CHAPTER

8

Psychodynamic and Psychoanalytic Psychotherapy

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OUTLINE

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 psychotherapies 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 Bellak 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 *psychodynamic* and *psychoanalytic* are often used interchangeably. However, within the psychodynamic and psychoanalytic 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 treatment three to five times weekly for 45- to 50-minute sessions. Treatment usually involves the patient lying on a couch and the analyst sitting behind the patient while the patient free associates — that is, says whatever comes to mind. Psychodynamic psychotherapy is characterized by the same basic techniques as psychoanalysis but tends to be briefer and less intensive than psychoanalysis. Although any given session of psychodynamic psychotherapy may be indistinguishable from a psychoanalytic session, in psychodynamic psychotherapy the therapist is more likely to be actively engaged with the patient, to resonate emotionally with the patient's affect states, and rely more 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 psychodynamic psychotherapy. These include the idea that some mental processes, such as motives, desires, and memories, are not available to awareness or 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 psychotherapy, 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 psychodynamic 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 from awareness. This concept of defense is generally well supported in the empirical literature examining narratives of adults (Main, 2000), psychophysiological data (Adams, Wright, & Lohr, 1996; Shedler, Mayman, & Manis, 1993), and neuroscience data (Anderson, Ochsner, Kuhl et al., 2004; Westen, Blagov, Harenski, Kilts, & Hamann, 2006) and is generally well accepted (Meehl, 1997). There is much

evidence from experimental, social, and neuroscience research suggesting the importance of *unconscious* mental processes; however, the data are still unclear as to whether or not this nonconscious processing is motivated.

A third tenet central to psychodynamic theory is that of a *developmental perspective* in which childhood relationships with caregivers are seen as playing a role in shaping current relationships. This is not to imply a linear relationship or critical period between early experience and later development. Psychodynamic theory, consistent with a developmental psychopathology perspective, is probabilistic rather than deterministic regarding this relationship. In addition, this does not mean that the psychodynamic perspective fails 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 experience of themselves and their overt behavior.

Finally, a psychodynamic perspective emphasizes the importance of *individual or personal meaning* of events. Psychodynamic clinicians are interested in the patient's phenomenological experience — how the patient experiences himself, important others, the world in general. In this way, psychodynamic clinicians are focused on 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 psychoanalytic 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 neuroscience provides validation for these basic premises (see Westen, 1999, for a review).

Several other concepts are central to the psychodynamic 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 stressed 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

Freud developed psychoanalysis over the course of many years and was influenced by a number of colleagues and experiences. Between 1895 and 1938 Freud was a prodigious writer. His compiled works amount to 23 volumes and cover thousands of pages of writing. During the 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. For these 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 his lab as an assistant. Many years later he would 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, protomyazin, and sexual organs of eels, supplying a missing 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 spinal neurons in humans and frogs 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. Thus, 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. Regardless of promotion, science and university academics did not portend of a particularly lucrative career. 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 commencing 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) and several books on paralysis 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

took their problems seriously. For most of the 1880s and well into the 1890s, he used the treatments popular at the time, including combinations of massage, rest therapy, hot baths, and weak electric currents. But he could tell that these treatments did not work very well on what we would today call psychosomatic disorders, and so he became interested in finding better procedures.[1]

In an effort to learn more about how to treat these patients, Freud applied for and won a grant to travel to Paris to study under famed neurologist Jean-Martin Charcot for six months at the Salpêtrière mental hospital in Paris. Charcot was a well-respected psychiatrist, the director of the Salpêtrière, who had turned his interest toward the problem of hysteria. Charcot had found that many patients experienced paralyses, pains, coughs, and a variety of other symptoms with no demonstrable physical etiology. Prior to Charcot's work, women were thought to have a wandering uterus (hence the Greek name "hysteria") for which pregnancy was often the prescribed treatment. In contrast, Charcot believed that after a physical trauma, a "hypnoid state" developed that made people who were predisposed to hysteria susceptible to the induction of hysterical symptoms. Thus, in contrast to the Viennese view that those suffering from hysteria were malingering, Charcot hypothesized that hysteria developed from mental degeneration or mental weakness.

Freud attended Charcot's lectures and demonstrations on hysteria. He managed to gain Charcot's attention by offering to translate some of his writings into German. In consultation, Charcot suggested to Freud that he write a paper analyzing the differences between hysterical and organic paralysis. This was a definitive work in the area. What he found was something called glove and sock paralysis, in which the physical symptoms corresponded to how the hysterical individual thought the symptom should be expressed (e.g., paralysis of the arm from the top of the shoulder to the tips of the fingers rather than paralysis that followed the actual nerve pathways) that is, hysterical symptoms were delimited according to popular beliefs, which led to a presentation that was not consistent with actual nerve tracts. This was for Freud a major breakthrough and led to what might be considered his first great discovery on the way to developing psychoanalysis — that ideas can create and shape physical symptoms. He shared this idea with Charcot, who promptly rejected it, preferring his own idea that hysteria was a disorder of function rather than structure.

Upon returning to Vienna, Freud employed hypnosis on his patients but found it inadequate because not everyone is hypnotizable. Only about 20% to 30% of people make really good hypnotic subjects. Therefore, in 1889 Freud returned to France to work with Hippolite Bernhiem at the Nancy School in Nancy, France, to try to perfect his hypnotic technique. Bernhiem was a well-known physician who became interested in hypnosis through the work of a country doctor named Auguste Liebeault. As opposed to Charcot, Bernhiem believed that hypnosis was a normal phenomenon. While working with Bernhiem, Freud learned four principles that influenced his thinking:

1. Posthypnotic suggestions — Normal patients were highly suggestible with regard to both onset and diminishment of physical symptoms. Further, the symptoms were indistinguishable from those of hysterics.

[1] Freud remained a scientist at heart; he wanted to figure out what caused these problems — a perspective he learned while working with Brücke. In contrast to typical physiologists of the time, Brücke was concerned with the function of particular cells and organs, not just with their structure. Brücke's work thus focused on the attempt to discover basic physical laws that governed the processes that took place in living systems.

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 recovered to consciousness.[2]
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 Pappenhiem, 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 squint, 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 it was being talked away

Thus, from Breuer's work with Anna O., Freud concluded that suppressed 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 when 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).

[2]I use only the word *conscious* because Freud himself had not yet postulated the idea of an *unconscious*.

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 and is unable to experience 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 obtrudes into consciousness disguised as 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, "Ueber den psychischen Mechanismus hysterische Phänomene" (On the Psychical Mechanism of Hysterical Phenomena, 1893, trans. 1909) 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 hypnotism provided only partial and/or temporary symptom relief (which we also know today). Third, he believed that hypnotism 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 thought 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 Brücke, who was a determinist, and based on his own findings while working with Charcot, Freud felt that hysterical symptoms 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 causes. Random thoughts, the inability to recall a familiar word or idea, saying or writing of wrong words, self-inflicted injuries, bungled actions, dreams, neurotic symptoms — all have underlying reasons, which may be *unconscious*. Thus, the forgetting of an appointment or a college exam happens for definite reasons. The explanation of these "parapraxes" 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 multidetermined. In a bold move, Freud reasoned that if nothing in the mind happens by chance, then all one needs to do is let the patient say 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-affective-

[3]Also known as the seduction theory.

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 free 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 15 years of work and only 2 or so years after 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 stories 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 sexual 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 were fantasies. This presented a real 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 yield a 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 a 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 that sexual abuse occurred or that it had profound effects on those who experienced it. He 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 sexual abuse at 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 internalized inhibitions. If Freud was alive today, no 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 hysteria grew into a deep theory of personality and development.

Freud is often portrayed as unscientific because many 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 by indicating that he "cannot put much value on these confirmations because the wealth 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 what it cannot give us" (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, Darwin, 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.

COMPONENTS OF PSYCHOANALYTIC AND PSYCHODYNAMIC PSYCHOTHERAPY

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 psychoanalytic 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 subjective experience. 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 inserting 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 thoroughly clarifying because the patient 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 understanding. 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* can be made regarding 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 of therapy are referred to as **extratransferential 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 psychodynamic therapist mistakenly believes 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 nonactive, 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 exploration of previously avoided 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 therapists and patients. 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 therapeutic orientation of the therapist. From a psychodynamic perspective, the transference situation has far-reaching effects and necessarily influences therapeutic outcome regardless of the therapeutic modality employed.

Countertransference has also been a central concept in psychodynamic psychotherapies. Initially, Freud defined *countertransference* as the analyst's transference to the patient, which referred to the emergence of the analyst's own unresolved or unanalyzed *unconscious* conflicts protruding into the patient's therapy. 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 analyst or therapist. This conceptualization is often referred to as the classical approach. However, since Freud's initial conceptualization, the concept has undergone considerable elaboration. Winnicott (1965), in working with personality disordered patients, saw some countertransference reactions as a natural reaction to the patient's outrageous 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 conscious and total emotional reaction to the patient, which is seen as appropriate to the patient's behavior. As Winncott 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 window or channel into the patient's internal and interpersonal world. Of course, the narrow (classical) and broad (totalistic) conceptions of countertransference are not mutually 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 and understand the 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, which provides the therapist with a sense of 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 core aspects of psychodynamic psychotherapy. The late Enrico Jones and his colleagues, particularly Stuart Ablon, investigated the psychotherapy process (Ablon

& Jones, 1999; Jones & Pulos, 1993). In an initial study, Jones and Pulos (1993) used archival records to compare the therapy process in 30 brief psychodynamic and 32 cognitive-behavioral therapies. Verbatim transcripts of 186 treatment sessions were rated with the Psychotherapy Process Q-set (Jones, 1985), which was designed to provide a standard language for the description of psychotherapy process. Factor analysis of the ratings of the Q-set items found four factors: psychodynamic technique, cognitive-behavioral technique, negative emotions, and *resistance*. Cognitive-behavioral therapy promoted control of negative emotions through the use of intellect and rationality combined with vigorous encouragement. Psychodynamic therapy emphasized (1) evocation of emotions; (2) bringing of troublesome feelings into awareness; (3) integration of current difficulties with previous life experience; and 4) use of the therapist-patient relationship to foster change. Blagys and Hilsenroth (2000) used the PsycLit database to perform a computer search to identify empirical studies that compared the process and technique of manualized psychodynamic psychotherapy with that of manualized cognitive-behavioral therapy. Their systematic literature review indicated that psychodynamic psychotherapy had seven distinctive features: (1) focus on affect and expression of emotion; (2) exploration of attempts to avoid aspects of experience; (3) identification of recurring themes and patterns; (4) discussion of past experience; (5) focus on interpersonal relations; (6) focus on the therapeutic relationship; and (7) exploration of wishes, dreams, and fantasies.

VARIANTS OF CLASSICAL OR FREUDIAN PSYCHOANALYSIS

Kleinian Psychoanalysis. Kleinian psychoanalysis is a highly expressive object relations–based treatment that emphasizes how external reality is perceived and shaped by the inner world of the patient. There is a strong focus on the primacy of the analysis of the transference, even early in treatment. Kleinian analysts 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 preparing 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* meaning 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, fears, and desires, along with the defensive 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 transference.

Supportive Psychotherapy (SPT). There are a number of different supportive psychotherapies (Appelbaum, 2005; Novalis, Rojcewicz, & 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 working alliance by creating an atmosphere of safety and security and facilitating a collaborative relationship between the patient and therapist.

In contrast to psychoanalysis or more expressive psychotherapies, in SPT the therapists provide 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 or 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.[4] In contrast, certain object relations–based therapies (e.g., 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. Finally, technical neutrality 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 systematically support patient awareness of harmful consequences, encourage sublimation, or help develop in the patient 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 & Crits-Christoph, 1989). Supportive-expressive (SE) psychotherapy derives from contemporary ego psychology *interpretation* of classical psychoanalytic principles. The techniques have been modified to make the treatment applicable to a broader range of patients. SE psychotherapies explicitly 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 exploration in the patient. The relative 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. For these patients, therapy resembles a more traditional psychoanalytic treatment. 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, 2000; 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 personality is shaped by both real and imagined relationships with others and how these relationship patterns are reenacted in the

[4]Positive transference is the good feelings the patient has toward the therapist. From some perspectives, such as Kernberg's, positive transference early in treatment is conceptualized as idealization and interpreted. In supportive psychotherapy, positive transference is used to strengthen the therapeutic alliance, especially the working alliance.

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 be a neutral outsider commenting objectively on the internal dynamics of the patient and regard objectivity as impossible. They see the transference-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 PSYCHOTHERAPY

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 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 extant 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, Corney, Knapp, McGuire, Tylee et al., 2001; Crits-Christoph, 1992; Gloaguen, Cottraux, Cucheret, & Blackburn, 1998; Leichsenring, 2001; Svartberg & Stiles, 1991). Two of them show no differences between psychodynamic psychotherapy and CBT (Crits-Christoph, 1992; Leichenring, 2001), while the other three have found various levels of superiority for CBT over psychodynamic (Churchill et al., 2001; Gloaguen et al., 1998; Svartberg & Stiles, 1991). In the Churchill et al. review, they found superiority for CBT in terms of percent recovered from depression; 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 disappeared 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 comparisons. The most recent meta-analytic review comparing 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 (Leichenring, 2001). All three treatments appeared equally effective. Effect sizes for psychodynamic psychotherapy were quite large (between 0.90 and 2.80), with the average depressed patient treated in psychodynamic psychotherapy better off than 82% to 100% of depressed patients before therapy. As a point of comparison, the effect sizes for antidepressant medications range between 0.24 for citalopram (Celexa) and 0.31 for escitalopram (Lexapro) (Turner et al., 2008). Effect sizes decrease when antidepressants are compared to active placebos (e.g., noninert placebo that mimics the side effects of an antidepressant drug but do not have antidepressant components).

Randomized Controlled Trials (RCT). 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 treatment is 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 Pulus (1993), described earlier, found that although patients in both CBT and psychodynamic psychotherapy treatment improved, 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, Raue, and Hayes (1996). In examining mechanisms of change in CBT for depression, they found that focusing on distorted cognitions was 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; Bögels, 2003; Brom, 1989; Durham et al., 1994; Milrod et al., 2007a; Wiborg & 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 (Bögels et al., 2003; Durham et al., 1994); one found no difference between the

treatments (Bögels et al., 2003), and the other found that analytic therapy provided significant improvement but to a lesser degree than CBT (Durham et al., 1994). However, in the Durham et al. study, in contrast to the CBT treatment, the dynamic treatment was not manualized, there was no specific training of therapists, and there was no adherence checks or treatment fidelity monitoring for the dynamic therapists.

The most recent and exciting trial comes from Milrod and colleagues (2007). They manualized a psychodynamic treatment based on theory and case reports that focused on symptom reduction through exploring *unconscious* determinants, such as unacknowledged anger and conflicts regarding autonomy and dependence. Panic focused psychodynamic psychotherapy (PFPP) is aimed at helping patients understand the underlying emotional meaning of their panic. Once that is achieved, patients can acknowledge previously unacceptable feelings and ideas that have led to panic in the past. This contrasts with CBT, which relies on exposure to panic triggers (e.g., bodily sensations such as breathlessness, tightness in the chest, heart palpitations) and a highly structured set of exercises aimed at easing attacks. Milrod and colleagues compared PFPP to applied relaxation therapy (ART), a 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 PFPP 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., 2007b) found that those panic patients with comorbid personality disorders did particularly well in the PFPP group. These findings are especially important given that a host of reviews suggest that anxiety patients with comorbid personality disorders do not do well in standard CBT (Brooks, Baltazar, & Munjack, 1989; Massion, Dyck, Shea, Phillops, Warshaw, & Keller, 2002; Noyes, Reich, Christiansen et al., 1990; 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, PFPP should be the initial treatment of choice.[5]

Borderline Personality Disorders

There are three psychodynamic treatments for borderline personality that have empirical support: Russell Meares's interpersonal-self 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-psychological approach (IP) for the treatment of borderline personality disorder (BPD) guided by the conversational model of Hobson (1985), the main aim of which is to foster the emergence of reflective consciousness that William James called *self consciousness* (James, 1890). A basic tenet of this approach is that self-consciousness is achieved through a particular form of conversation and reflects a deeper sense of relatedness. The nearest North American equivalent to this approach comes from Kohut (1971) and his followers (Ornstein, 1998).

A pre-post study that evaluated the effects of this approach for patients with BPD found that

[5]This conclusion is preliminary given the fact that PFPP 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 supportive 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 recently completed second quasi-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 (theory of mind), ego psychology, Kleinian theory, and attachment theory. Fonagy and Bateman (2006) posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization — the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Mentalizing involves both (1) implict or *unconscious* mental processes that are activated along with the attachment system in affectively charged interpersonal situations and (2) coherent integrated representations of mental states of self and others. The concept of mentalization has been operationalized in the Reflective Function (RF) scale (Fonagy et al., 1997).

In an RCT (Bateman & Fonagy, 1998), the effectiveness of 18 months of a psychoanalytically oriented day hospitalization program was compared with routine general psychiatric care for patients with BPD. Patients randomly assigned to the psychoanalytic day hospital program, now called mentalization-based therapy (Bateman & Fonagy, 2004), showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Patients were reassessed every 3 months for up to 18 months post-discharge (Bateman & Fonagy, 2001). Short-term follow-up results indicated that patients who completed the MBT not only maintained their substantial gains but also showed continued steady and significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended. At 18-month post-discharge follow-up, 59.1% of patients treated with MBT were below the BPD diagnostic threshold, compared to only 12.5% of those treated in routine general psychiatric care. In a second follow-up, 8 years post-randomization and 5 years post–end of treatment, even more impressive findings were obtained: those treated with MBT showed not only statistical superiority in reduced suicidality, service utilization, medication use, and increases in global and vocational functioning but a remarkable level of clinical change (only 13% met criteria for BPD compared to 87% of those in the TAU group).

Findings that establish the long-term significance of MBT are particularly important given the entrenched and chronic nature of BPD.

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 in self-destructive acts. In addition, a six-month follow-up from the Verheul et al. (Verheul et al., 2001) study found no differences between DBT and the TAU control on impulsive behavior, parasuicidality, alcohol use, and both soft and hard drug use (van den Bosch et al., 2005). Finally, in Linehan et al.'s (2006) recent RCT comparing DBT with community 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 parasuicidality or crisis services utilization. In addition, although patients in DBT were half as likely to make a suicide attempt as patients in the CTBE group if the treatment year and follow-up period are 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 impairment 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 diffusion 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 disorganized. In addition, the engaged, interactive, 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 a thoughtful and disciplined approach to emotional states (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 here and now of the transference frequently 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 Meares'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, 53% of participants no longer met 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 & Meares, 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 variables, severity of BPD symptomatology, 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 3.06 for the TFP-treated participants, with an average effect size of 1.19 (which is well above what is considered "large"; see Cohen, 1988).

In a recent controlled trial (Clarkin et al., 2007; Levy et al., 2006), 90 clinically referred patients between the ages of 18 and 50 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 (Levy et al., 2006) examined changes in attachment organization and reflective function 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 they found a significant increase 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 course of treatment. Findings suggest that 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 specific theory-driven mechanisms (Ablon & Jones, 1998; Ablon, Levy, & Katzenstein, 2002; Castonguay, Goldfried,

Wiser, & Raue, 1996; DeRubeis & Feeley, 1990; DeRubeis et al., 1990; Ilardi & Craighead, 1994; Jones & Pulos, 1993; Shaw et al., 1999; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004).

TFP was also examined as a control condition in a study in Amsterdam by Arntz and colleagues (Giesen-Bloo et al., 2006). They compared TFP with Young's schema focused therapy (Young, 1990; SFT), an integrative approach based on cognitive-behavioral or skills-based techniques along with object relations and gestalt approaches. Their study is unique in examining two active treatments over three years. Patients benefited from both treatments. At first glance, SFPT appeared more efficacious. However, a number of serious limitations argue against this conclusion.

First, despite randomization, the TFP condition included twice as many recently suicidal patients (76% vs. 38%); there was also a trend ($p = .09$) for the TFP condition to include more patients with recent self-injury behavior. (It has been shown that suicidality influences treatment outcome [Oldham, 2006]).

Second, the differences between the two groups were only apparent in the intent-to-treat (ITT) analyses but not in the completer analyses (Arntz, 2004; Kellogg & Young, 2006). A major factor in this difference appears to have been that patients in the TFP condition were significantly more likely to prematurely drop out of their treatment. Whereas intent-to-treat analyses speak to the external validity (e.g., generalizability), completer analyses speak to the issue of sufficient dose and thus the internal validity or integrity of the study. Differences in outcome between completer analyses and ITT suggest loss of validity due to nonrandom dropout. This can negate the control provided by randomization (Howard et al., 1986). Completer analyses did not show any statistically significant advantage for SFPT (Arntz, 2004; Kellogg & Young, 2006).

Third, the findings suggest inadequate implementation of TFP as indicated by lack of 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 50% 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 delivered treatment outperformed the poorly delivered treatment, but 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 supervision, 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 intervision (Yeomans, 2006). Intervision may work well when carried out by exceptionally adherent therapists as was the case for the SFPT. 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 monitoring? Yeomans (2006) reports the clinical observation that half the therapists were nonadherent, which is consistent with the author's own independently rated adherence scores. Most disturbing, however, is Yeomans' report (2006) that he informed the study's principal investigator of the nonadherence problem on numerous occasions, including by email and fax, and that no action was taken to deal with this problem.

Finally, therapists and assessors were not blind to ongoing outcome. Partial results were presented prior to study completion (Arntz, 2004; Giesen-Bloo et al., 2001, 2002; Young et al., 2003), creating another possible confound, which could have caused therapist demoralization in the TFP therapists or enhanced motivation in SFPT therapists (Chalmers et al., 1981). Given these concerns, it would be premature and irresponsible to conclude that TFP is not as efficacious as SFPT.

Accumulating evidence indicates that TFP may be an effective treatment for BPD. As more data from the RCT are assessed, we will have a better understanding of how the treatment performs under more stringent experimental conditions. Because the RCT better controls for unmeasured variables through randomization, offers controls for attention and support, and compares TFP to an already established, well-delivered alterative treatment, its outcome will be a strong indicator of the treatment's efficacy and effectiveness. In addition to assessment of outcome, the RCT has also generated process-outcome studies designed to assess the hypothesized mechanisms of action in TFP that result in the changes seen in these patients (Clarkin & Levy, 2006; Levy et al., 2006).

Mixed and Other Personality Disorders

Three studies have examined psychodynamic psychotherapy for personality disorders (Abbas, Sheldon, Gyra, & Kalpin, 2006; Winston, Pollach, McCullough, Flegenheimer, Kestenbaum, & Trujullo, 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 Davanloo (1992) 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 (GSI) of the sympton 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 STPP for outpatients with a range of personality disorders. The authors found significant improvement in 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; Svartberg, Stiles, & Seltzer, 2004). The authors examined a 40-week STPP compared with CT and found no statistically significant difference between the short-term psychotherapy group and CT groups on any measure for any time period. At two-year 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 pre-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 benefits endure over time. For 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, longer-term treatments might yield better outcomes, and psychodynamic treatments may have longer-lasting effects.

Eating Disorders

Eight RCTs have examined a psychodynamic treatment (Bachar et al., 1999; 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 longer-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 martial 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 independent 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., 2006; Milrod et al., 2007a, b; Snyder et al., 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 outcomes of mentalization-based therapy; and (3) the efficacy and effectiveness of TFP given the changes in hypothesized mechanisms of action.

COMMON MISCONCEPTIONS REGARDING PSYCHODYNAMIC AND PSYCHOANALYTIC 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. 507) contends that "in fact, psychoanalytic theories 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 description 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

(Milrod et al., 2007), and depression (Busch, Rudden, & Shaprio, 2004). These manuals tend to be less prescriptive and more principle based. For a review of pertinent issues in developing a psychodynamic manual, see Caligor (2005).

4. *Myth:* Psychodynamic therapists are largely silent, cold, and stone-faced. *Reality*: The psychoanalytic psychotherapist pays special attention to fostering the therapeutic alliance, being real, and showing warmth and concern for his or her clients. One recognizes that one's office location, office furniture and decorations, dress, jewelry, and so on all provide the patient with information about the therapist, as do his or her style and demeanor. Neutrality is not about creating an impossible situation or taking an expert authoritarian posture. Neutrality is a stance taken toward dealing with conflict within the patient to encourage exploration.
5. *Myth:* Psychoanalytic approaches focus exclusively or almost exclusively on *unconscious* processes. *Reality:* As indicated earlier in the chapter, *unconscious* motivations are clearly an important aspect of psychoanalytic work, but not to the extent of denying or failing to attend to conscious experience. Psychodynamic psychotherapists are keenly interested in phenomenology and intersubjectivity.
6. *Myth:* The main focus of therapy is the patient's sexuality, early childhood relationships, or traumatic experiences. *Reality:* Process research indicates that although psychodynamic psychotherapists may connect current relationship patterns with earlier 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 interminable. *Reality:* Although a traditional analysis will require the commitment of a number of sessions a week for many years, there are 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 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 result 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 8.1

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; Sayette, 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 victorious antitrust lawsuit against the AMA in the 1980s, which resulted in psychologists having access to psychoanalytic institutes for advance training (*Welch v. 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 jargon-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 psychotherapists 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*

HIGHLIGHT BOX 8.1 (*continued*)

Psychotherapy: A Basic Text, which are useful for both psychology doctoral students and psychiatry residents. Interested readers should also consult Huprich's (2008) *Psychodynamic Therapy: Conceptual and Empirical Foundations*. These works provide an excellent introduction to contemporary psychodynamic psychotherapy. For those working with more 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.

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 concordant?

8.2. You have just been assigned 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 distressed. 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 also 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 cheeking all week (i.e., hiding her medication in the side of her mouth). She was discovered accidentally during nightly rounds because she fell forward to the floor as opposed to back on her bed. Upon hearing the news, you feel angry toward the older brother, feeling that she tried to kill herself again because of what he had done. 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 became 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?

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 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 staffed by "incompetent" orderlies. 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.

Glossary

Clarification: A request for more information or further elaboration in order to better understand the patient's subjective experience.

Compromise formation: In the Freudian conflict model, a compromise formation 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. This kind of negative emotion causes a person to defend (e. g., repress or deny) or redirect the troublesome needs and wishes, which then can be expressed only indirectly -- in symptoms, dreams, jokes, and slips of the tongue or "accidental" behavior (so-called Freudian slips).

Confrontation: Tactfully pointing out discrepancies or incongruities in the patient's narrative or the patient's verbal and nonverbal behavior.

Countertransference: Originally viewed as the therapist's reaction to the patient, revealing unresolved conflicts in the therapist, but now seen more as a valuable diagnostic and therapeutic tool that provides the therapist with an emotional window or channel into the patient's internal and interpersonal world.

Defense mechanisms: Means by which people push threatening thoughts or feelings from awareness.

Extratransferential interpretations: Interpretations about relationships outside of therapy.

Genetic interpretations: Interpretations made about early experiences with caregivers.

Interpretation: Focus on the unconscious meaning of what has been clarified and confronted regarding experience in therapy, the relationship between the patient and therapist, or relationships outside of therapy.

Psychic determinism: The idea that nothing in the mind happens by chance, that all mental and physical behavior is determined by prior psychological causes.

Resistance: A reluctance to engage in treatment. Resistance can be an unconscious process designed to maintain current maladaptive ways of functioning because they are comfortable or because change is potentially scary.

Technical neutrality: A therapeutic strategy in which the therapist avoids communicating any judgment about the patient's conflicts while they are being discussed.

Transference: Believed to be a universal phenomenon in which aspects of important and formative relationships (such as with parents and siblings) are unconsciously ascribed 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.

References

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisley, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *The Cochrane Database of Systematic Reviews, 4*: CD004687.

Ablon, J. S. & Jones, E. E. (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive/behavioral therapy. *Psychotherapy Research, 8*, 71–83.

Ablon, J. S. & Jones, E. E. (1999). Psychotherapy process in the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology, 67*, 64–75.

Ablon, J. S., Levy, R. A., & Katzenstein, T. (2002). Beyond brand names of psychotherapy: identifying empirically supported change processes. *Psychotherapy: Theory, Research, Practice, and Traning, 23*, 15.

Adams, H. E., Wright, L. W., & Lohr, B. A. (1996). Is homophobia associated with homosexual arousal? *Journal of Abnormal Psychology, 105*, 440–445.

Alstrom, J. E., Norlund, C. L., Persson, G., Harding, M., & Ljungqvist, C. (1984a). Effects of four treatment methods on agoraphobic women not suitable for insight-oriented psychotherapy. *Acta Psychiatrica Scandinavica, 70*, 1–17.

Alstrom, J. E., Norlund, C. L., Persson, G., Harding, M., & Ljungqvist, C. (1984b). Effects of four treatment methods on social phobic patients not suitable for insight-oriented psychotherapy. *Acta Psychiatrica Scandinavica, 70*, 97–110.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.) Washington, DC: Author.

Anderson, M., Ochsner, K., Kuhl, B., Robertson, E., Gabrieli, S., Glover, G., & Gabrieli, J. (2004). Neural systems underlying the suppression of unwanted memories. *Science, 303*, 232–235.

Appelbaum, A. H. (2005). Supportive psychotherapy. In J. M. Oldham, A. E. Skodol, & D. S. Bender (Eds.), *Textbook of Personality Disorders* (pp. 335–346). Washington, DC: American Psychiatric Publishing.

Arntz, A. (2004). Borderline personality disorder. In T. A. Beck, A. Freedman, & D. D. Davis (Eds.), *Cognitive Therapy of Personality Disorders* (2nd ed.), pp. 187–215. New York: Guildford Press.

Bachar, E., Latzer, Y., Kreitler, S., & Berry, E. M. (1999). Empirical comparison of two psychological therapies: self psychology and cognitive orientation in the treatment of anorexia and bulimia. *Journal of Psychotherapy Practice Research, 8*, 115–128.

Barkham, M., Shapiro, D. A., Hardy, G. E., & Rees, A. (1999). Psychotherapy in two plus-one sessions: outcomes of a randomized controlled trial of cognitive behavioral and psychodynamic-interpersonal therapy for subsyndromal depression. *Journal of Consulting and Clinical Psychology, 67*, 201–211.

Bateman, A. W. & Fonagy, P. (1999). The effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *American Journal of Psychiatry, 156*, 1563–1569.

Bateman, A. W. & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *American Journal of Psychiatry, 158*, 36–42.

Bateman, A. W. & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic, 67*, 187–211.

Bateman, A. W. & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders, 18*, 36–51.

Bateman, A. W. & Fonagy, P. (2006). *Mentalization based treatment for borderline personality disorder: a practical guide.* Oxford, UK: Oxford University Press.

Bateman, A. & Fonagy, P. (2008). Comorbid antisocial and borderline personality disorders: Mentalization-based treatment. *Journal of Clinical Psychology, 64*, 181–194.

Berk, M. S. & Andersen, S. M. (2000). The impact of past relationships on interpersonal behavior: behavioral confirmation in the social-cognitive process of transference. *Journal of Personality and Social Psychology, 79*, 546–562.

Blagys, M. D. & Hilsenroth, M. J. (2000). Distinctive feature of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice, 7*, 167–188.

Blatt, S. J., Auerbach, J. S., & Levy, K. N. (1997). Mental representations in personality development, psychopathology, and the therapeutic process. *Review of General Psychology, 1*, 351–374.

Bögels, S., Wijts, P., & Sallaerts, S. (2003). Analytic psychotherapy versus cognitive behavioral therapy for social phobia. Paper presented at European Congress for Cognitive and Behavioural Therapies. Prague: Czech Republic.

Breuer, J. & Freud, S. (1895/1970). *Studien zur Hysterie.* (Neuausgabe Ed.). (Sigmund Freud Standard Edition, Vol. 2). Frankfurt/M.: Fischer Taschenbuch Verlag.

Breuer, J. & Freud, S. (1956). On the physical mechanism of hysterical phenomena. *International Journal of Psycho-Analysis, 37,* 8–13.

Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 57,* 607–612.

Brooks, R. B., Baltazar, P. L., & Munjack, D. J. (1989). Co-occurrence of personality disorders with panic disorder, social phobia, and generalized anxiety disorder: a review of the literature. *Journal of Anxiety Disorders, 3,* 259–285.

Brumbaugh, C. C. & Fraley, R. C. (2005). Transference and attachment: how do attachment patterns get carried forward from one relationship to the next? *Personality and Social Psychology Bulletin, 32,* 552–560.

Busch, F. N., Rudden, M., & Shapiro, T. (2004). *Psychodynamic treatment of depression.* Washington, DC: American Psychiatric Publishing.

Caligor, E. (2005). Treatment manuals and psychotherapy research. *Clinical Neuroscience Research, Special Issue,* 387–398.

Caligor, E., Kernberg, O. F., & Clarkin, J. F. (2007). *Handbook of dynamic psychotherapy for higher level personality pathology.* Washington, DC: American Psychiatric Publishing.

Castonguay, L. G., Goldfried, M. R., Wiser, S. L., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497–504.

Chalmers, T., Smith, H., Blackburn, B., Silverman, B., Schroeder, B., Reitman, D., & Ambroz, A. (1981). A method for assessing the quality of a randomized controlled trial. *Controlled Clinical Trials, 2,* 31–49.

Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Counseling, 66,* 7–18.

Churchill, R., Hunot, V., Corney, R., Knapp, M., McGuire, H., Tylee, A., & Wessely, S. (2001). A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. *Health Technology Assessment, 5,* 1–187.

Clarkin, J. F., Foelsch, P. A., Levy, K. N., Hull, J. W., Delaney, J. C., & Kernberg, O. F. (2001). The development of a psychodynamic treatment for patients with borderline personality disorder: a preliminary study of behavioral change. *Journal of Personality Disorders, 15,* 487–495.

Clarkin, J. F. & Levy, K. N. (2003). A psychodynamic treatment for severe personality disorders. *Psychoanalytic Inquiry, 23,* 248–267.

Clarkin, J. F. & Levy, K. N. (2006). Psychotherapy for patients with borderline personality disorder: focusing on the mechanisms of change. *Journal of Clinical Psychology, 62,* 405–410.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2004). The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomised controlled trial for borderline personality disorder: rationale, methods, and patient characteristics. *Journal of Personality Disorders, 18,* 52–72.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *American Journal of Psychiatry, 164,* 922–928.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: focusing on object relations.* Washington, DC: American Psychiatric Publishing.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, P. (2007). Freud is widely taught at universities, except in the psychology department. *New York Times,* November 25, 2007.

Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression, I. impact on maternal mood. *British Journal of Psychiatry, 182,* 412–419.

Crisp, A. H., Norton, K., Gowers, S., & Halek, C. (1991). A controlled study of the effect of therapies aimed at adolescent and family psychopathology in anorexia nervosa. *British Journal of Psychiatry, 159,* 325–333.

Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: a meta-analysis. *American Journal of Psychiatry, 149,* 151–158.

Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa: randomised controlled trial of out-patient treatments. *British Journal of Psychiatry, 178,* 216–221.

Davanloo, H. (1992). *Short-term dynamic psychotherapy.* Jason Aronson: New York, New York.

DeRubeis, R. J., Evans, M. D., Hollon, S. D., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1990). How does cognitive behavioral therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for depression. *Journal of Consulting and Clinical Psychology, 58,* 862–869.

DeRubeis, R. J. & Feeley, M. (1990). Determinants of change in cognitive behavioral therapy for depression. *Cognitive Therapy and Research, 14,* 469–482.

Durham, R. C., Murphy, T., Allan, T., Richard, K., Treliving, L. R., & Fenton, G. W. (1994). Cognitive therapy, analytic psychotherapy and anxiety management training for generalised anxiety disorder. *British Journal of Psychiatry, 165,* 315–323.

Fairburn, C. G., Kirk, J., O'Connor, M., & Cooper, P. J. (1986). A comparison of two psychological treatments for bulimia nervosa. *Behaviour Research Therapy, 24,* 629–643.

Fairburn, C. G., Norman, P. A., Welch, S. L., & O'Connor, M. E. (1995). A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. *Archives of General Psychiatry, 52,* 304–312.

Fonagy, P. & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of BPO. *Journal of Clinical Psychology, 62,* 411–430.

Fonagy, P., Target, M., Steele, M., & Steele, H. (1998). Reflective-Functioning Manual: Version 5.0. For Application to the Adult Attachment Interviews. Unpublished manuscript, University College London.

Freud, S. (1927). *The future of an illusion.* Standard edition, Vol. 21, p. 34–63. Garden City, NY: Doubleday & Company.

Gabbard, G. O. (1995). Countertransference: the emerging common ground. *International Journal of Psycho-Analysis, 76,* 475–485.

Gallagher-Thompson, D. & Steffen, A. M. (1994). Comparative effects of cognitive behavioral and brief psychodynamic psychotherapies for depressed family caregivers. *Journal of Consulting and Clinical Psychology, 62,* 543–549.

Garner, D. M., Rockert, W., Davis, R., Garner, M. V., Olmstead, M. P., & Eagle, M. (1993). Comparison of cognitive-behavioral and supportive-expressive therapy for bulimia nervosa. *American Journal of Psychiatry, 150,* 37–46.

George, C., Kaplan, N., & Main, M. (1985). The attachment interview for adults. Unpublished manuscript, University of California, Berkeley.

Giesen-Bloo, J. H., Arntz, A., van Dijck, R., Spinhoven, P. H., & van Tilburg, W. (2001). Outpatient treatment of borderline personality disorder: analytical psychotherapy versus cognitive behavior therapy. Paper presented at the World Congress of Behavioral and Cognitive Therapies, July 17–21, 2001, Vancouver.

Giesen-Bloo, J. H., Arntz, A., Van Dyck, R., Spinhoven, P., & Van Tilburg, W. (2002, September). Outpatient treatment of borderline personality disorder: analytical psychotherapy versus cognitive behavioral therapy. Paper presented at the Transference Focused Psychotherapy for Borderline Personality Symposium, New York, NY.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., et al. (2006). Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs. transference-focused psychotherapy: correction. *Archives of General Psychiatry, 63,* 1008.

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49,* 59–72.

Gowers, S., Norton, K., Halek, C., & Crisp, A. H. (1994). Outcome of outpatient psychotherapy in a random allocation treatment study of anorexia nervosa. *International Journal of Eating Disorders, 15,* 165–177.

Hall, A. & Crisp, A. H. (1987). Brief psychotherapy in the treatment of anorexia nervosa: outcome at one year. *British Journal of Psychiatry, 151,* 185–191.

Hersen, M., Bellack, A. S., Himmelhoch, J. M., & Thase, M. E. (1984). Effects of social skill training, amitriptyline, and psychotherapy in unipolar depressed women. *Behavior Therapy, 15,* 21–40.

Hobson, R. F. (1985). *Forms of feeling: the heart of psychotherapy.* London: Tavistock.

Hoffman, L. (2002). Review of psychotherapy for personality disorders. *American Journal of Psychiatry, 159,* 504–507.

Howard, K. I., Kopta, S. M., Kraase, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159–164.

Huprich, S. K. (2008 in press). *Psychodynamic therapy: conceptual and empirical foundations.* New York: Taylor & Francis.

Ilardi, S. S. & Craighead, W. E. (1994). The role of nonspecific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice, 1,* 138–156.

James, W. (1890). *The principles of psychology.* New York: Holt.

Jones, E. E. (1985). Manual for the Psychotherapy Process Q-set. Unpublished manuscript, University of California, Berkeley.

Jones, E. E. & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology, 61,* 306–316.

Kellog, S. H. & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62,* 445–458.

Kernberg, O. F. (1965). Countertransference. *Journal of the American Psychoanalytic Association, 13,* 38–56.

Kernberg, O.F., Yeomans, F.E., Clarkin, J. F., & Levy, K. N. Transference focused psychotherapy: overview and update. *International Journal of Psychoanalysis* (in press).

Kohlenberg, R. J. & Tsai, M. T. (1994). Functional analytic psychotherapy: a radical behavioral approach to treatment and integration. *Journal of Psychotherapy Integration, 4,* 175–201.

Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.

Koerner, K., Kohlenberg, R. J., & Parker, C. R. (1996). Diagnosis of personality disorder: a radical behavioral alternative. *Journal of Consulting and Clinical Psychology, 64*, 1169.

Korner, A., Gerull, F., Meares, R., & Stevenson, J. (2006). Borderline personality disorder treated with the conversational model: a replication study. *Comprehensive Psychiatry, 47*, 406–411.

Leichsenring, F. (2001). Comparative effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in depression: a meta-analytic approach. *Clinical Psychology Review, 21*, 401–419.

Leichsenring, F. & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behaviour therapy in the treatment of personality disorders: a meta-analysis. *American Journal of Psychiatry, 160*, 1223–1232.

Levy, K. N. (2008). The decline of psychodynamic psychology in academia. Unpublished manuscript.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized controlled trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 74*, 1027–1040.

Levy, K. N., Yeomans, F. E., & Diamond, D. (2007). Psychodynamic treatments of self-injury. *Journal of Clinical Psychology, 36*, 1105–1120.

Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A., & Allmon, D. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. treatment by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757–766.

Linehan, M. M., Tutek, D. A., Heard, H. L., & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151*, 1771–1776.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: a manual for supportive-expressive treatment*. New York: Basic Books.

Luborsky, L. & Crits-Christoph, P. (1989). A relationship pattern measure: the core conflictual relationship theme. *Psychiatry: Journal for the Study of Interpersonal Processes, 52*, 250–259.

Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S., et al. (1999). The researcher's own therapy allegiances: a "wild card" in comparisons of treatment efficacy. *Clinical Psychology: Science and Practice, 6*, 95–106.

Lynch, T. R. (2004, July). *Dialectical behavior therapy: recent research and developments*, Conference presentation: NIMH's international think tank for the more effective treatment of borderline personality disorder. Bethesda, MD.

Main, M. (2000). The organized categories of infant, child, and adult attachment: flexible vs. inflexible attention under attachment-related stress. *Journal of the American Psycboanalytic Association, 48*, 1055–1096.

Malan, D. H. (1976). *The frontier of brief psychotherapy*. New York: Plenum.

Massion, A. O., Dyck, I. R., Shea, M. T., Phillips, K. A., Warshaw, M. G., & Keller, M. B. (2002). Personality disorders and time to remission in generalized anxiety disorder, social phobia, and panic disorder. *Archives of General Psychiatry, 59*, 434–440.

McWilliams, N. (1999). *Psychoanalytic case formulation*. New York, NY: Guilford Press.

Meares, R., Stevenson, J., & Comerford, A. (1999). Psychotherapy with borderline patients: I. a comparison between treated and untreated cohorts. *Australian and New Zealand Journal of Psychiatry, 33*, 467–472.

Meehl, P. E. (1997). Credentialed persons, credentialed knowledge. *Clinical Psychology: Science and Practice, 4*, 91–98.

Mennin, D. S. & Heimberg, R. G. (2000). The impact of mood and personality disorder comorbidity in the cognitive-behavioral treatment of panic disorder. *Clinical Psychology Review, 20*, 339–357.

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., et al. (2007a). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry, 164*(2), 265–272.

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., Aronson, A., Singer, M., Turchin, W., Klass, E. T., Graf, E., Teres, J. J., & Shear, M. K. (2007b). Erratum: A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry, 164*(3), 259.

Mitchell, S. A. (1988). *Relational Concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S. A. (2000). *Relationality: from attachment to intersubjectivity*. Mahwah, NJ: Analytic Press.

Mitchell, S. A. & Black, M. J. (1996). *Freud and beyond: a history of modern psychoanalytic thought*. New York, NY: Basic Books.

Novalis, P. N., Rojcewicz, Jr., S. J., & Peele, R. (1993). *Clinical manual of supportive psychotherapy*. Washington, DC: American Psychiatric Association.

Noyes, R., Reich, J., Christiansen, J., Suelzer, M, et al. (1990). Outcome of panic disorder: relationship to diagnostic subtypes and comorbidity. *Archives of General Psychiatry, 47*, 809–818.

Oldham, J. M. (2006). Borderline personality and suicidality. *American Journal of Psychiatry, 163*, 20–26.

Ornstein, M. (1998). Trend report: survey research. *Current Sociology, 46*, 1–137.

Perry, J. C., Banon, E., & Ianni, F. (1999). Effectiveness of psychotherapy for personality disorders. *American Journal of Psychiatry, 156*, 1312–1321.

Pinsker, H. (1997). *A primer of supportive psychotherapy*. Mahwah, NJ: Analytic Press.

Pollack, M. H., Otto, M. W., & Neimeyer, R. A. (Eds) (1992). *Challenges in psychiatric treatment: pharmacologic and psychosocial perspectives*. New York, NY: Guilford Press.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 26*, 303–357.

Reich, J. H. (1991). Avoidant and dependent personality traits in relatives of patients with panic disorder, patients with dependent personality disorder, and normal controls. *Psychiatry Research, 39*, 89–98.

Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: a comprehensive review of controlled outcome research. *Psychological Bulletin, 108*, 30–49.

Rockland, L. H. (1989). *Supportive therapy: a psychodynamic approach*. New York: Basic Books.

Russell, G. F. M., Szmukler, G. I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry, 44*, 1047–1056.

Sayette, M. A., Mayne, T. J., & Norcross, J. C. (2006). *Insider's guide to graduate programs in clinical and counseling psychology*. New York, NY: Guilford Press.

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 522–534.

Shapiro, D. A., Rees, A., Barkham, M., & Hardy, G. E. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 378–387.

Shaw, B. F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T. M., Dobson, K. S., et al. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology, 67*, 837–846.

Shedler, J., Mayman, M., & Manis, M. (1993). The illusion of mental health. *American Psychologist, 48*, 1117–1131.

Snyder, D. K. & Willis, R. M. (1989). Behavioral versus insight-oriented marital therapy: effects on individual and interspousal functioning. *Journal of Consulting and Clinical Psychology, 57*, 39–46.

Snyder, D., Willis, R., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy. *Journal of Consulting and Clinical Psychology, 59*, 138–141.

Stevenson, J. & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry, 149*, 358–362.

Stevenson, J., Meares, R., & D'Angelo, R. (2005). Five-year outcome of outpatient psychotherapy with borderline patients. *Psychological Medicine, 35*, 79–87.

Strupp, H. H. (1984). Psychotherapy research: reflections on my career and the state of the art. *Journal of Social and Clinical Psychology, 2*, 3–24.

Svartberg, M. & Stiles, T. C. (1991). Comparative effects of short-term psychodynamic psychotherapy: a meta-analysis. *Journal of Consulting and Clinical Psychology, 59*, 704–714.

Svartberg, M., Stiles, T., & Seltzer, M. H. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. *American Journal of Psychiatry, 161*, 810–817.

Trepka, C., Rees, A., Shapiro, D., Hardy, G., & Barkham, M. (2004). Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research, 28*, 143–157.

Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine, 358*, 252–260.

van den Bosch, L. M. C., Koeter, M. W. J., Stijnen, T., Verheul, R., & van den Brink, W. (2005). Sustained efficacy of dialectical behavior therapy for borderline personality disorder. *Behavior Research Therapy, 43*, 1231–1241.

Verheul, R. (2001). Comorbidity of personality disorders in individuals with substance use disorders. *European Psychiatry, 16*(5):274–282.

Verheul, R., van den Bosch, L. M. C., Koeter, M. W. J., de Ridder, M. A. J., Stijnen, T., & van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder. *British Journal of Psychiatry, 182*, 135–140.

Wachtel, P. L. (2005). Anxiety, consciousness, and self-acceptance: placing the idea of making the unconscious conscious in an integrative framework. *Journal of Psychotherapy Integration, 15*, 243–253.

Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research, 7*, 21–43.

Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta-(re) analysis of the effects of cognitive therapy versus "other therapies" for depression. *Journal of Affective Disorders, 68*, 159–165.

Welch v. American Psychoanalytic Association, No. 85 Civ. 1651 (JFK), 1986 U. S. Dist. Lexis 27182 (S. D. N. Y., April 14, 1986).

Westen, D. (1999). The scientific status of unconscious processes: is Freud really dead? *Journal of the American Psychoanalytic Association, 47*, 1061–1106.

Westen, D., Blagov, P. S., Harenski, K., Kilts, C., & Hamann, S. (2006). Neural bases of motivated reasoning: an fMRI study of emotional constraints on partisan political judgment in the 2004 U.S. presidential election. *Journal of Cognitive Neuroscience, 18*, 1947–1958.

Wiborg, I. M. & Dahl, A. A. (1996). Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? *Archives of General Psychiatry, 53*, 689–694.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: studies in the theory of emotional development*. London: Hogarth Press.

Winston, A., Laikin, M., Pollack, J., Samstag, L. W., McCullough, L., & Muran, J. C. (1994). Short-term psychotherapy of personality disorders. *American Journal of Psychiatry, 151*, 190–194.

Winston, A., Pollach, J., McCullough, L, Flegenheimer, W., Kestenbaum, R., & Trujillo, M. (1991). Brief psychotherapy of personality disorders. *Journal of Nervous and Mental Disease, 179*, 188–193.

Woody, G. E., McLellan, A. T., Luborsky, L., & O'Brien, C. P. (1985). Sociopathy and psychotherapy outcome. *Archives of General Psychiatry, 42*, 1081–1086.

Yeomans, F. E. (2006). Questions concerning the randomized trial of schema-focused therapy vs. transference-focused psychotherapy. *Archives of General Psychiatry, 64*(5), 609–310.

Yeomans, F. E., Clarkin, J. F., & Kernberg, O. F. (2003). *A primer of transference-focused psychotherapy for the borderline patient*. Northvale, NJ: Jason Aronson.

Yonkers, K. A., Dyck, I. R., Warshaw, M., & Keller, M. B. (2000). Factors predicting the clinical course of generalised anxiety disorder. *British Journal of Psychiatry, 176*, 544–549.

Young, J. E. (1990). *Cognitive therapy for personality disorders: a schema-focused approach*. Sarasota, FL: Professional Resource Press.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: a practitioner's guide*. New York: Guilford Press.

CHAPTER

9

Interpersonal Psychotherapy

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OUTLINE

INTRODUCTION TO INTERPERSONAL PSYCHOTHERAPY

Psychotherapies and interpersonal relationships are inextricably 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