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Why Dynamic Psychotherapy?

PSYCHIATRIST: We are here to understand your unconscious.

MASON: My unconscious is none of my business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEFINING DYNAMIC PSYCHOTHERAPY

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

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

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

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

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

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

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

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

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

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

TABLE 1.1. Essential Features of Psychodynamic Psychotherapy in Current Practice

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

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

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

THE VALUE OF DYNAMIC PSYCHOTHERAPY

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

Empirical Database

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

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

A Deeper Dive: Psychodynamic Therapy Outcome Studies

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

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

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

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

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

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

Depth

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

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

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

Psychodynamic Narrative Is Woven into Culture

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

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

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

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

Therapy for Therapists

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

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

THE CHANGING FACE OF PSYCHODYNAMIC PSYCHOTHERAPY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A PRAGMATIC PSYCHODYNAMIC PSYCHOTHERAPY

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

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

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

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

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

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

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