

CHAPTER 1

Why Dynamic Psychotherapy?

PSYCHIATRIST: We are here to understand your unconscious.

MASON: My unconscious is none of my business.

—JACKIE MASON, “The World According to Me”

Some trainees have the intuitive sense that the dynamic model allows an entrée into human issues that are universal and deep. They are struck by the immediacy of their own emotional experiences, and their patients', while doing the therapy. They sense the pervasiveness of patterns and repetitions from the past. These trainees personally resonate with the deeper meanings suggested by the dynamic model. Other students think psychodynamic therapy is wildly subjective and lacking any scientific basis whatsoever. Students need the opportunity to process these gut reactions. It takes a while for trainees to immerse themselves in the ideas and feel and discuss their emotional reactions in order to reflect on the treatment more dispassionately.

Students react negatively to pronouncements made by dynamic practitioners about what is true. They want evidence and explanation. Traditional psychodynamic teaching methods can be more like catechism than intellectual exploration, and there can be a clash of paradigms between evidence-based practice (which includes empirically supported psychotherapies) and clinical anecdotes about psychodynamic work. Adding to the difficulties in learning about dynamic therapy, trainees are exposed to disagreements among faculty about the value of the treatment. For every pearl of psychodynamic wisdom that is taught, there is a critical comment made by another esteemed faculty member. Tanya Luhrmann's

(2000) study of psychiatry training in the early 1990s, *Of Two Minds*, documented the conceptual strains psychiatry residents feel between the objective, medical, and scientific approaches to patient care associated with psychopharmacology, and the intuitive, empathic experience of dynamic psychotherapy.

What is the best way to learn about psychodynamic therapy? We think that a pragmatic focus on patients and an experience of the therapeutic process helps to break down these barriers and tensions. The story of Beth, narrated by her therapist, illustrates many of the features of an effective dynamic therapy.

Beth was a 31-year-old single woman who came for treatment because of depression, loneliness, and problems with men. She was a clinical nurse specialist who was recognized for being compassionate and competent. She had an edge of insecurity that was partly obscured by her assertive manner and tall, imposing presence.

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

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

I quickly forgot Beth's mildly intimidating manner and appearance as I felt more and more compassion for her, and respect for how she had coped with what she had been through. My initial impression was that she had had a very traumatic childhood and that the early strife in her family made it difficult for her to trust

closeness. The abduction and the rigid stepfather probably contributed to her fears about men. In her world, women were preoccupied and men were potentially dangerous. Substances and travel helped her get away, but then there was just emptiness.

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

Soon Beth returned to talking about the recent breakup and ensuing depression. The abuse from the boyfriend seemed to have triggered her early memories of the divorce and abduction—she felt out of control with the boyfriend and had an old feeling of guilt and responsibility. Making the connection between the boyfriend and the father was frightening to her, but after discussing this several times, she began to feel some relief and an unaccustomed sense of calm. She grasped that her upset about the breakup and being hit was even more intense because of her childhood experiences, and this gave her more strength to deal with the present.

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

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

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

We continue to discuss this case throughout this chapter. This vignette captures the essence of dynamic psychotherapy—exploration of current conflicts and relationships in order to understand how they relate to the past, the search for recurring patterns, and a focus on the therapeutic relationship to see how conflicts are repeated. The treatment challenges the therapist to be warm and empathic in understanding the patient's feelings, but keep cool as the relationship deepens and old patterns are replayed.

There is no doubt that Beth's distant mother and scary father had something to do with why she had trouble with men and why she came for therapy. When she began to talk about her traumatic experiences and feel intense emotion in the sessions, the therapist became even more deeply engaged. When she suddenly became angry with the therapist, he recognized that her pattern of feeling and relating to others based on a traumatic scenario from her past was now being enacted with him. What was he supposed to do now? This moment is an interpersonal crisis, but also a psychodynamic opportunity. The task of the therapy is to elucidate what is going on in this moment. The patient did not come to therapy to solve her problem with the therapist, but rather to decrease her depression. However, the enactment in the therapeutic relationship makes it possible to understand the underlying issue better and therefore helps her solve it.

DEFINING DYNAMIC PSYCHOTHERAPY

Although widely practiced, the definition of psychodynamic psychotherapy is vague. Typically it has been regarded as a more efficient but watered-down psychoanalysis; that is, it is usually seen as lying along a continuum, with psychoanalysis at one end and supportive psychotherapy on the other. Many writers have used this fundamental concep-

tion (Rockland, 2003; Luborsky, 1984). Clustered at the psychoanalytic or expressive/interpretative end are the classical parameters and techniques, including frequent sessions, therapist neutrality and abstinence, interest in the past, the use of interpretation, and attention to resistance (the patient's difficulty in talking about problems), transference (the patient's feeling toward the therapist), and countertransference (the therapist's feeling toward the patient). We discuss each of these concepts later as we describe our pragmatic model. At the supportive end are ego support, advice, guidance, and a greater focus on the present. Psychoanalytic or psychodynamic psychotherapy (we regard these terms as synonymous) mixes and melds these approaches, typically during once- or twice-weekly meetings. Ironically, the treatment has been more defined by what it is not—psychoanalysis or supportive psychotherapy—than what it is.

Contemporary writers suggest other definitions. Kernberg (1999) regards dynamic psychotherapy as the judicious use of traditional psychoanalytic techniques. He observed that psychodynamic psychotherapy and psychoanalysis are convergent with respect to their interest in transference, countertransference, unconscious meanings in the here and now, the importance of analyzing character, and the impact of early relationships. He collaborated with colleagues (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989) on a manualized form of psychodynamic therapy with specific techniques for treating borderline personality disorder.

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

Luborsky's pioneering work on systematizing the theory and technique of psychodynamic psychotherapy, conceptualized by him as supportive–expressive psychotherapy (Luborsky, 1984), has had a widespread influence on modern dynamic therapy. This dynamic treatment model has been further defined by Book (1998) as appropriate for a wide range of patients and conditions. Supportive–expressive psychotherapy, like most manualized psychodynamic treatments, does not prescribe therapist interventions on a session-by-session basis; rather, it provides general principles of treatment and guidelines for therapists. For example, symptoms such as depression are understood in the context

of interpersonal/intrapsychic conflicts, which in supportive–expressive psychotherapy are called Core Conflictual Relationship Themes (CCRT; Luborsky & Crits-Christoph, 1990).

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

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

These features were represented in Beth’s treatment. The therapist has the challenge of figuring out how to respond to Beth’s anger and mistrust. He could soothe and support, reminding Beth that the therapy was a safe place and that he certainly did not mean to criticize, control, or judge her. This would be a supportive approach, and common to a variety of psychotherapies. He could note that there is a perceptual distortion and ask the patient to evaluate the evidence for this perception.

TABLE 1.1. Essential Features of Psychodynamic Psychotherapy in Current Practice

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- Use of exploratory, interpretative, and supportive interventions as appropriate
 - Frequent sessions
 - Emphasis on uncovering painful affects, understanding past painful experiences
 - Goal is to facilitate emotional experience and increase understanding
 - Focus on the therapeutic relationship, including attention to transference and countertransference
 - Use of a wide range of techniques, with variability in application by different practitioners
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This is a cognitive therapy intervention. Or the therapist could keep the patient's angry feelings in the room, helping to contain them and not argue them away. He could help her observe the feelings and connect them with the themes they have already discussed. This latter approach is unique to psychodynamic psychotherapy.

THE VALUE OF DYNAMIC PSYCHOTHERAPY

Although we do not seem to have to argue the value of psychodynamic psychotherapy in psychiatry training settings, it has nevertheless almost disappeared from many psychology training programs. The standing of psychodynamic psychotherapy reflects both scientific controversy and sociocultural forces. Dynamic therapy is the subject of cultural and style pieces in the *New York Times*, and it is the focus of contentious dialogue between outpatient mental health providers and their utilization reviewers. It is all too infrequently the focus of interest in our professional journals. There are four responses to those who question the value of psychodynamic psychotherapy.

Empirical Database

First, the question of psychodynamic therapy's effectiveness often devolves into a simplistic comparison with other treatments, most often cognitive-behavioral therapy. We consider this to be one aspect of the question of dynamic therapy's value, certainly a crucial one, and an empirical issue that is far from settled. We will address this question, but we will also broaden it and revise it.

There are relatively few empirical studies (summarized in Chapters 5 and 6 on core psychodynamic problems), relatively few funding sources, and few studies in the pipeline, although there may be a recent uptick (see Leichsenring et al., 2004; Høglend et al., 2008; and Milrod, Leon, Barber, Markowitz, & Graf, 2007). The most recent meta-analysis of long-term psychodynamic psychotherapy provided preliminary evidence for its efficacy in treating complex problems (Leichsenring & Rabung, 2008). Our conclusion about the current state of the literature is that there is some support for psychodynamic psychotherapy as an effective treatment for certain conditions, and certainly very few instances showing that dynamic therapy is less effective than other treatments.

In recent years a major controversy has raged among psychotherapy researchers regarding how one evaluates the efficacy of treatments. The

randomized clinical trial, with appropriate control groups, is regarded as the gold standard. Cognitive and behavioral therapists tried to establish the efficacy of their treatments from the beginning, understanding that this was missing in psychodynamic research. They valued the experimental method highly, and this led them to emphasize randomized clinical trials. The American Psychological Association's Presidential Task Force on Evidence-Based Practice (2006) concludes more broadly that "research, clinical expertise, and patient characteristics are all supported as relevant to good outcomes" (p. 271). Anecdotal and clinical case studies are compelling because of the inferential nature of psychodynamic concepts and the unique relational component of the treatment. Psychodynamic practitioners value case studies for these reasons and have tended to eschew involvement in empirical research. Alternative approaches, such as qualitative case studies, naturalistic follow-up, and process studies, are regarded with less favor by researchers; however, randomized clinical trials are not sufficient to provide the base needed for comprehensive evidence-based practice (Barber, 2009).

Like many therapies in long-standing use, what constitutes "the treatment" is hard to characterize and therefore hard to test. Several investigators developed manuals for dynamic therapy, including Luborsky for supportive-expressive therapy (Luborsky, 1984; Book, 1998), Kernberg and his colleagues for transference-focused psychodynamic psychotherapy for borderline personality disorder (Kernberg et al., 1989), and Milrod for panic disorder (Milrod, Busch, Cooper, & Shapiro, 1997). These protocols are an important step forward, but they raise many questions. Do these manualized treatments reflect all aspects of psychodynamic psychotherapy technique, or do they select out certain ones? Indeed, what are the most important aspects of the technique, what promotes change most effectively, and what kind of change?

The evidence-based approach to psychotherapy research has, under the influence of the NIMH and pharmaceutical companies, focused on patients with a clear-cut primary phenomenological diagnosis such as phobias, panic disorder, posttraumatic stress disorder (PTSD), or depression. This contributes to the dearth of psychodynamic therapy studies. Many psychodynamic therapists do not pay close attention to the phenomenology of Axis I disorders. Instead, they base their treatment interventions on psychodynamic formulations that include the phenomenological data along with other variables such as self-esteem, relationships, and life cycle issues. Because psychodynamic treatments focus relatively less on symptoms and more on other aspects of well-being and mental

functioning, then assessing only symptoms may underestimate the efficacy of the treatment.

Grants submitted to study the efficacy of psychodynamic therapy often meet an additional hurdle. They must justify why we should study the efficacy of the treatment when we already know that CBT is effective. By missing the boat to be first treatment to show efficacy, it is more difficult to gain the resources to meet this standard for subsequent treatments.

Depth

Second, psychodynamic therapy is valuable because it has been an incubator of psychotherapeutic innovation for almost a century. Most of the contemporary psychotherapies, and many developed and discarded along the way, have emerged from it. Later treatments were derived conceptually from the Freudian legacy, or developed by individuals who were trained in or exposed to it. We suggest that the depth of the treatment, intensity of the interpersonal engagement, and the intrinsic sense of meaning that arises when discussing issues of great personal importance stimulates creative thought. Perhaps this is why dynamic therapy has been so effective in spinning off new ideas. It attracts those with empathy and provides a meaningful model for a deep emotional exchange with a patient. Working with Beth was challenging and emotionally engaging for the therapist. Following a tightly prescribed protocol may not have provoked the same personal involvement and curiosity in the therapist.

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

The observation has been made that that only psychodynamic psychotherapy among the psychotherapies retains the ambition to cure or help patients transform themselves in a profound way (Seligman, 2002). Indeed, we recognize that a deep treatment may not be required for all patients. Much of the success of behavioral therapy is thought to reside in its focus on symptoms and in its parsimonious and directed use of therapeutic resources to decrease symptoms. It does not aim to be a therapy of depth, and this is one of its strengths. In contrast dynamic psychotherapy, which facilitates a patient's rewriting of his life narrative, his picture of himself, his past, present, and future, seems uniquely positioned to address the depth of a individual's experience.

Psychodynamic Narrative Is Part of Our Culture

Third, dynamic therapy is valuable because Freudian ideas permeate contemporary Western culture. The unconscious, the effect of early childhood on later experiences, internal conflict as a normal state of affairs, phases of development, and the ubiquity of anxiety are ideas we practically find in our drinking water. They are integral to our culture's picture of the individual, the life cycle, and interpersonal relationships. Because they inform and shape our worldview, our treatments must somehow involve, refer to, and embrace these beliefs. Indeed, Jerome Frank (Frank & Frank, 1991) said that therapy must reflect the prevailing values of the culture and address the individual through this language. At the same time that its importance is waning in therapeutics, the upsurge of interest in psychoanalysis and Freud in the humanities reflects how deeply embedded these ideas are in our cultural and intellectual tradition.

We suggest that psychodynamically based treatments have a special focus on the rewriting of a personal narrative. The need to develop a narrative understanding is essentially human, reflected in storytelling traditions, literature and art, and the autobiographical urge that strikes virtually everyone at some point in time. Dynamic psychotherapy takes this fundamentally human task as its challenge. We believe that psychodynamic psychotherapy retains its currency because it encourages patients to tell and rework their stories in an intensive way.

Therapy for Therapists

Fourth, therapists tend to choose psychodynamic psychotherapy for their own treatment, as documented in a recent study of psychiatry trainees (Habl, Mintz, & Bailey, 2009). Our impression is that other trainees tend to choose dynamically oriented treatments, as well. Why this occurs during a time when other psychotherapies are proliferating is an interesting question. Therapists often enter treatment early in their careers and are influenced by their teachers and mentors, and their treatment choice may simply reflect a cohort effect. As newer psychotherapies achieve greater dominance and their proponents fill the ranks of mentors and teachers, this is likely to diminish.

But perhaps therapists enter psychodynamic psychotherapy because it is particularly useful to them. Perhaps therapists themselves prefer the depth and explicit attention to narrative intrinsic to dynamic psychotherapy. The emphasis on affect and ways of understanding intense affective experiences, provides therapists with the clarity and resilience

needed to work with distressed and suffering individuals. The intense focus on the therapeutic relationship also helps us understand our enactments, transferences, and countertransferences.

THE CHANGING FACE OF PSYCHODYNAMIC PSYCHOTHERAPY

We have summarized current definitions of psychodynamic therapy and argued for its currency and value. But to stay current, the treatment must evolve. There are new ideas and new knowledge that suggest changes in theory and technique, and powerful social forces that are shaping its use (see Table 1.2). Some of the most current influences are detailed below.

Research on the *demand characteristics of social situations* and psychotherapy outcome and process research have demonstrated the importance of educating and socializing the patient into the process of psychotherapy, and have shown improved efficacy when this occurs (e.g., Greenberg, Constantino, & Bruce, 2006). Confusion, lost time, and uncertainty can result when patients start psychotherapy without adequate explanation and education. Orientation to psychotherapy and greater *transparency* about its processes and goals offer the potential of greater efficacy.

The impact of the *therapeutic alliance* on outcome is one of the most consistent findings in the field of psychotherapy research (Messer & Wampold, 2002), despite the fact that it accounts for only a small amount of variance in outcome (Barber, 2009). Different types of psychotherapy show precious little difference in outcomes. Rather, the development of a strong therapeutic alliance provides a path to success common to all psychotherapies. Increased awareness of the importance of the alliance and techniques for addressing rupture of the alliance have generated new ideas about how this factor can be optimized in psychodynamic psychotherapy, especially with reference to clinician abstinence and neutrality.

There is a convergence between the psychoanalytic concept of *unconscious fantasy* and the CBT concept of *schema*. Arising primarily in the CBT literature, schemas are the deep cognitive structures that develop out of early life experiences and are maintained by the subsequent distorted perceptions; their persistence is the essence of psychodynamic pathology. This concept shares similarities with Luborsky's CCRT (Luborsky & Crits-Christoph, 1990), which is an example of an interpersonally anchored schema. Slap's (Slap & Slap-Shelton, 1991)

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

New knowledge, social forces	Changes in psychotherapy theory and technique
Demand characteristics of therapy	Education, orientation, explanation
Increased recognition of the importance of the therapeutic alliance	New techniques for developing alliance and repairing ruptures
Convergence of concepts of fantasy, schema, pathogenic thoughts	Emphasis on schema resulting from traumatic experiences
Importance of narrative	Rewriting of narrative a focus of therapy
Reality of trauma; therapeutic relationship a result of patient and therapist factors	Less hierarchical treatment relationship, closer attention to minute-to-minute aspect of process
Positive psychology	Attention to character, positive emotion, and enhancement
Need to understand psychotherapy in combination with other treatments	Clarification of role of psychotherapy in overall treatment plan
Neurobiological understanding of psychotherapy	May provide additional scientific evidence for psychoanalytic concepts
Patient advocacy and empowerment	Education, transparency, informed consent
Concern about efficiency	Time-limited treatment; changes in technique, goals

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

Just as the critical study of texts forms the basis for analysis in academic humanities departments, methods for using *narrative in healing* have gained currency in medical circles and have been studied by psy-

choanalysts for some time (Spence, 1982). There is increased interest in narrative medicine (Charon, 2006), which emphasizes the importance of the patient's personal story as a way of understanding, managing, and healing. These developments have led to an increased focus on the role of narrative in psychotherapy. We see the central task of psychotherapy as the rewriting of a more complex and useful narrative of the patient's life and experience.

Awareness of the *importance and prevalence of trauma* has resulted in an increased interest and focus on the real experience of the patient. There is greater interest in the importance of external factors and less emphasis on internal fantasy in determining the impact of the traumatic experience. This shift makes for less hierarchy in the relationship between patient and therapist. When the patient's experience is understood to have actually occurred, and is not just a result of his or her construction of reality, then the reality of who the therapist is and how he behaves is real and important as well. This has led to more interest in the intersubjective elements in the therapist–patient dyad, a focus on the concept of enactment as opposed to transference, and a loosening of some of the constraints on therapist behavior. These developments parallel the increased interest in relational or interpersonal psychoanalysis, which conceives of the therapeutic relationship as a newly constructed entity created by patient and therapist. Relational psychoanalysis puts greater emphasis on the here and now of minute-to-minute interactions. Techniques suggested by these recent developments include greater therapist self-disclosure and close attention to the aspects of the therapeutic process generated by the therapist's attitudes, thoughts, and feelings (Mitchell, 1988).

The field of *positive psychology*, which explores positive emotion, happiness, and techniques for enhancing positive experience, provides a new perspective to psychotherapy (Seligman, 2002; Peterson, 2006). The contribution includes an emphasis on the concepts of character and virtue, the relative independence of positive emotions from negative emotions, and interventions for enhancing subjective satisfaction. The importance of positive experiences in promoting increased self-reflection and change suggest new therapeutic techniques.

Traditionally, psychotherapy was studied within its own “silo,” separated from its frequent integration with other treatments, for example, psychopharmacology, couple and systems therapy, and educational and behavioral treatments. The likely synergy (and also tension) with these treatments is just beginning to be studied. An example of this is the data showing that *psychotherapy and psychopharmacology may be syner-*

gistic in moderate to severe depression, but not be more effective than either treatment alone in mild depression (Thase, 1999). Findings like this clarify the role of psychotherapy in general and also, perhaps, of specific psychotherapies in the real naturalistic settings in which they are employed.

New neurobiological findings bear witness to the changes in the brain resulting from psychotherapy (Etkin, Pittenger, Polan, & Kandel, 2005) and open the door to understanding psychotherapeutic change and the specific changes resulting from specific psychotherapies (Goldapple et al., 2004). Although we cannot test and improve interventions using neuroimaging data yet, this is a possibility in the future. Several contemporary neuroscientists suggest that there are neurobiological data to support traditional psychoanalytic concepts (Westen & Gabbard, 2002; Kandel, 1999), including the theory of dreams (Solms, 1995).

There are a number of social forces generating change in the practice of psychodynamic psychotherapy. *Patient advocacy organizations* have reminded us of the importance of knowledge about illnesses for patient empowerment. This encourages educational interventions about the nature of symptoms and illness, and about treatment alternatives and treatments themselves. The need for informed consent for treatment has spread beyond medical and surgical treatments to include psychotherapy and has contributed to a more open, transparent process of diagnosis and treatment selection, and also of initiation of psychotherapy. Some anticipate that an explicit informed consent process, which includes spelling out the risks of psychotherapy, will become the standard for psychotherapy as it is for other procedures in the medical care system.

Greater *concern about efficiency* has led to time-limited treatments (e.g., Barber & Ellman, 1996; Crits-Christoph, Barber, & Kurcias, 1991). Both patients and payors are more focused on the speed of treatment. The resulting push to target symptoms and focus on goals has resulted in changes in both technique and objectives. This has been an impetus for technical innovation and reevaluation of goals. The interest in pruning the length and expense of treatment has sharpened interest in whether psychotherapy should decrease symptoms or promote healthy development, with the recognition that different therapies may have different goals. This has resulted in the development of psychodynamic treatment focused on specific disorders (e.g., Milrod et al., 1997, for panic disorder; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005, for generalized anxiety disorder). It has also clarified the continuing need for treatment of other problems such as developmental and lifecycle issues that are not symptom based, such as identity forma-

tion, intimacy and relationship problems, and loss and grieving. Common clinical scenarios include teenagers in conflict with their parents as they try to “find themselves,” young adults with difficulty committing to intimate relationships, and middle-aged adults struggling with adapting to new limitations in career or health.

A PRAGMATIC PSYCHODYNAMIC PSYCHOTHERAPY

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

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

Beth’s relationship with me was rocky at times, and in addition to trying to understand it, much time was spent helping Beth feel safe and comfortable in the therapy. This included education, explanation about the therapy, and attention to particular moments of mistrust. Beth seemed to alternate between trusting, positive feelings and sudden anger, suspiciousness, and withdrawal. She became more and more aware that these reactions reflected her old feelings, which alternated between childlike trust and then betrayal and fear. I became better at anticipating when the shifts would occur and could interpret and clarify them more clearly. We developed a kind of rhythm—discussion of her new relationship, her periodic interactions with her parents, and feelings and thoughts about me. As she moved from one to the other and was able to apply her understanding of the old relationship templates that played out in each situation, she became stronger and more confident. She also seemed looser, more playful, and wittier than before. This flexibility was evident in her description of her daily life. She said she felt more attractive, too.

Beth was pleased with her new relationship and expected that it might develop into marriage. Ultimately she decided it was time to

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

Beth's treatment was successful, and it incorporated traditional ideas about dynamic psychotherapy (emphasis on experiencing affects, exploring the past, looking for patterns, increasing awareness, working on the therapeutic relationship) as well as many of the new ideas we have discussed here (attention to the therapeutic relationship, education and explanation, transparency, rewriting the narrative). The next chapter sets out the basic theory and technique of the updated model, referred to as pragmatic psychodynamic psychotherapy, and the subsequent chapters will elucidate these ideas, explaining, giving examples, and providing specific practical tips.

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