CHAPTER 4

PSYCHODYNAMIC APPROACHES

Look to the Past to Set You Free

CHAPTER OUTLINE

Theories differ according to a number of dimensions, as we have seen in previous chapters. Some require a very active therapist role, whereas others put more responsibility on the client. Some focus particularly on changing cognitive activity, whereas others stress observable behavior or inner feelings. And theories vary in where they think most of the action takes place: the present, the past, or the future.

In our first set of therapeutic approaches, the emphasis is clearly on the past. Each of the psychoanalytic conceptions shares a strong belief that until you help people to resolve issues in the past, they will never come to terms fully with what is bothering them in the present.

FOR PERSONAL REFLECTION

Some clients come for help because they see themselves repeating past mistakes over and over again—choosing relationship partners who have problems with addictions or working for a mean boss in every job they take. How do you see your own history repeating itself in some aspect of your life? What are some of the ongoing personal struggles that you have faced? These could involve difficulties with intimacy, authority figures, or poor self-esteem, among others.

What are some possible sources in your early life that could be responsible for these personal struggles? What have you suffered previously that continues to plague you today?

For Group Discussion

In small groups, talk about some of these issues from the past that still make themselves known in the present.

● EARLY BACKGROUND

For all practical purposes, the fields of counseling and psychotherapy were launched when a young physician in the middle of the 19th century began using hypnosis to help his patients talk about their difficult problems. Sigmund Freud had been trained as a neurologist with the finest medical scholars of his day. In addition, he had a lifelong interest in reading novels, studying philosophy, and practicing amateur archaeology. In a sense, Freud fancied himself as much a historian and archaeologist as he did a medical practitioner.

In one of his first published papers, Freud collaborated with a mentor, Joseph Breuer, to describe cases of hysteria (physical symptoms of

psychological origin) they had treated using hypnosis (see Voices From the Past on page 83). It was their hypothesis that these patients suffered some sort of trauma at an early age and that they attempted to cope with this pain by blocking it out, repressing memories of the events (suspected to be sexual abuse). They theorized that strangling this emotional energy resulted in the development of symptoms that could only be treated by getting at the root of the problem. Although hints of the problem might slip out in dreams and unconscious acts, until the person could be helped to excavate and unearth the buried memories, the symptoms would endure.

During the next 50 years, Freud collaborated with a number of other medical colleagues, as well as students, to formulate a comprehensive theory of human development that includes the origins of problems as well as how they might best be resolved. Many of these individuals, whose names may be familiar to you, went on to establish their own unique brand of psychoanalytic theory that better fit their personalities, values, and therapeutic style.

FOR CLASS DISCUSSION

Although Freud is always discussed in courses on theories of counseling and psychotherapy, his original work is seldom assigned any more. Many students associate Freud with dry, dusty volumes of inscrutable depictions of arcane, nonexistent brain structures and are pleasantly surprised when they read something he has written.

See Voices From the Past at the end of this chapter. What was your reaction to this excerpt from Freud's work? Was it what you expected, or did it surprise you? Freud wrote about his clinical reasoning in addition to reporting the dialogue with his patient in this session. What did you think about his questioning and interpretation techniques? Contemporary adults still suffer from the aftermath of experiencing child sexual abuse; in your opinion, how far have we advanced from Freud's treatment strategy?

PSYCHOANALYTIC DISCIPLES AND REVISIONISTS ●

"While it is not true that there are as many psychoanalytic theories of personality and treatment as there are psychoanalysts, it often seems that way" (P. Buirski, 1994, p. 1). You have probably heard of many different names in this movement—Carl Jung, Alfred Adler, Harry Stack Sullivan, Theodore Reik, Anna Freud, Melanie Klein, Karen Horney, Erich Fromm—all once disciples of Freud who went on to develop their own schools.

Jung (1926/1954), for example, was very influential, creating a theory that is still quite popular among contemporary practitioners. Whereas Freud was big on sexual and biological roots of behavior, Jungian analysts favor more spiritual and cultural factors, which access the collective rather than the individual unconscious. Jung's theory remained true to Freud's original idea about the importance of the past and inaccessible memories, but Jung expressed these as archetypes, which are enduring cultural symbols.

Just as in traditional psychoanalysis, the Jungian therapist encourages clients to talk about their dreams and fantasies, but the interpretations of this material are constructed very differently. That is one of the curious aspects of this field: Jungian patients will dream in Jungian symbols of mythology, folklore, and religious icons, whereas Freudian patients dream in phallic symbols, Oedipal complexes, and wish fulfillment. Does this phenomenon validate the theory or rather reflect that people were indoctrinated into a particular system?

Jungian therapy remains popular precisely because it can be so easily combined with religion, spirituality, and cross-cultural experiences. Because Jung wasn't nearly as sexist, pessimistic, or rigid as Freud, he is also often embraced as an alternative.

● BASIC PRINCIPLES OF PSYCHOANALYTIC THEORY

It would normally take you at least 5 to 10 years of intensive study at an approved psychoanalytic institute to get a handle on psychoanalytic theory and its nuances. This would include reading the two dozen or more volumes that Freud wrote, plus 10 times that many of other related works. While you were completing this bookwork, you would also be expected to participate in psychoanalysis as a patient for 5 or more years because it is considered crucial that you work through your own issues before you attempt to help anyone else with their problems. Once your training began as a practitioner (traditionally open only to MDs and PhDs, though counselors and social workers have been included more recently), you would then be meeting with your training analyst several times per week to work on cases, as well as attend seminars at the institute.

There are approximately 29 training institutes for psychoanalysis in the United States accredited by the American Psychoanalytic Association (APsaA), 42 affiliate societies, and more than 3,500 graduated psychoanalysts practicing in the United States. The International Psychoanalytical Association accredits psychoanalytic training centers throughout the rest of

the world, including Serbia, France, Germany, Austria, Italy, Switzerland, and others. Institutes often operate low-fee clinics, where people who might not otherwise be able to benefit from analysis can obtain treatment. For a glimpse into the personal and professional relationships of a fictional contemporary institute, *The Saturday Morning Murder: A Psychoanalytic Case* by Batya Gur and Dalya Bilu (1993) provides a riveting education in the form of a mystery novel.

Fear not, however, if you have no inclination or intention of making a long-term commitment to the study of Freud. You would certainly be well advised to read a biography about him (see Breger, 2000, or Gay, 2006, as examples) because his life's work was so interesting and influential. You would also find it interesting to read a few of his classic works, notably *Interpretation of Dreams, The Psychopathology of Everyday Life,* or *An Outline of Psychoanalysis.* Because so many of Freud's original ideas are now part of our universal language and therapeutic principles, you would hardly be considered literate as a therapist if you didn't at least familiarize yourself with the following basic concepts of the theory. Freud's and his followers' key concepts are explained in *Comprehensive Dictionary of Psychoanalysis* (Ahktar, 2009); those most influential in psychoanalytic thought are reviewed below.

Intrapsychic Conflicts

Psychological symptoms and self-defeating patterns are the result of internal struggles in which a person attempts to reconcile battles between basic aggressive and sexual instincts (id) versus the conscience and moral beliefs (superego). This id is present at birth and is the seat of the instincts. It is unconscious, and it is impulsively driven by the "pleasure principle." In contrast, the ego and the superego are both unconscious and conscious. The superego is where self-criticism and judgmental capacities develop, as children internalize the restrictions and judgments adults place on them. The ego mediates between the id and the superego, attempting to reconcile raw desire with socially appropriate behavior. The ego develops slowly and operates by the "reality principle." One goal of psychoanalysis is to strengthen the ego so that it directs the personality more of the time, keeping the punitive aspects of the ego and the potentially destructive aspects of the id in check so appropriate, vitalizing choices can be made. Even though this "structural theory" is rarely applied as it was originally conceived, it supplies a valuable metaphor for looking at the struggles that people have between their raw aggressive/sexual instincts and their conscience.

FOR A CLASS ACTIVITY

In groups of three, each person should take on the role of the id (raw impulses), superego (moral conscience), or the ego (reasoning, logical self). Situate yourselves with the id facing the superego and the ego sitting in the middle like a referee. Now begin a conversation (more likely an argument) in which the id wants to do something wicked or socially inappropriate and the superego tries to cajole and scold the id into restraining himself or herself. Before things get totally out of hand, the ego's job is to mediate this struggle, trying to get the two sides to agree to a reasonable compromise.

According to psychoanalytic theory, this sort of debate among the three intrapsychic parts of the self occurs internally all the time. The therapist's job is to strengthen the ego as much as possible so it can do a more effective job of helping the client live productively and happily.

The more recent incarnation of Freud's original structural theory is "conflict theory" (Brenner, 1982). Most modern analysts don't think that the personality literally has an id, ego, and superego (Caper, 2008). Instead, they focus on conscious and unconscious conflict among desires to be controlling, dependent, aggressive, or sexual (Stern, 2009); relieving feelings of guilt, shame, anxiety, and jealousy (Wurmser, 2007); the ability to "mentalize" or simultaneously hold in mind one's own and others' perspective and thus relate well with others (Allen, Fonagy, & Bateman, 2008); and the intricacies of the analytic relationship (Civitarese, 2010). Treatment is deemed successful when the analysand (the patient or client) can bring more things to awareness and thus resolve conflicts, examine less adaptive solutions, and choose better ones.

Psychosexual Stages

Freud observed that children between 3 and 5 often developed a more intense bond with their opposite-sex parent. Freud borrowed from classical literature and termed this the Oedipal stage after Sophocles's play *Oedipus Rex,* in which an exiled son returns home and unknowingly murders a man who is his father and marries a woman who turns out to be his mother. He later went on the propose that development of the personality proceeded as physical development occurred, so personality traits in adulthood derived from childhood experiences of under- or oversatisfaction of the primary psychosexual need at that age.

Modern research has not confirmed this proposition (Caper, 2008), and the developmental stages are not the main focus of modern psychoanalytic theory. However, analysts continue to look for recurring themes and patterns in a person's life, and they expect that usually, these themes and patterns are related to early experiences with attachment figures. The hope is that by seeing how the past is echoed in current difficulties, patients can free themselves to live more fully in the present (Shedler, 2010).

The Past

Current problems stem from unresolved issues that have occurred in early childhood. Freud originally focused on such things as the impact of breastfeeding, toilet training, and early sexual feelings, but it is far more useful to expand this idea to include the influence of any traumatic or significant events. For example, instead of focusing on exactly when or how harshly someone was toilet trained, modern analysts listen for ways in which their patient might have been shamed when they enjoyed pleasant sensations in their body or expressed a desire for physical comfort or closeness (Lichtenberg, 2007).

Other traumas can be seen as disruptions to our sense of security with our early attachment figures who are, after all, our first loves (Diamond, Blatt, & Lichtenberg, 2007). These early traumas may have been *repressed* (buried), but it is generally thought that they continue to influence our internal templates for all our relationships. These templates set us up to expect to be safe and happy, insignificant and ignored, or painfully abandoned by others. It is an interesting exercise to look at our acquaintances in close relationships and to see how their behavior is related in some way to what they witnessed in their parents or experienced as a child. We probably all have friends who repeatedly get into relationships with partners who are abusive or distant, even though this causes them great distress. From this perspective, it is just early history repeating itself!

Unconscious Drives

People are motivated by forces beyond their awareness. This may sound rather obvious, but this notion was not given great meaning until Freud popularized ideas that, until that point, had only been portrayed in plays and novels. Freud believed that there were actually three levels of consciousness: (1) *conscious awareness* that includes everything that a person perceives,

senses, and experiences, as well as remembers; (2) *preconscious memories* that lie just beneath the surface ready to be accessed with just a little prodding; and (3) *unconscious memories* that lie deeply buried because they were threatening, traumatic, or involved unacceptable impulses.

The important thing to remember about memories is that they are *very* selective, ordering things according to the way a person wished they were rather than the way things really were. This has been described as the difference between historical truth, the way things really happened, and narrative truth, which is the way the story is told (Spence, 1982).

FOR PERSONAL REFLECTION AND A FIELD STUDY

Without having to look very hard, you will find evidence for all three levels of consciousness in your own experience, especially if you spend the time interviewing family members to compare what you remember to their own recollections.

For the sake of this exercise, assume that you have buried, repressed, or forgotten some powerful experiences in your life because they were too painful for you to deal with. They might have involved traumatic events about which you have no memory. They could involve abuse you suffered as a child. There could also have been some "convenient" rearranging of facts in which you remember things very differently from others who were around.

Get together with family members and look through old photograph albums together. Before you begin this task, tell yourself that you are going to remember things that you have forgotten previously. Tell stories to one another that are elicited by the photos but resist telling the same old tales. Instead, try to drum up new ones. Compare your different versions of the same events.

Resistance

People are not crazy about the idea of delving deeply into buried secrets and painful memories. Psychoanalytic theory predicts that there will be a certain amount of resistance to probes, however subtle, that are intended to bring unconscious material to the surface. A certain amount of client reluctance is, therefore, expected and anticipated. Another useful concept from this theory states that when you encounter ambivalence on the part of clients who say they want to change but sabotage their own efforts, it is a sign that progress is being made.

When practicing this theory, you anticipate and expect that your clients will become resistant during those times when you are getting close to painful, repressed material. This is considered a normal part of the growth process and is expected to be part of the treatment. In fact,

practitioners would get suspicious if clients were being a bit too enthusiastic and cooperative.

Whether you subscribe to this idea or not, it is of immeasurable help to remind yourself when you encounter client resistance and reluctance that clients are just doing the best job they can to protect themselves from perceived threats. In such circumstances, it may be not only that clients are being resistant but also that their therapists are unwilling to be more compassionate and flexible (Kottler, 1992). Here you are meddling in their lives, stirring up painful stuff, pressing and pushing them in areas they would rather not venture. It is like you are pulling off old scabs—and it hurts. A lot.

Defense Mechanisms

When threatened, people try to defend themselves with a variety of strategies, including withdrawal and counterattacks. As a neurologist, Freud noticed this same sort of process operating within the body when a system would mobilize defenses to deal with a perceived threat. It seemed reasonable to imagine that the same thing happens psychologically during those times when individuals believe they are under attack, sometimes even beyond their awareness. It is thus one of the therapist's roles to help clients identify their favored defenses and understand their impact on present behavior (Stern, 2009).

Many of the ego defenses have become part of everyday language. You have heard before, for example, things such as "You are in denial," or "You're just projecting your stuff on to me," "Stop intellectualizing," "He became so freaked out he just regressed." In each of these instances, what is being described is a way that a person is combating a situation that is experienced as overwhelming and so attempts are made to hide.

FOR A CLASS ACTIVITY

Working in small groups, supply examples for each of the following common defense mechanisms:

Rationalization—justifying a situation by making up rational reasons to explain irrational behavior

Repression—censoring painful experiences by excluding them from conscious awareness

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Projection—perceiving that others have those characteristics or behaviors that you find unacceptable in yourself

Denial—pretending that something undesirable is not really happening

Sublimation—converting unacceptable or forbidden impulses into socially acceptable behavior

Regression—a retreat to an earlier stage of development because of fear

Dreams

According to Freud, dreams were seen as the "royal road to the unconscious," the most useful means by which to decode what a person longs for most. In the traditional psychoanalytic format, complex symbols and metaphors were uncovered and interpreted as the means to discover hidden impulses and repressed material.

Along with many of Freud's original ideas, his notion of dreams as repressed wish fulfillment has not stood the test of time. Many other theories are now advanced to describe the purpose and meaning of dreams. That is not to say that dream interpretation cannot play an important role in therapy, just that the possible interpretations are now open to greater possibilities. Nowadays, practitioners of all orientations tend to be more flexible, asking the client to supply meaning in the images. A common intervention is thus "What is the dream saying to you?"

FOR HOMEWORK

Whenever a client brings a dream into session, it is often useful to explore possible meanings. Before you can hope to help others make sense of their dreams, it would be useful for you to have some practice examining your own inner experiences.

Keep a notebook and nightlight by your bed. Since you tend to forget your dreams unless you immediately write them down, make a promise to yourself that you will write down all your dreams for a week. Before you go to bed each night, tell yourself that you will remember your dreams. Each time you wake up in the middle of one (which is the only time you will actually remember them), scribble down some notes about the gist of what happened. In the morning, review your notes and draw some hypotheses about what the dream means to you.

Catharsis

This is the release of pent-up emotional energy that occurs through clients telling their stories. Almost all therapeutic approaches make some use of this process by allowing people to dump a lot of stored-up frustrations. It is generally not a good idea to let this go on and on without some intervention or rechanneling because clients can end up just feeling sorry for themselves or engaging in "poor me" victim roles.

You have experienced the power of catharsis many times in your own life. Perhaps you were talking to a friend or family member about something very upsetting and afterward you noticed how much better you felt. This confidante may have done nothing else but listen to you, allow you to leach out all your frustration, but that was quite enough.

It may strike you that it is not nearly enough to just sit there and listen to someone pour his or her heart out, but this is so often exactly what some people need to do (at least in the beginning). It is so rare that most people have anyone in their life who will really listen to them and make a sincere effort to understand without judgment.

Corrective Emotional Experience

Rather than merely talking about feelings, the contemporary analyst and other practitioners seek to help clients to alter their self-perceptions and behavior in light of their therapeutic experiences and, it is hoped, new insights. Of course, this is easier said than done. Holmes (2010) illustrates this in the preface to his recent book: "As one client said in response to the annunciation of Freud's (1912) rule—'say whatever comes into your mind, however irrelevant, embarrassing, or impolite'—'If I could do that I wouldn't need to be here in the first place.' The task of therapy is to both *explore insecurity,* its origins and ramifications, and to provide a space where a person can *explore in security*" (p. ix).

Once there is some degree of emotional arousal, sometimes directed toward the therapist in the form of transference, attempts will be made to work this through in constructive ways. In other words, within the security of the therapeutic relationship, the client can fully experience emotions and express them without being abandoned, shamed, ignored, or punished but rather being seen, heard, and valued (Buechler, 2008; Wurmser, 2007). This experience of safety with self and emotion becomes a model for how a client might experience herself with others in the outside world. The client grows in the ability to tolerate and explore her emotion because the therapist subtly cajoles her into fully experiencing it—in safety—and thus creates a chance for the intense feeling to change into something that offers relief.

An approach that shares some of these assumptions is emotionally focused therapy (EFT; Greenberg & Watson, 2005), which holds that you can't leave a place you've never been, so fully experiencing a disruptive emotion is the place to start. We will be discussing EFT much more in a later chapter. Suffice it to say now that a client is encouraged to reexperience a memory or thought and its associated emotion rather than avoiding it. The therapist and client stay with the emotion in all its nuances until it is fully felt and accepted; thus, the emotion is transformed into something constructive rather than festering away somewhere deep inside (Greenberg & Goldman, 2008).

● TREATMENT PROCEDURES

The psychoanalytic style of therapy is a relatively long-term relationship that is designed to help people explore their unconscious issues that are at the core of current problems. Through the use of interpretation, dream analysis, free association, transference, and other methods that access repressed material, the practitioner helps clients to understand the source of their troubles and apply what they learn to their daily lives. Several strategies are used to bring about this process, many of which are embedded in the special kind of relationship that is established.

Shedler (2010), a psychoanalyst and scholar who has become concerned that modern psychoanalysis has been misunderstood, came up a list of what he feels are the distinctive features of psychodynamic technique. These include the following:

1. Focus on affect and expression of emotion
2. Exploration of attempts to avoid distressing thoughts and feelings
3. Identification of recurring themes and patterns
4. Discussion of past experiences (developmental focus)
5. Focus on interpersonal relations
6. Focus on the therapy relationship
7. Exploration of fantasy life

Evenly Hovering Attention

Freud was the first to advocate a type of helping affiance in which the therapist would appear cool, calm, and collected. Consistent with Freud's

scientific training, practitioners were schooled in the importance of objectivity and neutrality in their chairside manner. It was hoped that the more neutrally and anonymously you present yourself, the more pure will be the client's *projections* (subjective perceptions) about who he or she believes you are. Thus, clients are actually encouraged to create fantasies toward their therapists, providing material for exploration and working through.

There is a very delicate balance to reach in which, on one hand, you present yourself as neutrally as possible so as to not contaminate the transference that must naturally develop. On the other hand, you don't want to appear so withholding and aloof that it is perceived as punitive. Psychoanalytic practitioners, while appearing somewhat neutral and objective, present themselves as empathic, caring, and nonjudgmental, with a kind of "evenly hovering attention" (Wolitzky & Eagle, 1997, p. 46). Remember that many people who attend counseling or therapy may have already experienced lots of rejection in their lives from parents who were neglectful.

FOR A CLASS ACTIVITY

Practice "evenly hovering attention" in helping relationships with a partner. One of you takes on the role of a client, thinking of a very provocative, sensitive, perhaps shocking issue you could talk about (being an abuser, a drug dealer, or perhaps a person in a witness protection program). Imagine that you are feeling very reluctant about your life because of fears of being judged.

The other person will be the therapist. Your job is to listen with neutrality, detachment, and evenly hovering attention. Present yourself as interested, nonjudgmental, and noncritical, encouraging the person to speak about his or her experience. For now, it does not matter which skills you use because this is only an exercise in practicing a relatively detached therapeutic stance.

Afterward, talk to one another about what the experience was like. Give feedback to one another. If time permits, switch roles and try another round.

Transference

Freud (1915/1953) originally conceived of transference as a projection of unconscious desires onto the therapist. Through the analysis of this fantasy, it becomes possible to work on repressed memories and unresolved conflicts of childhood, especially those involving parental figures. Whereas Freud saw the distortion that occurs in therapeutic relationships as a manifestation of past struggles, Kohut (1977/2009) reconceived of transference as something

else altogether: a real alliance in which the client creates a new parental relationship rather than merely reliving an old one. In contemporary practice, the transference is used in the following way (Murdin, 2009):

1. Observe how unconscious and unfulfilled needs are played out in sessions.
2. Notice the ways in which the therapist is idealized by the client as a need for more constructive "parenting."
3. Use positive transference as leverage without bringing the client's attention to this process.
4. Once a solid relationship has been established, the therapist can invite attention to the client's transference and explore it and its meaning for the client's other relationships.

Whether you subscribe to psychoanalytic thinking or not, it's rather obvious that therapeutic relationships have elements that are based on reality and fantasy. You see people as they really are, as well as how you imagine them to be. You impose onto others the images of others who have resembled them, often responding to them based on these prior associations. Sometimes you even project attributes that are created by your own past experiences rather than people's actual behavior.

FOR PERSONAL REFLECTION

Think of a time recently in which you projected onto someone feelings that were transferred from another relationship. For example, can you recall an incident where you had a strong emotional reaction, either positive or negative, to someone you had just encountered? And when, as you look back on it, you had little "data" for doing so?

One especially fertile place to look for such a process is related to authority figures. Notice, for example, the ways you perceive your instructor that are based less on his or her behavior and more on your images of what he or she is like. Whom does your instructor remind you of? What are ways your interactions with your instructor are similar to other relationships you have experienced before?

Typically, transferences involve the repetition of some previous relationship pattern, one that is inappropriate and distorts reality (Lopier & Maltby, 2004). For instance, when you look at your instructor for this course, you

react to him or her not only as he or she appears in reality (if you could watch a totally objective video) but also as you imagine him or her to be. This perception is based on all the prior experiences you've had with other authority figures who have served in a similar role. Sometimes you may feel judged or criticized by your instructor less because of his or her actions than by your prior associations with other teachers who you are reminded of in this situation.

Whereas Freud and traditional psychoanalysts believed that almost all the feelings one has toward a therapist are projections, fantasies, and distortions, some of the reactions are genuine and reflect what is actually occurring between two people involved in a very intimate, intense relationship (S. H. Cooper, 2010).

The relationship between client and therapist becomes a source of conflict and ambivalence, especially considering it is designed to be a blank slate upon which people may project their fantasies about unresolved authority figures. Once clients gain insight into their distortions, they are then able to work through the conflict first with the therapist and later by resolving issues related to other relationships in the past and present (Murdin, 2009).

FOR PERSONAL REFLECTION

Bring to mind the image of someone you don't like very much, someone who really gets underneath your skin. This may be a person who once betrayed you, someone who rejected you, or someone who has been repeatedly abusive toward you.

Now imagine that a new client comes in to see you who bears a striking resemblance to your nemesis, either in appearance or mannerisms. How do you suppose you would feel working with this individual who reminds you of another person whom you despise? Do you think there is any way possible that your strong feelings would not affect your relationship with this client?

Situations such as this (called countertransference) are why psychoanalytic theory considers it so crucial for you to work through all your own unresolved issues before you attempt to help others. Otherwise, your unconscious desires, repressed memories, and unresolved issues can infect the work you try to do with others.

Countertransference

The client isn't the only one who projects and distorts the relationship. Therapists, as well, have strong feelings toward their clients—both positive

and negative—that have little to do with that person. Our buttons sometimes get pushed by people who remind us of others we have encountered in our lives (Hirsch, 2008). We respond to them not as they really are but as we imagine them to be. Some of the most easily identifiable signs that countertransference may be going on include the following:

- The arousal of guilt from unresolved personal struggles that parallel those impulses and emotions of the client
- Impaired empathy in which you find it difficult to feel caring and respectful toward the client
- Inaccurate interpretations of the client's feelings due to your identification and projection
- Feelings of being generally blocked, helpless, and frustrated with a particular client
- Evidence of boredom or impatience in your inner world during work with a client
- Unusual memory lapses regarding the details of a case
- Mutual acting out in which the client begins living out your values and you begin acting out the client's pathology
- A tendency to speak about a client in derogatory terms
- An awareness that you are working harder than the client

I (Jeffrey) remember one instance in which I was seeing an elementary school principal as a client. Because I had been a rather precocious child who frequently found myself in trouble with the principal, I did not have the best of feelings toward this woman who reminded me of my former nemesis. Although ordinarily I am quite flexible about the ways I schedule sessions, doing my best to arrange appointments in a way that is most convenient for clients, with this woman I was more than a little unyielding. I might normally say something such as, "When would you like to reschedule?" but with the principal, I said instead, "I'll see you next Thursday at 3:00."

"But I can't make it then," she replied with astonishment. "You know I can't get away from school until 3:30 when the last children have left."

"Well then," I said with a scolding tone that gave me more pleasure than I'd like to admit, "if your therapy is really important to you, you'll find a way to be here, won't you?"

I am certainly not proud of the way I handled this case, but it is a good example of how my own personal feelings got in the way of my compassion. The worst part is that I really wasn't seeing this woman the way she was because I had projected onto her the image of other authority figures from my own past.

VOICES FROM THE FIELD

SHIRLEY MALOVE

In the infancy of psychoanalytic thought, many psychoanalysts considered countertransference to be an indication that the clinician had unresolved conflicts that needed to be further analyzed. Fortunately, as psychoanalysis developed over time, most psychoanalytically oriented psychotherapists and psychoanalysts learned to appreciate and use their countertransference reactions to better understand themselves, their patients, and the "pair" within the context of the therapeutic relationship.

Countertransference is now considered a useful tool that, when used properly, informs and deepens the treatment. The decision to share certain countertransference feelings and thoughts with a patient must be based on its ability to facilitate the treatment. Such candidness can demonstrate a deep understanding of a patient's struggle—an understanding that the patient probably never experienced in other relationships. This is not to suggest, however, that every thought and feeling is to be shared with the patient.

The following case vignette illustrates my use of countertransference and the way in which it deepened the treatment with a patient. As with any clinical writing, identifying information has been disguised to protect confidentiality.

Sophie began psychotherapy with me when my theoretical perspective was primarily through an ego psychology lens. During the time she was in therapy, however, I began advanced training, which focused on more contemporary (e.g., relational, intersubjective) psychoanalytic theories. As a result, my clinical views began to shift as I integrated these approaches into my practice.

Sophie, a 34-year-old woman, presented as clean and well groomed. Her manner of interacting was guarded and detached. She sought treatment for depressive symptoms intensified by a rapidly deteriorating marriage, which ended in divorce shortly after therapy began. Throughout childhood, Sophie was victim and witness to extreme domestic violence at the hands of her father. A victim herself, Sophie's mother was unable to provide protection. Consequently, Sophie withdrew into her own world. She recalled not fitting in with peers and feeling like an outsider in her family. It appeared that her entire life, she longed for inclusion yet greatly feared intimacy and therefore "hid" in relationships.

From the beginning, Sophie had a propensity for intellectualizing by digressing into lengthy, abstract topics. I originally viewed this as defensive. Most of the time, I attempted to explore or interpret her need to avoid uncomfortable topics. We never seemed to get very far with this approach. In retrospect, maybe I too was intellectualizing, which perpetuated the enacted mutual detachment. At times, I noticed myself becoming bored and "zoning out." Before and during her sessions, I frequently became so sleepy that I could hardly keep my eyes open, which was uncharacteristic for me. Perhaps I feared what was underlying the superficial dialogue and "checked out" to protect myself, just as Sophie did her entire life.

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(Continued)

Sophie distanced from others and me by being vague, abstract, and sometimes silent. This adaptive measure served Sophie well in her youth. She stated, "I became invisible in a room full of people. If they don't see you, you can't be a target." In the therapy, I responded in kind by not seeing her, not connecting with her, even unconsciously colluding with her by remaining too intellectual and removed in the way I interpreted her behavior. Thus, Sophie hid from me right in front of my eyes and I allowed it.

Fortunately, as my countertransference became apparent to me, I began to pay closer attention to what was occurring between us in the treatment room. When she became abstract and I noticed myself drifting, I shared these observations, as I believed this provided information that was important for us to understand together. Sophie recalled dissociating when she needed to escape the abuse in childhood. In therapy, she believed her tangents were efforts to avoid subjects she didn't want to discuss. Slowly, however, she began to recognize that she was avoiding connecting with me. Eventually, Sophie began to understand the way in which she used intellectualization and unconventional "shocking" statements to distance from others. These breakthroughs allowed Sophie and me to relate and connect on a much deeper level.

As a result of this shift in our therapeutic work, Sophie came alive to me. I looked forward to her sessions and listened intently. Shortly thereafter, I was required to be away for an extended period, during which time Sophie continued her sessions over the phone. She began one of these sessions stating that she had a difficult week and called her sister to talk. Sophie explained, "I had to leave a message on her machine, which really pisses me off because her son erases them and doesn't tell her. She never called back. I'm tired of being the one always calling my family." I was struck by the parallel quality here as I was away for the summer, which required Sophie to call me; however, any anger toward me was conspicuously missing. I asked her about this, and she quickly defended, "No. It's not any different calling you on the phone than going to your office." I persisted. She stated that it was "safer to practice (her anger) on them" but more difficult with me because "I still need you." At that point, I began to delve into an interpretation in which I suddenly lost my train of thought. I disclosed this to Sophie. She laughed and said, "Maybe you lost your train of thought because you knew I wasn't ready to go where you were going." I was impressed and encouraged her to continue. She went on, "Well, I don't think after spending so much time together that my thoughts can't help but influence you because you *know* me." Clearly, Sophie and I were deeply connected.

—Shirley Malove, LCSW
Fort Lauderdale, FL

SOURCE: Malove (2009, pp. 10–11).

FOR A FIELD STUDY

Talk to experienced therapists about instances in which they have had strong countertransference reactions toward particular clients. This is a difficult, risky area to discuss because it represents a loss of control and poor judgment on the part of the therapist, so be prepared from some resistance unless you have a trusting relationship with the professional.

CONTEMPORARY THEORISTS ●

In the last part of the 20th century, there was a strong movement among psychoanalytic practitioners to move away from Freud's emphasis on instinctual drives and psychosexual stages of development and focus instead on the ways that primary relationships are internalized as templates for future intimate relations. Termed *object relations* or *ego psychology,* several different theorists concentrated their treatment efforts on the basic bonds between infant and parent(s) and continue to influence practice today.

Donald Winnicott (1958) conceived of therapy as a kind of "holding environment" to provide a safe, secure, dependable relationship in which clients might work through early relationship conflicts. Typical of the way so many other revisionists took a central idea of Freud's and ran with it, Heinz Kohut (1971) was intrigued with one of Freud's papers on narcissism, which is the condition of excessive self-involvement. Although Freud and current diagnostic manuals treat narcissism as a pathological state marked by obsession with one's own needs, Kohut's theory stresses that the development can be healthy if it leads to productive activities and balanced self-esteem. Kohut (1984) emphasized the role of empathy in the therapeutic alliance, believing that one of the most important ingredients is helping people to feel understood.

Jacques Lacan was a maverick analyst who stirred up tremendous controversy because of his unconventional methods. He believed, for instance, that it was ridiculous to schedule sessions in 50-minute intervals because not all people need that exact amount of time, and some people needed more. He was thus notorious for not taking appointments—clients would simply show up to his office and wait until he would call them in. If he felt that someone was playing games or not in the mood to do serious work, he would abruptly stand up after 5 minutes of conversation and dismiss the client. If, on the other hand, he felt that a few

hours of treatment were indicated, then he would make himself available for that as well.

This text will look in greater detail at two of the contemporary theorists who have been most influential in today's therapeutic practice.

Object Relations Theory

Otto Kernberg (1975, 1984) applied concepts of self-psychology to the understanding of one severe type of personality disturbance known as borderline disorder. Unlike what it sounds, someone caught between the boundaries of being sane and insane, this type of personality disturbance is characterized by intense, contradictory interpersonal patterns. Such individuals tend to be manipulative and extremely difficult to deal with. It would be the consensus of most therapists that this is the most challenging case of all because such individuals are unpredictable and often do their best to get underneath others' skins as a means of self-protection. In fact, one of the major determinants as to whether a client is bestowed with this toxic label occurs when the client appears so annoying, manipulative, and irritating that the therapist can't get him or her out of mind.

Later in his career, Kernberg (1997) sought to integrate the contributions of other therapeutic systems into a more contemporary and responsive version of psychoanalytic treatment that brings in elements of empathy, the here and now, affective experience, and a more genuine relationship.

Just as in traditional psychoanalytic practice, contemporary object relations therapists see the past as a strong influence on behavior in the present (Frankland, 2010). However, rather than remaining aloof and completely detached, they often create a more natural, empathic, and supportive relationship that fosters a degree of attachment without complete dependence. The goal is to provide a secure environment with clear boundaries. This type of relationship encourages clients to explore the nature of their relationships with others, as well as with the therapist in sessions (Celani, 2010).

Self-Psychology Theory

Rather than only interpreting events of the past as a road to understand current problems, Heinz Kohut (1984) recommends a treatment in which here-and-now behaviors are identified and explored. Defenses are identified as they play themselves out in sessions. Rather than sparking

further resistance, if handled sensitively, such interpretations can lead to greater ego strength and resilience.

According to this theory, it is excessive self-centeredness and narcissism that lead to many personal problems. When you get stuck in the stage of egocentrism and grandiosity typical of a 4-year-old, you are likely to feel awfully disappointed with others not living up to your expectations. Like Masterson and Kernberg, Kohut specialized in working with severe personality disorders by structuring an empathic relationship with clear boundaries. Self-psychologists often call this type of relationship a "holding environment" because you are metaphorically holding someone with caring but consistent, stable force (P. Buirski & Kottler, 2007). Because you are likely to be tested a lot with these types of cases, it is crucial that you have in place clear rules and boundaries for handling inevitable acting out.

Whereas traditional psychoanalytic therapy as it was originally conceived by Freud is now virtually obsolete, self-psychology and object relations therapy are alive and flourishing, particularly in the area of treating personality disorders (see Masterson & Lieberman, 2004). This psychodynamic approach has evolved in such a way that it reflects the needs of contemporary practice. The applications of these theories will be described further in the next sections.

Interpersonal Psychotherapy

Karen Horney and Harry Stack Sullivan were analysts who drew attention to how individuals' dynamics develop and are most meaningfully viewed in the context of relationships with other people. Both have influenced not only contemporary psychoanalysis and psychodynamic therapy but other theoretical approaches as well.

Karen Horney was a German psychoanalyst who later immigrated to the United States. She questioned Freud's theory of sexuality, as well as its instinct orientation. She acknowledged that penis envy might occur for some women but thought that men, in parallel fashion, envied women's ability to bear children—hence, "womb envy." As one of the first female psychiatrists, she decided that female behavior was a neglected issue and wrote papers later collected in a book titled *Feminine Psychology* (1967). In these papers, she sketched out her ideas about how much of women's behavior that analysts depicted as "neurotic" actually fit within cultural expectations about how males and females should behave in relation to each other. She also developed a theory of the "coping strategies" that individuals develop in relationships (Horney, 1945). Each of us is thought to have a preferred or most

developed coping strategy. The first strategy, "moving with," is seen as healthy; the other three are seen as neurotic:

1. "Moving with"—Individuals with this style use communication and negotiation to agree, disagree, compromise, and build solutions.
2. "Moving toward"—These individuals tend to give others what they want at the expense of themselves. They might say, "If I give in, I won't get hurt."
3. "Moving against"—These individuals seek to control or exploit others. They might say, "If I beat them to the punch, I won't get hurt."
4. "Moving away"—These individuals distance themselves and try not to care. They might say, "If I don't let anyone get close to me, I won't get hurt."

Karen Horney founded the *American Journal of Psychoanalysis.* Contemporary psychoanalysts still build upon her ideas and find contemporary applications for them (I. Solomon, 2006). For example, her ideas have been recently applied to posthumous analyses of key figures such as Hitler, Shakespeare, and George Eliot.

FOR PERSONAL REFLECTION

We all like to think of ourselves as well-adjusted rather than neurotic, but being under stress can push us to use interpersonal styles that are less adaptive. In your lesser moments (in conflicts with your family, for example), which of the three neurotic coping strategies that Horney described do you tend to fall into? Do you think this might have implications for countertransference tendencies you might have when working with difficult clients?

Harry Stack Sullivan was a very strong influence on American psychoanalysis. He developed his ideas while studying schizophrenia and what we would now call severe borderline personality disorder. He, like Horney, challenged Freud's psychosexual theory and developed a life span theory of personality development that featured relational capacities. In addition, he emphasized how society and culture influence personality development and psychopathology. He coined the term *problems in living* to try to get away from words implying that his patients were mentally ill.

Building on Sullivan's (and, to some extent, Horney's) ideas, contemporary interpersonal psychotherapy (IPT) draws primarily on psychodynamic ideas, emphasizing how interactional problems (rather than intrapsychic problems)

contribute to individuals' problems. Interpersonal therapy was initially developed in the 1970s as a placebo (yes, a placebo!) to be used in clinical trials testing other therapeutic approaches, but it was found to have positive effect, particularly for people with depression (Hinrichsen & Clougherty, 2006). It is now a brief approach—12 to 16 sessions—and structured manual-based psychotherapy that is gaining attention because of its success with many hard-to-treat problems (i.e., severe depression, postnatal depression, bulimia, and bipolar disorder; Weissman, Markowitz, & Klerman, 2007). It has even been adapted for use in developing countries (Verdeli, Vidair, Neugebauer, & Singla, 2003).

A Different Set of Rules for Therapy

The type of cases that interested these theorists—narcissistic and borderline personality disorders, for example—involve a very different type of treatment than does "ordinary" therapy. As one example, you might usually present yourself as a very open, warm, and flexible professional. In my own work, I (Jeffrey) tend to smile a lot, use humor, and appear as supportive, empathic, caring, and flexible as I can. I might adapt this style if I am working with someone who is more straitlaced, older, or a member of some traditional culture in which formality is valued, but basically I am pretty easygoing.

The one major exception to this fluid approach is when I discover—often a little too late—that I am dealing with someone who might have one of these toxic interpersonal styles (I don't like to use the *DSM* terms of personality disorders because they sound so intractable and hopeless). Because people who are manipulative for a living are adept at making a good impression when they need to, it isn't until the third or fourth session that I might realize what is happening. I might begin to notice increasing intrusions on my time—phone calls at home, requests for special consideration, excuses to contact me. I also might sense that the person seems somewhat frightening to me—not that I feel in any physical danger—but rather that it seems as though this person is working awfully hard to figure me out to gain some leverage and control.

It is about this time that something dramatic happens—the client accuses me of abandoning him or her, figures out some vulnerable spot to exploit, or engages in some self-destructive gesture—that I realize that my usual kind of relationship is not going to work. With clients who display these manipulative patterns, it is very important to structure the type of relationship that is consistent, predictable, and with very firm boundaries. Because this type of person probably never had parenting in such a way, this holding environment becomes therapeutic beyond anything else that you do.

FOR PERSONAL REFLECTION AND A CLASS ACTIVITY

The management of boundaries plays an important part in ego psychology and self-psychology. Because these theories have been applied often to cases of severe personality disorder, it is especially important to provide a predictable, solid relationship to set appropriate limits that clients might not be able to maintain on their own.

Think of times you have been involved in teaching or helping relationships in which someone set firm boundaries about what you could and could not do. You understood that these rules existed for your own safety and welfare rather than as part of some arbitrary bureaucracy or the helper's convenience. How did this structure help you?

In small groups, identify the boundaries that have been established in your class. These include all rules, both explicit and implicit, that are designed to further goals, maintain safety, and keep things running smoothly. Talk about the ways these boundaries are enforced.

The hard part, of course, is recognizing as early as possible that you might be dealing with a "disordered self" type of client, requiring a kind of relationship that might be different from others you create. We say "might" because in most psychoanalytic relationships, there are always clear boundaries that are strictly enforced.

● CONTEMPORARY DEVELOPMENTS

Obviously, the world today is very different from the 19th-century Victorian Vienna that spawned Freud's original ideas. Furthermore, advances in neurology, psychology, and related social sciences have demonstrated that although many of Freud's theories have withstood the scrutiny of empirical investigation (i.e., unconscious conflict), others have not (i.e., dreams as repressed wishes, Oedipal complex).

Some of Freud's original disciples such as Alfred Adler, Franz Alexander, and Otto Rank began making revisions in the basic psychoanalytic model almost from their first involvement in the movement. They realized that if this novel psychological approach was going to help those who needed it the most, then somehow it would need to be abbreviated in such a way that symptoms could be relieved in a matter of months rather than years.

Most contemporary psychodynamic practitioners have abandoned many of Freud's original tenets, such as use of the couch or seeing instincts as the primary source of motivation. It makes sense, of course, that any theory devised over a hundred years ago in another world would need considerable

revision and adaptation to fit our current needs. Most dramatically, the changing therapeutic landscape of managed care and an increasingly diverse client population have forced practitioners to shorten their treatment methods.

Although there are as many different theories of brief psychodynamic treatment as there are traditional approaches to psychoanalysis (Charman, 2004; Kernberg, 1997; Kohut, 1984; Levenson, 2010; Malan & Osimo, 1992; Mallinckrodt, Porter, & Kivlighan, 2005; Mander, 2000; McWilliams, 2004; Messer, 2006; Sifneos, 1987; Stadter, 2009; Strupp & Binder, 1984; Wachtel, 1997), most of them follow similar clinical principles in their work.

1. Treatment has been abbreviated from the mandatory four times a week for 5 years to structures that are more realistic and cost-effective (weekly sessions for several months).
2. As with any form of brief therapy, clients are carefully screened and selected to make certain they are good candidates for abbreviated treatment (Charman, 2004). This includes those with
   a. Adjustment reactions (depression and anxiety that are the result of life events)
   b. Problems in everyday living (relationships, work, and family problems)
   c. Milder forms of personality disorder
3. The best clients for this approach (or probably any other therapy) are those in acute pain, those willing to attend regular appointments, and those who can relate to the therapist in a meaningful way. Level of motivation is also a key consideration, assessed by determining the client's degree of honesty, openness, psychological-mindedness, realistic expectations, and willingness to make reasonable sacrifices (Sifneos, 1987).
4. Sessions are devoted not only to coming to terms with the past but also to looking at present behavior and concerns. This might sound like a rather obvious approach but actually represents a recent innovation.
5. Treatment goals are defined in more specific, limited ways. Rather than seeking to reshape a person's whole personality, the brief dynamic therapist focuses on identified, negotiated goals related to presenting complaints. You would usually stick with one theme or set of issues—maladaptive relationships, ineffective coping styles, unresolved parental issues, unsatisfying work—rather than trying to cover the whole spectrum of a person's life.

6. Attention is directed more toward ego functioning rather than instinctual drives. This means that clients are helped to look at their characteristic ego defense mechanisms (i.e., denial, rationalization, sublimination).
7. Severe forms of personality disorder (borderline and narcissistic disorders) have been especially fertile ground for psychoanalytic theorists (e.g., Masterson & Lieberman, 2004) who have combined traditional thinking with a more strategic type of therapeutic relationship.
8. Within a psychodynamic framework, practitioners are inclined to use a variety of interventions from many other approaches as needed (Jacobs, 2004; McWilliams, 2004).

FOR A FIELD STUDY

Interview several people who have participated in psychoanalytic therapy to find out about their experiences. Ask them to comment on what they found most useful about the sessions. As they look back on the therapy, what stands out as having been the most enduring result?

9. Most psychodynamic clinicians make similar adaptations when borrowing behavioral, cognitive, systemic, or other strategies for specific presenting problems. Experience and empirical research have shown that insight alone often isn't enough, especially for those with impulse disorders, addictions, and other behavioral disorders. Thus, practitioners are far more inclined to be confrontive and direct instead of waiting patiently for clients to figure out things on their own.
10. It is no longer enough to rely purely on case studies, personal experience, and the collected works of Freud to plan interventions and seek guidance for treatment plans. For example, a number of empirical outcome studies (Barber, 1994; Svartberg & Stiles, 1994) have been undertaken to demonstrate the effectiveness of short-term psychodynamic therapy when compared to other approaches.

Psychoanalytic practitioners are also licensed psychologists, counselors, psychiatrists, and social workers; as such, they are mandated by their professions to practice in a way consistent with established standards of care that are based on empirical research. In other words, psychoanalysts have been

influenced strongly by developments outside their own discipline and have sought to integrate these innovations with their own training. Several writers, for example, have combined psychoanalytic thought with brief approaches (Charman, 2004): humanistic approaches (Orange, 2009), Gestalt therapy (Hycner & Jacobs, 2010), and behavior therapy (Goldenthal, 2005), to name just a few of the permutations.

VOICES FROM THE FIELD

Another Voice

Linda Sherby

Wicked

Not a particularly profound book; recommended by a friend who knew I wanted some escapist reading. It's not really having the desired effect and I'm again wondering why I feel compelled to finish every book I begin. And then, on page 482, there are two sentences: "Maybe the definition of home is the place where you are never forgiven, so you may always belong there, bound by guilt. And maybe the cost of belonging is worth it." I am amazed. The author has beautifully and succinctly described the struggles of a patient I have worked with multiple times a week for four years. This is a man who seems to have it all. He is smart, good looking, financially well off, and involved in a loving relationship. Yet, he is unable to leave "home," unable to stop trying to win the approval of the wife from whom he is long separated and the grandfather who raised him who is long dead.

I bring the book to the office. I want the option of reading the sentences to my patient, even if I don't know when or even if I will do so. Three sessions go by. The fourth session he is again wondering what's wrong with him, how he could be considering giving up a loving, sexual relationship to return home to his cold, rejecting wife who no longer even wants him.

I open the book and read him the two sentences. "Wow!" he says, "That's me!! I'm bound by my guilt, by my sense of responsibility. I'm bound by my need to belong, to be safe, to never wander far from home." Are these new insights? Absolutely not. We have been working on these issues for years. I have interpreted his wife as the embodiment of both his mother and his grandfather and his terror and guilt about leaving them all. We have discussed his mother's neediness. Widowed shortly after my patient's birth she was depressed and clingy, far too needy for him to leave her. We have talked about his taking in his grandfather's critical, moralistic voice, a voice that has inhibited and constricted him. And we've explored his feelings as a frightened little boy, feeling alone and abandoned in a house filled with dissension and despair.

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But today he has heard a different voice, the voice of an author who doesn't know him, but speaks as if he does. Perhaps my patient need not feel so "damaged," so "bad." If a best selling author writes of such issues, perhaps these are problems shared by millions. My patient is noticeably relieved. His burden has been lightened. He isn't the weak, fragile person his grandfather accused him of being. He isn't the self-absorbed child his wife claimed that he was. His conflicts have been humanized and he feels less alone.

As the weeks progress, I can hear the difference both in how he speaks and how he thinks when he is not with me. His voice is less judgmental and more his own. In the past I wondered if the words he spoke were more about his need to accept or reject my interpretations than about the interpretations themselves. Now he seems to think more in his own voice, rather than in acceptance or rebellion of me and, ultimately, his grandfather. As a result, he is freer to think, to reflect, to wonder. He is less confused, less impulsive, and even more aware that he is more aware. It is not that his issues have been resolved. He has not worked through his guilt. He has not been able to leave "home" and settle into a freer, more loving existence. But he seems closer, closer to opening the door and walking along the path that leads away from "home." Can I attribute this change only to *Wicked*? Of course not. We have struggled together too long to offer such a simplistic answer. Still, for both myself and my patient, I want to honor and applaud the voice of the author who has captured these complex human conflicts with such ease and clarity. So I guess the book was worth finishing after all.

—Linda Sherby, PhD, ABPP
Boca Raton, FL

SOURCE: Sherby (2009, pp. 4–5). Reprinted with permission.

● GENERAL PRINCIPLES OF BRIEF PSYCHODYNAMIC PRACTICE

As you will see in a later chapter on brief therapies in general, long- and short-term practitioners embrace different values in their work (Levenson, 2010). In traditional psychoanalytic treatment, the therapist attempts to deal with underlying characterological changes and expects to be around throughout the whole process of transformation. Therapy is viewed as the most important part of a person's life, and the participant is expected to make a major investment of time, money, and commitment. In any short-term treatment, including brief psychodynamic models, the emphasis is not on a cure but rather on relief of presenting symptoms. In addition, there is

considerable reality-based attention to time constraints and limited financial resources.

Among the various abbreviated psychoanalytic methods is the work of Charman (2004), Levenson (2010), and Mander (2000), who have developed methods that could be followed within a prearranged number of sessions as agreed, yet still don't abandon many of Freud's original premises. Basically, the process follows several distinct stages:

1. Help the person to tell his or her story.
2. Establish a solid relationship.
3. Deal with initial resistance to the therapy.
4. Gather relevant background information and limited history.
5. Select the problem(s) most amenable to short-term intervention.
6. Explore the precipitating events in a limited way.
7. Collaborate with the client to formulate a diagnosis and treatment plan.
8. Increase the client's awareness of defensiveness and self-defeating thinking.
9. Revisit resistance to interventions.
10. Explore the client's personal reactions to the relationship (limited transference).
11. Monitor personal reactions to the relationship (limited counter-transference reactions).
12. Examine ways that the past is influencing the present.
13. Help the client to behave more effectively in the relationship and in the outside world.
14. Provide feedback and confront discrepancies.
15. Negotiate homework assignments.
16. Continuously remind the client of the prearranged termination date.
17. End therapy as agreed.
18. Schedule follow-ups as needed.

Just as in regular versions of psychoanalysis, the relationship is critical but in an altered form that emphasizes a more present-oriented, authentic alliance in which the therapist becomes more of a teacher/consultant rather

than a parent figure. This approach does not much resemble the method first developed by Freud over a hundred years ago, but then not much in the way any profession currently operates is the same as it was in the past century.

● THINKING PSYCHODYNAMICALLY

Whereas there once was a time when almost all practicing therapists expressed allegiance to psychoanalytic theory, this approach is now restricted to mostly those in private practice, those doing relatively long-term personality reconstruction work, and those in urban areas with a fairly affluent client population. Obviously, because psychoanalytic therapy has been traditionally very time-consuming and expensive, it has been most well suited to those who have the time, inclination, and capacity for insight-oriented work. Several manuals (Jacobs, 2004; Maroda, 2010; Stadter, 2009; Weissman et al., 2007), however, have been designed to help clinicians adapt to the demands of contemporary practice.

There has been more than a century of criticisms leveled at Freud and his disciples—that the theory is too complex, that its concepts have not been empirically validated, that it is sexist and culturally biased, that it ignores the pragmatic realities of the disadvantaged and poor, that it overemphasizes the influence of the past to the exclusion of the present, and so on. There are literally hundreds, perhaps thousands, of books written that attack the model with passionate vehemence.

Psychodynamic therapy has been evaluated somewhat less often than other therapies, in part because conducting a systematic, long-term evaluation of any treatment or approach is very expensive. The theory also included, especially in its early years, concepts that were very difficult to conceptualize, operationalize, and measure (such as instincts, or transference). However, in the past 10 years, a number of meta-analyses (a rigorous method for summarizing and synthesizing the findings across several independent studies) have found intriguing results. For example, individuals involved in both short-term (less than 40 hours) and long-term psychodynamic therapy (more than 1 year or 50 sessions) experienced significant change from pretreatment to posttreatment compared to individuals in control groups. This is good news for adherents to this theory, but here is even better news: In many studies, the benefits of psychodynamic therapy actually increase with time after therapy has stopped! (For a review of these studies, see Shedler, 2010.) In addition, consistent with the intentions of its original proponents, psychodynamic therapy has proven to be efficacious for treating depression, anxiety, panic, somatoform disorders, eating disorders, substance use disorders, and personality disorders (Leichsenring, 2005; Milrod et al., 2007). And it appears that intrapsychic change may actually occur (Bateman & Fonagy, 2008).

FOR PERSONAL REFLECTION

Thinking psychodynamically means that when someone is encountering difficulties, you might ask yourself and the client several relevant questions such as the following:

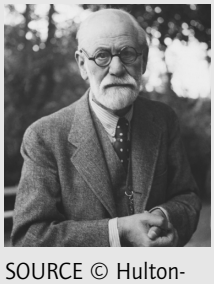
1. What is the relation of what you are experiencing now to what you have encountered in the past?
2. Which experiences in your early life have most shaped who you are today?
3. What motives and forces beyond your awareness might be affecting your judgment?
4. What fantasies and dreams have you had that might be related to your presenting problem?
5. How have your feelings for me, as your therapist, reflected the kind of relationships you have experienced with others?

Despite the limitations of psychoanalytic theory, it formed the foundation for all forms of therapy. It was the first systematic model and the one most widely practiced. Furthermore, many of its essential ideas have been so integrated into the public consciousness and therapeutic lore that it is very difficult not to think psychodynamically when looking at personal problems.

VOICES FROM THE PAST: SIGMUND FREUD

Katharina

In the summer vacation of the year 189- I made an excursion into the Hohe Tauern so that for a while I might forget medicine and more particularly the neuroses. I had almost succeeded in this when one day I turned aside from the main road to climb a mountain which lay somewhat apart and which was renowned for its views and for its well-run refuge hut. I reached the top after a strenuous climb and, feeling refreshed and rested, was sitting deep in contemplation of the charm of the distant prospect. I was so lost in thought that at first I did not connect it with myself when these words reached my ears: "Are you a doctor, sir?" But the question was addressed to me, and by the rather sulky-looking girl of perhaps eighteen who had served my meal and had been spoken to by the landlady as "Katharina." To judge by her dress and bearing, she could not be a servant, but must no doubt be a daughter or relative of the landlady's.



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Coming to myself I replied "Yes, I'm a doctor: but how did you know that?" "You wrote your name in the Visitors' Book, sir. And I thought if you had a few moments to spare . . . The truth is, sir, my nerves are bad. I went to see a doctor in L— about them and he gave me something for them; but I'm not well yet."

So there I was with the neuroses once again—for nothing else could very well be the matter with this strong, well-built girl with her unhappy look. I was interested to find that neuroses could flourish in this way at a height of over 6000 feet; I questioned her further therefore. I report the conversation that followed between us just as it is impressed on my memory and I have not altered the patient's dialect.

"Well, what is it you suffer from?"

"I get so out of breath. Not always. But sometimes it catches me so that I think I shall suffocate."

This did not, at first sight, sound like a nervous symptom. But soon it occurred to me that probably it was only a description that stood for an anxiety attack: she was choosing shortness of breath out of the complex sensations arising from anxiety and laying undue stress on that single factor.

"Sit down here. What is it like when you get 'out of breath'?"

"It comes over me all at once. First of all it's like something pressing on my eyes. My head gets so heavy, there's a dreadful buzzing, and I feel so giddy that I almost fall over. Then there's something crushing my chest so that I can't get my breath."

"And you don't notice anything in your throat?"

"My throat's squeezed together as though I were going to choke."

"Does anything else happen in your head?"

"Yes, there's a hammering, enough to burst it."

"And don't you feel at all frightened while this is going on?"

"I always think I'm going to die. I'm brave as a rule and go about everywhere by myself—into the cellar and all over the mountain. But on a day when that happens I don't dare go anywhere; I think all the time someone's standing behind me and going to catch hold of me all at once."

So it was in fact an anxiety attack, and introduced by the signs of hysterical "aura"—or, more correctly, it was a hysterical attack the content of which was anxiety. Might there not probably be some other content as well?

"When you have an attack do you think of something? And always the same thing? Or do you see something in front of you?"

"Yes. I always see an awful face that looks at me in a dreadful way, so that I'm frightened."

Perhaps this might offer a quick means of getting to the heart of the matter.

"Do you recognize the face? I mean, is it a face that you've really seen some time?"

"No."

"Do you know what your attacks come from?"

"No."

"When did you first have them?"

"Two years ago, while I was still living on the other mountain with my aunt. (She used to run a refuge hut there, and we moved here eighteen months ago.) But they keep on happening."

Was I to make an attempt at an analysis? I could not venture to transplant hypnosis to these altitudes, but perhaps I might succeed with a simple talk. I should have to try a lucky guess. I had found often enough that in girls anxiety was a consequence of the horror by which a virginal mind is overcome when it is faced for the first time with the world of sexuality.

So I said: "If you don't know, I'll tell you how *I* think you got your attacks. At that time, two years ago, you must have seen or heard something that very much embarrassed you, and that you'd much rather not have seen."

"Heavens, yes!" she replied, "that was when I caught my uncle with the girl, with Franziska, my cousin."

"What's this story about a girl? Won't you tell me all about it?"

"You can say *anything* to a doctor, I suppose. Well, at that time, you know, my uncle—the husband of the aunt you've seen here—kept the inn on the ——kogel. Now they're divorced, and it's my fault they were divorced, because it was through me that it came out that he was carrying on with Franziska."

"And how did you discover it?"

"This way. One day two years ago some gentlemen had climbed the mountain and asked for something to eat. My aunt wasn't home, and Franziska, who always did the cooking, was nowhere to be found. And my uncle was not to be found either. We looked everywhere, and at least Alois, the little boy, my cousin, said: 'Why, Franziska must be in Father's room!' And we both laughed; but we weren't thinking anything bad. Then we went to my uncle's room but found it locked. That seemed strange to me. Then Alois said: 'There's a window in the passage where you can look into the room.' We went into the passage; but Alois wouldn't go to the window and said he was afraid. So I said: 'You silly boy! I'll go. I'm not a bit afraid.' And I had nothing bad in my mind. I looked in. The room was rather dark, but I saw my uncle and Franziska; he was laying on her."

"Well?"

"I came away from the window at once, and leant up against the wall and couldn't get my breath—just what happens to me since. Everything went blank, my eyelids were forced together and there was a hammering and buzzing in my head."

"Did you tell your aunt that very same day?"

"Oh no, I said nothing."

"Then why were you so frightened when you found them together? Did you understand it? Did you know what was going on?"

"Oh no. I didn't understand anything at that time. I was only sixteen. I don't know what I was frightened about."

"Fraulein Katharina, if you could remember now what was happening in you at that time, when you had your first attack, what you thought about it—it would help you."

"Yes, if I could. But I was so frightened that I've forgotten everything."

(Translated into the terminology of our "Preliminary Communication" this means: "The affect itself created a hypnoid state, whose products were then cut off from associative connection with the ego-consciousness.")

"Tell me, Fraulein. Can it be that the head that you always see when you lose your breath is Franziska's head, as you saw it then?"

"Oh no, she didn't look so awful. Besides, it's a man's head."

"Or perhaps your uncle's?"

"I didn't see his face as clearly as that. It was too dark in the room. And why should he have been making such a dreadful face just then?"

"You're quite right."

(The road suddenly seemed blocked. Perhaps something might turn up in the rest of her story.)

"And what happened then?"

"Well, those two must have heard a noise, because they came out soon afterwards. I felt very bad the whole time. I always kept thinking about it. Then two days later it was a Sunday and there was a great deal to do and I worked all day long. And on the Monday morning I felt giddy again and was sick, and I stopped in bed and was sick without stopping for three days."

We [Breuer and I] had often compared symptomatology of hysteria with a pictographic script which had become intelligible after the discovery of a few bilingual inscriptions. In that alphabet being sick means disgust. So I said "If you were sick three days later, I believe that means that when you looked into the room you felt disgusted."

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"Yes, I'm sure I felt disgusted," she said reflectively, "but disgusted at what?"

"Perhaps you saw something naked? What sort of state were they in?"

"It was too dark to see anything; besides they both of them had their clothes on. Oh, if only I knew what it was I felt disgusted at!"

I had no idea either. But I told her to go on and tell me whatever occurred to her, in the confident expectation that she would think of precisely what I needed to explain the case.

Well, she went on to describe how at last she reported her discovery to her aunt, who found that she was changed and suspected her of concealing some secret. There followed some very disagreeable scenes between her uncle and aunt, in the course of which the children came to hear a number of things which opened their eyes in many ways and which it would have been better for them not to have heard. At last her aunt decided to move with her children and niece and take over the present inn, leaving her uncle alone with Franziska, who had meanwhile become pregnant. After this, however, to my astonishment she dropped these threads and began to tell me two sets of older stories, which went back two or three years earlier than the traumatic moment. The first set related to occasions on which the same uncle had made sexual advances to her herself, when she was only fourteen years old. She described how she had once gone with him on an expedition down into the valley in the winter and had spent the night in the inn there. He sat in the car drinking and playing cards, but she felt sleepy and went up to bed early in the room they were to share on the upper floor. She was not quite asleep when he came up; then she fell asleep again and woke up suddenly "feeling his body" in the bed. She jumped up and remonstrated with him: "What are you up to, Uncle? Why don't you stay in your own bed?" He tried to pacify her: "Go on, you silly girl, keep still. You don't know how nice it is."—"I don't like your 'nice' things; you don't even let one sleep in peace." She remained standing by the door, ready to take refuge outside in the passage, till at last he gave up and went to sleep himself. Then she went back to her own bed and slept till morning. From the way in which she reported having defended herself it seems to follow that she did not clearly recognize the attack as a sexual one. When I asked her if she knew what he was trying to do to her, she replied: "Not at the time." It had become clear to her much later on, she said; she had resisted because it was unpleasant to be disturbed in one's sleep and "because it wasn't nice."

I have been obliged to relate this in detail, because of its great importance for understanding everything that followed. She went on to tell me of yet other experiences of somewhat later date; how she had once again had to defend herself against him in an inn when he was completely drunk, and similar stories. In answer to a question as to whether on these occasions she had felt anything resembling her later loss of breath, she answered with decision that she had every time felt the pressure on her eyes and chest, but with nothing like the strength that had characterized the scene of discovery.

Immediately she had finished this set of memories she began to tell me a second set, which dealt with occasions on which she had noticed something between her uncle and Franziska. Once the whole family had spent the night in their clothes in a hay loft and she was woken up suddenly by a noise; she thought she noticed that her uncle, who had been lying between her and Franziska, was turning away, and that Franziska was just lying down. Another time they were stopping the night at an inn at the village of N— she and her uncle were in one room and Franziska in an adjoining one. She woke up suddenly in the night and saw a tall white figure by the door, on the point of turning the handle: "Goodness, is that you, Uncle? What are you doing at the door?"—"Keep quiet. I was only looking for something."—"But the way out's by the *other* door."—"I'd just made a mistake" . . . and so on.

I asked her if she had been suspicious at that time. "No, I didn't think anything about it; I only just noticed it and thought no more about it." When I inquired whether she had been frightened on these occasions too, she replied that she thought so, but she was not so sure of it this time.

At the end of these two sets of memories she came to a stop. She was like someone transformed. The sulky, unhappy face had grown lively, her eyes were bright, she was lightened and exalted. Meanwhile the understanding of her case had become clear to me. The later part of what she had told me, in an apparently aimless fashion, provided an admirable explanation of her behavior at the scene of the discovery. At that time she had carried about with her two sets of experiences which she remembered but did not understand, and from which she drew no inferences. When she caught sight of the couple in intercourse, she at once established a connection between the new impression and these two sets of recollections, she began to understand them and at the same time to fend them off. There then followed a short period of working-out, of "incubation," after which the symptoms of conversion set in, the vomiting as a substitute for moral and physical disgust. This solved the riddle. She had not been disgusted by the sight of two people but by the memory which that sight had stirred up in her. And, taking everything into account, this could only be the memory of the attempt on her at night when she had "felt her uncle's body."

So when she had finished her confession I said to her: "I know now what it was you thought when you looked into the room. You thought: 'Now he's doing with her what he wanted to do with me that night and those other times.' That was what you were disgusted at, because you remembered the feeling when you woke up in the night and felt his body.

"It may well be," she replied, "that that was what I was disgusted at and that was what I thought."

"Tell me just one thing more. You're a grown-up girl now and know all sorts of things . . ."

"Yes, now I am."

"Tell me just one thing. What part of his body was it that you felt that night?"

But she gave me no more definite answer. She smiled in an embarrassed way, as though she had been found out, like someone who is obliged to admit that a fundamental position had been reached where there is not much more to be said. I could imagine what the tactile sensation was which she had later learnt to interpret. Her facial expression seemed to me to be saying that she supposed that I was right in my conjecture. But I could not penetrate further, and in any case I owed her a debt of gratitude for having made it so much easier for me to talk to her than to the prudish ladies of my city practice, who regard whatever is natural as shameful.

Thus the case was cleared up.—But stop a moment! What about the recurrent hallucinations of the head, which appeared during her attacks and struck terror into her? Where did it come from? I proceeded to ask her about it, and, as though *her* knowledge, too, had been extended by our conversation, she promptly replied: "Yes, I know now. The head is my uncle's head—I recognize it now—but not from *that* time. Later, when all the disputes had broken out, my uncle gave way to a senseless rage against me. He kept saying that it was all my fault: if I hadn't chattered, it would never have come to a divorce. He kept threatening he would do something to me; and if he caught sight of me at a distance his face would get distorted with rage and he would make for me with his hand raised. I always ran away from him, and I always felt terrified that he would catch me some time unawares. The fact I always see now is his face when he was in a rage."

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This information reminded me that her first hysterical symptom, the vomiting, had passed away; the anxiety attack remained and acquired a fresh content. Accordingly, what we were dealing with was a hysteria which had to a considerable extent been abreacted. And in fact she had reported her discovery to her aunt soon after it happened.

"Did you tell your aunt the other stories—about his making advances to you?"

"Yes. Not at once, but later on, when there was already talk of a divorce. My aunt said: 'We'll keep that in reserve. If he causes trouble in the Court, we'll say that too.'"

I can well understand that it should have been precisely this last period—when there were more and more agitating scenes in the house and when her own state ceased to interest her aunt, who was entirely occupied with the dispute—that it should have been this period of accumulation and retention that left her the legacy of the mnemic symbol [of the hallucination face].

I hope this girl, whose sexual sensibility had been injured at such an early age, derived some benefit from our conversation. I have not seen her since.

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