Psychodynamic and Psychoanalytic Psychotherapy

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OUTLINE

What Is Psychodynamic and Psychoanalytic Psychotherapy? 182
Basic Tenets and Concepts 182
Development of Psychodynamic Psychotherapy 183
Components of Psychoanalytic and Psychodynamic Psychotherapy 189
Clariﬁcation, Confrontation, and Interpretation 189
Technical Neutrality 190
Transference 191
Core Aspects of Psychodynamic Psychotherapy 191
Variants of Classical or Freudian Psychoanalysis 192

Research on Psychodynamic Psychotherapy 194
Depression 194
Anxiety Disorders 195
Borderline Personality Disorders 196
Mixed and Other Personality Disorders 201
Meta-analysis of Psychodynamic Psychotherapy for Personality Disorders 201
Eating Disorders 202
Marital Therapy 202
Summary of Empirical Findings with Psychodynamic Psychotherapy 202
Common Misconceptions Regarding Psychodynamic and Psychoanalytic Psychotherapy 203

Writing about psychodynamic psychotherapy is difficult because it is not a unified approach. In fact, it is often said that psychoanalysis, though frequently used singularly, is in actuality a plural noun representing an array of theoretical ideas and technical applications. Nevertheless, we can say that psychodynamic psychotherapies are approaches to helping...
people that derive from the ideas of Sigmund Freud and his collaborators and followers. Contemporary psychoanalytic and psychodynamic approaches are influenced by at least four broad frameworks or schools: (1) ego psychology, derived from the classic psychoanalytic theory of Freud and elaborated by Hartman, Rapaport, and Belak among others; (2) object relations theory, derived from the work of Melanie Klein and members of the "British School," including Fairbairn, Guntrip, Winnicott, and Balint and best represented by the work of Kernberg; (3) self psychology, developed by Heinz Kohut and elaborated by subsequent contributors such as Ornstein and Adler; and (4) attachment theory, developed by John Bowlby and Mary Ainsworth and elaborated by a number of clinical and developmental researchers including Peter Fonagy and Mary Target. Volumes have been written on each of these schools of thought, and within each of these psychoanalytic approaches there are multiple perspectives.

WHAT IS PSYCHODYNAMIC AND PSYCHOANALYTIC PSYCHOTHERAPY?

The terms psychoanalytic and psychodynamic are often used interchangeably. However, within the psychoanalytic and psychodynamic communities, psychoanalysis is the term used when referring to a psychological treatment where the therapist, called a psychoanalyst or analyst, adheres to standard techniques focused on interpretation leading to insight in the context of the transference. In psychoanalysis the patient usually attends multiple sessions over weeks and months, and the relationship between the patient and therapist is often described as a "single" or "integrated" relationship. Psychoanalytic therapy, on the other hand, tends to be more brief and less intensive than psychoanalysis. Nevertheless, psychoanalysis is often used in the context of contemporary psychoanalytic theory, where the therapist is more actively engaged with the patient, to resonate emotionally with the patient's affective states, and more focused on the interpersonal relationship between client and therapist than in psychoanalysis.

Basic Tenets and Concepts

A number of basic tenets and concepts are central to psychoanalysis and psychodynamic therapy. These concepts include mental processes, such as motives, desires, and memories, that are not available to awareness or are conscious introspection. This idea is often referred to as unconscious mental functioning or unconscious processing. While attention to unconscious mental life remains central to psychoanalytic or psychodynamic therapy, this is not to say that all important processes are out of our awareness or unconscious. Of course, much of our experience is available and accessible for introspection, reflection, and conscious decision making. Moreover, as Wachtel (2005) has noted, consciousness is better conceptualized as a matter of degree of accessibility and articulation than as a discrete division between conscious and unconscious.

Another tenet of the psychoanalytic approach is the defense or defense mechanism — while some mental processes are out of our awareness, this is a process in which people are also motivated to push threatening thoughts or feelings into unconsciousness. This concept of defense is generally well supported in the empirical literature examining the transference (Main, 2000), psychophysiological data (Adams, Wright, & Lohr, 1996; Schlifer, Mayman, & Manis, 1993), and neuroimaging data (Anderson, Ochsner, Kuhl et al., 2004; Westen, Blagov, Harenski, Kuhl, & Huthmann, 2000) and is generally well accepted (Meehl, 1997). There is much evidence from experimental, social, and neuroscientific research suggesting the importance of unconscious mental processes; however, the data are still unclear as to whether or not these unconscious processing is motivated.

A third tenet central to psychoanalytic theory is that of a developmental perspective in which childhood relationships with caregivers are seen as playing a role in shaping current behavior. This is not to imply a linear relationship or critical period between early experience and later development. Psychoanalytic theory, consistent with a developmental psychopathology perspective, is probabilistic rather than deterministic regarding this relationship. In addition, this does not mean that the idea that the developmental history of the client is important to recognize the importance of biological contributions to development quite the contrary. From the very beginning of his theorizing, Freud discussed how these childhood experiences, in concert with genetic (what Freud called constitutional factors), influence people's internal experiences of themselves and their overt behavior.

Finally, a psychoanalytic perspective emphasizes the importance of individual and personal meaning of events. Psychoanalytic clinicians are interested in the patient's phenomenological experience — how the patient experiences himself, important others, the world in general. In this way, psychoanalytic clinicians are focused on finding out what those from the cognitive-behavioral therapy tradition call schemas or schemata. The difference, however, is that in a psychodynamic model, these schemas are seen as having explicit, conscious, and implicit unconscious aspects, and the implicit parts can be simply out of awareness or kept out of awareness for defensive purposes. The psychodynamic model posits that individuals may use one set of representations to defend against other intolerable representations. There is also greater attention to the emotional aspects of these schemas or representations and to the structural aspects of representation, that is, the degree of differentiation and hierarchical integration of representations (see Blatt, Auerbach, & Levy, 1997). Evidence from developmental, clinical, and neuroscientific research provides validation for these basic premises (see Westen, 1999, for a review).

Several other concepts are central to the psychoanalytic approach in addition to the ideas of unconscious processes, defense mechanisms, a developmental perspective, and subjectivity. These include transference, countertransference, and resistance. With the exception of transference (see Berk & Andersen, 2000; Brumbaugh & Fraley, 2005), these issues have less empirical support at this time. However, interestingly, countertransference has recently become of interest to those from the behavioral (Kohlenberg & Tsai, 1994; Koerner, Kohlenberg, & Parker, 1996) and cognitive-behavioral paradigms (Linehan, 1993). Although other concepts have been explored within psychoanalysis at various times, such as the Oedipus complex or psychosexual stages, it should be noted that these concepts are not as central or crucial to the psychoanalytic and psychodynamic models as the other tenets we have identified.

DEVELOPMENT OF PSYCHODYNAMIC PSYCHOTHERAPY

Freyd developed psychoanalysis over the course of many years and was influenced by a number of colleagues and experiences. Between 1895 and 1938 Freyd was a prodigious writer. His compiled works amount to 23 volumes and cover thousands of pages of writings. During this time he was developing psychoanalysis, his ideas changed, sometimes drastically, and he abandoned ideas when they did not coincide with new data. Many people are confused about his ideas because of the amount of writing he did and the fact that his ideas developed and changed over time, which has resulted in conflicting ideas. Why, for reasons it can be difficult to understand
psychoanalytic psychotherapy without some basic understanding of the context of how Freud’s ideas developed.

Although Freud is often portrayed as unscientific, he was a first-rate scientist and an active contributor in his day. While in medical school at the University of Vienna (1873–1881), Freud studied with the great physiologist Ernst Wilhelm von Brücke, the noted mechanist who in 1874 published Lectures on Physiology in which he discussed the principles of psychodynamics. Based on thermodynamics, Brücke suggested that all living organisms are energy systems, governed by the principle of energy conservation. Freud was supervised by Brücke during his first year in medical school and later worked in a lab as an assistant to Brücke. He was later to borrow the idea of a “dynamic” from physiology to help conceptualize how the human mind worked.

In medical school, Freud enjoyed his scientific work and never intended to practice medicine. In his research he described nerve cells of small fish, protozoon, and sexual organs of eels, aapparently in search of a link in the development of nerve cells from their forms in primitive species to their form in more evolved species. In 1877, Freud began working in Brücke’s laboratory, where he investigated brain anatomy and histology. Examining questions related to Darwin’s evolutionary theory, he also determined that the brain of man and frog were the same type; this work proved important at the time in providing evidence for evolutionary theory. Although Freud was a scientist, he was more typically an observer than an experimenter. This is an important distinction because observation is the method he brought to the study of behavior, in which he attempted to map out the mind just as he did nerve pathways in fish, eels, and frogs.

Freud would gladly have remained Brücke’s assistant working on evolutionary anatomy of the nervous system where the quality of his research was strong. However, in 1881 he met Martha Barneys, the sister of a classmate.

A year later at age 26, they became secretly engaged. Freud desperately wanted to marry Martha, but both were from poor families, and he would need money to support himself, Martha, and the children they wanted to have. Brücke advised Freud that despite his good work, his prospects for promotion were poor and that private practice as a physician was his most viable option. The prospects of Freud’s advancement in the professoriate were slim due in large part to the particularities of the European academic system. Unfortunately for Freud, there were two other assistants in the lab who had seniority and would most likely receive promotion before Freud. Furthermore, he was Jewish, and his promotion prospects were considered to be minimal. Thus, at Brücke’s advice, Freud reluctantly went into the private practice of medicine as a neurologist.

Freud initially took a position at Vienna General Hospital in order to gain experience treating patients prior to his private practice. After some time in surgery and dermatology, he began in the psychiatry department headed by Theodor Meynert. In his heart, however, Freud saw himself as a scientist, as evidenced by the fact that he authored scientific monographs on topics ranging from cocaine (Freud, 1884) to aphasia (Freud, 1891). Several books, paralyses in children, of which he was considered an authority, having developed expertise during his time at Vienna General Hospital.

In private practice, most of his patients were young middle-class women who suffered from a host of “neurological” symptoms—paralysis, partial blindness, hallucinations, loss of motor control—that appeared to have no real neurological cause. The prevailing view in Vienna, where Freud was practicing, was that these clients were malingering or faking it. Freud, however, realized that his patients were not simply “faking it.” Because he thought that many of his patients were talented and very bright, he not only believed his patients but also selected them in the first place.

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2. A hypnotized person can be virtually compelled, through posthypnotic suggestion, to perform a series of actions for reasons outside of his or her awareness. Importantly, when questioned, the individual would provide a seemingly rational but demonstrably irrelevant explanation. This rational but irrelevant explanation was important in Freud's development of different levels of psychic functioning, later to become conscious and unconscious.

3. Posthypnotic amnesia is not absolute. Ideas that were not conscious had the power to affect behavior and could be incorporated into consciousness.

4. Hypnotic lucidity. The mind has a storehouse of information that is not available to consciousness but is accessible under hypnosis.

Freud was also strongly influenced by the case he heard about in 1882 from Dr. Josef Breuer, an older mentor and medical colleague in Vienna. Breuer was treating a patient by the name of Bertha Pappenheim, who is popularly known as Anna O. According to Breuer, Anna was an intelligent woman of 21 with a strict upbringing, leaving her sexually immature. In July of 1880 her father became seriously ill. She nursed him day and night until she collapsed in December. Her symptoms included a severe nervous cough, a spuit, visual disturbances, paralysis of the right arm and neck, and a strange speech problem whereby she often replied to the German language questions in English. She was also agitated by hallucinations. She seemed to improve until her father's death. Then the hallucinations became more violent during the daytime, and at night she fell into a quiet trance and mumbled words to herself. Breuer repeated her words back to her as a way to encourage her to elaborate on her hallucinations, and when she came out of the trance, she reported having felt better. If she did not talk about her experience, she would continue with the symptom. Anna herself called this the "talking cure" or used the metaphor of chimney sweeping to represent the experience. However, she kept developing new symptoms: hydrophobia and a trance-like state. Breuer noticed that each symptom disappeared when it was traced back to its first occasion and that the symptoms were removed by recalling forgotten unpleasant events. Furthermore, the symptom emerged with greatest force while he was being talked away.

Thus, from Breuer's work with Anna O, Freud concluded that the expressed memory of a traumatic event gave rise to a symptom. Whereas Charcot thought that a physical trauma (e.g., train accident) combined with a mental defect (e.g., susceptibility to hypnoid states) caused hysterical symptoms, Freud believed that the cause was a psychic trauma and that the patient experienced the full force of the emotion. Then the symptom disappeared. This process of the symptom remitting as the patient experiences the full force of emotional expression is referred to as a catharsis.

Thus, in his own work with patients, his studies with Charcot and Bernheim, and his consultations with Breuer, Freud learned that:

1. Preconceived but incorrect ideas could influence symptom expression (with Charcot).
2. Physical symptoms can be suggested, and those symptoms are indistinguishable from symptoms of hysterics (with Charcot and Bernheim).
3. Posthypnotic suggestion compelled the person to perform actions for reasons he or she was unaware of, but they will give seemingly rational but demonstrably irrelevant explanations (with Bernheim).

4. Posthypnotic amnesia is not absolute — memory of events that are not conscious can be recalled to consciousness (with Bernheim).
5. Symptoms may be caused by unconscious "memories" of traumatic events (from Breuer's work with Anna O).
6. Catharsis as shown by Breuer with Anna O. (the uncovering of unconscious events accompanied by the commensurate emotion) can eliminate corresponding symptoms.
7. The mind is a storehouse of information that is not available to consciousness but is accessible under hypnosis.

With this knowledge in hand, Freud had the elements of a theory. In Freud's view, a person who has experienced a traumatic event is unable to express or express fully the appropriate emotion often experiences conflict over the feelings and the person's own moral standards. The painful memory is pushed out of one's conscious awareness and is lost to memory (e.g., later conceptualized as repressed and having become unconscious), but the memory is not completely lost, and it continues to have effects. It is shown in the symptom, which is called a symptom. When catharsis occurs, indirect expression is no longer necessary. This account is known as Freud's trauma theory.3 Breuer and Freud published a short preliminary communication, "Über den psychischen Mechanismus hystärer Phänomene" (On the Psychical Mechanism of Hysterical Phenomena, 1893) in the Neurologische Centralblatt, which they more fully developed in Studien über Hysterie (1895). Although neither was well received by the medical community, these publications marked the beginning of psychoanalysis.

Freud learned a great deal from hypnosis, but for a number of reasons, he slowly abandoned it. First, as mentioned earlier, not everyone is hypnotizable. Second, he found that hypnosis provided only partial and/or temporary symptom relief (which we also know today). Third, he believed that hypnosis also increased the erotic element of treatment by intensifying the transference, something that happened both to Mesmer and to Breuer with Anna O. and was now happening with Freud's patients. Finally, he believed that it was wrong to suggest away a symptom when the patient's suffering was real (as others who were using hypnosis were doing). But how is repression to be lifted if one does not use hypnosis? Influenced by Brièke, who was a determinist, and based on his own findings while working with Charcot, Freud felt that hypnism had meaning and that nothing happened by chance. This idea that everything that happens in the mind is predetermined is referred to as psychic determinism. Psychic determinism postulates that nothing in the psyche happens by chance; all mental and physical behavior is determined by prior events. Thus, Freud thought that whatever happens in the mind may be fairly simple, such as anger toward the person to be met or spite regarding the exam. However, the causes of psychic phenomena are usually numerous and multifactorial. In a bold move, Freud reasoned that if nothing in the mind happens by chance, then all one needs to do is learn what whatever comes to mind and sooner or later the patient will give a clue to what the trouble is. This technique is referred to as free association. Free association held the promise of revealing associational networks and mental transformations of ideas and feelings in which patients revealed interpersonal cognitive-ffective-
behavioral patterns that the analyst could observe directly.

During free association, many of Freud's patients referred to dreams, and he realized that often dreams give clues to unconscious conflicts. For this reason, Freud referred to dreams as the "royal road to the Unconscious." Freud also discovered what most of us take for granted today: that dreams were symbolic and specific to the dreamer. Using his association, Freud found that patients reported sexual assaults in childhood in the first 18 cases of hysteria he treated. Although some of the experiences were single or isolated instances perpetrated by pedophiles, most of the experiences were carried out by adults who were looking after the child. In 1897, after 5 to 7 years of latency, he had gone out on a limb — publicly proclaiming that childhood sexual abuse is the direct cause of hysteria — Freud repudiated this theory, citing a number of reasons including the difficulty of teasing out actual memories from fantasies. (Some of Freud's patients later recanted their original story of childhood seduction, and other patients' stories were found to be untrue or were implausible.) He also began to worry that his line of questioning and the forceful manner he applied during free association might have pressured patients to report such events. Importantly, Freud acknowledged his own neurotic symptoms and discovered during self-analysis (begun after his father's death) that as a child he had sexual fantasies about his mother, although he was never abused. Most importantly, however, was Freud's realization that the trauma or seduction theory was limited in its explanatory power because the relationship between their abuse and hysteria was not perfectly predictive, that is, he knew that not all victims of sexual abuse developed hysteria and that not all sufferers of hysteria had been sexually abused. Thus, many were not actual events but fantasies. This presented a new crisis in Freud's theory, for he had spent years analyzing cases within the trauma paradigm, because he had been working toward a rather tightly integrated theory that would have a particular and rational basis for treating neurosis, the discovery of this anomaly appeared to destroy what he had laboriously achieved over a period of 15 years.

Freud soon came to the conclusion, however, that the theory of an actual seduction was a dispensable element. Charcot thought that the cause of neurosis was physical trauma, and Freud initially thought that it was a psychic trauma caused by sexual abuse. Now he was carrying the theory one step further in proposing that sometimes the psychic trauma was simply a fantasy that was completely or partly imaginary. This is not to say that Freud did not realize this theory occurred if it had not been found to have a basis in reality. Freud never totally repudiated his original seduction theory, maintaining to the end of his life that actual incest did occur and that these instances contributed to the development of psychopathology. In fact, he had estimated the prevalence of childhood sexual abuse to be about 30%, an estimate we now know is accurate. However, in suggesting that children have sexual fantasies (known as infantile sexuality), he still needed an explanation for its occurrence. Here Freud proposed the concept of drives, which he thought tended to be aggressive and sexual in nature. (Later, John Bowlby and other object relations theorists would stress the importance of the drive for relatedness.) The idea of aggressive and sexual drives did not necessarily come out of the blue. Freud had approached this idea early in his theorizing when listening to patients who described conflicts around aggressive and sexual wishes, desires, and intentions. If Freud had not doubt he would not be surprised that we have censors for our TV and movies that focus almost exclusively on sexual and aggressive themes.

The drive theory became closely tied to what is referred to as the Freudian conflict model of compromise formation. This model posits that many of the conflicts that cause symptoms of mental and physical illness have a particular form; on one side there are intense wishes or desires, often of a selfish, sexual, or aggressive nature, and opposing these motives or drives are strong and disturbing feelings of guilt and fear. Negative emotion causes a person to repress, deny, or redirect troublesome needs and wishes, which then are expressed only indirectly — in symptoms, dreams, jokes, and slips of the tongue or "accidental" behavior (so-called Freudian slips). These drives or desires, and the prohibitions against their manifested behaviors, give rise to inner conflicts and then neurosis. Thus, what had started as a purely clinical theory of neurosis developed into a deep theory of personality and development.

Freud is often portrayed as unscientific because of the methods he used would be considered inadequate today. Critics often cite his famous postcard in 1934 to Saul Rosenzweig, in which he replies to Rosenzweig's studies of repression: "I have only one weakness, I cannot put much value on these confirmations because the weight of reliable observations on which these assertions rest make them independent of experimental verification." However, he also said that "science is no illusion but it would be an illusion that we could get anywhere with it without insight." Even this was a misquote (Freud, 1927/1953, p. 102). What this chapter hopes to show is that Freud was a serious scientist of his time and that he approached complex clinical problems scientifically. He was a consumer of most cutting-edge scientific knowledge of his time, integrating the theorizing and experimental work of Brücke, Charcot, and Bernheim into his thinking. He also carried out his own scientific research, which was integrated into his theory. In this manner, Freud was one of the first translational scientists, who translated basic research into ideas useful for applied work.

The aim of psychodynamic psychotherapy is to make what is unconscious conscious in an effort to better understand a person's motivations and thus respond to them in reality more honestly. Three essential features of the psychodynamic method are interpretation, including clarification and confrontation, and technical neutrality, and analysis of the transference.

Clarification, Confrontation, and Interpretation

The three main techniques used in psychodynamic psychotherapy are clarification, confrontation, and interpretation. Clarifications simply are requests for more information or further elaborations in order to better understand the patient's reasons. Beginning therapists, and those with only a cursory understanding of psychodynamic psychotherapy, often neglect this technique and move prematurely to interpretation. Even if a therapist could determine the appropriate interpretation without clarifying, it would be difficult for the patient to integrate it without first properly clarifying. Clarifying and confronting a patient's experience are preparatory steps for interpretation. The therapist should clarify thoroughly until both the therapist and the patient have a clear understanding of any areas of vagueness. It is important to recognize vague communications, which is not easily done because therapists prematurely foreclose clarification by meeting their own preconceptions when patients are vague or unclear. For example, if a patient says he feels depressed, the therapist should clarify what the patient means by the term. A standard technique is to start with short open-ended
questions and become more specific as needed. For example, a therapist might simply respond by saying “Can you say more about that?” A recommended device for determining if clarification is required is to ask oneself whether a patient’s presentation could be veridically described to a supervisor or consulting colleague. Frequently, a patient will become puzzled by contradictions in his or her thinking or experience during the clarification process.

Confrontations sound harsher than they are because they actually involve tactfully pointing out discrepancies or incongruities in the patient’s narrative or the patient’s verbal and nonverbal behavior (affect or actual behavior). It is difficult to successfully confront a patient without that patient being aware that the therapist may not be aware of what the therapist is observing. (Conversely, without clarifying, the therapist may incorrectly confront the patient regarding material that would otherwise be clear.) The therapist uses the clarified material or information that is contradictory for further exploration and analysis. This is done in an effort to better understand conflicting mental states or representations of experience that implicitly address the patient’s defensive operations.

Interpretations focus on the unconscious meaning of what has been clarified and confronted. Interpretations are made by relating the patient’s experience in the therapy or about the relationship between the patient and the therapist (interpretations of the “here and now”) or about relationships outside the therapy, with either important others or other people in the patient’s life. Interpretations about relationships outside the therapy refer to as extrasynter confrontational interpretations. Interpretations made about early experiences with caregivers are called genetic interpretations. In any regard, it is important that interpretations be timely, clear, and tactful and made in a collaborative manner only after clarifying the patient’s experience and pointing out gaps and inconsistencies. The interpretation is not offered until the patient is just about ready to discover it by him- or herself. Interpretation is offered as a hypothesis in the context of a collaborative endeavor and not as a pronouncement from an all-knowing authority as is frequently portrayed in movies, the media, and poorly trained individuals.

Technical Neutrality

The psychodynamic psychotherapist uses the techniques of clarification, confrontation, and interpretation in the context of technical neutrality. Technical neutrality, or therapeutic neutrality, is an often misinterpreted construct whereby the therapist neither accepts nor rejects the patient. The therapist may only believe that he or she needs to adopt a stone face or blank screen, say very little, refuse to self-disclose, or provide no advice, support, or reassurance. The therapist is seen as non-active, passive, maybe even bland, monotonous, or indifferent and at worst cold and lacking in concern. This is not what technical neutrality is supposed to be. Technical neutrality is a therapeutic strategy in which the therapist avoids communicating any judgment about the patient’s conflicts while they are being discussed (i.e., remains equidistant from all sides of the patient’s conflicts). Typically, therapists refrain from providing advice, praise, or reproof of the patient, and they restrain their own needs for a particular type of relationship (to be liked, valued, idealized, or the center of attention). Technical neutrality fosters warmth and genuine human concern. A nonjudgmental, noncritical stance provides the patient with a sense of safety that allows the patient to avoid memories, thoughts, and feelings. Adopting this position encourages the patient to become more fully aware of his or her mental life and can be validating to the patient. Connecting with the entirety of the patient’s internal experience is experienced as empathic. This strategy also helps the therapist avoid enactments and collusions with the patient. Finally, it is important to note that technical neutrality is modified to the extent required to maintain the structure of the treatment.

Transference

A cornerstone of psychodynamic theory and practice is the psychological phenomenon of transference. Transference is a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed to unrelated current relationships. This fundamental unconscious process also occurs in relationships between the therapist and the patient. In clinical practice, recognition of underlying fantasies that surround the therapeutic relationship can prove helpful to patients, regardless of the type of treatment or the therapist’s orientation. From a psychodynamic perspective, the transference situation has far-reaching effects and necessity influences therapeutic outcomes regardless of the therapeutic modality employed.

Countertransference has also been a central concept in psychodynamic psychotherapies. Initially, Freud defined countertransference as the analyst’s transferential response, which referred to the emergence of the analyst’s own unconscious or repressed conflicts or needs into the patient. Transference initially is a ‘transference’ of the patient to the therapist. Initially, Freud saw this as a nuisance that interfered with the therapist’s ability to treat the patient and recommended that he or she overcome his or her countertransference. Thus, the origin of countertransference was viewed as neurotic conflicts in the therapist. Freud conceptualized transference as a conceptualization of the classical approach. However, since Freud’s initial conceptualization, the concept has undergone considerable elaboration. Winnicot (1965), in working with personality disorder patients, saw some countertransference reactions as a natural reaction to the patient’s own behavior, implying that anyone would react similarly to such provocative behavior. This position is often referred to as the totalistic standpoint in that it holds that countertransference broadly includes the therapist’s unconscious and total emotional reaction to the patient, which is seen as appropriate to the patient’s behavior. As Winnicot implied and Kernberg (1965) elaborated, countertransference is not seen as unconscious reaction toward the patient deriving from the therapist’s unconscious needs and neurotic conflict but as a valuable diagnostic and therapeutic tool that provides the therapist with an emotional doorway into the patient’s internal and interpersonal world. Of course, the narrow (classical) and broad (totalistic) conceptions of countertransference are not necessarily exclusive. The task of the therapist is to monitor his or her reaction to a patient to discern between an internal conflict within the therapist and a reaction that would be evoked in most anyone. Gabbard (1995) points out that this is now the prevailing view across most theoretical schools. Therapists must be able to analyze their response as a source of their countertransference, which may be difficult and require reflection. Racker (1957) distinguished between concordant countertransference and complementary countertransference. In concordant countertransference, the therapist identifies with the patient’s current self-representation, whereas in complementary, the therapist identifies with the patient’s current internal state. In complementary countertransference, the therapist identifies with the patient’s projected or split-off mental states, which provides the therapist with a sense of what the patient may be defending against or may be concerned about.

Core Aspects of Psychodynamic Psychotherapy

A number of studies are particularly informative regarding the role of the core aspects of psychodynamic psychotherapy. The late Enrico Jones and his colleagues studied the psychotherapy process (Ablon
Kleinian Psychoanalysis. Kleinian psychoanalysis is a highly expressive object relations-based treatment that emphasizes how experience of reality is perceived and shaped by the inner world of the patient. There is a strong focus on the primary of the patient. Kleinian analysts argue that emotions, are more likely than other analysts to explore early childhood causes of neurosis. They are also known for the use of "deep" interpretations — that is, particularly bold, penetrating statements about unconscious motivations (historically, with less attention to interpreting the patient for such interpretations). There is also a greater emphasis on the analysis of primitive object relations, defenses, and aggressive drives than on libidinal needs. Contemporary Kleinian techniques focus more on the analysis of unconscious meanings in the "here and now" and take a more graduated and cautious approach to genetic reconstructions (that is, explaining how past events influence present ones).

Expressive Techniques. Expressive techniques are those that encourage exploration of the patient's internal world, particularly unconscious wishes, by allowing the therapist to undergo reparative processes that keep such thoughts and feelings out of awareness. As noted earlier, these techniques include clarification, confrontation, and interpretation. Expressive therapies stress technical neutrality and minimize supportive interventions in order to enhance transformation. Clinical neutrality and supportive interventions are common in a number of different supportive psychotherapies (Appelbaum, 2005; Novalis, Rojecewicz, & Peele, 1993; Pinsker, 1997; Rockland, 1989; Winston et al., 1994), many of which have derived from psychodynamic psychotherapy. The primary goal of SPT is to bring about change through developing a healthy collaborative relationship with the therapist and to replace self-destructive enactments with verbal expressions of conflicts. This transformation is thought to occur through the patient's identification with the reflective capacities of the therapist rather than through interpretation. SPT therapists focus on fostering the patient's positive experience of the therapist and the therapeutic alliance by creating an atmosphere of safety and security and facilitating a collaborative relationship between the patient and the therapist.

In contrast to psychoanalysis or more expressive psychotherapies, in SPT the therapist provides advice, encouragement, and/or self-disclosure. The SPT therapist may provide cognitive and emotional support by reinforcing adaptive compromises between impulses and defenses as well as supporting mastery of impulse and affect by expressing inspiration, hope, persuasion, advice, encouragement, suggestion, reassurance, praise, or concern. In addition, the SPT therapist may provide direct environmental intervention with relatives and other mental health providers or services that help to stabilize the patient's life when necessary. Typically, SPT therapists are attuned to dominant affect (the most central affect being expressed) and type of transference without interpreting it and will accept and utilize the positive transference. In contrast, certain object relations therapies, for example, Kernberg) suggest interpreting the positive transference. In SPT, more attention is given to clarification and confrontation and less to interpretation per se. Although the therapist identifies and attends to the transference by tracking it or following it, transference is not often interpreted as a vehicle for transformation. The transference is systematically abandoned, and the therapist advocates whatever position enhances the patient's adaptive functioning and potential. Thus, for an emotionally constricted patient, the therapist might encourage the expression of an inhibited impulse, whereas for an impulsive patient, the therapist might systematopically support patient awareness of harmful consequences, encourage sublimation, or help develop in the patient the other socially acceptable modes of impulse expression (e.g., exercise, sports).

Supportive-expressive (SE) Techniques. A number of writers have noted that a basic distinction or dimension in psychoanalytic psychotherapy is between expressive treatments and supportive treatments. Some theoreticians and clinicians have attempted to integrate these approaches (Gabbard, 1995; Luborsky & Crites-Christoph, 1989). Supportive-expressive (SE) psychotherapy derives from contemporary ego psychology and interpretation of classical psychoanalytic principles. The techniques have been modified to make the treatment applicable to a broader range of disorders and to incorporate supportive techniques to promote the working alliance with those of the more classical expressive techniques designed to promote exploration of the patient's mind in order to encourage self-understanding. The premise is that providing support allows for greater tolerance of the anxiety that arises during analytic procedures. In general, emphasis on expressive or supportive techniques is based on therapist evaluation of the patient's suitability for expressive interventions. Therapists use largely expressive techniques with patients who are relatively healthy, motivated, psychologically minded, and not in crisis. Therapists use predominantly supportive psychoanalytic treatments for patients with poor anxiety tolerance, greater emphasis is placed on supportive techniques designed to enhance the alliance and promote adaptive functioning.

Relational Psychoanalysis. Developed by Stephen Mitchell and colleagues (1988, 2003; Mitchell & Black, 1996), relational psychoanalysis draws on a diverse set of writings within psychoanalysis and combines interpersonal psychoanalysis with object relations theory. Those practicing from a relational perspective emphasize how the individual's psychological shape and his relationships with others and how these relationship patterns are reenacted in the
interactions between analyst and patient. Generally speaking, relational analysts focus on the interaction between therapist and patient and each party’s subjective experience of the interaction. Thus, countertransference is used to enter the dynamics of the patient’s subjective experience. These theorists challenge the idea that the analyst can objectify feelings evoked in the therapist. They see the countertransference as only objectively as impossible. They see the countertransference dynamic as constructed jointly by the two parties. In contrast to standard psychodynamic technique, the relational analyst relies on self-disclosure to the client of feelings evoked in the therapist. This is done in the interest of understanding what is being re-created in the clinical setting.

RESEARCH ON PSYCHODYNAMIC PSYCHO THERAPY

One major misconception about psychodynamic psychotherapy is that it lacks an empirical base. This misconception has become more problematic with the development of evidence-based medicine and empirically supported treatments. Many therapists assume either that psychodynamic treatments have not been tested or that they have not been found to be less effective. Although it is true that psychoanalytic and psychodynamic psychotherapies possess a smaller research base than cognitive-behavioral therapy, the truly informed clinician should be cognizant of the extent research. What follows is a review of the empirical status of psychodynamic psychotherapy for various psychological disorders.

Depression

Although the database is not nearly as large for psychodynamic treatments of depression as it is for cognitive behavioral therapy (CBT), there are enough data to suggest that psychodynamic psychotherapy (PP) is as effective as CBT and that further research is warranted on psychodynamic approaches. This conclusion is based on three sets of findings reviewed next: (1) meta-analytic studies; (2) randomized controlled trial (RCT); and (3) process-outcome studies.

Meta-analytic Studies

There are five meta-analytic studies that examine the efficacy of psychodynamic psychotherapy as compared with CBT (Churchill, Hunot, Cormey, Knapp, McGuire, Tyle et al., 2001; Crits-Christoph, 1997; Gloaguen, Cottraux, Cucherot, & Blackburn, 1998; Leichsenring, 2001; Svarberg & Stiles, 1991). Two of them show no differences between CBT and psychodynamic psychotherapy; however, there were no significant differences between groups post-treatment in symptoms, symptom reduction, or dropout. Furthermore, there were no differences between groups at 3 months and 1 year follow-up. In addition, the differences in recovery from depression between the groups did not remain when examining only the severely depressed patients. Finally, the authors note that in half the treatments they examined, the psychodynamic treatments were not bona fide therapies (see Wampold, 1997) as they were employed as a control condition that confounds the findings in favor of CBT. In the Gloaguen and colleagues’ meta-analysis, Wampold and colleagues (Wampold et al., 2002) showed that the superiority of CBT over other therapies could no longer be demonstrated once non-bona fide therapies were removed from the comparison.

The most recent meta-analytic review examining short-term psychodynamic psychotherapy for major depression to behavioral and CBT treatments found no significant differences between therapy modalities in terms of depressive symptoms, general psychiatric symptoms, or social functioning (Leichsenring, 2001). All three treatments appeared equally effective. Effect sizes for psychodynamic psychotherapy were quite large (between 0.90 and 2.40), with the average depressed patient treated in psychodynamic psychotherapy better off than 85% to 100% of patients treated before therapy. As a point of comparison, the effect sizes for antidepressant medications range between 0.24 for citalopram (Celexa) and 0.31 fordesipramine (Paxepro) (Turner et al., 2008). Effect sizes decrease when antidepressants are compared to active placebo (e.g., placebo where the main side effects are those of an antidepressant drug but do not have antidepressant components).

Randomized Controlled Trials (RCTs). Initially, brief dynamic therapy was used as a comparison from which to assess the validity of other treatments (Hersen et al., 1984). In these studies, psychodynamic psychotherapy was not a bona fide treatment as little attention was paid to the model of treatment, the appropriateness of the therapists, or the fidelity of the treatment. More recent studies have paid more attention to these issues and tend to show that psychodynamic treatments are as effective as other modalities (Barkham et al., 1999; Cooper et al., 2003; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994, 1995). For example, in a randomized controlled trial (RCT), Gallagher-Thompson and Steffen (1994) found that 20 sessions of brief psychodynamic psychotherapy were as effective as 20 sessions of CBT in reducing depression in caregivers of elderly family members. Shapiro et al. (1994, 1995) randomized patients to 8 or 16 weeks of psychodynamic-interpersonal psychotherapy (IPT) or CBT. They found that both treatments were equally effective for the 8-week and 16-week conditions and that there were no group differences at 1-year follow-up. In both therapy conditions, severe depressions responded better to 16 weeks of intervention. Thus, similar effect sizes were found when psychodynamic psychotherapy was compared with CBT, and these effects were comparable to those reported in other studies of CBT and IPT.

Process-outcome Studies. A number of process studies also suggest the value of a psychodynamic approach for depression. Jones and Pulss (1993), described earlier, found that although patients in both CBT and psychodynamic psychotherapy treatment improved significantly, the improvement in both therapies was dependent on the use of psychodynamic techniques. Indirect evidence for the importance of psychodynamic process also comes from the findings of Castonguay, Goldfried, Wiser, Rase, and Hayes (1996). In examining mechanisms of change in CBT for depression, they found that the distorted cognitions were inversely related to successful treatment outcome. However, a focus on feelings about the self, while elaborating and integrating emotional experience to develop an in-depth self-understanding, predicted positive treatment outcome. These findings suggest that cognitive-behavioral therapists use psychodynamic strategies, at least occasionally, and that it was these techniques that were associated with positive treatment outcome for patients of both psychodynamic and cognitive-behavioral therapists.

Anxiety Disorders

Seven RCTs of psychodynamic psychotherapy have been published with regard to the anxiety disorders (Alstrom, 1984a, 1984b; Bogels, 2003; Brom, 1989; Durham et al., 1994; Milrod et al., 2007a; Wilborg & Dahl, 1996). Overall, the evidence suggests that psychodynamic therapy may be beneficial for anxiety disorders. Three RCTs found that psychodynamic treatment was superior to a waitlist control or minimal care group, and one RCT found that psychodynamic treatment combined with pharmacotherapy was more effective in preventing relapse for panic disorder than pharmacotherapy alone. Two RCTs compared psychodynamic psychotherapy with CBT (Bögel et al., 2003; Durham et al., 1994); one found no difference between the...
Borderline Personality Disorders

There are three psychodynamic treatments for borderline personality that have empirical support. 5-8 The interpersonal psychological approach, Bateman and Fonagy's mentalization based therapy, and Kernberg's transference focused psychotherapy. The last two have been shown to be efficacious in RCTs.

Interpersonal Self-Psychological Approach. Russell Meares developed an interpersonal self- psychology (ART) standard and structured relaxation-focused approach that has often been used in trials aimed at assessing the effectiveness of other treatment approaches in a 12-week randomized, controlled clinical trial. The 26 patients in the PFP group had a greater reduction in their symptoms compared to the 23 patients in the ART group. In fact, by the trial's end, 73% of patients treated with the psychoanalytic approach met criteria for "response," using standard definitions of "response" criteria in the field, compared to just 39% of those in the ART cohort. In a second report examining personality disorders as a moderator of treatment response, Milrod and colleagues (Milrod et al., 2007) found that those patients with comorbid personality disorders did particularly well in the PFP group. These findings are especially important given that a host of reviews suggested that anxiety patients with comorbid personality disorders do not do well in standard CBT (Brooks, Bultzar, & Munjak, 1989; Massion, Dyck, Shea, Phillips, Warshaw, & Keller, 1992; Pollack, Otto, & Rosenbaum, 1992; Reich, 1991; Yonkers, Dyck, Warshaw, & Keller, 2000; see review by Mennin & Heimberg, 2000) and point to an important evidence-based conclusion: If a patient presents for treatment with symptoms of panic disorder and a comorbid personality disorder, PFP should be the initial treatment of choice.7

8This conclusion is preliminary given the fact that PFP is considered a probably supported treatment at this time.

patients at the end of treatment showed an increase in time employed and decreases in number of medical visits, number of self-harm episodes, and number and length of hospitalizations (Stevenson & Meares, 1992). Although the inferences that can be drawn from this study are limited by the lack of a control group, these findings supported the development and study of psychodynamic treatments for BPD. In a later quasi-experimental study (Meares, Stevenson, & Comerford, 1999), researchers compared BPD patients treated twice weekly for one year with those in a treatment-as-usual waitlist control group (all waitlisted patients received their usual treatments, which consisted of 15 sessions of psychotherapy, crisis intervention only, cognitive therapy, and pharmacotherapy). In all, 30% of IP-treated patients no longer met criteria for a DSM-III (American Psychiatric Association, 1980) BPD diagnosis at the end of the treatment year, whereas all of the treatment as usual (TAU) patients still met criteria for the diagnosis. These results demonstrated that psychotherapy based on psychodynamic principles is generally beneficial to patients with BPD in a naturalistic setting, having strong ecological validity. A five-year follow-up found that improvements were maintained (Stevenson, Meares, & D'Angelo, 2005). A recent patient-centered controlled experimental study (Korner, Gerull, Meares, & Stevenson, 2006) replicated these findings.

Mentalization-based Therapy. Bateman and Fonagy (2006) developed mentalization-based therapy (MBT) based on the developmental theory of mentalization, which integrates philosophy of mind, ego psychology, Kleinian object relations theory, and attachment theory. Fonagy and Bate

in 197.
Follow-up studies of CBT treatments for BPD have typically examined relatively short time frames (between 6 and 18 months), leaving the long-term efficacy of these treatments unclear. In addition, the outcomes for these studies have generally been mixed. For example, whereas the overall results of Linehan's outpatient psychotherapy study support the value of dialectic behavior therapy (DBT), results from her naturalistic follow-up of patients in DBT were uneven (Linehan et al., 1994). At the six-month follow-up, there were no differences between DBT and the TAU group in the number of days hospitalized, and at the end of a one-year follow-up there was no difference between groups in number of days hospitalized or suicide attempts. In addition, a six-month follow-up from the Verheul et al. (2001) study found no differences between DBT and the TAU control on impulsivity behavior, parasuicide, alcohol use, and both soft and hard drug use (van den Bosch et al., 2005). In Linehan et al.'s (2006) recent RCT comparing DBT with interpersonal treatment by experts (CTBE), the authors found that at one-year follow-up, there were no differences between the DBT and CTBE groups in terms of parasuicide or crisis services utilization. In addition, although patients in DBT were half as likely to die by suicide attempt as patients in the CTBE group if the one-year follow-up period is combined, this difference disappeared when examining only the follow-up period (Lynch, 2004). Taken together, these findings suggest variable maintenance of treatment effects and ongoing improvement in functioning in patients who may have initially experienced symptom relief.

Transference Focused Psychotherapy. The major goals of transference focused psychotherapy (TFP) are to reduce suicidality and self-injurious behaviors and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to pursue life goals (Clarkin, Yeomans, & Kernberg, 2006; Kernberg, Yeomans, Clarkin, & Levy, in press). This is believed to be accomplished through the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity confusion that perpetuate the fragmentation of the patient's internal representational world. In this treatment, analysis of the transference is the primary vehicle for the transformation of undifferentiated and unintegrated (e.g., split and polarized) to advanced (e.g., complex, differentiated, and integrated) and benign mental representations of self and others.

Using the triad of clarifications, confrontations, and interpretations, the TFP therapist provides the patient with the opportunity to integrate cognitions and affects that were previously split and autonomous, and to formulate a more realistic and emotionally intense stance of the therapist is typically experienced by patients as emotionally holding (containing) because the therapist conveys that he or she can tolerate the patient's negative affective states. The therapist's expectation of the patient's ability to have realistic thoughts, to function in an emotionally comprehensible way, and to make adaptive decisions (i.e., that the patient is a fledgling version of a capable, responsible, and reflective adult) is thought to be experienced as cognitively holding. The therapist's timely, clear, and tactful interpretations of the dominant affect laden themes and patient enactments in the transference provide early feedback about elements of a BPD personality, and shed light on the reasons that representations remain split off and thus facilitate integrating polarized representations of self and others.

There is now accumulating evidence for the effectiveness and efficacy of TFP. The initial study (Clarkin et al., 2001) examined the effectiveness of TFP in a pre-post study. Participants were women between the ages of 18 and 50 recruited from various treatment settings within the New York metropolitan area who met criteria for BPD through structured interviews. Overall, the major finding in this pre-post study was that patients with BPD who were treated with TFP showed marked reductions in the severity of parasuicidal behaviors; fewer emergency room visits, hospitalizations, and days hospitalized; and reliable increases in global functioning. The effect sizes were large and no less than those demonstrated by other BPD treatments (Bateman & Fonagy, 1999; Linehan et al., 1991). The one-year dropout rate was 19.1% and no patient committed suicide. These results compared well with other treatments for BPD. Linehan et al. (1991) had a 16.7% dropout rate and one suicide (4%); Stevenson and Meaney's study (1992) had a 16% dropout rate and no suicides; and Bateman and Fonagy's study (1999) had a 21% dropout rate and no suicides. None of the treatment completers deteriorated or were adversely affected by the treatment. Therefore, it appears that TFP is well tolerated. Furthermore, TFP provides no long-term benefits in terms of affective and emotional states, and it was also not associated with improved interpersonal functioning and affective states. The criteria for BPD after one year of twice-weekly outpatient treatment (Clarkin & Levy, 2003), this rate compared quite well with that found by others (Bateman & Fonagy, 2001; Stevenson & Meaney, 1992).

A second quasi-experimental study (Levy et al., 2007) provided further support for the effectiveness of TFP in treating BPD. In this study, 26 women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU group. There were no significant pretreatment differences between the treatment group and the comparison group in terms of demographic or diagnostic features. There were also no significant differences between the treatment and comparison groups in terms of baseline, baseline emergency room visits, hospitalizations, days hospitalized, or global functioning scores. The one-year attrition rate was 19%. Patients treated with TFP, compared to those treated with TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subject and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 0.86 for the TFP-treated participants, with an average effect size of 1.19 (which is well above what is considered "large"; Cohen, 1992). In a recent controlled trial (Clarkin et al., 2007; Levy et al., 2006), 90 clinically referred patients between the ages of 18 and 30 with BPD were evaluated using structured clinical interviews and randomized to one of the three treatments: TFP, DBT, and a credible psychodynamic SPT (Appelbaum, 2005). Results of individual growth-curve analysis indicated that both TFP- and DBT-treated groups, but not the SPT group, showed significant decrease in suicidality. Both transference-focused psychotherapy and supportive treatment were associated with improvement in anger and with improvement in facets of impulsivity. Only the TFP-treated group demonstrated significant improvements in irritability, verbal assault, and direct assault.

In an earlier report on this sample, Levy and colleagues (2006) found that the TFP group was associated with greater improvements in attachment organization and reflective functioning as putative mechanisms of change. Attachment organization was assessed using the Adult Attachment Interview (AAI, George, Kaplan, & Main, 1985) and the RF coding scale (Fonagy et al., 1998). After 12 months of treatment, the TFP group showed approximately a 16% decrease in the number of patients classified as secure with respect to attachment state of mind for TFP, but not the other two treatments. Significant changes in narrative coherence and RF were found as a function of treatment, with TFP showing increases in both constructs during the treatment and both constructs showing a 1 year of intensive TFP can increase patients' narrative coherence and reflective function. These findings are important because they show that TFP not only is an efficacious treatment for BPD but works in a theoretically predicted way and thus has implications for conceptualizing the mechanism by which patients with BPD may change. In addition, patients in TFP did better on these putative mechanisms (e.g., reflective function) than those in DBT and SPT. Our findings are especially important given the literature showing that many treatments do not show specific effects on these specific theory-driven mechanisms (Ablon & Jones, 1998; Ablon, Levy, & Katzenstein, 2002; Castonguay, Goldfried,
adherence by the TFP therapists. The authors report the median adherence level for TFP was 65.6%. Given that a score of 60 is considered adherent, about 50% of TFP therapists were nonadherent. In contrast, the SFT group had a median score of 85.6 (again with 60 as adherent), suggesting that 80% of the SFT were not just adherent but exceptionally so. Not only were adherence ratings relatively poor for TFP, but they also appear to be significantly lower than for SFT. Suffice it to say, the report compares an exceptionally well-delivered treatment with an inadequately delivered one. There should be no surprise that the exceptionally well-delivered treatment outperformed the poorly delivered one. It is not a fair test, and this fact alone may explain the differential outcome between the two treatments.

Fourth, treatment integrity includes having experienced treatment cell leaders, choosing experienced and adherent therapists with a proven track record, providing expert monitoring, providing ongoing monitoring of adherence, and having plans for dealing with nonadherence (Clarkin et al., 2004). Each of these issues was problematic in the current study. Supervision was carried out in the form of peer supervision, known as intervison (Yeomans, 2006). Interruption may also occur if the two therapists carried out by the experienced adherent therapists as was the case for the SFTP. However, such a model would not work well with nonadherent therapists and would be more akin to the blind leading the blind. The authors indicate that treatment integrity was monitored by means of supervision, but who was doing that? Flegennoch and Kestenbaum (1991), and Trujillo, 1991; Winston, Laiken, Pollack, Samstag, McCullough, & Muran, 1994). Winston and colleagues compared a short-term psychodynamic psychotherapy based on the work of Malan (1976) and Davanzo (1986) and a short-term psychodynamic psychotherapy called brief adaptive psychotherapy (BAP) with a waitlist control in a group of patients predominantly diagnosed with cluster C personality disorders. Both treatments address defensive behavior and elicit affect in interpersonal contexts, although the BAP treatment is less confrontational. The authors found that both treatment groups showed significant change on the global severity index (GES) of the symptom checklist (SCL) 90. The authors examined a 40-week post-treatment follow-up indicated the maintenance of treatment gains (Winston et al., 1994). Abbas et al. (2006) examined SFTP for outpatients with a range of personality disorders. The authors concluded that treatment of interpersonal problems, significantly more hours worked, and better employment outcomes relative to controls. One study using an RCT examined outpatients with cluster C personality disorders (avoidant, dependent, obsessive-compulsive; Sartorius, Stiles, & Seltzer, 2004). The authors examined a 40-week follow-up, 54% of the short-term dynamic psychotherapy patients and 42% of the CT patients had recovered symptomatically.

Mixed and Other Personality Disorders

Three studies have examined psychodynamic psychotherapy for personality disorders (Abbis, Shesely, Gyra, & Kalpin, 2006; Winston, Pollach, McCullough, Flegennoch, Kestenbaum, & Truijullo, 1991; Winston, Laiken, Pollack, Samstag, McCullough, & Muran, 1994). Winston and colleagues compared a short-term psychodynamic psychotherapy based on the work of Malan (1976) and Davanzo (1986) and a short-term psychodynamic psychotherapy called brief adaptive psychotherapy (BAP) with a waitlist control in a group of patients predominantly diagnosed with cluster C personality disorders. Both treatments address defensive behavior and elicit affect in interpersonal contexts, although the BAP treatment is less confrontational. The authors found that both treatment groups showed significant change on the global severity index (GES) of the symptom checklist (SCL-90) (approximately 1 SD) and some changes on the social adjustment scale. An 18-months post-treatment follow-up indicated the maintenance of treatment gains (Winston et al., 1994). Abbas et al. (2006) examined SFTP for outpatients with a range of personality disorders. The authors concluded that treatment of interpersonal problems, significantly more hours worked, and better employment outcomes relative to controls. One study using an RCT examined outpatients with cluster C personality disorders (avoidant, dependent, obsessive-compulsive; Sartorius, Stiles, & Seltzer, 2004). The authors examined a 40-week follow-up, 54% of the short-term dynamic psychotherapy patients and 42% of the CT patients had recovered symptomatically.

META-ANALYSIS OF PSYCHODYNAMIC PSYCHOTHERAPY FOR PERSONALITY DISORDERS

There have been two meta-analyses of psychotherapy for personality disorders (Leichsenring & Leibing, 2003; Perry et al., 1999). Perry and colleagues (1999) identified 15 studies, including 6 RCTs, and found post-effect sizes ranging from 1.1 to 1.3, which decreased to 0.7 when an
active control treatment was used. In a second meta-analysis, Leichsenring and Leibing (2003) examined the efficacy of both psychodynamic psychotherapy (14 studies) and CBT (11 studies) in the treatment of patients with personality disorders. Eleven of the studies were RCTs. They reported pretreatment to post-treatment effect sizes using the longest-term follow-up data reported in the studies. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end, and the pretreatment to posttreatment effect size was 1.46. The findings again indicate that psychodynamic treatment is superior to treatment by CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pretreatment to post-treatment effect size was 1.0. The authors concluded that both psychodynamic therapy and CBT demonstrated effectiveness for patients with personality disorders. However, evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. There was a nonsignificant correlation between treatment length and outcome. Thus, based on limited data, psychodynamic and CBT treatments appear to be equally effective for personality disorders, long-term follow-up yield better outcomes, and psychodynamic treatments may have longer-lasting effects.

Eating Disorders

Eight RCTs have examined a psychodynamic treatment (Bachar et al., 1995; Crisp et al., 1991; Dare et al., 2001; Fairburn et al., 1986; Garner et al., 1993; Gowers et al., 1994; Hall & Crisp, 1987; Russell et al., 1987). The general finding is that for anorexia nervosa, psychodynamic treatment is as effective as other treatments, including behavioral and strategic family therapy (Crisp et al., 1991; Dare et al., 2001; Gowers et al., 1994; Hall & Crisp, 1987; Russell et al., 1987). Gowers et al. found significant improvements in weight and body mass index as compared to a TAU control condition. Dare and colleagues found that both psychodynamic psychotherapy and family therapy were significantly superior to routine treatment in terms of weight gain. With regard to bulimia nervosa, Fairburn et al. (1986) and Garner et al. (1993) found that psychodynamic and CBT treatments resulted in comparable improvements in bulimic episodes and self-induced vomiting, although CBT was superior on other measures of psychopathology. At follow-up both were equally effective and superior to behavior therapy (Fairburn et al., 1995). Thus, although the initial findings favored CBT, the long-term outcome was comparable and differentiated from behavior therapy, suggesting that both CBT and psychodynamic treatment are preferred choices over behavior therapy, although CBT may work more quickly. More long-term follow-up is needed to determine the long-term significance of these findings.

Marital Therapy

In a controlled outcome study, Snyder et al. (1991) followed up 59 couples four years after receiving either behavioral or insight-oriented marital therapy. There were no group differences between the two treatment conditions at either termination or six-month follow-up. However, at four-year follow-up, couples who received the insight-oriented therapy were more likely to be happily married (79% vs. 50%), whereas the couples who received the behavioral therapy were more likely to be divorced (38% vs. 3%).

Summary of Empirical Findings with Psychodynamic Psychotherapy

In summary, contrary to uniform stereotypes, psychodynamic psychotherapy appears to be as effective as other treatments; effect sizes from meta-analyses suggest that it is more effective than psychotherapy in general, as effective as CBT, and more effective than antidepressants. However, there is no evidence from RCTs for psychoanalysis or for longer-term therapies for depression or anxiety disorders. The data from studies of depression strongly suggest the need for more intensive treatment because the long-term efficacy of CBT, IPT, medication, and psychodynamic psychotherapy treatments appears poor. Despite the consistency of the findings, no specific psychodynamic psychotherapy meets the criteria as an empirically supported treatment (Chambless & Hollon, 1998) because no two studies by specific research groups are of the same form of psychodynamic psychotherapy. Nevertheless, a number of psychodynamic psychotherapies do meet criteria for probably being empirically supported (Bateman & Fonagy, 1999, 2001, 2008; Clarkin et al., 2007; Gallagher-Thompson & Steffen, 1994; Levy et al., 2004; Morgan & Miller, 1989, 1991; Woody et al., 1985). Some particularly striking findings that deserve additional study concern (1) the outcome in marital therapy in terms of happiness and divorce rates, which strongly suggests an advantage for insight-oriented psychotherapy; (2) the long-term outcome in marital therapy; and (3) the efficacy and effectiveness of TFP given the changes in hypothesized mechanisms of action.

Common Misconceptions Regarding Psychodynamic and Psychosanalytic Psychotherapy

There are a number of common misconceptions regarding psychodynamic psychotherapy that the reader can now defend.

1. Myth: Psychodynamic constructs and therapy cannot be studied empirically.

Reality: Although it can be difficult to operationalize many psychoanalytic constructs, with effort and attention to avoiding post hoc explanations, it can be accomplished.

2. Myth: There is no empirical research on psychoanalysis. Reality: There is a much larger body of research on psychoanalytic ideas than is generally known or acknowledged. As evidence, there are now many studies of psychoanalytic constructs, particularly of unconscious and defensive processes that have found support for basic psychoanalytic ideas. Interested readers are directed to a review paper by Westen (1999) in Psychological Bulletin and to the 10 volumes of a series titled Empirical Studies of Psychoanalytic Theories edited or co-edited by Joseph Masling, Masling (cited in Hoffman, 2002, p. 307) contends that "in fact, Adlerian theorists have proven to be so robustly heuristic they have probably inspired more research in personality than any other set of ideas."

3. Myth: Psychodynamic psychotherapy is not or cannot be codified or manualized.

Reality: There are a number of excellent examples of psychoanalytic or psychodynamic psychotherapy manuals. More recently, there has been increased emphasis on clear explanation of techniques, including the development of treatment manuals. This trend began with the detailed descriptions of psychodynamic treatments for patients with interpersonal difficulties by Luborsky (1984) and Strupp (1984) and recently has been expanded with descriptions of psychodynamic treatments for those with severe personality disorders (Bateman & Fonagy, 2003; Clarkin, Yeomans, & Kernberg, 2006), panic disorder
patterns, the treatments tend to focus on current difficulties and interaction patterns and are more likely to connect these issues to the here and now of the therapy session than to reconstruct the past.

7. Myth: Psychodynamic psychotherapy is irremediable. Reality: Although a traditional analysis will require the commitment of a number of sessions a week for many years, there is a host of short-term treatments for depression, anxiety, and eating disorders. Psychodynamic treatments tend to be longer for personality disorders, as are cognitive-behavioral treatments for these types of problems.

8. Myth: Psychodynamic psychotherapy lacks an evidence base, and what exists indicates that it is largely ineffectual. Thus, it is probably unethical to utilize it as a treatment. Reality: There is excellent evidence for psychodynamic psychotherapies for many disorders, including depression, panic, PTSD, eating disorders, BPD, cluster C personality disorders, and marital therapy. The effect sizes are generally as large as for CBT. When there are differences favoring CBT, they usually disappear by follow-up and appear to be the result of allegiance effects (Luborsky et al., 1999; Robinson et al., 1990). There is also some evidence that effect sizes increase for psychodynamic treatments over time, suggesting that their effects may show themselves more slowly but also in increased effectiveness over other treatments (e.g., Bateman & Fonagy, 2008). This process whereby patients continued to improve after psychodynamic therapy ends has been referred to as a “sleeper effect.”

HIGHLIGHT BOX 81
ADVANCED TRAINING OPTIONS

There are fewer and fewer options available to individuals interested in psychodynamic training. Even at the undergraduate level, those interested in psychoanalytic ideas often cannot find them taught within psychology departments and instead take classes in the humanities where psychodynamic thought is better accepted (Cohen, 2007). At the graduate level, the vast majority of clinical training programs are cognitive-behavioral in their training orientation (Levy, 2008; Sayett, Mayne, & Norcross, 2006). A number of programs within the New York City area have a critical mass of psychoanalytic faculty (e.g., CUNY, Adelphi, Long Island University, New School University). However, only a handful of major research universities have psychodynamic faculty (e.g., Penn State, Emory, Tennessee). Most training programs have only one or maybe two dynamically trained faculty members. These numbers are down significantly from the situation in the 1950s through the 1980s when core faculty at major programs such as Michigan, Yale, NYU, Columbia, and Boston University were predominately psychodynamic in their orientation. Even PsyD programs are becoming less psychodynamic (Levy, 2008; Sayett, Mayne, & Norcross, 2007).

One possible reason for this change is the vicious antitrust lawsuit against the AMA in the 1980s, which resulted in psychologists having access to psychoanalytic institutes for advance training (Welch, et al., the American Psychoanalytic Association). This event, combined with the need for practitioners that arose in the 1970s and 1980s, the increasing emphasis in academia on obtaining grants, and the perception in academia that psychodynamic theory has been discredited or lacks empirical support resulted in a flood of dynamically oriented students giving up research-oriented careers and entering private practice. Nevertheless, there is an issue about how to get advanced training in psychodynamic psychotherapy at the doctoral level. The American Psychological Association Division 39 (Psychoanalysis) has an outreach link on its Web site that lists doctoral programs, internships, and postdoctoral sites that have psychodynamic representation. In addition, the American Psychoanalytic Association (APSA) lists psychoanalytic training institutes on its Web site. The APSA Web site lists only those programs that they have accredited. Many good training programs are not approved by the APSA but are approved by the International Psychoanalytic Association (IPA). Cities such as New York, Boston, Chicago, and Los Angeles often have multiple training institutes. Training is available in smaller cities such as Philadelphia, Pittsburgh, Cleveland, Durham, Atlanta, Houston, and Albany, among others.

For an accessible Jasper-free introduction to the principles underlying psychodynamic psychotherapy, the reader is directed to a triad of books by Nancy McWilliams: Psychoanalytic Diagnosis, Psychoanalytic Case Formulations, and Psychodynamic Psychotherapy: A Practitioner’s Guide (McWilliams, 1999). These books offer guidance for both beginning psychotherapists and more experienced therapists who are interested in a psychodynamic approach. In addition, Glenn Gabbard has a number of books, including Psychodynamic Psychiatry in Clinical Practice and Long-term Psychodynamic
Psychotherapy: A Basic Text, which are useful for both psychology doctoral students and psychiatry residents. Interested readers should also consult Huprich’s (2008) Psychoanalytic Therapy: Conceptual and Empirical Foundations. These works provide an excellent introduction to contemporary psychodynamic psychotherapy. For those working with severely disturbed patients, there are a number of books by Kernberg and colleagues, including Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology (Caligor et al., 2007), Psychotherapy for Borderline Personality: Focusing on Object Relations (Clarkin et al., 2007), and A Primer of Transference-focused Psychotherapy for the Borderline Patient (Yeomans et al., 2003). Fonagy and his group also have a number of books on mentalization-based therapy, including Psychotherapy for Borderline Personality Disorder, Mentalization-Based Treatment for Borderline Personality Disorder, The Handbook of Mentalization-based Treatment, and Affect Regulation, Mentalization, and the Development of the Self, which the reader would probably find useful.

8.4. You are seeing a parasuicidal patient who has been in therapy for a number of months. The patient calls one night in a suicidal crisis. You contract with him to go to his local emergency room. In your first meeting with the patient after his discharge from the hospital, he begins by recounting in detail how foolish the staff at the hospital was because they allowed him to cut himself while under supervision (he had snuck in a razor blade in a book and cut himself under his long-sleeve shirt). As the patient recounts this story, his affect is extremely positive and gleeful. You comment that perhaps he thought that you were incompetent or foolish, too, in that he may feel you didn’t take his suicidality seriously enough and that you suggested that he go to the hospital emergency room, an emergency room statistician in detail how he was able to do it. He responds with a big satisfied smile. At this point, you ask the patient if he realized he was smiling, to which he responds yes. You point out that although he was talking about suicide,

**HIGHLIGHT BOX 8.1 (continued)**

**THOUGHT QUESTIONS**

8.1. You’re sitting with a new patient whom you have only seen a few times. Although his affect and demeanor are friendly, he comments about your office being small: “This is the nicest broom closet I’ve ever seen.” Later he makes a disparaging comment about one of the paintings on your wall. In another session, he comments about not having bottled water available for patients. As the therapy progresses, you make what you feel are appropriate interventions. However, you begin to feel inadequate as a therapist, unhelpful, and demoralized about the prospects of the patient improving. Upon reflection, you realize that you generally don’t feel incompetent or inadequate as a therapist. You recall that your supervisors have consistently given you high ratings across a number of domains, and despite occasional self-doubts about your clinical work, your patients have generally improved. You recognize that you are experiencing countertransference, but what type of countertransference is it, narrow (classical) or broad (totalistic)? Is it complementary or discordant?

8.2. You have just seen a patient with panic disorder and a comorbid personality disorder. The clinic director is strongly supportive of providing evidence-based medicine and empirically supported therapies. Although you have been interested in working psychodynamically with a patient, she strongly advises you to proceed to choose a CBT supervisor for this patient. How might you respond to your supervisor’s advice?

8.3. A college-age student is admitted as your patient after a suicide attempt to an inpatient psychiatry unit where you are working as an extern. The patient is young, smart, articulate, but very disinterested. She explains that she tried to kill herself because she was the victim of sexual abuse by her older brother. The abuse started when she was very young and continued for many years into her teens and included intercourse. She explains that prior to this admission she had not told anyone of the abuse, not even her parents. You find the patient to be very compelling, and the case evokes a lot of feelings in you. You find yourself enraged at the brother for perpetrating such a terrible act on your patient, and you find yourself angry at the parents for letting such a thing happen and continue for so long. During your sessions, she is very open with her anger and disgust toward her older brother and her parents. At times, you find yourself so angered by what happened that you share with her your anger about the events and toward the brother. You work with the patient to help her tell her parents about what happened and to confront the older brother. The night before a family meeting with her parents, she attempts to kill herself by ingesting medications that she had been cheating all week (i.e., hiding her medication in the side of her mouth). She was discovered accidentally during nightly rounds because she was driven to the floor as opposed to back on her bed. Upon hearing the news, you feel angry toward the older brother, but she died. You try to kill her again because of what had happened. When you speak to her in the hospital, she is very tearful, and you try to allay her guilt by acknowledging how badly she feels about the abuse. However, she surprises you when she tells you that the abuse is not why she tried to kill herself. She then shares with you that she wanted to die because you had been so angry at the older brother for abusing her. She then confides in you that just as she had been sexually abused by her older brother, she had engaged her younger brother in sexual behavior for which she felt guilty, especially when you become angry at the older brother. How might a concept like technical neutrality have aided you in working with this patient? How would you continue in therapy while remaining technically neutral? You are seeing a parasuicidal patient who has been in therapy for a number of months. The patient calls one night in a suicidal crisis. You contract with him to go to his local emergency room. In your first meeting with the patient after his discharge from the hospital, he begins by recounting in detail how foolish the staff at the hospital was because they allowed him to cut himself while under supervision (he had snuck in a razor blade in a book and cut himself under his long-sleeve shirt). As the patient recounts this story, his affect is extremely positive and gleeful. You comment that perhaps he thought that you were incompetent or foolish, too, in that he may feel you didn’t take his suicidality seriously enough and that you suggested that he go to the hospital emergency room, an emergency room statistician in detail how he was able to do it. He responds with a big satisfied smile. At this point, you ask the patient if he realized he was smiling, to which he responds yes. You point out that although he was talking about suicide,
possibly dying and being cared for by "fools" and "incompetents," he was smiling and you wondered what he might be taking pleasure in. He did not seem to know, and you point out that maybe he was taking some pleasure in the fact that he perceived you and the hospital staff as inept. It is at this point that the patient realizes that he has been taking pleasure in the hospital staff's ineptness. Your question as to whether the patient was aware of the smile could be conceptualized as what psychodynamic technique? Your comments about the patient's affect and its discordance from the content of what he was discussing could be conceptualized as what psychodynamic technique? What might be your next technical move? Think about what you might say.

**Transference:** Believed to be a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously idealized or buffered to unrelated current relationships.

**Transference interpretation:** The process of interpreting a patient's exhibition of transference.

**Unconscious:** Some mental processes, such as motives, desires, and memories, that are not available to awareness or conscious introspection.

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**References**


of treatment efficacy. Clinical Psychology Science and Practice, 47, 109–118.


Interpersonal Psychotherapy

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INTRODUCTION TO INTERPERSONAL PSYCHOTHERAPY

Psychotherapies and interpersonal relationships are intricately bound together at many levels. There is a therapeutic relationship between therapist and patient (or patients—in group treatments). Beyond the therapeutic relationship, many patients seek help because they experience interpersonal problems that lead to difficulties forming relationships or repeatedly experiencing painful, conflictual, exploitative, enmeshed, or other maladaptive relationship patterns. Even when a patient seeks therapy for a specific anxiety, mood, eating, or substance use disorder, treatment will likely include examination of some of the various family, marital, social, and occupational relationships in the patient’s life. And finally, most approaches to psychotherapy also propose that there are interpersonal relationships that exist inside both therapist and patient. The psychological concept of mental representation (Blatt, Auerbach, & Levy, 1997) represents a pantheoretical construct of intrapsychic mental models of interpersonal relationships. Whether referred to as interpersonal schemas (cognitive therapies), internal object relations (psychodynamic psychotherapies), or internal working models...