

CHAPTER 1

Basic Goals and Vital Signs of Progress

Individuals come to psychotherapy with diverse needs and expectations. We try here to depict some general areas in which therapy can help patients to suffer less psychological pain and to improve their well-being and their relationships. We then identify some underlying capacities that make such improvements possible.

Overall Goals of Psychotherapy

Why do people seek psychotherapy? What do they hope to gain from it? In a recent study, Delboy and Michaels (2021) asked people what they wanted from therapy. Most people said that in addition to wanting to learn skills and coping strategies, they wanted to get to the root causes of their issues. The study concluded the following:

- Most people want to talk about their problems without risk of being judged.
- Most people want to feel understood by someone who cares about them.
- Most people want to make real changes in their lives.
- Most people understand that reliable change usually takes time.
- Most people are willing to invest time in psychotherapy because they believe making meaningful change is worth that investment.

In another empirical investigation, De Smet and colleagues (2020) attempted to understand how a good outcome would be experienced by patients after treatment. They found that patients not only noted improvement in symptoms but also reported that therapy helped them feel empowered, increased their self-confidence, improved their coping skills, helped them feel calmer, expanded their insight and self-understanding, and improved their interpersonal harmony.

Similarly, in a meta-analysis by Ladmanová and colleagues (2025), including 177 studies and more than 2,900 patients, the researchers found that after treatment there were nine clusters of psychotherapy benefits/outcomes that were ranked in descending order. While patients described symptom reduction as important, most benefits they experienced were not described as symptom reduction. Those included (1) improved self-awareness, self-understanding, and more adaptive cognitive processing; (2) increased self-acceptance, self-compassion, self-esteem, self-confidence, self-agency, and sense of personal growth; (3) improvements in empathy, communication skills, and sense of connection in relationships; (4) acquisition of new coping skills; (5) improved emotional regulation, resilience, and openness to emotional experiences; (6) better behavioral functioning; (7) decrease in psychological symptoms such as anxiety or depression; (8) enhanced sense of well-being; and (9) changes in perspective and reduction of needs to control. Patients thus certainly appreciate symptom reduction, but they also consider therapy more successful when their improvement includes more than that.

I (JFT) recall working with a young woman early in my career who was horribly anxious. Insecurity in friendships and romantic relationships, nail-biting, intense catastrophic thoughts and feelings, and all-or-nothing thinking were just some of her symptoms. After about 6 months of our working together, I was reflecting on her significant improvements. I thought our upcoming session would be a good time for me to introduce the idea that she may have achieved our treatment goals. Just a few minutes into that session, she said that there was something she had not shared with me (despite my inquiries early in our work) that she wanted to talk about—she had been sexually abused by an older cousin over the course of several years when she was a child. What she had not told me earlier was that she needed to know that, over time, I would prove trustworthy enough to listen to her most painful experiences. She wanted not only symptom abatement but also a dependable listener who could witness the outcomes of her victimization, in contrast to those who had ignored it when it was happening.

Some aspects of our patients' suffering go deeper, or are more shameful to them, than they can articulate in our initial interviews. This is true for those who literally cannot find the words to tell us their

experience, those who cannot bear the contempt they assume will be our response, and those who are highly articulate but still have trouble locating the central point that they want us to know. Individuals who have not attained a particular developmental milestone, such as the capacity to enjoy solitude, for example, cannot imagine what it would be like to reach it; patients who are trapped in either–or feelings cannot imagine living with normal ambivalence. But usually, they know that something is not working for them.

Psychological Vital Signs

Various systems, including our work settings and the insurance companies we contract with for payment, expect us to think in the language and logic of the DSM. The DSM's diagnostic system deliberately avoids inferring etiology, depicting not causes of psychological conditions but clusters of symptoms that tend to appear together. Each edition of the DSM has urged readers not to use it as a sufficient basis for treatment planning (see, e.g., DSM-5-TR, American Psychiatric Association, 2022, p. 21).

In this opening chapter, we discuss what we believe are the overall goals of therapy, the main destinations our practice aims to reach. We invite readers to reflect on the goals of their own treatment models and on how they may overlap with or diverge from our view. A few years ago, I (NMcW) published a book on psychoanalytic supervision (McWilliams, 2021) that included a chapter on “vital signs” of therapeutic progress. Interestingly, that chapter has received more positive comments from seasoned practitioners—and not just psychoanalytic practitioners—than any other part of the book. Clinicians seem hungry for articulations of the goals and change processes that both they and their patients most value. We review those vital signs in what follows in the hope that readers find them resonant and see in them a context for the rest of this book.

We suggest that these areas are useful not only for the purposes that were naturally in the foreground of the book on supervision—that is, for helping mentors help newer clinicians evaluate what is going well and not so well in a particular treatment—but also for orienting any therapist to assessing with patients what they most want and need from a treatment. These vital signs have considerable overlap with the “Profile of Mental Functioning” sections of the third edition of the *Psychodynamic Diagnostic Manual* (PDM-3; Lingardi & McWilliams, 2026), which is similarly oriented toward the needs of clinicians rather than those of the researchers for whom the DSM has been mainly oriented.

We think they offer some practical answers to the question of what eventual competencies clients are looking for and how therapists can help them mature psychologically in these areas. They constitute areas that we keep in mind as the therapy progresses; even when we do not focus on them explicitly in the treatment, we notice that they tend to improve over time as a developmental consequence of a safe, empathic relationship.

Relational Safety

A focus of psychoanalytic scholarship over the past 50 years or more involves security of attachment (Bowlby, 1988). There is now a huge evidentiary basis for this concept (see, e.g., Madigan et al., 2023; Park et al., 2023.), which in the analytic clinical literature has been called “basic trust” (Erikson, 1950) or “ontological security” (Laing, 1960/2010), and in the contemporary empirical analytic literature has been termed “epistemic trust” (Fonagy & Allison, 2014). It corresponds to the domain of basic security that cognitive-behavioral psychologists assume clients lack when they engage in pathological “safety behaviors” (Beck, 2021). We know that psychotherapy can increase attachment security (Mikulincer & Shaver, 2020).

Years ago, a woman came to my (JFT) office for an initial consultation. Although I was unable to speak with her by phone prior to our meeting, an email exchange suggested that she might suffer from panic attacks. When I introduced myself to her, I could see from her facial expression and tense posture that she was in a state of fear. She struggled to maintain eye contact, apologized for being early (which had not inconvenienced me), and seemed confused about where to sit even after I gestured toward the couch. It was apparent that she considered our meeting dangerous and was pushing herself through her fear to try to talk.

Another woman came some months later for a first consultation. She was focused, clear, engaged, even charming. She articulated her reasons for wanting to start therapy with ease and self-assurance. She seemed to fear nothing about our meeting and to enjoy our conversation. Curiously, both of these patients turned out to feel deeply unsafe, though the latter had developed ways of masking her fear. Both courses of therapy focused in part on the client’s insecurity.

Creating a sense of safety in the therapy relationship is a vital task of the early phase of psychotherapy. Research from attachment theory indicates that close, secure bonds with important others provides meaningful and lasting benefits (Wallin, 2007). Patients often report problems in their relationships that suggest they do not feel safe or secure.

For all of us, it is tempting to imagine that demonstrating to patients that they are safe will relieve their anxieties. But individuals enter the therapy relationship with an emotional template based on early experiences of how significant others have related to them. If they have come to the conclusion that people who love them do so intermittently, or only by hollow words, or in conjunction with hurting them deeply, then a few hours of empathy from a well-intentioned clinician will not suffice to create real security.

Those of us drawn to the mental health fields tend to have natural empathy. By the time we complete training, there is a good chance we have honed our inherent relational talent into a clinically useful style. Empathy is a good starting place for helping people who experience relationships as unsafe. It involves the capacity to set aside one's own experience temporarily (holding it within reach to reflect on at any time) in the service of understanding the experiences of others from a perspective as close as possible to theirs. It is this kind of attunement to another person's thoughts and feelings, consistently delivered over time, that sets the conditions necessary for felt safety. It is what we think of when we say we want to be seen or heard.

As powerful as the communication of empathy is, developing security in the therapy relationship may require more than this. One useful practice suggested by psychodynamic clinical experience is encouraging the patient to talk about feelings of being *unsafe*. Of course, the timing of this encouragement should not be forced into moments when the subject of safety is not in play. But when the clinician hears the client's experience of insecurity, it can be an opportunity to invite the person to say more about the sense of unsafety that the therapist is noticing. The patient may talk about experiences that created a basic distrust, and it may become clear not only that the client had no early experience with trustable others but also that any expression of childhood feelings of lack of safety would have fallen on deaf ears. Creating a moment to welcome the person's feelings of being *unsafe* in therapy may move the work forward. Once this can be talked about, the patient can begin to work through it.

Emotions that are tied to a general sense of unsafety in relationships may also be implicit. The father of my (JFT) former patient "David" was a military pilot. His job demanded that every few months he would be gone for a week or two without contact with his family. David dreaded these absences; as a young child he would cry when his father left; when he was older, he would act out in anger. His father's gruff, dismissive, abrupt way of responding only amplified David's intense feelings. It was no surprise that when my first vacation interrupted the treatment, David felt hurt and angry and then ashamed of these reactions. He oscillated

between these emotions while trying to shove them aside, fearing their expression would jeopardize our connection. It was only when I began to notice evidence of his feelings and invited him to speak about them that he began to tolerate his sadness, anger, and fear. As he became more comfortable with his emotions, his fear of my rejection diminished, and he began to handle his reactions playfully: He would tease me that I was abandoning him. He also began reporting that he felt less panicked when I was gone. He became able to talk with his wife about similar reactions when she had to be away for a few days for work. Although David was never rid of his feelings about separations, his talking about them prevented the arguments that he and his wife had previously tended to have, and the couple would remain warmly connected while she was away.

One of the more challenging aspects of developing safety in the therapy relationship is that the patient may need to express intense thoughts and feelings *toward* the therapist. From an analytic perspective, the clinician is inevitably the proxy (a “transference” figure—we consider later some implications of thinking in terms of transference) for other relationships in the patient’s life. In those relationships, clients are often unable, for a host of reasons, to say all of what is on their mind. Invitations to do so in therapy often elicit responses that feel pretty toxic to the clinician. With David, my being scolded by a grown man about my taking a needed vacation was not fun. While it was helpful to our work because we could explore what my vacation was triggering in him and where those feelings had originated, it was stressful. This kind of stress on the clinician is ubiquitous in psychodynamic treatments. It is one reason why personal therapy and ongoing supervision have been emphasized in that tradition.

Self-Continuity

The area of subjective continuity is somewhat more intangible, involving the sense that Winnicott (1960) called “going on being.” Other analytic writers have referred to the internal sense of continuity as “identity integration” (Erikson, 1950; Kernberg, 1972), “linking” (Bion, 1959), “self-constancy” (Jacobson, 1964), “self-cohesion” (Kohut, 1971), and “standing in the spaces” between different self-states (Bromberg, 1998). We tend to note the importance of this sense in its absence, identifying a deficit when patients seem to feel completely disconnected from the child they once were or from any image of a future self (temporal discontinuity), or from their own experience of a strikingly different state of mind (dissociation of cognition or affect), or from their body (physical dissociation).

One helpful way psychoanalysis has conceptualized the issue of continuity is through the lens of states of mind. We all understand that when we wake up groggy after an interrupted sleep, we are in a different state of mind than 30 minutes later, after some coffee. The state of mind we are in when we are sitting with a patient differs considerably from our experience when we are cheering for our team, reading bedtime stories to our children, or purchasing groceries. Many of us experience shifts in our states of mind as like the flow of a stream. Any given drop of water (thought, feeling, etc.) is indistinguishable from all the others that are flowing across the landscape. Moment to moment, we may notice only slight alterations in our mental states because we experience them as having continuity—one state of mind (thought, feeling, mood) leads to the next. We may take this continuity for granted and imagine that this is how all minds work. Yet not all minds are the same on this dimension.

Some people experience their minds as quite discontinuous (Chefet, 2015). In other words, their thoughts and feelings seem unconnected. In the middle of watching a comedy show, for example, they may suddenly feel dread or anguish. Not knowing how a comedy performance might be connected to their disturbing feelings makes them more uncomfortable with the workings of their mind. When reporting this experience to their therapist, they may describe themselves as crazy or irrational. They are only vaguely aware of the discontinuity of their states of mind but they do experience the discontinuity as psychological discomfort.

Recent analytic clinical writing has emphasized dissociation more than “repression” (the unconscious effort to keep out of awareness what one prefers not to know or remember), the concept that Freud preferred. This shift in emphasis may be partly due to changes in the kinds of clinical problems we see. Many contemporary patients feel little continuity in their sense of self: They lack the sense of going-on-being through time, or they completely lose any sense of good-enough-ness and feel entirely bad (or the reverse—they feel they are unambiguously right and see everyone else as blameworthy), or they treat their body like a foreign object that they can hit or cut up or burn or starve. Psychotherapy can help them feel more continuity: through time, between better and worse aspects of their personality, and between mind and body.

We find that it is rare that a client comes to us asking explicitly to have more continuity of experience—discontinuity for them may be like water to the fish. We do not typically have words for something we have never yet felt; such conditions are more like black holes in the person’s mental universe. Black holes do not emit or reflect visible light and are not visible by telescope (NASA, 2021). To view them, one must observe the effects they have on their nearby environment. Clinicians can often

infer that discontinuous experience is a major source of individuals' recurrent difficulties and can help them mend some of the splits from which they suffer. Once they can feel relative continuity and integration, they can describe their former feelings of fragmentation.

Sense of Agency

The vital sign of a sense of agency may similarly impress itself on a clinician's mind by its absence. One woman whom I (NMcW) asked why she had gone to bed with a guy she was not attracted to said, "Well, he wanted sex, and I thought that would be okay." She had no sense of having options or even personal desires. In the clinical literature, this capacity to feel some sense of choice has been called "individuation" (Jung, 1923), "autonomy" (Erikson, 1950; Mitchell, 2014), "effectance" (White, 1959), "internal locus of control" (Rotter, 1966), "self-efficacy" (Bandura, 1982), "agency" (Safran, 2016), and "self-agency" (Hagman, 2020). It is a goal of all types of psychotherapy to support and encourage a sense of agency in patients. Most of us learn, whatever our training, that telling people what to do, even if our advice is good, typically has unintended consequences, not the least of which is the fostering of excessive dependence.

Clients often seek psychotherapy because they feel "stuck." Something has gone wrong in their life that cannot be fixed by their current efforts. Often it is apparent that they have whatever skill is needed to solve the problems for which they seek help; they may use that skill in some settings and not others. For example, people who have recurrent difficulties around money with their partner sometimes feel no such difficulties with their coworkers when solving tough problems involving work expenditures. In such instances, teaching them relevant skills does not get to the heart of the problem. Somehow, they have lost touch with their sense of agency.

Internal conflicts are at the root of many dilemmas involving agency. For example, I (JFT) once worked with a heterosexual couple who had agreed that because the husband's job required significant financial aptitude, he would manage the money. Without discussing the details of the arrangement, the wife assumed that the husband would set aside sufficient funds for their retirement. The husband, however, felt insecure in their relationship (though not usually aware of that feeling). To soothe his insecurity, he would lavish gifts on his wife. He purchased trips, jewelry, concerts, bags, and other shiny things for her, no matter the cost, because he loved the surprise, joy, and gratitude she expressed upon receiving them. The wife assumed there was ample money to make these purchases *and* save for retirement.

The husband felt a growing internal conflict as he kept from his wife the fact that they had no savings. When she finally became aware of the monetary realities, she felt betrayed and was furious. She asked him why he had failed to tell her of their financial position and why he kept spending on her. Initially, he could not answer. But after some conversation in therapy, he realized that he believed at some level that he would lose her if he did not continue to impress her, a conviction created early in his life when he had concluded that he had to entertain his mother to keep her love. It was only after this belief became conscious in our conversations that the couple could change their behavior to reach their financial goals and also attend to their relational needs.

Some problems in agency derive from never having had one's autonomy supported. Children who are reared with a heavy emphasis on obedience and no parental pleasure in their capacity to make their own decisions often lack even a *concept* of personal agency. When a therapist asks them why they "chose" a particular course of study or job or friend or partner, they appear confused. One such patient whom I (NMcW) asked why she had married her husband replied, "I don't know. It just seemed the thing to do at the time, the thing that was expected."

In problems of agency caused by implicit conflicts, a patient's sense of self-efficacy can be supported through careful inquiry into what might be thwarting it. When trapped between competing needs, clients can find it difficult to know what to do. Clinicians can feel themselves stuck in parallel because they do not yet see all elements of the conflict. To support the patient's agency, it is helpful to explore all sides of an internal conflict (some conflicts have more than two sides). It is also helpful to observe rather than answer. When faced with a conflict for which they have no solution, patients often look to their therapist to weigh in on how to solve the problem. It can be tempting to offer an opinion. But psychodynamic experience suggests that it may be more useful to offer an observation of their wish to have the clinician solve their problem and then to explore the meanings, origins, and implications of that wish.

In problems of agency caused by the patient's lack of any internal sense of autonomy, often it is the therapist's behavior that models the capacity to find degrees of freedom in a situation. At the end of one long treatment, I (NMcW) asked my terminating patient what she looked back on as particularly helpful in our work. "The fact that when things went wrong, you just fixed them," she said. Confused by this response, I asked for clarification. "Well, when the light bulb went out, you just went somewhere, got another, and replaced it. When I said the air conditioning was too cold, you just came over and turned it down. In my family we would have just sat around and bemoaned the terrible state of light bulbs and air conditioners these days."

With this patient, who grew up without a concept of self-efficacy, it helped to raise, again and again, questions like, “What do you want to do about this?” or “What is your own preference?” or “What do *you* think about what she said?” or “When you found yourself doing that, was that the result of your deciding to do it, or was there some kind of passive inertia going on?” Instances when one suspects that the client disagrees with the therapist are particularly valuable for building agentic capacity because the disagreement can be invited into the open, and the patient can learn that the therapist reacts with respect and sometimes deference to the patient’s position. This *in vivo* support for the client’s nascent sense of agency can be deeply transformative. In an atmosphere of respect for their thoughts and feelings, patients who have never found any sense of internal locus of control will gradually develop it.

Realistic and Reliable Self-Esteem

The regulation of self-esteem is subtly and integrally woven into mental life. Clients frequently know that their self-esteem is problematic; they often explicitly tell therapists they would like to feel better about themselves (Mary, for example, in Chapter 6, framed her problem this way). Sometimes it is the therapist who discerns that the patient has a self-esteem problem when the person has made no complaint. Some individuals, for example, hold themselves to unreasonable standards or become devastated by any evidence of imperfection, and yet they have never considered that their criteria for evaluating themselves are problematic. Others, in contrast, feel entitled to constant admiration and go into rages when they are not treated as superior beings. In both instances, clinicians may see a problem that the patient has not explicitly formulated.

From caregivers, peers, and communities, we internalize standards that we either live up to adequately or fail to meet. I (NMcW) was recently contacted for therapy by a woman who was successfully leading a double life as both wife and lover of someone else’s husband. Her behavior was highly gratifying and apparently unsuspected by her spouse (in other words, she was getting away with cheating). Yet she complained that she felt “inauthentic, dishonest, and dirty.” She knew that to keep her self-respect, she would have to give up the lover. She was looking to therapy as a place to grieve a renunciation that she expected to be hard to bear. This is the kind of problem that is not captured easily in checklists of symptoms.

Self-esteem that can be considered “healthy” allows for ordinary confidence, pride in one’s achievements, and humility and self-compassion about one’s limitations. It needs to be *reliable* over the ordinary ups and

downs of life—that is, neither easily undone by criticism nor inflated by praise. Unreliable self-esteem leaves people vulnerable to many hazards, including substance use, relationship problems, impulsive action, and affect dysregulation. Self-esteem must also be *realistic*: A person's self-evaluation should reflect aspirations that are achievable. Because perfection is not attainable by human beings, someone who has to be “perfect” to feel okay has a problem. Contrastingly, when individuals feel entitled to a trophy for having done virtually nothing, we see this kind of self-esteem as unrealistic.

Problems in self-esteem can be traced to overly demanding standards of parents and other authorities, or to painful marginalization and bullying by peers, or to family neglect that lays the groundwork for a child's fantasies of ideal goodness, or to families and institutions that lavish praise on achievements that are quite ordinary. Individuals with self-esteem that is reliable and realistic can accept praise and gratitude that accurately validate their good behavior. They can apologize when they miss the mark and can ask for help when they need it without losing self-respect. They can tolerate reasonable criticism and learn from it without getting depressed or defensive, and they can talk levelheadedly about their strengths and weaknesses.

Our sense of self-worth is tied to our personal values (see McWilliams, 1999). Many therapists base their self-esteem on kindness to others. When they feel they have helped someone who suffers, they feel good about themselves. When they fail to do so, their self-esteem takes a hit. Because core values differ from person to person, the kinds of things that support a person's pride vary. Those whose self-esteem depends on being powerful may seek work that involves leadership or has a strong impact on others. For those whose values foreground relationship, self-esteem may come from making sacrifices for others. Those who have learned to prioritize being in control may seek self-esteem in order and precision. Because people are multifaceted, they may have multiple ways to find and retain self-esteem, some of which may occasionally be in conflict, as in the person who competes to be the “best” but also values supporting the ambitions of others.

Patients frequently mention a hope to improve their self-esteem because they have experienced challenges that have left them deeply self-critical. Those who have internalized unreasonable demands (for example, never to have a sexual thought or never to feel satisfaction in the misfortune of a disliked person) may need the therapist to challenge their basic assumptions. They may also be helped by identifying with a clinician who demonstrates reasonable and reliable self-esteem, as evidenced by behavior such as the therapist's apology for making a mistake if that apology conveys sincere regret without self-hatred.

Resiliency, Affect Tolerance, Affect Regulation

Although none of us escapes hardship, some of us are more resilient than others in the face of it. Being better able to endure hardship, to solve problems that are solvable, and to emerge from difficulties with minimal posttraumatic scars are capacities that individuals often hope to gain in therapy. Many people enter treatment having been battered by life for a long time. In response to stresses, we all develop coping skills, some of which are conscious and some of which are out of our awareness and function automatically. These strategies have both upsides and downsides. Consuming alcohol, for example, can reduce anxiety but often proves a costly way to deal with unwanted feelings.

Developing resiliency is ultimately tied to emotion. As we grow older, we need to learn to tolerate intense emotion as it occurs and to direct our attention to talking about it rather than acting it out. This capacity has been referred to as “ego strength” (Bellak & Hurvich, 1969; A. Freud, 1936), “affect regulation” (Tomkins, 1962, 1963), “emotional containment” (Bion, 1970), “affect tolerance” (Krystal, 1988), “emotion regulation” (Linehan, 1993), “affect modulation” (Jurist, 2018), and “use of mature defenses” (Kernberg, 2022). Individuals differ temperamentally on how easy or difficult they find such regulation. It is common for people to begin treatment by telling the therapist about strong, unpleasant feelings—often depressive or anxious emotions—that they want to get rid of. Psychodynamic clinicians tend to encourage patients to verbalize feelings and to explore the connections between emotions and memories, beliefs, or conclusions they have come to that affect their current lives.

The capacity to manage feelings starts in infancy. A primary task of parenting is to help children name their feelings, understand what they mean, and manage them, and also to teach them something about how their feelings may affect others. Over time, and with a lot of practice in the parent–child relationship, children develop stable and automatic ways of handling their emotions. The capacity to manage feelings can be taxed by the vicissitudes of life—problems at work, a failed marriage, financial issues, the loss of a parent, becoming seriously ill, and so on. Trauma may make some feelings particularly fraught.

Feelings fall on a continuum of intensity from overwhelming to seemingly absent. With clients who report an absence of feeling (“alexithymia” or “affective anhedonia”), a therapist might infer the person’s emotional state from non-verbal cues. Expression of feelings through words and behavior also falls on a continuum. Intensely felt emotions are often conveyed by bodily expressions such as blushing or tearing

up, tone and volume of voice, and physical movements. Expressing feelings in words can be difficult when they are particularly intense. In the middle of this continuum, people use words to depict their feelings. At its far end, words are unavailable. The therapist may notice nonverbal indications of a particular emotional state, but when asked, the patient reports no feelings at all.

Patients may feel pain at either end of the intensity and expression dimensions, though they may not recognize it. Most often, they feel it at the intense end of the spectrum, and they hope the therapist will know how to reduce it. When the intensity or expression is low, the patient may not identify the experience as painful, and yet it may be troubling in a vague way. Sometimes when clients seem in distress but cannot locate or articulate feelings, they are attempting to cope, implicitly or explicitly, with emotions they do not want to have. Or they may somehow sense that overregulation of affect interferes with or deadens relationships and reduces their capacity to make decisions. Some people with a tendency to overregulate report a sense of being lost or purposeless.

Some individuals with an obsessive personality style, for example, appear to be emotionless and robotic when relating to others. For them, most feelings, especially those that are associated with vulnerability, may be unwanted and even taboo. Yet they may come to therapy knowing that their attempts to find purely intellectual solutions to their distress are not working. They may understand that they need to address their feelings, but when feelings are taboo, there is no path to addressing them. Helping them identify this state of affairs may be a necessary precondition for helping them identify and express their emotional responses.

Underregulation of emotion, in contrast, can make individuals feel overwhelmed by affective states that have run amok or that are “too much.” One result of this problem can be, like overregulation of feelings, a loss of closeness with others. Intense feelings that are acted out can interrupt relationships, invade ordinary boundaries, and confuse partners, friends, or family. This can lead to simultaneous desires for closeness and distance that others experience as messages of “Come here; go away.”

To encourage patients toward affect regulation, psychoanalytic clinicians try to demonstrate affect tolerance and modulation in the therapeutic relationship. With time, this capacity, if exemplified consistently, can become internalized. A patient may encounter a previously stressful situation and think, “I wonder how my therapist might construe this.” This response is evidence that the therapeutic process has become a part of the client, who can now think through an emotionally intense dilemma independently.

To increase our understanding of what each feeling means to the patient, where feelings come from, how they may be connected to events in the person's history, and what impacts they have on relationships, psychodynamic clinicians tend to explore them rather than to move quickly to offering skills or direct management techniques such as breath control. This bias toward exploration is intended to encourage clients to observe their feelings and reflect on them. We hope that reflection will offer a deeper understanding of what their feelings mean. But this exploratory attitude is also a relational communication, a message that the therapist is with them in a shared emotional space and is willing to bear painful feelings with them.

Reflective Function and Capacity to Mentalize

Patients often seek psychotherapy because they want to understand themselves and others better (Ladmanová et al., 2025). Human beings are naturally curious about their motives, needs, feelings, and capacities. Even though insight is not always necessary to achieve positive change, self-knowledge has long been associated with mental health. More than 2,500 years ago, the oracle at Delphi counseled pilgrims to “Know thyself.” We human beings have been trying to understand our own complexities long before psychoanalysis, and we continue to do so. Improved insight is often a goal of therapy, irrespective of the theoretical preference of the clinician (Messer & McWilliams, 2006). The capacity for reflection on one's own and others' minds can be a profound help in getting through life. It is also true, however, that we can know quite a lot about ourselves and still struggle to make better choices. The capacity for insight is a necessary but not sufficient condition for change.

One example of limited insight with which most of us can identify involves falling in love. In states of infatuation, we suspend our usual thought process in favor of idealizing our love object. We see the lover's flaws as evidence of a unique preciousness, while the same flaw in someone else is just annoying. We ignore behavioral “red flags” that would cause us to run from others acting the same way. We go out of our way to do things for the beloved that we would not do for anyone else. If the relationship eventually goes horribly wrong, we come to appreciate that love is indeed blind. At that point, we may realize that we were being driven by internal forces that were invisible to us at the time we were making critical decisions.

Knowing oneself means coming to understand unconscious processes within us that operate in many scenarios, not just in the extreme instance of infatuation. Patients seek to learn about their dynamics and

how to cope with them when they become able to see the clues indicating that something is going on beneath the surface. Training programs in the psychoanalytic therapies tend to stress curiosity and the attitude of *not knowing* as central to the therapeutic project. Patients teach us about what they have been keeping out of awareness by their own discoveries of previously dissociated states of mind and also by enacting scenarios, inside and outside of therapy, of which they are not conscious. When these enactments come into the therapeutic relationship, we try to see our part in them and begin to put words to them so that we can discuss them with the patient, and repair any injuries they have involved.

Current psychoanalytic jargon for the domain of introspection is “reflective function” (Fonagy & Target, 1997). An appreciation of the importance of this capacity is evident in the origins of psychotherapy, often in the language of “insight” (A. Freud, 1981; Hartmann, 1958), the “search for meaning” (Frankl, 1959), or “self-reflexivity” (Aron, 2000). In the first half of the 20th century, psychiatrists took care to evaluate “insight into illness”; that is, whether a patient could see that a psychological problem was in fact a problem. Later, psychoanalytic clinicians learned to observe whether a symptom is “ego-alien” (something the person identifies as a problem) or “ego-syntonic” (something the person sees as normal or inevitable).

The prognosis for clients who have some capacity to name and think about a problem is better than for those who lack this ability. The man in a psychotic episode who fully believes in his delusions is harder to help than the man who wonders whether his ideas might be crazy. Individuals who harm themselves yet who cannot imagine behaving less self-destructively are harder to help than those who identify their behavior as problematically self-destructive. The woman who believes her compulsions are irrational will be much more quickly responsive to efforts to diminish her rituals than the woman who wholeheartedly believes that if she fails to perform them, all hell will break loose. Early in therapy, most clinicians encourage the patient to question an automatic reaction, behavior pattern, thought, or feeling.

The flip side of the capacity to reflect on the self is the ability to appreciate the separate subjectivities of others. In the contemporary psychoanalytic literature, this developmental achievement is termed “mentalization” (Fonagy & Target, 1997). Mentalization is a similar construct to the philosophical (Cartesian) concept of “theory of mind” and to the philosophical/theological concept of “I-thou” (as opposed to “I-it”) relationships (Buber, 1958). It is also comparable to the contemporary relational psychoanalytic concept of “recognition” (Benjamin, 2017). Individuals who lack the capacity for mentalization make errors

of attribution that Melanie Klein (1935) called “projection of intent”; that is, they assume that because another person has made them *feel* a certain way, that is how the person *intended* them to feel. For example, a young boy who is alarmed by his mother’s yelling at him to prevent his running into the street concludes that his mother is “mean” or that she likes to scare him, or, because he felt controlled, that she is determined to control him. It is a developmental achievement for him to realize that a communication that feels bad may be motivated by love.

Across our lives and without really being aware of it, all of us are attempting to build a model of how our own mind works and how the minds of others work. A patient used to tell me (JFT), for example, that she was “chill,” meaning that she experienced herself as unperturbed by everyday stresses. She repeated this often and seemed invested in thinking of herself this way. She did have an affable demeanor, and she imagined that if her life circumstances were stressful, her low-key attitude would protect her from the frustrations, anger, resentment, and hurt inherent in such situations. She could not see how such stresses might have been connected to her depression. She implicitly believed that her mind was protecting her from the impact of stress because she was “chill.” While her theory of how her mind was working was inaccurate (being “chill” was not protecting her from psychological pain), it was still a model she developed to try to understand herself. Part of helping people develop insight involves noticing that their views of how their minds work may contain inaccuracies. The exploration of those inaccuracies helps clients to reflect on the reasons they may like to see themselves in one way and not another.

The capacity to reflect on the self and to imagine other minds with separate motives is central to overall mental health. Its absence has been connected with psychopathologies in the borderline and psychotic areas. But even when capacities for reflection and mentalization are well developed, there may be occasions when one’s own perspective is too powerful to overcome. We can see this in couples who are arguing, when before one person has finished a sentence, the other is already forming a response. That partner’s view of what is happening has already been determined before the other can get out a whole sentence. In moments like this, self-examination is foreclosed. There are now whole therapies, some of them empirically supported, based on improving self-reflection and mentalization (Bateman & Fonagy, 2016).

Reflection that leads to insight about self and others takes time. It is hard to accomplish under pressure (and sometimes hard even in the absence of pressure). It can be complicated by patients’ self-concepts, self-esteem, social connections, history, and personality. But it is deeply valuable. Here is one example of the difference it made for a client. I

(JFT) once worked with a man whose parents believed that to get ahead in life one must be socially connected, preferably to powerful or wealthy people. Over and over, they told their son how gregarious and outgoing he was and how this would serve him well. He heard this so much that he thought it was an accurate description of himself. But, after describing the relentlessness of this message, he realized that he actually preferred to hang out with his wife at home rather than attend the social events that his parents thought were necessary for success. It was a relief when he concluded that he could do what he preferred rather than what his parents prescribed.

Capacity for Both Self-Definition and Relationship

Another area that has long been a focus of clinical theorizing and empirical study in the psychodynamic community involves the tension between acting on one's individual behalf and acting in accordance with the needs of others. We all feel some tension between individual and communal concerns, and we are perpetually navigating when to act independently of others and when to subordinate our desires to the needs of others. We want our overdependent patients to develop the capacity for self-definition and self-advocacy, and we want our relationally impaired clients to get better at acknowledging their normal dependency on others and to identify occasions when they should be subordinating their more selfish wishes to a greater familial or social purpose.

In the clinical and scholarly writing, this tension between self-definition and relationship has been construed in terms of introversion versus extroversion (Jung, 1923), isolation versus communion (Bakan, 1966), individualism versus collectivism (Hui & Triandis, 1986), independent versus interdependent self-construal (Markus & Kitayama, 1991), competition versus cooperation (Slavin & Kriegman, 1992), distance versus closeness (Luepnitz, 2002; Mitchell, 2003), power/achievement versus intimacy/love (McAdams, 2013), and self-definition versus self-in-relationship (Blatt, 2008). At the cultural level, it has been discussed in terms of more individualistic versus more collectivistic communities and societies (Hofstede, 1980; Sue, Sue, Neville, & Smith, 2022).

Both families and cultures vary on which end of the continuum from individualism to communalism they emphasize. Tribal, rural, religious, and Asian societies tend to encourage the sacrifice of individual wishes to collective needs, while urban, secular, and Western cultures tend to stress individual rights and desires. One of the ways that Western therapists (perhaps especially psychodynamic therapists, whose theories originated in an urban, secular, European environment) have often been guilty of insensitivity and even a kind of cultural colonization is their

tendency to privilege independence at the expense of communality. Historically, many North American clinicians have tended, for example, to interpret as pathology the behavior of people who live into adulthood with their family of origin, making an assumption that they have a problem with separation and individuation rather than that their cultural values are different.

All cultures, however, seem to recognize problems at the far ends of the individualism–collectivism continuum. Attributions of “codependency” or “dependent personality disorder” reflect our awareness that too much sacrifice of the self to the welfare of others is unhealthy. At the other end of the spectrum, we see psychopathic and antisocial behavior as pathologically oriented toward one’s own power at the expense of other people and the larger community. We know intuitively that excessive dependence creates strain on relationships and self-esteem, while excessive independence makes relationships difficult to sustain.

Because patients often come to us to address problems at one or the other end of this spectrum, clinicians of all orientations have ways of helping them develop more capacity on whichever side they are deficient: We help overly submissive individuals to find their own voice, whereas we encourage those who cannot tolerate their normal dependency on others to make their needs explicit without shame, to express gratitude for others’ care, and to apologize for their mistakes and for any negative effects they have on those who love them (McWilliams & Lependorf, 1990).

I (NMcW) have been thinking for many years about what constitutes overall mental and emotional wellness—beyond simply the reduction of measurable symptoms. When I began this mental project, I thought that psychological health probably equated with being in the middle of the independence–interdependence continuum. But Blatt’s (2008) research exposed something different: Individuals who tested as mentally healthy on a whole range of measures were not in the middle of the spectrum; instead, they were strong on both ends. They could stand alone and advocate for themselves when necessary, and they could surrender to the common good when personal sacrifice was called for. Patients rarely ask for help in being both autonomous and communitarian, but therapists can often see that they need to be encouraged to develop the orientation that they lack, and to become more comfortable in both.

Vitality

I (JFT) recall seeing a video of a mother and her infant boy. The child was sitting in his mother’s lap while she made popping sounds. Each time the pop would occur, he would laugh uproariously. His amusement

was deeply contagious, and his mother would burst out laughing as well. This process went on in a call-and-response pattern for several minutes. Both seemed alive, joyous, and full of vitality. By contrast, most of us eventually see a few clients who seem dead inside. They may describe themselves as numb, lacking energy, unable to enjoy life, or depressed. Sometimes locating their emotions can be difficult. Anhedonia has set in, and it is all they can do to get out of bed in the morning. Often, they experience themselves as fundamentally flawed and unable to find anything that gives their life purpose or meaning.

To fend off a sense of internal emptiness, people may use substances, injure themselves, binge on food or deprive themselves of it, seek out danger, engage in self-destructive activities, gamble, or seek excessive social media stimulation—anything to feel more alive. They seem to have a deficit in what Jaak Panksepp (Panksepp & Biven, 2012) called the “seeking system,” the motivational system in the brain that is mediated by dopamine and can be hijacked by substance use (and can be painfully depleted during recovery from addictive behavior). Because it is so painful, lack of vitality is a state that human beings do not tolerate well; it may impel us toward therapy with the hope of feeling alive again.

Individuals suffering a terrible internal emptiness rarely say that they are coming to therapy because they lack vitality. Instead, they may make comments like, “Life sucks and then you die” or “Sometimes I feel numb and just don’t want to keep going through the motions” or “I need to find some purpose in life” or “Life feels like it’s gone from color to black and white” or “My wife says I don’t have any interests anymore.” Therapists often detect that a person is deficient in vitality because when sitting with the patient, they too feel stuck, slowed down, bored, or lacking imagination. When I (NMcW) find myself with a client who feels internally empty, I try to identify *anything* about which the person talks with some animation. It may be music or a sports team or a hobby or video gaming, but some spark of life in any area feels like a relief to both of us. I then try to help the client expand the enthusiasm into other activities.

Perhaps especially if they are not part of a spiritual tradition or religious community in which questions about meaning and purpose are a central preoccupation, individuals who feel internally dead need an opportunity to explore what the meaning of life is to them, what they feel their purpose is, and what gives them gratification that goes deeper than momentary diversion. Such patients sometimes know how to feel hyped up and excited, but they lack any pleasure in calmer serenity and find ordinary life boring. They often look to psychotherapy as a place to explore how to enjoy ordinary pleasures.

Acceptance

Psychotherapy is not limited to changing maladaptive behavior or reducing painful symptoms. People seek a therapeutic relationship to go through a process of coming to accept things that cannot be changed. The personalities of our caregivers and partners are rarely transformable; they are who they are. Part of growing up involves giving up the nearly universal fantasy of somehow changing others, especially parents, in dramatic ways. Events of the past cannot be undone or their consequences completely controverted. A disease process, a tragic past, a physical disability, poverty and malnutrition in childhood, or having suffered trauma can have profound impacts on one's life. Any clinician who has heard a story of sexual assault against a patient during childhood can attest to the ways it shaped their subsequent thoughts and feelings, decision making, sexuality, and relationships.

We often notice the ways patients try to protect themselves from unwanted feelings connected to aversive events and painful intrusive memories of what has befallen them. Patients infer from events in their histories, often in a narrative that may function to protect them from future suffering. Accepting what is unchangeable frequently includes an exploration of how we have derived meaning from those parts of our lives. In many instances, seeing what is unchangeable with fresh eyes can help patients begin to develop a new perspective on their circumstances. The mourning process requires a witness to one's grief. As we go through this painful experience, we find ways to come to terms with the vicissitudes of life: a difficult divorce, the death of a parent, a lost homeland, a lost job, a crushed dream, the move away from people one loves, for example. Mourning is an emotionally titrated, natural process of accepting what is initially experienced as unbearable.

Capacities for forgiveness and gratitude emerge from the process of mourning, as the person moves toward acceptance. There are an infinite number of circumstances, both internal and external, that influence capacities for forgiveness and gratitude. I (JFT) once worked with a woman whose husband developed a serious health anxiety about a year into their marriage. He was so overwhelmed with dread that he was sick with cancer, despite there being no disease process detectable by multiple specialists, that he lost his job and became nearly unable to function. Fed up with him, my prospective client demanded he go to therapy. Thankfully, over time, he was able to work through his fears. She started therapy with me several years after her husband's anxiety receded because she could not overcome her own anxiety that at any time he might lapse back into dysfunction. During his problematic period, she had propped up their finances by working two jobs, and she still did the majority of

parenting for their children. Her resentment intruded into their everyday lives as her difficulty in forgiving him and being grateful for the real changes he had made overwhelmed her. The loss of the hoped-for marriage was painful, and it was difficult for her to accept the real marriage with all its flaws.

We all need to know that our life counts for something to ourselves and others. We want relationships that have depth, meaning, and intimacy. We want to take pride in our work. We need a relational milieu in which we feel understood, where our efforts to find meaning are supported. The role of the clinician does not end with empathy or validation but also includes knowing patients well enough to discuss the sensitive, difficult, or painful subjects that they may hesitate to explore. Non-shaming acceptance of their real inner experience is a part of the power of psychotherapy. Improvement in these vital signs culminates in the capacities to love, work, and play that mentally healthy people exemplify.

Integrative Approaches in Contemporary Psychotherapy

Many of the descriptions above apply best to changes that evolve in long-term or open-ended psychotherapies. But attention to them can be critical in clinical settings in which therapists are under pressure to resolve specific issues as quickly as possible. Under these circumstances, the integration of focused approaches with a psychodynamic sensibility is, among many practitioners, considered the treatment of choice. The following case comes, with the patient's permission, from a therapist who works in a setting that emphasizes integrative treatment. Readers can infer from this terse and timely summary how the therapist of an anguished father is paying attention not only to reducing anxiety but also to increasing the client's relational safety, self-continuity, sense of agency, realistic self-esteem, reflective function, and acceptance of what cannot be changed.

Client is a retired married father of one, exceptionally high-functioning, has a doctorate, esteemed academic—held previous jobs in presidential administration. Presenting problems: 1) extreme anxiety about Nov 2024 presidential election and fears of persecution if Trump were to win; 2) worry about adult middle-aged son that he still supports financially, despite son being very bright and capable (and avoidance of difficult conversations related to this). Due to presenting problems around anxiety, worry, and avoidance, CBT seemed to be a good starting point. Introduced thought records and challenged maladaptive automatic cognitions.

He was able to challenge some of his beliefs; however, when Trump did win, contrary to what he had anticipated, his depression and anxiety did not get worse, but rather improved. In exploring this, he came to understand that this also presented a new opportunity for him to engage his energy (whereas previously, he felt like he was pushed out of his prior position). Therapy integrated a psychodynamic approach to better understand his own sense of identity and source of self-worth, as well as an ACT approach of examining values and living consistent with his values.

Careful analyses of his worry thoughts led him to explore his fear that cutting off his son financially would result in his son's cutting off contact with him. This led to examinations of earlier memories, in one of which his son ran away from home (at the time, understood to be because of excessive pressure), and recollections of his own childhood in which he lost a parent and the fear and guilt that these experiences engendered.

We believe that this kind of integrated treatment is widespread and should be recognized more than it has been. Like the therapist who wrote the above case summary, clinicians tend to seek opportunities to increase their effectiveness by assimilating concepts and methods from directions that were not emphasized in their training.

Concluding Comments

Therapists approach each clinical encounter with an earnest wish to be of help. We read professional literature, consult with colleagues, attend continuing education seminars, and enroll in courses, all with the intent of improving our competence. We often look for the most practical ways to improve our clinical expertise. Concrete skills and techniques are attractive because they potentially offer a lot of bang for the buck. One of the many reasons psychoanalytic ideas have fallen out of favor is that therapists in that tradition tend to avoid skills and techniques. However, what the psychodynamic tradition lacks in some areas, it makes up for in others.

Of the many pressures currently facing clinicians, pressures to move through therapy quickly is perhaps the greatest. I (JFT) remember my first job after graduate school at a psychiatric hospital. I was eager to help patients. But I was disillusioned with the system when I realized that patients were "meeting criteria" for discharge on the exact day their insurance had been exhausted. I began to think I had to do more for them. Other staff also seemed to feel this pressure. One day, a senior

clinician instructed me to “break” a patient in a group I was facilitating. In our team meeting, she noted that the patient was not ready to discharge and had just a week left before her insurance would run out. Her logic was that if I would speed things up by intensely focusing on the patient in group therapy, she might have an emotional breakthrough. Even though I was a new therapist and she was my senior, I knew both intuitively and intellectually that this treatment would likely hurt the patient. I did not take her advice. I think my quiet decision not to comply with a directive that felt wrong preserved the patient’s fragile equilibrium. Therapy unfolds in its own time and at a pace dictated by many factors that are not under our control.

Many of us face daily a particular internal conflict: On one hand, we want to maximize helping patients by working as quickly as possible, since financial and other pressures can interrupt treatment; on the other, we know from experience that patients require time to accomplish the goals they have set, and we do not want to give the person an experience of failure by expecting too much too fast. The compromise that many of us make is to structure the treatment. By focusing on technique and skill building, at least we know we are using evidence-based strategies. But what happens to the many areas of life the patient wants to improve? We argue over the course of this book that despite the real and diverse limitations that clinicians face, there is value in integrating the psychoanalytic attitude with the vast array of effective models used by most therapists.