CHAPTER 2

Identifying Problems

As discussed briefly in Chapter 1, the identification of specific problems is a key therapeutic task of problem-focused psychodynamic psychotherapy (PrFPP; Busch, 2022). A set of core problems are identified early in the treatment, but others may emerge subsequently. Patients will report some problems as active sources of distress, whereas others are out of awareness or operate reflexively, taking more time to be recognized. Other problems come to light after barriers that obscure or hide them, such as shame, denial, or other defenses, are addressed. This chapter describes how the therapist goes about identifying the specific nature of the patient's problems, including the thoughts, feelings, and circumstances that accompany them, as well as how the therapist can address barriers that interfere with that identification. The chapter concludes with information on how to develop a problem list that can be used to maintain focus as the treatment proceeds with identifying relevant psychodynamic contributors and interventions.

DEVELOPING SELF-REFLECTIVE SKILLS

The initial efforts in PrFPP not only designate problems that become the focus of treatment, but also engage patients in the process of stepping back and exploring their difficulties, developing self-observational skills (described in greater depth in Chapter 3). As therapists ask guiding questions to identify the details, triggers, and contexts of problems, this exploratory process helps patients improve their capacity to attend to their own thoughts, feelings, and motivations. Patients can therefore begin to recognize that certain emotions, thoughts, behaviors, and situations contribute to their problems. This approach also helps patients see problems as distinct rather than as an inherent part of

themselves or caused by others, thereby framing them as something that potentially can be relieved. In addition, patients gain a better sense of control by recognizing that problems have specific contributors that can be addressed. The guiding questions described throughout this chapter encourage patients to think about situations, thoughts, and emotions that trigger or exacerbate problems. As is demonstrated in these cases, individual problems have unique features, triggers, and histories for patients that provide information that will be used to address and relieve them.

In the initial session or two, you want to give the patient a clear view of how you envision the therapy progressing. The educational handout provided at the end of this chapter (Handout 2.1, p. 42) can be given to patients to provide an overview of the treatment. (For your convenience, a downloadable version of this handout is available online at *www.guilford.com/busch-forms*.)

TYPES OF PROBLEMS

For the purposes of the PrFPP approach, problems are divided into symptoms, behavioral difficulties, personality issues, and relationship struggles. Each of these categories is used in elaborating a problem list but should not be seen as starkly discrete, as problem areas can overlap. Unassertiveness, for example, can be experienced in the form of symptoms, behavioral problems, or relationship difficulties. It is not essential, however, to clearly categorize a problem. The therapist and patient will define the language and components of problems in terms that are comprehensible for the patient. In some circumstances, a shorthand term can be useful in alluding to specific problems, such as "your depression," "your intense self-criticism," "your conflicts with your spouse," or "your difficulty controlling your temper."

The initial question set that follows here elicits information about the primary problem or problems patients are struggling with. As we move through the chapter, other guiding question sets are presented that are used to screen for the various categories of problems described above. Later, still other guiding questions are presented that seek to address problems that patients may hesitate to discuss because of guilt or shame, as well as other issues that they do not recognize as problems. You can use the questions as a guide for your clinical interview, or you can give patients the worksheet, saying, "Before our next session, I'd like you to try completing this worksheet. It asks you to describe the problems you have, including the history of them and the triggers that contribute to them."

Identifying the Patient's Presenting Problems

The guiding questions asked by the therapist in the case that follows here (of Mr. F) represent an initial step in obtaining information about the patient's problems, including associated thoughts and feelings, history, severity, and triggers.

For convenience, these questions are organized into Worksheet 2.1: Initial Identification of Problems (pp. 43–44; see *www.guilford.com/busch-forms*). As with all the guiding questions presented in the book, those that follow are offered as a guide for your work in session with the patient. But they are not intended as a rigid script to follow, as you may need to modify or adjust them based on the responses of the patient.

CASE EXAMPLE: MR. F'S COMPULSIVE BEHAVIOR

Mr. F, a 37-year-old White personal accountant, presented with feelings of intolerable pressure and anxiety at his job, which required him to work long hours and disrupted his relationship with his family. It emerged that he could readily reduce his workload by turning down new cases, but he felt compelled to accept each new referral. The work stress was so severe that he would be distracted during phone or zoom meetings with clients by unrelated paperwork that needed to be completed and would sometimes lose track of what they were saying. At first, he denied that this distraction and divided attention were an issue, but he soon acknowledged that he was worried about making an error or being "caught" by a client because he was focusing on something else. A key question that emerged in his treatment was why the patient put himself under this enormous pressure.

THERAPIST: How would you describe the main concerns or problems that brought you in for therapy?

MR. F: I guess I'd call my problem **overwork**. I get very stressed and **anxious** about completing what I need to do each day. I'm terrified my clients are going to get angry that I haven't finished their taxes. And then I run into **problems with my wife**. She's furious that I don't get home sooner and help more with the kids. I mean I'm the one earning the money, and I feel she should have a little more respect for what I'm doing.

THERAPIST: How severe are these problems? How much are they disrupting your life?

MR. F: They're definitely causing a lot of disruptions. I'm anxious much of the time, and the fights with my wife are a big source of tension.

THERAPIST: Do you believe there are triggers of these problems? If so, what might they be?

MR. F: I'm not sure. I've always felt pressure to work hard. Going way back to when I was in school. Somehow, I've always felt like I'm not accomplishing enough. Maybe because my father put a lot of pressure on me? I don't know. And my overwork then seems to set off all the other problems.

THERAPIST: What was going on in your life when you started having these problems? What were the various stresses in your life at that time? Are they still present?

MR. F: It worsened about 10 years ago, when I started my practice, and we also had our first child. I guess I felt more pressure when we had our third child a year ago. My

wife feels I should contribute more to child care, even though I do more than a lot of fathers I know. Also, I have some **financial pressure**. We bought a new house when we had our third child and maybe we bit off a bit more than we can chew. I certainly think about that when I consider turning down a client.

THERAPIST: Do you notice anything that happens or any thoughts or feelings you have just before your symptoms or problems get worse or return?

MR. F: I know when I think to myself you shouldn't take on another case, I start to feel lazy, and I feel anxious about not being busy enough or making enough money. Then if I do take the case, I feel anxious about that! Like, how am I going to get all this work done?

THERAPIST: Are there any other problems you've been having?

MR. F: I have the worries about money and the conflicts with my wife. I've also had a bit of a flirtation at the office. I feel guilty about it sometimes, but other times I feel I deserve more positive attention because I get so much trouble from my wife. It's pretty exciting. I mean nothing's happened yet, but we've talked about how we feel about each other. Oh, and my wife thinks I **drink too much**, but I don't think that's an issue for me.

Symptoms

When identifying symptoms, the therapist explores their severity and pervasiveness, circumstances in which they emerge, feelings and thoughts that accompany them, their history, and potential triggers. The following sections present guiding questions for evaluation of anxiety, depression, and somatic symptoms. (For your convenience, these sets of questions are also available in a variety of worksheets that you can download and use at *www.guilford.com/busch-forms*.) These guiding questions are not intended to be full evaluations of these various symptoms and disorders and are not meant to replace more complete clinical evaluation and systematic assessment tools. Their intent is to demonstrate how to define problems in PrFPP and begin to become aware of their triggers and contributors to them.

Initial Evaluation of Anxiety

The discussion that follows in the case of Ms. G uses the guiding questions in Worksheet 2.2: Initial Evaluation of Anxiety (pp. 45–46).

CASE EXAMPLE: MS. G'S ANXIETY

Ms. G was a 24-year-old White single woman paralegal presenting for treatment of anxiety. She initially described her primary problem as social anxiety. However, it emerged that she experienced anxiety in a much broader range of situations.

THERAPIST: Have you been experiencing anxiety?

MS. G: Yes, I would definitely say anxiety is my main problem.

THERAPIST: How severe has it been?

MS. G: Pretty severe. Sometimes I even avoid going to a social event because of the worry it's causing me.

THERAPIST: How frequently do you experience anxiety? Do you feel it much of the time or only occasionally?

MS. G: I guess all told I'm anxious pretty frequently. In addition to social anxiety, I worry about my health and about being alone at night. It starts to add up.

THERAPIST: What kinds of circumstances trigger your anxiety?

MS. G: I'm anxious to some degree in all social situations but much worse at a group activity. I get worried even when I think about going to a party. I try to figure out who will be there and how they might react to me. I might be preoccupied with it for a whole day before I go. But it can happen in almost any situation where I'm in front of a group. Let's say I have to give a speech. I get embarrassed and feel I'll be judged. I worry about saying something stupid and that others will criticize me.

THERAPIST: What kinds of thoughts accompany your anxiety? Can you describe them?

MS. G: I start thinking about whether this person is judging me. Did I just say something dumb? Or perhaps I said something insulting. I get so anxious that sometimes it's hard for me to talk at all. Then I feel worse. Like now they'll really judge me for not having anything to say. I can also become very anxious about having a disease. Sort of like a hypochondriac. I get a cough and worry it's cancer. And I get scared when I'm in my house alone at night that someone's going to break in and attack me, even though I live in a really safe neighborhood and I've never heard of this happening to anyone.

THERAPIST: When did your anxiety start? What was going on in your life at that time?

MS. G: I've felt anxious for a long time, at least since adolescence. Maybe that's when I was getting more social. Also, that's when my parents started arguing more.

THERAPIST: Do you have panic attacks (episodes of severe anxiety accompanied by symptoms such as chest pain, shortness of breath, palpitations, catastrophic feelings of doom)? Do you notice any particular circumstances or thoughts and feelings that trigger your panic episodes?

MS. G: Yes. Sometimes I get panicky when I'm in a really scary social situation. My heart starts beating really rapidly, and I feel a bit shaky One time, after I had a fight with my boyfriend, I had chest pain and thought I might be having a heart attack. But I was able to calm myself down by telling myself it was just anxiety.

Subsequently, the therapist explored the arguing between Ms. G's parents and the fight with her boyfriend as triggers of her fears. In addition, the therapist addressed her expectations of negative judgments by others in social situations.

Initial Evaluation of Depression

The discussion that follows in the case of Mr. H uses the guiding questions in Worksheet 2.3: Initial Evaluation of Depression (pp. 47–48).

CASE EXAMPLE: MR. H'S DEPRESSION

Mr. H was a 28-year-old gay White male graduate student who struggled with depressive symptoms for 6 months, after a breakup with his boyfriend.

THERAPIST: Have you felt down or depressed?

MR. H: I've felt down for about 6 months.

THERAPIST: How intense has your depression been?

MR. H: It's been pretty bad at times. Sometimes I just can't get any work done. I just lie in bed for hours. But I've never been suicidal or anything like that.

THERAPIST: Can you describe your symptoms?

MR. H: In addition to feeling down, my energy has been kind of low and I have trouble concentrating. I feel like my life is messed up and feel lonely.

THERAPIST: Have you noticed any triggers of your symptoms?

MR. H: One of them is pretty obvious. I broke up with my boyfriend about 6 months ago. That's when it started. And I guess my symptoms get worse when I'm alone. When I get together with friends, that can help.

THERAPIST: What kinds of thoughts and feelings do you have when you're down?

MR. H: I feel lonely. And I feel like a bad person. Like there's something wrong with me. Maybe I do something to drive people away.

THERAPIST: Do you get self-critical?

MR. H: I get really mad at myself for not getting things done. I feel I should be able to overcome my depression. And I think there's something wrong with me, like I have a mental illness. For example, I'm not really sure why I broke up with my boyfriend, who was actually a pretty good partner.

THERAPIST: Are there any other issues you believe are contributing to your depression?

MR. H: My family is in another country, so I feel kind of cut off from them. And we don't

get along that well. They didn't handle my coming out too well. I don't get much support from them. Also, I'm not 100% sure what to do after graduate school. It's hard finding a job here. I need to consider going back to the country I'm from, but I'm not very excited about that prospect.

The therapist followed up by saying, "It sounds like there are several stresses that contributed to your depression that are important to explore. We also need to address your intense self-criticism, even about being depressed!"

Initial Evaluation of Somatic Symptoms

It is common for patients with psychological problems to experience bodily symptoms and have varying degrees of concern about them. *The discussion that follows in the case of Ms. I uses the guiding questions in Worksheet 2.4: Initial Evaluation of Somatic Symptoms* (pp. 49–50) *to elaborate the content of her somatic symptoms along with associated triggers, thoughts, and emotions.*

CASE EXAMPLE: MS. I'S SOMATIC SYMPTOMS

Ms. I was a 36-year-old Black administrative assistant presenting with worries about her health and her body that were preoccupying her and causing her significant distress.

THERAPIST: Do you have any concerns or worries about your body? If so, can you describe them?

MS. I: Yes, I definitely have that. For example, recently I've had bad headaches and I'm worried it might be a brain tumor.

THERAPIST: How long have you had these worries?

MS. I: For several weeks. But I've had worries about my health in the past.

THERAPIST: What was going on in your life when these worries started? Any particular stresses?

MS. I: Nothing that had anything to do with my headache. But I did have a terrible fight with my friend around the time it started. I found out she went out with another friend of ours that she's not even close to and she didn't even invite me!

THERAPIST: Have these stresses caused you significant distress?

MS. I: Yes, I'm thinking about it a lot! I'm so furious with her, and I can't believe she did that. I feel I'm on the bottom of everyone's list in terms of priority. But I'm afraid to talk to her because I'm so mad I'm worried what I might say to her. And then at the same time, I've been worrying about this headache.

THERAPIST: Have you had fears like this before? Were any stresses associated with those fears?

MS. I: I have. I mean every now and then I developed a fear that something was wrong with my health. I don't recall if I was stressed at the time. I mean I've had a lot of problems socially. I grew up in a small town, and I was very popular, but I've had a lot of problems with friends here. Nobody really sticks together, and a lot of times I get left out. And sometimes I feel I'm excluded because I'm Black. But I wouldn't do that to anyone else. I always try to include everyone.

THERAPIST: Have you been to the doctor about this problem or other concerns about your health? What have the doctors said?

MS. I: I haven't gone to them about this problem. But I've been to them before about my health worries. So far, they never found anything. One or two have said it was psychological. That's why I'm here seeing you!

The therapist commented that it felt important to talk about her feelings of being excluded by others, as those experiences appeared to be contributing to her anxiety.

Behavioral Problems

Although behavioral problems can come in many forms, two primary categories are areas of inhibition and areas of poor impulse control. Both benefit from identifying the behavioral problems and associated feelings, thoughts, and circumstances. In general, efforts to change behavior have been considered disruptive of psychodynamic psychotherapy, whereas in PrFPP, behavior is a target of treatment.

Initial Evaluation of Behavior Problems

For many patients, inhibitions arise and become problematic when they interfere with their life activities, whether occupational or social. In addition, inhibitions create difficulties when they prevent addressing issues in relationships. For example, Mr. A was inhibited about talking to his husband about their problems due to fears of creating tensions between them. Impulse control problems, on the other hand (see Ms. J), occur when individuals have difficulty managing behaviors that create difficulties for them, such as their temper, sexual impulses, drug use, eating, or shopping. Clinical examples of inhibitions and impulse control problems are presented throughout this book.

Refer to the guiding questions in Worksheet 2.5: Initial Evaluation of Inhibited Behaviors (pp. 51–52) *and Worksheet 2.6: Initial Evaluation of Behaviors That Are Difficult to Control* (pp. 53–54). *The discussion that follows in the case of Ms. J uses the guiding questions in Worksheet 2.6.*

CASE EXAMPLE: MS. J'S ANGRY SHOPPING

Ms. J, a 40-year-old saleswoman and mother of two, complained of significant anger at her husband. He had lost his job, and she felt he was making inadequate efforts to find a new one. She considered him a "downer," moping around the house while refusing to get help. In the initial evaluation, problems emerged with impulse control involving her shopping behavior.

THERAPIST: Do you have trouble controlling certain behaviors or impulses? Sexual wishes? Temper? Alcohol or drugs? Shopping?

MS. J: I do have problems with shopping. I mean I really love to shop. But my husband gets very angry with me and tells me I spend too much. Especially when the credit card bill comes in. But then I get furious with him for trying to stop me.

THERAPIST: Do you notice any triggers for this behavior?

MS. J: I tend to buy things when I'm mad. For example, when I'm mad at my husband. I'm so upset with how negative he is. I want to get some enjoyment. Or when I'm frustrated with work. I'm not treated very well by the guys there, and I don't think anybody credits me for what I do. I'll leave work at the end of the day and head straight to the store.

THERAPIST: When did these problems start? Were there any particular stresses in your life at that time?

MS. J: I've always had some trouble with shopping. But it got much worse 5 years ago, when my husband lost his job. And, you know, he's not really making any efforts to find a new one. I get so annoyed about it. And he wants to tell me what to do about the money?

THERAPIST: Do you feel guilty about these behaviors?

MS. J: Sometimes I do and sometimes I don't. I have the right to buy things because I make most of the money in the house. But then when he brings me the credit card bills and shows me what I've spent I have a wave of guilt.

THERAPIST: What are the consequences of these behaviors?

MS. J: As I've mentioned before, I get huge credit card bills, and my husband gets very upset. Sometimes I return things but then I just do it again.

THERAPIST: Have you tried to get control over these behaviors?

MS. J: Oh, definitely. After he shows me the credit cards, I promise him and myself that I'm going to cut back or stop buying expensive things. But then something frustrating happens, and sure enough I'm online or go into a store. I don't even think about the promise I made.

Personality Problems

Personality difficulties are a source of persistent problems for many individuals. Personality issues are typically not recognized by patients, as the attitudes and behaviors stemming from them are experienced as part of who they are. Patients may make such comments as "Others are always taking advantage of me," "Other people don't follow rules like I do," "I can't manage my life without others' support," or "I just don't get recognized for my skills." Additionally, patients can feel injured or threatened by designating a problem as part of their personality. Therefore, with personality issues, the therapist should work to identify the specific characteristics as part of the problem list in ways that are acceptable and comprehensible for patients. For example, problems with assertiveness, difficulties controlling impulses, and being avoidant of others are ways of describing personality factors that help patients acknowledge them. It can be difficult to directly obtain information about personality issues, as patients are unable to recognize them directly. However, the therapist should be alert to the emergence of these factors in the context of people describing their problems.

Personality issues span a range of problems and functional difficulties for patients. Personality disorders can be grouped into clusters that share common features (American Psychiatric Association, 2022). Cluster C disorders are characterized by anxious and fearful thoughts, feelings, and behavior. Avoidant personality disorder, for example, is characterized by social anxiety, fears of rejection, and feelings of inadequacy that lead to avoidance of a variety of situations, including social interactions.

Initial Evaluation of Avoidant Personality

What follows here is a continuation of the case of Ms. G. *The guiding questions the therapist uses in this discussion are also available in the online Worksheet 2.7: Initial Evaluation of Avoidant Tendencies* (p. 55).

CASE EXAMPLE: MS. G'S AVOIDANT PERSONALITY

Avoidant personality problems emerged in the context of exploring Ms. G's difficulties. It is common for avoidant tendencies to accompany anxiety disorders.

THERAPIST: Does your anxiety lead you to avoid certain situations?

MS. G: I have a lot of trouble asserting myself with people. I'm kind of a people pleaser. I'm very frightened of confrontation, so I avoid that entirely.

THERAPIST: How long have you had these avoidance problems?

MS. G: This goes way back to childhood. I've always been on the wary side and hesitant to confront people about problems. Otherwise, I'm worried they'll get angry at me.

THERAPIST: Are you aware of triggers of this avoidance or of situations that make it worse?

MS. G: It definitely gets worse with authority figures and people who are demanding. That's where it really gets scary. They're a bit like my father. He was a real "my way or the highway" kind of guy. But really, any social or work situation can be scary.

THERAPIST: What kinds of thoughts precede or accompany your fears and avoidance?

MS. G: I'm worried that other people aren't going to like me and that they're going to reject me if I raise any concerns. Even if I get frustrated about something, I'm frightened that if I bring it up, the other person will get really mad. For instance, my friend picks where we'll go for dinner, and if I want to go to a different place, I won't say anything. I worry she'll get furious, and we'll just end up doing what she wants anyway.

Evaluation of Narcissistic Personality Problems

Another cluster of personality disorders, Cluster B, involves dramatic or emotional behavior that can appear unpredictable. Within that cluster, narcissistic personality issues represent a particularly sensitive area for patients, as they likely do not recognize these traits as problematic and tend to view pointing out these characteristics as attacks and can be dismissive or angry in response. Although criteria for these disorders often emphasize feelings of superiority or entitlement, such individuals may be more willing to consider that they have a sensitivity to rejection or feel underrecognized by others, triggering anger, anxiety, and depression. If patients acknowledge these concerns, other narcissistic issues may be identified as reactions to these vulnerabilities. Thus, the therapist can suggest that a patient's sense of certainty or pressure to be "special" can represent an attempt to compensate for negative self-perceptions and fears of being undermined by others.

The following case of Mr. K uses the guiding questions based on the initial Worksheet 2.1 (pp. 43–44) *to identify narcissistic issues.*

CASE EXAMPLE: MR. K AND PATHOLOGICAL NARCISSISM

Mr. K was a 52-year-old Asian highly successful lawyer who presented with depressive symptoms after feeling frustrated and disappointed with his new job. He had presumed he would be a star employee there and instead struggled and felt unrecognized.

THERAPIST: How would you describe the main concerns or problems that brought you in for therapy?

MR. K: I left my law firm job and moved to a tech start-up that focused on legal services.

But from the start there, I wasn't recognized for my skill set or given a proper role in the company. I tried to return to my old firm, but they weren't interested anymore. I was shocked! I was a major rainmaker there!

THERAPIST: How severe are these problems? How much are they disrupting your life?

MR. K: I've had a very difficult time. I feel down and angry most of the time since I've been treated so badly.

THERAPIST: Do you believe there are triggers of these problems? If so, what might they be?

MR. K: Yes, whenever I have to deal with the idiots at my current firm. They put me in a new work group, and they don't really know what they're doing. And the firm isn't doing well because they didn't listen to me. When I think about looking for another job, I'm worried no one will be interested in me because now I'll be seen as a loser.

THERAPIST: What was going on in your life when you started having these problems? What were the various stresses in your life at that time? Are they still present?

MR. K: I've been frustrated since I've been at this new firm. It's been a year now. I'm working with a bunch of idiots who don't know what they're doing. But I've been really down since my old firm rejected me. I just don't get that attitude after all that I accomplished for them.

THERAPIST: Do you notice anything that happens or any thoughts or feelings you have just before the onset of your symptoms or a worsening of your problems?

MR. K: Mostly, I'm furious when I'm being mistreated. I can't believe these jerks don't recognize what I can accomplish for them. But sometimes I feel bad, like a loser. Or at least that's what I think new companies are going to think of me. I'm so worried about it that I haven't even applied for a new job. So, I'm kind of getting depressed.

THERAPIST: Are there any other problems you've been having?

MR. K: These work problems have really affected my relationship with my girlfriend. I lose my temper with her. And she's not really helping me deal with the stress. It sounds like you are feeling deeply hurt and angry about your skills not being recognized and this is triggering your depression. We'll explore what other factors in your life might contribute to these intense feeling to help you better manage them.

Relationship Problems

As noted, interpersonal problems have not been a focus of most psychodynamic psychotherapies. However, in problem-focused treatment, relationships are a central concern of the therapy and are addressed alongside other problems of the patient. Interpersonal problems can arise from many factors, including an inhibition about addressing problems with the other person, a sense of dependency on the other person, fears of disrupting the

relationship, expressing aggression through rebellion or bullying, a lack of empathy for the other person's problems, and chronic conflicts that arise from a tendency to dramatize relationships or engage in sadomasochistic struggles.

Initial Evaluation of Relationship Problems

The dialogue that follows here revisits the case of Mr. F regarding his mention of relationship issues with his wife. It uses the guiding questions in Worksheet 2.8: Initial Evaluation of Relationship Problems (p. 56).

CASE EXAMPLE: MR. F'S RELATIONSHIP STRUGGLES

THERAPIST: What are the current problems you are struggling with in your relationships?

MR. F: The biggest problem is with my wife. She is constantly criticizing me about my working late and not doing enough with the kids. In actuality, I do a lot more than most fathers we know do. But somehow, it's not enough. But then she gets mad because we don't have more money. I get into big fights with her because I feel it's a no-win situation, and she doesn't seem to get it.

THERAPIST: Do you notice any triggers of these problems?

MR. F: The worst one is when I get home from work late. I try to get everything done and get home by 6, but a lot of times I end up staying late to complete everything. By the time I get home, she's in a big rage. Also, when she wants to buy something new for the house. I think she actually has kind of a shopping problem. Our financial problem really isn't that bad, but she's always wanting something new. This adds to the pressure.

THERAPIST: How long have you had these problems?

MR. F: We've always had some tension, but things got much worse with the new baby. Both the pressure I felt to work late and the amount of work at home shot up! I think that having a third kid was likely a mistake. Actually, I didn't really want another kid, but she insisted on it.

THERAPIST: How often do these problems occur?

MR. F: I guess it happens increasingly frequently. We fight a lot of the time. It's more like when *doesn't* it happen. There are stretches on weekends when I'm not busy where we can get along, and then we actually do great. But then, let's say on a Saturday afternoon, I say I have to work for an hour or so, she goes right back to being enraged. I just go work anyway. And that's when I might text with Sarah [the administrator with whom he has a flirtation] because I get so frustrated with my wife. At least that's fun and exciting. Or I may have a couple drinks.

Barriers to Recognizing Problems

Patients often have an inability or aversion to acknowledging or clarifying problems. Understanding these interfering factors is important for identifying both problems and associated intense negative feelings. Some of the more prevalent obstacles are denial, shame and guilt, and intrapsychic conflicts and defenses. Denial and shame often obscure substance use and other impulse-control problems. As noted above, patients with personality disorders often see these traits as part of themselves rather than as problems. Regarding interpersonal issues, patients often do not acknowledge their own contribution to difficulties, tending to blame the other person. Therapists help patients to both recognize their own contributions to problems and communicate more directly with others about problems.

Although it can take time for problems patients are embarrassed about to emerge in treatment, a simple query can sometimes help get a preliminary sense of some of these issues. Mr. F, for example, responded to his therapist by raising his conflicted feelings about the woman Sarah with whom he was having a flirtation.

THERAPIST: Are there problems or experiences that you're embarrassed to talk about?

MR. F: I don't really want to talk about my flirtation with Sarah. I mean nothing's happened, and I don't think I need to talk a lot about it. On the other hand, as I've been under more pressure and fighting with my wife, my urge to cross the line has increased. I know Susan isn't the type to put up with an affair. If she found out about it, things would probably be over between us.

Guilt, Shame, and Other Painful Feelings

The therapist should be alert and proceed tactfully with areas of difficulty that appear to make patients uncomfortable, as this can be an indicator of shame or guilt. A statement that many patients present with issues that are hard to talk about but are important to address can be helpful, along with a comment that the therapist will not be judgmental. Another way to get a sense of areas of shame is to ask patients directly about issues that trigger shame or guilt. Despite feeling embarrassed, some patients respond openly in the context of a general assessment, as they wish to talk about these painful issues. For example, the therapist picked up on Mr. H's distress as he talked about his family's reaction to his coming out, enabling him to describe some topics that were shameful to him.

THERAPIST: You seemed upset when you mentioned your family's reaction to your being gay. Can you say more about that?

MR. H: I still have some painful feelings about when I came out. It seemed to create a lot

of trouble in my family. I feel they're still not fully accepting of me. Also, I had an incident in which I was molested when I was 15. I don't know how important it is, but I'm still not that comfortable talking about it. Maybe after we talk about some other things? But I do still feel ashamed about it and I still kind of blame myself.

The therapist responded by saying that he understood these experiences were very upsetting and felt they were important to talk more about when Mr. H felt more comfortable.

Another way that guilt or shame emerge is when therapists ask patients for more details about their problems, an often crucial means of better defining problems and their contributors. Patients may become hesitant to describe such details because they trigger painful feelings. Therapists can explain that understanding more details about these problems will help in gaining a better sense of how to relieve them. Therapists may sometimes note the patient's discomfort, as in, "You seem to be having a hard time providing me with more details. Are the questions bringing up some uncomfortable feelings?" Consider this dialogue, in which Ms. G, who struggled with anxiety and avoidant personality disorder, was discussing aspects of her social anxiety:

THERAPIST: Can you say more about what you actually experienced with others at the party?

MS. G: I just don't feel comfortable. I feel awkward.

THERAPIST: What types of situations trouble you?

MS. G: I hate it when I'm alone, wandering around at a party, and I can't find anyone to talk to. Or if people are together in a group. I don't want to try to break in.

THERAPIST: What would be the problem?

MS. G: What if they don't want me to be with them? Then I'll feel rejected. Or what if someone is mean?

THERAPIST: That would be upsetting. It sounds like you most worry about people excluding or rejecting you.

MS. G: I guess so. I haven't really thought of it that way.

THERAPIST: One of the questions we want to understand is why you're so worried about rejection. At parties, sometimes people are nice and sometimes not, and no one likes being excluded, but why does it trouble you so much?

MS. G: I'm not sure. That's a good question. But this is why I want to know who's going to be at the party. Or if my friend is going, I'll feel protected.

THERAPIST: So, it sounds like a friend would provide some sense of safety. You've told me

that you have a number of friends and get along with others well. I think in general you overestimate the danger off rejection that you're in. And we want to understand why. Maybe something in your growing up.

MS. G: That's possible. I was attacked quite a bit by both my parents. I hadn't thought about that being connected.

This comment can now be followed up by exploring the patient's developmental history, as described in Chapter 3.

THERAPIST: Why don't you tell me something about those experiences?

Exploring Denial

Denial can function as a defense mechanism (see Chapter 5), a means of coping with internal states or external reality that feel intolerable or unacceptable. Although denial may be adaptive in certain circumstances when one is overwhelmed, persistent denial can lead to adverse outcomes with problems that must be addressed. For example, denial is common with substance misuse or abuse, as patients often deny or minimize their addictive behavior. Sometimes they will react quite negatively if the therapist presses them on these issues. So, while it is essential to inquire about possible addictive problems, the therapist should be sensitive in doing so. The therapist can also explore what makes the problem difficult to acknowledge.

CASE EXAMPLE: MR. F AND PROBLEM DRINKING

In the course of his evaluation of his overwork and anxiety, Mr. F revealed that he frequently drank alcohol on nights and weekends. He stated that this drinking helped him reduce work stress. He was cagey about the amount he drank. *The dialogue that follows here with Mr. F uses the guiding questions in Worksheet 2.9: Initial Evaluation of Addiction Problems* (pp. 57–58).

THERAPIST: Do you believe you have a drinking problem?

MR. F: I don't think I'm an alcoholic. I only end up having like three drinks a day. I know people who drink much more. And I can stop when I want. I've stopped for like a month a few weeks ago. But then I start again.

THERAPIST: Do you feel guilty about your drinking?

MR. F: I do feel guilty at times. I know I should stop entirely because it actually slows down my work, but I can't seem to do it. But I like getting the buzzed feeling. It gives me a big sense of relief from all the pressure, at least for a little while.

THERAPIST: Do you notice any triggers for your drinking?

MR. F: I feel so stressed out about work that I really need a few drinks in the evening when I get home to relax. And I'm still pretty anxious over the weekend, so I'll have a few drinks then, too.

THERAPIST: Have you tried to stop or cut back on your drinking? What happened with that?

MR. F: Yes, I did for about a month but then I got caught right back into the same pattern. I actually felt pretty good when I stopped. And guilty when I restarted. You'd think this would make it easier to try it again.

THERAPIST: What thoughts or feelings do you have about trying to cut back now?

MR. F: Well, I could say I'd be happy to try it but not right now because I have some get-togethers with friends coming up and we all drink together. I'm also worried that if I stop entirely, I'll get more anxious about work.

The Problem List

After identifying the patient's various problems, it is useful to construct a problem list. This list includes the problems the therapist and patient intend to target over the course of treatment. It can help maintain the focus in the treatment on the patient's problems, as is demonstrated throughout the course of this book. The list should not be rigidly adhered to, however, as new problems may emerge in the course of treatment that can be added to the list. The development of the list can enhance the therapeutic alliance, assuring that the problems the patient is concerned about are the focus of therapy. The problem list can also be used to assess the progress of treatment, in determining which problems are diminishing and which may be more persistent. In the latter case, a shift in strategy or therapeutic approach may be indicated. The therapist may create a mental list, share an actual list with the patient, or have patients develop their own list, which can be of value in maintaining focus and assessing progress on a given problem. For instance, the therapist created and presented the following problem list to Mr. F. He stated to him, "Here is my understanding of the problems we'll be working on together. Does this list make sense to you?"

1. Compulsive working
2. Generalized anxiety
3. Conflicts with your wife
4. Alcohol problems

Although he objected somewhat to his alcohol problems being noted, he did agree to consider that possibility and to leave it on the list.

RECOGNIZING THAT PROBLEMS HAVE MEANINGS AND FUNCTIONS

In the process of identifying problems, the PrFPP therapist communicates that they represent usually unconscious efforts to solve certain difficulties, which are often maladaptive. Defining problems and exploring the associated context and feelings provide information that is useful in understanding these meanings. For example, somatic symptoms are identified as an attempt to manage psychological and emotional states rather than as a bodily problem. Focus on the body can be a defense against painful conflicted feelings and fantasies, or it can symbolize an intrapsychic conflict, often involving dependency or aggression. For example, the therapist noted how Ms. I focused on her body when she had increased conflicts with her friends and that these symptoms seemed to be part of an effort to manage her very intense feelings of anger, hurt, and rejection. Her experience that her body was out of control (e.g., a brain tumor) could be linked to a fear that her emotions were out of control. The therapist indicates that understanding these meanings enables a means of addressing contributors to problems. Establishing that symptoms, behaviors, personality issues, and relationship difficulties have meanings and functions is a core part of PrFPP.

IDENTIFYING AND ADDRESSING THE IMPACT OF CULTURAL FACTORS

Recognizing and exploring the role of cultural factors is essential in the identification and treatment of problems. Patients' cultural backgrounds strongly influence both the nature and perception of their difficulties and which problems they feel safe or unsafe discussing. Additionally, some subcultures are more likely to experience certain forms of trauma, such as those that result from the impact of institutionalized racism and poverty. If such factors are not taken into account, it could interfere with the alliance with certain patients and their sense of safety in revealing problems. Examples that arose in the cases presented in this chapter included Ms. I, whose experiences of racism emerged as important contributors to her conflicted anger and anxiety. She recalled warnings from her mother to be deferential to White people, even if mistreated. In the case of Mr. H, the culture of the country he was from was very hostile toward homosexuality. In addition to his family, this attitude added to his internalized negative feelings about being gay.

RECOGNIZING RELEVANT DYNAMICS

Defining underlying dynamics that contribute to various problems is a key aspect of PrFPP. Preliminary dynamic information often emerges and can be identified when

creating a problem list. In an early session, for example, the therapist noted that Mr. A tended to take back angry comments or feel guilty after expressing anger. In the course of his treatment, the therapist identified how conflicts about angry feelings and fantasies contributed to various problems, including symptoms (anxiety/panic), behavioral problems (passive–aggressive behavior with his husband, as he was unable to express anger directly), personality difficulties (unassertiveness), and relationship issues (e.g., difficulty addressing his needs and frustrations with his husband). In addition, developmental contributors often begin to emerge, as with Ms. G's recognition that criticism from her family while growing up contributed to her fears.

A framework for identifying and addressing dynamics is described in Chapters 3 through 7, which focus on these topics.

QUESTIONS AND IDEAS TO THINK ABOUT

1. With a new patient or one you are currently working with, try identifying and dividing the patient's problems into a list, considering symptoms, personality issues, behavioral difficulties, and relationship problems. How does this affect your thinking and approach to the patient?
2. Once you have a problem list, explore what might contribute to exacerbation or relief of these problems. Do you notice any patterns or triggers? Does this information suggest any options for interventions that were not evident before?