childhood origins of the therapist's countertransference (Gabbard and Lester 2003). In this way, supervisors identify countertransference as being emblematic of the sort of interpersonal problems the patient experiences outside the therapy. They do not label the therapist's personal conflicts as the primary cause of the countertransference that emerges. This understanding about how countertransference will be discussed in supervision may help the supervisory alliance in that the supervisee will feel more comfortable and safe in disclosing emotional reactions to the patient. Education about countertransference and its ubiquity and acceptability may go a long way toward facilitating disclosures from the supervisee. Supervisors must avoid any implication of criticism or "catching" the therapist's countertransference as though it is something to be scrupulously avoided. In the past, countertransference was regarded as only an interference, something that could be eliminated if one had an in-depth personal analysis. We no longer view countertransference in that way, and the pejorative connotation should be eliminated from the discourse of supervision.

As noted in Chapter 8 ("Identifying and Working With Countertransference"), countertransference is often entirely unconscious and is discerned only through various kinds of enactment. The supervision process itself may serve as a fertile field for the hidden countertransferences to

emerge. Supervisees, in conveying the process of the therapy to the supervisor, may begin to relate to the supervisor in the same way the patient relates to them. This phenomenon is often referred in the literature as *parallel process* (Doehrman 1976; Gabbard and Lester 2003; Gediman and Wolkenfeld 1980). The mechanism of parallel process is not significantly different from the mechanism of enactment. Just as patients may repeat in action what they resist remembering, so may supervisees enact rather than verbalize something from the therapy. Through these reenactments, the therapist may unconsciously identify with the patient and replicate an aspect of the transference with the supervisor. Moreover, when the supervisee begins to treat the supervisor as the patient treats the therapist, then the supervisor may start to experience countertransference similar to that of the therapist. A clinical example illustrates this phenomenon:

> Dr. Z was growing frustrated in her supervision with Dr. AA. She felt she was having a great deal of difficulty making useful and effective therapeutic interventions with her patient. Week after week she would describe the patient and point out how elusive he was when she tried to get him to focus on specific conflicts that he wanted to address in therapy. The patient preferred to speak in abstract and metaphysical terms rather than talking about specific changes he would like to make in his life. Dr. Z would develop a number of formulations with her supervisor that were designed to focus the material, but none of them seemed to fit the patient's experience. For example, Dr. Z said at one point, "Is it possible you would prefer not to focus on any goals because the idea of change is frightening to you? The patient responded, "No, I don't think so. I feel really miserable most of the time, so I would really like to change things."
>
> When this line of interpretation was unsuccessful, Dr. AA suggested another strategy to Dr. Z: Was it possible that the patient was invested in defeating Dr. Z because it made him feel bad about himself to take help from Dr. Z? When Dr. Z tried out this strategy with the patient, he responded negatively again, emphasizing that he really wanted help from Dr. Z and really did not want to defeat her.
>
> This pattern of offering suggestions occurred repetitively, both in the therapy and in the supervision. Eventually, Dr. AA began to appreciate how helpless and impotent that Dr. Z was feeling in the therapy because he felt that way in the supervision. He asked Dr. Z if she were feeling helpless. Dr. Z confirmed, saying that she was feeling like nothing she said made a difference to the patient, and she was wondering if she were failing as a therapist. Dr. AA confided that he was experiencing exactly what she did in the parallel process of supervision—namely, that he was failing as a supervisor because none of his suggestions seemed to be paying off in the therapy. He then raised several questions to Dr. Z: Was something being recreated with her that reflected the patient's internal world? Would

there be some reason that he would want to induce a feeling of failure or helplessness in Dr. Z? When Dr. Z returned to see the patient, instead of offering possible interpretations and suggestions, she simply made an observation about the process and how she was feeling that nothing she said was useful to him. She wondered if this were recreating something, and the patient immediately said that his mother had always said the same thing to him. This led to an exploration of the transference to the therapist as a mother whom the patient needed to frustrate.

In psychotherapy the therapist must "detoxify" painful affect states projected by the patient. Something analogous happens in supervision when certain affects may be evoked in the supervisor resembling those with which the supervisee is struggling. Dr. AA tried to contain those affects and find ways to help the supervisee use them productively in the process (Gabbard and Lester 2003; Gabbard and Wilkinson 1994). He tried to translate the feelings of futility and impotence he was having into words that were useful to the supervisee in understanding the process with the patient. The supervisor's self-disclosure in this situation may be just as valuable as therapist self-disclosure to the patient.

This vignette also illustrates that the supervisor may at times project self and object representations along with their associated affects onto the supervisee. In other words, an alternative way of understanding the vignette is that the supervisor may have been "taking over" too much and telling the supervisee what to do with the patient. The supervisee may then have treated the patient as someone who also needed to be told what to do, rather than encouraging more self-initiative. The parallel process can work in either direction. However one understands the process between supervisor and supervisee, the most important principle to take from this discussion is that whatever is transpiring must be courageously examined by both supervisor and supervisee to see what it reveals about the difficulties in the therapy.

When a good level of trust has been established within the supervisory alliance, deliberate role playing may be an excellent way to facilitate the emergence of hidden countertransferences or blind spots in the therapist. When the supervisee assumes the role of the patient with the supervisor in the role of therapist, this arrangement also provides the supervisee with the opportunity to see how the supervisor might address problems the patient presents to the therapist. Also, while portraying the patient, the supervisee may gain greater empathy for the patient's experience of the therapist's efforts to help.

Common Problems in Supervision

The Chatty Supervisor

Many supervisors assigned to trainees are clinicians who spend a good deal of their time listening to their patients' problems. When the supervisee enters their office, they may seize the opportunity to chit-chat rather than help the supervisee with patient-based problems. Because they have to spend the day listening, they may see the arrival of a supervisee as an opportunity for a little socialization. A few minutes of this type of interaction may be tolerable and even comfortable, as it puts the supervisee at ease. When it becomes a pattern that interferes with the supervisee's learning process, however, some action may need to be taken.

Some supervisors who feel isolated in private practice may wish to gossip a bit about mutual acquaintances with their supervisees. They may pump them for information about the latest developments in a colleague's private life or in the academic department from which the trainee comes. Still others may wish to talk about movies, television programs, or books because they are starved for conversation after seeing patients all day.

Some supervisees can manage this type of supervisor by simply beginning their discussion of their patient as soon as they walk in the door. This "down-to-business" attitude makes it clear to the supervisor that the supervisee is there to get help with patient problems. If this technique fails to work because the supervisor interrupts the supervisee to chit-chat, a gentle confrontation may be necessary: "I don't mean to be impolite, Dr. X, but I really need help with this patient today, so if you don't mind, I'd like to get back to the material." Many supervisees are terrified of asserting their own right to get supervision because of their transference to the supervisor as a distinguished and powerful person in their community who has evaluative power over them. However, most supervisors recognize their obligation to supervise, and they may respond promptly to such gentle confrontation. If their behavior persists, the supervisee may need to bring it up with the training director.

The Sleepy Supervisor

Supervisors of psychotherapy trainees may work excessively long hours to accommodate the schedules of their patients, and they may allow their attention to lapse during supervision, where there is less pressure than there is with a patient. They may even drift into somnolence as they listen to the supervisee. This common experience is disconcerting to trainee

therapists, who fear that they could be boring the supervisor and may feel that they have some responsibility for putting the supervisor to sleep. In fact, supervisees have no obligation to entertain their supervisor. Nevertheless, it may be worth exploring whether there is some type of jointly constructed phenomenon in the supervision that could be processed between the two parties. A supervisee might say to the supervisor, "I notice your eyelids are getting heavy, and I wonder if I am presenting this in some way that is putting you to sleep. Would there be a better model of our doing supervision that would be more lively?" This approach allows for the possibility that the supervisee may contribute to the supervisor's sleepiness but also opens up the possibility of considering different models of supervision. Something as simple as sharing coffee together during supervision may be useful in some cases.

The Boundaryless Supervisor

One female trainee arrived in her male supervisor's office, and the supervisor asked her to sit next to him on his couch. She handled it admirably by simply saying that she preferred the chair. Not all trainees have the presence of mind to set limits with a supervisor who is boundaryless. Some may be intimidated because of transference to the supervisor. They may feel they have no choice than to go along with the supervisor's whim. The boundarylessness may also come in the form of nosiness. Some supervisors will ask their supervisees if they are single or married, if they are straight or gay, if they are in personal therapy or analysis, or if they had particular childhood difficulties. Some supervisors may hug the supervisee or offer a peck on the cheek. Supervisees need to feel free in these instances to openly express their discomfort with any boundaryless situation their supervisor presents. Often the simple statement that "I'm not comfortable with this" causes the behavior to cease. If it does not, the supervisee may need to resort to a complaint to the training director.

The Authoritarian Supervisor

Supervisors who appear to know exactly the right intervention in every situation of supervision may be daunting to the trainee. A sense of certainty may actually be extraordinarily appealing to the supervisee, since so much is uncertain in the practice of psychotherapy. The supervisor's certainty might grow out of a conviction that one particular theoretical model is the embodiment of "Truth." Hence authoritarian supervisors may convey that all the trainee needs to do is grasp the preferred theoretical model to have all the answers to their therapeutic dilemmas.

Although there may be appeal in the supervisor's certainty, many supervisees feel like they are falling short of their teacher's expectations whenever they do not adhere to the supervisor's favorite theory. At the very least, trainees should feel free to ask their supervisors to explicate the basis of their advice in terms of the underlying theoretical model. If a supervisor with a self psychological orientation, for example, insists that a trainee needs to have greater empathy for the patient's point of view, the trainee can ask the supervisor to explain the rationale for an empathic approach and then discuss what the supervisor sees as problems with alternative approaches. Trainees should not feel obligated to force their patients to fit the supervisor's preferred theory. If they see that other perspectives are a better fit for the patient, they should make the case to the supervisor and encourage open dialogue on the subject. Patients rarely benefit from a therapist who is simply going along with the authoritarian directives of a supervisor. A trainee therapist, like all therapists, must feel free to be flexible and spontaneous in the therapeutic situation.

Reluctance to Give Up the Supervisor or Supervisee

At the end of the training year, most training programs insist that students shift to another supervisor so they can benefit from different styles of supervision and gain exposure to different theoretical models of psychotherapy. Some supervisees may develop great attachment to their supervisors and might find it difficult to relinquish them at the end of the academic year. They might even request to continue for another year with the same supervisor. Although this may be flattering to the supervisor, it is probably in the student's best interest to learn multiple perspectives on psychotherapy during the training period. Occasionally, the request for continued supervision comes from the supervisor, who is having such a positive experience with a student that he or she does not wish to end the supervisory relationship. The supervisee must feel free to move on to a different supervisor in such cases, even if expression of that preference may hurt the supervisor's feelings. Policies in training programs that limit the duration of supervision may be helpful in allowing the supervisee to fall back on departmental policy when such questions arise.

From Supervision to Consultation

The effective use of supervision during one's training year sets the tone for ongoing consultation throughout one's professional life. Therapists should develop an attitude that they do not have to solve every problem

on their own. Even if therapists have their own personal treatment experience—which is extraordinarily helpful in dynamic therapy—they will still have blind spots. Consultants who are not immersed in the heat of the transference-countertransference dynamics bring an outside perspective to the dyad that is enormously valuable when one is stuck at an impasse with a patient.

Once one is out of training, consultation means extra expense. One must pay the consultant in most cases, and one also loses time in the office when traveling to the consultant's office. Hence therapists often think up numerous excuses and rationalizations to avoid consulting a colleague when they are in a difficult situation. Many individuals who choose to spend their lives as psychotherapists may have an unconscious need for a succession of one-to-one exclusive relationships guarded by the mantle of a radical form of privacy (Gabbard 2000). This quasi-incestuous arrangement that excludes an outside third party may create a situation of a secret, forbidden activity that is off limits to outsiders. Boundary violations are an ever-present risk in the lives of therapists, and scrutiny by a third party is an essential part of the prevention of serious transgressions. When a consultant is brought into the situation, the process is no longer an exclusively dyadic secret, and the quasi-incestuous arrangement is shattered by the presence of an observer. A consultant may also serve as a kind of auxiliary superego that helps the therapist think clearly about the appropriate boundaries of the therapeutic situation and avoid rationalizing various deviations from those boundaries.

Concerns about confidentiality can be used as a barrier to consultation, but a consultant has the same constraints on confidentiality as a therapist, so nothing can be shared by the consultant with any outside parties. To further preserve confidentiality, therapists may avoid using the name of the patient or specific identifying information. Some therapists prefer to telephone consultants who live in another city so the consultants have no way of discerning the identity of the patient.

One can always corrupt a consultation process by sharing only partial information with the consultant. Another common strategy that consultees have used is to choose a consultant they know will agree with them. If they are engaged in questionable behavior in the psychotherapy process, they can present it in such a way that the consultant will sanction what they are doing, and they can document what the consultant said to bolster their deviation from ordinary psychotherapy. The ideal consultant should be someone who creates an atmosphere of acceptance and tolerance but who also is willing to confront the therapist about problematic comments or behaviors in the therapy. Useful consultation begins with careful attention to the selection of the consultant. In both supervision

and consultation, there is no substitute for painstaking and rigorous honesty in reporting about both the patient's and the therapist's contributions.

Summary

Individual supervision of long-term psychodynamic psychotherapy usually occurs in a once-weekly format. The data of supervision can stem from videotapes, audiotapes, or detailed process notes. Each of the methods has advantages and disadvantages. When supervision begins, supervisor and supervisee should actively work at forging a supervisory alliance wherein the therapist feels safe enough to candidly reveal what is happening in the therapy process. Beginning therapists should keep in mind the axiom that what they most wish to avoid sharing in supervision is probably the most important issue to discuss with the supervisor. Supervisors must maintain a supervisory boundary in which countertransference is regarded as what the patient is inducing in the therapist rather than a reflection of the supervisee's personal problems and their origins in childhood experiences. A parallel process often occurs, in which what is enacted between supervisee and supervisor reflects what is enacted between patient and therapist. Both members of the supervisory dyad should be alert to these developments. After completion of a training program, beginning therapists should include the regular seeking of consultation as part of their practice as a way of improving their skills and avoiding boundary transgressions with patients.

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11

Evaluating Core Competencies in Long-Term Psychodynamic Psychotherapy

Evaluation of psychotherapists has always been challenging. By its very nature, psychotherapy is a treatment that requires privacy. As noted in Chapter 10 ("Use of Supervision"), the introduction of recording devices or a third-party observer alters the fundamental setting in such a way that both therapist and patient may behave differently than they do in private. Similarly, when one relies on notes to convey what happens in a psychotherapy session, the therapist may construct a version of the hour that has fictional elements, many of which may shed more favorable light on the therapist.

One must also confront the problem of defining what *competent* actually means. One useful definition, from the *New Shorter Oxford English Dictionary* (1993), is "Sufficient or adequate in amount, extent, or degree" (p. 459). This definition has the advantage of establishing modest expectations. One does not need to be an expert to be competent—only "adequate." Well-established, respected psychotherapists generally consider themselves to be life-long students who are always learning ways to improve their skills. True expertise feels elusive even to experienced therapists. Most of us are always striving for proficiency while dealing with misreadings of patient communications, failures of empathy, and counter-

transference enactments. The best we can do is continually monitor these shortcomings and work on repairing any damage to the therapeutic alliance that may result from them. To paraphrase Winnicott's phrase applied to expectations of mothering, we hope to be "good enough" therapists.

Within this context, psychiatric residents and other trainees in the mental health professions must be evaluated according to the level of their training and experience. Competency might best be linked to a minimum requirement established by training directors or supervisors that reflects a reasonable expectation for someone who is graduating from the training program. In this regard the graduating trainee should be capable of conducting psychotherapy with patients who may need it but is expected to grow in knowledge and proficiency with continuing education, practice, and supervision or consultation.

The Psychiatry Residency Review Committee suggests that competence in psychotherapy can be subdivided into three domains: knowledge, skills, and attitudes. The American Association of Directors of Psychiatric Residency Training established the Task Force on Competency, under the leadership of Eugene Beresin and Lisa Mellman. This group has been working on various measures for each of these domains. Other educators have also developed measures for competency (Bienenfeld et al. 2000; Beitman and Yue 1999; Weerasekera 2003). These contributions are all works in progress as the field grapples with the gap between the ideal and the practical. The work of these colleagues and numerous conversations with others have shaped my recommendations about the knowledge, skills, and attitudes necessary to attain competency in long-term psychodynamic psychotherapy. The standards I am proposing grow directly out of the material in the foregoing chapters of this text.

Psychotherapy Competency Domains

Knowledge

At the end of a student's training in long-term psychodynamic psychotherapy, a trainee should have acquired a rudimentary understanding of the following information:

1. The basic psychodynamic developmental theories and their implications for clinical practice
2. Unconscious mental functioning as it relates to modern neuroscience and psychotherapy practice
3. Transference, resistance, and countertransference
4. Suitability for long-term psychodynamic psychotherapy

5. Basic components of personality
6. The hierarchy of defense mechanisms
7. The difference between neurotic and borderline levels of ego organization
8. Mentalization/reflective function
9. Psychiatric disorders, in conjunction with patient suitability characteristics, that constitute indications for long-term psychodynamic psychotherapy
10. Psychiatric disorders, in conjunction with patient suitability characteristics, that constitute contraindications for long-term psychodynamic psychotherapy
11. The elements of professional boundaries that make up the therapeutic frame
12. The expressive-supportive continuum of interventions
13. The diverse goals of long-term psychodynamic psychotherapy
14. The modes of therapeutic action of long-term psychodynamic psychotherapy
15. The various forms of resistance encountered in psychotherapy and how they manifest themselves
16. The basic mechanisms of disguise in dreams
17. The principles of therapeutic technique in working with dreams
18. The psychological functions of fantasy
19. The process of working through in the course of long-term psychodynamic psychotherapy
20. Impasse phenomena and the negative therapeutic reaction
21. The varieties of termination and their management
22. Knowledge of when to refer a patient to another therapist

Skills

At the conclusion of a training program involving clinical experience in long-term psychodynamic psychotherapy, a trainee should have acquired the following skills:

1. Ability to listen empathically to the patient's account
2. Capacity to form a therapeutic alliance that enlists the patient's collaboration in the understanding of symptoms and problems
3. Ability to incorporate observations about the patient's nonverbal communication into assessment and therapy
4. Identification of defense mechanisms
5. Ability to assess suitability for long-term psychodynamic psychotherapy

6. Reasonable skill at writing a psychodynamic formulation within the context of a biopsychosocial model
7. Capacity to establish and maintain professional boundaries with appropriate flexibility when needed
8. Ability to formulate and deliver interpretations that provide insight to the patient
9. Identification of both transference and countertransference as they emerge in psychotherapy
10. Capacity to set appropriate therapeutic goals with the patient
11. Ability to identify, interpret, and confront resistances
12. Capacity to collaborate with a patient in understanding a dream
13. Ability to identify and work with fantasies
14. Therapeutic skill at shifting between an empathic immersion in the patient's point of view and an outside observer's perspective
15. Capacity to use countertransference to advance understanding of the patient and the therapeutic process
16. Ability to manage the termination process

Attitudes

Measuring attitudes is particularly challenging, but a set of specific attitudes are extremely significant in defining the therapist's professional role. These include the following:

1. Empathy and compassion
2. Firmness in setting limits and adhering to the therapeutic frame
3. Curiosity about the patient's inner experience and fantasy life
4. Restraint in passing judgment about the patient's thoughts, feelings, and behavior
5. Honesty and receptivity in supervision
6. Sensitivity to gender issues
7. Open-mindedness regarding the patient's sexual orientation and sexual behavior
8. Sensitivity to cross-cultural issues
9. Persistence in the pursuit of understanding, even in the face of a multitude of resistances
10. An ethical commitment to putting the patient's needs before one's own
11. Receptivity to countertransference feelings evoked by the patient

Optimal Experience

To gain the knowledge, skills, and attitudes required to be competent, a beginning therapist needs much more than a textbook. There is no sub-

stitute for sitting with patients over time and applying what one has learned. The optimal amount of experience is difficult to define, because some beginners are quick studies or "naturals," while others follow a different learning curve. Psychotherapy experience must begin relatively early in a training program, however, for a student to have the opportunity for a truly long-term process to evolve.

Residency programs continue to struggle with how to provide sufficient clinical experiences so that residents can develop competence in psychodynamic psychotherapy. Many requirements of residency training continue to be specified in ways that encroach on time that might be used for mastery of psychotherapy skills, especially those that take a long time to develop. Many programs use a progressively intensive exposure to dynamic therapy beginning in the second postgraduate year, with each program offering more or less experience depending on the program's faculty expertise and patient availability. In the second postgraduate year, for example, a resident could be expected to start two patients in individual psychodynamic psychotherapy. Two hours of weekly supervision during each year of training is a requirement of the Residency Review Committee.

In the third postgraduate year, at least one or more patients should be treated in longer-term psychodynamic psychotherapy. One would hope that patients who are started in the second postgraduate year would continue into the third and fourth years so that residents could encounter the many challenges that emerge later in the process. However, some patients are not interested in continuing past a certain point, and the resident sometimes needs to accept this outcome as unavoidable. The third-year resident would also have weekly meetings with two supervisors during this time. In addition, it is useful to add experience with children, adolescents, and families during the third postgraduate year. Working with children and adolescents is a wonderful way to learn about developmental issues for the psychotherapist who will eventually work with adults.

In the fourth postgraduate year, which is largely elective in nature, residents who are interested in psychotherapy can add more cases in dynamic therapy while also learning other modalities. Experience in long-term dynamic therapy with patients of both genders is optimal. Different transferences and countertransferences will emerge depending on the gender constellation of therapist and patient, and it is ideal to face these challenges with the help of a supervisor while one is in training.

Means of Evaluation

The knowledge, skills, and attitudes by which core competency is assessed may require different means of evaluation, depending on the kind

of information that is desired by the evaluator. Certain factors are more readily evaluated by one assessment tool than by another. There are several different methods of evaluation that should be considered, and each has its advantages and disadvantages for particular areas of competency.

Case Write-ups

A detailed case report of the patient can reveal a great deal about the knowledge that a trainee has mastered. Readers of the report can determine whether the trainee understands the basic developmental theories and knows how to apply them to clinical situations. An understanding of basic psychodynamic concepts, such as transference and resistance, can also be discerned from case reports, especially if these reports include process material from actual psychotherapy sessions. The requisite attitudes for competency are more difficult to assess from a case write-up, but one can often glean from written material some notion of whether the trainee is sensitive to cultural and gender differences and is basically curious about the patient. Certain skills, such as the capability of writing a psychodynamic formulation in the context of a biopsychosocial model, readily lend themselves to assessment from a case write-up. Other skills, such as how the trainee establishes a therapeutic alliance and times therapeutic interventions, are more difficult to assess from written material.

Oral Presentations at Case Conferences

A great deal can also be learned about a trainee's knowledge, skills, and attitudes from the way the trainee presents clinical material to a case conference. Since most presentations are based on written case reports, all of the competency factors that one can evaluate from a write-up can also be assessed during an oral presentation at a case conference. Moreover, additional information about the trainee's skills and attitudes is often ascertained by the way the trainee talks about the case and responds to questions from colleagues. The capacity to maintain a nonjudgmental attitude, for example, is readily discerned by how a therapist talks about a patient. Similarly, receptivity to countertransference feelings evoked by the patient is more easily evaluated when the therapist talks about how he or she feels in response to the patient. These aspects of a case are often censored or heavily edited when writing a case report. One of the most important distinctions between a case write-up and an oral presentation at a case conference is that the latter provides an opportunity for an exchange with instructors and other students. When one of the competency areas is questionable, inquiries from faculty members or students may shed further light on the trainee's mastery in that area.

Written Examinations

Although both faculty and students often find written examinations to be a good deal of work, they have the advantage of allowing comparison to other training programs in terms of basic knowledge. Almost all the material that involves knowledge can be evaluated through multiple-choice questions. In addition, if detailed case vignettes are supplied, some skills, such as identification of defense mechanisms, can be tested as well. Attitudes are very difficult to evaluate from a written examination, and many skills cannot be adequately assessed from a written examination either.

Oral Examinations

Although oral examinations are often seen as infantilizing in the postgraduate educational setting, they can be useful for assessing the knowledge base of the trainee as well as certain skills. If an oral examination is based on patient material, an evaluator can determine whether a trainee is capable of creating a formulation based on the history and psychiatric examination of the patient. Oral examinations also offer the examiner the opportunity to probe into areas where the knowledge base or skills are questionable. One of the disadvantages of the oral examination method, however, is that many trainees develop a kind of performance anxiety that may cause them to appear much less knowledgeable and skilled than they actually are.

Videotape Recordings and Direct Observations

Both videotape recording and direct observation of psychotherapy sessions have the great advantage of permitting assessment of how the beginning therapist actually interacts with the patient. An evaluator can gain a great deal of information about the competencies involving attitudes. The therapist's capacity to establish rapport and forge a therapeutic alliance is also readily evident from these sources. In addition, the faculty member doing the evaluation can directly observe nonverbal communications of the patient, which is greatly useful in assessing whether the beginning therapist is adept at identifying and using such communications. Moreover, after the session is viewed, either directly or on video, the examiner can ask specific questions that are related to what actually happened in the session. In this manner, all three domains—knowledge, skills, and attitudes—can be assessed at the same time.

As noted in Chapter 10 ("Use of Supervision"), among the major disadvantages of this approach are the invasion of the privacy of the therapeutic dyad and the risk that patients in such circumstances will feel their

confidentiality is being violated. Whether patients are really free to give informed consent in such situations is questionable, because the power of transference is such that it may be difficult to say no. Patients may be convinced that the therapist will be angry with them for declining consent. Even though most direct observation is done through a one-way mirror, the patient may still be distressed at the presence of an unseen observer. Moreover, patients may carefully filter what they say, knowing that someone else is listening and watching. Therapists may similarly be on their guard and might present a version of what they do in therapy that is quite different from their general practice.

Audiotape Recordings

Audio recording of psychotherapy sessions has roughly the same advantages and disadvantages as video recording. The lack of nonverbal information is one disadvantage, although the recording of tones of voice, pauses, and the complete verbal exchange of the session is extremely useful. Use of audiotape is a good way of assessing most of the skills and some of the attitudes of a beginning therapist. However, as with videotaping or direct observation, there is an intrusion into the field of therapy that may be highly problematic.

Supervision

By far the most widely used method of evaluating therapist competency is supervision. This approach has the great advantage of providing a longitudinal assessment over time. The faculty member who is in the role of supervisor gets to know the strengths and weaknesses of the supervisee in depth because the two meet weekly over a period of many months. Whether the supervisor uses the process notes, audiotapes, or videotapes of the supervisee, the therapist's knowledge, skills, and attitudes become apparent over time. The supervisor can also make evaluation an ongoing, evolving, collaborative task in which both supervisor and supervisee are constantly assessing areas that need improvement. Moreover, as discussed in Chapter 10 ("Use of Supervision"), the supervisor often gets a firsthand feeling for the therapist's countertransference by the way the therapist presents the patient in supervision. Role-playing exercises can also enhance the supervisor's capacity to evaluate the therapist's degree of empathy with the patient. At the end of a 6-month or 12-month period, supervisors can go over a checklist of knowledge, skills, and attitudes that comprise the psychotherapy competencies and can assess which are acceptable and which need further work.

Table 11–1. Advantages and disadvantages of evaluation methods

Means of evaluation	Knowledge	Skills	Attitudes
Case write-ups	+ +	±	−
Oral presentations at case conferences	+ +	+	±
Written examinations	+ + +	±	−
Oral examinations	+ + +	±	−
Videotape recordings or direct observations	+	+ +	+ +
Audiotape recordings	+	+ +	+
Supervision (over time)	+ + +	+ +	+ +

Note. +=useful; ++=very useful; +++=extremely useful; ±=mixed in its usefulness; −=not very useful.

Table 11–1 summarizes the advantages and disadvantages of the various means of evaluation.

Summary

Evaluation of competency in long-term psychodynamic psychotherapy is a complicated task. The notion of competency refers to a modest expectation: that the trainee has mastered the basics of the modality in an adequate way that will prepare him or her for practice after residency. Competency assessment should be geared to the level of training and experience. A set of variables under the headings of knowledge, skills, and attitudes can be listed and evaluated through a number of different means. Among the methods of assessment are 1) case write-ups, 2) oral presentations at case conferences, 3) written examinations, 4) oral examinations, 5) videotape recordings or direct observations, 6) audiotape recordings, and 7) supervision. Some of these methods are better suited for evaluation of knowledge, while others are better for evaluation of skills and attitudes. Supervision is the core means of evaluation because it provides a longitudinal perspective on the trainee's performance as a therapist.

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