CHAPTER 4

TREATMENTS IN DYNAMIC PSYCHIATRY

Individual Psychotherapy

Proficiency at individual psychotherapy is perhaps the hallmark of the dynamic psychiatrist. Evolving as it does from psychoanalysis, dynamic psychiatry understandably emphasizes the nuances of the healing relationship between psychotherapist and patient. Space considerations here limit us to a brief overview of the general principles derived from the vast literature on individual psychotherapy. Specific applications of those principles to disorders are demonstrated and explicated in Section II of this volume. Readers who are interested in a more comprehensive discussion of individual psychotherapy should consult any of several comprehensive texts (Basch 1980; Busch 1995; Cabaniss et al. 2011; Gabbard 2010; Luborsky 1984; McWilliams 2004; Roth 1987; Summers and Barber 2009).

Expressive-Supportive Continuum

Psychotherapy that is based on the technical principles of formal psychoanalysis has been designated by a number of different names: expressive, dynamic, psychoanalytically oriented, insight oriented, exploratory, uncovering, and intensive, to name a few. This form of treatment, geared toward analyzing defenses and exploring the transference, has traditionally

been viewed as wholly different from another entity known as supportive psychotherapy. The latter, which is more oriented to suppressing unconscious conflict and bolstering defenses, has been widely regarded as inferior to expressive therapy. This tendency is reflected in the clinical maxim that has guided psychotherapists for years: "Be as expressive as you can be, and as supportive as you have to be" (Wallerstein 1986, p. 688).

A number of authors have expressed concern about this traditional dichotomy (Gabbard 2010; Horwitz et al. 1996; Pine 1976, 1986; Wallerstein 1986; Werman 1984; Winston et al. 2004). One problem with the distinction is the implication that supportive psychotherapy is not psychoanalytically oriented. In practice, many forms of supportive psychotherapy are guided by psychoanalytic understanding every step of the way. Moreover, the dichotomy portrays expressive psychotherapy and supportive psychotherapy as highly discrete entities when, in fact, they rarely occur in pure form anywhere (Wallerstein 1986; Werman 1984). Finally, the value distinction associated with the greater prestige of expressive psychotherapy or psychoanalysis has always carried with it the assumption that change achieved as a result of insight or intrapsychic conflict resolution is somehow superior to that achieved through supportive techniques. No hard data support this assumption.

At the conclusion of a longitudinal study of 42 patients treated in The Menninger Foundation Psychotherapy Research Project, Wallerstein (1986) determined that all forms of psychotherapy contain a mixture of expressive and supportive elements and that changes achieved by the supportive elements are in no way inferior to those achieved by the expressive elements. Rather than regarding expressive psychotherapy and supportive psychotherapy as two distinct modalities of treatment then, we should view psychotherapy as taking place on an expressive-supportive continuum, which is in closer keeping with the reality of clinical practice and with empirical research. With certain patients and at certain points in the therapy, the therapy will be weighted more heavily toward expressive elements, whereas with other patients and at other times, the therapy will require more attention to supportive elements. As Wallerstein (1986) noted, "All proper therapy is always both expressive and supportive (in different ways), and the question at issue at all points in every therapy should be that of expressing *how* and *when,* and supporting *how* and *when*" (p. 689).

Individual psychotherapy geared to this continuum might best be termed *expressive-supportive* or *supportive-expressive*. Even psychoanalysis, situated at the most extreme point on the expressive end of the continuum, contains supportive elements. Meanwhile, most supportive psychotherapies at the opposite end of the continuum provide insight and understanding from time to time. Hence, the effective dynamic therapist will shift flexibly

back and forth along the expressive-supportive continuum depending on the needs of the patient at a given moment in the psychotherapy process.

The concept of the expressive-supportive continuum provides a framework for considering the goals, characteristics, and indications for individual psychotherapy.

Expressive-Supportive Psychotherapy

Goals

Historically, insight and understanding were always considered the ultimate goals of psychoanalysis and of psychotherapy derived from psychoanalytic principles. Since the 1950s, however, there has been considerable acceptance of the notion that the therapeutic relationship itself is healing independently of its role in delivering insight. Loewald (1957/1980) noted that the process of change is "set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new 'object relationship' between the patient and the analyst" (p. 224).

Although most psychoanalytic therapists endorse goals involving insight and the therapeutic relationship, there is variation in which dimension is given the most emphasis. Some focus more on conflict resolution through interpretation, whereas others stress the importance of developing authenticity or "the true self" (Winnicott 1962/1976). Some therapists are more ambitious regarding therapeutic outcomes; others conceptualize the psychotherapeutic process as a search for truth about oneself (Grinberg 1980). Still others believe that the capacity for reflectiveness about one's internal world should be the goal (Aron 1998). Kleinians would view the goal as the reintegration of aspects of the self that were previously lost through projective identification (Steiner 1989). Those influenced by attachment theory (Fonagy 2001) would argue that improved capacity for mentalization is the goal.

From an object relations standpoint, an improvement in the quality of one's relationships is a goal of psychotherapy, regardless of whether it is weighted toward the supportive or the expressive end of the continuum. As internal object relations change in the course of psychotherapy, one is able to perceive and relate to external persons differently. In contemporary practice, patients are much more likely to seek therapy because of dissatisfaction with the quality of their relationships than because of discrete symptoms, as they did in Freud's day. Hence, the importance of this goal cannot be overstated.

In self psychologically oriented psychotherapy, the goals involve strengthening the cohesiveness of the self and helping the patient choose more mature selfobjects, as alluded to in Chapter 2. In Kohut's (1984) words,

"The essence of the psychoanalytic cure resides in a patient's newly acquired ability to identify and seek out appropriate selfobjects as they present themselves in his realistic surroundings and to be sustained by them" (p. 77).

The goal of psychotherapy at the supportive end of the continuum is primarily to help the patient adapt to stresses and strengthen defenses to facilitate the patient's adaptive capacity to handle the stresses of daily living. Furthermore, because supportive techniques are often used in treating patients with serious ego weaknesses, ego building is a crucial aspect of supportive psychotherapies. For example, the therapist may serve as an auxiliary ego, helping patients to test reality more accurately or to anticipate consequences of their actions and thereby improve their judgment. Winston et al. (2004) provide a systematic approach to supportive psychotherapy that is tailored to the individual patient's needs.

Duration

The length of expressive-supportive psychotherapy is essentially independent of the expressive-supportive continuum. Therapies that are highly supportive or highly expressive can be either brief or long. Although definitions of brief and long-term dynamic psychotherapy vary, for purposes of this book, I conceptualize *long-term psychotherapy* as those treatments lasting longer than 6 months or 24 weeks in duration (Gabbard 2010). Most long-term therapies are open-ended, but some are fixed at a set number of sessions from the beginning. In this section I discuss long-term dynamic therapy and address brief therapy near the end of the chapter.

Frequency of Sessions

In contrast to the duration of therapy, the frequency of sessions per week tends to be highly correlated with the expressive-supportive continuum. As a general rule, a greater number of weekly sessions characterizes the expressive end of the continuum. Psychoanalysis, an extremely expressive treatment, is characterized by three to five sessions a week and is usually conducted with the patient lying on a couch while the analyst sits behind the couch. Highly expressive forms of psychotherapy usually involve one to three sessions a week with the patient sitting in an upright position. In contrast, psychotherapy with primarily supportive goals rarely takes place more than once a week and is often provided at a frequency of once a month.

The issue of frequency is connected with the role of transference in the psychotherapeutic process (discussed later in this chapter). Clinical experience has shown that transference intensifies as the frequency of sessions increases. Because the more expressive treatments focus on the transference,

these therapists usually prefer to see their patients at least once a week. In contrast, supportive processes work with transference to a lesser extent and thus do not require one session a week. Also, whereas highly expressive treatments are almost invariably administered in 45- or 50-minute sessions, supportive processes tend to use time more flexibly. Certain patients who require more frequent supportive contacts with the therapist do better with two 25-minute sessions than with one 50-minute session.

The reality of psychiatric practice is that practical matters may outweigh theoretical considerations in determining the frequency of sessions. Some patients may be able to afford only one session a week even though they might do better with three. Other patients, because of inconvenient work schedules or transportation problems, may be able to get to their therapist's office only once a week. Before accepting such limitations, however, the therapist should keep in mind that resistance often finds convenient hiding places. An investigation of these practical limitations may reveal that the patient has greater flexibility of time and money than can be readily acknowledged.

Free Association

Free association is often regarded as the major mode by which the patient communicates to the analyst. This requires patients to relax their usual control over their thought processes in an effort to say whatever comes to mind without censoring their words or thoughts. In actual practice, resistances inevitably intervene when patients try to free-associate. It is often asserted, only half-jokingly, that when a patient is able to free-associate without interference from resistance, then that patient may be ready for termination. Patients may also use free association itself as a resistance to focusing on a particular issue in their current life situation (Greenson 1967).

Free association is also useful in highly expressive therapies, although more selectively than in analysis. The therapist, for example, may ask the patient to associate to various elements of a dream to help both patient and therapist understand unconscious connections that make interpretation of the dream possible. The therapist may also find it useful to use the notion of free association as a way of helping the patient who is stuck or who falls silent. When the patient asks, "What do I do now?" the therapist can respond, "Simply say what comes to mind."

Free association is far less useful further along the continuum toward the more supportively based treatments. As Greenson (1967) pointed out, the process itself requires a mature and healthy ego to maintain a split between an observing ego and an experiencing ego. Patients who are prone to psychosis may become increasingly regressed if allowed to free-associate in a supportive process. Moreover, such patients often lack the ego capacity to re-

flect on their associations and to integrate them into a meaningful and coherent understanding of unconscious issues.

Neutrality, Anonymity, and Abstinence

Between 1912 and 1915, Freud published a series of prescriptions for technique that have formed the basis of what is often referred to as the "classical" model of treatment. Principles such as neutrality, anonymity, and abstinence evolved from those papers. In recent years, however, these concepts have become highly controversial, because it has become increasingly clear that the way Freud actually practiced differed considerably from some of his recommendations in his papers on technique (Lipton 1977; Lohser and Newton 1996). Whereas Freud at times admonished analysts to proceed with emotional detachment, to show nothing of themselves, and to put aside all of their own feelings, written accounts from his own patients demonstrate that he was transparent regarding his mood; frequently gossiped; offered his own opinions about other people, works of art, and current political issues; and was enthusiastically engaged as a "real person." His own subjectivity was very much in evidence. His written prescriptions for technique evidently were based on his concerns about the potential for countertransference acting out in his colleagues rather than what he felt was best to advance the analytic process. Freud was not very "Freudian."

Neutrality is perhaps the most misunderstood aspect of psychoanalytic and psychotherapeutic technique. Freud did not even use the word in his writings. James Strachey translated the German word *Indifferenz* as "neutrality," even though the German word actually implies an undercurrent of emotional participation in the analyst rather than detachment. It is frequently misinterpreted to mean coldness or aloofness (Chessick 1981). Even in the most expressive treatments, emotional warmth is a necessary part of the therapeutic relationship. Similarly, concern for the patient's unique situation is essential to establish rapport.

Therapists who remove themselves from the interpersonal field of the therapy by assuming an aloof, nonparticipatory attitude diminish their effectiveness by closing themselves off to the experience of the patient's internal object world (Hoffman and Gill 1988). There is a broad consensus that the therapist is a participant in the therapeutic process in a spontaneous way (Gabbard 1995; Hoffman and Gill 1988; Mitchell 1997; Racker 1968; Renik 1993; Sandler 1976). As Freud's own practice demonstrated, there is an irreducible subjectivity (Renik 1993) that cannot be eliminated with a mask of anonymity. Moreover, therapists who can allow themselves to respond to the patient's unconscious attempts to transform them into transference objects will gain a much greater appreciation of the patient's internal world. Thera-

pists may become aware of countertransference feelings only *after* they have responded like one of the patient's projected internal objects or self representations (Sandler 1976; see also Gabbard 1995). As noted in Chapter 1, the countertransference that is jointly created by the therapist's subjectivity and the patient's projected internal representations is a source of valuable information in the treatment process.

The most widely accepted contemporary meaning of *neutrality* is the assumption of a nonjudgmental stance regarding the patient's behaviors, thoughts, wishes, and feelings. Anna Freud (1936/1966), who did not use the term, suggested that the analyst should remain equidistant from the id, the ego, the superego, and the demands of external reality. This stance, however, is more of an *ideal* than a realistic position. Therapists are frequently making private judgments about what patients say or do, and a spontaneous, engaged therapist will sometimes reveal those judgments nonverbally if not in overt comments to the patient. Greenberg (1986) redefined neutrality as taking a position equidistant between an old object from the patient's past and the new object of the therapist in the present. This conceptual model may more accurately reflect the therapist's internal process. The therapist is drawn into a role evoked by the patient's internal world and then attempts to become disentangled from that role so as to reflect what is taking place between patient and therapist.

Anonymity has similarly been redefined in contemporary practice. Freud (1912/1958) wrote that the analyst should strive for the opacity of a mirror, but analysts and analytic therapists today recognize that anonymity is a mythical construct. Photographs, books, and other articles of personal interest are all over the therapist's office. When the therapist chooses to speak, both what he or she says and how he or she responds to the patient's material are highly revealing of the therapist's subjectivity. Hence, one is self-disclosing all the time in nonverbal as well as verbal modes. Most analysts and analytic therapists, however, still recognize that there is value in restraint. Revealing highly personal details about the therapist's family or the therapist's personal problems is rarely useful and may burden the patient in a manner that creates a role reversal in which the patient thinks he or she must take care of the therapist. Similarly, making harsh judgments about the patient's thoughts, feelings, or actions may be destructive by compounding the patient's self-criticism.

Abstinence is a third term that has been widely misconstrued by some practitioners. Freud suggested that the analyst needed to withhold gratification of transference wishes so that those wishes could be analyzed rather than satisfied. Today there is wide recognition that partial transference gratifications occur throughout the treatment. The therapist's laughter in response to a joke, the empathic listening intrinsic to psychotherapy, and the warmth

and understanding provided by the therapist all provide gratifications for the patient. The concept of therapeutic or analytic boundaries establishes limits on the physical relationship so that psychological and emotional boundaries can be crossed through the process of empathy, projective identification, and introjection (Gabbard and Lester 2003). Good professional boundaries should not be construed as promoting rigidity or coldness (Gutheil and Gabbard 1998). Good therapists feel free to laugh with the patient, and they may tear up when hearing a sad story. They may also greet the patient with enthusiasm at the beginning of the session. However, they do maintain abstinence regarding the gratification of sexual wishes and any other form of potential exploitation of the patient for their own personal needs.

Interventions

The interventions made by the therapist can be placed into eight categories along an expressive-supportive continuum: 1) interpretation, 2) observation, 3) confrontation, 4) clarification, 5) encouragement to elaborate, 6) empathic validation, 7) psychoeducational interventions, and 8) advice and praise (Figure 4–1).

Interpretation

In the most expressive forms of treatment, interpretation is regarded as the therapist's ultimate decisive instrument (Greenson 1967). In its simplest form, interpretation involves making something conscious that was previously unconscious. An interpretation is an explanatory statement that links a feeling, thought, behavior, or symptom to its unconscious meaning or origin. For example, the therapist might say to a patient who is reluctant to accept anything the therapist says, "Maybe you feel you have to disagree with my observations because I remind you so much of your dad." Depending on the point in therapy and the patient's readiness to listen, interpretations may focus on the transference (as in this example), on extratransference issues, on the patient's past or present situation, or on the patient's resistances or fantasies. As a general principle, the therapist does not address unconscious content via interpretation until the material is almost conscious and therefore relatively accessible to the patient's awareness.

Observation

Observation stops short of interpretation in that it does not attempt to explain unconscious meanings or make causative linkages. The therapist merely notes a nonverbal behavior, a pattern in the therapeutic process, a trace of emotion on the patient's face, or the sequence of moving from one

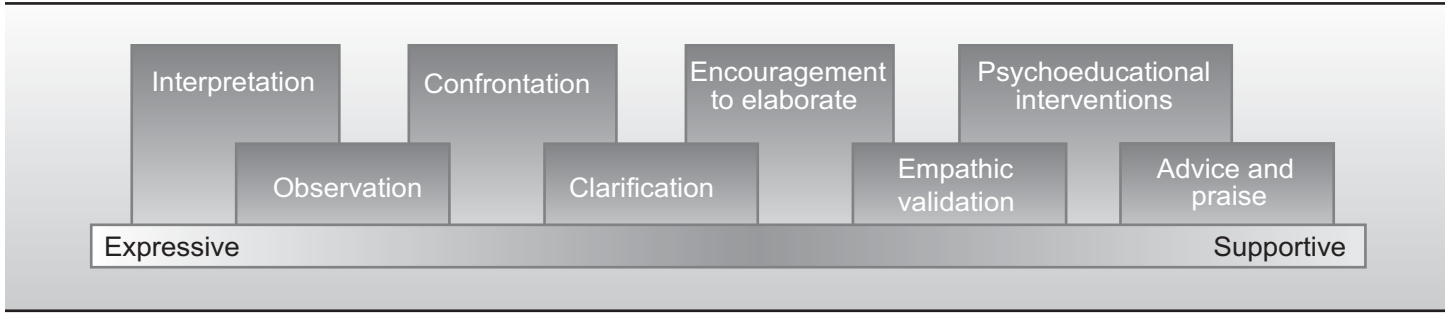

FIGURE 4–1. An expressive-supportive continuum of interventions.

comment to another. A therapist might, for example, say, "One pattern I've noted is that when you enter my office at the beginning of each session, you appear rather frightened and you pull the chair back to the wall before you sit down. Any thoughts about that?" As in this example, the therapist does not speculate about the motive for the behavior but instead invites the patient's collaboration on the matter.

Confrontation

The next most expressive intervention is confrontation, which addresses something the patient does not want to accept or identifies the patient's avoidance or minimization. Unlike observation, which usually targets something outside the patient's awareness, confrontation usually points out the avoidance of conscious material. Confrontation, which is often gentle, carries the unfortunate connotation in common parlance of being aggressive or blunt. The following example illustrates that confrontation is not necessarily forceful or hostile: In the last session of a long-term therapy process, one patient talked at great length about car problems he encountered on the way to the session. The therapist commented, "I think you'd rather talk about your car than face the sadness you're feeling about our last session."

Clarification

Farther along the continuum from expressive to supportive interventions, clarification involves a reformulation or pulling together of the patient's verbalizations to convey a more coherent view of what is being communicated. Clarification differs from confrontation because it lacks the element of denial or minimization. A clarification is aimed at helping the patient articulate something that is difficult to put into words.

Encouragement to Elaborate

Closer to the middle of the continuum come interventions that are neither supportive nor expressive in and of themselves. *Encouragement to elaborate* may be broadly defined as a request for information about a topic brought up by the patient. It may be an open-ended question such as "What comes to mind about that?" or a more specific request as in "Tell me more about your father." Such interventions are commonly used in both the most expressive and the most supportive treatments.

Empathic Validation

Empathic validation is a demonstration of the therapist's empathic attunement with the patient's internal state. A typically validating comment is "I

can understand why you feel depressed about that" or "It hurts when you're treated that way." In the view of the self psychologists, empathic immersion in the patient's internal experience is essential, regardless of the location of the therapy on the expressive-supportive continuum (Kohut 1984; Ornstein 1986). When patients feel that the therapist understands their subjective experiences, they are more likely to accept interpretations. Affirmative interventions (Killingmo 1995) may also be heard as empathic validation. A therapist of a patient who was abused as a child, for example, might say, "You have every right to be angry at your father."

Psychoeducational Interventions

Psychoeducational interventions involve information shared with a patient based on the therapist's training and knowledge. A therapist might, for example, explain the difference between grief and depression.

Advice and Praise

The category of advice and praise includes two interventions that are linked by the fact that they both prescribe and reinforce certain activities. Advice involves direct suggestions to the patient regarding how to behave, whereas praise reinforces certain patient behaviors by expressing overt approval of them. An example of the former is "I think you should stop going out with that man immediately." An example of the latter is "I'm very pleased that you were able to tell him that you would not see him anymore." These comments are on the opposite end of the continuum from traditional psychoanalytic interventions because they are departures from neutrality and to some extent compromise the patient's autonomy in making decisions.

The vast majority of psychotherapeutic processes contain all these interventions at some time during the course of treatment. However, a therapy is classified as primarily expressive or primarily supportive on the basis of which interventions predominate. These associations of interventions with the continuum are not ironclad.

Pine (1986) and Horwitz et al. (1996) advocated supportive techniques to "cushion the blow" of interpretations in the supportive therapy of fragile patients. Werman (1984, p. 83) proposed making "upward interpretations" of transference behavior or feelings to relate them to current situations rather than to early experiences, thereby preventing regression in patients with serious ego weakness. These interventions are the inverse of classical interpretations in that they provide conscious, rather than unconscious, explanations of the patient's behavior or feelings.

Although this continuum of interventions is provided for educational purposes, one must be wary as a psychotherapist not to sound like one is

performing a "procedure" on a patient. Technique should be invisible. From the patient's perspective, psychotherapy should feel like a conversation with a concerned person who is attempting to provide helpful understanding. One must avoid the appearance of making dogmatic pronouncements or speaking in archaic jargon that is off-putting to the patient.

Transference

Freud was fond of saying that what made a therapy process psychoanalytic was a focus on transference and resistance. Certainly all forms of dynamically oriented psychotherapy pay careful attention to the state of the transference. However, the specific manner in which the transference is addressed (or left unaddressed) varies considerably, depending on the expressive-supportive dimension. In formal psychoanalysis, the highlighting and understanding of the transference is of paramount importance, although contemporary analysts would speak of a set or series of transferences rather than *the* transference (Westen and Gabbard 2002). One may encounter mother, father, and sibling transferences all in the treatment of the same patient.

Both psychoanalysis and expressive psychotherapy employ extratransference interpretation as well as transference interpretation. Psychotherapy may be somewhat more limited than psychoanalysis in that it focuses on the transference dispositions most closely related to the presenting problems (Roskin 1982). In actual practice, however, the distinctions between psychoanalysis and expressive psychotherapy are blurred and difficult to delineate.

There is a long-standing tradition to think of transference interpretation as an intervention that is used in highly expressive psychotherapy for patients who are high functioning and neurotically organized. With more disturbed patients, the conventional wisdom has been to use very little transference interpretation because the patients have been regarded as too fragile to reflect on the here and now interaction. However, recent rigorous research has placed this conventional wisdom in question. A randomized control trial of dynamic psychotherapy (Høglend et al. 2006) randomly assigned 100 outpatients to either a group using interpretation of transference or a group that did not use transference interpretation. The group receiving transference interpretation had moderate levels of one to three per session. Although no overall differences in outcome between the two treatment cells were found, an unexpected finding was a reversal of the conventional wisdom. Patients with impaired object relations benefited more from therapies using transference interpretation than those without transference interpretation. This effect was sustained at 3-year follow-up. In a subsequent study (Høglend et al. 2011), the investigators examined the effects of transference work in the context of therapeutic alliance and quality of object relations in

more detail. They found that for patients with a strong alliance and higher levels of object relations, the specific effect of transference work tended to be smaller and only marginally significant. Transference work had the strongest specific effect for patients with low quality of object relations scale scores within the context of a weak alliance.

One implication of the study is that transference work may be crucial when treating patients who have difficulties establishing stable and fulfilling relationships. In other words, the therapeutic alliance will be more challenging for these patients unless one can examine the here and now situation with the patient and understand his or her anxieties about forming an alliance with the therapist. In so doing, the therapist is also helping the patient understand anxieties inherent in establishing stable relationships outside the transference. Another implication of the study is that patients with high levels of object relations may not require a good deal of transference interpretation. Those who are resourceful and who have a positive alliance may feel interpretation of transference is jarring. Paradoxically, that approach may result in increased resistance. This finding may be a reflection of the long-standing admonition of therapists that transference should not be interpreted until it becomes a resistance.

As noted in Chapter 1, transference is often viewed today as having a bidimensional quality involving a repetition of past experience with old objects on the one hand and a quest for a new object or selfobject experience that will be reparative and corrective for the patient on the other. In addition, the notion of transference as distortion has become more complex. The therapist must avoid a "blaming" approach to transference interpretation, because the patient may be legitimately responding to real behaviors or attitudes of the therapist. The therapist must always engage in ongoing self-scrutiny to sort out the repetitive, "template" aspect of transference stemming from the patient's intrapsychic world and the real contributions of the therapist to the interaction (Gabbard 1996; Hoffman 1998; Mitchell 1997).

In therapies designed primarily to be supportive, the therapist is involved in the same process of monitoring transference developments and countertransference responses. The transference is noted inwardly but is usually not addressed or interpreted to the patient. The treatment goal in refraining from interpretation is to build a solid therapeutic alliance along with a positive transference (Wallerstein 1986). This combination of positive transference attachment and collaborative therapeutic alliance is the mechanism of the "transference cure," whereby the patient works hard to please the therapist and to make the therapist proud. Although changes derived from this model have traditionally been disparaged as inferior to those stemming from conflict resolution, research suggests that they may be stable and lasting (Horwitz 1974; Wallerstein 1986).

Resistance

As noted in Chapter 1, resistance involves the emergence of the patient's characterological defenses within the therapeutic situation. In the more expressive therapies, analyzing and understanding resistance is part of the daily bread-and-butter work of the therapist. If, for example, the patient is consistently late to sessions or consistently silent during them, the therapist may regard these resistances with interest and curiosity rather than devalue them as defiant and willful behavior. Resistances are not met with proscriptions or censure. Instead, the therapist enlists the patient's help in understanding the origins of the resistance and then addresses the resistance with interpretation.

Resistance related to transference issues is referred to as *transference resistance*. This involves interferences with the therapeutic work deriving from transference perceptions. For example, a patient may feel unable to talk about masturbatory fantasies because he is convinced that his therapist disapproves of masturbation. To prevent receiving a negative judgment from the therapist, the patient therefore chooses to remain silent. In the parlance of object relations theory, a transference resistance may be understood as the patient's unconscious tendency to cling tenaciously to a particular internal object relationship. This may manifest itself as a therapeutic stalemate in which the therapist is repeatedly related to as someone else.

Students of psychoanalysis and psychoanalytic psychotherapy often raise the question, "Resistance to what?" Friedman (1991) noted that the true significance of resistance is that the feelings associated with it may compel the patient into nonreflective action instead of reflective observation. He pointed out that what is resisted is a particular mental attitude that he describes as "a simultaneous conscious activation of repressed wishes and a cool contemplation of their significance, so that they are experienced both as wishes and as objective features of the conflicted self" (p. 590). Moreover, the current emphasis on intersubjectivity would also suggest that the resistance of the patient may be paralleled by a counterresistance in the therapist that may collude with the patient's difficulties in achieving the reflective space necessary for psychoanalytic treatment.

In Chapter 2, I noted the different perspective on resistance that is held by self psychologists. They regard resistances as healthy psychic activities that safeguard the growth of the self (Kohut 1984). Rather than interpret resistances, they empathize with the patient's need for them. This view is in keeping with their concern that the classical approach of pursuing the content beneath resistance has moralistic overtones. However, this empathic approach has led some analysts to regard the self psychological technique as fundamentally supportive.

As implied by the previous comments about self psychology, resistance is viewed as essential and adaptive in the context of predominantly supportive psychotherapy. Resistances are often manifestations of defensive structures that need to be bolstered as part of therapy. The therapist might even encourage resistance by pointing out to the patient that certain matters are too upsetting to discuss and should be postponed until a more auspicious moment. Similarly, delay mechanisms may be reinforced in the interest of supporting a weakened ego beset by impulses. When a patient's actions usurp verbalization of painful feelings, as in acting-out, the therapist may be forced to set limits on self-destructive behavior rather than to interpret the resistance to talking, as in expressive treatment. This limit setting may involve hospitalization or insistence that the patient turn over illegal drugs to the therapist.

Working Through

Interpretations rarely result in "Aha!" responses and dramatic cures. Typically, they are warded off by the forces of resistance and require frequent repetition by the therapist in different contexts. This repetitive interpretation of transference and resistance until the insight has become fully integrated into the patient's conscious awareness is known as *working through*. Although the therapist's efforts are necessary, the patient does part of the work of accepting and integrating the therapist's insights between the actual therapy sessions (Karasu 1977). The triangle of insight (Menninger 1958) is a useful conceptual model for the process of working through (see Figure 4–2). Over the course of therapy, the therapist notes certain patterns 1) in the patient's outside relationships and then links them to 2) transference patterns and to 3) antecedent relationships with family members. Eventually, the patient makes these unconscious linkages conscious. These patterns can be tracked throughout the course of therapy as they relate to the three sides of the triangle, and they can be pointed out to the patient each time they appear. As the patient sees a pattern come up again and again in new contexts, it becomes less alien, and the patient gains greater mastery over it.

This same model can be restated in terms of object relations theory. Recurrent self–object–affect constellations appear in the transference, in current extratransference relationships, and in memories of past relationships. In self psychological terms, the pattern may be the expectation of mirroring or the need to idealize others. Regardless of which theoretical model is employed, however, all schools of thought view the re-experiencing of these central relationship patterns in the transference as critically important to a positive outcome. This working-through process is applied almost exclusively to treatments with a significant expressive component—it is rarely used to characterize primarily supportive processes.

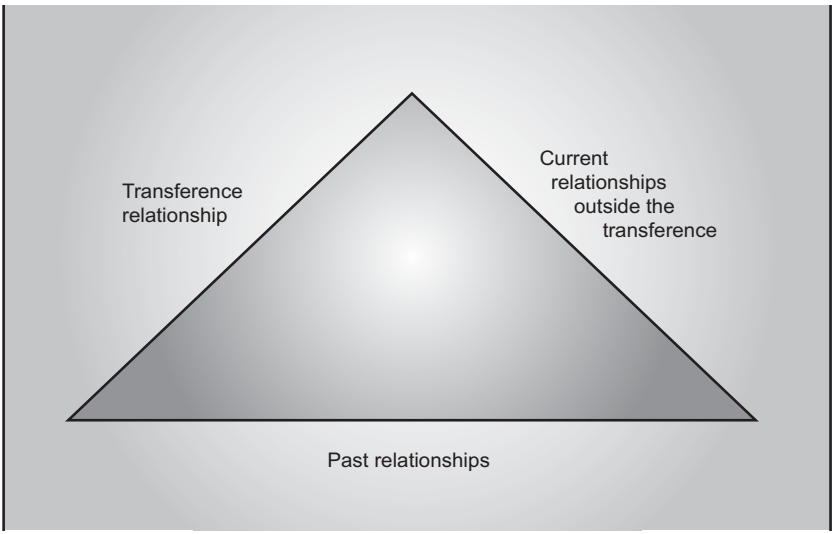

FIGURE 4–2. Triangle of insight (modeled after Menninger 1958).

Use of Dreams

In psychoanalysis and highly expressive forms of therapy, the interpretation of dreams is valued as "the royal road" to an understanding of the unconscious (Freud 1900/1953, p. 608). The patient's associations to the dream elements are used to understand the latent or hidden content of the dream that lies behind the manifest or overt content. The symbols of the dream can then be interpreted to help the patient further understand the unconscious issues in the dream. (See Gabbard 2010 for a more systematic account of working with dreams.)

In psychotherapies on the supportive end of the continuum, the therapist listens carefully to the patient's dream and thinks about it in the same way as would an expressive therapist. However, the therapist limits interpretive efforts to upward interpretations (Werman 1984, p. 83) that help the patient associate the dream with conscious feelings and attitudes toward the therapist as a real person and to other reality situations in waking life. Free association to the dream is not encouraged because it might lead to further regression.

In between the supportive and expressive ends of the continuum, there is room for selective dream interpretation in which the therapist relates the dream to conscious or unconscious issues in a limited sector of the patient's psychological life. The focus is more on the psychological surface than on the depths of the unconscious and is geared to the specific goals of the psychotherapy (Werman 1978).

Therapeutic Alliance

Freud (1913/1958) was aware that patients are unlikely to be able to use interpretive understanding unless a proper rapport has first been established. This relatively nonconflictual and rational rapport that the patient has with the analyst was termed the *working alliance* by Greenson (1965/1978). It involves the patient's capacity to collaborate productively with the therapist because the therapist is perceived as a helping professional with good intentions. A patient's relationship with his or her parents tends to predict the nature of the working alliance with the therapist (Lawson and Brossart 2003).

Major research efforts on the therapeutic alliance have confirmed its influence on the process and outcome of psychotherapy (Frieswyk et al. 1986; Hartley and Strupp 1983; Horvath and Symonds 1991; Horwitz 1974; Horwitz et al. 1996; Lawson and Brossart 2003; Luborsky et al. 1980; Martin et al. 2000; Marziali et al. 1981). Much of this research points to the strength of the therapeutic alliance as a dominant factor in the outcome of a broad range of therapies (Bordin 1979; Hartley and Strupp 1983; Horvath and Symonds 1991; Lawson and Brossart 2003; Luborsky et al. 1980; Martin et al. 2000).

A recent meta-analysis involving 200 research reports and more than 14,000 treatments (Flückiger et al. 2012) found that there is a robust correlation between the therapeutic alliance and positive outcome. The link is present regardless of whether or not disorder-specific manuals are used and regardless of the type of psychotherapy or the specificity of outcomes.

One application of this extensive research is that in all psychotherapies, regardless of their point on the expressive-supportive continuum, therapists must attend early on to the establishment and maintenance of the therapeutic alliance. This focus does not require the formation of a positive transference that will not allow the expression of negative feelings. Rather, therapists must help their patients identify their treatment goals and then must ally themselves with the healthy aspects of their patients' egos that are striving to reach those goals. Patients are then more likely to experience their therapists as collaborators who are working *with* them rather than *against* them. When working more supportively with patients with fragile egos, therapists find that the alliance is more difficult to develop and maintain (Horwitz et al. 1996). The borderline patient's chaotic transference reactions, for example, interfere with the formation of an alliance, and it is a major therapeutic accomplishment for the patient to eventually be able to perceive the therapist as a helpful person collaborating on common goals (Adler 1979).

Mechanisms of Change

The mechanism of change in the more expressive forms of psychotherapy depends in part on the goals of the treatment. Hence, views of change mecha-

nisms often vary according to these treatment goals. Insight and healing relational experiences, once thought to be mutually exclusive, are now regarded as compatible processes that work synergistically for therapeutic change (Cooper 1992; Gabbard 2010; Jacobs 1990; Pine 1998; Pulver 1992). In other words, a therapeutic relationship probably will not be sustained unless there is insight into what is going on in the relationship. Conversely, the relationship itself may provide an interpretive understanding of the patient's dynamics.

There is also greater acknowledgment of multiple modes of therapeutic action that vary according to the patient. Blatt (1992, 2004) identified two types of patients who change in different ways. *Introjective* patients are ideational and preoccupied with establishing and maintaining a viable self-concept rather than with establishing intimacy in the interpersonal realm. They appear to be more responsive to insight through interpretive interventions. On the other hand, *anaclitic* patients are more concerned with issues of relatedness than self-development and gain greater therapeutic value from the quality of the therapeutic relationship than from interpretation.

Patients change in a variety of ways using different therapeutic mechanisms. Recent developments in cognitive neuroscience help us articulate how change occurs and what therapists may do to facilitate change (Gabbard and Westen 2003). Links between associational networks are modified as a result of therapy so that a representation of an authority figure, for example, may not trigger the same emotional reaction after therapy as it did before. Moreover, new associative linkages are strengthened that were previously weak. In short, lasting change requires a relative deactivation of problematic links in activated networks associated with an increased activation of new, more adaptive connections. These alterations in associational networks may be facilitated by several techniques. The therapist may point out distinctions between different ways that patients reflect on themselves, conscious attitudes toward themselves, and how they tolerate feelings and become aware of them. Therapists may also address the frequency or intensity of conscious emotional states and help patients examine their conscious coping styles (Gabbard 2010; Gabbard and Westen 2003).

In addition, through interpretation, therapists provide insight into a wide array of mental events that are interconnected: fears, fantasies, wishes, expectations, defenses, conflicts, transferences, and relational patterns. Therapists may, for example, point out how a current problem with a supervisor is related to problems with a parent in the past. Such insight may also serve to modify connections among the nodes of a neural network.

In addition to interpretation, therapists provide observation from an outside perspective. They point out how certain habitual patterns of the patient reflect emotional conflict and turmoil within. This function of the psychotherapist is much like viewing oneself on videotape and learning how one

comes across to others. No matter how intelligent or insightful a patient may be, therapists always have an outside perspective—one that is different from the patient's (Gabbard 1997). However, for effective working through of the patient's issues, therapists must also validate the patient's subjective internal experience with empathy and understanding (Gabbard 2010). Hence, the optimal position of the therapist is to oscillate between observing from a third-person perspective and emphatically validating a figure who is attuned to the first-person perspective. Fonagy (1999) stressed that a crucial avenue for therapeutic change may lie in the patient's increasing capacity to "find himself" in the therapist's mind. By commenting on feelings and nonverbal communications that are seen only by the therapist, the patient may begin to assemble a portrait of himself based on the therapist's observations. Implicit patterns thus become more available for conscious reflection.

In a review of the comparative psychotherapy process literature, Blagys and Hilsenroth (2000) identified seven techniques that distinguish psychodynamic forms of therapy from cognitive-behavioral therapy. These features are summarized in Table 4–1.

Diener et al. (2007) conducted a meta-analysis on how the therapist facilitates the patient's emotional experience, a central thrust of dynamic therapy, as reflected in Table 4–1. They found that there is a statistically significant relationship between therapist facilitation of patient emotional experience or expression and positive outcome when more than one type of outcome construct is included. They noted several specific techniques that appear to be helpful in this regard, including making specific references to emotional indicators in the patient, increasing the patient's awareness of feelings that he or she may be avoiding, and focusing specifically on shifts in the patient's mood: muscle tension, tears, or other reflections of emotional states. These investigators noted that observing the affective states must precede any effort to interpret any meaning.

Another major mode of therapeutic action comes from elements of the therapeutic relationship itself that do not involve specific insight and understanding. Patients experience a new kind of relationship that may lead to internalization of the therapist's emotional attitudes and identification with the therapist's way of approaching problems. In addition, the therapist may be internalized as an internal presence that is soothing and comforting to the patient. The therapist's function as someone who contains and processes meaningful interactions is also internalized as a result of therapy.

In addition to techniques that are aimed at fostering insight and those that derive from the therapeutic relationship, there are secondary strategies that may be useful in bringing about change. These include the implicit or explicit use of suggestion, the confrontation of dysfunctional beliefs, the examination of a patient's problem-solving methods, forms of self-disclosure that help the

TABLE 4–1. Distinctive features of technique in psychodynamic psychotherapy

Focus on affect and expression of emotion
Exploration of attempts to avoid aspects of experience
Identification of recurring themes and patterns
Discussion of past experience
Focus on interpersonal relations
Focus on therapeutic relationship
Exploration of wishes, dreams, and fantasies

Source. Blagys and Hilsenroth (2000)

patient understand the impact that he or she has on others, and affirmation or validation of the patient's experience (Gabbard and Westen 2003).

In Wallerstein's (1986) analysis of data from The Menninger Foundation Psychotherapy Research Project, he found that changes produced by predominantly supportive measures involved a variety of mechanisms. The transference cure connected with the unanalyzed positive dependent transference has already been mentioned. One variant is the "therapeutic lifer" who loses the gains if termination is attempted but who can be sustained at a high level of functioning as long as contact with the therapist continues indefinitely. Many patients are able to reduce the contacts to once a month or less but are prone to decompensate if there is any talk of termination. Another supportive mechanism of cure is "transfer of the transference," in which the positive dependency in the therapeutic relationship is transferred to another person, usually a spouse. Yet another mechanism is termed "the antitransference cure" and involves change through defiance and acting-out against the therapist. Still other patients in Wallerstein's sample changed via a narrowly defined variant of the corrective emotional experience in which the patient's transference behavior was met by the therapist with steady, nonjudgmental concern. Finally, some patients appear to benefit from a supportive treatment geared to giving direct, nonjudgmental advice. Wallerstein termed this process "reality testing and re-education."

The interactions between therapist and patient in all therapies are accompanied by nonconscious affective and interactive connections that have been referred to by Lyons-Ruth et al. (1998) as *implicit relational knowing*. This knowing may occur in moments of meeting between therapist and patient that are not symbolically represented or dynamically unconscious in the ordinary sense. In other words, some changes in treatment occur in the realm of procedural knowledge involving how to act, feel, and think in a particular relational context.

Specific moments of mutual recognition—a look, a shared bit of humor, a feeling of intense involvement—may be remembered long after specific in-

terpretations are forgotten. Psychotherapy can be viewed as a new attachment relationship that restructures attachment-related implicit memory. Stored prototypes are modified by new interactions with an affectively engaged therapist (Amini et al. 1996). At the same time, explicit memory involving a conscious narrative is altered by interpretive understanding.

Another implication of this model of therapeutic action is that the expressive-supportive continuum of interventions depicted in Figure 4–1 does not account for all therapeutic change. Many moments of meeting between therapist and patient occur outside the realm of "technique" (Stern et al. 1998). Spontaneous human responses by the therapist may have a powerful therapeutic impact.

Recent research indicates that another reflection of change involves a modest improvement in defenses over long-term psychodynamic psychotherapy (Perry and Bond 2012). In a naturalistic study of 21 patients with severe depression and/or personality disorders who had been treated for a median of 228 weeks, the investigators found that improvement in defenses during the first 2.5 years was associated with significant improvement in external measures of symptoms and life functioning 5 years later. In other words, the patients relied less on primitive defenses and more on the defenses that are considered more mature, demonstrating that even relatively modest improvement in defenses can be associated with substantial improvement in real life.

Termination

Psychotherapists must resign themselves to living a professional life of continued loss. Patients come into their lives, share their most intimate thoughts and feelings, and then may never be heard from again. Because loss is an unpleasant experience for all of us, the ending of a psychotherapy process brings with it the vulnerability to transference and countertransference acting-out. Although an orderly, mutually agreed upon termination is the ideal, half or more of outpatients discontinue treatment prematurely (Baekeland and Lundwall 1975), and less than 20% of patients in community mental health center populations undergo a mutually negotiated termination process (Beck et al. 1987).

Termination may occur for a variety of reasons. It may be forced by external circumstances in the life of the therapist or the patient. Insurance companies or managed care firms may dictate the ending. The patient's own financial resources may be exhausted. The patient may abruptly leave and refuse to return because of dissatisfaction with the therapist or anxiety over highly charged subject matter. The therapist may feel that maximum benefit has been reached and recommend termination, or the therapist and the patient may mutually agree upon a termination date.

Indications for termination are not absolute, but a good rule of thumb is that the patient is ready to stop when the goals of psychotherapy are reached and/or the patient is able to internalize the psychotherapeutic process without the presence of the therapist. Presenting symptoms may have been eliminated or improved, the superego may have been modified, the patient's interpersonal relationships may have changed, and the patient may feel a new sense of independence. In cases of predominantly supportive psychotherapy, indications include a stability in the patient's functioning, a reversal of any regressive processes, and an overall quiescence of symptoms. Clinicians must always recognize, however, that a certain subset of highly disturbed patients may require ongoing, infrequent therapy indefinitely (Gabbard and Wilkinson 1994; Wallerstein 1986).

Once the therapist and patient have mutually agreed upon a date for termination, a number of transference manifestations may emerge. Some of the original symptoms may reappear (Dewald 1971; Roth 1987). Negative transference may surface for the first time when the patient realizes that the therapist will not be there forever. Therapists may need to assist their patients in mourning the fantasy of ultimate gratification in the transference. In supportive treatments, the therapist must stress continuing positive rapport and avoid the mobilization of unmanageable negative transferences (Dewald 1971). Because of the formidable challenges faced by the therapist during the termination process, many therapists prefer to continue the same frequency of sessions right up to the end. Others "wean" the patient by gradually decreasing the frequency of sessions.

When a patient terminates therapy unilaterally, therapists must deal with the feeling that they have somehow failed the patient. In such situations, therapists might remind themselves that the patient always has the privilege of ending the treatment and that such terminations may ultimately result in good outcomes. On the other hand, therapists can only help those patients who wish to be helped and who wish to collaborate in a process. Each therapist will have failures, and the limits of the craft must be recognized and accepted.

In instances in which the termination is the therapist's unilateral decision, a different set of problems arises. When the termination is forced because of training requirements to rotate to a new clinical assignment, the therapist-in-training may wish to avoid discussing the termination process because of guilt feelings. Some therapists will even avoid letting their patients know of their departure until the last minute. In general, whenever external constraints are placed on the duration of the process, patients should be informed as early as possible so that their reactions can be accommodated as part of the treatment. When a therapist must leave the treatment for external reasons, patients often feel that the arbitrary nature of certain parental

relationships has been re-created (Dewald 1971). Whatever the impact may be on the patient, the essential point is that the patient's reactions must be thoroughly explored even though the therapist may find it disconcerting to hear about the patient's anger and resentment. (For a fuller discussion of the complexities surrounding termination, see Gabbard 2010.)

Indications for Expressive or Supportive Emphasis in Psychotherapy

Before considering the indications for weighting a psychotherapy process toward the expressive or supportive end of the continuum, therapists must understand that predicting who will respond to what form of psychotherapy is an uncertain business at best. There is some indication in the literature that healthier patients tend to do better in psychotherapy than more severely ill patients (i.e., the rich get richer [Luborsky et al. 1980]). A study of who will benefit from psychotherapy (Luborsky et al. 1988) concluded that both a positive relationship at the outset and a congruence between the core conflictual relationship theme and the content of interpretations were predictors of good outcome. The strength of the therapeutic alliance in the first session or two may be the best predictor of eventual outcome, according to empirical research on the subject (Horvath and Symonds 1991; Martin et al. 2000; Morgan et al. 1982). However, this variable is greatly affected by the nature of the patient–therapist match, which is almost impossible to quantify.

Several patient characteristics can help clinicians decide whether a predominantly expressive or predominantly supportive focus is indicated (Table 4–2). Indications for a highly expressive modality, such as psychoanalysis, include 1) a strong motivation to understand oneself, 2) suffering that interferes with life to such an extent that it becomes an incentive for the patient to endure the rigors of treatment, 3) the ability not only to regress and give up control of feelings and thoughts but also to quickly regain control and reflect on that regression (regression in the service of the ego) (Greenson 1967), 4) tolerance for frustration, 5) a capacity for insight or psychological mindedness, 6) intact reality testing, 7) meaningful and enduring object relations, 8) reasonably good impulse control, and 9) ability to sustain a job (Bachrach and Leaff 1978). The ability to think in terms of metaphor and analogy, where one set of circumstances can be grasped as parallel to another, also augurs well for expressive treatment. Finally, reflective responses to trial interpretations during the evaluation period may suggest a suitability for expressive therapy.

Two general indications for supportive psychotherapy are chronic ego weaknesses or defects and regression in a healthy person who is undergoing a severe life crisis. The former might include problems such as impaired reality testing, poor impulse control, and poor anxiety tolerance. Brain-based

TABLE 4–2. Indications for expressive or supportive emphasis in psychotherapy

Expressive	Supportive
Strong motivation to understand	Significant ego defects of a chronic nature
Significant suffering	Severe life crisis
Ability to regress in the service of the ego	Low anxiety tolerance
Tolerance for frustration	Poor frustration tolerance
Capacity for insight (psychological mindedness)	Lack of psychological mindedness
Intact reality testing	Poor reality testing
Meaningful object relations	Severely impaired object relations
Good impulse control	Poor impulse control
Ability to sustain a job	Low intelligence
Capacity to think in terms of analogy and metaphor	Little capacity for self-observation
Reflective responses to trial interpretations	Organically based cognitive dysfunction
	Tenuous ability to form a therapeutic alliance

cognitive dysfunction and lack of psychological mindedness are other indications for weighting the psychotherapy in a supportive direction. Patients with severe personality disorders who are prone to a great deal of acting out may also require supportive measures (Adler 1979; Luborsky 1984). Other patients who frequently do better with a predominantly supportive approach are those with seriously impaired object relations and a tenuous ability to form a therapeutic alliance. Individuals who are in the midst of a serious life crisis, such as divorce or death of a spouse or child, or who are affected by a catastrophe such as a flood or tornado, are rarely suitable for expressive or exploratory approaches because their ego may be overwhelmed by the recent trauma. After beginning a supportive process, however, these patients will sometimes shift in an expressive direction.

Although these indications are focused on the two ends of the expressive-supportive continuum, most patients will present with a mixture of indications, some pointing in the expressive direction and others pointing toward the supportive end. The therapist must continually assess how—and when—to be supportive or expressive as the process proceeds. Moreover, in a naturalistic prospective longitudinal study (Scheidt et al. 2003), investigators

found that in the private practice of psychodynamic psychotherapy, psychiatric diagnosis and symptom severity contribute little to the decision to accept a patient for treatment. The therapist's emotional response to the patient and the patient's motivation were the strongest determinants of which patients received dynamic therapy.

Brief Psychotherapy

In the past 20 years, there has been a burgeoning interest and literature on forms of brief psychotherapy derived from psychoanalytic principles. Methodologically sophisticated comparisons with other treatment modalities have demonstrated that brief dynamic psychotherapy is just as helpful as other psychotherapies (Crits-Christoph 1992). A number of superb texts outline detailed guidelines for clinicians (Book 1998; Budman 1981; Davanloo 1980; Dewan et al. 2004; Garfield 1998; Gustafson 1986; Horowitz et al. 1984a; Malan 1976, 1980; Mann 1973; Sifneos 1972). Also available are several comprehensive review articles that compare and contrast the approaches and attempt to integrate them (Gustafson 1984; MacKenzie 1988; Ursano and Hales 1986; Winston and Muran 1996). Despite the variations and approaches, there are striking areas of consensus regarding the practice of brief psychotherapy. This brief discussion emphasizes those points of agreement.

Indications and Contraindications

In many ways, the indications for brief dynamic psychotherapy of an expressive nature parallel those associated with long-term expressive psychotherapy. Important selection criteria include 1) the capacity for insight or psychological mindedness, 2) high levels of ego functioning, 3) strong motivation to understand oneself beyond mere symptom relief, 4) the capacity to form in-depth relationships (particularly an initial alliance with the therapist), and 5) the ability to tolerate anxiety. An additional point is central to selecting patients for brief psychotherapy—namely, the issue of focus. By virtue of its brevity, time-limited psychotherapy must be focal in nature, in contrast to the pervasive breadth of psychoanalysis and highly expressive open-ended psychotherapy. Therefore, to proceed with brief therapy, the therapist and patient must identify the dynamic focus for the problem within the first or second evaluation session. Finally, brief therapy may be particularly helpful for relatively healthy individuals going through a developmental transition, such as moving from home, changing jobs, or having a first child.

Contraindications include the same factors that contraindicate long-term psychotherapy of an expressive nature, but they also encompass other